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 2 2 2018

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

RE: SPA #18-0050
Long Term Care Facility Services

Dear Mr. Cooley:

The State requests approval of the enclosed amendment #18-0050 to the Title XIX (Medicaid) State Plan for long term care facility services to be effective May 17, 2018 (Appendix I). This amendment is being submitted based on enacted litigation. A summary of the proposed amendment is provided in Appendix II.

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

A copy of the pertinent section of enacted litigation is enclosed for your information (Appendix III). A copy of the public notice of this proposed amendment, which was given in the New York State Register on May 16, 2018, 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 State Plan Amendment submission, please do not hesitate to contact Regina Deyette, Medicaid State Plan Coordinator, Division of Finance and Rate Setting, Office of Health Insurance Programs at (518) 473-3658.

Sincerely,

Donna Frescatore

Donna Frescatore
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: **18-0050**	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 **May 17, 2018**	

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: **Decision and Order to recalculate Medicaid rate, Index No. 260253/2010 dated September 9, 2015**	7. FEDERAL BUDGET IMPACT: **(in thousands)** **a. FFY 05/17/18-09/30/18 $ 2,157.00** **b. FFY 10/01/18-09/30/19 $ 0.00**
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: **Attachment 4.19-D Part I page: 110(d)(20.2)**	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

10. SUBJECT OF AMENDMENT:
The Bronx-Lebanon Highbridge-Woodycrest Center Litigation Payment (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: Donna Frescatore	16. RETURN TO: **New York State Department of Health** **Division of Finance & Rate Setting** **99 Washington Ave – One Commerce Plaza** **Suite 1432** **Albany, NY 12210**
13. TYPED NAME: **Donna Frescatore**	
14. TITLE: **Medicaid Director** **Department of Health**	
15. DATE SUBMITTED: JUN 2 2 2018	

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
2018 Title XIX State Plan
Second Quarter Amendment
Amended SPA Pages

New York
110(d)(20.2)

The New York State Supreme Court has ordered the Department of Health to recalculate The Bronx-Lebanon Highbridge-Woodycrest Center's Medicaid rate for the rate period of April 1, 2009 to December 31, 2011. Recalculation of the rates in accordance with the court's decision and order has been completed and the Department and provider have agreed to a payment in the amount of $4,314,009 to satisfy this judgement. This payment will be made in SFY 2018/2019.

Appendix II
2018 Title XIX State Plan
Second Quarter Amendment
Summary

SUMMARY
SPA #18-0050

This State Plan Amendment proposes to make a payment to The Bronx-Lebanon Highbridge Woodycrest Center on or after May 17, 2018, in response to a New York State Supreme Court decision in the Matter of The Bronx-Lebanon Highbridge Woodycrest Center vs. Richard F. Daines.

Appendix III
2018 Title XIX State Plan
Second Quarter Amendment
Authorizing Provisions

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF BRONX IA 20 X

In The Matter of The Application For A Judgment Pursuant To Article 78 Of The CPLR And For Declaratory Relief Pursuant To CPLR Section 3001 OF

THE BRONX-LEBANON HIGHBRIDE WOODYCREST CENTER,

Petitioner,

vs.

RICHARD F. DAINES, M.D., as COMMISSIONER OF THE NEW YORK STATE DEPARTMENT OF HEALTH and THE NEW YORK STATE DEPARTMENT OF HEALTH,

Respondents. X

Index No: 260253/2010

DECISION AND ORDER

Present:
HON. KENNETH L. THOMPSON, JR.

The following papers numbered 1 to 12 read on this Article 78

No On Calendar of August 20, 2015	PAPERS NUMBER
Notice of Motion-Order to Show Cause - Exhibits and Affidavits Annexed	1, 2
Answering Affidavit and Exhibits	3, 5, 6, 9
Replying Affidavit and Exhibits	7, 8
Affidavit	
Pleadings – Exhibit	
Memorandum of Law	4
Stipulation – Referee's Report –Minutes	12
Filed papers	10, 11

Upon the foregoing papers and due deliberation thereof, the Decision/Order on this motion is as follows:

Petitioner, The Bronx-Lebanon Highbridge Woodycrest Center, (Woodycrest), a residential health care facility, (facility), seeks a declaratory judgment in this Article 78 proceeding, declaring that certain Medicaid reimbursement rate determinations by Respondent, The New York State Department of Health, (DOH), are erroneous, arbitrary, capricious and contrary to law, and consequently, annulling such determinations and directing DOH to recalculate the determinations, fully reimbursing monies otherwise wrongfully withheld from Woodycrest. The disputed Medicaid reimbursement rates cover the period of April 1, 2009 to December 31, 2011. Since January 1, 2012, a new methodology for calculating Medicaid reimbursement rates went into effect. This post December 31, 2011 rate-setting methodology

and the rates so computed are not at issue in this action.

Preliminarily, DOH has submitted a sur-reply dated November 19, 2013, which was necessitated by arguments interposed in a reply memorandum of law. Notably, there was no memorandum of law submitted with the petition. As a matter of equity and at the written request of Woodycrest, since the Court considered the sur-reply papers, the Court also reviewed the letter from Woodycrest dated January 9, 2014, which contained two substantive paragraphs of argument, as well as reviewed the accompanying letter to the sur-reply, which was dated November 20, 2013.

Pursuant to stipulation dated August 28, 2015 the ninth cause of action regarding the statewide prescription drug percentage is withdrawn with prejudice.

In 2006, section 2-b was added to PHL §2808 and became commonly known as the rebasing law. Up until this time the base year for prospective rate setting was 1983. Section 2-b updated the base year to 2002 for facilities who would benefit from such an update in base years.

The rebasing law included what is commonly known as the hold harmless provision. (PHL §2808(2-b)(b)(i)(A) The hold harmless provision provided that any facility that received greater reimbursement in 2008 using 1983 as a base year, as adjusted for inflation, than the 2002 rebased year, as adjusted for inflation, could receive the greater reimbursement provided by the 2008 year adjusted for inflation. It is undisputed that Woodycrest is a hold harmless facility.

In 2009, financing legislation was enacted that limited the statewide level of additional reimbursement as a result of the rebasing law to $210,000,000. PHL §2808(2-b)(b). This law became commonly known as the scale back law as the state-wide additional expenditures to rebased facilities significantly exceeded the $210,000,000 allocated to reimburse facilities homes under the rebasing law.

STATEWIDE REDUCTION

Woodycrest argues that only facilities that benefitted from rebasing, and hence had responsibility for increased Medicaid expenditures should be subject to the reduction in benefits to limit the increase in benefits to $210,000,000. As a hold harmless facility Woodycrest argues it did not benefit from rebasing and therefore should not share the burden of statewide reduction.

The issue is whether the reduction in reimbursement for each facility should be proportional to the gain in compensation from rebasing, or is the reduction in reimbursement proportionate to overall Medicaid reimbursement provided to the facilities. DOH has chosen the latter method of calculating the scale back amount for each facility, resulting in Woodycrest receiving less Medicaid reimbursement than under a method of calculating the scale back rate proportional to the gain in compensation from rebasing. The method chosen by DOH to implement the scale back, more widely spreads the reduction in Medicaid reimbursement required by the scale back law. Moreover, by the very terms of the rebasing law, adjustments made pursuant to PHL §2808(2-b)(g), and L. 2011, Ch.59, Pt.D, section 96, amending L.2009, Ch. 58, Pt. D. section 2, affected the reimbursement rates of hold harmless as well as rebased facilities.

> "Generally, rate-setting actions of the Commissioner, being quasi-legislative in nature, may not be annulled except upon a compelling showing that the calculations from which [they] derived were unreasonable" (*Matter of Society of N.Y. Hosp. v Axelrod*, 70 NY2d 467, 473 [1987] [internal quotation marks omitted]). DOH is entitled to a "high degree of judicial deference, especially when . . . act[ing] in the area of its particular expertise," and thus petitioners bear the "heavy burden of showing" that DOH's rate-setting methodology "is unreasonable and unsupported by any evidence" (Consolation Nursing Home, 85 NY2d at 331-332).

(*Matter of Nazareth Home of the Franciscan Sisters v Novello*, 7 N.Y.3d 538, 544 [2006]).

More specifically, the Court of Appeals held in a case in which there was a legislative directive to exclude certain Medicaid payments, that the "interpretation and implementation [of the statute] was most appropriately left to [DOH's], sound discretion." (*Matter of Reconstruction Home & Health Care Ctr., Inc. v Daines*, 65 A.D.3d 786, 787 [3rd Dept 2009]). Woodycrest has failed to show that the method by which DOH effected a scale back was arbitrary, capricious and contrary to law.

Accordingly, the fifth and sixth cause of action of Woodycrest are dismissed.

ADDITIONAL STAFF ADD-ON

In calculating a post-rebasing reimbursement rate for Woodycrest, a hold harmless, facility, DOH did not include as an operating expense, a Nursing Salary Adjustment, which was added after the 1983 base year. 10NYCRR 86-2.10(r) However, under PHL §2808 (2-b)(b)(i)(A), the hold harmless facilities, such as Woodycrest, shall not receive an "operating cost component of rates of payment... [that is] less that the operating component received in the two thousand eight rate period, as adjusted for inflation on an annual basis."

10 NYCRR 86-2.10(r), directs that the Nursing Salary Adjustment applies to the "operating portion of the rate." Clearly the legislature, by statute, could have removed the Nursing Salary Adjustment from the operating expenses of the hold harmless facilities, but it did not. DOH's actions in not including the Nursing Salary Adjustment in its reimbursement rate calculations was arbitrary, capricious and contrary to law. Therefore, under statute and the regulations of the DOH, Woodycrest is entitled to the Nursing Salary Adjustment, Woodycrest received in 2008.

Accordingly, pursuant to Woodycrest's first and second causes of action, it is declared that Woodycrest is entitled to receive the Nursing Salary Adjustment of $12.09 per patient day,

for the pertinent period of time. The previous Medicaid rate determination by Respondents is annulled as arbitrary, capricious and contrary to law and DOH shall recalculate Woodycrest's Medicaid rate for the pertinent period to include the Nursing Salary Adjustment of $12.09 per day.

OBRA ADD-ON

Unlike the nursing add-on, the federal Omnibus Budget Reconciliation Act of 1987, (OBRA), add-on was designated to be added to the rate, rather than the operating expenses as it was with the Nursing Salary Adjustment. OBRA added $.84 per Medicaid patient day to the reimbursement provided to the facilities. The additional reimbursement under OBRA was to pay for federal requirements in the following area: "the completion of resident assessments, the development and review of comprehensive care plans for residents, staff training for the new resident assessment tool, quality assurance committee costs, nurse aide registry costs, psychotropic drug reviews, and surety bond requirements." 10 NYCRR 86-2.10(u)(1).

Under 10 NYCRR 86-2.10(u), facilities were "to receive a per diem adjustments to its rate." Therefore the hold harmless law, PHL §2808 (2-b)(b)(i)(A), does not apply to the OBRA add-on, as the hold harmless law refers exclusively to maintaining the operating component of the rate received, not the actual overall daily rate the facility received.

Accordingly, the third and fourth causes of action are dismissed.

RESERVED BED DAY

In setting rates, the dollar amount of the total of operating and capital costs of a facility is divided by the number of patient days. DOH calculation of the number of patient days for purposes of the aforementioned formula, included both the number of patient days when a patient physically was present at the facility and occupied a bed and also counted those days the

patient was temporarily absent from the facility. DOH reimbursed the facility at the resulting per diem rate for both types of patient days.

The reserved bed day issue has been definitively resolved by the First Department in the following holding:

> While deference is generally given to an agency's interpretation of its regulations, Supreme Court properly concluded that the Department of Health's (DOH) inclusion of reserved bed patient days in the total of patient days when calculating plaintiff nursing facilities' base per diem Medicaid reimbursement rate, is irrational, unreasonable and contrary to the plain language of 10 NYCRR 86-2.8—the controlling regulation (see *Matter of Nazareth Home of the Franciscan Sisters v Novello*, 7 NY3d 538, 544 [2006]; *Matter of Visiting Nurse Serv. of N.Y. Home Care v New York State Dept. of Health*, 5 NY3d 499, 506 [2005]). Indeed, the regulation makes clear that "patient days" and "reserved bed patient days" are mutually exclusive, are to be calculated separately, and bear no relation to each other (10 NYCRR 86-2.8 [a], [d]).

(Kateri Residence, a Not-For-Profit Corporation, et al., v Antonia C. Novello, M.D., as Commissioner of Department of Health of State of New York, et al., 95 AD3d 619, 619-620 [1st Dept 2012]).

Accordingly, pursuant to Woodycrest's seventh and eighth causes of action, it is declared that reserved bed days be removed from the total patient days when calculating Woodycrest's Medicaid rates, and DOH is directed to recalculate Woodycrest's Medicaid rates to exclude reserved bed days from total patient days.

CONCLUSION

Pursuant to Woodycrest's first and second causes of action, it is declared that Woodycrest is entitled to receive the Nursing Salary Adjustment of $12.09 per day, for the pertinent period of time. The previous Medicaid rate determination by Respondents is annulled as arbitrary, capricious and contrary to law and shall recalculate Woodycrest's Medicaid rate for the pertinent

period to include the Nursing Salary Adjustment of $12.09 per day.

Pursuant to Woodycrest's seventh and eighth causes of action, it is declared that reserved bed days be removed from the total patient days when calculating Woodycrest's Medicaid rates, and DOH is directed to recalculate Woodycrest's Medicaid rates to exclude reserved bed days from total patient days.

The third, fourth, fifth and sixth causes of action of Woodycrest are dismissed. The ninth cause of action is withdrawn with prejudice.

The foregoing shall constitute the decision and order of the Court.

Dated: SEP 0 9 2015

KENNETH L. THOMPSON JR., J.S.C.

Appendix IV
2018 Title XIX State Plan
Second Quarter Amendment
Public Notice

MISCELLANEOUS NOTICES/HEARINGS

Notice of Abandoned Property Received by the State Comptroller

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

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

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

PUBLIC NOTICE
Department of Health

Pursuant to 42 CFR Section 447.205, the Department of Health hereby gives public notice of the following:

The Department of Health proposes to amend the Title XIX (Medicaid) State Plan for long term care services to comply with enacted statutory provisions. The following changes are proposed:

Long Term Care Services

Effective on or after May 17, 2018, the 2018-2019 enacted budget authorizes the commissioner to impose a 2% penalty on poor performing nursing homes based on the two most recent years of nursing home quality initiative data. If the facility was ranked in the two lowest quintiles for the two most recent years, and the lowest quintile for the most recent year of NHQI data then the nursing home is subject to the 2% penalty. Additionally, financially distressed providers are excluded from this penalty.

The estimated annual net aggregate decrease in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal years 2018/2019 and 2019/2020 is ($20,000,000).

The public is invited to review and comment on this proposed State Plan Amendment, a copy of which will be available for public review on the Department's website at http://www.health.ny.gov/regulations/state_plans/status. Individuals without Internet access may view the State Plan Amendments at any 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, Division of Finance and Rate Setting, 99 Washington Ave., One Commerce Plaza, Suite 1432, Albany, NY 12210, e-mail: spa_inquiries@health.ny.gov

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 services to comply with enacted statutory provisions. The following changes are proposed:

Institutional Services

Effective on or after May 17, 2018, in response to a New York State Supreme Court decision in the Matter of The Bronx-Lebanon Highbridge Woodycrest Center, the Department of Health is required to make a payment to this facility in relation to the recalculation of reserve bed days.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this decision for state fiscal year 2018/2019 is $5.7 million.

The public is invited to review and comment on this proposed State Plan Amendment, a copy of which will be available for public review on the Department's website at http://www.health.ny.gov/regulations/state_plans/status. Individuals without Internet access may view the State Plan Amendments at any 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, Division of Finance and Rate Setting, 99 Washington Ave., One Commerce Plaza, Suite 1432, Albany, NY 12210, e-mail: spa_inquiries@health.ny.gov

PUBLIC NOTICE

Department of Health

The Department of Health is pleased to announce the date for Upstate Public Comment Day for New York's 1115 Waiver programs.

The Upstate Public Comment Day will be held on June 19th at the Empire State Plaza, Meeting Room 6, Albany, NY from 1:00 p.m. - 4:00 p.m. Any updates related to the forum will be sent via the MRT Listserv. Any written public comment may be submitted through June 29th to 1115waivers@health.ny.gov. Please include "1115 Public Forum Comment" in the subject line.

The 1115 waiver is designed to permit New York to use a managed care delivery system to deliver benefits to Medicaid recipients, create efficiencies in the Medicaid program, and enable the extension of coverage to certain individuals who would otherwise be without health insurance. In addition, New York's goals in implementing its 1115 waiver include improving access to health services and better health outcomes for New Yorkers through multiple programs. The Delivery System Reform Incentive Payment (DSRIP) program is a significant waiver initiative, and members of the DSRIP Project Approval and Oversight Panel will join DOH staff in listening to the feedback provided by members of the public and stakeholders at this meeting.

These meetings will be webcast live and will be open to the public. No pre-registration is required. Individuals who wish to provide comment will be asked to register on site no later than 2pm, and will speak in their order of registration.

We kindly request that all comments be limited to 5 minutes per presenter to ensure that all public comments may be heard. Please direct all questions to 1115waivers@health.ny.gov

PUBLIC NOTICE

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

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

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

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

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

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

BENEFICIARY NAME	PUBLICATION CITY	PUB STATE
GUIDO,WILL A ESTATE OF	DUNCAN	OK
COOK,LIDDIA MAE	ELLINGTON	CT
ROSA BURGOS,MARIA	GREENSBORO	NC
REED,SUSAN J	ELMIRA	NY
RODRIGUEZ,RAMON M ESTATE OF	NEW YORK	NY
MONROE,ESSIE	BROOKLYN	NY
SWARTZ,ADELINE ESTATE OF	SOUTH PASADENA	FL
FEENEY,ROSE ESTATE OF	ALBANY	NY
BUTLER,PATRICIA	ALBANY	NY
BOGAN,LILA ESTATE OF	UNKNOWN	NY
CANTOR,SHIRLEY	ROCHESTER	NY
MALKIEWICZ,ELEANOR D ESTATE OF	BUFFALO	NY
ANDERSON,WILLIAM ESTATE OF	JACKSONVILLE	FL
SCATTS,LUCY	WHITE PLAINS	NY
HEINNEY,ELEXAS	OCEANSIDE	NY
DEBIN,JEAN	DAYTONA BEACH	FL
RAMOS,ROSEMARIE	ALBANY	NY
MCDONALD,JAMES PERCY	HUDSON	NY
PORTER,SHEILIE M	SAUGERTIES	NY
DUNKEL,LINDA	BAYVILLE	NY
DUFF JR,LESTER	BAYSHORE	NY
SHENTON,KATHLEEN E	WILDWOOD	CT
PRATT,EDWARD ESTATE OF	TROY	NY
NUPP,MARK T	JAMESTOWN	NY
AUSTIN,CHARLES E ESTATE OF	BUFFALO	NY
KRALJIC,DANIELLE	ROCKVILLE CENTER	NY
LANGFORD,JOHN J	WATERVLEIT	AZ
SCHMICK,PETER J,JR	EAST SPANAWAY	WA
ABDUL ALI,SADIQ AMIN	BROOKLYN	NY
CARTER,AARON	EAST ELMHURST	NY
SNIPES,BRYAN	BRONX	NY
O'CONNOR,KEVIN J ESTATE OF	CHESAPEAKE	KS
WAITUS,MARTHA ANN	BURNDIGFE	AL
JOSEPH,JULIE A LECTORA	NEW YORK	NY
LECTORA,RENAE A	CORONA	FL
RODRIGUEZ LECTORA,MARY	NEW YORK	NY
SAMUELS,CALVIN	NEW YORK	NY
SMITH,ANJEANETTE LECTORA	NEW YORK	NY
MC LEOD,DARRELL	HOLLYWOOD	SC
BORDONARO,ROBIN C	LEROY	NY
ORTIZ,IRIS	ALBANY	TN
JACKSON,NASSIR	RALEIGH	NC

Appendix V
2018 Title XIX State Plan
Second Quarter Amendment
Responses to Standard Funding Questions

APPENDIX V
LONG TERM CARE SERVICES
State Plan Amendment #18-0050

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 the 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 2 CFR 200 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 Medicaid General Fund Local Assistance Account, which is part of the Global Cap. The Global Cap is funded by General Fund and HCRA resources

There have been no new provider taxes and no existing taxes have been modified.

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 447.272, 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 submit the 2018 Nursing Home UPL.

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 wage equalization factor. 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: The 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 17-0065, 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.