DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Center for Medicaid, CHIP, and Survey & Certification

JUL 18 2011

Jason Helgerson
Deputy Commissioner
New York State Department of Health
Corning Tower
Empire State Plaza
Albany, New York 12237

RE: TN 11-12

Dear Mr. Helgerson:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 11-12. Effective April 1, 2011, this SPA will continue reimbursement for Medicaid's portion of a provider tax on nursing home gross receipts and maintain various cost containment measures that otherwise would expired.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2) 1902(a)(13), 1902(a)(30), and 1903(a) of the Social Security Act and the regulations at 42 CFR 447 Subpart C. New York State plan amendment 11-12 is approved effective April 1, 2011. We have enclosed the HCFA-179 and the approved plan pages.

If you have any questions, please contact Tom Brady at 518-396-3810 or Rob Weaver at 410-786-5914.

Sincerely,

[redacted]

Cindy Mann
Director
Center for Medicaid, CHIP, and Survey & Certification

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: HEALTH CARE FINANCING ADMINISTRATION	1. TRANSMITTAL NUMBER: #11-12	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, 2011	

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

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

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

6. FEDERAL STATUTE/REGULATION CITATION: Section 1902(a) of the Social Security Act, and 42 CFR 447	7. FEDERAL BUDGET IMPACT: a. FFY 04/01/11-09/30/11 $48.4 million b. FFY 10/01/11-09/30/12 $90.5 million
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-B: Pages 47(x)(9), 47(x)(11), 47(x)(12), 47(x)(13), 47(x)(14), 51(a)(1), 51(a)(1)(a), 110(E)(1)	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: Attachment 4.19-B: Pages 47(x)(9), 47(x)(11), 47(x)(12), 47(x)(13), 47(x)(14), 51(a)(1), 110(E)(1)

10. SUBJECT OF AMENDMENT:
2011 Cost Containment - LTC
(FMAP = 56.88% 4/1/11-6/30/11; 50% 7/1/11 forward)

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: [redacted]	16. RETURN TO: New York State Department of Health Corning Tower Empire State Plaza Albany, New York 12237
13. TYPED NAME: Jason A. Helgerson	
14. TITLE: Medicaid Director & Deputy Commissioner Department of Health	
15. DATE SUBMITTED: June 9, 2011	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:	18. DATE APPROVED: JUL 18 2011
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: APR - 1 2011	20. S[redacted]
21. TYPED NAME: Penny Thompson	22. TITLE: Deputy Director, CMCS

23. REMARKS:

FORM HCFA-179 (07-92)

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

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

(2) Prior to February 1, 1996, the Commissioner of Health shall calculate the results of the statewide total of health care facility

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

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

(d) If the 1999 statewide target percentage is not at least two and one-quarter percentage points higher than the statewide base percentage, the Commissioner of Health shall determine the percentage by which the 1999 statewide target percentage is not at least two and one-quarter percentage points higher than the statewide base percentage. The percentage calculated pursuant to this paragraph shall be called the 1999 statewide reduction percentage. If the 1999 statewide target percentage is at least two and one-quarter percentage points higher than the statewide base percentage, the 1999 statewide reduction percentage shall be zero.

(4) (a) The 1995 statewide reduction percentage shall be multiplied by $34 million to determine the 1995 statewide aggregate reduction amount. If the 1995 statewide reduction percentage shall be zero, there shall be no reduction amount.

(b) The 1996 statewide reduction percentage shall be multiplied by $68 million to determine the 1996 statewide aggregate reduction amount. If the 1996 statewide reduction percentage shall be zero, there shall be no reduction amount.

(c) The 1997 statewide reduction percentage shall be multiplied by $102 million to determine the 1997 statewide aggregate reduction amount. If the 1997 statewide reduction percentage shall be zero, there shall be no 1997 reduction amount.

(d) The 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, [and] 2011, 2012, and 2013, statewide reduction percentage shall be multiplied by $102 million respectively to determine the 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, [and] 2011, 2012, and 2013, statewide aggregate reduction amount. If the 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, [and] 2011, 2012, and 2013, statewide reduction percentage shall be zero respectively, there shall be no 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, [and] 2011, 2012, and 2013, statewide reduction amount.

(e) The 1999 statewide reduction percentage shall be multiplied by $76.5 million to determine the 1999 statewide aggregate reduction amount. If the 1999 statewide reduction percentage shall be zero, there shall be no 1999 reduction amount.

(5) (a) The 1995 statewide aggregate reduction amount shall be allocated by the Commissioner of Health among residential health care facilities that are eligible to provide services to Medicare beneficiaries and residents eligible for payments pursuant to Title 11 of Article 5 of the Social Services Law on the basis of the extent of each facility's failure to achieve a one percentage point increase in the 1995 target percentage compared to the base percentage, calculated on a facility specific basis for this purpose, compared to the statewide total of the extent of each facility's failure to achieve a one percentage point increase in the 1995 target percentage compared to the base percentage. This amount shall be called the 1995 facility specific reduction amount.

(b) The 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, [and] 2011, 2012, and 2013, statewide aggregate reduction amounts shall for each year be allocated by the Commissioner of Health among residential health care facilities that are eligible to provide services to Medicare beneficiaries and residents eligible for payments pursuant to Title 11 of Article 5 of the Social Services Law on the basis of the extent of each facility's failure to achieve a two percentage point increase in the 1996 target percentage, a three percentage point increase in the 1997, 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, [and] 2011, 2012, and 2013, target percentage and a two and one-quarter percentage point increase in the 1999 target percentage for each year, compared to the base percentage, calculated on a facility specific basis for this purpose, compared to the statewide total of the extent of each facility's failure to achieve a two percentage point increase in the 1996, a three percentage point increase in the 1997, and a

three percentage point increase in the 1998 and a two and one-quarter percentage point increase in the 1999 target percentage and a three percentage point increase in the 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, [and] 2011, 2012, and 2013, target percentage compared to the base percentage. These amounts shall be called the 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, [and] 2011, 2012, and 2013, facility specific reduction amounts respectively.

(6) The facility specific reduction amounts shall be due to

(g) For reimbursement of services provided to patients for the period April 1, 1995 through December 31, 1995, the trend factors established in accordance with subdivisions (d), (e) and (f) of this section shall reflect no trend factor projections applicable to the period January 1, 1995 other than those reflected in 1994 rates of payment and provide further, that this subdivision shall not apply to use of the trend factor for the January 1, 1995 through December 31, 1995 period, any interim adjustment to the trend factor for such period, or the final trend factor for such period for purposes of projection of allowable operating costs to subsequent rate periods. The Commissioner of Health shall adjust such rates of payment to reflect the exclusion of trend factor projections pursuant to this subdivision. For reimbursement of services provided to patients effective April 1, 1996 through March 31, 1997, the rates will be established by the Commissioner of Health without trend factor adjustments, but shall include the full or partial value of the retroactive impact of trend factor final adjustments for prior periods.* For reimbursement of services provided to patients on and after April 1, 1996 through March 31, 1999 and for payments made on and after July 1, 1999 through March 31, 2011, and on and after April 1, 2011 through March 31, 2013, the rates shall reflect no trend factor projections or adjustments for the period April 1, 1996 through March 31, 1997.

(h) For reimbursement of nursing home services provided to patients beginning on and after April 1, 2006 through March 31, 2011, and on and after April 1, 2011 through March 31, 2013, the Commissioner of Health shall apply a trend factor projection of 2.25% attributable to the period January 1, 2006 through December 31, 2006. Upon reconciliation of this trend factor in accordance with the previously approved state methodology, the final 2006 trend factor shall be the U.S. Consumer Price Index (CPI) for all Urban Consumers, as published by the U.S. Department of Labor, Bureau of Labor Statistics, minus 0.25%.

(i) For reimbursement of nursing home services provided on and after April 1, 2007, the Commissioner of Health shall apply a trend factor equal to 75% of the otherwise applicable trend factor for calendar year 2007 as calculated in accordance with paragraph (f) of this section.

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

(j) For reimbursement of nursing home services provided on and after April 1, 2008, except for the nursing facilities which provide extensive nursing, medical, psychological, and counseling support services to children, the Commissioner of Health shall apply a trend factor equal to 65% of the otherwise applicable trend factor for calendar year 2008 as calculated in accordance with paragraph (f) of this section.

Effective January 1, 1997, the rates of payment will be adjusted to allow costs associated with a total State assessment of 5% of facility gross revenues which shall be a reimbursable cost to be included in calculating rates of payment. Effective March 1, 1997, the reimbursable assessment will be 3.1%. Effective April 1, 1997, the total reimbursable state assessment to be included in calculating rates of payment will be 4.8%. Effective April 1, 1999 through December 31, 1999, the total reimbursable state assessment of 2.4% of gross revenues as paid by facilities shall be included in calculating rates of payment. Effective April 1, 2002 through March 31, 2003, April 1, 2003 through March 31, 2005, and April 1, 2005 through March 31, [2011] 2013, the total reimbursable state assessment on each residential health care facility's gross receipts received from all patient care services and other operating income on a cash basis for hospital or health-related services, including adult day service, but excluding, effective October 1, 2002, gross receipts attributable to payments received pursuant to Title XVIII of the federal Social Security Act (Medicare), shall be 6%, 5%, and 6%, respectively.

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

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[1]The extent to which a facility is reimbursed for the additional cost of the assessment is dependent upon Medicaid volume of services.