



Department of Health

KATHY HOCHUL
Governor

JAMES V. McDONALD, M.D., M.P.H.
Commissioner

JOHANNE E. MORNE, M.S.
Executive Deputy Commissioner

March 29, 2024

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 #24-0025
Long Term Care Facility Services

Dear Mr. McMillion:

The State requests approval of the enclosed amendment #24-0025 to the Title XIX (Medicaid) State Plan for long term care facility services to be effective January 1, 2024 (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 is given in the New York State Register on December 27, 2023, 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,



Amir Bassiri
Medicaid Director
Office of Health Insurance Programs

Enclosures

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL
FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES**

1. TRANSMITTAL NUMBER <u>2 4 — 0 0 2 5</u>	2. STATE <u>NY</u>
3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT <input checked="" type="radio"/> XIX <input type="radio"/> XXI	

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

4. PROPOSED EFFECTIVE DATE
January 1, 2024

5. FEDERAL STATUTE/REGULATION CITATION
§ 1905(a)(4)(A) Nursing Facility Services

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a FFY 01/01/24-09/30/24 \$ 0
b FFY 10/01/24-09/30/25 \$ 0

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Att 4.19-D Part I: Pages 110(d)(21), 110(d)(22), 110(d)(22.1), 110(d)(22.1)(a), 110(d)(22.1)(b), 110(d)(22.2), 110(d)(22.3), 110(d)(24)

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable)
Att 4.19-D Part I: Pages 110(d)(21), 110(d)(22), 110(d)(22.1), 110(d)(22.1)(a), 110(d)(22.2), 110(d)(22.3), 110(d)(24)

9. SUBJECT OF AMENDMENT
Nursing Home Quality Incentive Changes

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. NAME OF SUBMITTER
Amir Bassiri

13. TITLE
Medicaid Director

14. DATE SUBMITTED
March 29, 2024

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

Attachment A
Annotated Pages

Annotated Page:

Attachment 4.19-D: Page 110(d)(22.1)(a)

**New York
110(d)(22.1)(a)**

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

~~Total Nursing Staff Turnover (by region) continued~~

~~The annual turnover percentages for all the NHQI facilities are downloaded from CMS for the MDS year. These percentages are used to calculate quintile cut points for Metropolitan (MARO) and Non-Metropolitan (Non-MARO) region in the New York state. Non-Metropolitan region include Western New York, Capital District, and Central New York. Nursing homes will be given points for this measure based on their performance in that region.~~

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

~~**Non-Metropolitan Area Regional Offices (Non-MARO):**~~

~~Albany, Allegany, Broome, Cattaraugus, Cayuga, Chautauqua, Chemung, Chenango, Clinton, Columbia, Cortland, Delaware, Erie, Essex, Franklin, Fulton, Genesee, Greene, Hamilton, Herkimer, Jefferson, Lewis, Livingston, Madison, Monroe, Montgomery, Niagara, Oneida, Onondaga, Ontario, Orleans, Oswego, Otsego, Rensselaer, Saint Lawrence, Saratoga, Schenectady, Schoharie, Schuyler, Seneca, Steuben, Tioga, Tompkins, Warren, Washington, Wayne, Wyoming, and Yates.~~

~~**Percentage of Current Residents Up to Date with COVID-19 Vaccines with No Medical Contraindications**~~

~~The vaccination rate for this measure is calculated as follows: (Number of Residents Staying in this Facility for At Least 1 Day This Week Up to Date with COVID-19 Vaccines / (Number of All Residents Staying in this Facility for At Least 1 Day This Week—Number of All Residents Staying in this Facility for At Least 1 Day This Week with a Medical Contraindication to a COVID-19 Vaccine at Any Time) * 100.~~

~~The weekly vaccination rates for this measure are downloaded from the CMS's COVID-19 Nursing Home data website. The Nursing Home COVID-19 Public File includes data reported by nursing homes to the CDC's National Healthcare Safety Network (NHSN) Long Term Care Facility (LTCF) COVID-19 Module: Surveillance Reporting Pathways and COVID-19 Vaccinations. One of the weekly vaccination rates during October to December 2022 will be used. The rates will be used to calculate quintile cut points. Nursing homes will be given points for this measure based on their performance.~~

~~**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 Long Stay Residents Experiencing One or More Falls with Major Injury~~
- ~~● Percent of Long Stay Residents with a Urinary Tract Infection~~

TN #24-0025

Approval Date _____

Supersedes TN #23-0016

Effective Date January 1, 2024

Appendix I
2024 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 ~~2022~~ 2023, then the MDS year is ~~2021~~ 2022. For NHQI ~~2022~~ 2023, the Commissioner will calculate a score and quintile ranking based on data from the MDS year ~~2021~~ 2022 (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, 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 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, Compliance, and Efficiency Measures. The measures in this NHQI are listed below:

Quality Measures		Measure Steward
1	Percent of Long Stay Residents Who Received the Pneumococcal Vaccine	CMS
2	Percent of Long Stay Residents Who Received the Seasonal Influenza Vaccine	CMS
3	Percent of Long Stay Residents Experiencing One or More Falls with Major Injury	CMS
4	Percent of Low Risk Long Stay Residents Who Lose Control of Their Bowels or Bladder	CMS
5	Percent of Long Stay High Risk Residents with Pressure Ulcers (As Risk Adjusted by the Commissioner)	CMS
6	Percent of Long Stay Residents Who have Depressive Symptoms	CMS
7	Percent of Long Stay Residents Who Lose Too Much Weight (As Risk Adjusted by the Commissioner)	CMS

TN #24-0025

Approval Date _____

Supersedes TN #23-0016

Effective Date January 1, 2024

**New York
110(d)(22)**

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

8.	Percent of Long Stay Antipsychotic Use in Persons with Dementia	Pharmacy Quality Alliance (PQA)
9. 8.	Percent of Long Stay Residents Whose Need for Help with Daily Activities Has Increased	CMS
10. 9.	Percent of Long Stay Residents with a Urinary Tract Infection	CMS
11. 10.	Percent of Employees Vaccinated for Influenza	NYS DOH
12. 11.	Percent of Contract/Agency Staff Used	NYS DOH
13. 12.	Rate of Staffing Hours per Resident per Day	NYS DOH
14. 13.	Total Nursing Staff Turnover (By Region)	CMS
15. 14.	Percentage of Current Residents Up to Date with COVID-19 Vaccines with No Medical Contraindications	CMS
<u>15.</u>	Percentage of Current Healthcare Personnel Up to Date with COVID-19 Vaccines	CMS
Compliance Measures		
16.	CMS Five-Star Quality Rating for Health Inspections as of April 1 of the NHQI year (By Region)	CMS
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	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 will receive for the Quality Component is 75. The applicable percentages or ratings for each of the 15 quality measures will be determined for each facility. 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
1 st Quintile	5
2 nd Quintile	3
3 rd Quintile	1
4 th Quintile	0
5 th Quintile	0

TN #24-0025

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Effective Date January 1, 2024

**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 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 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%.

~~**Percent of Employees Vaccinated for Influenza:**~~

~~The scoring methodology for this measure is changed from threshold based to quintile based.~~

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

Total Nursing Staff Turnover (by region)

Total nursing staff turnover is defined as the percentage of nursing staff that left the nursing home over a twelve-month period.

The turnover measure is derived based on data from the CMS Payroll-Based Journal (PBJ) System. Using data submitted through PBJ, annual turnover measure for total nurses (RNs, licensed practical/licensed vocational nurses (LPNs), and nurse aides) are constructed by CMS. The PBJ job codes included in the total nursing staff turnover measure are as follows: RN director of nursing (job code 5), RNs with administrative duties (job code 6), RNs (job code 7), LPNs with administrative duties (job code 8), LPNs (job code 9), certified nurse aides (job code 10), aides in training (job code 11), and medication aides/technicians (job code 12). Please refer to Nursing Home Five-Star Quality Rating System: Technical Users' Guide for additional measure specification details.

TN #24-0025

Approval Date _____

Supersedes TN #23-0016

Effective Date January 1, 2024

Appendix II
2024 Title XIX State Plan
First Quarter Amendment
Summary

SUMMARY
SPA #24-0025

This State Plan Amendment proposes to maintain the quality incentive for nursing homes into the 2023 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 2023 quality adjustments.

Appendix III
2024 Title XIX State Plan
First Quarter Amendment
Authorizing Provisions

SPA 24-0025

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 to be funded at the discretion of the commissioner by (i) adjustments in medical assistance rates, (ii) funds made available through state appropriations, or (iii) a combination thereof, 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
2024 Title XIX State Plan
First Quarter Amendment
Public Notice**

Institutional Services

Effective on or after January 1, 2024, the Department of Health will adjust Medicaid rates for hospital-based Chemical Dependence Inpatient Rehabilitation, Medically Managed and Medically Supervised Inpatient Withdrawal and Stabilization programs. Hospital-based Chemical Dependence Inpatient Rehabilitation programs will receive an across the board increase of 7.9%. Hospital-based Medically Managed Inpatient Withdrawal and Stabilization and Medically Supervised Inpatient Withdrawal and Stabilization programs will receive an across the board increase of 4.7%.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative is \$969,000.

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, 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 or after January 1, 2024, the quality incentive program for non-specialty nursing homes will continue to recognize improvement in performance and provide for other minor modifications in the measurement set. The following measure will be removed from the measurement set: Percent of Long Stay Residents with Dementia Who Received an Antipsychotic Medication (PQA). The following measure will be added to the measurement set: Percentage of Current Healthcare Personnel Up to Date with COVID-19 Vaccines.

There is no estimated change to the annual aggregate 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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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 non-institutional services to comply with the enacted New York State budget. The following changes are proposed:

Non-Institutional Services

Effective on or after January 1, 2024, the Department of Health will adjust rates statewide to reflect the impact of New York State Minimum Wage increases for Office of Mental Health (OMH) Outpatient Services, Clinic Services and Rehabilitative Services.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative is \$312,000.

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

Appendix V
2024 Title XIX State Plan
First Quarter Amendment
Responses to Standard Funding Questions

LONG-TERM SERVICES
State Plan Amendment #24-0025

CMS Standard Funding Questions

The following questions are being asked and should be answered in relation to all payments made to all providers reimbursed pursuant to a methodology described in 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 payments, a complete listing of providers that return a portion of their payments, 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 (except for OPWDD's ICF/DD) receive and retain 100 percent of total Medicaid expenditures claimed by the State and the State does not require any provider to return any portion of such payments to the State, local government entities, or any other intermediary organization.

OPWDD's ICF/DD facilities are subject to a 5.5% Medicaid-reimbursable tax on gross receipts that are not kept by the provider but remitted to the state general fund for both voluntary and State-operated ICF/DDs. This assessment is authorized by Public Law 102-234, Section 43.04 of the New York State Mental Hygiene Law, Federal Medicaid regulations at 42 CFR 433.68. OPWDD recoups the assessment from the ICF/DD Medicaid payment before the payment is sent to the voluntary provider. For State operated ICF/DDs, the legislature appropriates an amount for payment of the assessment. Aside from the assessments, providers receive and retain all the Medicaid payments for ICF/DD services.

- 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 through 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 governmental 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 Non-Federal share Medicaid provider payment (normal per diem and supplemental) is funded by a combination of the following funds/funding sources through enacted appropriations authority to the Department of Health (DOH) for the New York State Medicaid program or is funded by an IGT transferred from the counties.

Payment Type	Non-Federal Share Funding	4/1/23 – 3/31/24	
		Non-Federal	Gross
Nursing Homes Normal Per Diem	General Fund; Special Revenue Funds; County Contribution	\$3.545B	\$7.089B
Intermediate Care Facilities Normal Per Diem	General Fund; County Contribution	\$438M	\$877M
Nursing Homes Supplemental	General Fund	\$159M	\$318M
Intermediate Care Facilities Supplemental	General Fund	\$0	\$0
Nursing Homes UPL	IGT	\$92M	\$184M
Totals		\$4.234B	\$8.468B

A. **General Fund:** Revenue resources for the State’s General Fund includes taxes (e.g., income, sales, etc.), and miscellaneous fees (including audit recoveries and provider assessments). Medicaid expenditures from the State’s General Fund are authorized from Department of Health Medicaid.

- 1) New York State Audit Recoveries: The Department of Health collaborates with the Office of the Medical Inspector General (OMIG) and the Office of the Attorney General (AG) in recovering improperly expended Medicaid funds. OMIG conducts and coordinates the investigation, detection, audit, and review of Medicaid providers and recipients to ensure they are complying with all applicable laws and regulation. OMIG recovers any improper payments through cash collections and voided claim recoveries. Cash collections are deposited into the State’s General Fund to offset Medicaid costs.

In addition to cash collections, OMIG finds inappropriately billed claims within provider claims. To correct an error, OMIG and DOH process the current accurate claim, and reduce this claim by the inappropriate claim value to recoup the previous overclaim and decrease state spending.

- 2) Intermediate Care Facilities (ICF) Provider Service Assessment: Pursuant to New York State Mental Hygiene Law 43.04, a provider's gross receipts received on a cash basis for all services rendered at all ICFs is assessed at 5.5 percent. This assessment is deposited directly into the State's General Fund.

B. Special Revenue Funds:

Health Facility Cash Assessment Program (HFCAP) Fund: Pursuant to New York State Public Health Law 2807-d and Section 90 of Part H of Chapter 59 of the Laws of 2011, the total state assessment on each residential health care facility's gross receipts received from all patient care services and other operating income on a cash basis for residential health care facilities, including adult day service, but excluding, gross receipts attributable to payments received pursuant to Title XVIII of the federal Social Security Act (Medicare), is 6.8 percent.

NOTE: New York's Health Care taxes are either broad based and uniform (as in all HFCAP assessments except for the Personal Care Provider Cash Assessment) or have a specific exemption known as the "D'Amato provision (Federal PHL section 105-33 4722 (c))" which allows the HCRA surcharges to exist in their current format. The single tax which has been determined by the State to be an impermissible provider tax is the HFCAP charge on Personal Care Providers. The State does not claim any Federal dollars for the surcharge collected in this manner in order to comply with all Federal provider tax rules.

C. Additional Resources for Non-Federal Share Funding:

County Contribution: In State Fiscal Year 2006, through enacted State legislation (Part C of Chapter 58 of the laws of 2005), New York State "capped" the amount localities contributed to the non-Federal share of providers claims. This was designed to relieve pressure on county property taxes and the NYC budget by limiting local contributions having New York State absorb all local program costs above this fixed statutory inflation rate (3% at the time).

However, in State Fiscal Year 2013 New York State provided additional relief to Localities by reducing local contributions annual growth from three percent to zero over a three-year period. Beginning in State Fiscal Year 2016, counties began paying a fixed cost in perpetuity as follows:

Entity	Annual Amount
New York City	\$5.200B
Suffolk County	\$226M
Nassau County	\$217M
Westchester County	\$204M

Erie County	\$194M
Rest of State (53 Counties)	\$1.187B
Total	\$7.228B

By eliminating the growth in localities Medicaid costs, the State has statutorily capped total Statewide County Medicaid expenditures at 2015 levels. All additional county Medicaid costs are funded by the State through State funding as described above. DOH provides annual letters to counties providing weekly contributions. Contributions are deposited directly into State escrow account and used to offset 'total' State share Medicaid funding.

NOTE: The Local Contribution is not tied to a specific claim or service category and instead is a capped amount based on 2015 county spending levels as stated above. Each deposit received is reviewed and compared to the amount each county is responsible to contribute to the Medicaid program to verify the county funds received are eligible for Medicaid expenses.

D. IGT Funding:

New York State requests the transfer of the IGT amounts from entities prior to the release of payments to the providers. The entities transferring IGT amounts are all units of government, and the nonfederal share is derived from state or local tax revenue funded accounts only. The providers keep and retain Medicaid payments. Please note that entities have taxing authority, and the State does not provide appropriations to the entities for IGTs.

Provider	Entity Transferring IGT Funds	4/1/23-3/31/24 IGT Amount
A Holly Patterson Extended Care Facility	Nassau County	\$8M
Albany County Nursing Home	Albany County	\$3M
Chemung County Health Center	Chemung County	\$2M
Clinton County Nursing Home	Clinton County	\$1M
Coler Rehabilitation & Nursing Care Center	New York City	\$8M
Dr. Susan Smith McKinney Nursing and Rehab Center	Kings County	\$4M
Glendale Home	Schenectady County	\$3M
Henry J. Carter Nursing Home	New York City	\$3M
Lewis County General Hospital-Nursing Home Unit	Lewis County	\$2M
Livingston County Center for Nursing and Rehabilitation	Livingston County	\$5M
Monroe Community Hospital-Nursing Home Unit	Monroe County	\$9M
New Gouverneur Hospital-Nursing Home Unit	New York City	\$3M
Sea View Hospital Rehabilitation Center and Home	Richmond County	\$5M
Sullivan County Adult Care Center	Sullivan County	\$2M
Terrace View Long Term Care	Erie County	\$7M
The Pines Healthcare & Rehab Centers Machias Camp	Cattaraugus County	\$2M
The Pines Healthcare & Rehab Centers Olean Camp	Cattaraugus County	\$2M
The Valley View Center for Nursing Care and Rehab	Orange County	\$7M
Van Rensselaer Manor	Rensselaer County	\$6M

Wayne County Nursing Home	Wayne County	\$3M
Willow Point Rehabilitation & Nursing Center	Broome County	\$4M
Wyoming County Community Hospital-NH Unit	Wyoming County	\$3M
Total		\$92M

- 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: Below is a list of nursing home and ICF supplemental payments:

Payment Type	Private	State Government	Non-State Government	4/1/23-3/31/24 Gross Total
Advanced Training Initiative	\$43M	\$0	\$3M	\$46M
Cinergy	\$30M	\$0	\$0	\$30M
1% Supplemental Payment	\$130M	\$1M	\$9M	\$140M
Enhanced ATI (VAP Workforce)	\$102M	\$0	\$0	\$102M
Nursing Home UPL	\$0	\$0	\$184M	\$184M
Total	\$306M	\$1M	\$196M	\$502M

The Medicaid payments authorized under this State Plan Amendment are supplemental payments. The Nursing Home Quality Pool is a self-funded pool. All nursing homes are required to contribute a total of \$50 million to the pool and only those nursing homes which score in the top three quintiles for quality receive payments totaling \$50 million. The values in the table above specific to the Nursing Home Quality Pool reflect the incremental changes between provider types.

- 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 nursing home UPL calculation is a payment-to-payment calculation for state government and private facilities. Non-state Governmental facilities undergo a payment-to-cost calculation. The Medicaid payments under this State Plan Amendment will be included in the 2024 nursing home UPL submitted when it is submitted to CMS.

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: Providers do not receive payments that in the aggregate exceed their reasonable costs of providing services. If any providers received payments that in the aggregate exceeded their reasonable costs of providing services, the State would recoup the excess and return the Federal share of the excess to CMS on the 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 complies 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.