NEW YORK
state department of
HEALTH

Nirav R. Shah, M.D., M.P.H.
Commissioner

Sue Kelly
Executive Deputy Commissioner

January 28, 2013

Mr. Michael Melendez
Associate Regional Administrator
Department of Health & Human Services
Centers for Medicare & Medicaid Services
New York Regional Office
Division of Medicaid and Children's Health
26 Federal Plaza - Room 3800
New York, New York 10278

RE: SPA #12-35
Non-Institutional Services

Dear Mr. Melendez:

The State requests approval of the enclosed amendment #12-35 to the Title XIX (Medicaid) State Plan for non-institutional services to be effective January 1, 2013 (Appendix I). This amendment is being submitted based on section 1860D-2(e)(2)(A) of the Act as amended by section 175 of the Medicare Improvement for Patients and Providers Act of 2008 (MIPPA). A summary of the plan amendment is provided in Appendix II.

The State of New York reimburses these services through the use of rates that are consistent with and promote efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area as required by §1902(a)(30) of the Social Security Act and 42 CFR §447.204.

Copies of pertinent sections of section 1860D-2(e)(2)(A) of the Act are enclosed for your information (Appendix III). A copy of the public notice of this plan amendment, which was given in the New York State Register on December 26, 2012, is also enclosed for your information (Appendix IV).

If you have any questions regarding this State Plan Amendment submission, please do not hesitate to contact John E. Ulberg Jr., Medicaid Chief Financial Officer, Division of Finance and Rate Setting at (518) 474-6350.

Sincerely,

Jason A. Helgerson
Medicaid Director
Office of Health Insurance Programs

Enclosures

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: **12-35**	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 **January 1, 2013**	

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: **1860D-2(e)(2)(A) of the Social Security Act, amended by section 175 of the Medicare Improvement for Patients and Providers Act of 2008 (MIPPA)**	7. FEDERAL BUDGET IMPACT: **a. FFY 01/01/13-09/30/13 ($ 1,487,898)** **b. FFY 10/01/13-09/30/14 ($ 1,983,864)**
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: **Attachment 3.1-A Supplement: Page 2c** **Attachment 3.1-B Supplement: Page 2c**	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: **Attachment 3.1-A Supplement: Page 2c** **Attachment 3.1-B Supplement: Page 2c**

10. SUBJECT OF AMENDMENT:
Coverage of Benzodiazepines and Barbiturates as a Part D Drug (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:	16. RETURN TO: **New York State Department of Health** **Bureau of HCRA Oper & Financial Analysis** **99 Washington Ave – One Commerce Plaza** **Suite 810** **Albany, NY 12210**
13. TYPED NAME: **Jason A. Helgerson**	
14. TITLE: **Medicaid Director** **Department of Health**	
15. DATE SUBMITTED: January 28, 2013	

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:

Appendix I
2013 Title XIX State Plan
First Quarter Amendment
Non-Institutional Services
Amended SPA Pages

6. Effective January 1, 2006, the Medicaid agency will not cover any Part D drug for full-benefit dual eligible individuals who are entitled to receive Medicare benefits under Part A or Part B.

7. The Medicaid agency provides coverage for the following excluded or otherwise restricted drugs or classes of drugs or their medical uses to all Medicaid recipients, including full benefit dual eligible beneficiaries under the Medicare Prescription Drug Benefit –Part D.

☒ **The following excluded drugs are covered:**

- ☐ (a) agents when used for anorexia, weight loss, weight gain
- ☐ (b) agents when used to promote fertility
- ☐ (c) agents when used for cosmetic purposes or hair growth
- ☒ (d) agents when used for the symptomatic relief cough and colds: Some - benzonatate only
- ☒ (e) prescription vitamins and mineral products, except prenatal vitamins and fluoride: Some - select B Vitamins (niacin, pyridoxine, thiamine, cyanocobalamin); Folic Acid; Vitamin K; Vitamin D (ergocalciferol, cholecalciferol); Iron (including polysaccharide iron complex); Iodine
- ☒ (f) nonprescription drugs: Some - select allergy, asthma and sinus products; analgesics; cough and cold preparations; digestive products; insulin; feminine products; topical products; smoking cessation products, minerals and vitamin combinations
- ☐ (g) covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee
- ☒ (h) barbiturates: All (Except for dual eligible individuals, effective January 1, 2013, when used in the treatment of epilepsy, cancer or a chronic mental health disorder, as Part D will cover those indications.)
- ☒ (i) benzodiazepines: All (Except for dual eligible individuals, effective January 1, 2013, as Part D will cover all indications.)
- ☒ (j) smoking cessation for non-dual eligibles as Part D will cover: All

12b. Prior approval is required for all dentures.

12c. Prior approval is required for prosthetic and orthotic devices over a dollar amount established by the State Department of Health and identified for providers in the MMIS DME Provider Manual.

Prior approval is required for artificial eyes as specified in the MMIS Ophthalmic Provider Manual.

Program also includes coverage of orthotic appliances including hearing aids. All hearing aids require prior approval.

12d. Prior approval is required for certain special lenses and unlisted eye services as specified for providers in the MMIS Ophthalmic Provider Manual.

13a. Diagnostic Services (see 13.d Rehabilitative Services – Early Intervention).

13b. Screening Services (see 13.d Rehabilitative Services – Early Intervention).

13c. Preventive Services (see 13.d Rehabilitative Services – Early Intervention).

13d. Rehabilitative Services

(1) Directly Observed Therapy (DOT) – Clients must be assessed as medically appropriate for DOT based upon the client's risk of non adherence to a medication regimen necessary to cure an active, infectious, potentially fatal disease process and to prevent the development and spread of an infectious, potentially fatal disease which may not respond to conventional therapies.

6. Effective January 1, 2006, the Medicaid agency will not cover any Part D drug for full-benefit dual eligible individuals who are entitled to receive Medicare benefits under Part A or Part B.

7. The Medicaid agency provides coverage for the following excluded or otherwise restricted drugs or classes of drugs or their medical uses to all Medicaid recipients, including full benefit dual eligible beneficiaries under the Medicare Prescription Drug Benefit–Part D.

☒ **The following excluded drugs are covered:**

- ☐ (a) agents when used for anorexia, weight loss, weight gain
- ☐ (b) agents when used to promote fertility
- ☐ (c) agents when used for cosmetic purposes or hair growth
- ☒ (d) agents when used for the symptomatic relief cough and colds: Some - benzonatate only
- ☒ (e) prescription vitamins and mineral products, except prenatal vitamins and fluoride: Some - select B Vitamins (niacin, pyridoxine, thiamine, cyanocobalamin); Folic Acid; Vitamin K; Vitamin D (ergocalciferol, cholecalciferol); Iron (including polysaccharide iron complex); Iodine
- ☒ (f) nonprescription drugs: Some - select allergy, asthma and sinus products; analgesics; cough and cold preparations; digestive products; insulin; feminine products; topical products; smoking cessation products, minerals and vitamin combinations
- ☐ (g) covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee
- ☒ (h) barbiturates: All (Except for dual eligible individuals, effective January 1, 2013, when used in the treatment of epilepsy, cancer or a chronic mental health disorder, as Part D will cover those indications.)
- ☒ (i) benzodiazepines: All (Except for dual eligible individuals effective January 1, 2013, as Part D will cover all indications.)
- ☒ (j) smoking cessation for non-dual eligibles as Part D will cover: All

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13c. Preventive Services (see 13.d Rehabilitative Services – Early Intervention).

13d. Rehabilitative Services

Appendix II
2013 Title XIX State Plan
First Quarter Amendment
Non-Institutional Services
Summary

SUMMARY
SPA #12-35

This State Plan Amendment proposes to remove coverage of benzodiazepines, as well as barbiturates, used in the treatment of epilepsy, cancer, or a chronic mental health disorder for dually eligible beneficiaries effective January 1, 2013.

Section 175 of the Medicare Improvement for Patients and Providers Act of 2008 (MIPPA) amended section 1860D-2(e)(2)(A) of the Act to include barbiturates "used in the treatment of epilepsy, cancer, or a chronic mental health disorder" and benzodiazepines in Part D drug coverage effective as of January 1, 2013. Currently, barbiturates and benzodiazepines are among the excluded drugs covered for all Medicaid beneficiaries.

Since the coverage of barbiturates under Part D is limited to the treatment of epilepsy, cancer or a chronic mental health disorders, NYS proposes to continue to cover barbiturates for conditions other than the three covered by Part D. The coverage of benzodiazepines under Part D is inclusive of all indications, so NYS proposes to provide coverage for only non-dually eligible beneficiaries.

Appendix III
2013 Title XIX State Plan
First Quarter Amendment
Non-Institutional Services
Authorizing Provisions

AUTHORIZING PROVISIONS
SPA #12-35

Chapter 59 of the Laws of 2011
S.2809-D/A.4009-D – Part H

§ 20. Paragraph (g) of subdivision 4 of section 365-a of the social services law, as amended by section 61 of part C of chapter 58 of the laws of 2007, is amended to read as follows:

(g) for eligible persons who are also beneficiaries under part D of title XVIII of the federal social security act, drugs which are denominated as "covered part D drugs" under section 1860D-2(e) of such act[~~**; provided however that, for purposes of this paragraph, "covered part D drugs" shall not mean atypical anti-psychotics, anti-depressants, anti-retrovirals used in the treatment of HIV/AIDS, or anti-rejection drugs used for the treatment of organ and tissue transplants**~~].

H.R.6331

One Hundred Tenth Congress

of the

United States of America

AT THE SECOND SESSION

Begun and held at the City of Washington on Thursday,

the third day of January, two thousand and eight

An Act

To amend titles XVIII and XIX of the Social Security Act to extend expiring provisions under the Medicare Program, to improve beneficiary access to preventive and mental health services, to enhance low-income benefit programs, and to maintain access to care in rural areas, including pharmacy access, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) Short Title- This Act may be cited as the 'Medicare Improvements for Patients and Providers Act of 2008'.

(b) Table of Contents- The table of contents of this Act is as follows:

Part II--Low-Income Programs

Subtitle B--Provisions Relating to Part A

Subtitle C--Provisions Relating to Part B

Part I--Physicians' Services

Part II--Other Payment and Coverage Improvements

Sec. 147. Extension and expansion of the Medicare hold harmless provision under the prospective payment system for hospital outpatient department (HOPD) services for certain hospitals.

Sec. 148. Clarification of payment for clinical laboratory tests furnished by critical access hospitals.

Sec. 149. Adding certain entities as originating sites for payment of telehealth services.

Sec. 150. MedPAC study and report on improving chronic care demonstration programs.

Sec. 151. Increase of FQHC payment limits.

Sec. 152. Kidney disease education and awareness provisions.

Sec. 153. Renal dialysis provisions.

Sec. 154. Delay in and reform of Medicare DMEPOS competitive acquisition program.

Subtitle D--Provisions Relating to Part C

Sec. 161. Phase-out of indirect medical education (IME).

Sec. 162. Revisions to requirements for Medicare Advantage private fee-for-service plans.

Sec. 163. Revisions to quality improvement programs.

Sec. 164. Revisions relating to specialized Medicare Advantage plans for special needs individuals.

Sec. 165. Limitation on out-of-pocket costs for dual eligibles and qualified medicare beneficiaries enrolled in a specialized Medicare Advantage plan for special needs individuals.

Sec. 166. Adjustment to the Medicare Advantage stabilization fund.

Sec. 167. Access to Medicare reasonable cost contract plans.

Sec. 168. MedPAC study and report on quality measures.

Sec. 169. MedPAC study and report on Medicare Advantage payments.

Subtitle E--Provisions Relating to Part D

Part I--Improving Pharmacy Access

Sec. 171. Prompt payment by prescription drug plans and MA-PD plans under part D.

Sec. 172. Submission of claims by pharmacies located in or contracting with long-term care facilities.

Sec. 173. Regular update of prescription drug pricing standard.

Part II--Other Provisions

Sec. 175. Inclusion of barbiturates and benzodiazepines as covered part D drugs.

Sec. 176. Formulary requirements with respect to certain categories or classes of drugs.

Subtitle F--Other Provisions

Sec. 181. Use of part D data.

Sec. 182. Revision of definition of medically accepted indication for drugs.

Sec. 183. Contract with a consensus-based entity regarding performance measurement.

Sec. 184. Cost-sharing for clinical trials.

Sec. 185. Addressing health care disparities.

Sec. 186. Demonstration to improve care to previously uninsured.

Sec. 187. Office of the Inspector General report on compliance with and enforcement of national standards on culturally and linguistically appropriate services (CLAS) in Medicare.

Sec. 188. Medicare Improvement Funding.

Sec. 189. Inclusion of Medicare providers and suppliers in Federal Payment Levy and Administrative Offset Program.

PART II--OTHER PROVISIONS

SEC. 175. INCLUSION OF BARBITURATES AND BENZODIAZEPINES AS COVERED PART D DRUGS.

(a) In General- Section 1860D-2(e)(2)(A) of the Social Security Act (42 U.S.C. 1395w-102(e)(2)(A)) is amended by inserting after 'agents),' the following 'other than subparagraph (I) of such section (relating to barbiturates) if the barbiturate is used in the treatment of epilepsy, cancer, or a chronic mental health disorder, and other than subparagraph (J) of such section (relating to benzodiazepines),'.

(b) Effective Date- The amendments made by subsection (a) shall apply to prescriptions dispensed on or after January 1, 2013.

SEC. 176. FORMULARY REQUIREMENTS WITH RESPECT TO CERTAIN CATEGORIES OR CLASSES OF DRUGS.

Section 1860D-4(b)(3) of the Social Security Act (42 U.S.C. 1395w-104(b)(3)) is amended--

(1) in subparagraph (C)(i), by striking 'The formulary' and inserting 'Subject to subparagraph (G), the formulary'; and

(2) by inserting after subparagraph (F) the following new subparagraph:

'(G) REQUIRED INCLUSION OF DRUGS IN CERTAIN CATEGORIES AND CLASSES-

'(i) IDENTIFICATION OF DRUGS IN CERTAIN CATEGORIES AND CLASSES- Beginning with plan year 2010, the Secretary shall identify, as appropriate, categories and classes of drugs for which both of the following criteria are met:

'(I) Restricted access to drugs in the category or class would have major or life threatening clinical consequences for individuals who have a disease or disorder treated by the drugs in such category or class.

'(II) There is significant clinical need for such individuals to have access to multiple drugs within a category or class due to unique chemical actions and pharmacological effects of the drugs within the category or class, such as drugs used in the treatment of cancer.

'(ii) FORMULARY REQUIREMENTS- Subject to clause (iii), PDP sponsors offering prescription drug plans shall be required to include all covered part D drugs in the categories and classes identified by the Secretary under clause (i).

'(iii) EXCEPTIONS- The Secretary may establish exceptions that permits a PDP sponsor of a prescription drug plan to exclude from its formulary a particular covered part D drug in a category or class that is otherwise required to be included in the formulary under clause (ii) (or to otherwise limit access to such a drug, including through prior authorization or utilization management). Any exceptions established under the preceding sentence shall be provided under a process that--

'(I) ensures that any exception to such requirement is based upon scientific evidence and medical standards of practice (and, in the case of antiretroviral medications, is consistent with the Department of Health and Human Services Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents); and

'(II) includes a public notice and comment period.'.

Appendix IV
2013 Title XIX State Plan
First Quarter Amendment
Non-Institutional Services
Public Notice

- Extends effective beginning April 1, 2013 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.

There is no additional estimated annual change to gross Medicaid expenditures attributable to this initiative for state fiscal year 2013/14.

- Effective beginning April 1, 2013 and for state fiscal years thereafter, the supplemental upper payment limit payments made to general hospitals, other than major public general hospitals, increases to $339 million annually.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2013/2014 is $25 million.

Long Term Care Services

- Effective with the 2013 rate year, the Department of Health will implement quality measures and benchmarks and against those parameters make payments related to the implementation of a Quality Pool for non-specialty residential health care facilities (i.e., non-specialty nursing homes). The quality measures and benchmarks used to score and measure nursing home quality will include the following three categories.

1) Quality MDS Measures - will be calculated using data from MDS 3.0 data, New York State employee flu vaccination data, and the Centers for Medicare & Medicaid Services (CMS) 5-Star staffing measure;

2) Compliance Measures - will be calculated using data from the CMS' 5-Star Rating for health inspections, the timely filing of certified nursing home cost reports, and the timely filing of employee flu immunization data; and

3) Avoidable hospitalizations - will be calculated using MDS 3.0 data, and will be based upon a potentially preventable hospitalization quality indicator for short and long stay hospitalizations.

The scores will be based upon performance in the current year (as defined by the measures and the time period for which data is available) and improvements from the prior year. Certain nursing homes, including those which receive a survey outcome of immediate jeopardy, or substandard quality of care, a J, K, or L deficiency will be not be eligible for quality payments. Funding for the quality payments will be made from a redistribution of existing resources paid through the nursing home pricing methodology to non-specialty nursing homes, and as a result, the Quality Pool will not have an impact on annual gross Medicaid expenditures.

Non-Institutional Services

- Effective January 1, 2013, the State will be adding a new reimbursement methodology for providers who are participating in a Medicaid program integrating the delivery of physical and behavioral health services at a single clinic site.

The goal of this program is to improve the quality and coordination of care provided to individuals who have multiple physical and behavioral health needs. Presently, individuals with serious mental illness and/or addictions often receive regular care in specialized behavioral health settings. The specific clinic site in which these services are provided is licensed to provide such services by the Office of Mental Health (OMH) or the Office of Alcohol and Substance Abuse Services (OASAS) and is not licensed or authorized to provide physical/medical care under Article 28 of the Public Health Law. Patients receiving treatment in these clinics may therefore forgo primary care or, when they do receive physical/medical health care from an Article 28 Department of Health (DOH) certified clinic, the DOH certified clinic site is separate and distinct from the behavioral health clinic site. This leads to fragmented care, poorer health outcomes, and higher rates of emergency room and inpatient services. The goal of this program is to facilitate and promote the availability of both physical and behavioral health services at the site where that individual receives their regular care. For example, if an individual receives regular care in a mental health or substance abuse clinic, that clinic will now be authorized to provide both the physical/medical as well as behavioral health services required by that individual.

A number of steps will be undertaken by DOH, OMH and OASAS to facilitate and streamline this health care delivery model. DOH, OMH and OASAS will work together to:

- Provide an efficient approval process to add new services to a site that is not licensed for those services;
- Establish a single set of administrative standards and survey process under which providers will operate and be monitored; and
- Provide single state agency oversight of compliance with administrative standards for providers offering multiple services at a single site.

To insure quality and coordination of care provided to people with multiple needs, DOH, OMH and OASAS will:

- Ensure appropriate compliance with applicable federal and State requirements for confidentiality of records;
- Work with providers to ensure optimal use of clinical resources jointly developed by OASAS and OMH that support evidence based approaches to integrated dual disorders treatment; and
- Provide an opportunity for optimal clinical care provided in a single setting creating cost efficiencies and promoting quality of care.

Providers eligible to participate in the program include those with two or more licenses at different physical locations, providers who have co-located clinics (i.e., two separately licensed clinics that operate in the same physical location) and providers who are licensed by one State agency but choose to provide an array of services that would fall under the license or certification of another State agency.

Participating providers will be paid through the Ambulatory Patient Group (APG) reimbursement methodology when offering integrated services at an authorized clinic site. Recognizing that integration of physical and behavioral services may result in lower clinic patient billing volume, OMH and OASAS providers will have their APG payment blend accelerated so that they will now receive a 100% calculated APG payment instead of a blended payment - 25% or 50% of existing payment for blend/75% or 50% of APG payment (Note: DOH clinics are already receiving 100% APG payment with no blend). Additionally, the overall APG calculated payment for all providers will be increased by 5%.

The DOH projects that the new payment methodology will be cost neutral.

- The Ambulatory Patient Group (APG) reimbursement methodology is revised to include recalculated weights that will become effective on or after January 1, 2013.

There is no estimated annual change to gross Medicaid expenditures attributable to this initiative in state fiscal year 2013/14.

- Effective January 1, 2013, Medicaid will provide reimbursement to hospital and diagnostic and treatment center physicians for providing home visits to chronically ill patients.

There is no additional estimated annual change to gross Medicaid expenditures attributable to this initiative for state fiscal year 2013/14.

Pharmacy

- The Department of Health proposes to remove coverage of benzodiazepines as well as barbiturates used in the treatment of epilepsy, cancer, or a chronic mental health disorder for dually eligible beneficiaries, effective January 1, 2013.

Section 175 of the Medicare Improvement for Patients and Providers Act of 2008 (MIPPA) amended section 1860D-2(e)(2)(A) of the Act to include barbiturates "used in the treatment of epilepsy, cancer, or a chronic mental health disorder" and benzodiazepines in Part D drug coverage, effective as of January 1, 2013. Currently, barbiturates and benzodiazepines are among the excluded drugs covered for all Medicaid beneficiaries.

Since the coverage of barbiturates under Part D is limited to the treatment of epilepsy, cancer or a chronic mental health disorders, New York State (NYS) proposes to continue to cover barbiturates for conditions other than the three covered by Part D. The coverage of benzodiazepines under Part D is inclusive of all indications, so NYS proposes to provide coverage for only non-dually eligible beneficiaries.

The estimated annual net aggregate decrease in gross Medicaid expenditures attributable to this initiative for state fiscal year 2013/2014 is ($1,983,863).

The public is invited to review and comment on this proposed State Plan Amendment. Copies of which will be available for public review on the Department's website at http://www.health.ny.gov/regulations/state_plans/status.

Copies of the proposed State Plan Amendments will be on file in each local (county) social services district and available for public review.

For the New York City district, copies will be available at the following places:

New York County
250 Church Street
New York, New York 10018

Queens County, Queens Center
3220 Northern Boulevard
Long Island City, New York 11101

Kings County, Fulton Center
114 Willoughby Street
Brooklyn, New York 11201

Bronx County, Tremont Center
1916 Monterey Avenue
Bronx, New York 10457

Richmond County, Richmond Center
95 Central Avenue, St. George
Staten Island, New York 10301

The public is invited to review and comment on this proposed State Plan Amendment.

For further information and to review and comment, please contact: Department of Health, Bureau of HCRA Operations & Financial Analysis, 99 Washington Ave. - One Commerce Plaza, Suite 810, Albany, NY 12210, (518) 474-1673, (518) 473-8825 (FAX), e-mail: spa_inquiries@health.state.ny.us

PUBLIC NOTICE

Office for People with Developmental Disabilities and Department of Health

Pursuant to 42 CFR Section 447.205, the New York State Office for People With Developmental Disabilities (OPWDD) and the New York State Department of Health hereby give notice of the following:

The State proposes to make the following changes effective February 1, 2013. The State will expand the applicability of the reporting and audit requirements in OPWDD regulations to cover Medicaid Service Coordination (MSC), Home and Community Based Services Waiver services (HCBS Waiver services), and clinic treatment facilities ("Article 16 clinics") provided under the auspices of OPWDD. Additionally, the State proposes to reduce the number of cost report filing deadline extensions from two thirty-day extensions to one thirty-day extension. The State proposes to change the penalty for failure to file a cost report on time from a 5 percent penalty imposed at the discretion of the State and levied against the operating portion of existing rates, prices or fees, to a 2 percent mandatory reduction in reimbursements.

Another proposed change will require OPWDD to give the provider written notice that it missed the cost report deadline or that it must submit a revised cost report. This notice will give the provider a final opportunity to submit the cost report or explain that it cannot submit it because of unforeseeable factors beyond its control. If the provider submits the cost report or shows that there were unforeseeable factors beyond its control that prevented it from submitting on time, it will avoid the penalty. However, the penalty will be imposed if the provider submits an explanation of the unforeseeable factors and OPWDD sets a new deadline for the cost report, but the provider misses this new deadline.

The State would also change the procedures in cases where it is the provider that discovers that a cost report is incomplete, inaccurate or incorrect, and where the provider makes this discovery before receiving its new base period rate, fee or price. The change will eliminate the requirement that the provider first give OPWDD notice and then follow up with a revised cost report within 30 days. Instead, the provider will simply submit a revised cost report. Also, the change will eliminate the penalty in this situation, but keep the provision that allows, rather than requires, that OPWDD revise the rate, fee or price based on the revised cost data, and then only if and when OPWDD receives the revised cost report.

Finally, the State is proposing to clarify that service-specific records of expenditures and revenues must be kept at the program or site level, that providers must maintain underlying records which formed the basis for or which support the cost, budget and other reports and data submitted to OPWDD, that reports and records that were not used to establish a rate, price or fee must be kept until the later of six years from the due date or date of submission, and that reports and records that were used to establish a rate, price or fee must be kept for six years after the rate, price or fee was set.

The State does not expect this change to result in any aggregate increases or decreases in Medicaid expenditures.

The reasons for the proposed changes are as follows. The State is proposing to expand the reporting and audit requirements to MSC, HCBS Waiver services and Article 16 clinics because the State's regulations governing financial reporting, record keeping and audit requirements were promulgated in 1998. Since then, OPWDD has developed new services and existing services have been substantially changed.

The State is proposing to reduce the number of cost report deadline extensions from two to one to bring regulations in line with actual OPWDD practices.

The State is proposing the changes on sanctions for providers which fail to meet the deadlines because the current discretionary penalty has not been imposed and as a result, late filers do exist. Not only does this disrupt the efficient flow of rate setting operations, but providers need to examine the financial results of their operations at least on an annual basis to measure, assess and react to the factors influencing their financial health and to forge budgets and define their fiscal direction. OPWDD wants to assure that the compilation and submission of financial data occurs on a timely basis.

The State is proposing to apply the percentage reduction to reimbursements because this will not require that prices, rates and/or fees be recalculated and reissued. In contrast, the current system of applying reductions to a rate, price or fee requires that the State recalculate and reissue rates.

The State is proposing that OPWDD give the provider notice that it missed the cost report deadline or that it must submit a revised cost report, and that the provider have a final opportunity to submit the cost report or explain why it cannot submit it, because this will be both a fair and effective way of ensuring that penalties are imposed only on those providers that are truly at fault.

The State is proposing to change the procedures when the provider discovers that a cost report is incomplete, inaccurate or incorrect to increase efficiency. The State is proposing to eliminate the penalty in this situation in the interests of fairness.

The State is proposing the clarifications to requirements for the records that providers must keep so that these requirements will be better understood and so that there will be adequate records for the State to exercise necessary oversight of Medicaid funding.

Outside New York City, a detailed description of the changes is available for public review at the following addresses:

Albany
Albany County Department of Mental Health

APPENDIX VI
State Plan Amendment 12-35

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 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 coverage of benzodiazepines as well as barbiturates used in the treatment of epilepsy, cancer, or a chronic mental health disorder for dually eligible beneficiaries effective January 1, 2013.

   Section 175 of the Medicare Improvement for Patients and Providers Act of 2008 (MIPPA) amended section 1860D-2(e)(2)(A) of the Act to include barbiturates "used in the treatment of epilepsy, cancer, or a chronic mental health disorder" and benzodiazepines in Part D drug coverage effective as of January 1, 2013. Currently, barbiturates and benzodiazepines are among the excluded drugs covered for all Medicaid beneficiaries.

   Since the coverage of barbiturates under Part D is limited to the treatment of epilepsy, cancer or a chronic mental health disorders, NYS proposes to continue to cover barbiturates for conditions other than the three covered by Part D. The coverage of benzodiazepines under Part D is inclusive of all indications, so NYS proposes to provide coverage for only non-dually eligible beneficiaries. This will assure continuous coverage for all Medicaid enrollees, either through Medicare or Medicaid, with no duplication of coverage.

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: This is inapplicable.

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 2011-12 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: Medicare Part D is picking up coverage of benzodiazepines, and therefore the State is merely removing duplicate coverage. Should any dual eligible be denied barbiturates for indications considered covered by Medicare Part D, the State will provide coverage through a prior authorization upon receipt of an upheld denial by the Medicare Part D plan.

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: Over the course of the past three years, the State has undertaken a massive reform initiative to better align reimbursement with care. When fully implemented, the initiative will invest over $600 million in the State's ambulatory care system (outpatient, ambulatory surgery, emergency department, clinic and physicians) to incentivize care in the most appropriate setting. The State has also increased its physician reimbursement schedule to resemble Medicare payments for similar services, thus ensuring continued access for Medicaid beneficiaries. Further, the State is implementing initiatives that will award $600 million annually, over five years, to providers who promote efficiency and quality care through the Federal-State Health Reform Partnership(F-SHRP)/ NYS Healthcare Efficiency and Affordability Law (HEAL). 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.