Department of Health

KATHY HOCHUL
Governor

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

MEGAN E. BALDWIN
Acting Executive Deputy Commissioner

June 30, 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 #23-0084
Inpatient Hospital Services

Dear Mr. McMillion:

The State requests approval of the enclosed amendment #23-0084 to the Title XIX (Medicaid) State Plan for inpatient hospital services to be effective April 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.

Notices 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 29, 2023, and clarified on July 12, 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,

Amir Bassiri
Medicaid Director
Office of Health Insurance Programs

Enclosures

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER
2 3 — 0 0 8 4

2. STATE
N Y

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
April 1, 2023

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

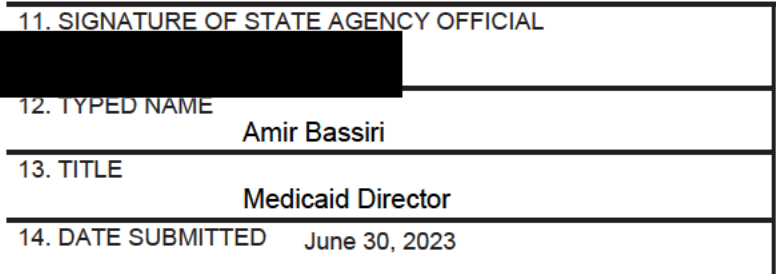
6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 04/01/23-09/30/23 $ 1,500
b. FFY 10/01/23-09/30/24 $ 3,000

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.19-A Part I: Page 117(m)

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 4.19-A Part I: Page 117(m)

9. SUBJECT OF AMENDMENT
4% COLA Adjustment for CPEP EOB Services

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
Amir Bassiri

13. TITLE
Medicaid Director

14. DATE SUBMITTED
June 30, 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

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

1905(a)(1) Inpatient Hospital Services

i. Eligible hospitals will be those general hospitals which receive approval for certificate of need applications submitted to the Department of Health between April 1, 2010 and March 31, 2011 for adding new behavioral health inpatient beds in response to the decertification of other general hospital behavioral health inpatient beds in the same service area, or which the Commissioner of Health, in consultation with the Commissioner of Mental Health, has determined to have complied with Department of Health requests to adjust behavioral health service delivery in order to ensure access.

ii. Eligible hospitals will, as a condition of their receipt of the rate adjustments, submit to the Department of Health proposed budgets for the expenditure of the additional Medicaid payments for the purpose of providing inpatient behavioral health services to Medicaid eligible individuals. The budgets must be approved by the Department of Health, in consultation with the Office of Mental Health, prior to the rate adjustments being issued.

iii. Distributions will be made as add-ons to each eligible facility's inpatient Medicaid rate and will be allocated proportionally, utilizing the proportion of each approved hospital budget to the total amount of all approved hospital budgets. Distributions will be subsequently reconciled to ensure that actual aggregate expenditures are within available aggregate funding.

l. For purposes of this section, the downstate region of New York State will consist of the following counties of: Bronx, New York, Kings, Queens, Richmond, Nassau, Suffolk, Westchester, Rockland, Orange, Putnam, and Dutchess; and the upstate region of New York State will consist of all other New York counties.

m. Reimbursement equivalent to the inpatient hospital per diem rate of reimbursement will be made for extended observation bed (EOB) services in hospital-based comprehensive psychiatric emergency programs (CPEP), subsequent to a CPEP full or triage and referral visit and where the beneficiary remains in the CPEP for longer than 24 hours. Such reimbursement ~~shall~~ will be limited to 72 hours. Effective ~~July~~ April 1, ~~2022~~ 2023, inpatient hospital rates for EOB services are available at the following Office of Mental Health website link:

https://omh.ny.gov/omhweb/medicaid_reimbursement/excel/cpep.xlsx

Appendix II
2023 Title XIX State Plan
Second Quarter Amendment
Summary

SUMMARY
SPA #23-0084

This State Plan Amendment proposes to increase the fees paid to reimburse Medicaid Comprehensive Psychiatric Emergency Program (CPEP) extended observation bed (EOB) services by 4% effective April 1, 2023.

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

SPA 23-0084

Authorizing Provisions

Part DD of Chapter 57 of the Laws of 2023

2 PART DD

3 Section 1. 1. Subject to available appropriations and approval of the
4 director of the budget, the commissioners of the office of mental
5 health, office for people with developmental disabilities, office of
6 addiction services and supports, office of temporary and disability
7 assistance, office of children and family services, and the state office
8 for the aging shall establish a state fiscal year 2023-24 cost of living
9 adjustment (COLA), effective April 1, 2023, for projecting for the
10 effects of inflation upon rates of payments, contracts, or any other
11 form of reimbursement for the programs and services listed in paragraphs
12 (i), (ii), (iii), (iv), (v), and (vi) of subdivision four of this
13 section. The COLA established herein shall be applied to the appropri-
14 ate portion of reimbursable costs or contract amounts. Where appropri-
15 ate, transfers to the department of health (DOH) shall be made as
16 reimbursement for the state share of medical assistance.
17 2. Notwithstanding any inconsistent provision of law, subject to the
18 approval of the director of the budget and available appropriations
19 therefore, for the period of April 1, 2023 through March 31, 2024, the
20 commissioners shall provide funding to support a four percent (4.0%)
21 cost of living adjustment under this section for all eligible programs
22 and services as determined pursuant to subdivision four of this section.
23 3. Notwithstanding any inconsistent provision of law, and as approved
24 by the director of the budget, the 4.0 percent cost of living adjustment
25 (COLA) established herein shall be inclusive of all other cost of living

26 type increases, inflation factors, or trend factors that are newly
27 applied effective April 1, 2023. Except for the 4.0 percent cost of
28 living adjustment (COLA) established herein, for the period commencing
29 on April 1, 2023 and ending March 31, 2024 the commissioners shall not
30 apply any other new cost of living adjustments for the purpose of estab-
31 lishing rates of payments, contracts or any other form of reimbursement.
32 The phrase "all other cost of living type increases, inflation factors,
33 or trend factors" as defined in this subdivision shall not include
34 payments made pursuant to the American Rescue Plan Act or other federal
35 relief programs related to the Coronavirus Disease 2019 (COVID-19)
36 pandemic Public Health Emergency. This subdivision shall not prevent
37 the office of children and family services from applying additional
38 trend factors or staff retention factors to eligible programs and
39 services under paragraph (v) of subdivision four of this section.
40 4. Eligible programs and services. (i) Programs and services funded,
41 licensed, or certified by the office of mental health (OMH) eligible for
42 the cost of living adjustment established herein, pending federal
43 approval where applicable, include: office of mental health licensed
44 outpatient programs, pursuant to parts 587 and 599 of title 14 CRR-NY of
45 the office of mental health regulations including clinic, continuing day
46 treatment, day treatment, intensive outpatient programs and partial
47 hospitalization; outreach; crisis residence; crisis stabilization,
48 crisis/respite beds; mobile crisis, part 590 comprehensive psychiatric
49 emergency program services; crisis intervention; home based crisis
50 intervention; family care; supported single room occupancy; supported
51 housing; supported housing community services; treatment congregate;
52 supported congregate; community residence - children and youth;
53 treatment/apartment; supported apartment; community residence single

1 room occupancy; on-site rehabilitation; employment programs; recreation;
2 respite care; transportation; psychosocial club; assertive community
3 treatment; case management; care coordination, including health home
4 plus services; local government unit administration; monitoring and
5 evaluation; children and youth vocational services; single point of
6 access; school-based mental health program; family support children and
7 youth; advocacy/support services; drop in centers; recovery centers;
8 transition management services; bridger; home and community based waiver
9 services; behavioral health waiver services authorized pursuant to the
10 section 1115 MRT waiver; self-help programs; consumer service dollars;
11 conference of local mental hygiene directors; multicultural initiative;
12 ongoing integrated supported employment services; supported education;
13 mentally ill/chemical abuse (MICA) network; personalized recovery
14 oriented services; children and family treatment and support services;
15 residential treatment facilities operating pursuant to part 584 of title
16 14-NYCRR; geriatric demonstration programs; community-based mental
17 health family treatment and support; coordinated children's service
18 initiative; homeless services; and promises zone.
19 (ii) Programs and services funded, licensed, or certified by the
20 office for people with developmental disabilities (OPWDD) eligible for
21 the cost of living adjustment established herein, pending federal
22 approval where applicable, include: local/unified services; chapter 620
23 services; voluntary operated community residential services; article 16
24 clinics; day treatment services; family support services; 100% day
25 training; epilepsy services; traumatic brain injury services; hepatitis
26 B services; independent practitioner services for individuals with
27 intellectual and/or developmental disabilities; crisis services for
28 individuals with intellectual and/or developmental disabilities; family

29 care residential habilitation; supervised residential habilitation;
30 supportive residential habilitation; respite; day habilitation; prevoca-
31 tional services; supported employment; community habilitation; interme-
32 diate care facility day and residential services; specialty hospital;
33 pathways to employment; intensive behavioral services; basic home and
34 community based services (HCBS) plan support; health home services
35 provided by care coordination organizations; community transition
36 services; family education and training; fiscal intermediary; support
37 broker; and personal resource accounts.
38 (iii) Programs and services funded, licensed, or certified by the
39 office of addiction services and supports (OASAS) eligible for the cost
40 of living adjustment established herein, pending federal approval where
41 applicable, include: medically supervised withdrawal services - residen-
42 tial; medically supervised withdrawal services - outpatient; medically
43 managed detoxification; medically monitored withdrawal; inpatient reha-
44 bilitation services; outpatient opioid treatment; residential opioid
45 treatment; KEEP units outpatient; residential opioid treatment to absti-
46 nence; problem gambling treatment; medically supervised outpatient;
47 outpatient rehabilitation; specialized services substance abuse
48 programs; home and community based waiver services pursuant to subdivi-
49 sion 9 of section 366 of the social services law; children and family
50 treatment and support services; continuum of care rental assistance case
51 management; NY/NY III post-treatment housing; NY/NY III housing for
52 persons at risk for homelessness; permanent supported housing; youth
53 clubhouse; recovery community centers; recovery community organizing
54 initiative; residential rehabilitation services for youth (RRSY); inten-
55 sive residential; community residential; supportive living; residential
56 services; job placement initiative; case management; family support

1 navigator; local government unit administration; peer engagement; voca-
2 tional rehabilitation; support services; HIV early intervention
3 services; dual diagnosis coordinator; problem gambling resource centers;
4 problem gambling prevention; prevention resource centers; primary
5 prevention services; other prevention services; and community services.
6 (iv) Programs and services funded, licensed, or certified by the
7 office of temporary and disability assistance (OTDA) eligible for the
8 cost of living adjustment established herein, pending federal approval
9 where applicable, include: nutrition outreach and education program
10 (NOEP).
11 (v) Programs and services funded, licensed, or certified by the office
12 of children and family services (OCFS) eligible for the cost of living
13 adjustment established herein, pending federal approval where applica-
14 ble, include: programs for which the office of children and family
15 services establishes maximum state aid rates pursuant to section 398-a
16 of the social services law and section 4003 of the education law; emer-
17 gency foster homes; foster family boarding homes and therapeutic foster
18 homes; supervised settings as defined by subdivision twenty-two of
19 section 371 of the social services law; adoptive parents receiving
20 adoption subsidy pursuant to section 453 of the social services law; and
21 congregate and scattered supportive housing programs and supportive
22 services provided under the NY/NY III supportive housing agreement to
23 young adults leaving or having recently left foster care.
24 (vi) Programs and services funded, licensed, or certified by the state
25 office for the aging (SOFA) eligible for the cost of living adjustment
26 established herein, pending federal approval where applicable, include:
27 community services for the elderly; expanded in-home services for the
28 elderly; and supplemental nutrition assistance program.

29 5. Each local government unit or direct contract provider receiving

30 funding for the cost of living adjustment established herein shall

31 submit a written certification, in such form and at such time as each

32 commissioner shall prescribe, attesting how such funding will be or was

33 used to first promote the recruitment and retention of non-executive

34 direct care staff, non-executive direct support professionals, non-exe-

35 cutive clinical staff, or respond to other critical non-personal service

36 costs prior to supporting any salary increases or other compensation for

37 executive level job titles.

38 6. Notwithstanding any inconsistent provision of law to the contrary,

39 agency commissioners shall be authorized to recoup funding from a local

40 governmental unit or direct contract provider for the cost of living

41 adjustment established herein determined to have been used in a manner

42 inconsistent with the appropriation, or any other provision of this

43 section. Such agency commissioners shall be authorized to employ any

44 legal mechanism to recoup such funds, including an offset of other funds

45 that are owed to such local governmental unit or direct contract provid-

46 er.

47 § 2. This act shall take effect immediately and shall be deemed to

48 have been in full force and effect on and after April 1, 2023.

Mental Hygiene (MHY) CHAPTER 27, TITLE B, ARTICLE 7

§ 7.09 Powers of the office and commissioner; how exercised.

(a) The commissioner shall exercise all powers vested in the office.
He may delegate any function, power, or duty assigned to him or to the
office of mental health to a director of a facility operated by such
office or to any other officer or employee of such office, unless
otherwise provided by law. He may enter into agreements with the
executive director of the justice center for the protection of people
with special needs or the other commissioners of the department in order
to ensure that programs and services are provided for all of the

mentally disabled.

(b) The commissioner may adopt regulations necessary and proper to implement any matter under his jurisdiction. Proposed rules and regulations shall be submitted at least sixty days prior to action thereon to the mental health services council for its advice, in accordance with section 7.05 of this chapter, unless the commissioner finds that the public health, safety or general welfare requires that such submission be dispensed with.

Mental Hygiene (MHY) CHAPTER 27, TITLE E, ARTICLE 31

§ 31.04 Regulatory powers of the commissioner.

(a) The commissioner shall have the power to adopt regulations to effectuate the provisions and purposes of this article, including, but not limited to, the following:

1. establishing classes of operating certificates based upon such factors as physical plant, program, and staff.

2. setting standards of quality and adequacy of facilities, equipment, personnel, services, records, and programs for the rendition of services for the mentally disabled pursuant to an operating certificate.

3. specifying a definite period for which the operating certificate will be in effect for each class.

* 4. establishing procedures for the issuance, amendment, and renewal of operating certificates, including temporary operating certificates, and for the suspension or revocation of operating certificates. Such procedures shall specify that no application for the issuance or renewal of an operating certificate for a hospital, which is operated as part of a hospital as defined in article twenty-eight of the public health law, shall be effective until such hospital is granted approval to admit patients in emergencies for immediate observation, care and treatment in accordance with section 9.39 or 9.40 of this chapter, provided that the commissioner shall waive this requirement for two year periods upon his determination that (i) there is no need for additional beds for emergency psychiatric admissions in the local geographic area, (ii) the hospital lacks the physical capacity to reasonably accommodate such emergency admissions without extensive structural changes, (iii) the hospital does not and reasonably could not provide the scope of services necessary to assure adequate and appropriate psychiatric care and

treatment for patients in emergency situations, or (iv) the hospital has
agreed to accept referrals of involuntary psychiatric patients under an
emergency admissions system which has been approved by the commissioner.
Provided, however, nothing in this paragraph shall be interpreted to
require a hospital without an onsite emergency room to accept patients
in need of emergency observation, care and treatment.

* NB Effective until July 1, 2024

* 4. establishing procedures for the issuance, amendment, and renewal
of operating certificates, including temporary operating certificates,
and for the suspension or revocation of operating certificates. Such
procedures shall specify that no application for the issuance or renewal
of an operating certificate for a hospital, which is operated as part of
a hospital as defined in article twenty-eight of the public health law,
shall be effective until such hospital is granted approval to admit
patients in emergencies for immediate observation, care and treatment in
accordance with section 9.39 of this chapter, provided that the
commissioner shall waive this requirement for two year periods upon his
determination that (i) there is no need for additional beds for
emergency psychiatric admissions in the local geographic area, (ii) the
hospital lacks the physical capacity to reasonably accommodate such
emergency admissions without extensive structural changes, (iii) the
hospital does not and reasonably could not provide the scope of services
necessary to assure adequate and appropriate psychiatric care and
treatment for patients in emergency situations, or (iv) the hospital has
agreed to accept referrals of involuntary psychiatric patients under an
emergency admissions system which has been approved by the commissioner.
Provided, however, nothing in this paragraph shall be interpreted to
require a hospital without an onsite emergency room to accept patients
in need of emergency observation, care and treatment.

* NB Effective July 1, 2024

5. setting for the operation of certified family care homes standards
governing adequacy of the building and equipment, fire protection,
safety, sanitation, food service, programs for the rendition of service,
recreation and religious participation, medical services, personnel,
insurance, record keeping procedures and statistical records as well as
appropriate standards governing or precluding ownership of more than one
such home.

6. establishing criteria for use by staff of department facilities,
social services officials and directors of local governmental units for

determining the appropriateness of referring patients to family care
homes, other community residences and residential care centers for
adults.

7. establishing criteria for determining the public need for family
care homes, other community residences and residential care centers for
adults in each geographical area of the state.

8. establishing a schedule of fees for the purpose of processing
applications for the issuance of operating certificates. All fees
pursuant to this section shall be payable to the office for deposit into
the general fund.

Mental Hygiene (MHY) CHAPTER 27, TITLE E, ARTICLE 31

**** § 31.27 Comprehensive psychiatric emergency programs.**

(a) As used in this section:

(1) "Commissioner" means the commissioner of mental health.

(2) "Crisis intervention services" means services provided in an
emergency room located within a general hospital, which shall include
but not be limited to: psychiatric and medical evaluations and
assessments; prescription or adjustment of medication, counseling, and
other stabilization or treatment services intended to reduce symptoms of
mental illness when appropriate.

(3) "Crisis outreach services" means psychiatric emergency services
provided outside an emergency room setting including evaluation,
assessment and stabilization services; crisis reduction services;
referral services; and other psychiatric emergency services.

(5) "Extended observation bed" means an inpatient bed which is in or
adjacent to an emergency room located within a general hospital or
satellite facility approved by the commissioner, designed to provide a
safe environment for an individual who, in the opinion of the examining
physician, requires extensive evaluation, assessment, or stabilization
of the person's acute psychiatric symptoms, except that, if the
commissioner determines that the program can provide for the privacy and
safety of all patients receiving services in a hospital, he or she may
approve the location of one or more such beds within another unit of the
hospital.

(6) "General hospital" shall be defined as in article twenty-eight of
the public health law.

(9) "Psychiatric emergency services" means services designed to
stabilize and, when possible, reduce acute psychiatric symptoms of an
individual who appears to be mentally ill and in crisis.

(10) "Triage and referral services" means services designed to provide
preliminary diagnosis, assessment and evaluation of individuals served
by a comprehensive psychiatric emergency program in order to direct such
person to those services which appropriately address their needs.

(11) "Voluntary agency" shall be defined as in section 41.03 of this
chapter.

(12) "Satellite facility" means a medical facility providing
psychiatric emergency services that is managed and operated by a general
hospital who holds a valid operating certificate for a comprehensive
psychiatric emergency program and is located away from the central
campus of the general hospital.

(b) (1) The commissioner may license the operation of comprehensive
psychiatric emergency programs by general hospitals which are operated
by state or local governments or voluntary agencies. The provision of
such services in general hospitals may be located either within the
state or, with the approval of the commissioner and the director of the
budget and to the extent consistent with state and federal law, in a
contiguous state. The commissioner is further authorized to enter into
interstate agreements for the purpose of facilitating the development of
programs which provide services in another state. A comprehensive
psychiatric emergency program shall serve as a primary psychiatric
emergency service provider within a defined catchment area for persons
in need of psychiatric emergency services including persons who require
immediate observation, care and treatment in accordance with section
9.40 of this chapter. Each comprehensive psychiatric emergency program
shall provide or contract to provide psychiatric emergency services
twenty-four hours per day, seven days per week, including but not
limited to: crisis intervention services, crisis outreach services,
extended observation beds, and triage and referral services.

(2) The commissioner of mental health shall require that each
comprehensive psychiatric emergency program submit a plan. The plan must
be approved by the commissioner prior to the issuance of an operating
certificate pursuant to this article. Each plan shall include: (i) a

description of the program's catchment area; (ii) a description of the program's psychiatric emergency services, including but not limited to crisis intervention services, crisis outreach services, extended observation beds, and triage and referral services, whether or not provided directly or through agreement with other providers of services; (iii) agreements or affiliations with hospitals, as defined in section 1.03 of this chapter, to receive and admit persons who require inpatient psychiatric services; (iv) agreements or affiliations with general hospitals to receive and admit persons who have been referred by the comprehensive psychiatric emergency program and who require medical or surgical care which cannot be provided by the comprehensive psychiatric emergency program; (v) a description of local resources available to the program to prevent unnecessary hospitalizations of persons, which shall include agreements with local mental health, health, substance abuse, alcoholism or alcohol abuse, developmental disabilities, or social services agencies to provide appropriate services; (vi) a description of the program's linkages with local police agencies, emergency medical services, ambulance services, and other transportation agencies; (vii) a description of local resources available to the program to provide appropriate community mental health services upon release or discharge, which shall include case management services and agreements with state or local mental health and other human service providers; (viii) written criteria and guidelines for the development of appropriate discharge planning for persons in need of post emergency treatment or services; (ix) a statement indicating that the program has been included in an approved local services plan developed pursuant to article forty-one of this chapter for each local government located within the program's catchment area; and (x) any other information or agreements required by the commissioner.

(c) Each comprehensive psychiatric emergency program shall have at least one physician, who is a member of the psychiatric staff of the program, on duty and available at all times, provided, however, the commissioner may promulgate regulations to permit the issuance of a waiver of this requirement when the volume of service of a program does not require such level of staff coverage.

(d) The commissioner shall promulgate regulations to establish a maximum number and location of extended observation beds which may be provided in a program, including provisions to maximize the privacy and safety of all patients receiving services in the hospital in which such extended observation beds are located.

(e) The commissioner may prevent new presentations and admissions from

entering a comprehensive psychiatric emergency program when the
commissioner concludes that the ability of the program to deliver
quality services would be jeopardized. Before reaching such a
conclusion, the commissioner shall consider the effect presenting new
presentations and admissions may have on other hospital emergency rooms
which provide psychiatric emergency services, and the commissioner shall
review the continued necessity for such prevention at least once every
twenty-four hours.

(f) The commissioner and the commissioner of health shall enter into a
cooperative agreement to govern the operation of comprehensive
psychiatric emergency programs including visitation, inspection and
supervision of such programs, enforcement of the conditions of operating
certificates issued by the office of mental health and the department of
health, and the protection of the confidentiality of clinical
information regarding patients at such programs.

(g) The office of mental health, the department of social services and
the department of health shall establish a uniform system by which
general hospitals which operate comprehensive psychiatric emergency
programs shall report the cost of operating such programs.

(h) Notwithstanding any other provision of law, nothing in this
section shall be interpreted to create an entitlement for any individual
to receive psychiatric emergency services in a comprehensive psychiatric
emergency program.

Mental Hygiene (MHY) CHAPTER 27, TITLE E, ARTICLE 43

**§ 43.02 Rates or methods of payment for services at facilities subject
to licensure or certification by the office of mental health, the office for people with developmental
disabilities or the office of alcoholism and substance abuse services.**

(a) Notwithstanding any inconsistent provision of law, payment made by
government agencies pursuant to title eleven of article five of the
social services law for services provided by any facility licensed by
the office of mental health pursuant to article thirty-one of this
chapter or certified by the office of alcoholism and substance abuse
services pursuant to this chapter to provide inpatient chemical
dependence services, as defined in section 1.03 of this chapter, shall
be at rates or fees certified by the commissioner of the respective
office and approved by the director of the division of the budget,
provided, however, the commissioner of mental health shall annually
certify such rates or fees which may vary for distinct geographical

areas of the state and, provided, further, that rates or fees for
service for inpatient psychiatric services or inpatient chemical
dependence services, at hospitals otherwise licensed pursuant to article
twenty-eight of the public health law shall be established in accordance
with section two thousand eight hundred seven of the public health law
and, provided, further, that rates or fees for services provided by any
facility or program licensed, operated or approved by the office for
people with developmental disabilities, shall be certified by the
commissioner of health; provided, however, that such methodologies shall
be subject to approval by the office for people with developmental
disabilities and shall take into account the policies and goals of such
office.

(b) Operators of facilities licensed by the office of mental health
pursuant to article thirty-one of this chapter, licensed by the office
for people with developmental disabilities pursuant to article sixteen
of this chapter or certified by the office of alcoholism and substance
abuse services pursuant to this chapter to provide inpatient chemical
dependence services shall provide to the commissioner of the respective
office such financial, statistical and program information as the
commissioner may determine to be necessary. The commissioner of the
appropriate office shall have the power to conduct on-site audits of
books and records of such facilities.

(c) The commissioner of the office of mental health, the commissioner
of the office for people with developmental disabilities and the
commissioner of the office of alcoholism and substance abuse services
shall adopt rules and regulations to effectuate the provisions of this
section. Such rules and regulations shall include, but not be limited
to, provisions relating to:

(i) the establishment of a uniform statewide system of reports and
audits relating to the quality of care provided, facility utilization
and costs of providing services; such a uniform statewide system may
provide for appropriate variation in the application of the system to
different classes or subclasses of facilities licensed by the office of
mental health pursuant to article thirty-one of this chapter or licensed
or operated by the office for people with developmental disabilities
pursuant to article sixteen of this chapter, or certified by the office
of alcoholism and substance abuse services pursuant to this chapter to
provide inpatient chemical dependence services; and

(ii) methodologies used in the establishment of the schedules of rates
or fees pursuant to this section provided, however, that the

commissioner of health shall adopt rules and regulations including methodologies developed by him or her for services provided by any facility or program licensed, operated or approved by the office for people with developmental disabilities; provided, however, that such rules and regulations shall be subject to the approval of the office for people with developmental disabilities and shall take into account the policies and goals of such office.

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

MISCELLANEOUS NOTICES/HEARINGS

Notice of Abandoned Property Received by the State Comptroller

Pursuant to provisions of the Abandoned Property Law and related laws, the Office of the State Comptroller receives unclaimed monies and other property deemed abandoned. A list of the names and last known addresses of the entitled owners of this abandoned property is maintained by the office in accordance with Section 1401 of the Abandoned Property Law. Interested parties may inquire if they appear on the Abandoned Property Listing by contacting the Office of Unclaimed Funds, Monday through Friday from 8:00 a.m. to 4:30 p.m., at:

1-800-221-9311
or visit our web site at:
www.osc.state.ny.us

Claims for abandoned property must be filed with the New York State Comptroller's Office of Unclaimed Funds as provided in Section 1406 of the Abandoned Property Law. For further information contact: Office of the State Comptroller, Office of Unclaimed Funds, 110 State St., Albany, NY 12236.

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, non-institutional and long-term care services to comply with statutory provisions. The following changes are proposed:

All Services

Effective on or after April 1, 2023, the Department of Health will adjust rates statewide to reflect a 2.5% percent Cost of Living Adjustment for the following Office of Mental Health (OMH), Office of Addiction Services and Supports (OASAS), and Office for People With Developmental Disabilities (OPWDD) State Plan Services: OMH Outpatient Services, OMH Clinic Services, OMH Rehabilitative Services, Children Family Treatment Support Services, Health Home Plus, Psychiatric Residential Treatment Facilities for Children and Youth, OASAS Outpatient Addiction Services, OASAS Freestanding (non-hospital) Inpatient Rehabilitation Services, OASAS Freestanding Inpatient Detox Services, OASAS Addiction Treatment Centers, OASAS Part 820 Residential Services, OASAS Residential Rehabilitation Services for Youth, Intermediate Care Facility (ICF/IDD), Day Treatment, Article 16 Clinic Services, Specialty Hospital, Health Home Services Provided by Care Coordination Organizations, Independent Practitioner Services for Individual with Developmental Disabilities (IPSIDD), and OPWDD Crisis Services.

The estimated net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2023-2024 is $53.6 million.

Non-Institutional Services

Effective on and after April 1, 2023, the New York State Department of Health proposes to amend the State Plan to allow for reimbursement of Medicaid covered services provided by pharmacists within their lawful scope of practice, including pharmacist prescribing oral contraceptives and smoking cessation products.

The estimated net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2023-2024 is $1.6 million. In the out years the net aggregate in gross Medicaid expenditure for smoking cessation products will be a savings.

Effective on or after April 1, 2024, this proposal would eliminate Prescriber Prevails which applies to the Medicaid fee-for-service pharmacy program. Doing so would reduce inappropriate prescribing, remove barriers that limit the State's ability to manage pharmacy programs, and minimize the inappropriate influence of pharmaceutical manufacturers in the prior authorization process.

The estimated net aggregate decrease in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2024-2025 is ($99 million).

Effective on or after April 1, 2023, the Department will remove copayments for over the counter (OTC) products and limit OTC products to those that are medically necessary. Clinically critical products such as aspirin and vitamins and minerals used for deficiencies will continue to be covered, as will less expensive OTC products that are in Preferred Drug Program (PDP) drug classes.

The estimated net aggregate decrease in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2023-2024 is ($17.4 million).

Effective on and after April 1, 2023, the New York State Department of Health proposes to amend the State Plan to modify the specific drug class language for excluded drugs, to alternatively use current publicly available Department resources for coverage transparency.

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

Effective on or after April 1, 2023, this proposal continues the supplemental upper payment limit payments made to general hospitals, other than major public general hospitals under non-institutional services of $339 million annually.

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

For state fiscal year beginning April 1, 2023, through March 31, 2024, this proposal continues hospital outpatient payment adjustments that increase the operating cost components of rates of payment for hospital outpatient and emergency departments on and after April 1, 2011, for public general hospitals other than those operated by the State of New York or the State University of New York, which are located in a city with a population of over one million. The amount to be paid will be up to $287 million 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 may be added to rates of payment or made as aggregate payments.

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

For state fiscal year beginning April 1, 2023, through March 31, 2024, this proposal continues payment of up to $5.4 million in additional annual Medicaid payments to county operated free-standing clinics, not including facilities operated by the New York City Health

and Hospitals Corporation, for services provided by such DTC and those provided by a county operated freestanding mental health or substance abuse DTC. Distributions shall be based on each eligible facility's proportionate share of the sum of all DTC and clinic visits for all eligible facilities receiving payments for the base year two years prior to the rate year. The proportionate share payments may be added to rates of payment or made as aggregate payments to eligible facilities.

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

Effective April 1, 2023, and each state fiscal year thereafter, this amendment proposes to revise the calculation to extract data later on in the calendar year for the applicable dates of service. The current authority to make supplemental payments for services provided by physicians, nurse practitioners and physician assistants will continue.

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

Effective on or after April 1, 2023, the Department of Health will adjust rates for Assisted Living Program (ALP) providers by a 5% across the board increase to the most recently active Operating rate in effect on March 31, 2023, for each provider.

The estimated net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2023-2024 is $18 million.

Effective on or after April 1, 2023, the Department of Health will adjust rates for Adult Day Health Care providers by a 5% across the board increase to the most recently active Operating rate in effect on March 31, 2023, for each provider.

The estimated net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2023-2024 is $838,000.

Effective on and after April 1, 2023, this notice provides for a temporary rate adjustment with an aggregate payment totaling no less than $7.5 million annually for Critical Access Hospitals (CAHs), for the periods April 1, 2023, through March 31, 2024, and April 1, 2024, through March 31, 2025. Funding will be allocated to financially distressed hospitals with plans to reconfigure operations by improving financial management, improving quality of care and service delivery and/or improving operational efficiency and cost effectiveness.

The estimated net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2023-2024 is $7.5 million and contained in the budget for state fiscal year 2024-2025 is $7.5 million.

Effective on and after April 1, 2023, this notice provides for a temporary rate adjustment with an aggregate payment amount totaling no less than $10 million annually, for Essential Community Providers (ECPs) for the periods April 1, 2023, through March 31, 2024, and April 1, 2024, through March 31, 2025. Funding will be allocated to financially distressed hospitals with plans to reconfigure operations by improving financial management, improving quality of care and service delivery and/or improving operational efficiency and cost effectiveness.

The estimated net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2023-2024 is $10 million and contained in the budget for state fiscal year 2024-2025 $10 million.

Effective on or after April 1, 2023, this notice proposes to establish Medical Assistance coverage and rates of payment for rehabilitative services for individuals residing in OMH-licensed residential settings who have been diagnosed with an eating disorder, in order to provide appropriate care and treatment to adults and children with eating disorders.

The estimated net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2023-2024 is $4 million.

Effective on or after May 1, 2023, the NYS Medicaid Program proposes to reimburse enrolled ambulance services for administration of vaccinations performed by Emergency Medical Technicians (EMT) / Paramedics employed by the ambulance service. This proposal is intended to ensure ongoing access to vaccinations after the end of the federal COVID-19 Public Health Emergency.

The estimated net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2023-24 is $35,000.

Effective March 11, 2021 and ending on the last day of the first calendar quarter that begins one year after the last day of the emergency period described in section 1135(g)(1)(B) of the Social Security Act, the Medicaid program assures coverage of COVID-19 vaccines and administration of the vaccines, COVID-19 treatment, including specialized equipment and therapies (including preventive therapies), and COVID-19 testing consistent with the Centers for Disease Control and Prevention (CDC) recommendations.

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

Effective December 1, 2021 and ending on the last day of the first calendar quarter that begins one year after the last day of the emergency period described in section 1135(g)(1)(B) of the Social Security Act, the Medicaid program proposes to reimburse providers for medically necessary COVID-19 vaccine counseling for children under 21 at a fee of $25.00 per session.

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

Effective on or after April 1, 2023, the Department of Health will adjust rates statewide to reflect up to a twenty-five percent rate increase for all services provided by School-based Mental Health Outpatient Treatment and Rehabilitative Service (SBMH MHOTRS) programs licensed by the Office of Mental Health.

The estimated net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2023-2024 is $9.2 million.

Effective on or after April 1, 2023, Medicaid will increase the APG Base Rates by ten percent for School Based Health Centers (SBHC).

The estimated net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2023-2024 is $2.8 million.

Effective on or after April 1, 2023, a Supplemental Payment Program will be established to reimburse eligible Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs) and Diagnostic and Treatment Centers (DTCs) for potential loss of funding associated with the 340B Drug Pricing Program due to State policy change. Additionally, this Amendment clarifies the reimbursement methodology for the Supplemental Payment Wrap Program for FQHCs and RHCs which provides supplemental payments that are equal to 100% of the difference between the facility's reasonable cost per visit rate and the amount per visit reimbursed by the Medicaid managed care health plan.

The estimated net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2023-2024 is $250 million.

Institutional Services

Effective on or after April 1, 2023, 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 estimated change to gross Medicaid expenditures as a result of this proposed amendment.

For state fiscal year beginning April 1, 2023 through March 31, 2024, 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 will 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.

For publication in the July 12 edition of the New York State Register

Public Notice
NYS 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, non-institutional and long-term care services to comply with statutory provisions. The following clarifications are proposed:

All Services

The following is a clarification to the March 29, 2023, noticed provision to adjust rates statewide to reflect a 2.5% Cost of Living Adjustment for the following Office of Mental Health (OMH), Office of Addiction Services and Supports (OASAS), and Office for People With Developmental Disabilities (OPWDD) State Plan Services: OMH Outpatient Services, OMH Clinic Services, OMH Rehabilitative Services, Children Family Treatment Support Services, Health Home Plus, Psychiatric Residential Treatment Facilities for Children and Youth, OASAS Outpatient Addiction Services, OASAS Freestanding (non-hospital) Inpatient Rehabilitation Services, OASAS Freestanding Inpatient Detox Services, OASAS Addiction Treatment Centers, OASAS Part 820 Residential Services, OASAS Residential Rehabilitation Services for Youth, Intermediate Care Facility (ICF/IDD), Day Treatment, Article 16 Clinic Services, Specialty Hospital, Health Home Services Provided by Care Coordination Organizations, Independent Practitioner Services for Individual with Developmental Disabilities (IPSIDD), and OPWDD Crisis Services. **With clarification**, the Cost of Living Adjustment will be four percent (4%) and includes the following services:

For publication in the July 12 edition of the New York State Register

OMH Outpatient Services, OMH Inpatient Services, OMH Clinic Services, OMH Rehabilitative Services, Children Family Treatment Support Services, Health Home Plus, Psychiatric Residential Treatment Facilities for Children and Youth, OASAS Outpatient Addiction Services, OASAS Freestanding (non-hospital) Inpatient Rehabilitation Services, OASAS Freestanding Inpatient Detox Services, OASAS Addiction Treatment Centers, OASAS Part 820 Residential Services, OASAS Residential Rehabilitation Services for Youth, Intermediate Care Facility (ICF/IDD), Day Treatment, Article 16 Clinic Services, Specialty Hospital, Health Home Services Provided by Care Coordination Organizations, Independent Practitioner Services for Individual with Developmental Disabilities (IPSIDD), and OPWDD Crisis Services.

The estimated net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2023-2024 is $89.8 million.

Institutional Services and Non-Institutional

The following is a clarification to the March 29, 2023, noticed provision to adjust inpatient rates for hospital providers, certified under Article 28 of the Public Health Law, by an additional five percent (5%) across the board increase to the operating portion of the rates. **With clarification**, the across the board increase to the operating portion of the rates will now be seven and one-half percent (7.5%) and includes a non-institutional additional six and one-half percent (6.5%) across the board increase to the operating portion of outpatient rates for hospital providers, for services certified under Article 28 of the Public Health Law.

The estimated net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2023-2024 is $244.4 million.

Non-Institutional

The following is a clarification to the March 29, 2023, noticed provision for the Assisted Living Program (ALP) and Adult Day Health Care (ADHC) which stated the Department of Health will adjust rates for these providers by a five percent (5%) across the board increase to the most recently active Operating rate in effect on 3/31/23. **With clarification,** the Department of Health will provide a seven and one-half percent (7.5%) across the board increase for Adult Day Health Care rates (ADHC) and a six and one-half percent (6.5%) across the board increase for Assisted Living Program rates (ALP), to the most recently active operating rate in effect on 3/31/23, for each provider.

The estimated net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2023-2024 is $24.7 million.

Long Term Care Services

The following is a clarification to the March 29, 2023, noticed provision to adjust rates for Nursing Home (NH) providers by a five percent (5%) across the board increase to the most recently active Operating rate in effect on March 31, 2023, for each provider. **With clarification**, the across the board increase to the most recently active operating base rates will now be seven and one-half percent (7.5%).

The estimated net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2023-2024 is $403 million.

For publication in the July 12 edition of the New York State Register

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:

New York State Department of Health
Division of Finance and Rate Setting
99 Washington Ave
One Commerce Plaza
Suite 1432
Albany, New York 12210
spa_inquiries@health.ny.gov

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

INSTITUTIONAL SERVICES
State Plan Amendment #23-0084

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.