



Department of Health

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

June 28, 2019

Mr. Ricardo Holligan
Acting Associate Regional Administrator
Department of Health & Human Services
Centers for Medicare & Medicaid Services
New York Regional Office
Division of Medicaid and Children's Health Operations
26 Federal Plaza - Room 37-100 North
New York, New York 10278

RE: SPA #19-0033
Long Term Care Facility Services

Dear Mr. Holligan:

The State requests approval of the enclosed amendment #19-0033 to the Title XIX (Medicaid) State Plan for long term care facility services to be effective April 1, 2019 (Appendix I). This amendment is being submitted based on enacted legislation. A summary of the proposed amendment is provided in Appendix II.

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

A copy of the pertinent section of enacted legislation is enclosed for your information (Appendix III). Copies of the public notice of this proposed amendment, which was given in the New York State Register on March 27, 2019, is also enclosed for your information (Appendix IV). In addition, responses to the five standard funding questions and the 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,


Donna Frescatore
Medicaid Director
Office of Health Insurance Programs

Enclosures
cc: Mr. Tom Brady

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES		1. TRANSMITTAL NUMBER <div style="text-align: center; font-family: monospace;"> 1 9 — 0 0 3 3 </div>	2. STATE <div style="text-align: center;">New York</div>
TO: REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE & MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID) TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
5. TYPE OF PLAN MATERIAL <i>(Check One)</i> <input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT		4. PROPOSED EFFECTIVE DATE <div style="text-align: center;">April 1, 2019</div>	
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT <i>(Separate transmittal for each amendment)</i>			
6. FEDERAL STATUTE/REGULATION CITATION § 1902(a) of the Social Security Act and 42 CFR 447		7. FEDERAL BUDGET IMPACT a. FFY 04/01/19-09/30/19 \$ (47,750.00) b. FFY 10/01/19-09/30/20 \$ (95,500.00)	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT Attachment 4.19-D: Page 110(d)(13) Attachment 4.19-D: Page 110(d)(14)		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT <i>(If Applicable)</i> Attachment 4.19-D: Page 110 (d)(13) Attachment 4.19-D: Page 110(d)(14)	
10. SUBJECT OF AMENDMENT Nursing Home Case Mix Adjustments (FMAP=50%)			
11. GOVERNOR'S REVIEW <i>(Check One)</i> <input checked="" type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input type="checkbox"/> OTHER, AS SPECIFIED <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL			
12. SIGNATURE <div style="background-color: black; width: 280px; height: 30px; margin-top: 5px;"></div>		16. RETURN TO New York State Department of Health Division of Finance and Rate Setting 99 Washington Ave – One Commerce Plaza Suite 1432 Albany, NY 12210	
13. TYPED NAME <div style="text-align: center;">Donna Frescatore</div>		15. DATE SUBMITTED <div style="text-align: center;">June 28, 2019</div>	
14. TITLE <div style="text-align: center;">Medicaid Director, Department of Health</div>			
17. DATE RECEIVED			
FOR REGIONAL OFFICE USE ONLY			
18. DATE APPROVED		20. SIGNATURE OF REGIONAL OFFICIAL	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL		21. TYPED NAME	
22. TITLE		23. REMARKS	

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

**New York
110(d)(13)**

Calculation of 2007 All Payer Base Year Case Mix			
Peer Group	Case Mix Total (Count x Weight)*	Total Patient Days	Weighted Average Case Mix (Case Mix Total/ Patient Days)
NSHB/NS300+	12,385,293	13,623,548	0.9091
NS300-	22,137,438	24,403,182	0.9072
Statewide/All Non-Specialty Facilities	34,522,731	38,026,730	0.9079
2007 Base Year Case Mix = NSHB/NS300+ (50% NSHB/NS300+/ 50% Statewide)			0.9085
2007 Base Year Case Mix = NS300- (50% NS300- / 50% Statewide)			0.9075

*Count is defined as the number of patients in each Resource Utilization Group and Weight is calculated and defined as described above in paragraph g(1) and g(2).

- 4) (a) Subsequent case mix adjustments to the direct component of the price for rate periods effective after January 1, 2012, [shall] will be made in July and January of each calendar year and [shall] will use Medicaid-only case mix data applicable to the previous case mix period (e.g., July 1, 2012, case mix adjustment will use January 2012 case mix data, and January 1, 2013, case mix adjustment will use July 2012 case mix data).
- 4) (b) The case mix adjustment to the direct component of the price for the rate period effective on July 1, 2019, will use all Medicaid-only case mix data submitted to CMS applicable to the August 2018 – March 2019 period.
- 4) (c) The case mix adjustment to the direct component of the price for rate periods effective after July 1, 2019, will be made in January and July of each calendar year and will use all Medicaid-only case mix data submitted to CMS applicable to the previous six-month period (e.g., April – September for the January case mix adjustment; October – March for the July case mix adjustment).

TN 19-0033

Approval Date _____

Supersedes TN #11-23-A

Effective Date _____

New York
110(d)(14)

- 5) Case mix adjustments to the direct component of the price for facilities for which facility-specific case mix data is unavailable or insufficient [shall] will be equal to the [base year] previous case mix of the peer group applicable to such facility.
- 6) The adjustments and related patient classifications for each facility [shall] will be subject to audit review by the Office of Medicaid Inspector General, and/or other agents as authorized by the Department.
- h) The indirect component of the price [shall] will consist of a blended rate to be determined as follows:
 - 1) For NSHB/NS300+ the indirect component of the price [shall] will consist of a blended rate equal to:
 - i) 50% of the Statewide indirect NSF price which [shall] will be the allowable operating costs and statistical data for the indirect component of the price as reported by all non-specialty facilities in its cost reports for the 2007 calendar year, reduced by the allowable costs percent reduction, and divided by total 2007 patient days; and
 - ii) 50% of the indirect NSHB/NS300+ price which [shall] will be the allowable operating costs and statistical data for the indirect component of the price as reported by all non-specialty hospital-based facilities and all non-specialty freestanding facilities with certified bed capacity of 300 beds or more in its cost reports for the 2007 calendar year, reduced by the allowable costs percent reduction, and divided by total 2007 patient days; or
 - 2) For NS300- the indirect component of the price [shall] will consist of a blended rate equal to:
 - i) 50% of the Statewide indirect NSF price which [shall] will be the allowable operating costs and statistical data for the indirect component of the price as reported by all non-specialty facilities in its cost reports for the 2007 calendar year, reduced by the allowable costs percent reduction, and divided by total 2007 patient days; and
 - ii) 50 % of the indirect NS300- prices which [shall] will be the allowable operating costs and statistical data for the indirect component of the price as reported by all non-specialty facilities with certified bed capacity of less than 300 beds in its cost reports for the 2007 calendar year, reduced by the allowable costs percent reduction, and divided by total 2007 patient days.

TN 19-0033 **Approval Date** _____

Supersedes TN #11-23-A **Effective Date** _____

Appendix II
2019 Title XIX State Plan
Second Quarter Amendment
Summary

Summary
SPA #19-0033

This State Plan Amendment proposes to establish a new methodology for the Minimum Data Set (MDS) data in the calculation of the case mix index.

The direct price is subject to a case mix adjustment and a wage index adjustment. Effective April 1, 2019, the case mix index used to adjust the direct component price will be based on all MDS data submitted by NYS nursing facilities for a six-month period preceding the effective date of the Medicaid rates.

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

15 § 9. Residential health care facilities case mix adjustment workgroup.
16 The commissioner of health or his or her designee shall convene and
17 chair a workgroup on the implementation of the change in case mix
18 adjustments to Medicaid rates of payment of residential health care
19 facilities that will take effect on July 1, 2019. The workgroup shall be
20 comprised of residential health care facilities or representatives from
21 such facilities, representatives from the statewide associations and
22 other such experts on case mix as required by the commissioner or his or
23 her designee. The workgroup shall review recent case mix data and
24 related analyses conducted by the department with respect to the depart-
25 ment's implementation of the July 1, 2019 change in methodology, the
26 department's minimum data set collection process, and case mix adjust-
27 ments authorized under subparagraph (ii) of paragraph (b) of subdivision
28 2-b of section 2808 of the public health law. Such review shall seek to
29 promote a higher degree of accuracy in the minimum data set data, and
30 target abuses. The workgroup may offer recommendations on how to improve
31 future practice regarding accuracy in the minimum data set collection
32 process and how to reduce or eliminate abusive practices. In developing
33 such recommendations, the workgroup shall ensure that the collection
34 process and case mix adjustment recognizes the appropriate acuity for
35 residential health care residents. The workgroup may provide recommenda-
36 tions regarding the proposed patient driven payment model and the admin-
37 istrative complexity in revising the minimum data set collection and
38 rate promulgation processes. The commissioner shall not modify the meth-
39 od used to determine the case mix adjustment for periods prior to June
40 30, 2019. Notwithstanding any changes in federal law or regulation
41 relating to nursing home acuity reimbursement, the workgroup shall
42 report its recommendations no later than June 30, 2019.

Appendix IV
2019 Title XIX State Plan
Second Quarter Amendment
Public Notice

the 2006 final trend factor equal to the final Consumer Price Index (CPI) for all urban consumers less 0.25%.

Institutional Services

Effective on or after April 1, 2019, annual indigent care pool distributions for certain providers will be reduced.

The estimated annual net aggregate decrease in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2019/2020 is (\$275.6 million).

Effective on or after April 1, 2019, continues the supplemental upper payment limit payments made to general hospitals, other than major public general hospitals under institutional services of \$339 million annually.

For state fiscal year beginning April 1, 2019 through March 31, 2020, continues specialty hospital adjustments for hospital inpatient services provided on and after April 1, 2012, to public general hospitals, other than those operated by the State of New York or the State University of New York, located in a city with a population of over one million and receiving reimbursement of up to \$1.08 billion annually based on criteria and methodology set by the Commissioner of Health, which the Commissioner may periodically set through a memorandum of understanding with the New York City Health and Hospitals Corporation. Such adjustments shall be paid by means of one or more estimated payments. Payments to eligible public general hospitals may be added to rates of payment or made as aggregate payments.

Additional medical assistance, known as, Intergovernmental Transfer (IGT) payments, for inpatient hospital services may be made to public general hospitals operated by the State of New York or the State University of New York, or by a county which shall not include a city with a population over one million, and those public general hospitals located in the counties of Westchester, Erie, or Nassau, up to one hundred percent (100%) of each such public hospital's medical assistance, and uninsured patient losses after all other medical assistance, including disproportionate share hospital (DSH) payments to such public general hospitals. Payments will be made by means of one or more estimated distributions initially based on the latest DSH audit results, which shall later be reconciled to such payment year's actual DSH audit uncompensated care costs. Payments may be added to rates of payment or made as aggregate payments. Such payments will continue April 1, 2019 through March 31, 2021.

There is no change in gross Medicaid expenditures for this update.

Extends current provisions for services on April 1, 2019 through March 31, 2024 and thereafter, the reimbursable operating cost component for general hospital inpatient rates will be established with the 2006 final trend factor equal to the final Consumer Price Index (CPI) for all urban consumers less 0.25%.

The estimated annual net aggregate decrease in gross Medicaid expenditures for state fiscal year 2019/2020 is (\$114.5 million).

Capital related costs of a general hospital excluding 44% of the major movable costs and excluding staff housing costs will continue effective April 1, 2019 through March 31, 2024 and thereafter.

The estimated annual net aggregate decrease in gross Medicaid expenditures for state fiscal year 2019/2020 is (\$48.4 million).

Budgeted capital inpatient costs of a general hospital applicable to the rate year will be decreased to reflect the percentage amount by which the budget for the base year two years prior to the rate year for capital related inpatient expenses of the hospital exceeded actual expenses will continue effective April 1, 2019 through March 31, 2024 and thereafter.

The estimated annual net aggregate decrease in gross Medicaid expenditures for state fiscal year 2019/2020 is (\$15.9 million).

Effective for dates of service on or after April 1, 2019, update the historical year Medicaid claims used in the general hospital acute rate statewide price development from 2014 to 2017.

There is no change in gross Medicaid expenditures for this update.

Long Term Care Services

Effective on or after April 1, 2019, continues additional payments to non-state government operated public residential health care facilities,

including public residential health care facilities located in Nassau, Westchester, and Erie counties, but excluding public residential health care facilities operated by a town or city within a county, in aggregate amounts of up to \$500 million. The amount allocated to each eligible public RHCF will be in accordance with the previously approved methodology, provided, however that patient days shall be utilized for such computation reflecting actual reported data for 2016 and each representative succeeding year as applicable. Payments to eligible RHCF's may be added to rates of payment or made as aggregate payments.

Effective on or after April 1, 2019 and thereafter, the appeals cap in PHL 2808(1)(a)(17)(b) is extended. The current appeals cap provision establishes an eighty-million-dollar annual budget for the processing of rate appeals or reimbursement for construction that has been approved by the commissioner.

There is no additional estimated annual change to gross Medicaid expenditures as a result of the extension.

Effective on or after April 1, 2019 and thereafter the provision that rates of payment for RHCFs shall not reflect trend factor projection or adjustments for the period April 1, 1996 through March 31, 1997 is extended.

The estimated annual net aggregate decrease in gross Medicaid expenditures attributable to this initiative is (\$12.7 million).

Effective on or after April 1, 2019 and thereafter this provision continues a 0.25 reduction in the statutory trend factors of 2006.

The estimated annual net aggregate decrease in gross Medicaid expenditures attributable to this initiative is (\$13.4 million).

Effective on or after April 1, 2019 nursing home reimbursement case mix collections which impact the direct price component of nursing home Medicaid reimbursement. The direct statewide price shall be adjusted by a Medicaid-only case mix and shall be updated for a Medicaid-only case mix in January and July of each year, using the case mix data applicable to the previous period.

The estimated annual net aggregate decrease in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2019-2020 is (\$191 million).

Effective for dates of service on or after April 1, 2019 and thereafter, Certified Home Health Agencies (CHHAs) payments will continue to be based on episodic payments, except for such services provided to children under 18 years of age.

There is no additional estimated annual change to gross Medicaid expenditures as a result of this extension.

Effective on or after April 1, 2019, The Consumer Directed Personal Assistance Program (CDPAP), a personal care service model, permits chronically ill and/or physically disabled individuals receiving home care under the medical assistance program greater flexibility and freedom of choice in obtaining such services. Reimbursement for CDPAP services has been based on a per hour billing methodology. This change will move the administrative reimbursement methodology for CDPAP to a per member per month basis and maintains an hourly/daily reimbursement for service delivery.

The estimated annual net aggregate decrease in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2019-2020 is (\$28.7 million).

Effective on or after April 1, 2019 and thereafter, current provisions for certified home health agency administrative and general costs reimbursement limits are extended.

There is no additional estimated annual change to gross Medicaid expenditures as a result of this extension.

Effective on or after April 1, 2019 and thereafter, the total reimbursable 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 inpatient or health-related services, including adult day service, but excluding gross receipts attributable to payments received pursuant to Title XVII of the federal Social Security Act (Medicare), at six percent.

The extent to which a facility is reimbursed for the additional cost of the assessment is dependent upon Medicaid volume of services.

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

APPENDIX V
LONG TERM CARE SERVICES
State Plan Amendment #19-0033

CMS Standard Funding Questions (NIRT Standard Funding Questions)

The following questions are being asked and should be answered in relation to all payments made to all providers under Attachment 4.19-D of the state plan.

- 1. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by States for services under the approved State plan. Do providers receive and retain the total Medicaid expenditures claimed by the State (includes normal per diem, supplemental, enhanced payments, other) or is any portion of the payments returned to the State, local governmental entity, or any other intermediary organization? If providers are required to return any portion of payments, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the amount or percentage of payments that are returned and the disposition and use of the funds once they are returned to the State (i.e., general fund, medical services account, etc.)**

Response: Providers do retain the payments made pursuant to this amendment. However, this requirement in no way prohibits the public provider, including county providers, from reimbursing the sponsoring local government for appropriate expenses incurred by the local government on behalf of the public provider. The State does not regulate the financial relationships that exist between public health care providers and their sponsoring governments, which are extremely varied and complex. Local governments may provide direct and/or indirect monetary subsidies to their public providers to cover on-going unreimbursed operational expenses and assure achievement of their mission as primary safety net providers. Examples of appropriate expenses may include payments to the local government which include reimbursement for debt service paid on a provider's behalf, reimbursement for Medicare Part B premiums paid for a provider's retirees, reimbursement for contractually required health benefit fund payments made on a provider's behalf, and payment for overhead expenses as allocated per federal Office of Management and Budget Circular 2 CFR 200 regarding Cost Principles for State, Local, and Indian Tribal Governments. The existence of such transfers should in no way negate the legitimacy of these facilities' Medicaid payments or result in reduced Medicaid federal financial participation for the State. This position was further supported by CMS in review and approval of SPA 07-07C when an on-site audit of these transactions for New York City's Health and Hospitals Corporation was completed with satisfactory results.

2. Section 1902(a)(2) provides that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan. Please describe how the state share of each type of Medicaid payment (normal per diem, supplemental, enhanced, other) is funded. Please describe whether the state share is from appropriations from the legislature to the Medicaid agency, through intergovernmental transfer agreements (IGTs), certified public expenditures (CPEs), provider taxes, or any other mechanism used by the state to provide state share. Note that, if the appropriation is not to the Medicaid agency, the source of the state share would necessarily be derived through either an IGT or CPE. In this case, please identify the agency to which the funds are appropriated. Please provide an estimate of total expenditure and State share amounts for each type of Medicaid payment. If any of the non-federal share is being provided using IGTs or CPEs, please fully describe the matching arrangement including when the state agency receives the transferred amounts from the local government entity transferring the funds. If CPEs are used, please describe the methodology used by the state to verify that the total expenditures being certified are eligible for Federal matching funds in accordance with 42 CFR 433.51(b). For any payment funded by CPEs or IGTs, please provide the following:

- (i) a complete list of the names of entities transferring or certifying funds;**
- (ii) the operational nature of the entity (state, county, city, other);**
- (iii) the total amounts transferred or certified by each entity;**
- (iv) clarify whether the certifying or transferring entity has general taxing authority; and,**
- (v) whether the certifying or transferring entity received appropriations (identify level of appropriations).**

Response: Payments made to service providers under the provisions of this SPA are funded through a budget appropriation received by the State agency that oversees medical assistance (Medicaid), which is the Department of Health.

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

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

3. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan. If supplemental or

enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to each provider type.

Response: No additional payments are included as part of the Amendment.

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 2019 Nursing Home UPL is currently under CMS review.

5. **Does any governmental provider receive payments that in the aggregate (normal per diem, supplemental, enhanced, other) exceed their reasonable costs of providing services? If payments exceed the cost of services, do you recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report?**

Response: Effective January 1, 2012, the rate methodology included in the approved State Plan for non-specialty nursing facility services for the operating component of the rate is a blended statewide/peer group price adjusted for case mix and wage equalization factor (WEF). Specialty nursing facilities and units are paid the operating rate in effect on January 1, 2009. The capital component of the rate for all specialty and non-specialty facilities is based upon a cost-based methodology. We are unaware of any requirement under current federal law or regulation that limits individual provider payments to their actual costs.

ACA Assurances:

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

MOE Period.

- **Begins on:** March 10, 2010, and
- **Ends on:** The date the Secretary of the Federal Department of Health and Human Services determines an Exchange established by a State

under the provisions of section 1311 of the Affordable Care Act is fully operational.

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

- 2. Section 1905(y) and (z) of the Act provides for increased FMAPs for expenditures made on or after January 1, 2014 for individuals determined eligible under section 1902(a)(10)(A)(i)(VIII) of the Act. Under section 1905(cc) of the Act, the increased FMAP under sections 1905(y) and (z) would not be available for States that require local political subdivisions to contribute amounts toward the non-Federal share of the State's expenditures at a greater percentage than would have been required on December 31, 2009.**

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

Response: This SPA would [] / would not [✓] violate these provisions, if they remained in effect on or after January 1, 2019.

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

Response: The State does comply with the requirements of section 1902(a)(37) of the Act regarding prompt payment of claims.

Tribal Assurance:

Section 1902(a)(73) of the Social Security Act the Act requires a State in which one or more Indian Health Programs or Urban Indian Organizations furnish health care services to establish a process for the State Medicaid agency to seek advice on a regular ongoing basis from designees of Indian health programs whether operated by the Indian Health Service HIS Tribes or Tribal organizations under the Indian Self Determination and Education Assistance Act ISDEAA or Urban Indian Organizations under the Indian Health Care Improvement Act.

IHCIA Section 2107(e)(I) of the Act was also amended to apply these requirements to the Children's Health Insurance Program CHIP.

Consultation is required concerning Medicaid and CHIP matters having a direct impact on Indian health programs and Urban Indian organizations.

- a) Please describe the process the State uses to seek advice on a regular ongoing basis from federally recognized tribes Indian Health Programs and Urban Indian Organizations on matters related to Medicaid and CHIP programs and for consultation on State Plan Amendments waiver proposals waiver extensions waiver amendments waiver renewals and proposals for demonstration projects prior to submission to CMS.**
- b) Please include information about the frequency inclusiveness and process for seeking such advice.**
- c) Please describe the consultation process that occurred specifically for the development and submission of this State Plan Amendment when it occurred and who was involved.**

Response: Tribal consultation was performed in accordance with the State's tribal consultation policy as approved in SPA 17-0065, and documentation of such is included with the original submission. To date, no feedback has been received from any tribal representative in response to the proposed change in this SPA.

Appendix VI
2019 Title XIX State Plan
Second Quarter Amendment
Responses to Standard Access Questions

**APPENDIX VI
LONG TERM CARE SERVICES
State Plan Amendment 19-0033**

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 rationalize the case mix reimbursement system. This will be accomplished through a change from a census-based case mix calculation to a system which will use all valid MDS assessments filed during a six-month period.

- 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, particularly since there is excess bed capacity for both hospitals and nursing homes. Additionally, hospital and nursing home providers must notify and receive approval from the Department's Office of Health Systems Management (OHSM) 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 adequate provider capacity for Medicaid Managed Care plans as part of its process to approve managed care rates and plans. Should the necessary 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 2019-2020 Budget. The impact of this change was weighed in the context of the overall State Budget. 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: 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.