



Department of Health

ANDREW M. CUOMO
Governor

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

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

JUN 26 2015

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

RE: SPA #15-0043
Long Term Care Facility Services

Dear Mr. Cooley:

The State requests approval of the enclosed amendment #15-0043 to the Title XIX (Medicaid) State Plan for long term care facility services to be effective April 23, 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).

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 April 22, 2015, 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., Medicaid Chief Financial Officer, Division of Finance and Rate Setting at (518) 474-6350.

Sincerely,

Jason A. Helgeson
Medicaid Director
Office of Health Insurance Programs

Enclosures

cc: Mr. Michael Melendez
Mr. Tom Brady

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL**

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER:
15-0043

2. STATE
New York

3. PROGRAM IDENTIFICATION: **TITLE XIX OF THE
SOCIAL SECURITY ACT (MEDICAID)**

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
April 23, 2015

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: (in thousands)
a. FFY 04/23/15-09/30/15 (\$22,750)
b. FFY 10/01/15-09/30/16 (\$45,500)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-D: 51(a)(2)

9. PAGE NUMBER OF THE SUPERSEDED PLAN
SECTION OR ATTACHMENT (If Applicable):
Attachment 4.19-D: 51(a)(2)

10. SUBJECT OF AMENDMENT:
**Eliminate Trend Factor Adjustments - LTC
(FMAP = 50%)**

11. GOVERNOR'S REVIEW (Check One):

- GOVERNOR'S OFFICE REPORTED NO COMMENT OTHER, AS SPECIFIED:
 COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
 NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME: **Jason A. Helgeson**

14. TITLE: **Medicaid Director
Department of Health**

15. DATE SUBMITTED: **JUN 26 2015**

16. RETURN TO:

**New York State Department of Health
Division of Finance and Rate Setting
99 Washington Ave - One Commerce Plaza
Suite 1460
Albany, NY 12210**

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED:

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:

22. TITLE:

23. REMARKS:

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

**New York
51(a)(2)**

- (k) For rates of payment effective for nursing home services provided on and after January 1, 2009 through March 31, 2009, the otherwise final trend factor attributable to the 2008 calendar year period shall be adjusted such that any increase to the average trend factor for the period April 1, 2008 through December 31, 2008 shall be reduced, on an annualized basis, by 1.3% and no retroactive adjustment to such 2008 trend factor shall be made for the period April 1, 2008 through December 31, 2008. Effective on and after April 1, 2009, the otherwise applicable final trend factor attributable to the 2008 calendar year period shall be zero.
- (l) For rates of payment effective for nursing home services provided on and after January 1, 2009 through March 31, 2009, a trend factor equal to the otherwise applicable trend factor attributable to the period January 1, 2009 through December 31, 2009, as calculated in accordance with paragraph (f) of this section, less 1% shall be applied. Effective on and after April 1, 2009, the otherwise applicable trend factor attributable to the 2009 calendar year period shall be zero.
- (m) For rates of payment effective for nursing home services provided for the period January 1, 2010 through March 31, 2010, the otherwise applicable trend factor attributable to the 2010 calendar year period shall be zero.
- (n) For rates of payment effective for inpatient services provided by residential health care facilities on or after April 1, 2010, except for residential health care facilities that provide extensive nursing, medical, psychological, and counseling support services to children, the otherwise applicable trend factors attributable to:
 - i. the 2010 through 2012 calendar year periods shall be no greater than zero.
 - ii. the 2013 and 2014 calendar year periods shall be no greater than zero.
 - iii. the 2015 calendar year period shall be no greater than zero for rates effective for the period January 1, 2015 through March 31, 2015[.] and April 23, 2015 through December 31, 2015.
 - iv. the 2016 calendar year period shall be no greater than zero.
 - v. the 2017 calendar year period shall be no greater than zero for rates effective for the period January 1, 2017 through March 31, 2017.

Effective July 1, 1994, payment rates for the 1994 rate setting cycle will be calculated using the proxy data described in this section that is available through the third quarter of 1993. Proxy data, which becomes available subsequent to the third quarter of 1993, will not be considered in setting or adjusting 1994 payment rates.

TN #15-0043 _____

Approval Date _____

Supersedes TN #13-0032 _____

Effective Date _____

Appendix II
2015 Title XIX State Plan
Second Quarter Amendment
Summary

SUMMARY
SPA #15-0043

This State Plan Amendment proposes to limit the trend factor to an amount no greater than zero for nursing home services provided on and after April 1, 2015 through March 31, 2017.

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

SPA 15-0042

Chapter 57 of the Laws of 2015

Part D

§29. Section 4-a of part A of chapter 56 of the laws of 2013 amending chapter 59 of the laws of 2011 amending the public health law and other laws relating to general hospital reimbursement for annual rates relating to the cap on local Medicaid expenditures, is amended to read as follows:

§ 4-a. Notwithstanding paragraph (c) of subdivision 10 of section 2807-c of the public health law, section 21 of chapter 1 of the laws of 1999, or any other contrary provision of law, in determining rates of payments by state governmental agencies effective for services provided on and after January 1, ~~2015~~ 2017 through March 31, ~~2015~~ 2017, for inpatient and outpatient services provided by general hospitals, for inpatient services and adult day health care outpatient services provided by residential health care facilities pursuant to article 28 of the public health law, except for residential health care facilities or units of such facilities providing services primarily to children under twenty-one years of age, for home health care services provided pursuant to article 36 of the public health law by certified home health agencies, long term home health care programs and AIDS home care programs, and for personal care services provided pursuant to section 365-a of the social services law, the commissioner of health shall apply no greater than zero trend factors attributable to the ~~2015~~ 2017 calendar year in accordance with paragraph (c) of subdivision 10 of section 2807-c of the public health law, provided, however, that such no greater than zero trend factors attributable to such ~~2015~~ 2017 calendar year shall also be applied to rates of payment provided on and after January 1, ~~2015~~2017 through March 31, ~~2015~~ 2017 for personal care services provided in those local social services districts, including New York city, whose rates of payment for such services are established by such local social services districts pursuant to a rate-setting exemption issued by the commissioner of health to such local social services districts in accordance with applicable regulations, and provided further, however, that for rates of payment for assisted living program services provided on and after January 1, ~~2015~~ 2017 through March 31, ~~2015~~ 2017, such trend factors attributable to the ~~2015~~ 2017 calendar year shall be established at no greater than zero percent.

§ 29-a. Notwithstanding paragraph (c) of subdivision 10 of section 2807-c of the public health law, section 21 of chapter 1 of the laws of 1999, or any other contrary provision of law, in determining rates of payments by state governmental agencies effective for services provided on and after January 1, 2015, for inpatient and outpatient services provided by general hospitals, for inpatient services and adult day health care outpatient services provided by residential health care facilities pursuant to article 28 of the public health law, except for residential health care facilities or units of such facilities providing services primarily to children under twenty-one years of age, for home health care services provided pursuant to article 36 of the public health law by certified home health agencies, long term home health care programs and AIDS home care programs, and for personal care services provided pursuant to section 365-a of the social services law, the commissioner of health shall apply no

greater than zero trend factors attributable to the 2015 and 2016 calendar year in accordance with paragraph(c) of subdivision 10 of section 2807-c of the public health law, provided, however, that such no greater than zero trend factors attributable to such 2015 and 2016 calendar year shall also be applied to rates of payment provided on and after January 1, 2015 for personal care services provided in those local social services districts, including New York city, whose rates of payment for such services are established by such local social services districts pursuant to a rate-setting exemption issued by the commissioner of health to such local social services districts in accordance with applicable regulations, and provided further, however, that for rates of payment for assisted living Program services provided on and after January 1, 2015, such trend factors attributable to the 2015 and 2016 calendar year shall be established at no greater than zero percent.

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

MISCELLANEOUS NOTICES/HEARINGS

Notice of Abandoned Property Received by the State Comptroller

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

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

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

PUBLIC NOTICE 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 and prescription drugs to comply with recently proposed statutory provisions. The following provides clarification to provisions previously noticed on March 25, 2015, unless otherwise indicated, and notification of new significant changes.

All Services

Permanently Eliminate Trend Factors Clarification (Part D/29-a)

- As previously noticed March 27, 2013, clarifies, effective on and after January 1, 2015, no greater than zero trend factors attributable to the 2015 and 2016 calendar year pursuant to the provisions of Public Health Law § 2807-c(10)(c) to rates of payment for hospital inpatient and outpatient services, inpatient and adult day health care outpatient services provided by residential health care facilities pursuant to Article 28 of the Public Health Law, except for residential health care facilities or units of such facilities providing services primarily to children under 21 year of age, certified home health agencies, AIDS home care programs, and for personal care services pursuant to section 365-a of the Social Services Law, including personal care services provided in those local social services districts, including New York City, whose rates of payment for services is established by such social services districts pursuant to a rate-setting exemption granted by the Department, and assisted living program services.

The annual decrease in gross Medicaid expenditures for state fiscal year 2015/16 is (\$436.4) million.

VAP Award Criteria Considerations (Part B/51)

- Effective on or after April 1, 2015, the Commissioner of Health shall consider criteria for vital access provider (VAP) applications submitted to the Department that includes, but is not limited to:

- The applicant's financial condition as evidenced by operating margins, negative fund balance or negative equity position;

- The extent to which the applicant fulfills or will fulfill an unmet health care need for acute inpatient, outpatient primary or residential health care services in a community;

- The extent to which the application will involve savings to the Medicaid program;

- The quality of the application as evidenced by such application's long term solutions for such applicant to achieve sustainable health care services, improving the quality of patient care, and/or transforming the delivery of health care services to meet community needs;

- The extent to which such applicant is geographically isolated in relation to other providers; or

- The extent to which such applicant provides services to an underserved area in relation to other providers.

Institutional Services

- IP Cost Containment - Appropriately Allocate Capital Costs Clarification (Part D/2)

- Clarifies, 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, will continue effective April 1, 2015 through March 31, 2017.

- IP Cost Containment - Continuation of .25 Trend Reduction Clarification (Part D/6)

- Clarifies, 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% and extends current provisions for services on and after 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 \$114.5 million.

- Hospital VAP Applications for Financially Distressed (Additional Article VII)

- Effective for the periods of April 1, 2015 through March 31, 2016, the Commissioner of Health may award a temporary adjustment to the non-capital component of rates, or make temporary lump-sum medical assistance payments to eligible general hospitals in severe financial distress to enable such facilities to maintain operations and vital services while such facilities establish long term solutions to achieve sustainable health services. Eligible general hospitals shall include: a public general hospital operated by a county or municipality, but shall exclude any such hospital operated by a public benefit corporation; a federally designated critical access hospital; a federally designated sole community hospital; or a general hospital that is a safety net hospital.

- A safety net hospital shall be defined as having at least 30% of its inpatient discharges made up of Medicaid eligible individuals, uninsured individuals or Medicaid dually-eligible individuals; or

- Such hospital must serve at least 30% of the residents of a county or a multi-county area who are Medicaid eligible individuals, uninsured individuals or Medicaid dually-eligible individuals.

- Eligible applicants must demonstrate that without such award, they will be in severe financial distress through March 31, 2016. Evidence of such distress will be by:

- 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

board rate increases of one half the value of monies collected under such cost containment measures will be made.

Non-institutional Services

Non-institutional Cost Containment – Continuation of .25 Trend Reduction Clarification (Part D/6)

- Clarifies, the reimbursable operating cost component for general hospital outpatient rates and adult day health care services provided by 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.

Non-institutional Cost Containment – CHHA A&G Cap Clarification (Part D/11-12)

- Clarifies, for certified home health agency administrative and general cost reimbursement limits, current provisions will be extended for the periods on and after April 1, 2015 through March 31, 2017.

Non-institutional Cost Containment – Home Care Medicare Max Clarification (Part D/10)

- Clarifies, home health 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 \$17.8 million.

Apply Cost-Sharing Limits for Medicare Part C Cross-Over Services Clarification (Part B/32)

- The initiative previously noticed to apply cost sharing limits for Medicare Part C cross over services was eliminated from the budget for state fiscal year 2015/2016.

CHHA Episodic Payment Extender (Part D/22)

- Continues, effective on and after April 1, 2015 through March 31, 2019, payments by government agencies for services provided by certified home health agencies, except for such services provided to children under 18 and other discreet groups, shall be based on episodic payments. A statewide base price, for such payments, shall be established for each 60-day episode of patient care and adjusted by a regional wage index factor and an individual patient case mix index. Such episodic payments may be further adjusted for low utilization cases and to reflect a percentage limitation of the cost for high utilization cases that exceed outlier thresholds of such payments.

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

Annual Supplemental Assistance Payment for Emergency Medicaid Transportation (Part B/53)

Effective on and after April 1, 2015, provides a supplemental medical assistance payment to providers of emergency medical transportation not to exceed \$6 million in state fiscal year 2015/2016.

Apply Cost-Sharing Limits for Medicare Part B Cross-Over Services Clarification (Part B/31)

- Clarifies the initiative related to cost-sharing limits will be applied to Medicare Part B cross-over services will now be effective July 1, 2015.

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.

Prescription Drugs

AWP Discount for Brand Name Drugs & Dispensing Fee Adjustment Clarification (Part B/2-3)

- The initiative for the Average Wholesale Price (AWP) for sole or multiple source brand name drugs and the dispensing fee for such was eliminated from the budget for state fiscal year 2015/2016.

340B Drugs Clarification (Part B/7)

- The initiative previously noticed related to claims for payment of outpatient prescription drugs submitted to a managed care provider by a covered entity pursuant to section 340B of the federal public health service act (42 USCA § 256b) was eliminated from the budget for state fiscal year 2015/2016.

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

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

For further information and to review and comment, please contact: Department of Health, Bureau of Federal Relations & Provider Assessments, 99 Washington Ave. – One Commerce Plaza, Suite 1460, Albany, NY 12210, or e-mail: spa_inquiries@health.state.ny.us

PUBLIC NOTICE

**New York State and Local Retirement Systems
Unclaimed Amounts Payable to Beneficiaries**

Pursuant to the Retirement and Social Security Law, the New York State and Local Retirement Systems hereby gives public notice of the amounts payable to beneficiaries.

The State Comptroller, pursuant to Sections 109(a) and 409(a) of the Retirement and Social Security Law has received, from the New York State and Local Retirement Systems, a listing of beneficiaries or estates having unclaimed amounts in the Retirement System. A list of the names contained in this notice is on file and open to public inspection at the office of the New York State and Local Retirement Systems located at 110 State St., in the City of Albany, New York.

Set forth below are the names and addresses (last known) of beneficiaries and estates appearing from the records of the New York State and Local Retirement Systems, entitled to the unclaimed benefits.

At the expiration of six months from the date of publication of this list of beneficiaries and estates, unless previously paid to the claimant, the amounts shall be deemed abandoned and placed in the pension accumulation fund to be used for the purpose of said fund.

Any amounts so deemed abandoned and transferred to the pension accumulation fund, may be claimed by the executor or administrator of the estates or beneficiaries so designated to receive such amounts, by filing a claim with the State Comptroller. In the event such claim is properly made, the State Comptroller shall pay over to the estates or to the person or persons making such claim, the amount without interest.

- ABRAMTSEV, CHRISTINA T ESTATE OF MOUNT KISCO NY
- ACKERMAN, CARL W ESTATE OF LAKE HAVASU CITY AZ
- ADAMS, ROBYN L SPARTANBURG SC
- ADCOCK, BEULAH M ESTATE OF PHOENIX NY
- ADLER, GORDON ELIZABETH CO
- AIELLO, VERA UTICA NY
- ALIX, EVELYN NEW ROCHELLE NY
- ALLEN, LEO M ESTATE OF PLATTSBURGH NY

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

**APPENDIX V
LONG TERM CARE SERVICES
State Plan Amendment #15-0043**

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 is currently working with CMS to finalize the 2014 nursing home UPL demonstration which the 2015 demonstration is 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, 2015.

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

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

Tribal Assurance:

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

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

- a) **Please describe the process the State uses to seek advice on a regular ongoing basis from federally recognized tribes Indian Health Programs and Urban Indian Organizations on matters related to Medicaid and CHIP programs and for consultation on State Plan**

Amendments waiver proposals waiver extensions waiver amendments waiver renewals and proposals for demonstration projects prior to submission to CMS.

- b) Please include information about the frequency inclusiveness and process for seeking such advice.**
- c) Please describe the consultation process that occurred specifically for the development and submission of this State Plan Amendment when it occurred and who was involved.**

Response: Tribal consultation was performed in accordance with the State's tribal consultation policy as approved in SPA 11-06, and documentation of such is included with the original submission. To date, no feedback has been received from any tribal representative in response to the proposed change in this SPA.

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

LONG TERM CARE SERVICES
State Plan Amendment #15-0043

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 implement a trend factor no greater than zero for nursing home services. This is an overall effort to control Medicaid spending. The change should not significantly impact providers since overall rates are being held 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.