NEW YORK
state department of
HEALTH

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

Sue Kelly
Executive Deputy Commissioner

June 24, 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 Operations
26 Federal Plaza - Room 37-100 North
New York, New York 10278

RE: SPA #13-45
Non-Institutional Services

Dear Mr. Melendez:

The State requests approval of the enclosed amendment #13-45 to the Title XIX (Medicaid) State Plan for non-institutional services to be effective April 1, 2013 (Appendix I). This amendment is being submitted based on enacted legislation. 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 enacted State statute 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 March 27, 2013, is also enclosed for your information (Appendix IV). In addition, responses to the five standard funding questions are also enclosed (Appendix V).

If you have any questions regarding this State Plan 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: **13-45**	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, 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: **Section 1902(a) of the Social Security Act, and 42 CFR 447**	7. FEDERAL BUDGET IMPACT: **a. FFY 04/01/13-09/30/13 $ 0** **b. FFY 10/01/13-09/30/14 $ 0**
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: **Attachment 4.19-B: Page 4(c)(ii)**	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

10. SUBJECT OF AMENDMENT:
Debt Service Reimbursement for Adult Homes Converting to ALPs (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 Federal Relations & Provider Assessments** **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: June 24, 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:

FORM HCFA-179 (07-92)

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

New York
4(c)(ii)

Reimbursement for real property capital construction costs:

Effective April 1, 2013, real property capital construction costs will only be included in ALP rates of payment if:

1) the facility houses exclusively ALPs beds authorized pursuant to section 461-l(3)(j) of the Social Services Law, or

2) the facility is operated by a not-for-profit corporation; the facility commenced operation after 1998 and at least 95% of the certified approved beds are provided to residents who are subject to the ALP; and the ALP is in a county with a population of no less than 280,000 persons.

The methodology used to calculate the rate for such capital construction costs shall be the same methodology used to calculate the capital construction costs at RHCFs for such costs, provided that the Commissioner may adopt rules and regulations which establish a cap on real property capital construction costs for those facilities that house exclusively ALP beds authorized pursuant to section 461-l(3)(j) of the Social Services Law.

Section 461-l(3)(j) of the Social Services Law authorizes the Commissioner of Health to add up to 4,500 ALP beds to the gross number of ALP beds having been determined to be available as of April 1, 2012. Applicants eligible to submit an application are limited to adult homes established with, as of September 1, 2012, a certified capacity of 80 beds or more in which 25% or more of the resident population are persons with serious mental illness as defined in regulations promulgated the Commissioner.

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

SUMMARY
SPA #13-45

This State Plan Amendment proposes to authorize capital debt reimbursement for certain adult homes which convert to assisted living programs.

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

SPA 13-45

CHAPTER 56 OF THE LAWS OF 2013 - PART A

§ 69. Paragraph (b) of subdivision 6 of section 3614 of the public health law, as added by chapter 645 of the laws of 2003, is amended to read as follows:

(b) For purposes of this subdivision, real property capital construction costs shall only be included in rates of payment for assisted living programs if: the facility houses exclusively assisted living program beds authorized pursuant to paragraph (j) of subdivision three of section four hundred sixty-one-l of the social services law or (i) the facility is operated by a not-for-profit corporation; (ii) the facility commenced operation after nineteen hundred ninety-eight and at least ninety-five percent of the certified approved beds are provided to residents who are subject to the assisted living program; and (iii) the assisted living program is in a county with a population of no less than two hundred eighty thousand persons. The methodology used to calculate the rate for such capital construction costs shall be the same methodology used to calculate the capital construction costs at residential health care facilities for such costs, provided that the commissioner may adopt rules and regulations which establish a cap on real property capital construction costs for those facilities that house exclusively assisted living program beds authorized pursuant to paragraph (j) of subdivision three of section four hundred sixty-one-l of the social services law.

§ 70. Subdivision 3 of section 461-l of the social services law is amended by adding a new paragraph (j) to read as follows:

(j) The commissioner of health is authorized to add up to four thousand five hundred assisted living program beds to the gross number of assisted living program beds having been determined to be available as of April first, two thousand twelve. Applicants eligible to submit an application under this paragraph shall be limited to adult homes established pursuant to section four hundred sixty-one-b of this article with, as of September first, two thousand twelve, a certified capacity of eighty beds or more in which twenty-five percent or more of the resident population are persons with serious mental illness as defined in regulations promulgated by the commissioner of health. The commissioner of health shall not be required to review on a comparative basis applications submitted for assisted living program beds made available under this paragraph.

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

• Continues, for periods April 1, 2013 through March 31, 2016, the current provisions of the Statewide Health Care Home Program.

• Continues, effective for state fiscal year periods on and after April 1, 2013, the reduction of $25 million to the APG investment for general hospital outpatient services, general hospital emergency services and ambulatory surgical services.

• Effective April 1, 2013, individual psychotherapy services provided by licensed social workers to persons under the age of 21 and to persons requiring such services as a result of or related to pregnancy or giving birth, pursuant to federal approval, shall be reimbursed, provided, however, the Commissioner of Health is authorized to establish criteria for such services in accordance with federal law or regulation.

The annual increase in gross Medicaid expenditures for state fiscal year 2013/14 is $2.5 million.

• Effective April 1, 2013, real property capital construction costs will only be included in rates of payment for assisted living programs (ALPs) if: the facility houses exclusively ALP beds or the facility is operated by a not-for-profit corporation; the facility commenced operation after 1998 and at least 95% of the certified approved beds are provided to residents who are subject to the ALP; and the ALP is in a county with a population of no less than 280,000 persons.

The methodology used to calculate the rate for such capital construction costs shall be the same methodology used to calculate the capital construction costs at residential health care facilities for such costs, provided that the Commissioner may adopt rules and regulations which establish a cap on real property capital construction costs for those facilities that house exclusively ALP beds.

The Commissioner of Health is authorized to add up to 4,500 ALP beds to the gross number of ALP beds having been determined to be available as of April 1, 2012. Applicants eligible to submit an application shall be limited to adult homes established with, as of September 1, 2012, a certified capacity of 80 beds or more in which 25% or more of the resident population are persons with serious mental illness as defined in regulations promulgated the the Commissioner.

• Effective April 1, 2013, streamline and improve the cost-effectiveness of the Early Intervention Program (EIP) eligibility determination process by (1) requiring children referred with no qualifying diagnosis to be screened to determine whether a delay or disability is suspected; (2) using medical and other records to document eligibility for children referred with a qualifying diagnosis (e.g. Down syndrome, hearing loss); and (3) conducting partial evaluations for children previously referred to the EIP, evaluated, and found ineligible who are re-referred after 3 months and within six months of that determination (re-referrals prior to 3 months will not be accepted) with a concern in only one area of development, and new concerns in the child's developmental/medical status.

The annual decrease in gross Medicaid expenditures for state fiscal year 2013/14 is $960,000.

Prescription Drugs

• Effective July 1, 2013, for sole or multi-source brand name drugs the Estimated Acquisition Cost (EAC) is defined as Average Wholesale Price (AWP) minus seventeen and six-tenths (17.6) percent and the Average Acquisition Cost (AAC) with an appropriate dispensing fee(s) will be incorporated into the prescription drug reimbursement methodology.

The annual decrease in gross Medicaid expenditures for state fiscal year 2013/14 is $3.6 million.

• Effective April 1, 2013, the Department of Health will move to average actual acquisition cost (AAC) as the primary basis for reimbursement of prescription drugs submitted for payment to the medical assistance program. In the event AAC cannot be established for a particular drug, the Department will revert to the existing lower of methodology. Use of AAC allows the State to set reimbursement rates based on an actual acquisition cost (invoice data) and an appropriate dispensing fee.

• Effective October 1, 2013, the minimum supplemental rebate initiative would require manufacturers of brand name drugs to provide a minimum level supplemental rebate to the State or be subject to prior authorization of their drug.

The annual decrease in gross Medicaid expenditures for state fiscal year 2013/14 is $.90 million.

• Effective April 1, 2013, the e-prescription financial incentives of $.80 per dispensed electronic prescription paid to medical practitioners, clinics and the $.20 per dispensed electronic prescription paid to pharmacies for the purpose of encouraging the electronic transmission of prescriptions for drugs prescribed and dispensed in accordance with State and federal requirements will terminate.

The annual decrease in gross Medicaid expenditures attributed to this initiative for state fiscal year 2013/14 is $2.08 million.

The estimated annual net aggregate decrease in gross Medicaid expenditures attributable to reform and other initiatives contained in the budget for state fiscal year 2013/2014 is $648.8 million; and the estimated annual net aggregate increase in gross Medicaid expenditures attributable to an extension of pertinent disproportionate share (DSH) and upper payment limit (UPL) payments for state fiscal year 2013/2014 is $2.4 billion.

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 and Financial Analysis, Corning Tower Building, Rm. 984, Empire State Plaza, Albany, NY 12237, (518) 474-1673, (518) 473-8825 (fax), spa_inquires@health.state.ny.us

PUBLIC NOTICE

New York City Deferred Compensation Plan/NYCE IRA

The New York City Deferred Compensation Plan/NYCE IRA (the "Plan") is seeking qualified vendors to provide daily or as necessary liquidity through the use of a low duration wrapped bond portfolio, an insurance company separate account portfolio and/or a commingled stable value fund for the Stable Income Fund investment option of the Plan. To be considered, vendors must submit their product information to Mercer Investment Consulting. Vendors should input or update their product information, as applicable, on Mercer's Global Investment Management Database (GIMD). The address for the website is: www.mercergimd.com. Vendors not already registered, please call Jay Livnat at (212) 345-2719 for a user I.D. and password to access the database. There is no fee for entering product information on the database. Please complete the submission of product information in the Mercer database no later than 4:30 P.M. Eastern Time on Friday, April 19, 2013. Also, please visit the Plan's website at www.nyc.gov/

Appendix V
2013 Title XIX State Plan
Second Quarter Amendment
Non-Institutional Services
Responses to Standard Funding Questions

NON-INSTITUTIONAL SERVICES
State Plan Amendment #13-45

CMS Standard Funding Questions

The following questions are being asked and should be answered in relation to all payments made to all providers reimbursed pursuant to a methodology described in Attachment 4.19-B of this SPA. For SPAs that provide for changes to payments for clinic or outpatient hospital services or for enhanced or supplemental payments to physician or other practitioners, the questions must be answered for all payments made under the state plan for such service.

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 payments, a complete listing of providers that return a portion of their payments, 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 A-87 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.

2. **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 through 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 governmental 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 general appropriation received by the State agency that oversees medical assistance (Medicaid), which is the Department of Health. The source of the appropriation is the Local Assistance Account under the General Fund/Aid to Localities.

3. **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.

4. **For clinic or outpatient hospital services 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.

Response: Medicaid payments for medical services provided to residents in Assisted Living Programs are not subject to the upper payment limit requirement.

5. **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: The rate methodology included in the State Plan for Assisted Living Program services is a capitated per diem payment rate related to the average residential health care facility rate established for calendar year 1992 for each of 16 patient classification groups in each of 16 regions, increased by a roll factor for each subsequent calendar year. Payment rates cannot exceed prevailing charges in the locality. We are unaware of any requirement under current federal law or regulation that limits individual providers' 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, 2014.

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: This SPA 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 11-06, and documentation of such is included with this submission. To date, no feedback has been received from any tribal representative in response to the proposed change in this SPA.