



Department of Health

KATHY HOCHUL
Governor

JAMES V. McDONALD, MD, MPH
Commissioner

JOHANNE E. MORNE, MS
Executive Deputy Commissioner

June 30, 2026

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 #26-0023
Inpatient Hospital Services

Dear Director McMillion:

The State requests approval of the enclosed amendment #26-0023 to the Title XIX (Medicaid) State Plan for inpatient hospital services to be effective April 1, 2026 (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 March 25, 2026. 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,

A black rectangular box redacting the signature of Amir Bassiri.

Amir Bassiri
Medicaid Director
Office of Health Insurance Programs

Enclosures

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

1. TRANSMITTAL NUMBER

2 6 — 0 0 2 3

2. STATE

N Y3. 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, 2026

5. FEDERAL STATUTE/REGULATION CITATION

§ 1905(a)(1) Inpatient Hospital Services

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)

a. FFY 04/01/26-09/30/26 \$ 206,275,000b. FFY 10/01/26-09/30/27 \$ 412,550,000

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT

Attachment 4.19-A: Pages 161(d), 161(j)

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION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

Attachment 4.19-A: Pages 161(d), 161(j)

9. SUBJECT OF AMENDMENT

Indigent Care Pool Extender and Continuation of Pool Reductions

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, 2026

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
2026 Title XIX State Plan
Second Quarter Amendment
Amended SPA Pages

Indigent Care Pool Reform – effective January 1, 2013

(a) Indigent Care Pool Reform Methodology. Each hospital's uncompensated care nominal need will be calculated in accordance with the following:

- 1. Inpatient Uncompensated Care.** Inpatient units of service for uninsured (self-pay and charity) patients, as reported in Exhibit 32 of the Institutional Cost Report (ICR) for the calendar year two years prior to the distribution year for each inpatient service area which has a distinct reimbursement rate, excluding hospital-based residential health care facility (RHCF) and hospice units of service, will be multiplied by the applicable Medicaid inpatient rates in effect for January 1 of the distribution year.

Medicaid inpatient rates for acute and psychiatric services will be the statewide base price adjusted for hospital-specific factors including an average case mix adjustment plus all rate add-ons except the public goods surcharge. Medicaid inpatient rates for all other inpatient services will be the per diem rate, excluding the public goods surcharge add-on. Units of service for acute care services will be uninsured patient discharges; units of service for all other inpatient services will be uninsured patient days, not including alternate level of care (ALC) days.

- 2. Outpatient Uncompensated Care.** Outpatient units of service for those uninsured (self-pay and charity) patients reported in Exhibit 33 of the ICR for the calendar year two years prior to the distribution year, excluding referred ambulatory services and home health units of service, will be multiplied by the average paid Medicaid outpatient rates that reflect the exclusive utilization of the ambulatory patient groups (APG) rate-setting methodology; however, for those services for which APG rates are not available the applicable Medicaid rate in effect for January 1 of the distribution year will be utilized. The outpatient rates used are exclusive of the public goods surcharge.

Units of service for ambulatory surgery services will be uninsured procedures, not including those which result in inpatient admissions; units of service for all other outpatient services will be uninsured visits, not including those which result in inpatient admissions.

TN #26-0023 Approval Date _____

Supersedes TN #23-0051 Effective Date April 1, 2026

**New York
161(j)**

1905(a)(1) Inpatient Hospital Services

4. Voluntary ICP Pool Reduction. For calendar years 2020 through ~~2025~~2029, total distributions made to eligible voluntary general hospitals will reflect a reduction of one hundred fifty million dollars annually. For calendar years 2023 through ~~2025~~2029, total distributions made to eligible voluntary general hospitals will reflect an additional reduction of eighty five million four hundred thousand dollars annually. Hospitals that qualify as Enhanced Safety Net hospitals under §2807-c(34) of the Public Health Law in State Fiscal Year 2019-2020 are exempt from such reductions. The methodology to allocate the reduction will take into account the payor mix of each voluntary hospital, including the percentage of inpatient days paid by Medicaid. Such methodology will calculate the total public payor mix of each facility and calculate a statewide average public payor mix. For the purposes of this subparagraph, public payor mix means the percentage of total reported Medicaid and Medicare inpatient days, as reported in Exhibit 32 of the Institutional Cost Report (ICR) for the reporting period two years prior to the distribution year, where Medicaid and Medicare were the primary payors, out of total reported inpatient days which includes all inpatient services but excludes Alternate Level of Care days. Hospitals exceeding the calculated average of public payor mix will be exempt from reductions pursuant to this subparagraph. Hospitals that fall below the calculated average of public payor mix will be subject to a proportionate reduction pursuant to this subparagraph.

5. Enhanced Safety Net Transition Collar Pool. For calendar years 2020 through ~~2025~~2029, sixty-four million six hundred thousand dollars will be distributed to voluntary hospitals qualifying as Enhanced Safety Net Hospitals under §2807-c(34) of the Public Health Law in State Fiscal Year 2019-2020 that experience a reduction in their distribution year Indigent Care Pool payments when compared to their 2019 ICP payments. The methodology to allocate this funding will be proportional to the reduction received by the facility. The proportionate allocation will be equal to each qualifying Enhanced Safety Net Hospital's percentage share of total ICP losses when compared to CY 2019 distributions for all qualifying Enhanced Safety Net Hospitals.

6. Voluntary UPL Payment Reductions. The distributions in this section will be reduced by the final payment amounts paid to the eligible voluntary general hospitals, excluding government general hospitals, made in accordance with the Voluntary Supplemental Inpatient and Outpatient Payments section.

7. DSH Payment Limits. The distributions in this section are subject to the provisions of the Disproportionate share limitations section. Should a facility's total payments exceed its DSH cap, the facility will receive the State share only of any ICP award in excess of the hospital specific DSH limit as set out in paragraph 9 (Reconciliation and Redistribution of Overpayments) below.

8. Financial Assistance Compliance Pool. For calendar years 2014 through ~~2025~~2029, an amount equivalent to one percent of total DSH funds will be segregated into the Financial Assistance Compliance Pool (FACP) and allocated to all hospitals which prior to December 31, 2015 demonstrate substantial compliance with §2807-k(5-d)(b)(iv) of the Public Health Law (New York State Financial Aid Law) as in effect on January 1, 2013. There will be separate pool amounts for major governmental and voluntary hospitals. The DSH funds in the FACP will be proportionately allocated to all compliant hospitals using the Indigent Care Methodology described in paragraph (a) of this section. Compliance will be on a pass/fail basis. When a hospital is deemed compliant, one hundred percent of its share of the FACP funds will be released; there will be no partial payment for partial compliance. Any unallocated funds resulting from hospitals being non-compliant will be proportionally reallocated to compliant hospitals in each respective group based on their relative share of the distributions calculated in paragraph (a).

TN #26-0023

Supersedes TN #23-0051

Approval Date

Effective Date April 1, 2026

Appendix II
2026 Title XIX State Plan
Second Quarter Amendment
Summary

SUMMARY
SPA #26-0023

This State Plan Amendment proposes to extend the Indigent Care Pool (ICP) Methodology through December 31, 2029, and continue the reductions included in previous budgets, including the following:

- \$150.0 million (gross) reduction in ICP payments to voluntary hospitals implemented in the FY 2021 Enacted Budget,
- Additional reduction of \$85.4 million (gross) in ICP payments to voluntary hospitals implemented in the FY 2024 Enacted Budget, and
- Discontinuing ICP payments for public general hospitals in New York City operated by New York City Health and Hospitals, which was implemented in the FY 2026 Enacted Budget and provides a total Global Cap savings of \$113.4 million (gross), or \$56.7 million State share.

Appendix III
2026 Title XIX State Plan
Second Quarter Amendment
Authorizing Provisions

SPA 26-0023

§15 of Part B of Chapter 57 of the Laws of 2026.

§ 15. Subdivision 5-d of section 2807-k of the public health law, as amended by section 1 of part E of chapter 57 of the laws of 2023, clause (A) of subparagraph (ii) of paragraph (b) as amended by section 2 of part D of chapter 57 of the laws of 2025, is amended to read as follows:

5-d. (a) Notwithstanding any inconsistent provision of this section, section twenty-eight hundred seven-w of this article or any other contrary provision of law, and subject to the availability of federal financial participation, for periods on and after January first, two thousand twenty, through ~~March~~ December thirty-first, two thousand ~~twenty-six~~ twenty-nine, all funds available for distribution pursuant to this section, except for funds distributed pursuant to paragraph (b) of subdivision five-b of this section, and all funds available for distribution pursuant to section twenty-eight hundred seven-w of this article, shall be reserved and set aside and distributed in accordance with the provisions of this subdivision.

(b) The commissioner shall promulgate regulations, and may promulgate emergency regulations, establishing methodologies for the distribution of funds as described in paragraph (a) of this subdivision and such regulations shall include, but not be limited to, the following:

(i) Such regulations shall establish methodologies for determining each facility's relative uncompensated care need amount based on uninsured inpatient and outpatient units of service from the cost reporting year two years prior to the distribution year, multiplied by the applicable medicaid rates in effect January first of the distribution year, as summed and adjusted by a statewide cost adjustment factor and reduced by the sum of all payment amounts collected from such uninsured patients, and as further adjusted by application of a nominal need computation that shall take into account each facility's medicaid inpatient share.

(ii) Annual distributions pursuant to such regulations for the two thousand twenty through two thousand ~~twenty-five~~ twenty-nine calendar years shall be in accord with the following:

(A) (1) one hundred thirty-nine million four hundred thousand dollars shall be distributed as Medicaid Disproportionate Share Hospital ("DSH") payments to major public general hospitals;

(2) for the calendar years two thousand twenty-five and thereafter, the total distributions to major public general hospitals shall be subject to an aggregate reduction of one hundred thirteen million four hundred thousand dollars annually, provided that general hospitals operated by the New York city health and hospitals corporation as established by chapter one thousand sixteen of the laws of nineteen hundred sixty-nine, as amended, shall not receive distributions pursuant to this subdivision; and

(B) nine hundred sixty-nine million nine hundred thousand dollars as Medicaid DSH payments to eligible general hospitals, other than major public general hospitals.

For the calendar years two thousand twenty through two thousand twenty-two, the total distributions to eligible general hospitals, other than major public general hospitals, shall be subject to an aggregate reduction of one hundred fifty million dollars annually, provided that eligible general hospitals, other than major public general hospitals, that qualify as enhanced safety net hospitals under section two thousand

eight hundred seven-c of this article shall not be subject to such reduction.

For the calendar years two thousand twenty-three through two thousand [~~twenty-five~~] twenty-nine, the total distributions to eligible general hospitals, other than major public general hospitals, shall be subject to an aggregate reduction of two hundred thirty-five million four hundred thousand dollars annually, provided that eligible general hospitals, other than major public general hospitals that qualify as enhanced safety net hospitals under section two thousand eight hundred seven-c of this article as of April first, two thousand twenty, shall not be subject to such reduction.

Such reductions shall be determined by a methodology to be established by the commissioner. Such methodologies may take into account the payor mix of each non-public general hospital, including the percentage of inpatient days paid by Medicaid.

(iii) For calendar years two thousand twenty through two thousand [~~twenty-five~~] twenty-nine, sixty-four million six hundred thousand dollars shall be distributed to eligible general hospitals, other than major public general hospitals, that experience a reduction in indigent care pool payments pursuant to this subdivision, and that qualify as enhanced safety net hospitals under section two thousand eight hundred seven-c of this article as of April first, two thousand twenty. Such distribution shall be established pursuant to regulations promulgated by the commissioner and shall be proportional to the reduction experienced by the facility.

(iv) Such regulations shall reserve one percent of the funds available for distribution in the two thousand fourteen and two thousand fifteen calendar years, and for calendar years thereafter, pursuant to this subdivision, subdivision fourteen-f of section twenty-eight hundred seven-c of this article, and sections two hundred eleven and two hundred twelve of chapter four hundred seventy-four of the laws of nineteen hundred ninety-six, in a "financial assistance compliance pool" and shall establish methodologies for the distribution of such pool funds to facilities based on their level of compliance, as determined by the commissioner, with the provisions of subdivision nine-a of this section.

(c) The commissioner shall annually report to the governor and the legislature on the distribution of funds under this subdivision including, but not limited to:

(i) the impact on safety net providers, including community providers, rural general hospitals and major public general hospitals;

(ii) the provision of indigent care by units of services and funds distributed by general hospitals; and

(iii) the extent to which access to care has been enhanced.

Appendix IV
2026 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 all services to comply with the 2026-2027 proposed executive budget. The following changes are proposed:

All Services

Effective on or after April 1, 2026, the Department of Health will adjust Medicaid rates statewide to reflect a 1.7% percent Targeted Inflationary Increase 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, Comprehensive Psychiatric Emergency Program, including Extended Observation Beds, Children and Family Treatment and Support Services, Health Home Plus, Psychiatric Residential Treatment Facilities for Children and Youth, OASAS Part 822 Outpatient Addiction Services, OASAS Part 818 Substance Use Disorder Residential Rehabilitation Services (freestanding), OASAS Part 816 Residential Medically Supervised Withdrawal and Stabilization Services (freestanding), OASAS Part 820 Residential Services, OASAS Part 817 Substance Use Disorder Residential Rehabilitation Services for Youth, Intermediate Care Facility (ICF/IDD), Day Treatment, Article 16 Clinic Services, Specialty Hospital, Independent Practitioner Services for Individual with Developmental Disabilities (IPSIDD), and OPWDD Crisis Services.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative is \$24.9 million.

Non-Institutional Services

Effective on or after April 1, 2026, the Department of Health will adjust Medicaid rates statewide to account for increased labor costs resulting from statutorily required increases in New York State minimum wage for the following Office of Mental Health (OMH) State

Plan Services: OMH Outpatient Services, OMH Clinic Services, and OMH Rehabilitative Services.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative is \$85,000.

Effective on or after April 1, 2026, the State will invest up to \$60 million in diagnostic and treatment centers, including Federally Qualified Health Centers and Rural Health Clinics, licensed under Article 28 of the Public Health Law, by an aggregate amount up to \$60 million per year.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative is up to \$60 million.

Effective on April 1, 2026, for the 2026 rate year and thereafter, the reimbursement methodology for personal care services will be revised. Personal care direct services rates will be based on reported allowable costs not to exceed, or fall below, one standard deviation of the mean for the applicable geographic group. The administrative portion of the rate will not exceed 15 percent of the total rate. Providers' payments for nursing services will be a fee.

The estimated annual net aggregate decrease in gross Medicaid expenditures attributable to this initiative is (\$15 million).

Effective on or after April 1, 2026 through March 31, 2027, the State will invest up to \$1.5 billion in hospital outpatient services when combined with investments in hospital inpatient and residential health care facility services. The State will invest up to \$1.0 billion, collectively, in each state fiscal year thereafter.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative is up to \$1.5 billion.

Effective on or after April 1, 2026, the State will provide Medicaid reimbursement to freestanding birth centers, including midwifery birth centers and birth centers licensed as diagnostic and treatment centers. The Ambulatory Patient Group (APG) payment methodology will be utilized to reimburse services provided in freestanding birth centers. A separate payment will also be made to the healthcare professionals providing services in freestanding birth centers.

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

Institutional Services

Effective on or after April 1, 2026, this proposal continues the indigent care pool payments made to general hospitals, subject to all provisions of PHL 2807-k.

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

Effective on or after April 1, 2026, the proposed amendment to the State Plan will allow Title XIX (Medicaid) reimbursement to general hospitals, as defined in Subdivision 10 of Section 2801 of the Public Health Law, for provision of inpatient acute care that is provided off-site, pursuant to the conditions set forth in proposed Subdivision 15 of Section 2803 of the Public Health Law (see Proposed Executive Budget, Health and Mental Hygiene, Part K, Section 6). Reimbursement rates will match those provided for inpatient acute care services provided on-site in licensed general hospital settings.

Under the proposed law, the Commissioner of Health of the State of New York may allow general hospitals to provide off-site acute care medical services that are (a) not home care services or professional services as defined in Subdivisions 1 and 2 of Section 3602 of the

Public Health Law; (b) provided by a medical professional, including a physician, registered nurse, nurse practitioner, or physician assistant, to a patient with a preexisting clinical relationship with the general hospital or with the health care professional providing the service; and (c) provided to a patient for whom a medical professional has determined is appropriate to receive acute medical services at their residence. To participate, the general hospital must also have appropriate discharge planning in place to coordinate discharge to a home care agency where medically necessary and consented to by the patient after the patient's acute care episode ends, consistent with all applicable federal, state, and local laws.

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

Effective on or after April 1, 2026 through March 31, 2027, the State will invest up to \$1.5 billion in hospital inpatient services when combined with investments in hospital outpatient and residential health care facility services. The State will invest up to \$1.0 billion, collectively, in each state fiscal year thereafter.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative is up to \$1.5 billion.

Long Term Care

Effective on or after April 1, 2026, this proposal would end-date the previously enacted 10% reduction to nursing home capital reimbursement. The 10% reduction will not continue going forward.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative is \$58 million.

Effective on or after April 1, 2026 through March 31, 2027, the State will invest up to \$1.5 billion in residential health care facility services when combined with investments in hospital inpatient and hospital outpatient services. The State will invest up to \$1.0 billion, collectively, in each state fiscal year thereafter.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative is up to \$1.5 billion.

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, spa-inquiries@health.ny.gov

PUBLIC NOTICE

New York City Deferred Compensation Plan

The New York City Deferred Compensation Plan (the "Plan") is seeking qualified vendors to provide US small-cap equity core investment management services for the Small Cap Equity Fund ("the Fund") investment option of the Plan. The objective of the Fund is to provide long term growth of capital by investing primarily in the stocks of smaller rapidly growing companies. To be considered, vendors must submit their product information to Segal Marco Advisors at the following e-mail address: nycdcp.procurement@segalmarco.com. Please complete the submission of product information no later than 4:30 P.M. Eastern Time on April 2, 2026.

Consistent with the policies expressed by the City, proposals from certified minority-owned and/or women-owned businesses or proposals that include partnering arrangements with certified minority-owned and/or women-owned firms are encouraged. Additionally, proposals from small and New York City-based businesses are also encouraged.

PUBLIC NOTICE

New York City Deferred Compensation Plan

The New York City Deferred Compensation Plan (the "Plan") is seeking qualified vendors to provide liquidity support services, including maintenance of daily liquidity, for the Stable Income Fund ("the Fund") investment option of the Plan. The objective of the Fund is to provide an opportunity to invest in high quality fixed income securities with an emphasis on safety of principal and consistency of returns. To be considered, vendors must submit their product information to Segal Marco Advisors at the following e-mail address: nycdcp.procurement@segalmarco.com. Please complete the submission of product information no later than 4:30 P.M. Eastern Time on April 2, 2026.

Consistent with the policies expressed by the City, proposals from certified minority-owned and/or women-owned businesses or proposals that include partnering arrangements with certified minority-owned and/or women-owned firms are encouraged. Additionally, proposals from small and New York City-based businesses are also encouraged.

PUBLIC NOTICE

Department of State

F-2026-0002

Date of Issuance – March 25, 2026

The New York State Department of State (DOS) is required by Federal regulations to provide timely public notice for the activities described below, which are subject to the consistency provisions of the Federal Coastal Zone Management Act of 1972, as amended.

The applicant has certified that the proposed activity complies with and will be conducted in a manner consistent with the approved New York State Coastal Management Program.

In F-2026-0002, the applicant, Joseph Milito, PHH Bank, is proposing to install an approx. 200' long rock revetment along the toe of the bluff, including 10' and 12' returns, and place erosion control matting with approx. 1,400 cubic yards of clean sand backfill to be planted with indigenous species to revegetate the bluff face. This project is located at 10 Richards Path, Village of St. James, Suffolk County, Long Island Sound.

The applicant's consistency certification and supporting information are available for review at:

<https://dos.ny.gov/f-2026-0002> or at <https://dos.ny.gov/public-notices>

The proposed activity would be located within or has the potential to affect the following Special Management or Regulated Area(s):

- Town of Smithtown Local Waterfront Revitalization Program:
<https://dos.ny.gov/location/town-smithtown-local-waterfront-revitalization-program>
- Villages of Head of the Harbor and Nissequogue Local Waterfront Revitalization Program:

Appendix V
2026 Title XIX State Plan
Second Quarter Amendment
Responses to Standard Funding Questions

INSTITUTIONAL SERVICES
State Plan Amendment #26-0023

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.

		4/1/26 – 3/31/27	
Payment Type	Non-Federal Share Funding	Non-Federal	Gross
Hospital Inpatient Normal Per Diem	General Fund; Special Revenue Funds; County Contribution	\$2,624B	\$5,249B
Residential Treatment Facilities Normal Per Diem	General Fund; County Contribution	\$41M	\$81M
Indigent Care Pool	General Fund; Special Revenue Funds	\$413M	\$825M
Indigent Care Pool Adjustment	General Fund; IGT	\$348M	\$697M
Disproportionate Share Program	General Fund; IGT	\$398M	\$795M
State Public Inpatient UPL	General Fund	\$41M	\$82M
Non-State Government Inpatient UPL	IGT	\$306M	\$612M
Totals		\$4,170B	\$8,341B

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 percent 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	\$5.378B
Suffolk County	\$256M
Nassau County	\$241M
Westchester County	\$223M
Erie County	\$216M

Rest of State (53 Counties)	\$1.320B
Total	\$7.634B

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	4/1/26-3/31/27 IGT Amount
Bellevue Hospital Center	New York City	\$98M
Coney Island Hospital	New York City	\$32M
City Hospital Center at Elmhurst	New York City	\$20M
Harlem Hospital Center	New York City	\$51M
Henry J Carter Spec Hospital	New York City	\$1M
Jacobi Medical Center	New York City	\$38M
Kings County Hospital Center	New York City	\$72M
Lincoln Medical & Mental Health Center	New York City	\$32M
Metropolitan Hospital Center	New York City	\$30M
North Central Bronx Hospital	New York City	\$0M
Queens Hospital Center	New York City	\$18M
Woodhull Medical and Mental Health Center	New York City	\$61M
Erie County Medical Center	Erie County	\$64M
Lewis County General Hospital	Lewis County	\$3M
Nassau County Medical Center	Nassau County	\$50M
Westchester County Medical Center	Westchester County	\$161M
Wyoming County Community Hospital	Wyoming County	\$0M
NYC Health + Hospitals	New York City	\$20M
Total		\$749M

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	4/1/26-3/31/27 Gross Total
Indigent Care Pool/Voluntary UPL \$339M Guarantee	\$656M	\$9M	\$159M	\$825M
Indigent Care Pool Adjustment	\$0M	\$145M	\$552M	\$697M
Disproportionate Share Program	\$0M	\$772M	\$23M	\$795M
Vital Access Program	\$11M	\$0M	\$0M	\$11M
State Public Inpatient UPL	\$0M	\$0M	\$0M	\$0M
Non-State Government Inpatient UPL	\$0M	\$0M	\$612M	\$612M
Total	\$667M	\$927M	\$1,346B	\$2,940B

The Medicaid payments authorized under this State Plan Amendment are supplemental payments and total \$825.1 million for State Fiscal Year 2026-27.

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 Medicaid payments authorized under this State Plan Amendment do not impact the UPL demonstrations.

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.