NEW YORK STATE OF OPPORTUNITY. Department of Health

KATHY HOCHUL
Governor

MARY T. BASSETT, M.D., M.P.H.
Commissioner

KRISTIN M. PROUD
Acting Executive Deputy Commissioner

March 31, 2022

Todd McMillion
Director
Department of Health and Human Services
Centers for Medicare and Medicaid Services
233 North Michigan Ave, Suite 600
Chicago, IL 60601

RE: SPA #22-0008
Long Term Care Facility Services

Dear Mr. McMillion:

The State requests approval of the enclosed amendment #22-0008 to the Title XIX (Medicaid) State Plan for long term care facility services to be effective January 1, 2022 (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). A copy of the public notice of this proposed amendment, which was given in the New York State Register on December 29, 2021, 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]

Brett R. Friedman
Acting Medicaid Director
Office of Health Insurance Programs

Enclosures

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: 22 — 0008

2. STATE: NY

3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT ◯ XIX ◯ XXI

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
January 01, 2022

5. FEDERAL STATUTE/REGULATION CITATION
§1902(r)(5) of the Social Security Act, and 42 CFR

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 01/01/22-09/30/22 $ 0
b. FFY 10/01/22-09/30/23 $ 0

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachments 4.19-D Part I Pages: 110(d)(21), 110(d)(22), 110(d)(22.1), 110(d)(22.2), 110(d)(22.3), 110(d)(23), 110(d)(23.1) 110(d)(24), 110(d)(25), 110(d)(26)

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachments 4.19-D Part I Pages: 110(d)(21), 110(d)(22), 110(d)(22.1), 110(d)(22.2), 110(d)(22.3), 110(d)(23), 110(d)(23.1) 110(d)(24), 110(d)(25),110(d)(26)

9. SUBJECT OF AMENDMENT
Nursing Home Quality Care Incentive Changes (FMAP = 50%)

10. 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:

11. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

12. TYPED NAME
Brett R. Friedman

13. TITLE
Acting Medicaid Director

14. DATE SUBMITTED
March 31, 2022

15. 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 CMS USE ONLY

16. DATE RECEIVED

17. DATE APPROVED

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL

19. SIGNATURE OF APPROVING OFFICIAL

20. TYPED NAME OF APPROVING OFFICIAL

21. TITLE OF APPROVING OFFICIAL

22. REMARKS

Instructions on Back

Appendix I
2022 Title XIX State Plan
First Quarter Amendment
Amended SPA Pages

New York
110(d)(21)

1905(a)(4)(A) Nursing Facility Services

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] 2021, then the MDS year is [2018] 2020. For [the NHQI year] NHQI 2021, the Commissioner will calculate a score and quintile ranking based on data from the MDS year 2020 (January 1 of the MDS year through December 31 of the MDS year), for each non-specialty facility. The score will be calculated based on measurement components comprised of Quality [,] and 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] will 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 [,] and Compliance [, and Efficiency] Measures. To offset the impact of COVID-19, some of the quality and the efficiency measures are removed from NHQI 2021 with the intent of bringing back the measures for future NHQI. The measures in this NHQI are listed below:

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]

1905(a)(4)(A) Nursing Facility Services

[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 Resident per Day	NYS DOH
	Compliance Measures	
[15]	CMS Five-Star Quality Rating for Health Inspections as of April 1 of the NHQI year (By Region)	CMS
[16]	Timely Submission and Certification of Complete 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 of the MDS year - March 31 of the NHQI year Influenza Season by the deadline [of May 1 of the NHQI year]	NYS DOH
	[Efficiency Measure]	
[18]	[Rate of Potentially Avoidable Hospitalizations for Long Stay Residents January 1 of the MDS year – December 31 of the MDS year (As Risk Adjusted by the Commissioner)]	[NYS DOH]

Quality Component:
The maximum points a facility may receive for the Quality Component is [70] 50. The applicable percentages or ratings for each of the [14] 10 quality measures will be determined for each facility. Four quality measures are removed in this NHQI year. Three of these measures are temporarily removed to offset the impact of COVID-19 (Percent of Long Stay High Risk Residents with Pressure Ulcers, Percent of Long Stay Residents Who have Depressive Symptoms, Percent of Long Stay Residents Who Lose Too Much Weight). These measures would be reassessed and brought back in the next NHQI year as appropriate. One measure was retired by CMS in October 2019 (The Percent of Long Stay Residents Who Self-Report Moderate to Severe Pain).

The quality measures will be awarded points based on quintile values or threshold values. For quintile-based measures, the measures will be ranked and grouped by quintile with points awarded as follows:

Scoring for quintile-based Quality Measures	
Quintile	**Points**
1st Quintile	5
2nd Quintile	3
3rd Quintile	1
4th Quintile	0
5th Quintile	0

New York
110(d)(22.1)

1905(a)(4)(A) Nursing Facility Services

For threshold-based measures, the points will be awarded based on threshold values. The threshold-based measures are:

- 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.
- Percent of Long Stay Residents Experiencing One or More Falls with Major Injury: facilities will be awarded five points if the rate is equal to or less than 5%, and zero points if the rate is greater than 5%.
- [Percent of Long Stay Residents Who Self-Report Moderate to Severe Pain: facilities will be awarded five points if the rate is equal to or less than 5%, and zero points if the rate is greater than 5%.]
- Percent of Long Stay Residents with a Urinary Tract Infection: facilities will be awarded five points if the rate is equal to or less than 5%, and zero points if the rate is greater than 5%.

Rate of Staffing Hours per Resident per Day

NYS DOH will calculate an annualized adjusted rate of staffing hours per resident per day using staffing information downloaded from the Centers for Medicare & Medicaid Services (CMS) appropriate for that year. The staffing information is based on Payroll Based Journal Public Use Files (PBJ PUFs). PBJ PUFs are public data sets prepared by the CMS. For this measure, staffs are defined as RNs, LPNs, and Aides. The rate of reported staffing hours and the rate of case-mix staffing hours will be taken from the staffing information and the adjusted rate of staffing hours will be calculated using the formula below.

Rate Adjusted = (Rate Reported/Rate Case-Mix) * Statewide average

Awarding for Improvement

Nursing homes will be awarded improvement points from previous years' performance in selected measures in the Quality Component only. One improvement point will be awarded for a nursing home that improves in its quintile for a specific quality measure, compared to its quintile in the previous year for that quality measure. Nursing homes that obtain the top quintile in a quality measure will not receive an improvement point because maximum points per measure cannot exceed five. The threshold-based quality measures below will not be eligible to receive improvement points:

- Percent of Employees Vaccinated for Influenza
- Percent of Long Stay Residents Experiencing One or More Falls with Major Injury
- [Percent of Long Stay Residents Who Self-Report Moderate to Severe Pain]
- Percent of Long Stay Residents With a Urinary Tract Infection

New York
110(d)(22.2)

1905(a)(4)(A) Nursing Facility Services

- Percent of Contract/Agency Staff Used

The quintile-based 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 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 Whose Need for Help with Daily Activities Has Increased
- 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 Resident Per Day

The grid below illustrates the method of awarding improvement points.

MDS year Performance						
NHQI year Performance	Quintiles	1 (best)	2	3	4	5
	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 MDS year performance is in the third quintile, and NHQI year 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 three risk-adjusted quality measures are removed in this NHQI year (Percent of Long Stay Residents Who Self-Report Moderate to Severe Pain, Percent of Long Stay High Risk Residents with Pressure Ulcers, Percent of Long Stay Residents Who Lose Too Much Weight).

[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, BMI, prognosis of less than six months of life expected, diabetes, heart failure, deep vein thrombosis, anemia, renal failure, hip fracture, bowel incontinence, cancer, paraplegia, and quadriplegia.]

New York
110(d)(22.3)

1905(a)(4)(A) Nursing Facility Services

[

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

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

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

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

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

- When a quality measure has a denominator of less than 30

New York
110(d)(23)

1905(a)(4)(A) Nursing Facility Services

Compliance Component: The maximum points a facility may receive for the Compliance Component is 20 points. Points [shall] will 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 New York State Nursing Home Cost Report to the Commissioner of the MDS year	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 of the NHQI year 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 of the NHQI year will be adjusted by region. This is not a risk adjustment. For eligible New York State nursing homes, the health inspection scores from CMS will be stratified by region. Cut points for health inspection scores within each region will be calculated using the CMS 10-70-20% distribution method. Per CMS' methodology, the top 10% of nursing homes receive five stars. The middle 70% receive four, three, or two stars, with an equal percentage (~23.33%) receiving four, three, or two stars. The bottom 20% receive one star. Each nursing home will be awarded a star rating based on the health inspection score cut points specific to its region. Regions include the Metropolitan Area (MARO), Western New York (WRO), Capital District (CDRO), and Central New York (CNYRO). Regions are defined by the New York State Health Facilities Information System (NYS HFIS). The counties within each region are shown below.

Metropolitan Area Regional Offices (MARO): Bronx, Dutchess, Kings, Nassau, New York, Orange, Putnam, Queens, Richmond, Rockland, Suffolk, Sullivan, Ulster, and Westchester.

Central New York Regional Offices (CNYRO): Broome, Cayuga, Chenango, Cortland, Herkimer, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, Saint Lawrence, Tioga, and Tompkins.

Capital District Regional Offices (CDRO): Albany, Clinton, Columbia, Delaware, Essex, Franklin, Fulton, Greene, Hamilton, Montgomery, Otsego, Rensselaer, Saratoga, Schenectady, Schoharie, Warren, and Washington.

New York
110(d)(23.1)

1905(a)(4)(A) Nursing Facility Services

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

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

Efficiency Component:

The potentially avoidable hospitalizations measure is temporarily removed in this NHQI year. This is to offset the impact of COVID-19 and the incompleteness of hospitalization data. This measure will be reassessed and brought back in the next NHQI year as appropriate.

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

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

The Efficiency Measure will be risk adjusted for certain conditions chosen from a pool of covariates as reported in the MDS 3.0 data to account for the impact of individual risk factors: gender, age, shortness of breath, falls with injury, pressure ulcer, activities of daily living, renal disease, cognitive impairment, dementia, diabetes, parenteral nutrition, rheumatologic disease, gastrointestinal disease, multi-drug-resistant infection, indwelling catheter, wound infection, deep vein thrombosis, cancer, feeding tube, coronary artery disease, liver disease, paralysis, peripheral vascular disease, and malnutrition.]

New York
110(d)(24)

Reserved

1905(a)(4)(A) Nursing Facility Services

[A potentially avoidable hospitalization is found by matching a discharge assessment in the MDS 3.0 data to its hospital record in SPARCS. The following primary ICD-10 diagnoses on the SPARCS hospital record are potentially avoidable:

Potentially Avoidable Hospitalization Condition	Source of ICD-10-CM Codes
Respiratory infection	MULTI CCS LVL 2 LABEL "Respiratory infections" *
Sepsis	CCS category descriptions "Septicemia (except in labor)" and "Shock" (only "Severe sepsis with septic shock") *
Urinary tract infection	CCS category description "Urinary tract infections" *

]

1905(a)(4)(A) Nursing Facility Services

[Electrolyte imbalance]	[CCS category description "Fluid and electrolyte disorders" *]
[Heart failure]	[PQI 08 Heart Failure Admission Rate †]
[Anemia]	[MULTI CCS LVL 2 LABEL "Anemia" *]

[* From Healthcare Cost and Utilization Project (HCUP) Clinical Classifications Software (CCS) files found at https://www.hcup-us.ahrq.gov/tools_software.jsp

† Agency for Healthcare Research and Quality (AHRQ) Prevention Quality Indicators (PQI) https://www.qualityindicators.ahrq.gov/Downloads/Modules/PQI/V2019/TechSpecs/PQI_08_Heart_Failure_Admission_Rate.pdf

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 payments, which will be applicable to the 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 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 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 lump sum payment outside of the Nursing Home rate for the NHQI Year. Such shares and payments will be calculated as follows:

New York
110(d)(26)

1905(a)(4)(A) Nursing Facility Services

The following facilities will not be eligible for 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 of the MDS year through June 30 of the NHQI year. Deficiencies will be reassessed on October 1 of the NHQI year to allow a three-month window (after the June 30 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 of the NHQI year and September 30 of the NHQI year. Any *new* J/K/L deficiencies between July 1 of the NHQI year and September 30 of the NHQI year will *not* be included in the NHQI. If a JKL citation is found to be expunged or lowered based upon an IDR panel review, the Department reserves the right to make the adjustments.

Appendix II
2022 Title XIX State Plan
First Quarter Amendment
Summary

SUMMARY
SPA #22-0008

This State Plan Amendment proposes to maintain the quality incentive for nursing homes into the 2022 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 2022 quality adjustments.

Appendix III
2022 Title XIX State Plan
First Quarter Amendment
Authorizing Provisions

SPA 22-0008

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
2022 Title XIX State Plan
First Quarter Amendment
Public Notice

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, 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 all qualifying Mental Hygiene services to comply with enacted statutory provisions. The following changes are proposed:

Non-Institutional

Effective on or after December 30, 2021 the Department of Health will adjust rates to reflect labor costs resulting from statutorily required increases in the New York State minimum wage. The minimum wage rate increases apply to services provided in Office of Mental Health licensed rehabilitation programs, effective December 31, 2021.

The estimated annual aggregate increase in gross Medicaid expenditures attributable to the rate increase is $14,032 in State Fiscal Year 2022 and $56,128 in State Fiscal Year 2023.

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:

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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, 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, 2022, 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 estimated annual change to gross Medicaid expenditures as a result of this proposed amendment.

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:

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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, New York 12210, pa_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:

Appendix V
2022 Title XIX State Plan
First Quarter Amendment
Responses to Standard Funding Questions

APPENDIX V
LONG TERM CARE SERVICES
State Plan Amendment #22-0008

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 withholding from Medicaid cycle checks and a reallocation of the funds to those facilities which score in the top three quintiles. The funds are general Medicaid funds paid as a lump sum supplemental payment in MMIS.

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 and CMS are working toward completing and approval of current year 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: There are various state agencies that perform audits each year to determine the appropriateness of Medicaid payments. In the event that inappropriate payments are determined, recoupments would be initiated, and the Federal share would be returned to CMS within the associated quarterly expenditure report.

ACA Assurances:

1. **Maintenance of Effort (MOE). Under section 1902(gg) of the Social Security Act (the Act), as amended by the Affordable Care Act, as a condition of receiving any Federal payments under the Medicaid program during the MOE period indicated below, the State shall not have in effect any eligibility standards, methodologies, or procedures in its Medicaid program which are more restrictive than such eligibility provisions as in effect in its Medicaid program on March 10, 2010.**

   MOE Period.
   - **Begins on: March 10, 2010, and**
   - **Ends on: The date the Secretary of the Federal Department of Health and Human Services determines an Exchange established by a State under the provisions of section 1311 of the Affordable Care Act is fully operational.**

   Response: This SPA complies with the conditions of the MOE provision of section 1902(gg) of the Act for continued funding under the Medicaid program.

2. **Section 1905(y) and (z) of the Act provides for increased FMAPs for expenditures made on or after January 1, 2014 for individuals determined eligible under section 1902(a)(10)(A)(i)(VIII) of the Act. Under section 1905(cc) of the Act, the increased FMAP under sections 1905(y) and (z)**

would not be available for States that require local political subdivisions to contribute amounts toward the non-Federal share of the State's expenditures at a greater percentage than would have been required on December 31, 2009.

Prior to January 1, 2014 States may potentially require contributions by local political subdivisions toward the non-Federal share of the States' expenditures at percentages greater than were required on December 31, 2009. However, because of the provisions of section 1905(cc) of the Act, it is important to determine and document/flag any SPAs/State plans which have such greater percentages prior to the January 1, 2014 date in order to anticipate potential violations and/or appropriate corrective actions by the States and the Federal government.

Response: This SPA would [ ] / would not [✓] violate these provisions, if they remained in effect on or after January 1, 2014.

3. **Please indicate whether the State is currently in conformance with the requirements of section 1902(a)(37) of the Act regarding prompt payment of claims.**

   Response: 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 this submission. To date, no feedback has been received from any tribal representative in response to the proposed change in this SPA.