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

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 #23-0004
Inpatient Hospital Services

Dear Mr. McMillion:

The State requests approval of the enclosed amendment #23-0004 to the Title XIX (Medicaid) State Plan for inpatient hospital services to be effective February 1, 2023 (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 was given in the New York State Register on January 25, 2023. 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,

[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: 23 — 0004

2. STATE: NY

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
February 01, 2023

5. FEDERAL STATUTE/REGULATION CITATION
§ 1905(a)(1) Inpatient Hospital Services

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 02/01/23-09/30/23 $ 1,050,000
b. FFY 10/01/23-09/30/24 $ 1,575,000

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.19-A Part I: Page 119

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 4.19-A Part I: Page 119

9. SUBJECT OF AMENDMENT
Kings County DD

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
[redacted]

12. TYPED NAME
Amir Bassiri

13. TITLE
Medicaid Director

14. DATE SUBMITTED
March 31, 2023

15. 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 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

Instructions on Back

Appendix I
2023 Title XIX State Plan
First Quarter Amendment
Amended SPA Pages

1905(a)(1) Inpatient Hospital Services

12. *New hospitals and new hospital units*. The operating cost component of rates of payment for new hospitals, or hospital units, without adequate cost experience will be computed based on either budgeted cost projections, subsequently reconciled to actual reported cost data, or the regional ceiling calculated in accordance with paragraph (10) of this section, whichever is lower. The capital cost component of such rates will be calculated in accordance with the capital cost provisions of this Attachment.

13. Effective July 1, 2018, Hospitals that have been approved by the Office of Mental Health to operate distinct units to provide specialized inpatient psychiatric care to stabilize adults with co-morbid mental illness and intellectual developmental disability diagnoses as defined in the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association, will be reimbursed a flat per diem operating rate of $1,177.11, and the rate- setting methodology provided in paragraph 8 of this section will not apply to services furnished in such units. Effective February 1, 2023, the flat per diem operating rate will be$1,965.97. Capital costs will be reimbursed on a per diem basis for the cost of capital in accordance with paragraph 11 of this section. Specialized inpatient psychiatric units are a new approach to treating dually-diagnosed individuals. The units are physically distinct and have been approved by the State to provide such care and services based on a review of the unit's physical plant specifications, enhanced staffing, and adherence to specialized clinical protocols, which demonstrate sufficient specialization in the assessment and treatment of adults with co-occurring intellectual or developmental disability, including autism spectrum disorder, and mental illness diagnoses, who exhibit destructive behaviors, or an acute safety risk or decrease in functioning.

14. Effective August 1, 2019, Hospitals that have been approved by the Office of Mental Health to operate distinct units to provide specialized inpatient psychiatric care to stabilize children with co-morbid mental illness and intellectual developmental disability diagnoses as defined in the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association, will be reimbursed a flat per diem operating rate of $1,792.50, and the rate- setting methodology provided in paragraph 8 of this section will not apply to services furnished in such units. Capital costs will be reimbursed on a per diem basis for the cost of capital in accordance with paragraph 11 of this section. Specialized inpatient psychiatric units are a new approach to treating dually-diagnosed individuals. The units are physically distinct and have been approved by the State to provide such care and services based on a review of the unit's physical plant specifications, enhanced staffing, and adherence to specialized clinical protocols, which demonstrate sufficient specialization in the assessment and treatment of children with co-occurring intellectual or developmental disability, including autism spectrum disorder, and mental illness diagnoses, who exhibit destructive behaviors, or an acute safety risk or decrease in functioning.

Appendix II
2023 Title XIX State Plan
First Quarter Amendment
Summary

SUMMARY
SPA #23-0004

This State Plan Amendment proposes an adjustment of a flat per-diem reimbursement for specialized hospital-based inpatient psychiatric units dedicated solely to the treatment of adults with diagnoses of both developmental disability and serious mental illness.

Appendix III
2023 Title XIX State Plan
First Quarter Amendment
Authorizing Provisions

SPA 23-0004

New York Consolidated Laws, Mental Hygiene Law - MHY § 41.35 Demonstration programs

Current as of January 01, 2023

(a) [Eff. until March 31, 2024, pursuant to L.2015, c. 58, pt. NN, § 2. See, also, subd. (a), below.] The commissioners of the offices in the department shall cause to be developed plans for three or more time-limited demonstration programs, the purpose of which shall be to test and evaluate new methods or arrangements for organizing, financing, staffing and providing services for the mentally disabled in order to determine the desirability of such methods or arrangements. Subject to regulations established by the commissioners and notwithstanding section one hundred sixty-three of the state finance law and section one hundred forty-two of the economic development law, or any other provision of law, such programs may include but shall not be limited to comprehensive organizational structures to serve all mentally disabled persons within the purview of a local governmental unit, innovative financing and staffing arrangements and specific programs to serve the mentally disabled. Such demonstration programs shall be consistent with established statewide goals and objectives and local comprehensive plans, shall be developed in conjunction with the local comprehensive planning process, and shall be submitted to the single agent jointly designated by the commissioners of the department for review and approval by the commissioner or commissioners having jurisdiction of the services.

(a) [Eff. March 31, 2021, pursuant to L.2015, c. 58, pt. NN, § 2. See, also, subd. (a), above.] The commissioners of the offices in the department shall cause to be developed plans for three or more time-limited demonstration programs, the purpose of which shall be to test and evaluate new methods or arrangements for organizing, financing, staffing and providing services for the mentally disabled in order to determine the desirability of such methods or arrangements.

Subject to regulations established by the commissioners and notwithstanding any other provision of law, such programs may include but shall not be limited to comprehensive organizational structures to serve all mentally disabled persons within the purview of a local governmental unit, innovative financing and staffing arrangements and specific programs to serve the mentally disabled. Such demonstration programs shall be consistent with established statewide goals and objectives and local comprehensive plans, shall be developed in conjunction with the local comprehensive planning process, and shall be submitted to the single agent jointly designated by the commissioners of the department for review and approval by the commissioner or commissioners having jurisdiction of the services.

(b) The demonstration programs required to be developed pursuant to this section shall include at least one single system program for comprehensive services for all

mentally disabled persons or all services to one or more of the following classes of mentally disabled: persons with mental illness, a developmental disability; those suffering from alcohol abuse or alcoholism; or alcoholics, alcohol abusers and substance abusers. Such comprehensive services provided pursuant to a single system program shall be provided by a local governmental unit or group of local government units or an approved non-governmental agent or a combination of providers of service and a local governmental unit or units.

(1) A local governmental unit or group of local governmental units may propose that such unit or units, or a non-governmental agent designated by such unit or units, or a combination of providers of service and a local governmental unit assume responsibility for provision of comprehensive services. A plan embodying such a proposal shall be submitted to the single agent jointly designated by the commissioners of the offices of the department in accordance with regulations of the commissioners. Such a plan shall provide that the local governmental unit or units or a designated non- governmental agent, or a combination of providers of service and local governmental unit or units shall be responsible for the provision of and shall direct the operation of all facilities and programs or portions thereof serving the class or classes of mentally disabled in the area for whom the unit or non-governmental agent proposes to provide comprehensive services.

(2) A proposed plan submitted in accordance with the provisions of this subdivision shall contain at least the following with respect to the class or classes of mentally disabled covered by the plan:

A. a commitment to provide necessary comprehensive services for all residents, regardless of diagnostic category or severity of disability or ability to pay, subject to availability of funds, of the local government or local governments submitting such plan throughout the course of their mental disability.

B. a commitment to provide comprehensive services which shall include, but not be limited to, preventive services, emergency services, acute, intermediate and long-term services, including both hospital and non-hospital based inpatient and outpatient services, day care, night care and weekend care services, diagnostic and referral services, residential and non-residential services, vocational, educational and training programs, staff training, consultive services, necessary manpower and support services.

C. an assurance that comprehensive services will be provided to all mentally disabled residents regardless of age, income or area of residence in all age and population groups, including all such residents receiving service irrespective of the location and auspices under which such services are provided at the time of the plan's submission.

D. a statement describing the proposed administrative organization of the system under which comprehensive services to mentally disabled residents of the locality or

localities are to be provided, including a description of the respective roles and relationships of all providers, governmental and non-governmental.

E. an inventory of all public and private resources available to the class or classes of mentally disabled residents of the local area and a statement of their responsibilities.

F. a proposed fiscal plan for comprehensive services during the next local and state fiscal years, which proposed fiscal plan shall include, but not be limited to, all projected needs; a breakdown of services to be provided by disability and service category; estimated expenditures by purpose; estimated revenues by source and amounts, including estimated local, state and federal government funds; and a comparison of proposed expenditures and revenues with those of the existing year.

G. a projected utilization rate of services and programs of facilities of the offices of the department including any planned expansion or contraction of such services and programs.

H. a plan, developed in consultation with the recognized representative of employees of the offices of the department, for the retraining and continuation of employment of persons whose employment in a program of a facility of an office may be terminated because of planned contraction of such program, and for the continuation of all employment-related benefits vested by contract, by state or local law, or by rule or regulation in the persons employed by the offices in the department in facilities to be transferred to the control of the local governmental unit or units or the non- governmental agent of such unit or units, as long as those persons shall continue to be employed pursuant to the single system plan or until such employment-related benefits are modified or superseded pursuant to law or successor agreements.

I. a commitment that all facilities will comply with all applicable state and federal standards, including accreditation standards and standards required to be met as a condition for eligibility for federal funds.

J. a statement of the mechanisms to be utilized in evaluating the effectiveness of comprehensive services to the mentally disabled and describing the conditions and procedures under which responsibility for programs and services of facilities in the offices of the department at the time of submission of the plan shall revert to the state.

(3) Each commissioner of an office in the department shall review the portion of the single system plan for comprehensive services to the mentally disabled over which his office has jurisdiction and approve or disapprove such portion of the plan. In acting upon such portion of the plan, each commissioner shall consider whether it offers a reasonable expectation of improved services to the particular class of the mentally disabled over which his office has jurisdiction; whether the plan as a whole assures comprehensive services to mentally disabled persons who suffer from more than one disability; whether the plan provides for the efficient use of available funds and existing

services; and whether such plan adequately meets the conditions set forth in paragraph
two of this subdivision.

(4) Each commissioner of an office in the department who has approved a single system plan is authorized to take such actions as may be necessary, in accordance with applicable state law, including, but not limited to, the delegation of administrative responsibility to a director of community services in order to facilitate the implementation of the approved single system plan. If a commissioner of an office in the department and one or more local governmental units mutually agree, state facilities of such office may, in whole or in part, be used by, leased, or rented, to such local governmental unit or units, to an approved non-governmental agent, or to a combination of providers of service and the local governmental unit or units in accordance with applicable state law, for operation by or through it pursuant to the single system plan approved in accordance with the provisions of this article. Such local governmental unit or units or an approved non-governmental agent or combination of providers of service and the local governmental unit or units may lease a facility or facilities from an office in the department, if the program to be housed in such facility is part of the single system plan for comprehensive services to the mentally disabled approved in accordance with the provisions of this article.

(5) Each commissioner of an office in the department shall conduct evaluation studies of approved single system plans, or portions thereof, over which his office has jurisdiction to determine the relative costs and effectiveness of different types and patterns of services being provided under such plans. The results of such studies shall be used to determine standards for statewide program requirements and priorities.

(c) Upon approval of a plan for a demonstration program by a commissioner or commissioners of the office having jurisdiction over the services, said commissioner or commissioners shall, in cooperation with the appropriate representative or representatives of the local governmental unit or units, prepare for submission to the director of the budget for inclusion in the executive budget, a request for the appropriations of funds and authorization for implementation of the demonstration program.

(d) Quarterly reviews and evaluations of the program shall be undertaken and a final report shall be developed by representatives of the commissioner or commissioners having jurisdiction over the services and the local governmental unit assessing the program, indicating its potential for continuation or use elsewhere, and making any further recommendations related to the program. Copies of such quarterly evaluations and final reports shall be sent to the director of the division of the budget, and the chairmen of the senate finance committee and the assembly committee on ways and means.

(e) A local governmental unit may file a notice of intent to submit a single system plan with the single agent jointly designated by the commissioners of the offices. The

commissioner or commissioners having jurisdiction of the services are authorized to make grants of funds, from appropriations specifically made for such purpose, to any such local governmental unit in an amount not to exceed seventy-five percentum of the local government costs approved by the commissioner and the director of the budget, of preparing a single system plan; provided, however, that in the case of a local government receiving state aid at the rate of seventy-five percent of its approved net operating costs, such grant of funds may not exceed ninety percent of the approved local government's costs of preparing the single system plan.

Appendix IV
2023 Title XIX State Plan
First Quarter Amendment
Public Notice

7 ADHCP #7 1
8 ADHCP #9 3
9 ADHCP#10 1
10 ADHCP #11 1
11 ADHCP #12 1
12 ADHCP #13 3
13 ADHCP #14 3
14 ADHCP #15 3
15 ADHCP #16 1
16 ADHCP #17 1
17 ADHCP #18 1
18 ADHCP #19 1
19 ADHCP #20 1
20 ADHCP #21 3
21 ADHCP #22 3
22 ADHCP #23 3
23 ADHCP #24 1
24 ADHCP #25 1
25 ADHCP #26 3
26 ADHCP #27 3
27 ADHCP #28 1
28 ADHCP #29 1
29 ADHCP #30 1
30 ADHCP #31 3
31 ADHCP #32 1
32 ADHCP #33 1
33 ADHCP #34 1
34 ADHCP #35 2
35 ADHCP #36 3
36 ADHCP #37 1
37 ADHCP #38 2
38 ADHCP #39 1
39 ADHCP #40 2
40 ADHCP #41 1
41 ADHCP #42 1
42 ADHCP #43 1
43 ADHCP #44 1
44 ADHCP #45 1
45 ADHCP #47 1
46 ADHCP #48 1
47 ADHCP #49 1
48 ADHCP #50 1
49 ADHCP #51 1

Number of Settings That Cannot Overcome the Presumption:

None.

A List of Presumptively Institutional Due to Isolation (Prong Three Settings)

Please see the chart above which lists all prong three settings, of which there are 13 ADHCPs in this category.

Contact Information to Submit Public Comment

A draft of the Heightened Scrutiny evidence data packet(s) will be available for review at: https://www.health.ny.gov/facilities/nursing/public_notice/heightened_scutiny/

For individuals with limited online access and require special accommodation to access paper copies, please call (518) 408-1282.

Prior to finalizing the proposed Part 425 Adult Day Health Care Statutory Authority: Public Health Law, section 2803(2); Social Services Law, section 363-a (2) Heightened Scrutiny evidence packet(s), NYS DOH, Office of Aging and Long-Term Care, Bureau of Quality Assurance and Surveillance - ADHCP will consider all written and verbal comments received, amending determination(s) of compliance, and conducting further remediation activities as needed.

Please direct all questions to: ADHCP.HCBS@health.ny.gov

Written comments will be accepted by email at ADHCP.HCBS@health.ny.gov or by mail at: ADHCP, Bureau of Quality Assurance and Surveillance, Division of Nursing Homes and ICF/IID Surveillance, Department of Health, 875 Central Ave., Albany, NY 12206, e-mail: ADHCP.HCBS@health.ny.gov

All comments must be postmarked or emailed by 30 days of the date of this notice.

PUBLIC NOTICE
Department of Health

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

The Department of Health proposes to amend the Title XIX (Medicaid) State Plan for institutional services in accordance with § 41.35 of Mental Hygiene Law. The following changes are proposed:

Institutional Services

Effective on or after February 1, 2023, the Department of Health will adjust the operating reimbursement rate for the specialized inpatient psychiatric units that provide treatment for adults with a diagnosis of both developmental disability and either serious mental illness or serious emotional disturbance.

The estimated net aggregate increase in gross Medicaid expenditures attributable to this adjustment for State Fiscal Year 2023 is $525,000 for the period February 1 to March 31, 2023.

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. Individuals without Internet access may view the State Plan Amendments at any local (county) social services district.

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

New York County
250 Church Street
New York, New York 10018

Queens County, Queens Center
3220 Northern Boulevard
Long Island City, New York 11101

Kings County, Fulton Center
114 Willoughby Street
Brooklyn, New York 11201

Bronx County, Tremont Center
1916 Monterey Avenue
Bronx, New York 10457

Richmond County, Richmond Center
95 Central Avenue, St. George
Staten Island, New York 10301

For further information and to review and comment, please contact: Department of Health, Division of Finance and Rate Setting, 99 Washington Ave., One Commerce Plaza, Suite 1432, Albany, NY 12210, email: spa_inquiries@health.ny.gov

PUBLIC NOTICE
Department of Health

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

The Department of Health proposes to amend the Title XIX (Medicaid) State Plan for Institutional Services as authorized by § 2826 of New York Public Health Law. The following changes are proposed:

Appendix V
2023 Title XIX State Plan
First Quarter Amendment
Responses to Standard Funding Questions

INSTITUTIONAL SERVICES
State Plan Amendment #23-0004

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 inpatient UPL demonstration utilizes cost-to-payment and payment-to-payment methodologies to estimate the upper payment limit for each class of providers. The Medicaid payments under this State Plan Amendment will be included in the 2023 inpatient UPL when it 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.