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

MAR 2 9 2019

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

RE: SPA #19-0012
Long Term Care Facility Services

Dear Mr. Cooley:

The State requests approval of the enclosed amendment #19-0012 to the Title XIX (Medicaid) State Plan for long term care facility services to be effective January 1, 2019 (Appendix I). This amendment is being submitted based on enacted legislation. A summary of the proposed amendment is provided in Appendix II.

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

A copy of the pertinent section of enacted legislation 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 December 26, 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,

[redacted]

Donna Frescatore
Medicaid Director
Office of Health Insurance Programs

Enclosures
cc: Mr. Ricardo Holligan
Mr. Tom Brady

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 19 — 0012

2. STATE: New York

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

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
January 1, 2019

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(r)(5) of the Social Security Act, and 42 CFR

7. FEDERAL BUDGET IMPACT
a. FFY 01/01/19-09/30/19 $ 0.00
b. FFY 10/01/19-09/30/20 $ 0.00

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT

Attachment: 4.19-D Part I: Pages 110(d)(21), 110(d)(22), 110(d)(22.2), 110(d)(23), 110(d)(25), 110(d)(25.1), 110(d)(26)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*

Attachment: 4.19-D Part I: Pages 110(d)(21), 110(d)(22), 110(d)(22.2), 110(d)(23), 110(d)(25), 110(d)(25.1), 110(d)(26)

10. SUBJECT OF AMENDMENT

Nursing Home Quality Care Incentive Changes
(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
[redacted]

13. TYPED NAME
Donna Frescatore

14. TITLE
Medicaid Director, Department of Health

15. DATE SUBMITTED
MAR 29 2019

16. RETURN TO
New York State Department of Health
Division of Finance and Rate Setting
99 Washington Ave – One Commerce Plaza
Suite 1432
Albany, NY 12210

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED

18. DATE APPROVED

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL

20. SIGNATURE OF REGIONAL OFFICIAL

21. TYPED NAME

22. TITLE

23. REMARKS

Instructions on Back

Appendix I
2019 Title XIX State Plan
First Quarter Amendment
Amended SPA Pages

New York
110(d)(21)

The New York State Nursing Home Quality Pool (NHQP) is an annual budget-neutral pool of $50 million dollars. The intent of the NHQP is to incentivize Medicaid-certified nursing facilities across New York State to improve the quality of care for their residents, and to reward facilities for quality based on their performance. The set of measures used to evaluate nursing homes are part of the Nursing Home Quality Initiative (NHQI). The performances of facilities in the NHQI determine the distribution of the funds in the NHQP.

NHQI is described below using MDS (Minimum Data Set) year and NHQI (Nursing Home Quality Initiative) year. MDS year refers to the year the assessment data is collected. NHQI year refers to the year when the nursing home performance is evaluated. For example, if the NHQI year is 2019, then the MDS year is 2018. For the [calendar year 2018] NHQI year, the Commissioner will calculate a score and quintile ranking based on data from the [2017 calendar year] MDS year (January 1[, 2017] of the MDS year through December 31[, 2017] of the MDS year), for each non-specialty facility. The score will be calculated based on measurement components comprised of Quality, Compliance, and Efficiency Measures. These measurement components and their resulting score and quintile ranking will be referred to as the Nursing Home Quality Initiative. From the NHQI, the Commissioner will exclude specialty facilities consisting of non-Medicaid facilities, Special Focus Facilities as designated by the Centers for Medicare and Medicaid Services (CMS), Continuing Care Retirement Communities, Transitional Care Units, specialty facilities, and specialty units within facilities. Specialty facilities and specialty units shall include AIDS facilities or discrete AIDS units within facilities, facilities or discrete units within facilities for residents receiving care in a long-term inpatient rehabilitation program for traumatic brain injured persons, facilities or discrete units within facilities that provide specialized programs for residents requiring behavioral interventions, facilities or discrete units within facilities for long-term ventilator dependent residents, facilities or discrete units within facilities that provide services solely to children, and neurodegenerative facilities or discrete neurodegenerative units within facilities. The 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	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
13	Percent of Contract/Agency Staff Used	NYS DOH
14	Rate of Staffing Hours per Day	NYS DOH
	Compliance Measures	
15	CMS Five-Star Quality Rating for Health Inspections as of April 1[, 2018] of the NHQI year (By Region)	CMS
16	Timely Submission and Certification of Complete [2017] New York State Nursing Home Cost Report to the Commissioner for the MDS year	NYS DOH
17	Timely Submission of Employee Influenza Immunization Data for the September 1[, 2017] of the MDS year - March 31[, 2018] of the NHQI year Influenza Season by the deadline of May 1[, 2018] of the NHQI year	NYS DOH
	Efficiency Measure	
18	Rate of Potentially Avoidable Hospitalizations for Long Stay Residents January 1[, 2017] of the MDS year – December 31[, 2017] of the MDS year (As Risk Adjusted by the Commissioner)	NYS DOH

The maximum points a facility may receive for the Quality Component is 70. The applicable percentages or ratings for each of the 14 measures will be determined for each facility. Two measures will be awarded points based on threshold values. The remaining 12 measures will be ranked and grouped by quintile with points awarded as follows:

Scoring for 12 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 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.

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110(d)(22.2)

- Percent of Contract/Agency Staff Used (based on threshold)

The remaining 12 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 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
- Percent of Long Stay Antipsychotic Use in Persons with Dementia
- Percent of Long Stay Residents Who Received the Pneumococcal Vaccine
- Rate of Staffing Hours per Day

The grid below illustrates the method of awarding improvement points.

		[2017] MDS year Performance				
	Quintiles	1 (best)	2	3	4	5
[2018] NHQI year 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 [2017] MDS year NHQI performance is in the third quintile, and [2018] NHQI year 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.

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110(d)(23)

The maximum points a facility may receive for the Compliance Component is 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	10
4 Stars	7
3 Stars	4
2 Stars	2
1 Star	0
Timely Submission and Certification of Complete [2017] New York State Nursing Home Cost Report to the Commissioner <u>of the MDS year</u>	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[, 2018] <u>of the NHQI year</u> deadline (Facilities that fail to submit timely influenza data by the deadline will receive zero points)

CMS Five-Star Quality Rating for Health Inspections
The CMS Five-Star Quality Rating for Health Inspections as of April 1[, 2018] <u>of the NHQI year</u> 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.

Electrolyte imbalance		E860, E861, E869, E870, E871, E872, E873, E874, E875, E876, E878
Congestive heart failure		I0981, I501, I5020, I5021, I5022, I5023, I5030, I5031, I5032, I5033, I5040, I5041, I5042, I5043, I509
Anemia		D500, D501, D508, D509, D510, D511, D513, D518, D520, D521, D528, D529, D530, D531, D532, D538, D539, D62, D638

Reduction of Points Base: When the number of long stay residents 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] payments, which will be applicable to the [2018 calendar year] NHQI Year, will be made to fund the NHQP and to make payments based upon the scores calculated from the NHQI as described above.

- Each non-specialty facility will be subject to a Medicaid rate reduction to fund the NHQI, which will be calculated as follows:

- For each such facility, Medicaid revenues, calculated by multiplying each facility's NHQI Year promulgated rate in effect for such period by reported Medicaid days, as reported in a facility's MDS Year [2017] 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 as reported in a facility's cost report of the MDS Year. If a facility fails to submit a timely filed [2017] cost report in the MDS Year, the most recent cost report will be used.

- The total 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 payment. Such payments will be paid as a [per diem adjustment] lump sum payment for the [2018] NHQI Year [calendar year]. Such shares and payments will be calculated as follows:

New York
110(d)(25.1)

Distribution of NHQP Payments			
Facilities Grouped by Quintile	**A Facility's Medicaid Revenue Multiplied by Award Factor**	**B Share of $50 Million [NHQI] NHQP Payments Allocated to Facility**	**[C Facility Per Diem Quality Payment]**
1st Quintile	Each facility's [2017] MDS Year Medicaid days multiplied by [2018] Medicaid Rate as of January 1[, 2018] of the NHQI Year = 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] Column A, Multiplied by $50 million	[Each facility's column B divided by the facility's 2017 Medicaid days]
2nd Quintile	Each facility's [2017] MDS Year Medicaid days multiplied by [2018] Medicaid Rate as of January 1[, 2018] of the NHQI Year = 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] Column A, Multiplied by $50 million	[Each facility's column B divided by the facility's [2017] Medicaid days]
3rd Quintile	Each facility's [2017] MDS Year Medicaid days multiplied by [2018] Medicaid Rate as of January 1[, 2018] of the NHQI Year = 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] Column A, Multiplied by $50 million	[Each facility's column B divided by the facility's 2017 Medicaid days]
Total	Sum of [Total Medicaid Revenue for all facilities] Column A	Sum of quality pool funds: $50 million	--

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110(d)(26)

The following facilities will not be eligible for [2018] NHQP payments and the scores of such facilities will not be included in determining the share of the NHQP payments:

- A facility with health inspection survey deficiency data showing a level J/K/L deficiency during the time period of July 1[, 2017] of the MDS year through June 30[, 2018] of the NHQI year. Deficiencies will be reassessed on October 1[, 2018] of the NHQI year to allow a three-month window (after the June 30[, 2018] of the NHQI year cutoff date) for potential Informal Dispute Resolutions (IDR) to process. The deficiency data will be updated to reflect IDRs occurring between July 1[, 2018] of the NHQI year and September 30[,2018] of the NHQI year. Any *new* J/K/L deficiencies between July 1[, 2018] of the NHQI year and September 30[, 2018] of the NHQI year will *not* be included in the [2018] NHQI.

Appendix II
2019 Title XIX State Plan
First Quarter Amendment
Summary

SUMMARY
SPA #19-0012

This State Plan Amendment proposes to maintain the quality incentive for nursing homes into the 2019 rate year and will continue to recognize improvement in performances as an element in the program and provide for other minor modifications. This SPA will clarify the reporting requirements related to the 2019 quality adjustments.

Appendix III
2019 Title XIX State Plan
First Quarter Amendment
Authorizing Provisions

SPA 19-0012

Pub. Health § 2808(2-c)(d)

(d) 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
2019 Title XIX State Plan
First Quarter Amendment
Public Notice

expenditures attributable to this initiative contained in the budget for state fiscal year 2019/2020 is $1,908,000.

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

Copies of the proposed State Plan Amendments will be on file in each local (county) social services district and available for public review.

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, or 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 long term care services to comply with Public Health Law Section 2808 (2-c)(d) . The following changes are proposed:

Long Term Care Services

Effective on and after January 1, 2019, the quality incentive program for non-specialty nursing homes will continue to recognize improvement in performance and provide for other minor modifications.

There is no additional estimated annual change to gross Medicaid expenditures attributable to this initiative for State Fiscal year 2019/2020.

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, or e-mail: spa_inquiries@health.ny.gov

PUBLIC NOTICE

Department of Health

Pursuant to 42 CFR Section 447.205, the Department of Health and Office for People With Developmental Disabilities (OPWDD), hereby give public notice of the following:

The Department of Health proposes to amend the Title XIX (Medicaid) State Plan for non-institutional services to make New York, Systemic, Therapeutic Assessment, Resources and Treatment (NYSTART) available as a Medicaid State Plan service. This action is being taken based on (OPWDD)'s statutory responsibility to provide and encourage the provision of appropriate programs, supports, and services in the areas of care, treatment, habilitation, rehabilitation, and other education and training of persons with developmental disabilities (NYS Mental Hyg. Law § 13.07). OPWDD also has the authority to plan, promote, establish, develop, coordinate, evaluate, and conduct programs and services for prevention, diagnosis, examination, care treatment, rehabilitation, training, and research for the benefit of individuals with developmental disabilities, to take all actions necessary, desirable, or proper to implement the purposes of the Mental Hygiene Law, and to carry out its purposes and objectives within available funding (Mental Hyg. Law § 13.15(a)).

The following changes are proposed:

Non-Institutional Services

NYSTART is a community-based program that provides crisis prevention and response services to individuals with intellectual and developmental disabilities who present with complex behavioral and mental health needs, and will be available to those individuals, their families and others in the community who provide support, effective on or after Jan 1, 2019. NYSTART uses a person-centered, positive, evidence-informed approach to help individuals, families, caregivers, agencies, and other providers.

NYSTART offers training, consultation and technical assistance on the use of positive behavioral supports services and other therapeutic tools. The program builds on existing resources by providing clinical assessments (including psychiatric, behavioral and medical), consultation, education and training, crisis response and therapeutic intervention. NYSTART services are available to individuals age 6 or over who have intellectual and developmental disabilities and present with behavioral and mental health concerns. An OPWDD eligibility determination is required to receive the full array of NYSTART services, including clinical team support, In Home stabilization supports and short term Resource Center (site-based) stabilization services. Services are provided based on clinical assessment and individual needs.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2018/2019 is $22 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/

Appendix V
2019 Title XIX State Plan
First Quarter Amendment
Responses to Standard Funding Questions

APPENDIX V
LONG TERM CARE SERVICES
State Plan Amendment #19-0012

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: The Nursing Home Quality Pool is paid through a proportionate reduction to nursing home rates of $50M and a reallocation of the fund to those facilities which score in the top three quintiles. The funds are general Medicaid fund paid though the non-specialty nursing home rate.

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 are not enhancements to the rates in that no additional monies are expended to fund or pay the NHQI. The pool is self-funded

and reallocates the proceeds proportionately from all nursing facilities to those in the top three quintiles.

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 2019 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 equalization factor (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: 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.