NEW YORK STATE OF OPPORTUNITY. Department of Health

KATHY HOCHUL
Governor

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

MEGAN E. BALDWIN
Acting Executive Deputy Commissioner

March 31, 2023

James G. Scott, Director
Division of Program Operations
Centers for Medicare & Medicaid Services
601 E. 12th St., Room 355
Kansas City, Missouri 64106

RE: SPA #20-0081
General Services

Dear Mr. Scott:

The State requests approval of the enclosed amendment #20-0081 to the Title XIX (Medicaid) State Plan to be effective July 1, 2020.

This amendment is being submitted based on the ongoing public health emergency. A summary of the plan amendment is provided.

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,

[redacted]

Amir Bassiri
Medicaid Director
Office of Health Insurance Programs

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 20 — 0081

2. STATE: New York

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)
TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

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

4. PROPOSED EFFECTIVE DATE
July 1, 2020

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
§ 1905(a)(16): IMD under age 21

7. FEDERAL BUDGET IMPACT
a. FFY 07/01/20 - 09/30/20 $ 466,217
b. FFY 10/01/20 - 09/30/21 $ 1,380,138

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment: 7.4 - Pages TBD

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment:

10. SUBJECT OF AMENDMENT
Disaster relief
(FMAP=50%)

11. GOVERNOR'S REVIEW *(Check One)*

☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED

12. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

13. TYPED NAME
Amir Bassiri

14. TITLE
Medicaid Director, Department of Health

15. DATE SUBMITTED
March 31, 2023

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

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED

18. DATE APPROVED

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL

20. SIGNATURE OF REGIONAL OFFICIAL

21. TYPED NAME

22. TITLE

23. REMARKS

Instructions on Back

State/Territory: New York

Section 7 – General Provisions
7.4. Medicaid Disaster Relief for the COVID-19 National Emergency

On March 13, 2020, the President of the United States issued a proclamation that the COVID-19 outbreak in the United States constitutes a national emergency by the authorities vested in him by the Constitution and the laws of the United States, including sections 201 and 301 of the National Emergencies Act (50 U.S.C. 1601 et seq.), and consistent with section 1135 of the Social Security Act (Act). On March 13, 2020, pursuant to section 1135(b) of the Act, the Secretary of the United States Department of Health and Human Services invoked his authority to waive or modify certain requirements of titles XVIII, XIX, and XXI of the Act as a result of the consequences COVID-19 pandemic, to the extent necessary, as determined by the Centers for Medicare & Medicaid Services (CMS), to ensure that sufficient health care items and services are available to meet the needs of individuals enrolled in the respective programs and to ensure that health care providers that furnish such items and services in good faith, but are unable to comply with one or more of such requirements as a result of the COVID-19 pandemic, may be reimbursed for such items and services and exempted from sanctions for such noncompliance, absent any determination of fraud or abuse. This authority took effect as of 6PM Eastern Standard Time on March 15, 2020, with a retroactive effective date of March 1, 2020. The emergency period will terminate, and waivers will no longer be available, upon termination of the public health emergency, including any extensions.

The State Medicaid agency (agency) seeks to implement the policies and procedures described below, which are different than the policies and procedures otherwise applied under the Medicaid state plan, during the period of the Presidential and Secretarial emergency declarations related to the COVID-19 outbreak (or any renewals thereof), or for any shorter period described below:

For the period beginning 07/01/2020 – 12/31/21

NOTE: States may not elect a period longer than the Presidential or Secretarial emergency declaration (or any renewal thereof). States may not propose changes on this template that restrict or limit payment, services, or eligibility, or otherwise burden beneficiaries and providers.

Request for Waivers under Section 1135

__x__ The agency seeks the following under section 1135(b)(1)(C) and/or section 1135(b)(5) of the Act:

a.__ SPA submission requirements – the agency requests modification of the requirement to submit the SPA by March 31, 2020, to obtain a SPA effective date during the first calendar quarter of 2020, pursuant to 42 CFR 430.20.

b. __x____ Public notice requirements – the agency requests waiver of public notice requirements that would otherwise be applicable to this SPA submission. These requirements may include those specified in 42 CFR 440.386 (Alternative Benefit Plans), 42 CFR 447.57(c) (premiums and cost sharing), and 42 CFR 447.205 (public notice of changes in statewide methods and standards for setting payment rates).

c. x Tribal consultation requirements – the agency requests modification of tribal consultation timelines specified in [insert name of state] Medicaid state plan, as described below:

New York will reduce the tribal consultation to zero days before submission to CMS. Tribal consultation will still be completed and mailed as per guidelines in New York's approved state plan.

Section A – Eligibility

1. _ The agency furnishes medical assistance to the following optional groups of individuals described in section 1902(a)(10)(A)(ii) or 1902(a)(10)(c) of the Act. This may include the new optional group described at section 1902(a)(10)(A)(ii)(XXIII) and 1902(ss) of the Act providing coverage for uninsured individuals.

Include name of the optional eligibility group and applicable income and resource standard.

2. _ The agency furnishes medical assistance to the following populations of individuals described in section 1902(a)(10)(A)(ii)(XX) of the Act and 42 CFR 435.218:

   a. __ All individuals who are described in section 1905(a)(10)(A)(ii)(XX)

      Income standard: _____

      -or-

   b. _ Individuals described in the following categorical populations in section 1905(a) of the Act:

      Income standard: _____

3. _ The agency applies less restrictive financial methodologies to individuals excepted from financial methodologies based on modified adjusted gross income (MAGI) as follows.

   Less restrictive income methodologies:

Less restrictive resource methodologies:

4. _ The agency considers individuals who are evacuated from the state, who leave the state for medical reasons related to the disaster or public health emergency, or who are otherwise absent from the state due to the disaster or public health emergency and who intend to return to the state, to continue to be residents of the state under 42 CFR 435.403(j)(3).

5. _ The agency provides Medicaid coverage to the following individuals living in the state, who are non-residents:

6. _ The agency provides for an extension of the reasonable opportunity period for non- citizens declaring to be in a satisfactory immigration status, if the non-citizen is making a good faith effort to resolve any inconsistences or obtain any necessary documentation, or the agency is unable to complete the verification process within the 90-day reasonable opportunity period due to the disaster or public health emergency.

Section B – Enrollment

1. _ The agency elects to allow hospitals to make presumptive eligibility determinations for the following additional state plan populations, or for populations in an approved section 1115 demonstration, in accordance with section 1902(a)(47)(B) of the Act and 42 CFR 435.1110, provided that the agency has determined that the hospital is capable of making such determinations.

Please describe the applicable eligibility groups/populations and any changes to reasonable limitations, performance standards or other factors.

2. _ The agency designates itself as a qualified entity for purposes of making presumptive eligibility determinations described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L.

Please describe any limitations related to the populations included or the number of allowable PE periods.

3. _ The agency designates the following entities as qualified entities for purposes of making presumptive eligibility determinations or adds additional populations as described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L. Indicate if any designated entities are permitted to make presumptive eligibility determinations only for specified populations.

Please describe the designated entities or additional populations and any limitations related to the specified populations or number of allowable PE periods.

4. _ The agency adopts a total of _____ months (not to exceed 12 months) continuous eligibility for children under age enter age _____ (not to exceed age 19) regardless of changes in circumstances in accordance with section 1902(e)(12) of the Act and 42 CFR 435.926.

5. _ The agency conducts redeterminations of eligibility for individuals excepted from MAGI- based financial methodologies under 42 CFR 435.603(j) once every _____ months (not to exceed 12 months) in accordance with 42 CFR 435.916(b).

6. _ The agency uses the following simplified application(s) to support enrollment in affected areas or for affected individuals (a copy of the simplified application(s) has been submitted to CMS).

   a.__ The agency uses a simplified paper application.

   b. _ The agency uses a simplified online application.

   c.__ The simplified paper or online application is made available for use in call-centers or other telephone applications in affected areas.

Section C – Premiums and Cost Sharing

1. _ The agency suspends deductibles, copayments, coinsurance, and other cost sharing charges as follows:

Please describe whether the state suspends all cost sharing or suspends only specified deductibles, copayments, coinsurance, or other cost sharing charges for specified items and services or for specified eligibility groups consistent with 42 CFR 447.52(d) or for specified income levels consistent with 42 CFR 447.52(g).

2. _ The agency suspends enrollment fees, premiums and similar charges for:

   a.__ All beneficiaries

   b. _ The following eligibility groups or categorical populations:

Please list the applicable eligibility groups or populations.

3. _ The agency allows waiver of payment of the enrollment fee, premiums and similar charges for undue hardship.

Please specify the standard(s) and/or criteria that the state will use to determine undue hardship.

Section D – Benefits

Benefits:

1. _ The agency adds the following optional benefits in its state plan (include service descriptions, provider qualifications, and limitations on amount, duration or scope of the benefit):

2. _ The agency makes the following adjustments to benefits currently covered in the state plan:

3. _ The agency assures that newly added benefits or adjustments to benefits comply with all applicable statutory requirements, including the statewideness requirements found at 1902(a)(1), comparability requirements found at 1902(a)(10)(B), and free choice of provider requirements found at 1902(a)(23).

4. _ Application to Alternative Benefit Plans (ABP). The state adheres to all ABP provisions in 42 CFR Part 440, Subpart C. This section only applies to states that have an approved ABP(s).

   a.__ The agency assures that these newly added and/or adjusted benefits will be made available to individuals receiving services under ABPs.

   b. _ Individuals receiving services under ABPs will not receive these newly added and/or adjusted benefits, or will only receive the following subset:

Please describe.

State/Territory: New York

Telehealth:

5. _ The agency utilizes telehealth in the following manner, which may be different than outlined in the state's approved state plan:

Please describe.

Drug Benefit:

6. _ The agency makes the following adjustments to the day supply or quantity limit for covered outpatient drugs. The agency should only make this modification if its current state plan pages have limits on the amount of medication dispensed.

Please describe the change in days or quantities that are allowed for the emergency period and for which drugs.

7. _ Prior authorization for medications is expanded by automatic renewal without clinical review, or time/quantity extensions.

8. _ The agency makes the following payment adjustment to the professional dispensing fee when additional costs are incurred by the providers for delivery. States will need to supply documentation to justify the additional fees.

Please describe the manner in which professional dispensing fees are adjusted.

9. _ The agency makes exceptions to their published Preferred Drug List if drug shortages occur. This would include options for covering a brand name drug product that is a multi-source drug if a generic drug option is not available.

Section E – Payments

Optional benefits described in Section D:

1. _ Newly added benefits described in Section D are paid using the following methodology:

   a.__ Published fee schedules –

   Effective date (enter date of change): _____

   Location (list published location): _____

b. _ Other:

Describe methodology here.

Increases to state plan payment methodologies:

2. X The agency increases payment rates for the following services:

Psychiatric Residential Treatment Facility (PRTF)

a.__ Payment increases are targeted based on the following criteria:

Please describe criteria.

b. Payments are increased through:

i.____ A supplemental payment or add-on within applicable upper payment limits:

Please describe.

ii. X An increase to rates as described below.

Rates are increased:

_____ Uniformly by the following percentage: _____

_____ Through a modification to published fee schedules –

Effective date (enter date of change): _____

Location (list published location): _____

_____ Up to the Medicare payments for equivalent services.

X By the following factors:

The current State Plan authority utilizes the cost reports of two-years prior to determine rates; however, this method alone cannot be used to accurately determine the unprecedented impacts of the COVID-19 Public Health Emergency (PHE), which affected the operational efforts

of providers within the Psychiatric Residential Treatment Facility (PRTF) program due to difficulties in maintaining staffing levels required to ensure the health and safety of admitted residents.

To address shortfalls in Clinical/Direct Care (C/DC) reimbursement during the PHE, resulting from the utilization of historic cost report data, and to maintain necessary bed capacity, the DOH intends to increase PRTF rates of payment in accordance with the below:

Other State Provider ID Number	Provider Name	7/1/20 - 12/31/20 Disaster SPA Per Diem Add-on Applicable to 2021 UPL Demonstration	1/1/21 - 6/30/21 Disaster SPA Per Diem Add-on Applicable to 2021 UPL Demonstration	7/1/21 - 12/31/21 Disaster SPA Per Diem Add-on Applicable to 2022 UPL Demonstration
7211040	Astor	$0.00	$0.00	$0.00
8385004	A. Aichhorn JJ –Brooklyn RTF	$0.00	$0.00	$0.00
7577040	Baker Victory Services/OLV	$0.00	$0.00	$0.00
7484163	Hillside – Stillwater (050)	$57.93	$57.93	$0.00
7511022	Conners RTF	$5.34	$5.34	$119.29
7484049	Hillside – Crestwood (036)	$0.00	$0.00	$86.95
6709041	J. Goldsmith RTF	$0.00	$0.00	$0.00
7484040	Hillside – Rochester (014)	$10.97	$10.97	$128.86
7484041	Hillside - Finger Lakes (004)	$10.82	$10.82	$23.97
8927040	House of the Good Shepherd	$35.48	$35.48	$65.83
6709040	Ittleson Center RTF	$119.13	$0.00	$0.00
6709042	Linden Hill	$0.00	$0.00	$0.00
6277040	Madonna Heights	$74.10	$74.10	$0.00
6223040	Parsons	$48.29	$48.29	$122.42
7573040	St. Christopher's – Ottilie	$54.12	$0.00	$0.00
7598040	St. Joseph's – Villa of Hope	$84.42	$84.42	$347.70
6734037	The Child Center of NY, INC	$0.00	$0.00	$27.63

If upon filing of the actual Consolidated Fiscal Report (CFR) for the period it is determined that provider costs for applicable periods are less than those utilized to calculate the per-diem add-on, rates of payment shall be retroactively

updated to remove C/DC reimbursements in excess of provider costs for the period.

Payment for services delivered via telehealth:

3. _ For the duration of the emergency, the state authorizes payments for telehealth services that:

   a.__ Are not otherwise paid under the Medicaid state plan;

   b. _ Differ from payments for the same services when provided face to face;

   c. Differ from current state plan provisions governing reimbursement for telehealth;

   Describe telehealth payment variation.

   d. _ Include payment for ancillary costs associated with the delivery of covered services via telehealth, (if applicable), as follows:

      i.____ Ancillary cost associated with the originating site for telehealth is incorporated into fee-for-service rates.

      ii.____ Ancillary cost associated with the originating site for telehealth is separately reimbursed as an administrative cost by the state when a Medicaid service is delivered.

Other:

4. _ Other payment changes:

Please describe.

Section F – Post-Eligibility Treatment of Income

1. _ The state elects to modify the basic personal needs allowance for institutionalized individuals. The basic personal needs allowance is equal to one of the following amounts:

   a.__ The individual's total income

   b. _ 300 percent of the SSI federal benefit rate

   c.__ Other reasonable amount: _____

2. _ The state elects a new variance to the basic personal needs allowance. (Note: Election of this option is not dependent on a state electing the option described the option in F.1. above.)

The state protects amounts exceeding the basic personal needs allowance for individuals who have the following greater personal needs:

Please describe the group or groups of individuals with greater needs and the amount(s) protected for each group or groups.

Section G – Other Policies and Procedures Differing from Approved Medicaid State Plan /Additional Information

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148 (Expires 03/31/2021). The time required to complete this information collection is estimated to average 1 to 2 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. Your response is required to receive a waiver under Section 1135 of the Social Security Act. All responses are public and will be made available on the CMS web site. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. ***CMS Disclosure*** Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact the Centers for Medicaid & CHIP Services at 410-786-3870.

SUMMARY
SPA #20-0081

This State Plan Amendment is a temporary amendment in response to COVID-19 Emergency Relief.

INSTITUTIONAL SERVICES State Plan Amendment #20-0081

CMS Standard Funding Questions

The following questions are being asked and should be answered in relation to all payments made to all providers reimbursed pursuant to a methodology described in Attachment 4.19-A 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 receive and retain 100 percent of total Medicaid expenditures claimed by the State and the State does not require any provider to return any portion of such payments to the State, local government entities, or any other intermediary organization.

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

		4/1/22 – 3/31/23	
Payment Type	**Non-Federal Share Funding**	**Non-Federal**	**Gross**
Hospital Inpatient Normal Per Diem	General Fund; Special Revenue Funds; County Contribution	$2.199B	$4.398B
Residential Treatment Facilities Normal Per Diem	General Fund; County Contribution	$40M	$80M
Hospital Inpatient Supplemental	General Fund	$39M	$77M
Indigent Care Pool	General Fund; Special Revenue Funds	$342M	$685M
Voluntary UPL	General Fund	$184M	$367M
Indigent Care Pool Adjustment	General Fund; IGT	$206M	$412M
Disproportionate Share Program	General Fund; IGT	$1.377B	$2.754B
State Public Inpatient UPL	General Fund	$8M	$16M
Non-State Government Inpatient UPL	IGT	$254M	$507M
Totals		**$4.648B**	**$9.297B**

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

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

In addition to cash collections, OMIG finds inappropriately billed claims within provider claims. To correct an error, OMIG and DOH process the current accurate

claim, and reduce this claim by the inappropriate claim value to recoup the previous overclaim and decrease state spending.

B. Special Revenue Funds:

1) Health Care Reform Act (HCRA) Resource Fund: as authorized in section 92-dd of New York State Finance Law and was established in 1996, pursuant to New York State Public Health Law 2807-j and 2807-s (surcharges), 2807-c (1 percent), and 2807-d-1 (1.6 percent). HCRA resources include:

    - Surcharge on net patient service revenues for Inpatient Hospital Services.
        - The rate for commercial payors is 9.63 percent.
        - The rate for governmental payors, including Medicaid, is 7.04 percent.
        - Federal payors, including Medicare, are exempt from the surcharge.
    - 1 percent assessment on General Hospital Inpatient Revenue.
    - 1.6 percent Quality Contribution on Maternity and Newborn (IP) Services.

2) Health Facility Cash Assessment Program (HFCAP) Fund: Pursuant to New York State Public Health Law 2807-d, the total state assessment on each hospital's gross receipts received from all patient care services and other operating income, excluding gross receipts attributable to payments received pursuant to Title XVIII of the federal Social Security Act (Medicare), is 0.35 percent.

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

C. Additional Resources for Non-Federal Share Funding:

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

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

Entity	Annual Amount
New York City	$4.882B
Suffolk County	$216M

Nassau County	$213M
Westchester County	$199M
Erie County	$185M
Rest of State (53 Counties)	$979M
Total	**$6.835B**

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

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

D. IGT Funding:

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

Provider	Entity Transferring IGT Funds	4/1/22-3/31/23 IGT Amount
Bellevue Hospital Center	New York City	$171M
Coney Island Hospital	New York City	$9M
City Hospital Center at Elmhurst	New York City	$17M
Harlem Hospital Center	New York City	$91M
Henry J Carter Spec Hospital	New York City	($8M)
Jacobi Medical Center	New York City	$106M
Kings County Hospital Center	New York City	$136M
Lincoln Medical & Mental Health Center	New York City	$88M
Metropolitan Hospital Center	New York City	$67M
North Central Bronx Hospital	New York City	$12M
Queens Hospital Center	New York City	$18M
Woodhull Medical and Mental Health Center	New York City	$37M
Erie County Medical Center	Erie County	$49M
Lewis County General Hospital	Lewis County	$1M
Nassau County Medical Center	Nassau County	$66M
Westchester County Medical Center	Westchester County	$143M

Wyoming County Community Hospital	Wyoming County	$1M
NYC Health + Hospitals	New York City	$254M
Total		**$1.258B**

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: Please see list of supplemental payments below:

Payment Type	Private	State Government	Non-State Government	4/1/22-3/31/23 Gross Total
Indigent Care Pool/Voluntary UPL $339M Guarantee	$912M	$8M	$133M	$1.052B
Indigent Care Pool Adjustment	$0	$86M	$326M	$412M
Disproportionate Share Program	$0	$1.071B	$1.684B	$2.754B
Vital Access Program	$77M	$0	$0	$77M
State Public Inpatient UPL	$0	$16M	$0	$16M
Non-State Government Inpatient UPL	$0	$0	$507M	$507M
Total	**$989M**	**$1.181B**	**$2.649B**	**$4.819B**

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

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

   Response: The Psychiatric Residential Treatment Facilities (PRTF) UPL calculation is payment-to-cost for private facilities (note: there are no state or non-state governmental PRTFs). The Medicaid payments under this State Plan Amendment were included in the 2021 PRTF UPL submitted to CMS on January 25th, 2023 and deemed reasonable by CMS on February 23rd, 2023. The Medicaid payments will also be included in the 2022 PRTF UPL once the demonstration is submitted to CMS.

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

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

ACA Assurances:

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

   MOE Period.
   - **Begins on: March 10, 2010, and**
   - **Ends on: The date the Secretary of the Federal Department of Health and Human Services determines an Exchange established by a State under the provisions of section 1311 of the Affordable Care Act is fully operational.**

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

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

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

Response: This SPA would [ ] / would not [✓] violate these provisions, if they remained in effect on or after January 1, 2014.

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

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

Tribal Assurance:

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

IHCIA Section 2107(e)(I) of the Act was also amended to apply these requirements to the Children's Health Insurance Program CHIP. Consultation is required concerning Medicaid and CHIP matters having a direct impact on Indian health programs and Urban Indian organizations.

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

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