NEW YORK STATE OF OPPORTUNITY. 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 3 0 2015

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

RE: SPA #15-0036
Long Term Care Facility Services

Dear Mr. Cooley:

The State requests approval of the enclosed amendment #15-0036 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, 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
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: **15-0036**	2. STATE **New York**
	3. PROGRAM IDENTIFICATION: **TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)**	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE **April 1, 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: **§ 1902(a) of the Social Security Act, and 42 CFR 447**	7. FEDERAL BUDGET IMPACT: **(in thousands)** **a. FFY 04/01/15-09/30/15 $ 0** **b. FFY 10/01/15-09/30/16 $ 0**
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: **Attachment 4.19-D: Pages 110(d)(21), 110(d)(22), 110(d))22.1), 110(d)(22.2), 110(d)(22.3), 110(d)(23), 110(d)(23.1), 110(d)(24), 110(d)(25), 110(d)(25.1)**	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: **Attachment 4.19-D: Pages 110(d)(21), 110(d)(22), 110(d))22.1), 110(d)(22.2), 110(d)(22.3), 110(d)(23), 110(d)(23.1), 110(d)(24), 110(d)(25), 110(d)(25.1)**

10. SUBJECT OF AMENDMENT:
2015 NH Quality Incentive Pool Revisions
(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** **Division of Finance and Rate Setting** **99 Washington Ave – One Commerce Plaza** **Suite 1460** **Albany, NY 12210**
13. TYPED NAME: **Jason A. Helgerson**	
14. TITLE: **Medicaid Director** **Department of Health**	
15. DATE SUBMITTED: JUN 3 0 2015	

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
110(d)(21)

[p) For the calendar year 2012, the operating component of the price of each non-specialty facility that fails to submit to the Commissioner a timely and properly certified 2011 nursing home cost report and nursing home employee influenza immunization data for September 1, 2011 through March 31, 2012 will be subject to a per diem reduction. The per diem reduction will be calculated as follows:

(Number of Medicaid Days of the non-specialty facility that fails to report/ total Medicaid days of all non-specialty facilities) * $50 million]

For the calendar year 2015 [2014], the Commissioner will calculate a quality score, based on quality data from the 2014 [2013] calendar year (January 1, 2014 [2013] through December 31, 2014 [2013]), for each non-specialty facility. For purposes of calculating a 2015 [2014] quality score, non-specialty facilities will exclude non-Medicaid facilities and CMS Special Focus Facilities. The quality score for each such non-specialty facility will be calculated using the following Quality, Compliance, and Efficiency Measures.

Quality Measures		**Measure Steward**
1	Percent of Long Stay High Risk Residents With Pressure Ulcers (As Risk Adjusted by the Commissioner)	CMS
2	Percent of Long Stay Residents Who Received the Pneumococcal Vaccine	CMS
3	Percent of Long Stay Residents Who Received the Seasonal Influenza Vaccine	CMS
4	Percent of Long Stay Residents Experiencing One or More Falls with Major Injury	CMS
5	Percent of Long Stay Residents Who have Depressive Symptoms	CMS
6	Percent of Low Risk Long Stay Residents Who Lose Control of Their Bowels or Bladder	CMS
7	Percent of Long Stay Residents Who Lose Too Much Weight (As Risk Adjusted by the Commissioner)	CMS
8	Percent of Long Stay Antipsychotic Use in Persons with Dementia [Percent of Long Stay Residents Who Received an Antipsychotic Medication]	Pharmacy Quality Alliance (PQA)
9	Percent of Long Stay Residents Who Self-Report Moderate to Severe Pain (As Risk Adjusted by the Commissioner)	CMS
10	Percent of Long Stay Residents Whose Need for Help with Daily Activities Has Increased	CMS
11	Percent of Long Stay Residents with a Urinary Tract Infection	CMS
12	Percent of Employees Vaccinated for Influenza	NYS DOH

New York
110(d)(22)

13	Percent of Contract/Agency Staff Used	NYS DOH
14	Rate of Nursing Hours per Day [CMS Five-Star Quality Rating for Staffing as of April 1, 2014]	NYS DOH
15	Percent of Staff Turnover	NYS DOH
	Compliance Measures	
16 [15]	CMS Five-Star Quality Rating for Health Inspections as of April 1, 2015 [2014] (By Region)	CMS
17 [16]	Timely Submission and Certification of Complete 2014 [2013] New York State Nursing Home Cost Report to the Commissioner	NYS DOH
18 [17]	Timely Submission of Employee Influenza Immunization Data for the September 1, 2014 [2013] - March 31, 2015 [2014] Influenza Season by the deadline of May 1, 2015 [2014]	NYS DOH
	Efficiency Measure	
19 [18]	Rate of Potentially Avoidable Hospitalizations for Long Stay Residents [Episodes] January 1, 2014 [2013] – December 31, 2014 [2013] (As Risk Adjusted by the Commissioner)	NYS DOH

The maximum points a facility may receive for the Quality Component is 75 [70]. The applicable percentages or ratings for each of the 15 [14] measures will be determined for each facility. [Three] Two measures will be awarded points based on threshold values. The remaining 13 [11] measures will be ranked and grouped by quintile with points awarded as follows:

Scoring for 12 [11] Quality Measures	
Quintile	**Points**
1st Quintile	5
2nd Quintile	3
3rd Quintile	1
4th Quintile	0
5th Quintile	0

Note: The following quality measures will not be ranked into quintiles and points will be awarded based on threshold values:

- Percent of employees vaccinated for influenza: facilities will be awarded five points if the rate is 85% or higher, and zero points if the rate is less than 85%.
- [Percent of long stay residents who received the pneumococcal vaccine: facilities will be awarded five points if the rate is 85% or higher, and zero points if the rate is less than 85%.]
- Percent of contract/agency staff used: facilities will be awarded five points if the rate is less than 10%, and zero points if the rate is 10% or higher.

New York
110(d)(22.1)

Addition of New Measures to Quality Component

Percent of Long Stay Antipsychotic Use in Persons with Dementia

This measure will replace the current CMS measure, Percent of Long Stay Residents Who Received an Antipsychotic Medication. NYS DOH will follow the measure specifications developed and endorsed by the Pharmacy Quality Alliance Quality Metrics Expert Panel. The measure specifications can be found at http://pqaalliance.org/measures.

Rate of Nursing Hours per Day

This measure will replace the current CMS Five-Star Quality Rating for Staffing. NYS DOH will calculate an annualized adjusted rate of staff hours per resident per day. For this measure, staff are defined as RNs, LPNs, and Aides. The observed staffing hours will be taken from the 2014 nursing home cost reports. The expected staffing hours will be determined using Resource Utilization Group data on the 2014 MDS 3.0 and the CMS 1995-1997 Staff Time Measurement Study. The observed-to-expected staffing hours will be adjusted using the statewide distribution and the formula adapted from the CMS Five-Star Quality Rating for Staffing at http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/Downloads/usersguide.pdf . The formula below will be used:

[Hours worked reported from cost reports /# of residents from MDS 3.0] / 365 days

Divided by

[(RUG distribution from MDS 3.0*hours from CMS time study)/# of residents from MDS 3.0] / 365 days

Percent of Staff Turnover

This measure is an addition to the Quality Component. NYS DOH will calculate an annual average staff turnover rate using 2014 nursing home cost report data. For this measure, staff are defined as full time and contract RNs, LPNs, and Aides. Per diem staff are excluded. NYS DOH will use the staff turnover formula put forth by the Advancing Excellence in America's Nursing Homes Campaign. The staff turnover formula can be found at https://www.nhqualitycampaign.org/goaldetail.aspx?g=ss#tab2.

Awarding for Improvement

[Effective in the 2014 Nursing Home Quality Initiative (NHQI), n] Nursing homes will be awarded improvement points from previous years' performance in selected measures in the Quality Component only. One improvement point will be awarded for a nursing home that improves in its quintile for a specific quality measure, compared to its quintile in the previous year for that quality measure. Nursing homes that obtain the top quintile in a quality measure will not receive an improvement point because maximum points per measure cannot exceed five. The six [Five] quality measures below will not be eligible to receive improvement points:

- Percent of Long Stay Residents Who Received the Pneumococcal Vaccine (based on threshold in 2014 NHQI)
- Percent of Employees Vaccinated for Influenza (based on threshold)

New York

110(d)(22.2)

- Percent of Contract/Agency Staff Used (based on threshold)
- Long Stay Antipsychotic Use in Persons with Dementia (new measure)
- NYS Five-Star Rating for Staffing (new measure)
- Annual Average Percent of Staff Turnover (new measure)

[These include the three quality measures that are based on threshold values, the CMS Five-Star Quality Rating for Staffing, and the Percent of Long Stay Residents Who Received the Seasonal Influenza Vaccine. The Percent of Long Stay Residents Who Received the Seasonal Influenza Vaccine measure was based on a threshold value in the 2013 NHQI, but has been changed to quintiles in the 2014 NHQI.]

The remaining nine quality measures that are eligible for improvement points are listed below:

- Percent of Long Stay High Risk Residents With Pressure Ulcers
- Percent of Long Stay Residents Experiencing One or More Falls with Major Injury
- Percent of Long Stay Residents Who have Depressive Symptoms
- Percent of Low Risk Long Stay Residents Who Lose Control of Their Bowels or Bladder
- Percent of Long Stay Residents Who Lose Too Much Weight
- [Percent of Long Stay Residents Who Received an Antipsychotic Medication]
- Percent of Long Stay Residents Who Self-Report Moderate to Severe Pain
- Percent of Long Stay Residents Whose Need for Help with Daily Activities Has Increased
- Percent of Long Stay Residents with a Urinary Tract Infection
- Percent of Long Stay Residents Who Received the Seasonal Influenza Vaccine

The grid below illustrates the method of awarding improvement points.

		2014 [2013] Performance				
	Quintiles	1 (best)	2	3	4	5
2015 [2014] Performance	1 (best)	5	5	5	5	5
	2	3	3	4	4	4
	3	1	1	1	2	2
	4	0	0	0	0	1
	5	0	0	0	0	0

For example, if 2014 [2013] NHQI performance is in the third quintile, and 2015 [2014] NHQI performance is in the second quintile, the facility will receive four points for the measure. This is three points for attaining the second quintile and one point for improvement from the previous year's third quintile.

Risk Adjustment of Quality Measures

The following quality measures will be risk adjusted using the following covariates as reported in the MDS 3.0 data to account for the impact of individual risk factors:

- Percent of Long Stay Residents Who Self-Report Moderate to Severe Pain: the covariate includes cognitive skills for daily decision making on the prior assessment.

- Percent of Long Stay High Risk Residents with Pressure Ulcers: The covariates include gender, age, healed pressure ulcer since the prior assessment, BMI, prognosis of less than six months of life expected, diabetes, heart failure, deep vein thrombosis, anemia, renal failure, hip fracture, bowel incontinence, cancer, paraplegia, and quadriplegia.

New York
110(d)(22.3)

- Percent of Long Stay Residents who Lose Too Much Weight: The covariates include age, hospice care, cancer, renal failure, prognosis of less than six months of life expected.

For these three measures the risk adjusted methodology includes the calculation of the observed rate; that is the facility's numerator-compliant population divided by the facility's denominator.

The expected rate is the rate the facility would have had if the facility's patient mix was identical to the patient mix of the state. The expected rate is determined through the risk-adjusted model and follows the CMS methodology found in the MDS 3.0 Quality Measures User's Manual, Appendix A-1.

The facility-specific, risk-adjusted rate is the ratio of observed to expected measure rates multiplied by the overall statewide measure rate.

Reduction of Points Base: When a quality measure is not available for a nursing home, the number of points the measure is worth will be reduced from the base of 100 maximum NHQI points. The nursing home's total score will be the sum of its points divided by the base. This reduction can happen in the following scenarios:

- When nursing homes do not have enough cost report data to calculate a percent of contract/agency staff used; or
- When a quality measure has a denominator of less than 30
- [When a quality measure has a denominator of less than 30; or
- When a facility does not have a CMS Five-Star Quality Rating for Staffing

For example, if 2013 NHQI performance is in the third quintile, and 2014 NHQI performance is in the second quintile, the facility will receive four points for the measure. This is three points for attaining the second quintile and one point for improvement from the previous year's third quintile.]

New York
110(d)(23)

The maximum points a facility may receive for the Compliance Component is 15 [20] points. Points shall be awarded as follows:

Scoring for Compliance Measures	
CMS Five-Star Quality Rating for Health Inspections (By Region)	**Points**
5 Stars	5 [10]
4 Stars	3.5 [7]
3 Stars	2 [4]
2 Stars	1 [2]
1 Star	0
Timely Submission and Certification of Complete 2014 [2013] New York State Nursing Home Cost Report to the Commissioner	5 (Facilities that fail to submit a timely, certified, and complete cost report will receive zero points)
Timely Submission of Employee Influenza Immunization Data	5 for the May 1, 2015 [2014] deadline (Facilities that fail to submit timely influenza data by the deadline will receive zero points)

CMS Five-Star Quality Rating for Staffing Regional Adjustment
The CMS Five-Star Quality Rating for Health Inspections as of April 1, 2015 [2014] will be adjusted by region. This is not a risk adjustment. For eligible New York State nursing homes, the health inspection scores from CMS will be stratified by region. Cut points for health inspection scores within each region will be calculated using the CMS 10-70-20% distribution method. Per CMS' methodology, the top 10% of nursing homes receive five stars. The middle 70% receive four, three, or two stars, with an equal percentage (~23.33%) receiving four, three, or two stars. The bottom 20% receive one star. Each nursing home will be awarded a star rating based on the health inspection score cut points specific to its region. Regions include the Metropolitan Area (MARO), Western New York (WRO), Capital District (CDRO), and Central New York (CNYRO). Regions are defined by the New York State Health Facilities Information System (NYS HFIS). The counties within each region are shown below.

Metropolitan Area Regional Offices (MARO): Bronx, Dutchess, Kings, Nassau, New York, Orange, Putnam, Queens, Richmond, Rockland, Suffolk, Sullivan, Ulster, and Westchester.
Central New York Regional Offices (CNYRO): Broome, Cayuga, Chenango, Cortland, Herkimer, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, Saint Lawrence, Tioga, and Tompkins.
Capital District Regional Offices (CDRO): Albany, Clinton, Columbia, Delaware, Essex, Franklin, Fulton, Greene, Hamilton, Montgomery, Otsego, Rensselaer, Saratoga, Schenectady, Schoharie, Warren, and Washington.

New York

110(d)(23.1)

Western New York Regional Offices (WRO): Allegany, Cattaraugus, Chautauqua, Chemung, Erie, Genesee, Livingston, Monroe, Niagara, Ontario, Orleans, Schuyler, Seneca, Steuben, Wayne, Wyoming, and Yates.

Reduction of Points Base: When a compliance measure is not available for a nursing home, the number of points the measure is worth will be reduced from the base of 100 maximum NHQI points. The nursing home's total score will be the sum of its points divided by the base. This reduction can happen when a facility does not have a CMS Five-Star Quality Rating for Health Inspections.

The maximum points a facility may receive for the Efficiency Component is 10 points. The rates of potentially avoidable hospitalizations will be determined for each facility and each such rate will be ranked and grouped by quintile with points awarded as follows:

Scoring for Efficiency Measure	
Quintile	**Points**
1st Quintile	10
2nd Quintile	8
3rd Quintile	6
4th Quintile	2
5th Quintile	0

The Efficiency Measure will be risk adjusted using the following covariates as reported in the MDS 3.0 data to account for the impact of individual risk factors: gender, age, race/ethnicity, payor, prior hospitalization (hospitalization less than or equal to 90 days before the long stay episode began), pneumonia, urinary tract infection, pressure ulcer, feeding tube, septicemia, parenteral nutrition, indwelling catheter, antibiotic-resistant infection, and Charlson Index*.

*The Charlson Index is a score based on several comorbidities following CMS specifications. In the statistical model, the Charlson Index is separated into the following three groups: Low (a score of less than or equal to 1), Mid (2-4), and High (5 and greater).The comorbidities were determined using (1) any MDS assessment during the resident's long stay episode, or (2) a hospitalization record up to 12 months before the resident's long stay episode began, or (3) a hospitalization record up to three days after the resident's long stay episode ended. The comorbidities used to create the Charlson Index include the following: myocardial infarction, congestive heart failure, peripheral vascular disease, cerbrovascular disease, dementia, chronic pulmonary disease, rheumatolic disease, peptic ulcer disease, mild liver disease, diabetes with complications, diabetes without complications, paraplegia and hemiplegia, renal disease, cancer/leukemia, moderate or severe liver disease, metastatic carcinoma, and AIDS/HIV.

New York
110(d)(24)

A potentially avoidable hospitalization is found by matching a discharge assessment in the MDS 3.0 data to its hospital record in SPARCS. The following primary admitting diagnoses on the SPARCS hospital record are potentially avoidable:

Respiratory infections
466 Acute bronchitis
480.0-487.8 Pneumonia
507 Pneumonia
Sepsis
038.0-038.9 Septicemia
UTI
590.00-590.9 Infections of kidney
595.0-595.4 Cystitis
595.9 Cystitis
595.89 Other type of cystitis
597 Urethral abscess
598 Urethral stricture due to infection 598.01 Urethral stricture due to infection
599 Urinary tract infection
601.0-604 Inflammation of prostate
Electrolyte imbalance
276.0-276.9 Disorders of fluid, electrolyte and acid-base balance
CHF
428.0-428.9 Heart Failure
398.91 Rheumatic heart failure
Anemia
280-280.9 Iron deficiency anemias
281.0-281.9 Other deficiency anemias
285.1 Acute posthemorrhagic anemia
285.29 Anemia of chronic illness

Reduction of Points Base: When the number of long stay episodes that contribute to the denominator of the potentially avoidable hospitalization measure is less than 30, the number of points the measure is worth will be reduced from the base of 100 maximum NHQI points. The nursing home's total score will be the sum of its points divided by the base.

The following rate adjustments, which will be applicable to the 2015 [2014] calendar year, will be made to fund the NHQI and to make quality payments based upon the scores calculated as described above.

- Specialty facilities, such as AIDS and pediatrics facilities, and discrete units within facilities that provide extensive nursing, medical, psychological and counseling support services solely to children, are excluded from the NHQI. Each such non-specialty facility, as defined by this paragraph, will be subject to a negative per diem adjustment to fund the NHQI. Specialty facility will mean: AIDS facilities or discrete AIDS units within facilities; discrete units for residents receiving care in a long-term inpatient rehabilitation program for traumatic brain injured persons; discrete units providing specialized programs for residents requiring behavioral interventions; discrete units for long-term ventilator dependent residents; and facilities

or discrete units within facilities that provide extensive nursing, medical, psychological and counseling support services solely to children. Non-specialty will mean all other facilities not defined as a specialty facility. Each such non-specialty facility will be subject to a negative per diem adjustment to fund the NHQI which will be calculated as follows:

- For each such facility, Medicaid revenues, calculated by multiplying each facility's promulgated rate in effect for such period by reported Medicaid days, as reported in a facility's 2014 [2013] cost report, will be divided by total Medicaid revenues of all non-specialty facilities. The result will be multiplied by the $50 million dollars, and divided by each facility's most recently reported Medicaid days. If a facility fails to submit a timely filed 2014 [2013] cost report, the previous year's cost report will be used.

- The total quality scores as calculated above for each such facility will be ranked and grouped by quintile. Each of the top three quintiles will be allocated a share of the $50 million NHQI and each such facility within such top three quintiles will receive a quality payment. Such quality payment will be paid as a per diem adjustment for the 2015 [2014] calendar year. Such shares and payments will be calculated as follows:

New York
110(d)(25.1)

Distribution of NHQI and Quality Payments			
Facilities Grouped by Quintile	**A** **Facility's Medicaid Revenue Multiplied by Award Factor**	**B** **Share of $50 Million NHQI Allocated to Facility**	**C** **Facility Per Diem Quality Payment**
1st Quintile	Each facility's 2014 [2013] Medicaid days multiplied by 2015 [2014] Medicaid Rate as of January 1, 2015 [2014] = Total Medicaid Revenue multiplied by an award factor of 3	Each facility's column A Divided by Sum of Total Medicaid Revenue for all facilities, Multiplied by $50 million	Each facility's column B divided by the facility's 2014 [2013] Medicaid days
2nd Quintile	Each facility's 2014 [2013] Medicaid days multiplied by 2015 [2014] Medicaid Rate as of January 1, 2015 [2014] = Total Medicaid Revenue multiplied by an award factor of 2.25	Each facility's column A Divided by Sum of Total Medicaid Revenue for all facilities, Multiplied by $50 million	Each facility's column B divided by the facility's 2014 [2013] Medicaid days
3rd Quintile	Each facility's 2014 [2013] Medicaid days multiplied by 2015 [2014] Medicaid Rate as of January 1, 2015 [2014] = Total Medicaid Revenue multiplied by an award factor of 1.5	Each facility's column A Divided by Sum of Total Medicaid Revenue for all facilities, Multiplied by $50 million	Each facility's column B divided by the facility's 2014 [2013] Medicaid days
Total	Sum of Total Medicaid Revenue for all facilities	Sum of quality pool funds: $50 million	--

Payments made pursuant to this program will be subject to this rate adjustment and will be reconciled using actual Medicaid claims data.

Appendix II
2015 Title XIX State Plan
Second Quarter Amendment
Summary

SUMMARY
SPA #15-0036

This State Plan Amendment proposes to maintain the quality incentive for nursing homes 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. This SPA will clarify the reporting requirements related to the 2015 quality adjustments.

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

Authorizing Provisions
SPA #15-0036

Chapter 60 – Laws of 2014, Part C Section 26-a

§ 26-a. Paragraph (d) of subdivision 2-c of section 2808 of the public health law, as added by section 95 of part H of chapter 59 of the laws of 2011, is amended to read as follows:

The commissioner shall promulgate regulations, and may promulgate emergency regulations, to implement the provisions of this subdivision. Such regulations shall be developed in consultation with the nursing home industry and advocates for residential health care facility residents and, further, the commissioner shall provide notification concerning such regulations to the chairs of the senate and assembly health committees, the chair of the senate finance committee and the chair of the assembly ways and means committee. Such regulations shall include provisions for rate adjustments or payment enhancements to facilitate a minimum four-year transition of facilities to the rate-setting methodology established by this subdivision and may also include, but not be limited to, provisions for facilitating quality improvements in residential health care facilities. **For purposes of facilitating quality improvements through the establishment of a nursing home quality pool, those facilities that contribute to the quality pool, but are deemed ineligible for quality pool payments due exclusively to a specific case of employee misconduct, shall nevertheless be eligible for a quality pool payment if the facility properly reported the incident, did not receive a survey citation from the commissioner or the Centers for Medicare and Medicaid Services establishing the facility's culpability with regard to such misconduct and, but for the specific case of employee misconduct, the facility would have otherwise received a quality pool payment. Regulations pertaining to the facilitation of quality improvement may be made effective for periods on and after January first, two thousand thirteen.**

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

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 RHCF 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 RHCF's 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 polices 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 #15-0036

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.