



# Department of Health

**ANDREW M. CUOMO**  
Governor

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

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

**JUN 22 2015**

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

RE: SPA #15-0027  
Long Term Care Facility Services

Dear Mr. Cooley:

The State requests approval of the enclosed amendment #15-0027 to the Title XIX (Medicaid) State Plan for long term care facility services to be effective April 1, 2015 (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). 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 proposed State statute is enclosed for your information (Appendix III). Copies of the public notice of this proposed amendment, which was given in the New York State Register on March 25, 2015, and clarified on April 22, 2015 are 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 VI, respectively).

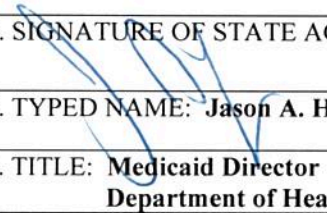
If you have any questions regarding this matter, please do not hesitate to contact John E. Ulberg, Jr., Medicaid Chief Financial Officer, Division of Finance and Rate Setting at (518) 474-6350.

Sincerely,

Jason A. Helgerson  
Medicaid Director  
Office of Health Insurance Programs

Enclosures

cc: Mr. Michael Melendez  
Mr. Tom Brady

<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</b>  <b>FOR: HEALTH CARE FINANCING ADMINISTRATION</b>		1. TRANSMITTAL NUMBER: <b>15-0027</b>	2. STATE <b>New York</b>
		3. PROGRAM IDENTIFICATION: <b>TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)</b>	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE <b>April 1, 2015</b>	
5. TYPE OF PLAN MATERIAL ( <i>Check One</i> ):  <input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT ( <i>Separate Transmittal for each amendment</i> )			
6. FEDERAL STATUTE/REGULATION CITATION: <b>§ 1902(a) of the Social Security Act, and 42 CFR 447</b>		7. FEDERAL BUDGET IMPACT: ( <i>in thousands</i> ) a. FFY 04/01/15-09/30/15 \$ (51,500.00) b. FFY 10/01/15-09/30/16 \$ (103,000.00)	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:  <b>Attachment 4.19-D: Pages 47(x)(9), 47(x)(11), 47(x)(12), 47(x)(13), 47(x)(14), 51(a)(1), 110(E)(1)</b>		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT ( <i>If Applicable</i> ):  <b>Attachment 4.19-D: Pages 47(x)(9), 47(x)(11), 47(x)(12), 47(x)(13), 47(x)(14), 51(a)(1), 110(E)(1)</b>	
10. SUBJECT OF AMENDMENT: <b>2015 LTC Cost Containment (FMAP = 50%)</b>			
11. GOVERNOR'S REVIEW ( <i>Check One</i> ): <input checked="" type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input type="checkbox"/> OTHER, AS SPECIFIED: <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL			
12. SIGNATURE OF STATE AGENCY OFFICIAL: 		16. RETURN TO: <b>New York State Department of Health Division of Finance and Rate Setting 99 Washington Ave – One Commerce Plaza Suite 1460 Albany, NY 12210</b>	
13. TYPED NAME: <b>Jason A. Helgerson</b>			
14. TITLE: <b>Medicaid Director Department of Health .</b>			
15. DATE SUBMITTED: <b>JUN 22 2015</b>			
<b>FOR REGIONAL OFFICE USE ONLY</b>			
17. DATE RECEIVED:		18. DATE APPROVED:	
<b>PLAN APPROVED – ONE COPY ATTACHED</b>			
19. EFFECTIVE DATE OF APPROVED MATERIAL:		20. SIGNATURE OF REGIONAL OFFICIAL:	
21. TYPED NAME:		22. TITLE:	
23. REMARKS:			

**Appendix I**  
**2015 Title XIX State Plan**  
**Second Quarter Amendment**  
**Amended SPA Pages**



New York  
47(x)(9)

facility days of care provided to beneficiaries of Title XVIII of the Social Security Act (Medicare), divided by the sum of such days of care plus days of care provided to residents eligible for payments pursuant to Title 11 of Article 5 of the Social Services Law minus the number of days provided to residents receiving hospice care, expressed as a percentage, for the period commencing January 1, 1999 through November 30, 1999, based on such data for such period. This value shall be called the 1999 statewide target percentage.

- (f) Prior to February 1, 2001, February 1, 2002, February 1, 2003, February 1, 2004, February 1, 2005, February 1, 2006, February 1, 2007, February 1, 2008, February 1, 2009, February 1, 2010, February 1, 2011, February 1, 2012, February 1, 2013, February 1, 2014, [and] February 1, 2015, February 1, 2016, and February 1, 2017, the Commissioner of Health [shall] will calculate the result of the statewide total of residential health care facility days of care provided to beneficiaries of Title XVIII of the Social Security Act (Medicare), divided by the sum of such days of care plus days of care provided to residents eligible for payments pursuant to Title 11 of Article 5 of the Social Services Law minus the number of days provided to residents receiving hospice care, expressed as a percentage, for the period commencing January 1, through November 30, of the prior year respectively, based on such data for such period. This value shall be called the 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, [and] 2015, 2016, and 2017 the statewide target percentage respectively.
- (2) Prior to February 1, 1996, the Commissioner of Health [shall] will calculate the results of the statewide total of health care facility

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Supersedes TN           #13-0024          

Effective Date \_\_\_\_\_

**New York  
47(x)(11)**

1996 statewide target percentage is at least two percentage points higher than the statewide base percentage, the 1996 statewide reduction percentage [shall] will be zero.

- (c) If the 1997, 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, [and] 2015, 2016, and 2017 statewide target percentages are not for each year at least three percentage points higher than the statewide base percentage, the Commissioner of Health [shall] will determine the percentage by which the statewide target percentage for each year is not at least three percentage points higher than the statewide base percentage. The percentage calculated pursuant to this paragraph [shall] will be called the 1997, 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, [and] 2015, 2016, and 2017 statewide reduction percentage respectively. If the 1997, 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, [and] 2015, 2016, and 2017 statewide target percentage for the respective year is at least three percentage points higher than the statewide base percentage, the statewide reduction percentage for the respective year [shall] will be zero.
  
- (d) If the 1999 statewide target percentage is not at least two and one-quarter percentage points higher than the statewide base percentage, the Commissioner of Health [shall] will determine the percentage by which the 1999 statewide target percentage is not at least two and one-quarter percentage points higher than the statewide base percentage. The percentage calculated pursuant to this paragraph [shall] will be called the 1999 statewide reduction percentage. If the 1999 statewide target percentage is at least two and one-quarter percentage points higher than the statewide base percentage, the 1999 statewide reduction percentage [shall] will be zero.

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**New York  
47(x)(12)**

- (4) (a) The 1995 statewide reduction percentage [shall] will be multiplied by \$34 million to determine the 1995 statewide aggregate reduction amount. If the 1995 statewide reduction percentage [shall] will be zero, there [shall] will be no reduction amount.
- (b) The 1996 statewide reduction percentage [shall] will be multiplied by \$68 million to determine the 1996 statewide aggregate reduction amount. If the 1996 statewide reduction percentage [shall] will be zero, there [shall] will be no reduction amount.
- (c) The 1997 statewide reduction percentage [shall] will be multiplied by \$102 million to determine the 1997 statewide aggregate reduction amount. If the 1997 statewide reduction percentage [shall] will be zero, there [shall] will be no 1997 reduction amount.
- (d) The 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, [and] 2015, 2016, and 2017 statewide reduction percentage [shall] will be multiplied by \$102 million respectively to determine the 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, and 2013, statewide aggregate reduction amount. If the 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, [and] 2015, 2016 and 2017 statewide reduction percentage [shall] will be zero respectively, there [shall] will be no 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, [and] 2015, 2016, and 2017 statewide reduction amount.

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**New York  
51(a)(1)**

- (g) For reimbursement of services provided to patients for the period April 1, 1995 through December 31, 1995, the trend factors established in accordance with subdivisions (d), (e) and (f) of this section [shall] will reflect no trend factor projections applicable to the period January 1, 1995 other than those reflected in 1994 rates of payment and provide further, that this subdivision [shall] will not apply to use of the trend factor for the January 1, 1995 through December 31, 1995 period, any interim adjustment to the trend factor for such period, or the final trend factor for such period for purposes of projection of allowable operating costs to subsequent rate periods. The Commissioner of Health [shall] will adjust such rates of payment to reflect the exclusion of trend factor projections pursuant to this subdivision. For reimbursement of services provided to patients effective April 1, 1996 through March 31, 1997, the rates will be established by the Commissioner of Health without trend factor adjustments, but [shall] will include the full or partial value of the retroactive impact of trend factor final adjustments for prior periods.\* For reimbursement of services provided to patients on and after April 1, 1996 through March 31, 1999 and for payments made on and after July 1, 1999 through March 31, 2011, and on and after April 1, 2011 through March 31, 2013, and on and after April 1, 2013 through March 31, 2015, and on and after April 1, 2015 through March 31, 2017, the rates [shall] will reflect no trend factor projections or adjustments for the period April 1, 1996 through March 31, 1997.
- (h) For reimbursement of nursing home services provided to patients beginning on and after April 1, 2006 through March 31, 2011, and on and after April 1, 2011 through March 31, 2013, and on and after April 1, 2013 through March 31, 2015, and on and after April 1, 2015 through March 31, 2017, the Commissioner of Health [shall] will apply a trend factor projection of 2.25% attributable to the period January 1, 2006 through December 31, 2006. Upon reconciliation of this trend factor in accordance with the previously approved state methodology, the final 2006 trend factor [shall] will be the U.S. Consumer Price Index (CPI) for all Urban Consumers, as published by the U.S. Department of Labor, Bureau of Labor Statistics, minus 0.25%.
- (i) For reimbursement of nursing home services provided on and after April 1, 2007, the Commissioner of Health [shall] will apply a trend factor equal to 75% of the otherwise applicable trend factor for calendar year 2007 as calculated in accordance with paragraph (f) of this section.

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\*This means that since the rates for the April 1, 1996 through March 31, 1997 period are based on 1983 base year costs trended to this period, the rate impacts of any differences between, say, the final value of the 1995 trend factor and the preliminary 1995 trend factor value that may have been used when initially calculating the rate, would be incorporated into the rates for the April 1, 1996 through March 31, 1997 rate period.

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**New York  
110(E)(1)**

Effective January 1, 1997, the rates of payment will be adjusted to allow costs associated with a total State assessment of 5% of facility gross revenues which [shall] will be a reimbursable cost to be included in calculating rates of payment. Effective March 1, 1997, the reimbursable assessment will be 3.1%. Effective April 1, 1997, the total reimbursable state assessment to be included in calculating rates of payment will be 4.8%. Effective April 1, 1999 through December 31, 1999, the total reimbursable state assessment of 2.4% of gross revenues as paid by facilities [shall] will be included in calculating rates of payment. Effective April 1, 2002 through March 31, 2003, April 1, 2003 through March 31, 2005, [and] April 1, 2005 through March 31, 2013, and April 1, 2013 through March 31, 2015, and April 1, 2015 through March 31, 2017 the total reimbursable state assessment on each residential health care facility's gross receipts received from all patient care services and other operating income on a cash basis for hospital or health-related services, including adult day service, but excluding, effective October 1, 2002, gross receipts attributable to payments received pursuant to Title XVIII of the federal Social Security Act (Medicare), [shall] will be 6%, 5%, and 6%, respectively.

The reimbursable operating costs of facilities for purposes of calculating the reimbursement rates will be increased prospectively, beginning July 1, 1992, to reflect an estimate of the provider cost for the assessment for the period, provided, however, that effective October 1, 2002 the adjustment to rates of payment made pursuant to this paragraph shall be calculated on a per diem basis and based on total reported patient days of care minus reported days attributable to Title XVIII of the federal social security act (Medicare) units of service. As soon as practicable after the assessment period, an adjustment will be made to RHCF rates of payments applicable within the assessment period, based on a reconciliation of actual assessment payments to estimated payments.<sup>1</sup>

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<sup>1</sup>The extent to which a facility is reimbursed for the additional cost of the assessment is dependent upon Medicaid volume of services.

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**Appendix III**  
**2015 Title XIX State Plan**  
**Second Quarter Amendment**  
**Authorizing Provisions**



SPA 15-0027

CHAPTER 57 OF THE LAWS OF 2015

PART D

§ 3. Subparagraph (vi) of paragraph (b) of subdivision 2 of section 2807-d of the public health law, as amended by section 5 of part B of chapter 56 of the laws of 2013, is amended to read as follows:

(vi) Notwithstanding any contrary provision of this paragraph or any other provision of law or regulation to the contrary, for residential health care facilities the assessment shall be six percent of each residential health care facility's gross receipts received from all patient care services and other operating income on a cash basis for the period April first, two thousand two through March thirty-first, two thousand three for hospital or health-related services, including adult day services; provided, however, that residential health care facilities' gross receipts attributable to payments received pursuant to title XVIII of the federal social security act (medicare) shall be excluded from the assessment; provided, however, that for all such gross receipts received on or after April first, two thousand three through March thirty-first, two thousand five, such assessment shall be five percent, and further provided that for all such gross receipts received on or after April first, two thousand five through March thirty-first, two thousand nine, and on or after April first, two thousand nine through March thirty-first, two thousand eleven such assessment shall be six percent, and further provided that for all such gross receipts received on or after April first, two thousand eleven through March thirty-first, two thousand thirteen such assessment shall be six percent, and further provided that for all such gross receipts received on or after April first, two thousand thirteen through March thirty-first, two thousand fifteen such assessment shall be six percent, and further provided that for all such gross receipts received on or after April first, two thousand fifteen through March thirty-first, two thousand seventeen such assessment shall be six percent.

§ 5. Subdivision 1 of section 194 of chapter 474 of the laws of 1996, amending the education law and other laws relating to rates for residential health care facilities, as amended by section 9 of part B of chapter 56 of the laws of 2013, is amended to read as follows:

1. Notwithstanding any inconsistent provision of law or regulation, the trend factors used to project reimbursable operating costs to the rate period for purposes of determining rates of payment pursuant to article 28 of the public health law for residential health care facilities for reimbursement of inpatient services provided to patients eligible for payments made by state governmental agencies on and after April 1, 1996 through March 31, 1999 and for payments made on and after July 1, 1999 through March 31, 2000 and on and after April 1, 2000 through March 31, 2003 and on and after April 1, 2003 through March 31, 2007 and on and after April 1, 2007 through March 31, 2009 and on and after April 1, 2009 through March 31, 2011 and on and after April 1, 2011 through March 31, 2013 and on and after April 1, 2013 through March 31, 2015,

and on and after April 1, 2015 through March 31, 2017 shall reflect no trend factor projections or adjustments for the period April 1, 1996, through March 31, 1997.

§ 6. Subdivision 1 of section 89-a of part C of chapter 58 of the laws of 2007, amending the social services law and other laws relating to enacting the major components of legislation necessary to implement the health and mental hygiene budget for the 2007-2008 state fiscal year, as amended by section 10 of part B of chapter 56 of the laws of 2013, is amended to read as follows:

1. Notwithstanding paragraph (c) of subdivision 10 of section 2807-c of the public health law and section 21 of chapter 1 of the laws of 1999, as amended, and any other inconsistent provision of law or regulation to the contrary, in determining rates of payments by state governmental agencies effective for services provided beginning April 1, 2006, through March 31, 2009, and on and after April 1, 2009 through March 31, 2011, and on and after April 1, 2011 through March 31, 2013, and on and after April 1, 2013 through March 31, 2015, and on and after April 1, 2015 through March 31, 2017 for inpatient and outpatient services provided by general hospitals and for inpatient services and outpatient adult day health care services provided by residential health care facilities pursuant to article 28 of the public health law, the commissioner of health shall apply a trend factor projection of two and twenty-five hundredths percent attributable to the period January 1, 2006 through December 31, 2006, and on and after January 1, 2007, provided, however, that on reconciliation of such trend factor for the period January 1, 2006 through December 31, 2006 pursuant to paragraph (c) of subdivision 10 of section 2807-c of the public health law, such trend factor shall be the final US Consumer Price Index (CPI) for all urban consumers, as published by the US Department of Labor, Bureau of Labor Statistics less twenty-five hundredths of a percentage point.

§ 7. Paragraph (f) of subdivision 1 of section 64 of chapter 81 of the laws of 1995, amending the public health law and other laws relating to medical reimbursement and welfare reform, as amended by section 11 of part B of chapter 56 of the laws of 2013, is amended to read as follows: (f) Prior to February 1, 2001, February 1, 2002, February 1, 2003, February 1, 2004, February 1, 2005, February 1, 2006, February 1, 2007, February 1, 2008, February 1, 2009, February 1, 2010, February 1, 2011, February 1, 2012, February 1, 2013 [and], February 1, 2014 [and], February 1, 2015, February 1, 2016 and February 1, 2017 the commissioner of health shall calculate the result of the statewide total of residential health care facility days of care provided to beneficiaries of title XVIII of the federal social security act (medicare), divided by the sum of such days of care plus days of care provided to residents eligible for payments pursuant to title 11 of article 5 of the social services law minus the number of days provided to residents receiving hospice care, expressed as a percentage, for the period commencing January 1, through November 30, of the prior year respectively, based on such data for such period. This value shall be called the 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014 [and], 2015, 2016 and 2017 statewide target percentage respectively.



§ 8. Subparagraph (ii) of paragraph (b) of subdivision 3 of section 64 of chapter 81 of the laws of 1995, amending the public health law and other laws relating to medical reimbursement and welfare reform, as amended by section 12 of part B of chapter 56 of the laws of 2013, is amended to read as follows:

(ii) If the 1997, 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014 [and], 2015, 2016 and 2017 statewide target percentages are not for each year at least three percentage points higher than the statewide base percentage, the commissioner of health shall determine the percentage by which the statewide target percentage for each year is not at least three percentage points higher than the statewide base percentage. The percentage calculated pursuant to this paragraph shall be called the 1997, 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014 [and], 2015, 2016 and 2017 statewide reduction percentage respectively. If the 1997, 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013[+], 2014 [and], 2015, 2016 and 2017 statewide target percentage for the respective year is at least three percentage points higher than the statewide base percentage, the statewide reduction percentage for the respective year shall be zero.

§ 9. Subparagraph (iii) of paragraph (b) of subdivision 4 of section 64 of chapter 81 of the laws of 1995, amending the public health law and other laws relating to medical reimbursement and welfare reform, as amended by section 13 of part B of chapter 56 of the laws of 2013, is amended to read as follows:

(iii) The 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014 [and], 2015, 2016 and 2017 statewide reduction percentage shall be multiplied by one hundred two million dollars respectively to determine the 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014 [and], 2015, 2016 and 2017 statewide aggregate reduction amount. If the 1998 and the 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014 [and], 2015, 2016 and 2017 statewide reduction percentage shall be zero respectively, there shall be no 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014 [and], 2015, 2016 and 2017 reduction amount.



**Appendix IV  
2015 Title XIX State Plan  
Second Quarter Amendment  
Public Notice**

- Certification that such applicant has less than 15 days cash and equivalents;

- Such applicant has no assets that can be monetized other than those vital to operations; and

- Such applicant has exhausted all efforts to obtain resources from corporate parents and affiliated entities to sustain operations.

- For those applicants meeting such criteria, awards shall be made upon application to the Department of Health. Such awards shall include a multi-year transformation plan that is aligned with the Delivery System Reform Incentive Program (DSRIP) program goals and objectives which must be approved by the Department and demonstrate a path towards long term sustainability and improved patient care.

- Initial award payments to eligible applicant may be based solely on the aforementioned criteria; however, the Department may suspend or repeal an award if the eligible applicant fails to submit a multi-year transformation plan that is acceptable to the Department by no later than September 30, 2015.

- Applicants also must detail the extent to which the affected community has been engaged or consulted on potential projects within the application, as well as any outreach to stakeholder and health plans.

- Applications shall be reviewed by the Department to determine an applicant's eligibility; each applicant's projected financial status; each applicant's proposed use of funds to maintain critical services needed by the community; and the anticipated impact of the loss of such services.

- The Department, after review of all applications and determination of the aggregate amount of requested funds, shall make awards to eligible applicants; provided, however, that such awards may be in an amount lower than such requested funding, on a per applicant or aggregate basis.

- Awards issued may not be used for: capital expenditures, including, but not limited to construction, renovation and acquisition of capital equipment, including major medical equipment; consultant fees; retirement of long term debt; or bankruptcy-related costs.

- Payments made to awardees shall be made on a monthly basis. Such payments will be based on the applicant's actual monthly financial performance during such period and the reasonable cash amount necessary to sustain operations for the following month. The applicant's monthly financial and activity reports, which shall include, but not be limited to: actual revenue and expenses for the prior month, projected cash need for current month, and projected need for the following month.

#### Long Term Care Services

##### LTC Cost Containment – Eliminate 96/97 Trend Factor Clarification (Part D/5)

- Clarifies, rates of payment for RHCs shall not reflect trend factor projections or adjustments for the period April 1, 1996 through March 31, 1997 and continues the provision effective on and after April 1, 2015 through March 31, 2017.

##### LTC Cost Containment – Continuation of .25 Trend Reduction Clarification (Part D/6)

- Clarifies, the reimbursable operating cost component for RHCs 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% and extends current provisions to services on and after April 1, 2015 through March 31, 2017.

##### LTC Cost Containment – NH Medicare Maximization Clarification (Part D/7-9)

- Clarifies, long-term care Medicare maximization initiatives will continue effective April 1, 2015 through March 31, 2017.

The estimated annual net decrease in gross Medicaid expenditures attributable to these cost containment initiatives contained in the budget for state fiscal year 2015/2016 is \$117 million.

##### NH Cash Assessment Extension Clarification (Part D/3)

- Clarifies, the total reimbursable state assessment on each residential health care facility's gross receipts received from all patient care services and other operating income on a cash basis for inpatient or

health-related services, including adult day service, but excluding gross receipts attributable to payments received pursuant to Title XVIII of the federal Social Security Act (Medicare), at six percent will be effective for periods April 1, 2015 through March 31, 2017. The extent to which a facility is reimbursed for the additional cost of the assessment is dependent upon Medicaid volume of services.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2015/2016 is \$420 million.

##### Spousal Support Clarification (Part B/33)

- The initiative previously noticed regarding medical assistance being furnished to applicants in cases where, although such applicant has a responsible relative with sufficient income and resources to provide medical assistance, the income and resources of the responsible relative are not available to such applicant because of the absence of such relative and the refusal or failure of such absent relative to provide the necessary care and assistance was eliminated from the budget for state fiscal year 2015/2016.

##### Young Adult (Part B/47)

- Effective on or after April 1, 2015, the Commissioner of Health shall establish up to three young adult special populations demonstration programs to provide cost effective, necessary services and enhanced quality of care for targeted populations. Eligible individuals included in the programs shall have severe and chronic medical or health problems or multiple disabling conditions which may be combined with developmental disabilities. Such programs shall provide more appropriate settings and services for these individuals, help prevent out of state placements and allow repatriation back to their home communities. Eligible operators of such programs must have demonstrated expertise in caring for the targeted population and have a record of providing quality care.

- Funds for such programs may include, but not be limited to start up funds, capital investments and enhanced rates.

- Of the demonstrations at least one program shall be designed to serve persons ages 21-35 who are aging out of pediatric acute care hospitals or nursing homes; and at least one program shall be designed to serve persons 21-35 who have a developmental disability in addition to their severe and chronic medical or health problems and who are aging out of pediatric acute care hospitals, pediatric nursing homes or children's residential homes operated under the New York State Office for Persons With Developmental Disabilities.

- The Department of Health shall be responsible for monitoring the quality, appropriateness, and effectiveness of such programs.

The estimated annual net increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal years 2015/2016 and 2016/2017 is \$2M for each state fiscal year.

##### Refinancing/Shared Savings (Part B/52)

- Effective on or after April 1, 2015, for facilities with operating certificates granted on or after March 10, 1975, real property costs shall be based on historical costs to the owner of the facility, provided payment for real property costs shall not be in excess of the actual debt service, including principal and interest, and payment with respect to owners' equity.

- Owners' equity shall be calculated without regard to any surplus created by revaluation of assets and shall not include amounts resulting from mortgage amortization where the payment has been provided by real property cost reimbursement.

- Further provided, the Commissioner of Health may modify such payments for real property cases for purposes of effectuating a shared savings program where facilities share a minimum of 50% of savings, for those facilities that elect to refinance their mortgage loans.

There is no additional estimated annual change to gross Medicaid expenditures attributable to this initiative for state fiscal year 2015/2016.

##### ATB 1% Give Back

- Clarifies, while alternative methods of cost containment continue, as partial restoration of the two per cent annual uniform reduction of Medicaid payments which was noticed on March 26, 2014, across the



expenditures attributable to this initiative contained in the budget for state fiscal year 2015/2016 is \$21.4 million.

- Continues, effective April 1, 2015, and thereafter, 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 on and after April 1, 2015, 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, 2015, and thereafter, long-term care Medicare maximization initiatives.

The estimated annual net decrease in gross Medicaid expenditures attributable to these cost containment initiatives contained in the budget for state fiscal year 2015/2016 is \$117 million.

- Continues, effective for periods on and after April 1, 2015, the total reimbursable state assessment on each residential health care facility's gross receipts received from all patient care services and other operating income on a cash basis for inpatient or health-related services, including adult day service, but excluding gross receipts attributable to payments received pursuant to Title XVIII of the federal Social Security Act (Medicare), at six percent. The extent to which a facility is reimbursed for the additional cost of the assessment is dependent upon Medicaid volume of services.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2015/2016 is \$420 million.

- For state fiscal years beginning April 1, 2015, continues additional payments to non-state government operated public residential health care facilities, including public residential health care facilities located in Nassau, Westchester, and Erie counties, but excluding public residential health care facilities operated by a town or city within a county, in aggregate amounts of up to \$500 million. The amount allocated to each eligible public RHCFS will be in accordance with the previously approved methodology, provided, however that patient days shall be utilized for such computation reflecting actual reported data for 2013 and each representative succeeding year as applicable. Payments to eligible RHCFS may be added to rates of payment or made as aggregate payments.

- Effective with the 2013 rate year, the Department of Health provided a new incentive to improve quality for non-specialty nursing homes by linking incentive payments to quality. Under the program, nursing homes are scored and compared on a define set of quality measures. This amendment will maintain the quality incentive program into the 2015 rate year and will continue to recognize improvement in performance as an element in the program and provide for other minor modifications.

#### Non-Institutional Services

- For state fiscal year beginning April 1, 2015 through March 31, 2016, continues hospital outpatient payment adjustments that increase the operating cost components of rates of payment for hospital outpatient and emergency departments on and after April 1, 2011, for public general hospitals other than those operated by the State of New York or the State University of New York, which are located in a city with a population of over one million. The amount to be paid will be up to \$287 million annually based on criteria and methodology set by the Commissioner of Health, which the Commissioner may periodically set through a memorandum of understanding with the New York City Health and Hospitals Corporation. Such adjustments shall be paid by means of one or more estimated payments, which shall be reconciled to the final adjustment determinations after the disproportionate share hospital payment adjustment caps have been calculated for such period under sections 1923(f) and (g) of the federal Social Security Act. Payments may be added to rates of payment or made as aggregate payments.

- Extends current provisions to services on and after April 1, 2013, 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%.

- Extends current provisions for certified home health agency administrative and general cost reimbursement limits for the periods April 1, 2015 through March 31, 2018.

- Continues, effective April 1, 2015, and thereafter, home health care Medicare maximization initiatives.

The estimated annual net decrease in gross Medicaid expenditures attributable to these cost containment initiatives contained in the budget for state fiscal year 2015/2016 is \$17.8 million.

- Effective April 1, 2015, in accordance with 42 CFR 447.56, "Limitations on Premiums and Cost Sharing", which requires that State Medicaid fee-for-service (FFS) co-payment policies have to be applied consistently across all Medicaid payers including managed care. The State Plan is being amended to expand Medicaid co-payment requirements to eligible Medicaid managed care (MMC) beneficiaries for eligible procedures, services and supplies. Specifically, the non-pharmacy services in which Medicaid managed care co-payments will apply include: clinic and non-urgent Emergency Department visits (\$3.00), lab tests (\$0.50), radiology (\$1.00), medical supplies (\$1.00), and inpatient hospitalizations (\$25.00). Consistent with the current co-payment policy, children under age 21; pregnant women; American Indians; and recipients with incomes at or below 100% of the Federal Poverty Level (FPL) will not be subject to co-payments. Additionally, the \$200 Medicaid cap that limits the total co-payment amount a recipient can be charged on annual basis will apply to both FFS and managed care. Pharmacy co-payments currently apply to managed care recipients for new prescriptions, fiscal orders and refills.

The estimated annual net aggregate decrease in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2015/2016 is \$1.9 million.

- Effective April 1, 2015, in accordance with an amendment to Section 367-a(1)(d)(iii) of the Social Services Law, cost-sharing limits will be applied to Medicare Part B cross-over services. Such limits are being applied to prevent the Medicaid program from paying any cost-sharing amount more than the maximum amount that Medicaid would pay for the same service.

Currently, Medicare Part B, which provides medical insurance for professional practitioners' services, reimburses the provider 80% of the Medicare approved amount. The remaining 20% is the Medicare Part B coinsurance or patient responsibility amount. The Medicaid program then reimburses the provider 20% of the coinsurance amount even if the Medicare payment exceeds what the Medicaid program would have paid for the same service. Under the new limitations, the Medicaid program would not pay any cost sharing if the provider received payment greater than the Medicaid fee. Under the new limitations, the Medicaid program would not pay any cost sharing if the provider received payment greater than the Medicaid fee. The provider would be required to accept the Medicare payment as full payment for the service and the recipient could not billed for any co-insurance amount that is not reimbursed by Medicaid.

The estimated annual net aggregate decrease in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2015/2016 is \$49.7 million.

- Effective April 1, 2015, in accordance with an amendment to Section 367-a(1)(d)(iv) of the Social Services Law, cost-sharing limits will be applied to Medicare Part C (Medicare Advantage or Medicare managed care) claims. Such limits are being applied to prevent the Medicaid program from paying any cost-sharing amount more than the maximum amount that Medicaid would pay for the same service.

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

In FFS Medicaid, the state reduces the payment it makes to a provider by the amount of a beneficiary's cost sharing obligation.



**Appendix V**  
**2015 Title XIX State Plan**  
**Second Quarter Amendment**  
**Responses to Standard Funding Questions**

**APPENDIX V**  
**LONG TERM CARE SERVICES**  
**State Plan Amendment #15-0027**

**CMS Standard Funding Questions (NIRT Standard Funding Questions)**

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

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

**Response:** Providers do retain the payments made pursuant to this amendment. However, this requirement in no way prohibits the public provider, including county providers, from reimbursing the sponsoring local government for appropriate expenses incurred by the local government on behalf of the public provider. The State does not regulate the financial relationships that exist between public health care providers and their sponsoring governments, which are extremely varied and complex. Local governments may provide direct and/or indirect monetary subsidies to their public providers to cover on-going unreimbursed operational expenses and assure achievement of their mission as primary safety net providers. Examples of appropriate expenses may include payments to the local government which include reimbursement for debt service paid on a provider's behalf, reimbursement for Medicare Part B premiums paid for a provider's retirees, reimbursement for contractually required health benefit fund payments made on a provider's behalf, and payment for overhead expenses as allocated per federal Office of Management and Budget Circular 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:** The State and CMS are having ongoing discussions to resolve remaining issues with the 2014 nursing home UPL, which the 2015 UPL will be contingent upon.

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

#### **ACA Assurances:**

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

#### **MOE Period.**

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

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

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

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

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



**Appendix VI**  
**2015 Title XIX State Plan**  
**Second Quarter Amendment**  
**Responses to Standard Access Questions**

**APPENDIX VI  
LONG TERM CARE SERVICES  
State Plan Amendment 15-0027**

**CMS Standard Access Questions**

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

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

**Response:** This amendment seeks to permanently continue cost saving measures previously enacted. This is an overall effort to control Medicaid Spending. The change should not significantly impact providers since overall rates are being constant, not being reduced.

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

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

For providers that are not subject to an approval process, the State will continue to monitor provider complaint hotlines to identify geographic areas of concern and/or service type needs. If Medicaid beneficiaries begin to encounter access issues, the Department would expect to see a marked increase in complaints. These complaints will be identified and analyzed in light of the changes proposed in this State Plan Amendment.

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



the State would be alerted and would take appropriate action to ensure retention of access to such services.

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

**Response:** This change was enacted by the State Legislature as part of the negotiation of the 2015-16 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, 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. 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.