NEW YORK STATE OF OPPORTUNITY. Department of Health

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

National Institutional Reimbursement Team
Attention: Mark Cooley
CMS, CMCS
7500 Security Boulevard, M/S S3-14-28
Baltimore, MD 21244-1850

JUN 27 2018

RE: SPA #18-0044
Long Term Care

Dear Mr. Cooley:

The State requests approval of the enclosed amendment #18-0044 to the Title XIX (Medicaid) State Plan for long term care facility services to be effective April 1, 2018 (Appendix I). This amendment is being submitted based on enacted legislation. A summary of the proposed amendment is provided in Appendix II.

This amendment is submitted pursuant to §1902(a) of the Social Security Act (42 USC 1396a(a)) and Title 42 of the Code of Federal Regulations, Part 447, Subpart C, (42 CFR §447).

A copy of the pertinent section of enacted legislation is enclosed for your information (Appendix III). Copies of the public notice of this proposed amendment, which was given in the New York State Register March 30, 2016 is also enclosed for your information (Appendix IV). In addition responses to the five standard funding questions and standard access questions are also enclosed (Appendix V and VII, respectively).

If you have any questions regarding this matter, please do not hesitate to contact Regina Deyette, Medicaid State Plan Coordinator, Division of Finance and Rate Setting, Office of Health Insurance Programs at (518) 473-3658.

Sincerely,

Donna Frescatore

Donna Frescatore
Medicaid Director
Office of Health Insurance Programs

Enclosures
cc: Mr. Michael Melendez
Mr. Tom Brady

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: HEALTH CARE FINANCING ADMINISTRATION	1. TRANSMITTAL NUMBER: **18-0044**	2. STATE **New York**
	3. PROGRAM IDENTIFICATION: **TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)**	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE **April 1, 2018**	
5. TYPE OF PLAN MATERIAL *(Check One)*: ☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT		
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*		
6. FEDERAL STATUTE/REGULATION CITATION: **NYCRR 86-2.10**	7. FEDERAL BUDGET IMPACT: **(in thousands)** **a. FFY 04/01/18-09/30/18 ($1,000.00)** **b. FFY 10/01/18-09/30/19 ($2,000.00)**	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: **Attachment 4.19-D – Pages: 110(d)(6); 110(d)(7)**	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: **Attachment 4.19-D – Pages: 110(d)(6); 110(d)(7)**	
10. SUBJECT OF AMENDMENT: **Elimination of NH Transportation Costs (FMAP = 50%)**		
11. GOVERNOR'S REVIEW *(Check One)*: ☒ GOVERNOR'S OFFICE REPORTED NO COMMENT ☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED ☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL	☐ OTHER, AS SPECIFIED:	
12. SIGNATURE OF STATE AGENCY OFFICIAL: Donna Frescatore 13. TYPED NAME: **Donna Frescatore** 14. TITLE: **Medicaid Director** **Department of Health** 15. DATE SUBMITTED: JUN 27 2018	16. RETURN TO: **New York State Department of Health** **Bureau of Federal Relations & Provider Assessments** **99 Washington Ave – One Commerce Plaza** **Suite 1460** **Albany, NY 12210**	
FOR REGIONAL OFFICE USE ONLY		
17. DATE RECEIVED:	18. DATE APPROVED:	
PLAN APPROVED – ONE COPY ATTACHED		
19. EFFECTIVE DATE OF APPROVED MATERIAL:	20. SIGNATURE OF REGIONAL OFFICIAL:	
21. TYPED NAME:	22. TITLE:	
23. REMARKS:		

FORM HCFA-179 (07-92)

Appendix I
2018 Title XIX State Plan
Second Quarter Amendment
Amended SPA Pages

New York
110(d)(6)

Direct Component of the Price Medicare Ineligible Price, Medicare Part D Eligible Price (NSHB/NS300+ Peer Group)					
Effective Date of Prices	**Direct NSF Price (a)**	**50% of Direct NSF Price (b)**	**Direct NSHB/NS300+ Price (c)**	**50% of Direct NSHB/NS300 + Price (d)**	**Total Direct Component of Price for NSHB/NS300+ Peer Group (b)+(d)**
January 1, 2012	$105.79	$52.90	$117.48	$58.74	$111.64
January 1, 2013	$111.82	$55.91	$124.17	$62.09	$118.00
January 1, 2014	$116.58	$58.29	$129.46	$64.73	$123.02
January 1, 2015	$117.94	$58.97	$130.97	$65.49	$124.46
January 1, 2016	$118.48	$59.24	$131.57	$65.79	$125.03
April 1, 2016	$117.92	$58.96	$131.01	$65.51	$124.47
January 1, 2017	$119.02	$59.51	$132.17	$66.09	$125.60
April 1, 2018	$118.80	$59.40	$131.95	$65.98	$125.38
Direct Component of the Price Medicare Part B Eligible Price, Medicare Part B and Part D Eligible Price (NSHB/NS300 + Peer Group)					
Effective Date of Prices	**Direct NSF Price (a)**	**50% of Direct NSF Price (b)**	**Direct NSHB/NS300+ Price (c)**	**50% of Direct NSHB/NS300 + Price (d)**	**Total Direct Component of Price for NSHB/NS300+ Peer Group (b)+(d)**
January 1, 2012	$104.34	$52.17	$115.94	$57.97	$110.14
January 1, 2013	$110.28	$55.14	$122.54	$61.27	$116.41
January 1, 2014	$114.98	$57.49	$127.76	$63.88	$121.37
January 1, 2015	$116.33	$58.17	$129.25	$64.63	$122.79
January 1, 2016	$116.86	$58.43	$129.84	$64.92	$123.35
April 1, 2016	$116.30	$58.15	$129.28	$64.64	$122.79
January 1, 2017	$117.39	$58.70	$130.43	$65.22	$123.91
April 1, 2018	$117.17	$58.59	$130.21	$65.11	$123.69

New York
110(d)(7)

Direct Component of the Price Medicare Ineligible Price, Medicare Part D Eligible Price (NS300- Peer Group)					
Effective Date of Prices	**Direct NSF Price (a)**	**50% of Direct NSF Price (b)**	**Direct NS300- Price (c)**	**50% of Direct NS300- Price (d)**	**Total Direct Component of Price for NS300- Peer Group (b)+(d)**
January 1, 2012	$105.79	$52.90	$99.30	$49.65	$102.55
January 1, 2013	$111.82	$55.91	$104.95	$52.48	$108.39
January 1, 2014	$116.58	$58.29	$109.43	$54.72	$113.01
January 1, 2015	$117.94	$58.97	$110.70	$55.35	$114.32
January 1, 2016	$118.48	$59.24	$111.21	$55.61	$114.85
April 1, 2016	$118.04	$59.02	$110.77	$55.39	$114.41
January 1, 2017	$119.02	$59.51	$111.71	$55.86	$115.37
April 1, 2018	$118.93	$59.46	$111.62	$55.81	$115.27

Direct Component of the Price Medicare Part B Eligible Price, Medicare Part B and Part D Eligible Price (NS300- Peer Group)					
Effective Date of Prices	**Direct NSF Price (a)**	**50% of Direct NSF Price (b)**	**Direct NS300- Price (c)**	**50% of Direct NS300- Price (d)**	**Total Direct Component of Price for NS300- Peer Group (b)+(d)**
January 1, 2012	$104.34	$52.17	$97.90	$48.95	$101.12
January 1, 2013	$110.28	$55.14	$103.47	$51.74	$106.88
January 1, 2014	$114.98	$57.49	$107.88	$53.94	$111.43
January 1, 2015	$116.33	$58.17	$109.14	$54.57	$112.74
January 1, 2016	$116.86	$58.43	$109.64	$54.82	$113.25
April 1, 2016	$116.42	$58.21	$109.20	$54.60	$112.81
January 1, 2017	$117.39	$58.70	$110.14	$55.07	$113.77
April 1, 2018	$117.28	$58.64	$110.04	$55.02	$113.66

As used in this subdivision, Medicare Ineligible Price shall mean the price applicable to Medicaid patients that are not Medicare eligible, Medicare Part B Eligible Price shall mean the price applicable to Medicaid patients that are Medicare Part B eligible, Medicare Part D Eligible Price shall mean the price applicable to Medicaid patients that are Medicare Part D eligible, and Medicare Part B and Part D eligible Price shall mean the price applicable to Medicaid patients that are Medicare Part B and Part D eligible.

Appendix II
2018 Title XIX State Plan
Second Quarter Amendment
Summary

SUMMARY
SPA #18-0044

This State Plan Amendment proposes to eliminate the nursing home transportation cost from the direct component of the rate which will now only include non-medical transportation for reimbursement.

Appendix III
2018 Title XIX State Plan
Second Quarter Amendment
Authorizing Provisions

(c) Direct component of the rate. (1) Allowable costs for the direct component of the rate shall include costs reported in the following functional cost centers on the facility's annual cost report (RHCF-4) or extracted from a hospital-based facility's annual cost report (RHCF-2) and the institutional cost report of its related hospital, after first deducting for capital costs and allowable items not subject to trending:

(i) nursing administration;
(ii) activities;
(iii) social service;
(iv) transportation;
(v) physical therapy;
(vi) occupational therapy;
(vii) speech and hearing therapy-(speech therapy portion only);
(viii) pharmacy;
(ix) central service supply; and
(x) residential health care related facility.

(2) For purposes of calculating the direct component of the rate, the department shall utilize the allowable direct costs reported by all facilities with the exception of specialty facilities as defined in subdivision (i) of this section.

(3) The statewide mean, base and ceiling direct price for patients in each patient classification group shall be determined as follows:

(i) Allowable costs for the direct cost centers for each facility after first deducting capital costs and items not subject to trending, shall be multiplied by the appropriate Regional Direct Input Price Adjustment Factor ("RDIPAF"), as determined pursuant to paragraph (5) of this subdivision. The RDIPAF neutralizes the difference in wage and fringe benefit costs between and among the regions caused by differences in the wage scale of each level of employee.

(ii) The statewide distribution of patients in each patient classification group shall be determined for 1986 payments utilizing the patient data obtained in the patient assessment period, March 1, 1985 through September 30, 1985, conducted pursuant to section 86-2.30 of this Subpart.

(iii) A statewide mean direct case mix neutral cost, a statewide base direct case mix neutral cost and a statewide ceiling direct case mix neutral cost shall be determined as follows:

(a) Allowable direct costs for each facility, after first deducting capital costs and items not subject to trending and adjusted by applying the RDIPAF shall be summed to determine total statewide direct costs.

(b) The aggregate statewide case mix index shall be determined by multiplying number of patients on a statewide basis in each patient classification group by the case mix index for each patient classification group and the results summed.

(c) A statewide mean direct cost per day shall be determined by dividing total statewide direct costs by the aggregate number of statewide 1983 patient days.

(d) A statewide mean direct case mix neutral cost per day shall be determined by dividing the statewide mean direct cost per day by the ratio of the aggregate statewide case mix index to the number of patient review instruments received pursuant to section 86-2.30 of this Subpart.

(e) The statewide mean direct case mix neutral cost per day shall be the basis to establish a corridor between the statewide base direct case mix neutral cost per day and the statewide ceiling direct case mix neutral cost per day.

(f) The corridor shall be established by use of a base factor and a ceiling factor expressed as a percentage of the statewide mean direct case mix neutral cost per day.

(g) A statewide base direct case mix neutral cost per day shall be determined by multiplying the base factor times the statewide mean direct case mix neutral cost per day.

(h) A statewide ceiling direct case mix neutral cost per day shall be determined by multiplying the ceiling factor times the statewide mean direct case mix neutral cost per day.

(i) A statewide mean direct price per day for each patient classification group shall be determined by multiplying the statewide mean direct case mix neutral cost per day by the case mix index for each patient classification group, provided however that the index for reduced physical functioning A shall be .4414.

(j) A statewide base direct price per day for each patient classification group shall be determined by multiplying the statewide base direct case mix neutral cost per day by the case mix index for each patient classification group, provided however that the index for reduced physical functioning A shall be .4414.

(k) A statewide ceiling direct price per day for each patient classification group shall be determined by multiplying the statewide ceiling direct case mix neutral cost per day by the case mix index for each patient classification group, provided however that the index for reduced physical functioning A shall be .4414.

(l) The corridor referred to in clause (e) of this subparagraph shall be calculated as follows:

(1) The base factor referred to in clause (f) of this subparagraph shall be approximately 90 percent for the period January 1, 1986 through December 31, 1986. For the period January 1, 1987 through December 31, 1987, such factor shall be approximately 90 percent. For the period January 1, 1988 through June 30, 1989, such factor shall be increased to approximately 95 percent. For the period July 1, 1989 through March 31, 1990, such factor shall be reduced to approximately 88.25 percent. For the period April 1, 1990, and thereafter, such factor shall be increased to approximately 90 percent.

(2) The ceiling factor referred to in clause (f) of this subparagraph shall be approximately 115 percent for the period January 1, 1986 through December 31, 1986. For the period January 1, 1987 through December 31, 1987, such factor shall be reduced to approximately 110 percent. For the period January 1, 1988 through December 31, 1988, and thereafter, such factor shall be reduced to approximately 105 percent.

(3) For the period January 1, 1986 through December 31, 1986, the base factor and ceiling factor contained in the clause shall initially be determined to result in a 20-percent corridor. The ceiling factor shall then be increased by five percent. For the period January 1, 1987 through December 31, 1987, the application of the base factor and ceiling factor contained in this clause shall result in a 20-percent corridor. For the period January 1, 1988 through December 21, 1988, and thereafter, the base factor and ceiling factor contained in this clause shall result in a 10-percent corridor.

(4) The facility specific direct adjusted payment price per day shall be determined as follows:

(i) The facility specific mean direct price per day shall be determined by multiplying the statewide mean direct price per day for each patient classification group times the number of patients properly assessed and reported by the facility in each patient classification group pursuant to section 86-2.30 of this Subpart and dividing the sum of the results by the total number of patients properly assessed and reported by the facility pursuant to section 86-2.30 of this Subpart.

(ii) The facility specific base direct price per day shall be determined by multiplying the statewide base direct per day for each patient classification group times the number of patients properly assessed and reported by the facility in each patient classification group pursuant to section 86-2.30 of this Subpart and dividing the sum of the results by the total number of patients properly assessed and reported by the facility pursuant to section 86-2.30 of this Subpart.

(iii) The facility specific ceiling direct price per day shall be determined by multiplying the statewide ceiling direct price per day for each patient classification group times the number of patients properly assessed and reported by the facility in each patient classification group pursuant to section 86-2.30 of this Subpart and dividing the sum of the results by the total number of patients properly assessed and reported by the facility pursuant to section 86-2.30 of this Subpart.

(iv) The facility specific cost based direct price per day shall be determined by dividing a facility's adjusted allowable reported direct costs after first deducting capital costs and items not subject to trending and, after application of the RDIPAF, by the facility's 1983 total patient days.

(v) Except as contained in subparagraph (vi) of this paragraph, the facility specific direct adjusted payment price per day shall be determined by comparison of the facility specific cost based price per day

with the facility specific base direct price per day and the facility specific ceiling direct per day pursuant to the following table:

Facility Specific Cost Based Direct Price Per Day	Facility Specific Direct Adjusted Payment Price Per Day
Below Facility Specific Base Direct Price Per Day	Facility Specific Base Direct Price Per Day
Between Facility Specific Base Direct Price Per Day and Facility Specific Ceiling Direct Price Per Day	Facility Specific Cost Based Direct Price Per Day
Above Facility Specific Ceiling Direct Price Per Day	Facility Specific Ceiling Direct Price Per Day

(vi) The facility specific direct adjusted payment price per day shall be considered to be the facility specific cost based direct price per day when such price is below the facility specific base direct price per day subject to the provisions of paragraph (6) of this subdivision for the following operators of residential health care facilities:

(a) an operator who has had an operating certificate revoked pursuant to section 2806(5) of the Public Health Law and is operating a residential health care facility pursuant to an order of the Commissioner of this department; and

(b) operator of a facility in which the Federal Health Care Financing Administration (HCFA) has imposed a ban on payment for all Medicare and Medicaid admissions after a specified date pursuant to section 1866(f) of the Federal Social Security Act until the lifting of the ban in writing by HCFA.

(vii) The direct component of a facility's rate shall be the facility specific direct adjusted payment price per day determined in subparagraph (v) or (vi) of this paragraph as applicable after applying the RDIPAF.

(5) The RDIPAF shall be based on the following factors:

(i) Residential health care facilities shall be grouped, by county, into 16 regions within the State as outlined in Appendix 13-A, infra.

(ii) The facility's staffing, based on case mix predicted staffing for registered professional nurses, licensed practical nurses, and aides, orderlies and assistants for each facility. The case mix predicted staffing shall be adjusted annually on January 1st of each rate year based on the PRI's submitted by each facility for the fourth quarter of the preceding calendar year, in accordance with sections 86-2.11(b) and 86-2.30 of this Subpart. Until such PRI's are available, the case mix

predicted staffing shall be based on the most current PRI's available prior to calculation of the initial rate effective January 1st of each rate year. The case mix predicted staffing shall subsequently be revised based on more recent PRI submissions until such time as the PRI's for the fourth quarter of the preceding calendar year are available.

(iii) The proportion of salaries and fringe benefit cost for the direct care cost centers indicated in subdivision (c) of this section to the total costs of such direct care cost centers.

(6) Case mix adjustment. A facility shall receive an increase or decrease in the direct component of its rate if the facility has increased or decreased its case mix from one assessment period to the next and, in accordance with subparagraph (4)(v) of this subdivision, would not have received any change in the direct component of its rate from that determined as of January 1, 1986 to the current calculation date. The increases or decreases in the direct component of the rate shall be determined as follows:

(i) The facility specific mean price per day effective January 1, 1986 as determined in accordance with subparagraph (4)(i) of this subdivision shall be compared to the facility specific mean price per day determined as a result of the submissions required in accordance with section 86-2.11(b) of this Subpart. Any increase or decrease determined as a result of such comparison, shall be expressed as a percentage, positive or negative, of the facility specific mean price per day effective January 1, 1986.

(ii) This percentage shall be applied to the facility specific cost based direct price per day determined as of January 1, 1986, and an adjustment factor shall be determined.

(iii) This adjustment factor shall be added to or subtracted from the facility specific cost based direct price per day determined as of January 1, 1986, to arrive at an adjusted facility specific cost based direct price per day which shall become for a facility their facility specific adjusted payment price per day for the applicable rate period for which payment rates are adjusted pursuant to section 86-2.11 of this Subpart.

Appendix IV
2018 Title XIX State Plan
Second Quarter Amendment
Public Notice

MISCELLANEOUS NOTICES/HEARINGS

Notice of Abandoned Property Received by the State Comptroller

Pursuant to provisions of the Abandoned Property Law and related laws, the Office of the State Comptroller receives unclaimed monies and other property deemed abandoned. A list of the names and last known addresses of the entitled owners of this abandoned property is maintained by the office in accordance with Section 1401 of the Abandoned Property Law. Interested parties may inquire if they appear on the Abandoned Property Listing by contacting the Office of Unclaimed Funds, Monday through Friday from 8:00 a.m. to 4:30 p.m., at:

1-800-221-9311
or visit our web site at:
www.osc.state.ny.us

Claims for abandoned property must be filed with the New York State Comptroller's Office of Unclaimed Funds as provided in Section 1406 of the Abandoned Property Law. For further information contact: Office of the State Comptroller, Office of Unclaimed Funds, 110 State St., Albany, NY 12236.

PUBLIC NOTICE
Deferred Compensation Board

Pursuant to the provisions of 9 NYCRR, Section 9003.2 authorized by Section 5 of the State Finance Law, the New York State Deferred Compensation Board, beginning March 30, 2016 is soliciting proposals from Financial Organizations to provide Target Date Fund and Balanced Fund management services. The funds will represent two or more of the investment options under the Deferred Compensation Plan for Employees of the State of New York and Other Participating Public Jurisdictions, a plan meeting the requirements of Section 457 of the Internal Revenue Code and Section 5 of the State Finance Law, including all rules and regulations issued pursuant thereto.

A copy of the request for proposals may be obtained from Millie Viqueira and Thomas Shingler of Callan Associates (viqueira@callan.com and shingler@callan.com).

All proposals must be received no later than the close of business on Friday, April 29, 2016.

Product Design for Target Date Funds (TDFs): The Plan is seeking responses from providers that offer target maturity funds that automatically adjust their asset allocation to become more conservative over time. Responding TDFs must be designed to achieve the appropriate level of risk for each stage of a participant's life. Responding target maturity funds should be designed to be a simple ''one-fund'' retirement savings solution for participants in the Plan. The funds should be issued in five-year intervals, with each fund targeting a specific retirement date.

Product Design for Balanced Funds: Responding balanced funds should offer exposure to both equities and fixed income within one fund. Unlike with TDFs, which adjust the asset allocation over time as the participant nears and enters retirement, the equity/fixed income weights of responding balanced funds must be relatively static (e.g. two-thirds equities and one-third fixed income). The weight in equities must be at least 60% (predominantly U.S. equities), with the remainder in fixed income (predominantly U.S. investment grade fixed income). We are soliciting responses from balanced funds which manage to these targets and use Environmental, Social and Governance (ESG) factors in their investment process as well as from those that do not. This RFP does not seek responses from funds that dynamically allocate between stocks and bonds.

PUBLIC NOTICE
Department of Health

Pursuant to 42 CFR Section 447.205, the Department of Health hereby gives public notice of the following:

The Department of Health proposes to amend the Title XIX (Medicaid) State Plan for institutional, non-institutional, long term care, and prescription drug services to comply with proposed statutory provisions. The following changes are proposed:

Institutional Services

• For the state fiscal year beginning April 1, 2016 through March 31, 2017, continues specialty hospital adjustments for hospital inpatient services provided on and after April 1, 2012, to public general hospitals, other than those operated by the State of New York or the State University of New York, located in a city with a population of over one million and receiving reimbursement of up to $1.08 billion annually based on criteria and methodology set by the Commissioner of Health, which the Commissioner may periodically set through a memorandum of understanding with the New York City Health and Hospitals Corporation. Such adjustments shall be paid by means of one or more estimated payments, which shall be reconciled to the final adjustment determinations after the disproportionate share hospital payment adjustment caps have been calculated for such period under sections 1923(f) and (g) of the federal Social Security Act. Payments to eligible public general hospitals may be added to rates of payment or made as aggregate payments.

• Effective April 1, 2016, continues the supplemental upper payment limit payments made to general hospitals, other than major public general hospitals of $339 million annually.

Indigent Care

• Extends effective beginning April 1, 2016 and for each state fiscal year thereafter, Intergovernmental Transfer Payments to eligible major public general hospitals run by counties and the State of New York.

Long Term Care Services

• For state fiscal year beginning April 1, 2016, continues additional payments to non-state government operated public residential health care facilities, including public residential health care facilities located in Nassau, Westchester, and Erie counties, but excluding public residential health care facilities operated by a town or city within a county, in aggregate amounts of up to $500 million. The amount allocated to each eligible public RHCF will be in accordance with the previously approved methodology, provided, however that patient days shall be utilized for such computation reflecting actual reported data for 2014 and each representative succeeding year as applicable. Payments to eligible RHCF's may be added to rates of payment or made as aggregate payments.

• Effective on or after April 1, 2016, nursing home rates shall not consider transportation costs as allowable expenses pursuant to NYCRR § 86-2.10 and § 86-2.40. The direct price component of the rates for non-capital reimbursement will be revised effective April 1, 2016, to reflect to removal of transportation as an allowable costs.

The estimated annual net aggregate decrease in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2016/2017 is ($12 million).

• Effective on or after April 1, 2016, a new specialty rate will be implemented for the Neurodegenerative disease population. The population shall include only those patients who are diagnosed with Huntington's disease (HD) and Amyotrophic Lateral Sclerosis (ALS). Individuals within New York State that have neurodegenerative motor function disorders (and their families/caretakers) will have access to comprehensive and coordinated outpatient and inpatient services within New York State throughout the continuum of the disease.

The rate has been created to enable participating providers to deliver more appropriate and necessary care to those residents who have been diagnosed with Huntington's or Amyotrophic Lateral Sclerosis.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2016/2017 is $6.3 million.

• The quality incentive program for non-specialty nursing homes will continue for the 2016 rate year to recognize improvement in performance as an element in the program and provide for other minor modifications.

There is no additional estimated annual change to gross Medicaid expenditures attributable to this initiative for state fiscal year 2016/17.

Non-Institutional Services

• For state fiscal year beginning April 1, 2016 through March 31, 2017, continues hospital outpatient payment adjustments that increase the operating cost components of rates of payment for hospital outpatient and emergency departments on and after April 1, 2011, for public general hospitals other than those operated by the State of new York or the State University of New York, which are located in a city with a population of over one million. The amount to be paid will be up to $287 million annually based on criteria and methodology set by the Commissioner of Health, which the Commissioner may periodically set through a memorandum of understanding with the New York City Health and Hospitals Corporation. Such adjustments shall be paid by means of one or more estimated payments, which shall be reconciled to the final adjustment determinations after the disproportionate share hospital payment adjustment caps have been calculated for such period under sections 1923(f) and (g) of the federal Social Security Act. Payments may be added to rates of payment or made as aggregate payments.

• For the state fiscal year beginning April 1, 2016 through March 31, 2017, continues upon the election of the social services district in which an eligible diagnostic and treatment center (DTC) is physically located, up to $12.6 million in additional annual Medicaid payments may be paid to public DTCs operated by the New York City Health and Hospitals Corporation. Such payments will be based on each DTC's proportionate share of the sum of all clinic visits for all facilities eligible for an adjustment for the base year two years prior to the rate year. The proportionate share payments may be added to rates of payment or made as aggregate payments to eligible DTCs.

• For the state fiscal year beginning April 1, 2016 through March 31, 2017, continues up to $5.4 million in additional annual Medicaid payments may be paid to county operated free-standing clinics, not including facilities operated by the New York City Health and Hospitals Corporation, for services provided by such DTC and those provided by a county operated freestanding mental health or substance abuse DTC. Distributions shall be based on each eligible facility's proportionate share of the sum of all DTC and clinic visits for all eligible facilities receiving payments for the base year two years prior to the rate year. The proportionate share payments may be added to rates of payment or made as aggregate payments to eligible facilities.

• Early Intervention Program rates for approved services rendered on or after April 1, 2016 shall be increased by one percent. The rate increase adjusts for additional administrative activities required of providers for billing and claiming of approved Early Intervention services associated with the implementation of a State Fiscal Agent.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2016/2017 is $2.4 million.

• Effective April 1, 2016, eligibility procedures will be streamlined for infants and toddlers referred to the Early Intervention Program (EIP). Children referred to the EIP will be screened to determine whether the child is suspected of having a disability and requires a multidisciplinary evaluation to determine eligibility. Children referred to the EIP with a diagnosed condition with a high probability of developmental delay that establishes the child's eligibility for the program will not be screened and will receive an abbreviated multidisciplinary evaluation. New screening and evaluation rates are being established. Until such time as new screening and evaluation rates are established, existing rates for screening and supplemental evaluation rates will be used to reimburse for these services.

The estimated annual net aggregate decrease in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2016/17 is ($5.4 million).

• Effective April 1, 2016, in accordance with an amendment to Section 367-a(I)(d)(iv) of the Social Services Law, cost-sharing limits will be applied to Medicare Part C (Medicare Advantage or Medicare managed care) claims. Such limits are being applied to prevent the Medicaid program from paying any cost-sharing amount more than the maximum amount that Medicaid would pay for the same service for a member that only has Medicaid coverage.

Currently, the Medicaid program pays the full co-payment or co-insurance amounts for Medicare Part C claims, even when the provider has received more than the amount the Medicaid program would have paid for that service. Under the new limitations, the Medicaid program would not pay any co-payment/co-insurance amount if the provider received payment equal to or greater than the Medicaid amount. The provider would be required to accept the Medicare Part C health plan payment as payment in full for the service and the member could not be billed for any co-payment/co-insurance amount that was not reimbursed by Medicaid.

The estimated annual net aggregate decrease in Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2016/2017 is ($22.9 million) gross.

• Effective April 1, 2016, the Department of Health will increase access, and improve education/outreach, for the comprehensive coverage and promotion of long acting reversible contraception (LARC) by requiring separate payments be made for the cost of post-partum LARC methods to providers and allowing Federally Qualified Health Centers (FQHCs) providers to be paid for the cost of LARC in addition to the PPS rate.

Long acting reversible contraception (LARC) methods include the intrauterine device (IUD) and the birth control implant. According to The American College of Obstetricians and Gynecologists (ACOG), both methods are highly effective in preventing pregnancy and are reversible.

Potential savings would result from a reduction in unintended pregnancies and better spacing between pregnancies (improved health outcomes for baby and mother). In particular, increasing use of LARC in the adolescent population has significant potential to reduce unintended pregnancies.

The estimated annual net aggregate decrease in gross Medicaid expenditures attributable to this initiative in the budget for state fiscal year 2016/2017 is ($12.6 million).

• Effective on or after April 1, 2016, the State will claim additional FMAP for certain services provided to managed care recipients. CMS authorizes states to claim 1% additional FMAP for USPSTF A&B recommended preventive services when there is no cost-sharing. The State Plan will be amended so that the additional 1% FMAP can be claimed for all USPSTF A&B recommended preventative services provided to managed care recipients for which there is no cost sharing.

Prescription Drugs:

• Effective April 1, 2016, establish price ceilings on critical prescription drugs for which there is a significant public interest in ensuring rational pricing by drug manufacturers. When a critical prescription drug dispensed to a NYS Medicaid enrollee (managed care or fee-for-service) exceeds the ceiling price for the drug, the drug manufacturer will be required to provide rebates to the Department, in

Appendix V
2018 Title XIX State Plan
Second Quarter Amendment
Responses to Standard Funding Questions

APPENDIX V
LONG TERM CARE SERVICES
State Plan Amendment #18-0044

CMS Standard Funding Questions (NIRT Standard Funding Questions)

The following questions are being asked and should be answered in relation to all payments made to all providers under Attachment 4.19-D of your state plan.

1. **Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by States for services under the approved State plan. Do providers receive and retain the total Medicaid expenditures claimed by the State (includes normal per diem, supplemental, enhanced payments, other) or is any portion of the payments returned to the State, local governmental entity, or any other intermediary organization? If providers are required to return any portion of payments, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the amount or percentage of payments that are returned and the disposition and use of the funds once they are returned to the State (i.e., general fund, medical services account, etc.)**

   Response: Providers do retain the payments made pursuant to this amendment. However, this requirement in no way prohibits the public provider, including county providers, from reimbursing the sponsoring local government for appropriate expenses incurred by the local government on behalf of the public provider. The State does not regulate the financial relationships that exist between public health care providers and their sponsoring governments, which are extremely varied and complex. Local governments may provide direct and/or indirect monetary subsidies to their public providers to cover on-going unreimbursed operational expenses and assure achievement of their mission as primary safety net providers. Examples of appropriate expenses may include payments to the local government which include reimbursement for debt service paid on a provider's behalf, reimbursement for Medicare Part B premiums paid for a provider's retirees, reimbursement for contractually required health benefit fund payments made on a provider's behalf, and payment for overhead expenses as allocated per federal Office of Management and Budget Circular 2 CFR 200 regarding Cost Principles for State, Local, and Indian Tribal Governments. The existence of such transfers should in no way negate the legitimacy of these facilities' Medicaid payments or result in reduced Medicaid federal financial participation for the State. This position was further supported by CMS in review and approval of SPA 07-07C when an on-site audit of these transactions for New York City's Health and Hospitals Corporation was completed with satisfactory results.

Section 1902(a)(2) provides that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan. Please describe how the state share of each type of Medicaid payment (normal per diem, supplemental, enhanced, other) is funded. Please describe whether the state share is from appropriations from the legislature to the Medicaid agency, through intergovernmental transfer agreements (IGTs), certified public expenditures (CPEs), provider taxes, or any other mechanism used by the state to provide state share. Note that, if the appropriation is not to the Medicaid agency, the source of the state share would necessarily be derived through either an IGT or CPE. In this case, please identify the agency to which the funds are appropriated. Please provide an estimate of total expenditure and State share amounts for each type of Medicaid payment. If any of the non-federal share is being provided using IGTs or CPEs, please fully describe the matching arrangement including when the state agency receives the transferred amounts from the local government entity transferring the funds. If CPEs are used, please describe the methodology used by the state to verify that the total expenditures being certified are eligible for Federal matching funds in accordance with 42 CFR 433.51(b). For any payment funded by CPEs or IGTs, please provide the following:

- **(i) a complete list of the names of entities transferring or certifying funds;**
- **(ii) the operational nature of the entity (state, county, city, other);**
- **(iii) the total amounts transferred or certified by each entity;**
- **(iv) clarify whether the certifying or transferring entity has general taxing authority; and,**
- **(v) whether the certifying or transferring entity received appropriations (identify level of appropriations).**

Response: Payments made to service providers under the provisions of this SPA are funded through a budget appropriation received by the State agency that oversees medical assistance (Medicaid), which is the Department of Health. The source of the appropriation is the Medicaid General Fund Local Assistance Account, which is part of the Global Cap. The Global Cap is funded by General Fund and HCRA resources. Also, there have been on new provider taxes and no existing taxes have been modified.

Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan. If supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to each provider type.

Response: The payments authorized for this provision are not supplemental or enhanced payments.

2. **Please provide a detailed description of the methodology used by the state to estimate the upper payment limit (UPL) for each class of providers (State owned or operated, non-state government owned or operated, and privately owned or operated). Please provide a current (i.e. applicable to the current rate year) UPL demonstration. Under regulations at 42 CFR 4447.272, States are prohibited from setting payment rates for Medicaid inpatient services that exceed a reasonable estimate of the amount that would be paid under Medicare payment principals.**

   Response: The State is currently working with CMS to finalize the 2018 NH UPL.

3. **Does any governmental provider receive payments that in the aggregate (normal per diem, supplemental, enhanced, other) exceed their reasonable costs of providing services? If payments exceed the cost of services, do you recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report?**

   Response: Effective January 1, 2012, the rate methodology included in the approved State Plan for non-specialty nursing facility services for the operating component of the rate is a blended statewide/peer group price adjusted for case mix and wage differentials (WEF). Specialty nursing facility and units are paid the operating rate in effect on January 1, 2009. The capital component of the rate for all specialty and non-specialty facilities is based upon a cost based methodology. We are unaware of any requirement under current federal law or regulation that limits individual provider payments to their actual costs.

ACA Assurances:

1. **Maintenance of Effort (MOE). Under section 1902(gg) of the Social Security Act (the Act), as amended by the Affordable Care Act, as a condition of receiving any Federal payments under the Medicaid program during the MOE period indicated below, the State shall not have in effect any eligibility standards, methodologies, or procedures in its Medicaid program which are more restrictive than such eligibility provisions as in effect in its Medicaid program on March 10, 2010.**

   MOE Period.
   - **Begins on: March 10, 2010, and**
   - **Ends on: The date the Secretary of the Federal Department of Health and Human Services determines an Exchange established by a State under the provisions of section 1311 of the Affordable Care Act is fully operational.**

Response: This SPA complies with the conditions of the MOE provision of section 1902(gg) of the Act for continued funding under the Medicaid program.

2. **Section 1905(y) and (z) of the Act provides for increased FMAPs for expenditures made on or after January 1, 2014 for individuals determined eligible under section 1902(a)(10)(A)(i)(VIII) of the Act. Under section 1905(cc) of the Act, the increased FMAP under sections 1905(y) and (z) would not be available for States that require local political subdivisions to contribute amounts toward the non-Federal share of the State's expenditures at a greater percentage than would have been required on December 31, 2009.**

   Prior to January 1, 2014 States may potentially require contributions by local political subdivisions toward the non-Federal share of the States' expenditures at percentages greater than were required on December 31, 2009. However, because of the provisions of section 1905(cc) of the Act, it is important to determine and document/flag any SPAs/State plans which have such greater percentages prior to the January 1, 2014 date in order to anticipate potential violations and/or appropriate corrective actions by the States and the Federal government.

   Response: This SPA would [ ] / would not [✓] violate these provisions, if they remained in effect on or after January 1, 2015.

3. **Please indicate whether the State is currently in conformance with the requirements of section 1902(a)(37) of the Act regarding prompt payment of claims.**

   Response: The State does comply with the requirements of section 1902(a)(37) of the Act regarding prompt payment of claims.

Tribal Assurance:

Section 1902(a)(73) of the Social Security Act the Act requires a State in which one or more Indian Health Programs or Urban Indian Organizations furnish health care services to establish a process for the State Medicaid agency to seek advice on a regular ongoing basis from designees of Indian health programs whether operated by the Indian Health Service HIS Tribes or Tribal organizations under the Indian Self Determination and Education Assistance Act ISDEAA or Urban Indian Organizations under the Indian Health Care Improvement Act.

IHCIA Section 2107(e)(I) of the Act was also amended to apply these requirements to the Children's Health Insurance Program CHIP. Consultation is required concerning Medicaid and CHIP matters having a direct impact on Indian health programs and Urban Indian organizations.

a) **Please describe the process the State uses to seek advice on a regular ongoing basis from federally recognized tribes Indian Health**

Programs and Urban Indian Organizations on matters related to Medicaid and CHIP programs and for consultation on State Plan Amendments waiver proposals waiver extensions waiver amendments waiver renewals and proposals for demonstration projects prior to submission to CMS.

b) **Please include information about the frequency inclusiveness and process for seeking such advice.**

c) **Please describe the consultation process that occurred specifically for the development and submission of this State Plan Amendment when it occurred and who was involved.**

Response: Tribal consultation was performed in accordance with the State's tribal consultation policy as approved in SPA 17-0065, and documentation of such is included with the original submission. To date, no feedback has been received from any tribal representative in response to the proposed change in this SPA.

Appendix VI
2018 Title XIX State Plan
Second Quarter Amendment
Responses to Standard Access Questions

APPENDIX VI
LONG TERM CARE SERVICES
State Plan Amendment 18-0044

CMS Standard Access Questions

The following questions have been asked by CMS and are answered by the State in relation to all payments made to all providers under Attachment 4.19-D of the state plan.

1. **Specifically, how did the State determine that the Medicaid provider payments that will result from the change in this amendment are sufficient to comply with the requirements of 1902(a)(30)?**

   Response: This amendment seeks to remove duplicate reimbursement for Medicaid Transportation. The 2016/17 enacted State Budget proposed to amend NYCRR 86-2.10 and 86-2.40 designating that medical transportation costs shall not be considered as allowable expenses for Nursing Home Medicaid reimbursement. The Nursing Home prices as published in NYCRR 86-2.40 must be revised effective 04/01/2016 and 01/01/2017 to reflect to removal of transportation as an allowable costs. Effective 4/1/2016 a revision to the prices shall be calculated to remove the value of transportation costs in the Nursing Home Medicaid rate. The rate will be based on reported costs as submitted by the residential health care facility in the 2007 cost. This program will have a negligible impact on providers in that the base period Medical Transportation dollars are being removed from the rate in favor of direct payment to the facilities based upon billings from the transportation manager.

2. **How does the State intend to monitor the impact of the new rates and implement a remedy should rates be insufficient to guarantee required access levels?**

   Response: The State has various ways to ensure that access levels in the Medicaid program are retained and is currently not aware of any access issues, particularly since there is excess bed capacity for both hospitals and nursing homes. Additionally, hospital and nursing home providers must notify and receive approval from the Department's Office of Health Systems Management (OHSM) in order to discontinue services. This Office monitors and considers such requests in the context of access as they approve/deny changes in services. Finally, providers cannot discriminate based on source of payment.

   For providers that are not subject to an approval process, the State will continue to monitor provider complaint hotlines to identify geographic areas of concern and/or service type needs. If Medicaid beneficiaries begin to

encounter access issues, the Department would expect to see a marked increase in complaints. These complaints will be identified and analyzed in light of the changes proposed in this State Plan Amendment.

Finally, the State ensures that there is sufficient provider capacity for Medicaid Managed Care plans as part of its process to approve managed care rates and plans. Should sufficient access to services be compromised, the State would be alerted and would take appropriate action to ensure retention of access to such services.

3. **How were providers, advocates and beneficiaries engaged in the discussion around rate modifications? What were their concerns and how did the State address these concerns?**

   Response: This change was enacted by the State Legislature as part of the negotiation of the 2018-2019 Budget. The impact of this change was weighed in the context of the overall Budget in the State. The legislative process provides opportunities for all stakeholders to lobby their concerns, objections, or support for various legislative initiatives.

4. **What action(s) does the State plan to implement after the rate change takes place to counter any decrease to access if the rate decrease is found to prevent sufficient access to care?**

   Response: Should any essential community provider experience Medicaid or other revenue issues that would prevent access to needed community services, per usual practice, the State would meet with them to explore the situation and discuss possible solutions, if necessary.

5. **Is the State modifying anything else in the State Plan which will counterbalance any impact on access that may be caused by the decrease in rates (e.g. increasing scope of services that other provider types may provide or providing care in other settings)?**

   Response: The State has undertaken initiatives to provide continued access and quality of care to Nursing Homes. Such initiatives are the Vital Access Program (VAP), Minimum Wage increase, 1% Across the Board, Advanced Training Initiative and Refinanced Shared Savings. While some of these initiatives are outside the scope of the State Plan, they represent some of the measures the State is taking to ensure quality care for the State's most vulnerable population.