Department of Health and Human Services
Centers for Medicare & Medicaid Services

Section 42 C.F.R. § 438.6(c) Preprint – January 2021
STATE/TERRITORY ABBREVIATION: New York State
CMS Provided State Directed Payment Identifier:
NY_Fee_HCBS3_New_20210401-20220331

Section 438.6(c) Preprint

42 C.F.R. § 438.6(c) provides States with the flexibility to implement delivery system and provider payment initiatives under MCO, PIHP, or PAHP Medicaid managed care contracts (i.e., state directed payments). 42 C.F.R. § 438.6(c)(1) describes types of payment arrangements that States may use to direct expenditures under the managed care contract. Under 42 C.F.R. § 438.6(c)(2)(ii), contract arrangements that direct an MCO's, PIHP's, or PAHP's expenditures under paragraphs (c)(1)(i) through (c)(1)(ii) and (c)(1)(iii)(B) through (D) must have written approval from CMS prior to implementation and before approval of the corresponding managed care contract(s) and rate certification(s). This preprint implements the prior approval process and must be completed, submitted, and approved by CMS before implementing any of the specific payment arrangements described in 42 C.F.R. § 438.6(c)(1)(i) through (c)(1)(ii) and (c)(1)(iii)(B) through (D). Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules using State plan approved rates as defined in 42 C.F.R. § 438.6(a).

Submit all state directed payment preprints for prior approval to: StateDirectedPayment@cms.hhs.gov.

SECTION I: DATE AND TIMING INFORMATION

1. Identify the State's managed care contract rating period(s) for which this payment arrangement will apply (for example, July 1, 2020 through June 30, 2021):

   April 1, 2021 through March 31, 2022

2. Identify the State's requested start date for this payment arrangement (for example, January 1, 2021). *Note, this should be the start of the contract rating period unless this payment arrangement will begin during the rating period.*

   March 30, 2022

3. Identify the managed care program(s) to which this payment arrangement will apply:

   Managed Long-Term Care Partial Capitation (MLTCP)

   Medicaid Advantage Plus (MAP)

4. Identify the estimated **total dollar amount** (federal and non-federal dollars) of this state directed payment:

   $361.25 million

   a. Identify the estimated federal share of this state directed payment:

      $180.63 million

   b. Identify the estimated non-federal share of this state directed payment:

      $180.63 million

Please note, the estimated total dollar amount and the estimated federal share should be described for the rating period in Question 1. If the State is seeking a multi-year approval (which is only an option for VBP/DSR payment arrangements (42 C.F.R. § 438.6(c)(1)(i)-(ii))), States should provide the estimates per rating period. For amendments, states should include the change from the total and federal share estimated in the previously approved preprint.

5. Is this the initial submission the State is seeking approval under 42 C.F.R. § 438.6(c) for this state directed payment arrangement? ☒ Yes ☐ No

6. If this is not the initial submission for this state directed payment, please indicate if:

a. ☐ The State is seeking approval of an amendment to an already approved state directed payment.

b. The State is seeking approval for a renewal of a state directed payment for a new rating period.

i. If the State is seeking approval of a renewal, please indicate the rating periods for which previous approvals have been granted:

c. Please identify the types of changes in this state directed payment that differ from what was previously approved.

☐ Payment Type Change

☐ Provider Type Change

☐ Quality Metric(s) / Benchmark(s) Change

☐ Other; please describe:

☐ No changes from previously approved preprint other than rating period(s).

7. ☒ Please use the checkbox to provide an assurance that, in accordance with 42 C.F.R. § 438.6(c)(2)(ii)(F), the payment arrangement is not renewed automatically.

SECTION II: TYPE OF STATE DIRECTED PAYMENT

8. In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(A), describe in detail how the payment arrangement is based on the utilization and delivery of services for enrollees covered under the contract. The State should specifically discuss what must occur in order for the provider to receive the payment (e.g., utilization of services by managed care enrollees, meet or exceed a performance benchmark on provider quality metrics).

The State will pay this pool of $361.25 million to Managed Long-Term Care Partial Capitation (MLTCP) and Medicaid Advantage Plus (MAP) plans to distribute to the most highly utilized personal care provider agencies, as defined by licensed home care services agencies (LCHSAs) whose 2019 managed care revenue received from MLTCP and MAP plans falls in the top third of providers in their designated MLTC rate regions and that attest to using the funding on State-directed programs and/or services in SFY 2022 (April 1, 2021 through March 31, 2022) and 2023 (April 1, 2022 through March 31, 2023). Payments made to providers will be based on the utilization of services by enrollees in applicable managed care plans from April 1, 2021 through September 30, 2021, such that distribution is based on utilization in the same rating year for which the funds would be paid.

The attestations will include a project plan regarding intended uses and a projected budget for each use of the funding. Providers will also be required to report on the actual and projected use of ARPA HCBS funding to the State in order to retain their awards and to be eligible for continued HCBS enhanced FMAP funding. The State-directed programs and services in which providers can choose to invest include the following:

- Adopting workforce retention strategies, including recognition and retention bonuses, employee development and promotion initiatives, enhanced job benefits (e.g., health insurance for part-time and full-time workforce), paid training time, and other job satisfaction strategies;

- Developing and promoting completion of training programs and providing paid training opportunities for home care workers, such that eligible providers would utilize training for skills development, including the qualification of home care workers as Advanced Home Health Aides that are authorized under New York law to perform advanced tasks (e.g., administration of routine or pre-filled medications under the supervision of a registered nurse);

- Utilizing innovative technologies that assist with Value-Based Payment (VBP) contracting and increasing employee satisfaction, such as consumer-personal assistant matching technology, technologies that enable aides to maximize care hours to achieve full-time work, and other technologies that improve care management and VBP;

- Developing or utilizing strategies to recruit and retain a racially and ethnically diverse and culturally competent workforce, with adequate levels of demographic and linguistic representation based on historical consumer populations;

- Implementing strategies for effective care management and reductions in health care spending associated with effective service delivery, which would include long-term relationship development between consumer and home care worker, as the longevity of this relationship promotes effective and lower cost care delivery; and

- Building appropriate personal protected equipment (PPE) stockpiles from state authorized sources for ensuring that home care workers are able to deliver care in a safe and effective manner through the end of COVID-19 and beyond.

Use of ARPA HCBS funding for these State-directed programs and services have received approval from CMS as part of its partial approval letter to New York State dated August 25, 2021. A copy of this letter may be found here: https://www.medicaid.gov/media/file/ny-arp-9817-partial-08-25-210.pdf

a. ☒ Please use the checkbox to provide an assurance that CMS has approved the federal authority for the Medicaid services linked to the services associated with the SDP (i.e., Medicaid State plan, 1115(a) demonstration, 1915(c) waiver, etc.).

b. Please also provide a link to, or submit a copy of, the authority document(s) with initial submissions and at any time the authority document(s) has been renewed/revised/updated.

https://www.health.ny.gov/health_care/medicaid/redesign/medicaid_waiver_1115.htm

9. Please select the general type of state directed payment arrangement the State is seeking prior approval to implement. (Check all that apply and address the underlying questions for each category selected.)

a. ☐ **PAYMENTS / DELIVERY SYSTEM REFORM:** In accordance with 42 C.F.R. § 438.6(c)(1)(i) and (ii), the State is requiring the MCO, PIHP, or PAHP to implement value-based purchasing models for provider reimbursement, such as alternative payment models (APMs), pay for performance arrangements, bundled payments, or other service payment models intended to recognize value or outcomes over volume of services; or the State is requiring the MCO, PIHP, or PAHP to participate in a multi-payer or Medicaid-specific delivery system reform or performance improvement initiative.

If checked, please answer all questions in Subsection IIA.

b. ☒ **FEE SCHEDULE REQUIREMENTS:** In accordance with 42 C.F.R. § 438.6(c)(1)(iii)(B) through (D), the State is requiring the MCO, PIHP, or PAHP to adopt a minimum or maximum fee schedule for network providers that provide a particular service under the contract; or the State is requiring the MCO, PIHP, or PAHP to provide a uniform dollar or percentage increase for network providers that provide a particular service under the contract. **[Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules using State plan approved rates as defined in 42 C.F.R. § 438.6(a).]**

If checked, please answer all questions in Subsection IIB.

SUBSECTION IIA: VALUE-BASED PAYMENTS (VBP) / DELIVERY SYSTEM REFORM (DSR):

This section must be completed for all state directed payments that are VBP or DSR. This section does not need to be completed for state directed payments that are fee schedule requirements.

10. Please check the type of VBP/DSR State directed payment the State is seeking prior approval for. *Check all that apply; if none are checked, proceed to Section III.*

☐ Quality Payment/Pay for Performance (Category 2 APM, or similar)

☐ Bundled Payment/Episode-Based Payment (Category 3 APM, or similar)

☐ Population-Based Payment/Accountable Care Organization (Category 4 APM, or similar)

☐ Multi-Payer Delivery System Reform

☐ Medicaid-Specific Delivery System

☐ Reform Performance Improvement Initiative

☐ Other Value-Based Purchasing Model

11. Provide a brief summary or description of the required payment arrangement selected above and describe how the payment arrangement intends to recognize value or outcomes over volume of services. If "other" was checked above, identify the payment model. The State should specifically discuss what must occur in order for the provider to receive the payment (e.g., meet or exceed a performance benchmark on provider quality metrics).

12. In Table 1 below, identify the measure(s), baseline statistics, and targets that the State will tie to provider performance under this payment arrangement (provider performance measures). Please complete all boxes in the row. To the extent practicable, CMS encourages states to utilize existing, validated, and outcomes-based performance measures to evaluate the payment arrangement, and recommends States use the CMS Adult and Child Core Set Measures when applicable.

TABLE 1: Payment Arrangement Provider Performance Measures

Measure Name and NQF # (if applicable)	**Measure Steward/ Developer**[1]	**Baseline**[2] **Year**	**Baseline**[2] **Statistic**	**Performance Measurement Period**[3]	**Performance Target**	**Notes**[4]
Example: Percent of High-Risk Residents with Pressure Ulcers –Long Stay	*CMS*	*CY 2018*	*9.23%*	*Year 2*	*8%*	*Example notes*

1. Baseline data must be added after the first year of the payment arrangement
2. If state-developed, list State name for Steward/Developer.
3. If this is planned to be a multi-year payment arrangement, indicate which year(s) of the payment arrangement that performance on the measure will trigger payment.
4. If the State is using an established measure and will deviate from the measure steward's measure specifications, please describe here. Additionally, if a state-specific measure will be used, please define the numerator and denominator here.

13. For the measures listed in Table 1 above, please provide the following information:

a. Please describe the methodology used to set the performance targets for each measure.

b. If multiple provider performance measures are involved in the payment arrangement, discuss if the provider must meet the performance target on each measure to receive payment or can providers receive a portion of the payment if they meet the performance target in some but not all measures?

c. For state-developed measures, please briefly describe how the measure was developed?

14. Is the State seeking a multi-year approval of the state directed payment arrangement?

☐ Yes ☐ No

a. If this payment arrangement is designed to be a multi-year effort, denote the State's managed care contract rating period(s) the State is seeking approval for.

b. If this payment arrangement is designed to be a multi-year effort and the State is **NOT** requesting a multi-year approval, describe how this application's payment arrangement fits into the larger multi-year effort and identify which year of the effort is addressed in this application.

15. Use the checkboxes below to make the following assurances:

a. ☐ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(A), the state directed payment arrangement makes participation in the value-based purchasing initiative, delivery system reform, or performance improvement initiative available, using the same terms of performance, to the class or classes of providers (identified below) providing services under the contract related to the reform or improvement initiative.

b. ☐ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(B), the payment arrangement makes use of a common set of performance measures across all of the payers and providers.

c. ☐ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(C), the payment arrangement does not set the amount or frequency of the expenditures.

d. ☐ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(D), the payment arrangement does not allow the State to recoup any unspent funds allocated for these arrangements from the MCO, PIHP, or PAHP.

SUBSECTION IIB: STATE DIRECTED FEE SCHEDULES:

This section must be completed for all state directed payments that are fee schedule requirements. This section does not need to be completed for state directed payments that are VBP or DSR.

[2] Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules that use State plan approved rates as defined in 42 C.F.R. § 438.6(a).

16. Please check the type of state directed payment for which the State is seeking prior approval. *Check all that apply; if none are checked, proceed to Section III.*

a. ☐ Minimum Fee Schedule for providers that provide a particular service under the contract *using rates other than State plan approved rates* [1] (42 C.F.R. § 438.6(c)(1)(iii)(B))

b. ☐ Maximum Fee Schedule (42 C.F.R. § 438.6(c)(1)(iii)(D))

c. ☒ Uniform Dollar or Percentage Increase (42 C.F.R. § 438.6(c)(1)(iii)(C))

17. If the State is seeking prior approval of a fee schedule (options a or b in Question 16):

a. Check the basis for the fee schedule selected above.

i. ☐ The State is proposing to use a fee schedule based on the **State-plan approved rates** as defined in 42 C.F.R. § 438.6(a). [2]

ii. ☐ The State is proposing to use a fee schedule based on the **Medicare or Medicare-equivalent rate**.

iii. ☐ The State is proposing to use a fee schedule based on an **alternative fee schedule established by the State**.

1. If the State is proposing an alternative fee schedule, please describe the alternative fee schedule (e.g., 80% of Medicaid State-plan approved rate)

b. Explain how the state determined this fee schedule requirement to be reasonable and appropriate.

18. If using a maximum fee schedule (option b in Question 16), please answer the following additional questions:

a. ☐ Use the checkbox to provide the following assurance: In accordance with 42 C.F.R. § 438.6(c)(1)(iii)(C), the State has determined that the MCO, PIHP, or PAHP has retained the ability to reasonably manage risk and has discretion in accomplishing the goals of the contract.

b. Describe the process for plans and providers to request an exemption if they are under contract obligations that result in the need to pay more than the maximum fee schedule.

c. Indicate the number of exemptions to the requirement:

i. Expected in this contract rating period (estimate)

ii. Granted in past years of this payment arrangement

d. Describe how such exemptions will be considered in rate development.

[2] Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules that use State plan approved rates as defined in 42 C.F.R. § 438.6(a).

19. If the State is seeking prior approval for a uniform dollar or percentage increase (option c in Question 16), please address the following questions:

a. Will the state require plans to pay a ☒ uniform dollar amount **or** a ☐ uniform percentage increase? (*Please select only one.*)

b. What is the magnitude of the increase (e.g., $4 per claim or 3% increase per claim?)

The increase is $3.80 per hour of service.

c. Describe how will the uniform increase be paid out by plans (e.g., upon processing the initial claim, a retroactive adjustment done one month after the end of quarter for those claims incurred during that quarter).

The uniform increase will be paid out by plans in the last month of the managed care rating period, i.e., March 2022. Plans will pay providers the total increase based on actual claims experience as reported to the State from April 2021 – September 2021 run out through December 13, 2021.

d. Describe how the increase was developed, including why the increase is reasonable and appropriate for network providers that provide a particular service under the contract.

The increase was developed using utilization of personal care services provided by LHCSAs in the provider class for enrollees in MLTCP and MAP plans in the first two quarters of SFY 2022. To calculate the amount that each provider will receive, DOH divided the $361 million by the total hours of service provided by LHCSAs in the provider class for enrollees in the applicable managed care plans from April to September 2021. This resulted in a uniform dollar increase that will be applied to each hour of service from the selected dates of service to determine the amount that each provider will receive. This increase is reasonable and appropriate because it will help network providers that provide personal care services under these contracts to strengthen their workforce that has been hard hit by the COVID-19 pandemic, prepare to meet growing demand in services, and become ready to participate effectively in value-based payment (VBP) arrangements.

SECTION III: PROVIDER CLASS AND ASSESSMENT OF REASONABLENESS

20. In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(B), identify the class or classes of providers that will participate in this payment arrangement by answering the following questions:

a. Please indicate which general class of providers would be affected by the state directed payment (check all that apply):

☐ inpatient hospital service
☐ outpatient hospital service
☐ professional services at an academic medical center
☐ primary care services
☐ specialty physician services
☐ nursing facility services
☒ HCBS/personal care services
☐ behavioral health inpatient services

☐ behavioral health outpatient services
☐ dental services
☐ Other:

b. Please define the provider class(es) (if further narrowed from the general classes indicated above).

The provider class includes licensed home care services agencies whose managed care revenue received from Managed Long-Term Care Partial Capitation (MLTCP) and Medicaid Advantage Plus (MAP) plans in CY 2019 falls in the top third of providers in their designated MLTC rate region and have completed required attestations and surveys.

c. Provide a justification for the provider class defined in Question 20b (e.g., the provider class is defined in the State Plan.) If the provider class is defined in the State Plan, please provide a link to or attach the applicable State Plan pages to the preprint submission. Provider classes cannot be defined to only include providers that provide intergovernmental transfers.

This directed payment is aimed at increasing the quality and capacity of the HCBS workforce, such that the licensed home care services agencies are able to implement evidence-based care interventions, promote quality, and prepare to participate effectively in value-based payment (VBP) arrangements. The top third of LHCSAs in each region represent the bulk of the home care sector in the state. In 2019, the top third of LHCSAs received 92% of managed care revenue from MLTCP and MAP plans. An emphasis on the top third provides for greater, more targeted and meaningful investments, while the regional division leads to support in both urban and rural areas.

The provider class is further limited to the LHCSAs that complete required survey questions and attest to using the funding to strengthen the workforce and prepare for participation in VBP arrangements. The survey will provide key baseline data on the state of the LHCSA workforce and attestations will allow the State to distribute funds to providers that commit to using consistent with the purpose of this preprint.

21. In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(B), describe how the payment arrangement directs expenditures equally, using the same terms of performance, for the class or classes of providers (identified above) providing the service under the contract.

The pool of HCBS funding is established through the American Rescue Plan Act (ARPA) in order to promote the quality of services and access to care for the Medicaid population covered through Managed Long-Term Care Partial Capitation and Medicaid Advantage Plus plans.

All members of the provider class will have equal opportunity to qualify for payments from plans. Plans will pay providers according to the units of service they provided to enrollees in the applicable Medicaid managed care programs from April 2021 through September 2021 as reported to the State as of December 13, 2021.

22. For the services where payment is affected by the state directed payment, how will the state directed payment interact with the negotiated rate(s) between the plan and the provider? Will the state directed payment:

a. ☐ Replace the negotiated rate(s) between the plan(s) and provider(s).

b. ☐ Limit but not replace the negotiated rate(s) between the plans(s) and provider(s).

c. ☒ Require a payment be made in addition to the negotiated rate(s) between the plan(s) and provider(s).

23. For payment arrangements that are intended to require plans to make a payment in addition to the negotiated rates (as noted in option c in Question 22), please provide an analysis in Table 2 showing the impact of the state directed payment on payment levels for each provider class. This provider payment analysis should be completed distinctly for each service type (e.g., inpatient hospital services, outpatient hospital services, etc.).

This should include an estimate of the base reimbursement rate the managed care plans pay to these providers as a percent of Medicare, or some other standardized measure, and the effect the increase from the state directed payment will have on total payment. *Ex: The average base payment level from plans to providers is 80% of Medicare and this SDP is expected to increase the total payment level from 80% to 100% of Medicare.*

TABLE 2: Provider Payment Analysis

Provider Class(es)	Average Base Payment Level from Plans to Providers (absent the SDP)	Effect on Total Payment Level of State Directed Payment (SDP)	Effect on Total Payment Level of Other SDPs	Effect on Total Payment Level of Pass-Through Payments (PTPs)	Total Payment Level (after accounting for all SDPs and PTPs
Ex: Rural Inpatient Hospital Services	*80%*	*20%*	*N/A*	*N/A*	*100%*
Licensed Home Care Services Agencies	99.8%	15.1%	*N/A*	*N/A*	114.9%

24. Please indicate if the data provided in Table 2 above is in terms of a percentage of:

a. ☐ Medicare payment/cost

b. ☐ State-plan approved rates as defined in 42 C.F.R. § 438.6(a) *(Please note, this rate cannot include supplemental payments.)*

c. ☒ Other; Please define:

The data above is in terms of the percentage of the average fee-for-service (FFS) hourly cost for personal care services provided by LHCSAs from April 1, 2021 through September 30, 2021. The FFS fee schedule approved by CMS can be found here: https://www.health.ny.gov/facilities/long_term_care/reimbursement/pcr/2020_pc_rates.htm.

25. Does the State also require plans to pay any other state directed payment for providers eligible for the provider class described in Question 20b? ☐ Yes ☒ No

If yes, please provide information requested under the column "Other State Directed Payments" in Table 2.

26. Does the State also require plans to pay pass-through payments as defined in 42 C.F.R. § 438.6(a) to any of the providers eligible for any of the provider class(es) described in Question 20b? ☐ Yes ☒ No

If yes, please provide information requested under the column "Pass-Through Payments" in Table 2.

27. Please describe the data sources and methodology used for the analysis provided in response to Question 23.

The average FFS personal care hourly cost was used as the average base payment level. The average hourly FFS cost of personal care services provided from April through September 2021 was used– the same period for which the uniform increase will apply to hours paid by applicable managed care plans. The comparison above is provided in terms of hourly FFS and managed care costs as this uniform increase methodology is based off units of service, in hours, for this directed payment. FFS hourly rates for personal care

have been approved by CMS. The FFS fee schedule approved by CMS can be found here: https://www.health.ny.gov/facilities/long_term_care/reimbursement/pcr/2020_pc_rates.htm.

28. Please describe the State's process for determining how the proposed state directed payment was appropriate and reasonable.

The state directed payment invests HCBS enhanced funding proceeds generated by Medicaid program spending on personal care services back into the personal care sector. This directed payment increases licensed home care services agencies' hourly reimbursement by 15.1% from April through September 2021. The State believes that this investment will play a critical role in helping the personal care workforce recover from COVID-19, prepare to meet growing demand, and become ready to participate effectively in value-based payment arrangements. The State has determined that this investment is appropriate and reasonable in light of these factors.

SECTION IV: INCORPORATION INTO MANAGED CARE CONTRACTS

29. States must adequately describe the contractual obligation for the state directed payment in the state's contract with the managed care plan(s) in accordance with 42 C.F.R. § 438.6(c). Has the state already submitted all contract action(s) to implement this state directed payment? ☐ Yes ☒ No

a. If yes:

i. What is/are the state-assigned identifier(s) of the contract actions provided to CMS?

ii. Please indicate where (page or section) the state directed payment is captured in the contract action(s).

b. If no, please estimate when the state will be submitting the contract actions for review.

The contract amendment will be included in the State's next contract amendment submission to CMS. The contract amendment language that will be included is attached to this preprint.

SECTION V: INCORPORATION INTO THE ACTUARIAL RATE CERTIFICATION

Note: Provide responses to the questions below for the first rating period if seeking approval for multi-year approval.

30. Has/Have the actuarial rate certification(s) for the rating period for which this state directed payment applies been submitted to CMS? ☒ Yes ☐ No

a. If no, please estimate when the state will be submitting the actuarial rate certification(s) for review.

b. If yes, provide the following information in the table below for each of the actuarial rate certification review(s) that will include this state directed payment

Table 3: Actuarial Rate Certification(s)

Control Name Provided by CMS (List each actuarial rate certification separately)	Date Submitted to CMS	Does the certification incorporate the SDP?	If so, indicate where the state directed payment is captured in the certification (page or section)
i. MLTCP: New York_MLTC_20210401-20220331_Certification_20211101	11/5/21	Yes*	Page 27*
ii. MAP: No control name provided but submitted as "NY-MLTC Medicaid Advantage Plus – April 2021 Rate Approval Request – R"	11/5/21	Yes*	Page 28*

* The certification states that once the directed payment in response to Section 9817 Additional Support for Medicaid Home and Community-Based Services is finalized, it will be incorporated in a future update.

Please note, states and actuaries should consult the most recent Medicaid Managed Care Rate Development Guide for how to document state directed payments in actuarial rate certification(s). The actuary's certification must contain all of the information outlined; if all required documentation is not included, review of the certification will likely be delayed.)

c. If not currently captured in the State's actuarial certification submitted to CMS, note that the regulations at 42 C.F.R. § 438.7(b)(6) requires that all state directed payments are documented in the State's actuarial rate certification(s). CMS will not be able to approve the related contract action(s) until the rate certification(s) has/have been amended to account for all state directed payments. Please provide an estimate of when the State plans to submit an amendment to capture this information.

31. Describe how the State will/has incorporated this state directed payment arrangement in the applicable actuarial rate certification(s) (please select one of the options below):

a. ☐ An adjustment applied in the development of the monthly base capitation rates paid to plans.

b. ☒ Separate payment term(s) which are captured in the applicable rate certification(s) but paid separately to the plans from the monthly base capitation rates paid to plans.

c. ☐ Other, please describe:

32. States should incorporate state directed payment arrangements into actuarial rate certification(s) as an adjustment applied in the development of the monthly base capitation rates paid to plans as this approach is consistent with the rate development requirements described in 42 C.F.R. § 438.5 and consistent with the nature of risk-based managed care. For state directed payments that are incorporated in another manner, particularly through separate payment terms, provide additional justification as to why this is necessary and what precludes the state from incorporating as an adjustment applied in the development of the monthly base capitation rates paid to managed care plans.

The directed payment will be incorporated through separate payment terms so that the State can pay plans upfront and so that funding can be tracked towards approved program

expenditures. This arrangement will provide LHCSAs with upfront funding to help build provider capacity and maintain financial stability.

33. ☒ In accordance with 42 C.F.R. § 438.6(c)(2)(i), the State assures that all expenditures for this payment arrangement under this section are developed in accordance with 42 C.F.R. § 438.4, the standards specified in 42 C.F.R. § 438.5, and generally accepted actuarial principles and practices.

SECTION VI: FUNDING FOR THE NON-FEDERAL SHARE

34. Describe the source of the non-federal share of the payment arrangement. Check all that apply:

a. ☐ State general revenue

b. ☐ Intergovernmental transfers (IGTs) from a State or local government entity

c. ☐ Health Care-Related Provider tax(es) / assessment(s)

d. ☐ Provider donation(s)

e. ☒ Other, specify:

State funds equivalent to the amount of federal funds attributable to the increased FMAP in accordance with Section 9817 of the ARP and in accordance with the requirements outlined in associated guidance, including SMD 21-003.

35. For any payment funded by **IGTs (option b in Question 34)**,

a. Provide the following (respond to each column for all entities transferring funds). If there are more transferring entities than space in the table, please provide an attachment with the information requested in the table.

Table 4: IGT Transferring Entities

Name of Entities transferring funds (enter each on a separate line)	Operational nature of the Transferring Entity (State, County, City, Other)	Total Amounts Transferred by This Entity	Does the Transferring Entity have General Taxing Authority? (Yes or No)	Did the Transferring Entity receive appropriations? If not, put N/A. If yes, identify the level of appropriations	Is the Transferring Entity eligible for payment under this state directed payment? (Yes or No)
i.					
ii.					
iii.					
iv.					
v.					
vi.					
vii.					
viii.					
ix.					
x.					

b. ☐ Use the checkbox to provide an assurance that no state directed payments made under this payment arrangement funded by IGTs are dependent on any agreement or arrangement for providers or related entities to donate money or services to a governmental entity.

c. Provide information or documentation regarding any written agreements that exist between the State and healthcare providers or amongst healthcare providers and/or related entities relating to the non-federal share of the payment arrangement. This should include any written agreements that may exist with healthcare providers to support and finance the non-federal share of the payment arrangement. Submit a copy of any written agreements described above.

36. For any state directed payments funded by **provider taxes/assessments (option c in Question 34)**,

a. Provide the following (respond to each column for all entries). If there are more entries than space in the table, please provide an attachment with the information requested in the table.

Table 5: Health Care-Related Provider Tax/Assessment(s)

Name of the Health Care-Related Provider Tax / Assessment (enter each on a separate line)	Identify the permissible class for this tax / assessment	Is the tax / assessment broad-based?	Is the tax / assessment uniform?	Is the tax / assessment under the 6% indirect hold harmless limit?	If not under the 6% indirect hold harmless limit, does it pass the "75/75" test?	Does it contain a hold harmless arrangement that guarantees to return all or any portion of the tax payment to the tax payer?
i.						
ii.						
iii.						
iv.						
v.						

b. If the state has any waiver(s) of the broad-based and/or uniform requirements for any of the health care-related provider taxes/assessments, list the waiver(s) and its current status:

Table 6: Health Care-Related Provider Tax/Assessment Waivers

Name of the Health Care-Related Provider Tax/Assessment Waiver (enter each on a separate line)	Submission Date	Current Status (Under Review, Approved)	Approval Date
i.			
ii.			
iii.			
iv.			
v.			

37. For any state directed payments funded by **provider donations (option d in Question 34)**, please answer the following questions:

a. Is the donation bona-fide? ☐ Yes ☐ No

b. Does it contain a hold harmless arrangement to return all or any part of the donation to the donating entity, a related entity, or other provider furnishing the same health care items or services as the donating entity within the class?

☐ Yes ☐ No

38. ☒ **For all state directed payment arrangements**, use the checkbox to provide an assurance that in accordance with 42 C.F.R. § 438.6(c)(2)(ii)(E), the payment arrangement does not condition network provider participation on the network provider entering into or adhering to intergovernmental transfer agreements.

SECTION VII: QUALITY CRITERIA AND FRAMEWORK FOR ALL PAYMENT ARRANGEMENTS

39. ☒ Use the checkbox below to make the following assurance, "In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(C), the State expects this payment arrangement to advance at least one of the goals and objectives in the quality strategy required per 42 C.F.R. § 438.340."

40. Consistent with 42 C.F.R. § 438.340(d), States must post the final quality strategy online beginning July 1, 2018. Please provide:

- **a.** A hyperlink to State's most recent quality strategy:
- **b.** The effective date of quality strategy.

41. If the State is currently updating the quality strategy, please submit a draft version, and provide:

https://www.health.ny.gov/health_care/medicaid/redesign/2021/docs/2021-10-05_qual_strat_cy2020-2022.pdf

- **a.** A target date for submission of the revised quality strategy (month and year):

  The State submitted the updated quality strategy to CMS on December 13, 2021 and received feedback from CMS on January 24, 2022. The State is currently assessing the feedback.

- **b.** Note any potential changes that might be made to the goals and objectives.

  The State does not foresee any changes to the goals and objectives.

Note: The State should submit the final version to CMS as soon as it is finalized. To be in compliance with 42 C.F.R. § 438.340(c)(2) the quality strategy must be updated no less than once every 3-years.

42. To obtain written approval of this payment arrangement, a State must demonstrate that each state directed payment arrangement expects to advance at least one of the goals and objectives in the quality strategy. In the Table 7 below, identify the goal(s) and objective(s), as they appear in the Quality Strategy (include page numbers), this payment arrangement is expected to advance. If additional rows are required, please attach.

Table 7: Payment Arrangement Quality Strategy Goals and Objectives

Goal(s)	Objective(s)	Quality strategy page
Example: Improve care coordination for enrollees with behavioral health conditions	*Example: Increase the number of managed care service recipients utilizing follow-up behaviorhealth counseling by 15%*	*5*
a. Promote Prevention with Access to High Quality Care – Network Adequacy	Increase the number of health care providers to provide appropriate access to care for Medicaid enrollees, which includes being geographically accessible (meeting time/distance standards based on geographic location), being accessible for the disabled, and promoting and ensuring the delivery of services in a culturally competent manner	42
b. Support Members in Their Communities	Expand access to high-quality care in the least restrictive settings	49

43. Describe how this payment arrangement is expected to advance the goal(s) and objective(s) identified in Table 7. If this is part of a multi-year effort, describe this both in terms of this year's payment arrangement and in terms of that of the multi-year payment arrangement.

This payment arrangement focuses on strengthening the long-term care workforce in order to expand capacity in and increase access to high-quality, home and community-based care for the Medicaid population. The State aims to achieve this by directing providers to implement new workforce recruitment and retention strategies, develop a more diverse and culturally competent workforce, expand training programs, and use innovative technologies that advance efficiency.

44. Please complete the following questions regarding having an evaluation plan to measure the degree to which the payment arrangement advances at least one of the goals and objectives of the State's quality strategy. To the extent practicable, CMS encourages States to utilize existing, validated, and outcomes-based performance measures to evaluate the payment arrangement, and recommends States use the CMS Adult and Child Core Set Measures, when applicable.

a. ☒ In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(D), use the checkbox to assure the State has an evaluation plan which measures the degree to which the payment arrangement advances at least one of the goals and objectives in the quality strategy required per 42 C.F.R. § 438.340, and that the evaluation conducted will be *specific* to this payment arrangement. *Note:* States have flexibility in how the evaluation is conducted and may leverage existing resources, such as their 1115 demonstration evaluation if this payment arrangement is tied to an 1115 demonstration or their External Quality Review validation activities, as long as those evaluation or validation activities are *specific* to this payment arrangement and its impacts on health care quality and outcomes

b. Describe how and when the State will review progress on the advancement of the State's goal(s) and objective(s) in the quality strategy identified in Question 42. For each measure the State intends to use in the evaluation of this payment arrangement,provide in Table 8 below: 1) the baseline year, 2) the baseline statistics, and 3) the performance targets the State will use to track the impact of this payment arrangement on the State's goals and objectives. Please attach the State's evaluation plan for this payment arrangement.

TABLE 8: Evaluation Measures, Baseline and Performance Targets

Measure Name and NQF # (if applicable)	**Baseline Year**	**Baseline Statistic**	**Performance Target**	**Notes[1]**
Example: Flu Vaccinations for Adults Ages 19 to 64 (FVA-AD); NQF # 0039	*CY 2019*	*34%*	*Increase the percentage of adults 18–64 years of age who report receiving an influenza vaccinationby 1 percentage point per year*	*Example notes*
i. Provider Ability to Meet Demand	CY 2021		Increase the number of providers in all regions who report that they are able to meet a greater percentage of requests for services due to improved staffing by 25%	*Numerator:* change in # of LHCSAs reporting meeting a greater percentage of requests for services than in CY21 due to improved staffing *Denominator:* # of LHCSAs who reported not being able to meet all requests for services in CY21
ii. Personal Care Provider Capacity	CY 2021		Increase the size of the MLTC workforce in all regions by 5%	*Numerator:* change in # of direct care workers (FTEs) employed by LHCSAs in the provider class *Denominator:* # of direct care workers (FTEs) employed by LHCSAs in the provider class in CY21

1. If the State will deviate from the measure specification, please describe here. If a State-specific measure will be used, please define the numerator and denominator here. Additionally, describe any planned data or measure stratifications (for example, age, race, or ethnicity) that will be used to evaluate the payment arrangement.

c. If this is any year other than year 1 of a multi-year effort, describe (or attach) prior year(s) evaluation findings and the payment arrangement's impact on the goal(s) and objective(s) in the State's quality strategy. Evaluation findings must include 1) historical data; 2) prior year(s) results data; 3) a description of the evaluation methodology; and 4) baseline and performance target information from the prior year(s) preprint(s) where applicable. If full evaluation findings from prior year(s) are not available, provide partial year(s) findings and an anticipated date for when CMS may expect to receive the full evaluation findings.