



## Department of Health

KATHY HOCHUL  
Governor

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

KRISTIN M. PROUD  
Acting Executive Deputy Commissioner

September 30, 2021

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 #21-0050  
Long Term Care Facility Services

Dear Mr. McMillion:

The State requests approval of the enclosed amendment #21-0050 to the Title XIX (Medicaid) State Plan for long term care facility services to be effective July 1, 2021 (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 June 23, 2021 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,

Brett Friedman  
Acting Medicaid Director  
Office of Health Insurance Programs

Enclosures  
cc: Todd McMillion

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

1. TRANSMITTAL NUMBER _____	2. STATE
3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
4. PROPOSED EFFECTIVE DATE	

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

5. TYPE OF PLAN MATERIAL (*Check One*)

- NEW STATE PLAN       AMENDMENT TO BE CONSIDERED AS NEW PLAN       AMENDMENT


COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (*Separate transmittal for each amendment*)

6. FEDERAL STATUTE/REGULATION CITATION	7. FEDERAL BUDGET IMPACT a. FFY _____ \$ _____ b. FFY _____ \$ _____
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT ( <i>If Applicable</i> )

10. SUBJECT OF AMENDMENT

11. 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

12. SIGNATURE OF STATE AGENCY OFFICIAL 	16. RETURN TO
13. TYPED NAME	
14. TITLE	
15. DATE SUBMITTED    September 30, 2021	

**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED	18. DATE APPROVED
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**PLAN APPROVED - ONE COPY ATTACHED**

19. EFFECTIVE DATE OF APPROVED MATERIAL	20. SIGNATURE OF REGIONAL OFFICIAL
21. TYPED NAME	22. TITLE

23. REMARKS

**Appendix I**  
**2021 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 rate periods effective July 1, 2021 and thereafter, 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 21-0050

Approval Date \_\_\_\_\_

Supersedes TN #11-23-A

Effective Date July 1, 2021

**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 21-0050 Approval Date \_\_\_\_\_

Supersedes TN #11-23-A Effective Date July 1, 2021

**Appendix II**  
**2021 Title XIX State Plan**  
**Second Quarter Amendment**  
**Summary**

**Summary**  
**SPA #21-0050**

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.

Effective for rate periods on or after July 1, 2021, the case mix index used to adjust the direct component price will be based on all Medicaid-only case mix data submitted by NYS nursing facilities 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).

**Appendix III**  
**2021 Title XIX State Plan**  
**Second Quarter Amendment**  
**Authorizing Provisions**



Authorizing Provisions – 21-0050

Chapter 57 of the Laws of 2020  
Part G

S. 1507--C

34

A. 2007--C

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**  
**2021 Title XIX State Plan**  
**Second Quarter Amendment**  
**Public Notice**

**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 July 2021 will be conducted on July 14th and July 15th 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. One, Albany, NY 12239, (518) 473-6598

**PUBLIC NOTICE**

## Office of Fire Prevention and Control

Pursuant to Section 176-b of the Town Law, the Office of Fire Prevention and Control hereby gives notice of the following:

Application for Waiver of the Limitation of Non-resident Members of Volunteer Fire Companies

An application for a waiver of the requirements of paragraph a of subdivision 7 of section 176-b of the Town Law, which limits the membership of volunteer fire companies to forty-five per centum of the actual membership of the fire company, has been submitted by the Delmar Fire District, County of Albany.

Pursuant to section 176-b of the Town Law, the non-resident membership limit shall be waived provided that no adjacent fire department objects within sixty days of the publication of this notice.

Objections shall be made in writing, setting forth the reasons such waiver should not be granted, and shall be submitted to: Francis J. Nerney, Jr., State Fire Administrator, Office of Fire Prevention and Control, 1220 Washington Ave., Bldg. 7A, Fl. 2, Albany, NY 12226

Objections must be received by the State Fire Administrator within sixty days of the date of publication of this notice.

In cases where an objection is properly filed, the State Fire Administrator shall have the authority to grant a waiver upon consideration of (1) the difficulty of the fire company or district in retaining and recruiting adequate personnel; (2) any alternative means available to the fire company or district to address such difficulties; and (3) the impact of the waiver on adjacent fire departments.

For further information, please contact: Deputy Chief William H. Rifenburgh, Office of Fire Prevention and Control, 1220 Washington Ave., Bldg. 7A, Fl. 2, Albany, NY 12226, (518) 474-6746, [William.Rifenburgh@dhses.ny.gov](mailto:William.Rifenburgh@dhses.ny.gov)

**PUBLIC NOTICE**

## Department of Health

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

The Department of Health proposes to amend the Title XIX (Medicaid) State Plan for all services to comply with enacted statutory provisions. The following changes are proposed:

**Long Term Care Services**

Effective for rate periods on or after July 1, 2021, the case mix index used to adjust the direct component price will be based on all Medicaid-only case mix data submitted by NYS nursing facilities 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). This amendment allows for the inclusion of all assessments submitted by nursing homes which will achieve a higher degree of accuracy in case mix reimbursement, and the reimbursement will be appropriate for the acuity levels.

The estimated annual net aggregate decrease in gross Medicaid expenditures attributable to the change in case mix methodology for State Fiscal Year 2022 is \$132 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](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](mailto:spa_inquiries@health.ny.gov)

**PUBLIC NOTICE**

## Department of State

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

The Department of Health proposes to amend the Title XIX (Medicaid) State Plan for all services to comply with enacted statutory provisions. The following changes are proposed:

**Long Term Care Services**

Effective for rate periods on or after July 1, 2021, the case mix index used to adjust the direct component price will be based on all Medicaid-only case mix data submitted by NYS nursing facilities 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). This amendment allows for the inclusion of all assessments submitted by nursing homes which will achieve a higher degree of accuracy in case mix reimbursement, and the reimbursement will be appropriate for the acuity levels.

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

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](mailto:spa_inquiries@health.ny.gov)

**PUBLIC NOTICE**Department of State  
Program Change

STATEWIDE — Pursuant to 15 CFR 923, the New York State Department of State (DOS) hereby gives notice that the National

**Appendix V**  
**2021 Title XIX State Plan**  
**Second Quarter Amendment**  
**Responses to Standard Funding Questions**

**APPENDIX V**  
**LONG TERM CARE SERVICES**  
**State Plan Amendment #21-0050**

**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 general appropriation received by the State agency that oversees medical assistance (Medicaid), which is the Department of Health. Also, 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:** The payments authorized for this provision are not supplemental or enhanced 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 state and CMS are working toward completing and approval of current year UPL.

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

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

### **ACA Assurances:**

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

#### **MOE Period.**

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

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

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

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

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

**Response:** This SPA would [  ] / would not [] violate these provisions, if they remained in effect on or after January 1, 2015.

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

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

**Tribal Assurance:**

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

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



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

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

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

**Appendix VI**  
**2021 Title XIX State Plan**  
**Second Quarter Amendment**  
**Responses to Standard Access Questions**

**APPENDIX VI  
LONG TERM CARE SERVICES  
State Plan Amendment 21-0050**

**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 mx 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. 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 2019-20 Enacted 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:** The State continues to implement Medicaid reform initiatives to better align reimbursement and to ensure access to quality of care in the appropriate setting. The approved 1.5% nursing home rate increase will help assist facilities whose rates are negatively impacted by the change in case mix policy.