



Department
of Health

KATHY HOCHUL
Governor

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

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

June 28, 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 #24-0042
Long Term Care Facility Services

Dear Director McMillion:

The State requests approval of the enclosed amendment #24-0042 to the Title XIX (Medicaid) State Plan for long term care facility services to be effective April 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 March 27, 2024, is also enclosed for your information (Appendix IV). In addition, responses to the five standard funding questions and standard access questions are also enclosed (Appendix V and VI, respectively).

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 2 4 — 0 0 4 2 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
April 1, 2024

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

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 04/01/24-09/30/24 \$ (13,695,000)
b. FFY 10/01/24-09/30/25 \$ (27,390,000)

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.19-D Part I - Page: 42

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable)
Attachment 4.19-D Part I - Page: 42

9. SUBJECT OF AMENDMENT
Nursing Home Additional 10% Capital Reduction

10. GOVERNOR'S REVIEW (Check One)
 GOVERNOR'S OFFICE REPORTED NO COMMENT OTHER, AS SPECIFIED:
 COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
 NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

11. SIGNATURE OF STATE AGENCY OFFICIAL

12. TYPED NAME
Amir Bassiri
13. TITLE
Medicaid Director
14. DATE SUBMITTED
June 28, 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
20. TYPED NAME OF APPROVING OFFICIAL

19. SIGNATURE OF APPROVING OFFICIAL
21. TITLE OF APPROVING OFFICIAL

22. REMARKS

Appendix I
2024 Title XIX State Plan
Second Quarter Amendment
Amended SPA Pages

Appendix II
2024 Title XIX State Plan
Second Quarter Amendment
Summary

SUMMARY
SPA #24-0042

This State Plan Amendment proposes to reduce the capital component of the Medicaid rates for all residential health care facilities, excluding pediatric residential health care facilities, by 10%.

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

§ 2. Subparagraph (iv) of paragraph (b) of subdivision 2-b of section 2808 of the public health law, as amended by section 1 of part NN of chapter 56 of the laws of 2020, is amended to read as follows:

(iv) The capital cost component of rates on and after January first, two thousand nine shall: (A) fully reflect the cost of local property taxes and payments made in lieu of local property taxes, as reported in each facility's cost report submitted for the year two years prior to the rate year; (B) provided, however, notwithstanding any inconsistent provision of this article, commencing April first, two thousand twenty for rates of payment for patients eligible for payments made by state governmental agencies, the capital cost component determined in accordance with this subparagraph and inclusive of any shared savings for eligible facilities that elect to refinance their mortgage loans pursuant to paragraph (d) of subdivision two-a of this section, shall be reduced by the commissioner by five percent; and (C) provided, however, notwithstanding any inconsistent provision of this article, commencing April first, two thousand twenty-four for rates of payment for patients eligible for payments made by state governmental agencies, the capital cost component determined in accordance with this subparagraph and inclusive of any shared savings for eligible facilities that elect to refinance their mortgage loans pursuant to paragraph (d) of subdivision two-a of this section, shall be reduced by the commissioner by an additional ten percent, provided, however, that such reduction shall not apply to rates of payment for patients in pediatric residential health care facilities as defined in paragraph (c) of subdivision two of section twenty-eight hundred eight-e of this article.

Appendix IV
2024 Title XIX State Plan
Second Quarter Amendment
Public Notice

MISCELLANEOUS NOTICES/HEARINGS

Notice of Abandoned Property Received by the State Comptroller

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

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

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

PUBLIC NOTICE Department of Civil Service

Pursuant to the Open Meetings Law, the New York State Civil Service Commission hereby gives public notice of the following:

Please take notice that the regular monthly meeting of the State Civil Service Commission for April 2024 will be conducted on April 17 and April 18 commencing at 10:00 a.m. This meeting will be conducted at NYS Media Services Center, Suite 146, South Concourse, Empire State Plaza, Albany, NY with live coverage available at: <https://www.cs.ny.gov/commission/>

For further information, contact: Office of Commission Operations, Department of Civil Service, Empire State Plaza, Agency Bldg. 1, Albany, NY 12239 (518) 473-6598

PUBLIC NOTICE Office of General Services

Pursuant to section 30-a of the Public Lands Law, the Office of General Services hereby gives notice to the following:

Notice is hereby given that the Department of Environmental Conservation has determined that:

Address: .21 acres of land, Plank Road
Berlin, NY
Rensselaer County

.21 ± acres of land, known as a portion of the Cowee State Forest, is surplus and no longer useful or necessary for state program purposes and has abandoned the property to the Commissioner of General Services for sale or other disposition as Unappropriated State land.

For further information, please contact: Frank Pallante, Office of General Services, Legal Services, 36th Fl., Corning Tower, Empire State Plaza, Albany, NY 12242, (518) 474-8831

PUBLIC NOTICE Department of Health

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

The Department of Health proposes to amend the Title XIX (Medicaid) State Plan for institutional, non-institutional and long term care services to comply with the 2024-2025 proposed executive budget. The following changes are proposed:

All Services

Effective on or after April 1, 2024, the Department of Health will adjust rates statewide to reflect a 1.5% percent Cost of Living Adjustment for the following Office of Mental Health (OMH), Office of Addiction Services and Supports (OASAS), and Office for People With Developmental Disabilities (OPWDD) State Plan Services: OMH Outpatient Services, OMH Clinic Services, OMH Rehabilitative Services, Comprehensive Psychiatric Emergency Program, including Extended Observation Beds, Children Family Treatment Support Services, Health Home Plus, Psychiatric Residential Treatment Facilities for Children and Youth, OASAS Outpatient Addiction Services, OASAS Freestanding (non-hospital) Inpatient Rehabilitation Services, OASAS Freestanding Inpatient Detox Services, OASAS Addiction Treatment Centers, OASAS Part 820 Residential Services, OASAS Residential Rehabilitation Services for Youth, Intermediate Care Facility (ICF/IDD), Day Treatment, Article 16 Clinic Services, Specialty Hospital, Independent Practitioner Services for Individual with Developmental Disabilities (IPSIDD), and OPWDD Crisis Services.

The estimated net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2024-2025 is \$25.1 million.

Non-Institutional Services

Effective on or after April 1, 2024, noticed provision for a rate change regarding Emergency Medical Services will be revised. All such Emergency Medical Services will be paid established fees for ambulance services providing treatment in place (TIP) without transport, a base fee without a mileage charge. This change will reduce unnecessary Emergency Department (ED) trips, thus relieving ED wait times, improving overall ED and EMS care and reducing Medicaid costs.

The estimated net aggregate decrease in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2024-2025 is (\$1.2 million).

Effective on or after April 1, 2024, the reimbursement rate for Early Intervention services will increase by 5%. These rates are being increased to address capacity issues that municipalities are facing statewide.

The estimated net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2024-2025 is \$12 million.

Effective on or after April 1, 2024, rates of payment for Early and Periodic Screening Diagnosis and Treatment (EPSDT) related to behavioral health services provided by Health Facilities licensed under Article 29-I of the Public Health Law to individuals under age 21 years, will be increased to account for enhanced programmatic requirements related to delivery of care in Qualified Residential Treatment Facilities.

The estimated net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2024-2025 is \$18 million.

Effective on April 1, 2024, conflicts of interest between Consumer Directed Personal Assistance Program (CDPAP) CDPAP Fiscal Intermediaries (FIs) and Licensed Home Care Service Agencies (LHCSAs) will be eliminated.

Effective on October 1, 2024, consumer self-direction will be required in the CDPAP program, and proposed regulation authority relating to quality-of-care standards and labor protections for the CDPAP and Personal Care programs shall take effect.

Effective on or after January 1, 2025, FI procurement will be repealed and replaced with an authorization process.

Effective on or after April 1, 2025, conflicts of interest between CDPAP Fis, Managed Long-term Care Plans (MLTCs), and Health Maintenance Organizations will be eliminated.

The estimated net aggregate decrease in gross Medicaid expenditures attributable to these initiatives contained in the budget for state fiscal year 2025 is (\$200 million) and for state fiscal year 2026 is (\$400 million).

Long Term Care Services

Effective on or after April 1, 2024, the case mix adjustment from the operating component of the rates for skilled nursing facilities shall remain unchanged from the July 2023 rates during the development and until full implementation of a new case mix methodology in accordance with Federal acuity data.

There is no estimated change to gross Medicaid expenditures as a result of this proposed amendment.

Effective on or after April 1, 2024 and each SFY thereafter, the Department proposes to reduce funding associated with residential health care facilities' capital reimbursement by 10 percent.

The estimated net aggregate decrease in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2024-2025 is (\$57 million).

The public is invited to review and comment on this proposed State Plan Amendment, a copy of which will be available for public review on the Department's website at http://www.health.ny.gov/regulations/state_plans/status. Individuals without Internet access may view the State Plan Amendments at any local (county) social services district.

For the New York City district, copies will be available at the following places:

New York County
250 Church Street
New York, New York 10018

Queens County, Queens Center
3220 Northern Boulevard
Long Island City, New York 11101

Kings County, Fulton Center
114 Willoughby Street
Brooklyn, New York 11201

Bronx County, Tremont Center
1916 Monterey Avenue
Bronx, New York 10457

Richmond County, Richmond Center
95 Central Avenue, St. George
Staten Island, New York 10301

For further information and to review and comment, please contact: Department of Health, Division of Finance and Rate Setting, 99 Washington Ave., One Commerce Plaza, Suite 1432, Albany, NY 12210, 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 as authorized by § 2826 of New York Public Health Law. The following changes are proposed:

Long Term Care Service

Effective on or after April 1, 2024, the Department of Health proposes to amend the Title XIX (Medicaid) State Plan for long term care services related to temporary rate adjustments to long term care providers that are undergoing closure, merger, consolidation, acquisition or restructuring themselves or other health care providers. These payments are authorized by current State statutory and regulatory provisions. The temporary rate adjustments will be reviewed and approved by the CINERGY Collaborative.

The estimated net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2024-2025 is \$30 million.

The public is invited to review and comment on this proposed State Plan Amendment, a copy of which will be available for public review on the Department's website at http://www.health.ny.gov/regulations/state_plans/status. Individuals without internet access may view the State Plan Amendments at any local (county) social services district.

For the New York City district, copies will be available at the following places:

New York County
250 Church Street
New York, New York 10018

Queens County, Queens Center
3220 Northern Boulevard
Long Island City, New York 11101

Kings County, Fulton Center
114 Willoughby Street
Brooklyn, New York 11201

Bronx County, Tremont Center
1916 Monterey Avenue
Bronx, New York 10457

Richmond County, Richmond Center
95 Central Avenue, St. George
Staten Island, New York 10301

For further information and to review and comment, please contact: Department of Health, Division of Finance and Rate Setting, 99 Washington Ave., One Commerce Plaza, Suite 1432, Albany, NY 12210, 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 statutory provisions. The following changes are proposed:

Non-Institutional Services

Effective on or after April 1, 2024, this amendment proposes to revise the payment eligibility criteria, for Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs), that are eligible for the Alternative Payment Methodology (APM) which provides for an additional payment annually to preserve and improve beneficiary

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

LONG-TERM SERVICES
State Plan Amendment #24-0042

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	4/1/24 – 3/31/25	
		Non-Federal	Gross
Nursing Homes Normal Per Diem	General Fund; Special Revenue Funds; County Contribution	\$3.667B	\$7.334B
Intermediate Care Facilities Normal Per Diem	General Fund; County Contribution	\$398M	\$797M
Nursing Homes Supplemental	General Fund	\$169M	\$338M
Intermediate Care Facilities Supplemental	General Fund	\$0	\$0
Nursing Homes UPL	IGT	\$106M	\$213M
Totals		\$4.341B	\$8.682B

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	\$5.210B
Suffolk County	\$243M
Nassau County	\$231M
Westchester County	\$215M

Erie County	\$205M
Rest of State (53 Counties)	\$1.260B
Total	\$7.364B

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	4/1/24-3/31/25 IGT Amount
A Holly Patterson Extended Care Facility	Nassau County	\$9M
Albany County Nursing Home	Albany County	\$5M
Chemung County Health Center	Chemung County	\$3M
Clinton County Nursing Home	Clinton County	\$2M
Coler Rehabilitation & Nursing Care Center	New York City	\$8M
Dr. Susan Smith Mckinney Nursing and Rehab Center	Kings County	\$6M
Glendale Home	Schenectady County	\$4M
Henry J. Carter Nursing Home	New York City	\$3M
Lewis County General Hospital-Nursing Home Unit	Lewis County	\$3M
Livingston County Center for Nursing and Rehabilitation	Livingston County	\$4M
Monroe Community Hospital-Nursing Home Unit	Monroe County	\$10M
New Gouverneur Hospital-Nursing Home Unit	New York City	\$4M
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	\$8M

Wayne County Nursing Home	Wayne County	\$4M
Willow Point Rehabilitation & Nursing Center	Broome County	\$5M
Wyoming County Community Hospital-NH Unit	Wyoming County	\$3M
Total		\$106M

- 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	4/1/24-3/31/25 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)	\$96M	\$0	\$6M	\$102M
Nursing Home UPL	\$0	\$0	\$213M	\$213M
Total	\$300M	\$1M	\$230M	\$531M

The Medicaid payments under this State Plan Amendment are not supplemental payments.

- 4. Please provide a detailed description of the methodology used by the state to estimate the upper payment limit (UPL) for each class of providers (State owned or operated, non-state government owned or operated, and privately owned or operated). Please provide a current (i.e. applicable to the current rate year) UPL demonstration. Under regulations at 42 CFR 447.272, States are prohibited from setting payment rates for Medicaid inpatient services that exceed a reasonable estimate of the amount that would be paid under Medicare payment principals.**

Response: The 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 FMAs 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 FMA 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.

Appendix VI
2024 Title XIX State Plan
Second Quarter Amendment
Responses to Standard Access Questions

**APPENDIX VI
LONG TERM CARE SERVICES
State Plan Amendment 24-0042**

CMS Standard Access Questions

The following questions have been asked by CMS and are answered by the State in relation to all payments made to all providers under Attachment 4.19-D of the state plan.

- 1. Specifically, how did the State determine that the Medicaid provider payments that will result from the change in this amendment are sufficient to comply with the requirements of 1902(a)(30)?**

Response: This amendment seeks to reduce capital reimbursement by 10% for all Residential Health Care Facilities, excluding Pediatric Residential Health Care Facilities. Although these actions will cause a reduction in reimbursement, it is being uniformly applied and it is not expected to result in major impacts to the payments made for provision of services.

- 2. How does the State intend to monitor the impact of the new rates and implement a remedy should rates be insufficient to guarantee required access levels?**

Response: The State has various ways to ensure that access levels in the Medicaid program are retained and is currently not aware of any access issues. Certain classes of providers must notify and receive approval from the Department's Office of Primary Care and Health Systems Management in order to discontinue services. This office monitors and considers such requests in the context of access as they approve/deny changes in services. Finally, providers cannot discriminate based on source of payment.

For providers that are not subject to an approval process, the State will continue to monitor provider complaint hotlines to identify geographic areas of concern and/or service type needs. If Medicaid beneficiaries begin to encounter access issues, the Department would expect to see a marked increase in complaints. These complaints will be identified and analyzed in light of the changes proposed in this State Plan Amendment.

Finally, the State ensures that there is sufficient provider capacity for Medicaid Managed Care plans as part of its process to approve managed care rates and plans. Should access to services be compromised, the State would be alerted and would take appropriate action to ensure retention of access to such services.

- 3. How were providers, advocates and beneficiaries engaged in the discussion around rate modifications? What were their concerns and how did the State address these concerns?**

Response: This change was enacted by the State Legislature as part of the negotiation of the 2024-25 Budget. The impact of this change was weighed in the context of the overall Budget in the State. The legislative process provides opportunities for all stakeholders to lobby their concerns, objections, or support for various legislative initiatives.

- 4. What action(s) does the State plan to implement after the rate change takes place to counter any decrease to access if the rate decrease is found to prevent sufficient access to care?**

Response: Should any essential community provider experience Medicaid or other revenue issues that would prevent access to needed community services, per usual practice, the State would meet with them to explore the situation and discuss possible solutions, if necessary.

- 5. Is the State modifying anything else in the State Plan which will counterbalance any impact on access that may be caused by the decrease in rates (e.g. increasing scope of services that other provider types may provide or providing care in other settings)?**

Response: In the past two years there have been major investments within the Residential Health Care System. In the 2023-24 Enacted Budget, a 7.5% increase was applied to the operating component of the rates (pending CMS approval - SPA 23-0042). In the current 2024-25 Budget another funding increase for this program area was enacted (SPA pending development).

Additionally, over the course of the past three years, the State has undertaken a massive reform initiative to better align reimbursement with care. When fully implemented, the initiative will invest over \$600 million in the State's ambulatory care system (outpatient, ambulatory surgery, emergency department, clinic and physicians) to incentivize care in the most appropriate setting. The State has also increased its physician reimbursement schedule to resemble Medicare payments for similar services, thus ensuring continued access for Medicaid beneficiaries. While some of these initiatives are outside the scope of the State Plan, they represent some of the measures the State is taking to ensure quality care for the State's most vulnerable population.