



# Department of Health

KATHY HOCHUL  
Governor

MARY T. BASSETT, M.D., M.P.H.  
Commissioner

KRISTIN M. PROUD  
Acting Executive Deputy Commissioner

June 28, 2022

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 #22-0047  
Inpatient Hospital Services

Dear Mr. McMillion:

The State requests approval of the enclosed amendment #22-0047 to the Title XIX (Medicaid) State Plan for inpatient hospital services to be effective April 1, 2022 (Appendix I). This amendment is being submitted based upon enacted legislation. A summary of the proposed amendment is contained 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 (CFR), Part 447, Subpart C.

Notice of the changes in the methods and standards for setting payment rates for general hospital inpatient services were given in the New York State Register on March 30, 2022. A copy of pertinent sections of enacted legislation is enclosed for your information (Appendix III). In addition, responses to the five standard funding questions are also enclosed (Appendix V).

If you have any questions regarding this State Plan Amendment submission, please do not hesitate to contact Regina Deyette, Medicaid State Plan Coordinator, Division of Finance and Rate Setting, Office of Health Insurance Programs at (518) 473-3658.

Sincerely,



Amir Bassiri  
Acting Medicaid Director  
Office of Health Insurance Programs

Enclosures

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

1. TRANSMITTAL NUMBER

2. STATE

3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT

XIX

XXI

TO: CENTER DIRECTOR  
CENTERS FOR MEDICAID & CHIP SERVICES  
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE

5. FEDERAL STATUTE/REGULATION CITATION

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)

a. FFY \_\_\_\_\_ \$ \_\_\_\_\_

b. FFY \_\_\_\_\_ \$ \_\_\_\_\_

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable)

9. SUBJECT OF AMENDMENT

10. 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:

11. SIGNATURE OF STATE AGENCY OFFICIAL

12. TYPED NAME

13. TITLE

14. DATE SUBMITTED June 28, 2022

15. RETURN TO

**FOR CMS USE ONLY**

16. DATE RECEIVED

17. DATE APPROVED

**PLAN APPROVED - ONE COPY ATTACHED**

18. EFFECTIVE DATE OF APPROVED MATERIAL

19. SIGNATURE OF APPROVING OFFICIAL

20. TYPED NAME OF APPROVING OFFICIAL

21. TITLE OF APPROVING OFFICIAL

22. REMARKS

**Appendix I**  
**2022 Title XIX State Plan**  
**Second Quarter Amendment**  
**Amended SPA Pages**

**New York  
117(d)**

1905(a)(1) Inpatient Hospital Services

8. *Inpatient psychiatric services provided in general hospitals, or distinct units of general hospitals, specializing in such inpatient psychiatric services, for patients admitted on and after October 20, 2010, will be reimbursed on a per diem basis as follows:*

- a. Reimbursement will use the All Patient Refined Diagnostic Related Group (APR-DRG) patient classification system.
- b. The operating component of the rate will be a statewide price, calculated utilizing 2005 Medicaid fee-for-service (FFS) inpatient costs developed using the ratio of cost to charges approach to determine costs and a regression model to price out various components of the costs to determine cost significance in such components. The components include patient age, rural designation, comorbidities, length of stay, and presence of mental retardation. The costs of these components as developed in the regression model were excluded in developing the statewide price.
  - i. The facility-specific old operating per diem rates were trended to 2010, and for each case, these rates were multiplied by the length of stay (LOS) to calculate the "old payment."
  - ii. Facility-specific 2005 Direct Graduate Medical Education (DGME) costs were divided by 2005 patient days to calculate DGME per diem rates. These rates were then trended to 2010.
  - iii. The 2010 payment rate for Electroconvulsive Therapy (ECT) was established as \$281 (based on the ECT rate in effect for Medicare psychiatric patients during the first half of 2010). This rate was then adjusted by each facility's wage equalization factor (WEF).
  - iv. For each case, the proper DGME payment (DGME rate multiplied by the LOS) and ECT payment (WEF-adjusted ECT rate times the number of ECT treatments) was subtracted from the "old payments" to derive the "old payments subject to risk adjustment."
  - v. For each case, a payment adjustment factor was derived based on the regression model, including the LOS adjustment factor as defined by the new payment methodology.
  - vi. The sum of the old payments subject to risk adjustment from step iv (\$502,341,057), was divided by the sum of payment adjustment factors from step v (\$831,319), which resulted in the statewide per diem rate of \$604.27 as of October 20, 2010.  
The current statewide per diem rate of \$642.66 reflects the effect of restoring transition funds back into the statewide price pursuant to the Transition Fund Pool section of this Attachment. Effective October 1, 2018, the statewide price will be increased to \$676.21. Effective August 1, 2021, the statewide fee-for-service price will be increased to \$742.86. Effective April 1, 2022, the statewide fee-for service price will be increased to \$950.43.

TN #22-0047

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

Supersedes TN #21-0018

Effective Date April 1, 2022

**Appendix II**  
**2022 Title XIX State Plan**  
**Second Quarter Amendment**  
**Summary**

**SUMMARY**  
**SPA #22-0047**

This State Plan Amendment proposes to increase reimbursement for Article 28 hospital inpatient psychiatric services to better meet community mental health needs.

**Appendix III**  
**2022 Title XIX State Plan**  
**Second Quarter Amendment**  
**Authorizing Provisions**

SPA 22-0047

Section 2807 - c(4)(e-1) of Public Health Law.

4. Modifications and exceptions to case payment rates. Case based rates of payment shall be modified and per diem or other unit of service payments shall be provided, or exceptions shall be made to case payments, in accordance with rules and regulations adopted by the council and approved by the commissioner, in the following circumstances:

(a) where a case that is eligible for payment under the case based payment system is transferred between general hospitals, the receiving hospital shall be reimbursed its total case payment amount for the diagnosis-related group (including any payments made in accordance with this subdivision), and the transferring hospital shall receive reimbursement on a basis consistent with the methodology developed for the elimination of transfer patient costs in accordance with subparagraph (i) of paragraph (c) of subdivision six of this section plus additions contained in subparagraph (ii) of paragraph (a) of subdivision one of this section on a per diem basis. The payment to a transferring general hospital shall not exceed the case payment amount for the diagnosis-related group computed in accordance with this section;

(b) where the cost per case for a patient that does not qualify for payment pursuant to paragraph (a) or (d) of this subdivision is in excess of the basic case payment rate for the diagnosis-related group multiplied by two and the overall hospital-specific average cost per case multiplied by six, the payment to the general hospital in addition to the basic case payment rate will be one hundred percent, or such percentage as computed in accordance with subparagraph (ii) of paragraph (c) of subdivision six of this section, multiplied by the difference between the general hospital's cost for the case and the greater of the basic case payment rate for the diagnosis-related group multiplied by two or the overall hospital-specific cost per case multiplied by six. In determining whether a case qualifies for payment under this paragraph, prospective rate adjustments made in accordance with paragraph (c) of subdivision eleven of this section to reflect the retroactive impact of an adjustment on prior rates, shall be excluded. Where a case qualifies for payment pursuant to both this paragraph and paragraph (c) of this subdivision then payment shall be made in accordance with this paragraph if such payment exceeds that which would be made in accordance with paragraph (c) of this subdivision. The general hospital's costs per case shall be computed by adjusting the general hospital's actual charges for the case by the general hospital's inpatient cost to charge ratio;

(c) where a patient is identified as a long stay patient, payment to the general hospital in addition to the basic case payment rate shall be on a basis consistent with the methodology developed for the elimination of long stay patient costs in accordance with subparagraph (iii) of paragraph (c) of subdivision six of this section. Where a case qualifies for payment pursuant to both this paragraph and paragraph (b) of this subdivision then payment shall be made in accordance with paragraph (b) of this subdivision if such payment exceeds that which would be made in accordance with this paragraph. A long stay patient is defined as an



inpatient whose hospital stay exceeds the long stay outlier threshold for the diagnosis-related group;

(d) where a patient is identified as a short stay patient, payment to the general hospital shall be on a basis consistent with the methodology developed for the elimination of short stay patient costs in accordance with subparagraph (iv) of paragraph (c) of subdivision six of this section plus additions contained in subparagraph (ii) of paragraph (a) of subdivision one of this section on a per diem basis. A short stay patient is defined as an inpatient discharged from the hospital on the same day of admission, or the day after admission except for those stays where the statewide mean length of stay for the diagnosis-related group is less than three days, or whose hospital stay is not greater than twenty percent of the statewide mean length of stay for the diagnosis-related group with which the patient is identified, excluding normal newborn cases and normal deliveries;

(e) in cases where a general hospital or distinct unit of a general hospital is not or would not have been reimbursed on a case based payment per diagnosis-related group for inpatient services provided on or before December thirty-first, two thousand one, to beneficiaries of title XVIII of the federal social security act (medicare), reimbursement shall be on a per diem basis computed for excluded general hospitals based on the hospital's reimbursable inpatient operating cost base, or for excluded distinct units of general hospitals based on the distinct unit's reimbursable inpatient operating cost base, determined in accordance with paragraph (d) of subdivision one of this section, projected to the applicable rate period by the trend factor determined in accordance with subdivision ten of this section, and increased in accordance with subparagraphs (i), (iii) and (iv) of paragraph (e) of subdivision one of this section to reflect special additional inpatient operating costs, and adjusted to exclude a factor for operating costs of patients who required an alternate level of care developed consistent with the provisions of paragraph (h) of this subdivision, and increased for excluded general hospitals to reflect the product of the group category percentage amount applicable for purposes of determining group category average inpatient reimbursable operating cost per discharge (price) in the rate period pursuant to paragraph (b) of subdivision five of this section for general hospitals reimbursed on a case based payment per diagnosis-related group applied to such excluded general hospital's additional cost increases determined in accordance with subparagraph (ii) of paragraph (e) of subdivision one of this section, and adjusted on a payor category basis to reflect allocation of malpractice insurance costs in accordance with the methodology developed pursuant to subparagraph (ii) of paragraph (h) of subdivision eleven of this section, for those patients included in the payor categories pursuant to the provisions of paragraph (a) or (b) of subdivision one of this section; provided, however, for those patients included in the payor categories pursuant to the provisions of paragraph (b) of subdivision one of this section payment shall be at the per diem payment to the hospital or distinct unit of the hospital for services provided to subscribers of corporations organized and operating in accordance with article forty-three of the insurance law, adjusted for uncovered services, and increased by thirteen percent or by five percent, as the case may be; provided further, however, for those general hospitals that are not reimbursed on a case-based payment per diagnosis-related group for inpatient services provided to beneficiaries of title XVIII of the

federal social security act (medicare) as a result of their designation by the secretary of health and human services as a comprehensive cancer hospital or as a result of their status as an acute care exempt children's hospital, the base year for determining payments for services in such facilities shall be nineteen hundred eighty-seven, provided, however, such hospitals shall be allowed adjustments in rates of payment to reflect costs incurred subsequent to nineteen hundred eighty-seven but not reflected in such base. Funds received by a general hospital based on the payment differential in accordance with paragraph (b) of subdivision one of this section applied pursuant to this paragraph shall be hospital funds for patient care purposes. For those patients not covered under the provisions of paragraph (a) or (b) of subdivision one of this section, or who are not covered under the provisions of paragraph (a) of subdivision two of this section, payment shall be on the basis of the hospital's charge schedule, limited to one hundred twenty percent of the total per diem payment that would have been made if the patient were included in the payor categories pursuant to the provisions of paragraph (b) of subdivision one of this section. Rates of payment for excluded general hospitals and excluded distinct units of general hospitals for a rate period shall be increased on a per diem basis by additions and allowances specified in subparagraphs (ii) and (iii) of paragraph (a) of subdivision one of this section. In adopting regulations for purposes of determining rates of payment for psychiatric services pursuant to this paragraph, the council and the commissioner shall consider the advice of the commissioner of mental health and may include case mix and other adjustments for such rates of payment. The commissioner of mental health shall study and report on alternative procedures for the development of rates of payment for inpatient psychiatric care. Such report shall be submitted to the governor, the legislature and the commissioner of health by January first, nineteen hundred ninety-three. Recommendations for alternative financing shall take into consideration methods to improve access to inpatient care for seriously mentally ill persons.

(e-1) Notwithstanding any inconsistent provision of paragraph (e) of this subdivision or any other contrary provision of law and subject to the availability of federal financial participation, per diem rates of payment by governmental agencies for a general hospital or a distinct unit of a general hospital for inpatient psychiatric services that would otherwise be subject to the provisions of paragraph (e) of this subdivision shall, with regard to days of service associated with admissions occurring on and after April first, two thousand ten, be in accordance with the following:

(i) For rate periods on or after April first, two thousand ten, the commissioner, in consultation with the commissioner of the office of mental health, shall promulgate regulations, and may promulgate emergency regulations, establishing methodologies for determining the operating cost components of rates of payments for services described in this paragraph. The commissioner may make such adjustments to the methodology for computing such rates as is necessary to achieve no aggregate, net growth in overall Medicaid expenditures related to such rates, as compared to such aggregate expenditures from the prior year. In determining the updated base year to be utilized pursuant to this subparagraph, the commissioner shall take into account the base year determined in accordance with paragraph (c) of subdivision thirty-five of this section.

Furthermore, the commissioner shall establish such rates in consultation with industry representatives to achieve an appropriate base year update to the operating cost components of rates of payment for services described in this paragraph and that takes into account facility cost, mix of services, and patient specific conditions.

(ii) Rates of payment established pursuant to subparagraph (i) of this paragraph shall reflect an aggregate net statewide increase in reimbursement for such services of up to twenty-five million dollars on an annual basis.

(iii) Capital cost reimbursement for general hospitals otherwise subject to the provisions of this paragraph shall remain subject to the provisions of subdivision eight of this section.

**Appendix IV**  
**2022 Title XIX State Plan**  
**Second Quarter Amendment**  
**Public Notice**

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2022/2023 is \$9.8 million.

Effective on or after April 1, 2022, the Medicaid fee-for-service Schedule will be adjusted to increase the reimbursement rate for midwifery services such that midwives will be reimbursed at 95% of the physician fee-for-service schedule.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this action contained in the budget for state fiscal year 2022/2023 is \$2.8 million.

Effective on or after April 1, 2022, this notice proposes to enhance (increase) state established reimbursement rates as follows:

Contingent upon approval of the Fiscal Year 2023 State Budget, established rates will be enhanced for the top twenty (20) state-plan approved orthotics and prosthetics (O & P) for Fee-for Service (FFS) and managed care members from the current Medicaid rate to 80% of the Medicare reimbursement rate.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2023 is \$8 million.

#### Institutional Services

Effective on or after April 1, 2022, this proposal continues the supplemental upper payment limit payments made to general hospitals, other than major public general hospitals under institutional services of \$339 million annually.

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

For state fiscal year beginning April 1, 2022 through March 31, 2023, this proposal continues adjustments for hospital inpatient services provided on and after April 1, 2012, to public general hospitals, other than those operated by the State of New York or the State University of New York, located in a city with a population of over one million and receiving reimbursement of up to \$1.08 billion annually based on criteria and methodology set by the Commissioner of Health, which the Commissioner may periodically set through a memorandum of understanding with the New York City Health and Hospitals Corporation. Such adjustments shall be paid by means of one or more estimated payments. Payments to eligible public general hospitals may be added to rates of payment or made as aggregate payments.

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

For state fiscal year beginning April 1, 2022, through March 31, 2023, this proposal continues supplemental payments to State government owned hospitals. These payments will not exceed the upper payment limit for inpatient services provided by state government-owned hospitals when aggregated with other Medicaid payments.

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

Effective on or after April 1, 2022, this proposal would extend the requirement to rebase and update the Service Intensity Weights (SIWs) for the acute Diagnostic Related Group (DRG) hospital rates no less frequently than every four years from July 1, 2022, to on or after January 1, 2024. It also revises the requirement for the base year used for rebasing. The new base year may be more than four years prior to the first applicable rate period that utilizes such new base year.

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

Effective on or after April 1, 2022, additional medical assistance, known as, Intergovernmental Transfer (IGT) payments, for inpatient hospital services may be made to public general hospitals operated by the State of New York or the State University of New York, or by a county which shall not include a city with a population over one million, and those public general hospitals located in the counties of Westchester, Erie, or Nassau, up to one hundred percent (100%) of each such public hospital's medical assistance, and uninsured patient losses after all other medical assistance, including disproportionate share hospital (DSH) payments to such public general hospitals. Payments will be made by means of one or more estimated distributions

initially based on the latest DSH audit results, which shall later be reconciled to such payment year's actual DSH audit uncompensated care costs. Payments may be added to rates of payment or made as aggregate payments. Such payments will continue April 1, 2022, through March 31, 2025.

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

Effective on and after April 1, 2022, through March 31, 2024, this notice provides for funding to distressed hospitals.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for State Fiscal Year 2023 is \$200 million.

Effective for days of service on or after April 1, 2022, The Department of Health will adjust inpatient psychiatric fee-for-service per diem rates of reimbursement for distinct exempt units specializing in inpatient psychiatric services, in Article 28 hospitals, by increasing the case mix neutral psychiatric statewide per diem base price to produce a full annual net aggregate increase in gross Medicaid expenditures of \$55 million. This State Plan Amendment is necessary to more adequately reimburse hospitals for providing these services and to better meet the community's mental health needs.

#### Long Term Care Services

Effective on or after April 1, 2022, this proposal continues additional payments to non-state government operated public residential health care facilities, including public residential health care facilities located in Nassau, Westchester, and Erie Counties, but excluding public residential health care facilities operated by a town or city within a county, in aggregate amounts of up to \$500 million. The amount allocated to each eligible public RHCf will be in accordance with the previously approved methodology, provided, however that patient days shall be utilized for such computation reflecting actual reported data. Payments to eligible RHCf's may be added to rates of payment or made as aggregate payments.

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

Effective on and after April 1, 2022, this notice provides for \$30 million annually in temporary rate adjustments to long term care providers that are undergoing closure, merger, consolidation, acquisition or restructuring themselves or other health care providers. These payments are authorized by current State statutory and regulatory provisions. The temporary rate adjustments will be reviewed and approved by the CINERGY Collaborative.

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

Effective on and after April 1, 2022, through March 31, 2024, this notice provides for temporary rate adjustments to long term care providers that are undergoing closure, merger, consolidation, acquisition or restructuring themselves or other health care providers. These payments are authorized by current State statutory and regulatory provisions.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for State Fiscal Year 2023 is \$200 million.

#### Eligibility

Effective January 1, 2023, the Medicaid program will eliminate the resource test for aged, blind and disabled applicants and recipients and raise the income eligibility level to 138% of the federal poverty level for aged, blind, disabled and other medically needy applicants and recipients.

The estimated net aggregate increase in gross Medicaid expenditures as a result of the proposed amendment for State Fiscal Year 2023 is \$10 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). In addition, approved SPA's beginning in 2011 are also available for viewing on this website.

Copies of the proposed State Plan Amendments will be on file in

**Appendix V**  
**2022 Title XIX State Plan**  
**Second Quarter Amendment**  
**Responses to Standard Funding Questions**

**INSTITUTIONAL SERVICES**  
**State Plan Amendment #22-0047**

**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 do receive and retain the 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.

		4/1/22 – 3/31/23	
Payment Type	Non-Federal Share Funding	Non-Federal	Gross
Normal Per Diem	General Fund; Special Revenue Funds; County Contribution	\$1,832,582,301	\$3,665,164,603

1) **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.

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

In addition to cash collections, OMIG finds inappropriately billed claims within provider claims. To correct an error, OMIG and DOH process the current accurate claim, and reduce this claim by the inappropriate claim value to recoup the previous overclaim and decrease state spending.

**2) Special Revenue Funds:**

- a. 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. HCRA resources include health care related surcharges, assessments on hospital revenues, and a "covered



lives" assessment paid by insurance carriers pursuant to chapter 820 of the laws of 2021.

- b. Health Facility Cash Assessment Program (HFCAP) Fund: HFCAP requires New York State designated providers to pay an assessment on cash operating receipts on a monthly basis. The assessment includes Article 28 Residential Health Care Facilities, Article 28 General Hospitals, Article 36 Long Term Home Health Care Programs, Article 36 Certified Home Health Agencies and Personal Care Providers that possess a Title XIX (i.e. Medicaid) contract with a Local Social Services District for the delivery of personal care services pursuant to Section 367-i of the New York State Social Services Law.

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.

### **3) Additional Resources for State Share Funding:**

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

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

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 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 inpatient UPL demonstration utilizes cost-to-payment and payment-to-payment methodologies to estimate the upper payment limit for each class of providers. The State is in the process of completing the 2022 inpatient UPL as well as the Procedural Manual which describes the methodology for eligible providers and will be submitting both documents 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.