NEW YORK
state department of
HEALTH

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

Sue Kelly
Executive Deputy Commissioner

June 28, 2012

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

RE: SPA #12-22
Long Term Care Facility Services

Dear Mr. Cooley:

The State requests approval of the enclosed amendment #12-22 to the Title XIX (Medicaid) State Plan for long term care facility services to be effective April 26, 2012 (Appendix I). This amendment is being submitted based on enacted legislation. A summary of the proposed amendment is provided in Appendix II.

This amendment is submitted pursuant to §1902(a) of the Social Security Act (42 USC 1396a(a)) and Title 42 of the Code of Federal Regulations, Part 447, Subpart C, (42 CFR §447).

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

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

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

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

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

A copy of the pertinent section of enacted State statute is enclosed for your information (Appendix III). Copies of the public notice of this proposed amendment, which was given in the New York State Register on April 25, 2012, is also enclosed for your information (Appendix IV). In addition responses to the five standard funding questions are also enclosed (Appendix V).

If you have any questions regarding this 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
Deputy Commissioner
Office of Health Insurance Programs

Enclosures

cc: Mr. Michael Melendez
Mr. Tom Brady

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL **FOR: HEALTH CARE FINANCING ADMINISTRATION**	1. TRANSMITTAL NUMBER: **12-22**	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 26, 2012**	

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION: **Section 1902(a) of the Social Security Act, and 42 CFR 447**	7. FEDERAL BUDGET IMPACT: **a. FFY 04/26/12 -09/30/12 $ 0** **b. FFY 10/01/12– 09/30/13 $ 0**
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: **Attachment 4.19-B: page 4(c)(i)** **Attachment 3.1-A: page 2(a)(i)** **Attachment 3.1-B: page 2(a)(i)**	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: **Attachment 4.19-B: page 4(c)(i)** **Attachment 3.1-A: page 2(a)(i)** **Attachment 3.1-B: page 2(a)(i)**

10. SUBJECT OF AMENDMENT:
Assisted Living Programs (ALP) Reform
(FMAP = 50%)

11. GOVERNOR'S REVIEW *(Check One)*:
☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:	16. RETURN TO: **New York State Department of Health** **Corning Tower** **Empire State Plaza** **Albany, New York 12237**
13. TYPED NAME: **Jason A. Helgerson**	
14. TITLE: **Medicaid Director & Deputy Commissioner** **Department of Health**	
15. DATE SUBMITTED: JUN 2 8 2012	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:	18. DATE APPROVED:
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL:	20. SIGNATURE OF REGIONAL OFFICIAL:
21. TYPED NAME:	22. TITLE:

23. REMARKS:

FORM HCFA-179 (07-92)

Appendix I
2012 Title XIX State Plan
Second Quarter Amendment
Long-Term Care Facility Services
Amended SPA Pages

[Type of Service] **[Method of Reimbursement]**
Assisted Living Programs

[In accordance with Public Health law section 3614(6) and 10 NYCRR Subpart 86-7,] T[t]he Commissioner of Health, [and] subject to approval for the State Director of the Budget, establishes per diem payment rates that are payment-in-full for the [Title XIX] [P]personal [C]care [S]services that the Assisted Living Program (ALP) provides directly or through contracts with [a Long Term Home Health Care Program,] a certified home health agency (CHHA) or other qualified provider[s]; nursing services, home health aide services, physical therapy, occupational therapy, speech equipment not requiring prior approval, personal emergency response services, and adult day health care provided in a program approved by the Commissioner of Health.

Payment rates are established for 1992 for each of sixteen patient classification groups in each of sixteen regions, and the 1992 payment rates are increased by a roll factor for each subsequent year. The payment rates are related to fifty percent of the amounts which otherwise would have been expanded to provide the appropriate level of care in a residential health care facility (RHCF) in the applicable regions and consist of a direct component and other than direct component. For 1992, the direct and other than direct components for each patient classification group in each of sixteen regions are summed and multiplied by fifty percent. For subsequent calendar years, the 1992 payment rates are increased by the applicable roll factor. Payment rates cannot exceed prevailing charges in the locality. The reimbursement rate for preadmission assessments conducted directly by the ALP will be equal to the statewide weighted average rate for nursing visits, which has been determined by the Commissioner for CHHAs and is in effect, as of the date of the preadmission assessment, for the calculation of low utilization payment amounts and outlier reimbursement amounts in the Episodic Payment System for CHHAs.

The State assures the provision of Home Health services will be provided in accordance with 42 CFR 440.70.

7b. Patients must be assessed as being appropriate for home health aide services ordered by a physician pursuant to a written plan of care [provided by a home health agency] upon admission to an Assisted Living Program (ALP)[, no later than 45 days from the date of admission,] and at least once during each subsequent six month period. [The social services district must review the assessment and prior authorize the service.]

Home Health aide shall mean a person who carries out health care tasks under the supervision of a registered nurse or licensed therapist and who may also provide assistance with personal hygiene, housekeeping and other related supportive tasks to a patient with health care needs in his/her home. Home health aides shall have successfully completed a basic training program in home health aide services or an equivalent exam approved by the Department and possess written evidence of such completion.

Certified home health agencies may provide home health services to individual's diagnosed by a physician as having AIDS and are not required to hold a specific designation for providing home health services to AIDS patients.

Providers of AIDS home care services must possess a valid certificate of approval issued pursuant to the provisions of Article 36 of the Public Health Law (PHL), or a residential health care facility or hospital possessing a valid operating certificate issued under Article 28 of the PHL which is authorized under Article 36 of the PHL to provide an AIDS home care program; or an AIDS Center, specifically authorized pursuant to Article 36 of the PHL to provide an AIDS home care program, be certified in accordance with certified home health agency certification and authorization pursuant to sections 3606, 3611 and 3612 of PHL and provide services in accordance with minimum standards pursuant to section 3612 of PHL. Such an agency or program must participate as a home health agency under the provisions of Titles XVIII and XIX of the Federal Social Security Act.

The State assures the provision of Home Health services will be provided in accordance with 42 CFR 440.70.

7b. Patients must be assessed as being appropriate for home health aide services ordered by a physician pursuant to a written plan of care [provided by a home health agency] upon admission to an Assisted Living Program (ALP)[, no later than 45 days from the date of admission,] and at least once during each subsequent six month period. [The social services district must review the assessment and prior authorize the service.]

Home Health aide shall mean a person who carries out health care tasks under the supervision of a registered nurse or licensed therapist and who may also provide assistance with personal hygiene, housekeeping and other related supportive tasks to a patient with health care needs in his/her home. Home health aides shall have successfully completed a basic training program in home health aide services or an equivalent exam approved by the Department and possess written evidence of such completion.

Certified home health agencies may provide home health services to individual's diagnosed by a physician as having AIDS and are not required to hold a specific designation for providing home health services to AIDS patients.

Providers of AIDS home care services must possess a valid certificate of approval issued pursuant to the provisions of Article 36 of the Public Health Law (PHL), or a residential health care facility or hospital possessing a valid operating certificate issued under Article 28 of the PHL which is authorized under Article 36 of the PHL to provide an AIDS home care program; or an AIDS Center, specifically authorized pursuant to Article 36 of the PHL to provide an AIDS home care program, be certified in accordance with certified home health agency certification and authorization pursuant to sections 3606, 3611 and 3612 of PHL and provide services in accordance with minimum standards pursuant to section 3612 of PHL. Such an agency or program must participate as a home health agency under the provisions of Titles XVIII and XIX of the Federal Social Security Act.

Appendix II
2012 Title XIX State Plan
Second Quarter Amendment
Long-Term Care Facility Services
Summary

SUMMARY
SPA #12-22

This State Plan Amendment proposes to allow an Assisted Living Program (ALP) to bill for the preadmission assessment of residents directly. This preadmission assessment was previously required to be performed by certified home health agencies. This SPA allows the ALP to perform the assessment, thus there is no additional cost to the Medicaid program.

Appendix III
2012 Title XIX State Plan
Second Quarter Amendment
Long-Term Care Facility Services
Authorizing Provisions

SPA #12-22

CHAPTER 56 OF THE LAWS OF 2012 – PART D

§ 4-a. Paragraph (a) of subdivision 6 of section 3614 of the public health law, as amended by section 17 of part D of chapter 58 of the laws of 2009, is amended to read as follows:

(a) The commissioner shall, subject to the approval of the state director of the budget, establish capitated rates of payment for services provided by assisted living programs as defined by paragraph (a) of subdivision one of section four hundred sixty-one-l of the social services law. Such rates of payment shall be related to costs incurred by residential health care facilities. The rates shall reflect the wage equalization factor established by the commissioner for residential health care facilities in the region in which the assisted living program is provided and real property capital construction costs associated with the construction of a free-standing assisted living program such rate shall include a payment equal to the cost of interest owed and depreciation costs of such construction. The rates shall also reflect the efficient provision of a quality and quantity of services to patients in such residential health care facilities, with needs comparable to the needs of residents served in such assisted living programs. Such rates of payment shall be equal to fifty percent of the amounts which otherwise would have been expended, based upon the mean prices for the first of July, nineteen hundred ninety-two (utilizing nineteen hundred eighty-three costs) for freestanding, low intensity residential health care facilities with less than three hundred beds, and for years subsequent to nineteen hundred ninety-two, adjusted for inflation in accordance with the provisions of subdivision ten of section twenty-eight hundred seven-c of this chapter, to provide the appropriate level of care for such residents in residential health care facilities in the applicable wage equalization factor regions plus an amount equal to capital construction costs associated with the construction of an assisted living program facility as provided for in this subdivision. The commissioner shall also promulgate regulations, and may promulgate emergency regulations, to provide for reimbursement of the cost of preadmission assessments conducted directly by assisted living programs.

§ 5. Notwithstanding any contrary provision of law, inpatient hospitals licensed pursuant to the mental hygiene law by the office of mental health shall be subject to audit fees as set forth in regulations issued by the department of health pursuant to subparagraph (xiii) of paragraph (D) of subdivision 35 of section 2807-c of the public health law, with regard to cost reports submitted to the department of health on and after April 1, 2012.

Appendix IV
2012 Title XIX State Plan
Second Quarter Amendment
Long-Term Care Facility Services
Public Notice

An application for a waiver of the requirements of paragraph a of subdivision 7 of section 176-b of the Town Law, which limits the membership of volunteer fire companies to forty-five per centum of the actual membership of the fire company, has been submitted by the Sauquoit Fire District #1, County of Oneida.

Pursuant to section 176-b of the Town Law, the non-resident membership limit shall be waived provided that no adjacent fire department objects within sixty days of the publication of this notice.

Objections shall be made in writing, setting forth the reasons such waiver should not be granted, and shall be submitted to: Bryant D. Stevens, State Fire Administrator, Office of Fire Prevention and Control, 99 Washington Ave., Suite 500, Albany, NY 12210-2833

Objections must be received by the State Fire Administrator within sixty days of the date of publication of this notice.

In cases where an objection is properly filed, the State Fire Administrator shall have the authority to grant a waiver upon consideration of (1) the difficulty of the fire company or district in retaining and recruiting adequate personnel; (2) any alternative means available to the fire company or district to address such difficulties; and (3) the impact of the waiver on adjacent fire departments.

For further information, please contact: Deputy Chief Donald Fischer, Office of Fire Prevention and Control, 99 Washington Ave., Suite 500, Albany, NY 12210-2833, (518) 474-6746, Dfischer@dhses.ny.gov

PUBLIC NOTICE

City of Glen Cove
Transfer Station Operation & Maintenance
Solid Waste Transport
Recycling and Disposal Services
Final Request for Proposals (FRFP)

PLEASE TAKE NOTICE, that pursuant to, and accordance with, Subdivision 4 of Section 120-w of the General Municipal Law, the City of Glen Cove hereby gives notice of its Final Request for Proposals (FRFP) for the financing, provision of transportation means and services and the facilities, having to do with the operation and maintenance of the City of Glen Cove solid waste transfer station and for the transportation, recycling and disposal of City of Glen Cove municipal solid waste. The means, services and facilities are expected to include: certain capital improvements to the City of Glen Cove solid waste transfer station; the operation and maintenance of the City of Glen Cove solid waste transfer station; transfer haul vehicles; the processing, transportation, recycling and disposal of solid waste; administrative management; maintenance support; and customer service support to perform services as specified in FRFP. Issued with the FRFP, may be comments filed in relation to the previously released Draft Request for Proposals (DRFP), and the City's findings related to the substantive elements of such comments.

Copies of the FRFP may be obtained at the City of Glen Cove Finance Department, Purchasing Division, Attn: Ms. Nancy Andreiev, City Purchasing Agent, City of Glen Cove City Hall, First Floor, 9 Glen Street, Glen Cove, New York 11542 between the hours of 9:00 A.M., 4:30 P.M., except Saturdays, Sundays and Holidays, on and after Monday, April 30, 2012 for a nonrefundable fee of ONE HUNDRED DOLLARS ($100.00), until Tuesday, May 22, 2012.

One (1) original and 4 (four) copies of the FRFP must be received at the office of William Archambault, Director of Public Works, City of Glen Cove City Hall, Room 301, 9 Glen Street, Glen Cove, New York 11542, no later than 3:00 p.m. on Tuesday, May 22, 2012.

The City of Glen Cove shall also provide a copy of the FRFP for review on or after April 30, 2012 until May 22, 2012, at the following two locations: (1) the Office of the City Clerk, City Hall, 9 Glen Street, New York 11542, and (2) the Glen Cove Public Library, 4 Glen Cove Avenue, Glen Cove, New York 11542.

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 institutional, long term care, and non-institutional services to comply with recently enacted statutory provisions. The following provides clarification to provisions previously noticed on March 30, 2012, and notification of new significant changes:

All Services

- The amount appropriated for previously noticed provisions regarding the Essential Community Provider Network and the Vital Access Providers initiatives in the enacted budget is now $86.4 million, which is a reduction of $13.6 million for state fiscal year 2012/13; however, the annual increase in state fiscal year 2013/14 remains $100 million.
- To clarify, effective April 1, 2012, regularly scheduled phased reductions to hospital inpatient Transition II funding of $25 million will be redirected to the Safety Net/VAP funding instead of the development of the inpatient statewide base price.

The annual increase in gross Medicaid expenditures for both initiatives for state fiscal year 2012/13 is $86.4, including the redirection of the hospital inpatient Phase II funding.

Institutional Services

- Effective May 1, 2012, the statewide base price will be reduced by $19.2 million for state fiscal year 2012/13 and $19.2 million for state fiscal year 2013/14 as compared to the $24.2 million in state fiscal year 2011/12.

Long Term Care Services

- Effective on and after April 1, 2012, for rate periods on and after July 1, 2012, for services provided to residential health care facility residents 21 years of age and older, the Commissioner of Health shall implement a methodology which establishes reimbursement rates for reserved bed days.
  - Such methodology shall, for each Medicaid patient for any 12-month period, provide for reimbursement for reserved bed days for up to an aggregate of 14 days for hospitalizations and for other therapeutic leave of absences consistent with a plan of care ordered by such patient's treating health care professional, and up to an aggregate of 10 days of other leaves of absence.
  - If the Commissioner, in consultation with the Director of the Budget, determines that such methodology shall achieve projected aggregate Medicaid savings of less than $40 million for state fiscal year beginning April 1, 2012, and each state fiscal year thereafter, the Commissioner shall establish a prospective per diem rate adjustment for all nursing homes, other than those providing services primarily to children under the age of 21, sufficient to achieve such $40 million in savings for each such state fiscal year.
- Effective April 1, 2012, an assisted living program (ALP), that is not itself a certified home health agency (CHHA), shall contract with one or more CHHAs for the provision of services pursuant to Article 36 of the Public Health Law.
  - An ALP shall, either directly or through contract with a certified home health agency, conduct an initial assessment to determine whether a person would otherwise require placement in a residential health care facility if not for the availability of the ALP and is appropriate for admission to an ALP.
  - No person shall be determined eligible for and admitted to an ALP unless the ALP finds that the person meets the criteria provided above.
  - Appropriate services shall be provided to an eligible person only in accordance with a plan of care which is based upon an initial assessment and periodic reassessments conducted by an ALP, either directly or through contract with a CHHA. A reassessment shall be conducted as frequently as is required to respond to changes in the resident's condition and ensure immediate access to necessary and appropriate services by the resident, but in no event less frequently than once every six months. No person shall be admitted to or retained in an ALP unless the person can be safely and adequately cared for with the provision of services determined by such assessment or reassessment.

- The Commissioner of Health will also provide for reimbursement of the cost of preadmission assessments conducted directly by ALPs, which previously would have been performed by and reimbursed to the CHHA. There is no annual increase or decrease in gross Medicaid dollars for this initiative in state fiscal year 2012/13.

Non-institutional Services

- Effective April 1, 2012, the APG investment for hospital outpatient payments will be reduced by $25 million.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to these initiatives contained in the budget for state fiscal year 2012/2013 is $26.4 million.

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

In addition, copies of the proposed state plan amendments will be on file and available for public review in each local (county) social services district.

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 HCRA Operations & Financial Analysis, Corning Tower Bldg., Rm. 984, Empire State Plaza, Albany, NY 12237, (518) 474-1673, (518) 473-8825 (FAX), spa_inquiries@health.state.ny.us

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 long term care services to comply with regulations authorized under existing State statute. The following significant changes are proposed:

Long Term Care Services

- Effective for services provided on and after May 1, 2012, Medicaid payments for certified home health care agencies (CHHA), except for such services provided to children under 18 years of age and except for services provided to a special needs population of medically complex and fragile children, adolescents and young disabled adults by a CHHA operating under a pilot program approved by the Department of Health, shall be based on payment amounts calculated for 60-day episodes of care.
  - The base price paid for 60-day episodes of care shall be adjusted by an individual patient case mix index, and also by a regional wage index factor. Such case mix adjustments shall include an adjustment factor for CHHAs providing care primarily to a special needs patient population coming under the jurisdiction of the Office of People with Developmental Disabilities (OPWDD) and consisting of no fewer than 200 such patients. The annual increase in gross Medicaid expenditures attributable to this initiative for state fiscal year 2012/13 is $600,000.
- Effective July 1, 2012 or upon the effective date of the applicable regulation, the capital cost component of the Medicaid rates of eligible residential health care facilities (RHCF) shall be adjusted, as determined by the Commissioner of Health, to reflect the costs of the annual debt service related to the financing of an automatic sprinkler system that will be in compliance with applicable federal regulations set forth in 42 CFR 483.70(a)(8).
  - Eligible facilities are those facilities which the Commissioner determines are financially distressed in terms of their being unable to finance the installation of automatic sprinkler systems as required by the federal regulations. In making such determinations of eligibility, the Commissioner shall consider information obtained from a facility's cost report, and such other information as may be required by the Commissioner, including, but not limited to:
    - operating profits and losses;
    - eligibility for funding pursuant to the capital cost reimbursement section of Subpart 86-2 of the Public Health Law;
    - unrestricted fund balances;
    - documentation demonstrating the inability of the facility to independently access the credit markets;
    - information related to the health and safety of a facility's residents;
    - other financial information as may be required from the facility by the Commissioner; and
    - the filing of Certificate of Need (CON) information, or the receipt of required CON approvals, as appropriate.
  - As a condition for the receipt of sprinkler funding, each eligible RHCF shall:
    - Prepare a schedule setting forth, by month, the estimated debt service payable, assuming level principal and interest payments over the life of the financing. Such schedule, along with such other information as may be required by the Commissioner, shall be provided to the Commissioner for review and approval at least 60 days prior to the due date of such first debt service payment (or such shorter period as the Commissioner may permit); and
    - Deposit into a separate account maintained by the facility, Medicaid revenues attributable to the capital rate adjustments for such sprinklers, and any other additional facility revenues needed to cover the scheduled debt service payments attributable to such sprinklers. All such deposits in such account shall be used solely for the purpose of satisfying such debt service payments.
  - The estimated annual increase in gross Medicaid expenditures attributable to this initiative for state fiscal year 2102/13 is $17 million.
- Effective for services provided on and after May 1, 2012, rates of payment for residential health care facilities which have received approval by the Commissioner of Health to provide services to more than 25 patients whose medical condition is HIV Infection Symptomatic, and the facility is not eligible for separate and distinct payment rates for AIDS facilities or discrete AIDS units, shall be adjusted by a per diem adjustment that shall not be in excess of the difference between such facility's 2010 allowable cost per day, as determined by the Commissioner, and the weighted average non-capital component of the rate in effect on and after January 1, 2012, and as subsequently updated by case mix adjustments made in July and January of each calendar year. The estimated annual increase in gross Medicaid expenditures attributable to this initiative for state fiscal year 2012/13 is $1 million.

Appendix V
2012 Title XIX State Plan
Second Quarter Amendment
Long-Term Care Facility Services
Responses to Standard Funding Questions

APPENDIX V
LONG TERM CARE SERVICES
State Plan Amendment 12-22

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 Department is not aware of any UPL requirement for the ALP program.

5. **Does any governmental provider receive payments that in the aggregate (normal per diem, supplemental, enhanced, other) exceed their reasonable costs of providing services? If payments exceed the cost of services, do you recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report?**

   Response: The rate methodology included in the approved state plan for ALP services is cost based subject to ceilings. 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: The process that New York State uses is detailed in SPA #11-06, which was approved by CMS on 8/4/11. The tribal leaders were sent information regarding the SPA via postal mail, and the health clinic administrators were emailed the same information. Copies of the tribal notifications are enclosed.

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