NEW YORK
state department of
HEALTH

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

Sue Kelly
Executive Deputy Commissioner

June 9, 2011

National Institutional Reimbursement Team
Attention: Mark Cooley
CMS, CMCS
7500 Security Boulevard, M/S S2-01-16
Baltimore, MD 21244-1850

RE: SPA #11-60
Long Term Care Facility Services

Dear Mr. Cooley:

The State requests approval of the enclosed amendment #11-60 to the Title XIX (Medicaid) State Plan for long term care facility services to be effective May 1, 2011 (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).

1. The State of New York pays for long-term care services using rates determined in accordance with methods and standards specified in an approved State Plan following a public process which complies with §1902(a)(13)(A) of the Social Security Act.

2. (a) It is estimated that the changes represented by the estimated average payment rates for long-term care facility services will have no noticeable short-term or long-term effect on the availability of services on a statewide and geographic area basis.

   (b) It is estimated that the changes represented by the estimated average payment rates for long-term care facility services will have no noticeable short-term or long-term effect on care furnished.

   (c) It is estimated that the changes represented by the estimated average payment rates for long-term care facility services will have no noticeable short-term or long-term effect on the extent of provider participation.

In accordance with 42 CFR §447.272, New York assures that the aggregate Medicaid payments for inpatient services provided by nursing facilities for each prescribed category of providers does not exceed the upper payment limit for the particular category of providers.

A copy of the pertinent section of enacted State statute is enclosed for your information (Appendix III). A copy of the public notice of this proposed amendment, which was given in the New York State Register on April 27, 2011, 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 John E. Ulberg, Jr., Director, Division of Health Care Financing at (518) 474-6350.

Sincerely,

Jason A. Helgerson
Medicaid Director
Deputy Commissioner
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: **#11-60**	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 **May 1, 2011**	

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 5/1/11 – 9/30/11 ($15,414,480)** **b. FFY 10/1/11 – 9/30/12 $0**
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: **Attachment 4.19-D: 50(h)**	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: **Attachment 4.19-D: 50(h)**

10. SUBJECT OF AMENDMENT:
Uniform Rate Reductions - Nursing Homes
(Based on FMAP of 56.88% for 4/1/11 – 6/30/11)

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** **Corning Tower** **Empire State Plaza** **Albany, New York 12237**
13. TYPED NAME: **Jason A. Helgerson**	
14. TITLE: **Medicaid Director & Deputy Commissioner Department of Health**	
15. DATE SUBMITTED: June 9, 2011	

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:

(l) For the rate period May 1, 2009 through March 31, 2010, adjustments to the rates of payment resulting from the rebase to 2002 reported base year costs, including initial adjustments for case mix, shall be held to an aggregate increase of $210 million. If the total adjustments are more or less than $210 million, proportional adjustments to the rates shall be made as necessary to result in an increase in aggregate expenditures of $210 million. Such proportional adjustments shall be based on each facility's proportionate share of total spending from the April 1, 2009 rates that reflect the impact of rebasing and Medicaid only case mix. The rate adjustment required to adjust spending to the required $210 million amount will be reflected as the "scale back adjustment" in the rates effective May 1, 2009 through March 31, 2010. The operating component of such rates shall not be subject to the update adjustments for case mix as otherwise scheduled for January of 2010.

For the annual periods April 1, 2010 through March 31, 2012, if adjustments to the rates of payment prior to the adjustment for inflation results in an increase in total payments for such services on an annual basis, such rates shall be further adjusted proportionally as is necessary to reduce the aggregate increase to no greater than the proportionally adjusted aggregate for the period April 1, 2009 through March 31, 2010. Proportional adjustments made to rates within the aggregate expenditure limit shall not be subject to subsequent correction or reconciliation.

(m) For the period May 1, 2011 through June 30, 2011, the non-capital components of rates will be subject to a uniform percentage reduction sufficient to reduce such rates by an aggregate amount of $27,100,000. Such reductions will not be included in the computation of the residential health care facility cap.

Appendix I
2011 Title XIX State Plan
Second Quarter Amendment
Long-Term Care Facility Services
Amended SPA Pages

Appendix II
2011 Title XIX State Plan
Second Quarter Amendment
Long-Term Care Facility Services
Summary

SUMMARY
SPA #11-60

This State Plan Amendment proposes that for the period May 1, 2011 through June 30, 2011, the non-capital component of rates for residential health care facilities will be subject to a uniform percentage reduction sufficient to reduce rates by an aggregate amount of $27.1 million.

Appendix III
2011 Title XIX State Plan
Second Quarter Amendment
Long-Term Care Facility Services
Authorizing Provisions

§ 99. Subdivision 2-b of section 2808 of the public health law is amended by adding a new paragraph (h) to read as follows:

(h) Notwithstanding any contrary provision of law and subject to the availability of federal financial participation, for the period April first, two thousand eleven through June thirtieth, two thousand eleven, the non-capital components of rates shall be subject to a uniform percentage reduction sufficient to reduce such rates by an aggregate amount of twenty-seven million one hundred thousand dollars, and provided further, however, that such reductions shall be disregarded in computations made pursuant to section two of part D of chapter fifty-eight of the laws of two thousand nine, as amended.

Appendix IV
2011 Title XIX State Plan
Second Quarter Amendment
Long-Term Care Facility Services
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

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 inpatient, long term care, and non-institutional services to comply with recently enacted statutory provisions. The following provides clarification to provisions previously noticed on March 30, 2011, and notification of new significant changes:

All Services

• To clarify the previously noticed provision, the elimination of the trend factor has been revised to be effective on and after April 1, 2011 through March 31, 2013 and no greater than zero trend factors shall be applied. This is also revised to exclude residential health care facilities or units of such facilities that provide services primarily to children under 21 years of age, and to include hospital outpatient services. The annual decrease in gross Medicaid expenditures for state fiscal year 2011/12 is ($56) million.

• To clarify the previously noticed provision regarding the uniform two percent Medicaid payment reduction, the effective period is now April 1, 2011 through March 31, 2013. The annual decrease in gross Medicaid expenditures for state fiscal year 2011/12 is ($517.80) million.

Institutional Services

• Extends current provisions to services for the periods April 1, 2011 through March 31, 2013, the reimbursable operating cost component for general hospital inpatient rates will be established with the 2006 final trend factor equal to the final Consumer Price Index (CPI) for all Urban Consumers less 0.25%.

The State proposes to extend, effective April 1, 2011 through March 31, 2013, certain cost containment initiatives that were enacted in Chapter 81 of the Laws of 1995 and extended by subsequent legislation. The extended provisions are as follows: (1) hospital capital costs shall exclude 44% of major moveable equipment costs; (2) elimination of reimbursement of staff housing operating and capital costs; and (3) budgeted capital inpatient costs of a general hospital applicable to the rate year shall be decreased to reflect the percentage amount by which the budgeted costs for capital related inpatient costs of the hospital for the base year two years prior to the rate year exceeded actual costs.

The annual decrease in gross Medicaid expenditures for state fiscal year 2011/12 is ($7.85) million.

• The Commissioner of Health shall incorporate quality related measures including, potentially preventable re-admissions (PPRs) and other potentially preventable negative outcomes (PPNOs) and provide for rate adjustments or payment disallowances related to same. Such rate adjustments or payment disallowances will be calculated in accordance with methodologies, as determined by the Commissioner of Health, and based on a comparison of the actual and risk adjusted expected number of PPRs and other PPNOs in a given hospital and with benchmarks established by the Commissioner. Such adjustments or disallowances for PPRs and other PPNOs will result in an aggregate reduction in Medicaid payments of no less than $51 million for the period April 1, 2011 through March 31, 2012, provided that such aggregate reductions shall be offset by Medicaid payment reductions occurring as a result of decreased PPRs for the period July 1, 2011 through March 31, 2011, and as a result of decreased PPRs and PPNOs for the period April 1, 2011 through March 31, 2012. The annual decrease in gross Medicaid expenditures, not previously noticed, for state fiscal year 2011/12 is ($4) million.

Long Term Care Services

• Continues, effective April 1, 2011 through March 31, 2013, the provision that rates of payment for RHCFs shall not reflect trend factor projections or adjustments for the period April 1, 1996 through March 31, 1997.

Extends current provisions to services for the periods April 1, 2011 through March 31, 2013, the reimbursable operating cost component for RHCFs rates will be established with the final 2006 trend factor equal to the final Consumer Price Index (CPI) for all urban consumers less 0.25%.

Continues, effective April 1, 2011 through March 31, 2013, the long-term care Medicare maximization initiatives.

The annual decrease in gross Medicaid expenditures for state fiscal year 2011/12 is ($214) million.

• Effective April 1, 2011, for inpatient services provided by residential health care facilities (RHCFs), the Commissioner of Health may grant approval of temporary adjustments to Medicaid rates to provide short term assistance to eligible facilities to accommodate additional patient services requirements resulting from the closure of other facilities in the area, including but not limited to additional staff, service reconfiguration, and enhancing information technology (IT) systems.

– Eligible facilities shall submit written proposals demonstrating the need for additional short-term resources and how such additional resources will result in improvements to the cost effectiveness of service delivery; quality of care; and other factors. Written proposals must be submitted to the department at least sixty days prior to the requested effective date of the temporary rate adjustment. The temporary rate adjustment shall be in effect for a specified period of

time and at the end of the specified timeframe, the facility will be reimbursed in accordance with otherwise applicable rate-setting methodologies. The commissioner may establish, as a condition of receiving such a temporary rate adjustment, benchmarks and goals to be achieved in accordance with the facility's approved proposals and may also require that the facility submit periodic reports evaluating the progress made in achieving the benchmarks and goals. Failure to achieve satisfactory progress, as determined by the commissioner, in accomplishing such benchmarks and goals shall be a basis for ending the facility's temporary rate adjustment. The estimated increase in Medicaid expenditures for the rate increases will be offset by the decrease in Medicaid expenditures resulting from the closure of other providers.

• The 2002 rebasing methodology and the 2002 wage equalization factor methodology will be extended and will remain in effect until such time as the Statewide pricing methodology takes effect. Case mix adjustments as scheduled for July 2011 will not be made.

– The regional pricing methodology previously approved to be effective July 1, 2011 for inpatient services provided by residential health care facilities is replaced with a Statewide pricing methodology to be effective on or after October 1, 2011 but no later than January 1, 2012.

– The Statewide pricing methodology for the non-capital component of the rates of payment for inpatient services provided by residential health care facilities shall utilize allowable operating costs for a base year, determined by the Commissioner of Health by regulation, and shall reflect:

•A direct statewide price component adjusted by a wage equalization factor (which shall be periodically updated to reflect current labor market conditions) and other factors to recognize other cost differentials. The direct statewide price shall also be subject to a Medicaid-only case mix adjustment.

•An indirect statewide price component adjusted by a wage equalization factor (which shall be periodically updated to reflect current labor market conditions); and

•A facility specific non-comparable component.

– Such rate components shall be periodically updated to reflect changes in operating costs.

– The non-capital component of the "specialty" rates for AIDS facilities or discrete AIDS units within facilities; discrete units for residents receiving care in a long-term inpatient rehabilitation program for traumatic brain injured persons; discrete units providing specialized programs for residents requiring behavioral interventions; discrete units for long-term ventilator dependent residents; and facilities or discrete units within facilities that provide extensive nursing, medical, psychological and counseling support services solely to children shall be the rates in effect on January 1, 2009, as adjusted for inflation and rate appeals. The AIDS rates in effect January 1, 2009 shall be adjusted to reflect the elimination of the AIDS occupancy factor enacted in 2009. In addition, the trend factors attributable to 2008 and 2009 and included in such specialty rates shall be subject to the residential health care facility cap. The Commissioner may promulgate regulations, including emergency regulations, to implement the provisions of the methodology. The regulations will include provisions for rate adjustments or payment enhancements to facilitate a minimum four year transition of facilities to the methodology and may also include provisions for rate adjustments or payment enhancements to facilitate the transition of facilities to the rate-setting methodology and for facilitating quality improvements in residential health care facilities. The regulations will be developed in consultation with the nursing home industry and advocates for residential health care facility residents. The Commissioner shall notify the Chairs of the Legislative Fiscal Committees and Health Committees in the Senate and the Assembly of such regulations. There is no increase or decrease in gross Medicaid expenditures for state fiscal year 2011/12 (including the $210 million cap).

For the period May 1, 2011 through May 31, 2011, supplemental payments in an amount not to exceed $221.3 million will be made to eligible residential health care facilities as determined by the Commissioner of Health, which experienced a net reduction in their payment rate for the period April 1, 2009 through March 31, 2011 as a result of the 2002 rebasing methodology, Medicaid only case mix methodology, and the application of proportional adjustments required to be made by the application of the residential health care facility (RHCF) cap. In determining the net reduction, the impact of case mix adjustments applicable to July 2010 and certain rate adjustments processed for payment after October 19, 2010 will be disregarded by the Commissioner. The following facilities, as determined by the Commissioner, are eligible for such supplemental payments.

– Facilities which were eligible for Financially Disadvantaged distributions for the 2009 period; non- government owned or operated facilities whose total operating losses equal or exceed five percent of total operating revenue and whose Medicaid utilization equals or exceeds 70 percent (based on either their 2009 cost report or their most recently available cost report); and pediatric facilities or distinct units, which will receive a supplemental payment that is equal to 100 percent of the net reduction determined above.

– Eligible facilities, other than those described in the previous paragraph above will receive supplemental payments equal to 50 percent of their net reduction. Eligible facilities which after the application of these rate adjustments that remain subject to a net reduction in their inpatient Medicaid revenue which is in excess of two percent (as measured with regard to the non-capital components of facility inpatient rates in effect on March 31, 2009 computed prior to the application of trend factor adjustments attributable to the 2008 and 2009 calendar years), will have their payments further adjusted so that the net reduction does not exceed two percent. Eligible facilities which have experienced a net reduction in their inpatient rates of more than $6 million over the period April 1, 2009 through March 31, 2011, as a result of the application of proportional adjustments required to be made by the application of the RHCF cap, will have their payments further adjusted so that their net reduction is reduced to zero.

The supplemental payments previously described will not be subject to subsequent adjustment or reconciliation and will be disregarded for purposes of calculating the limitations on Medicaid rates required by the application of the residential health care facility cap.

Additional rate adjustments, in the form of rate add-ons, will be made to the eligible facilities previously described for the period May 1, 2011 through May 31, 2011 in an aggregate amount equal to 25% of the payments previously described (or 25% of $221.3 million which equals $55.3 million). The payments will be distributed to eligible facilities in the same proportion as the total $221.3 million of distributions made to each eligible facility.

The Commissioner may, with the approval of the Director of the Budget, and subject to the identification of sufficient nursing home related Medicaid savings to offset the expenditures authorized by this paragraph, make additional rate adjustments, in the form of rate add-ons, to the eligible facilities previously described, for the rate periods December 1, 2011 through December 31, 2012 in an aggregate amount equal to 12.5% of the payments previously described (or 12.5% of $221.3 million which equals about $27.7 million).

The annual increase in gross Medicaid expenditures for state fiscal year 2011/12 is $304.30 million.

• For the rate period April 1, 2011 through June 30, 2011 the non-capital component of residential health care facility rates will be subject to a uniform percentage reduction sufficient to reduce rates by $27.1 million. The dollar amount of this uniform reduction will be disregarded for purposes of calculating the limitations on Medicaid rates required by the application of the RHCF cap. The annual decrease in gross Medicaid expenditures for state fiscal year 2011/12 is ($27.1) million.

• Facilities that receive a Financially Disadvantaged (FD) payment, for the period May 1, 2010 through April 30, 2011, shall have their Medicaid rates for the rate period December 1, 2011 through December 31, 2011 reduced by an amount equal to such FD payments. FD payments made for the annual period May 1, 2011 through April 30, 2012, shall not be made. The annual decrease in gross Medicaid expenditures for state fiscal year 2011/12 is ($60) million.

• Effective April 1, 2011, the capital cost component of Medicaid rates of payment for services provided by RHCFs may not include any

payment factor for return on or return of equity, or for residual reimbursement. In addition, provisions authorizing adjustments to the capital cost component of rates for proprietary facilities that would otherwise be eligible for residual reimbursement to take into account any capital improvements and/or renovations made to the facility's existing infrastructure for the purpose of converting beds to alternative long-term care uses or protecting the health and safety of patients are repealed. The annual decrease in gross Medicaid expenditures for state fiscal year 2011/12 is ($64) million.

Non-institutional Services

• Revision to the methodology used to establish peer groups for Federally Qualified Health Centers (FQHC's) to align the counties considered upstate and downstate with those used for the ambulatory care groups' methodology. The grouping methodology is used to determine reasonable costs for FQHC's in their respective region. The downstate region is defined as all counties comprising New York City, Nassau, Suffolk, Richmond, Westchester, Rockland, Putnam, Orange and Dutchess. All other counties are considered upstate. The annual increase in gross Medicaid expenditures for state fiscal year 2011/12 is $4.8M.

• Effective for the period April 1, 2011 through March 31, 2012, early intervention program rates for approved services rendered on and after April 1, 2011 shall be reduced by five percent. The annual decrease in gross Medicaid expenditures for state fiscal year 2011/12 is ($13) million.

Effective for the period April 1, 2011 through March 31, 2012, early intervention program rates for home and community based rates for approved services rendered on and after April 1, 2011 shall be adjusted to reflect updated wage equalization factors and overhead adjustments. The annual decrease in gross Medicaid expenditures for state fiscal year 2011/12 is ($2) million.

Effective July 1, 2011 early intervention program rates for home and community based rates for approved services rendered on and after July 1, 2011 shall be adjusted to reflect 15 minute billing increments. The annual decrease in gross Medicaid expenditures for state fiscal year 2011/12 is ($3) million.

• To clarify the previously noticed provision, the uniform payment reduction will not apply to physicians, nurse practitioners, midwives and dentists in the office setting; or to free-standing clinics and free-standing ambulatory surgery centers. The $37.5M balance of the ambulatory patient group investment will be reduced on April 1, 2011 to cover the cost of this exemption. The annual decrease in gross Medicaid expenditures for state fiscal year 2011/12 is ($12.3) million, and is included in the overall fiscal cited for the uniform across the board reduction under all services.

• Extends current provisions to services for the periods April 1, 2011 through March 31, 2011, the reimbursable operating cost component for general hospital outpatient rates and adult day health care services provided by RHCFs rates will be established with the final 2006 trend factor equal to the final consumer price index (CPI) for all urban consumers less 0.25%.

Continues, effective April 1, 2011 through March 31, 2011, certain cost containment initiatives currently in effect for Medicaid rates of payments. These are as follows: diagnostic and treatment center and certified home health agency administrative and general cost reimbursement limits; home health care Medicare maximization initiatives; hospital outpatient and emergency department reimbursement reductions attributable to exclusion of 44% of major moveable equipment capital costs; and elimination of staff housing costs.

The annual decrease in gross Medicaid expenditures for state fiscal year 2011/12 is ($53.73) million.

• Physical therapy, occupational therapy, and speech-language pathology are federal optional Medicaid services. New York State Medicaid presently covers these rehabilitation services with no limits. In order to eliminate delivery of excessive and/or unnecessary services, effective October 1, 2011, the New York State Medicaid Program is establishing utilization limits for the provision of these rehabilitation services. Enrollees will be permitted to receive up to a maximum of 20 visits in a 12 month period each for physical therapy, occupational therapy, and speech-language pathology. The utilization limits will apply to services provided by practitioners in private practice settings as well as for services provided in Article 28 certified hospital outpatient departments and diagnostic and treatment centers (free-standing clinics). The service limits will not apply to services provided in hospital inpatient settings, skilled nursing facilities, or in facilities operated by the Office of Mental Health or the Office of Persons with Developmental Disabilities. Additionally, the utilization limits will not apply for services provided to Medicaid enrollees less than 21 years of age or to enrollees who are developmentally disabled. The annual decrease in gross Medicaid expenditures for state fiscal year 2011/12 is ($4.94) million.

• Effective for dates of service on and after May 1, 2011, coverage of enteral formula and nutritional supplements for adults age 21 and over will be limited to formula administered by feeding tube or formula for treatment of an inborn metabolic disease, or to address growth and development problems in children. This will preserve coverage for medical need and eliminate coverage of orally consumed formulas for adults who can obtain nutrients through other means. The annual decrease in gross Medicaid expenditures for state fiscal year 2011/12 is ($30.8) 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 2011/2012 is ($749.12) million.

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), e-mail: spa_inquiries@health.state.ny.us

PUBLIC NOTICE

Department of Health

The Department of Health is proposing to modify its two 1115 waivers, the Partnership Plan (PP) 11-W-00114/2 and the Federal-State Health Reform Partnership (F-SHRP) 11-W-00234/2, as part of a major redesign of New York State's Medicaid program. Changes affecting the State's waiver programs are intended to streamline and maximize enrollment in managed care programs, simplify the program, improve quality of care and reduce costs.

Appendix V
2011 Title XIX State Plan
Second Quarter Amendment
Long-Term Care Facility Services
Responses to Standard Funding Questions

LONG-TERM CARE FACILITY SERVICES
State Plan Amendment #11-60

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-(A or 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 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 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 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. **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: Based on guidance from CMS, the State and CMS staff will engage in discussions to develop a strategic plan to complete the UPL demonstration for 2011.

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 approved state plan for nursing facility services is a cost based prospective payment methodology subject to ceiling. We are unaware of any requirement under current federal law or regulation that limits individual provider payments to their actual costs.

Assurances:

1. **In compliance with provisions of the Recovery Act, the State should provide assurances that they are in compliance with the terms of the Recovery Act concerning (1) Maintenance of Effort (MOE); (2) State or local match; (3) Prompt payment; (4) Rainy day funds; and (5) Eligible expenditures (e.g. no DSH or other enhanced match payments).**

   Response: The State hereby provides assurances that it remains in compliance with the terms of the Recovery Act with regard to the requirements pertaining to the maintenance of effort, State or local match, prompt payment, rainy day funds, and eligible expenditures. In addition,

the HHS Office of Inspector General has reviewed the State's compliance with the political subdivision requirement for increased FMAP under ARRA and found the State to be in compliance with this provision (Report A-02-09-01029).

2. **The State needs to verify it is in compliance with the provisions of Section 5006 of the Recovery Act concerning tribal consultations for the SPA, or an explanation why the provisions did not apply in this instance.**

   Response: In New York State, Indian Health Programs and Urban Indian Organizations do not furnish long-term care services; therefore, solicitation of advice on this issue was not applicable.

Appendix VI
2011 Title XIX State Plan
Second Quarter Amendment
Long-Term Care Facility Services
Responses to Standard Access Questions

LONG TERM CARE SERVICES
State Plan Amendment #11-60

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 will reduce the operating component of the residential health care facility rates by $27.1 million over the period May 1, 2011 through June 30, 2011. The reduction will be offset by the increase in the trend factor paid for the January 1, 2011 through March 31, 2011 period.

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) or Office of Long Term Care (OLTC), as appropriate, in order to discontinue services. These Offices monitor and consider 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.

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: 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: 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 in 2010-11, 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.