



Department of Health

KATHY HOCHUL
Governor

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

KRISTIN M. PROUD
Acting Executive Deputy Commissioner

June 30, 2022

Todd McMillion
Director
Department of Health and Human Services
Centers for Medicare and Medicaid Services
233 North Michigan Ave, Suite 600
Chicago, IL 60601

RE: SPA #22-0049
Long Term Care Facility Services

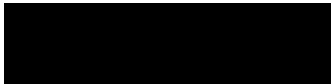
Dear Mr. McMillion:

The State requests approval of the enclosed amendment #22-0049 to the Title XIX (Medicaid) State Plan for long term care facility services to be effective April 1, 2022 (Appendix I). This amendment is being submitted based on enacted legislation. A summary of the proposed amendment is provided 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, Part 447, Subpart C, (42 CFR § 447).

A copy of the pertinent section of enacted legislation is enclosed for your information (Appendix III). A copy of the public notice of this proposed amendment, which was given in the New York State Register on March 30, 2022, is also enclosed for your information (Appendix IV). 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.


Amir Bassiri
Acting Medicaid Director
Office of Health Insurance Programs

Enclosures

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

1. TRANSMITTAL NUMBER

2. STATE

3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT

XIX

XXI

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

4. PROPOSED EFFECTIVE DATE

5. FEDERAL STATUTE/REGULATION CITATION

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)

a. FFY _____ \$ _____

b. FFY _____ \$ _____

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable)

9. SUBJECT OF AMENDMENT

10. GOVERNOR'S REVIEW (Check One)

GOVERNOR'S OFFICE REPORTED NO COMMENT
COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

OTHER, AS SPECIFIED:

11. SIGNATURE OF STATE AGENCY OFFICIAL

[REDACTED]

15. RETURN TO

12. TYPED NAME

13. TITLE

14. DATE SUBMITTED

June 30, 2022

FOR CMS USE ONLY

16. DATE RECEIVED

17. DATE APPROVED

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL

19. SIGNATURE OF APPROVING OFFICIAL

20. TYPED NAME OF APPROVING OFFICIAL

21. TITLE OF APPROVING OFFICIAL

22. REMARKS

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

**New York
47(aa)(9.1)**

Reserved

[Nursing Homes (Continued)]:

Provider Name	Gross Medicaid Rate Adjustment	Rate Period Effective
Schulman and Schachne Institute for Nursing and Rehabilitation*	\$1,852,978	01/01/2015 – 03/31/2015
	\$1,877,938	04/01/2015 – 03/31/2016
	\$1,873,785	04/01/2016 – 03/31/2017
	\$1,225,719	04/01/2020 – 03/31/2021
	\$1,225,719	04/01/2021 – 03/31/2022
	(\$14,577)	10/01/2021 – 03/31/2022
Silvercrest*	\$1,293,304	01/01/2015 – 03/31/2015
	\$1,310,725	04/01/2015 – 03/31/2016
	\$1,307,827	04/01/2016 – 03/31/2017
	\$833,785	04/01/2020 – 03/31/2021
	\$833,785	04/01/2021 – 03/31/2022
	(\$11,670)	10/01/2021 – 03/31/2022
St Cabrini Nursing Home*	\$748,048	04/01/2020 – 03/31/2021
	\$748,048	04/01/2021 – 03/31/2022
	\$10,327	10/01/2021 – 03/31/2022
St Johnland Nursing Center*	\$400,000	04/01/2020 – 03/31/2021
	\$400,000	04/01/2021 – 03/31/2022
	\$120,596	10/01/2021 – 03/31/2022
St. Mary's Hospital for Children Inc.*	\$1,777,136	01/01/2015 – 03/31/2015
	\$1,795,679	04/01/2015 – 03/31/2016
	\$1,792,470	04/01/2016 – 03/31/2017
	\$1,053,645	04/01/2020 – 03/31/2021
	\$1,053,645	04/01/2021 – 03/31/2022
	(\$9,241)	10/01/2021 – 03/31/2022
St. Patrick's Home	\$920,596	10/01/2021 – 03/31/2022
St Vincent Depaul Residence*	\$417,641	01/01/2015 – 03/31/2015
	\$423,266	04/01/2015 – 03/31/2016
	\$422,330	04/01/2016 – 03/31/2017
	\$276,263	04/01/2020 – 03/31/2021
	\$276,263	04/01/2021 – 03/31/2022
	\$72,414	10/01/2021 – 03/31/2022]

*Denotes provider is part of CINERGY Collaborative.]

TN #22-0049 Approval Date _____
 Supersedes TN #21-0059 Effective Date April 1, 2022

**New York
47(aa)(9.2)**

1905(4)(a): Nursing Facility Services
Nursing Homes (Continued):

<u>Provider Name</u>	<u>Gross Medicaid Rate Adjustment</u>	<u>Rate Period Effective</u>
<u>Schulman and Schachne Institute for Nursing and Rehabilitation*</u>	<u>\$1,852,978</u>	<u>01/01/2015 – 03/31/2015</u>
	<u>\$1,877,938</u>	<u>04/01/2015 – 03/31/2016</u>
	<u>\$1,873,785</u>	<u>04/01/2016 – 03/31/2017</u>
	<u>\$1,225,719</u>	<u>04/01/2020 – 03/31/2021</u>
	<u>\$1,225,719</u>	<u>04/01/2021 – 03/31/2022</u>
	<u>(\$14,577)</u>	<u>10/01/2021 – 03/31/2022</u>
	<u>\$1,204,270</u>	<u>04/01/2022 – 03/31/2023</u>
<u>Silvercrest*</u>	<u>\$1,293,304</u>	<u>01/01/2015 – 03/31/2015</u>
	<u>\$1,310,725</u>	<u>04/01/2015 – 03/31/2016</u>
	<u>\$1,307,827</u>	<u>04/01/2016 – 03/31/2017</u>
	<u>\$833,785</u>	<u>04/01/2020 – 03/31/2021</u>
	<u>\$833,785</u>	<u>04/01/2021 – 03/31/2022</u>
	<u>(\$11,670)</u>	<u>10/01/2021 – 03/31/2022</u>
	<u>\$798,351</u>	<u>04/01/2022 – 03/31/2023</u>
<u>St Cabrini Nursing Home*</u>	<u>\$748,048</u>	<u>04/01/2020 – 03/31/2021</u>
	<u>\$748,048</u>	<u>04/01/2021 – 03/31/2022</u>
	<u>\$10,327</u>	<u>10/01/2021 – 03/31/2022</u>
	<u>\$788,645</u>	<u>04/01/2022 – 03/31/2023</u>

*Denotes provider is part of CINERGY Collaborative.

TN #22-0049 Approval Date _____
Supersedes TN #NEW Effective Date April 1, 2022

**New York
47(aa)(9.3)**

1905(4)(a): Nursing Facility Services
Nursing Homes (Continued):

<u>Provider Name</u>	<u>Gross Medicaid Rate Adjustment</u>	<u>Rate Period Effective</u>
<u>St Johnland Nursing Center*</u>	<u>\$400,000</u>	<u>04/01/2020 – 03/31/2021</u>
	<u>\$400,000</u>	<u>04/01/2021 – 03/31/2022</u>
	<u>\$120,596</u>	<u>10/01/2021 – 03/31/2022</u>
	<u>\$495,826</u>	<u>04/01/2022 – 03/31/2023</u>
<u>St. Mary's Hospital for Children Inc.*</u>	<u>\$1,777,136</u>	<u>01/01/2015 – 03/31/2015</u>
	<u>\$1,795,679</u>	<u>04/01/2015 – 03/31/2016</u>
	<u>\$1,792,470</u>	<u>04/01/2016 – 03/31/2017</u>
	<u>\$1,053,645</u>	<u>04/01/2020 – 03/31/2021</u>
	<u>\$1,053,645</u>	<u>04/01/2021 – 03/31/2022</u>
	<u>(\$9,241)</u>	<u>10/01/2021 – 03/31/2022</u>
	<u>\$1,052,354</u>	<u>04/01/2022 – 03/31/2023</u>
<u>St. Patrick's Home*</u>	<u>\$920,596</u>	<u>10/01/2021 – 03/31/2022</u>
	<u>\$486,674</u>	<u>04/01/2022 – 03/31/2023</u>
<u>St Vincent Depaul Residence*</u>	<u>\$417,641</u>	<u>01/01/2015 – 03/31/2015</u>
	<u>\$423,266</u>	<u>04/01/2015 – 03/31/2016</u>
	<u>\$422,330</u>	<u>04/01/2016 – 03/31/2017</u>
	<u>\$276,263</u>	<u>04/01/2020 – 03/31/2021</u>
	<u>\$276,263</u>	<u>04/01/2021 – 03/31/2022</u>
	<u>\$72,414</u>	<u>10/01/2021 – 03/31/2022</u>
	<u>\$336,588</u>	<u>04/01/2022 – 03/31/2023</u>

*Denotes provider is part of CINERGY Collaborative.

TN #22-0049 Approval Date _____
Supersedes TN #NEW Effective Date April 1, 2022

Appendix II
2022 Title XIX State Plan
Second Quarter Amendment
Summary

SUMMARY
SPA #22-0049

This State Plan Amendment proposes to provide temporary rate adjustments to long term care providers that are undergoing closure, merger, consolidation, acquisition or restructuring themselves or other health care providers. These payments are authorized by current State statutory and regulatory provisions.

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

Public Health Law

§ 2826. Temporary adjustment to reimbursement rates. (a) Notwithstanding any provision of law to the contrary, within funds appropriated and subject to the availability of federal financial participation, the commissioner may grant approval of a temporary adjustment to the non-capital components of rates, or make temporary lump-sum Medicaid payments, to eligible general hospitals, skilled nursing facilities, clinics and home care providers, provided however, that should federal financial participation not be available for any eligible provider, then payments pursuant to this subdivision may be made as grants and shall not be deemed to be medical assistance payments.

(b) Eligible providers shall include:

(i) providers undergoing closure;

(ii) providers impacted by the closure of other health care providers;

(iii) providers subject to mergers, acquisitions, consolidations or restructuring; or

(iv) providers impacted by the merger, acquisition, consolidation or restructuring of other health care providers.

(c) Providers seeking temporary rate adjustments under this section shall demonstrate through submission of a written proposal to the commissioner that the additional resources provided by a temporary rate adjustment will achieve one or more of the following:

(i) protect or enhance access to care;

(ii) protect or enhance quality of care;

(iii) improve the cost effectiveness of the delivery of health care services; or

(iv) otherwise protect or enhance the health care delivery system, as determined by the commissioner.

(c-1) The commissioner, under applications submitted to the department pursuant to subdivision (d) of this section, shall consider criteria that includes, but is not limited to:

(i) Such applicant's financial condition as evidenced by operating margins, negative fund balance or negative equity position;

(ii) The extent to which such applicant fulfills or will fulfill an unmet health care need for acute inpatient, outpatient, primary or residential health care services in a community;

(iii) The extent to which such application will involve savings to the Medicaid program;

(iv) The quality of the application as evidenced by such application's long term solutions for such applicant to achieve sustainable health care services, improving the quality of patient care, and/or transforming the delivery of health care services to meet community needs;

(v) The extent to which such applicant is geographically isolated in relation to other providers; or

(vi) The extent to which such applicant provides services to an underserved area in relation to other providers.

(d) (i) Such written proposal shall be submitted to the commissioner at least sixty days prior to the requested effective date of the temporary rate adjustment, and shall include a proposed budget to achieve the goals of the proposal. Any Medicaid payment issued pursuant to this section shall be in effect for a specified period of time as determined by the commissioner, of up to three years. At the end of the specified timeframe such payments or adjustments to the non-capital

component of rates shall cease, and the provider shall be reimbursed in accordance with the otherwise applicable rate-setting methodology as set forth in applicable statutes and regulations. The commissioner may establish, as a condition of receiving such temporary rate adjustments or grants, benchmarks and goals to be achieved in conformity with the provider's written proposal as approved by the commissioner and may also require that the facility submit such periodic reports concerning the achievement of such benchmarks and goals as the commissioner deems necessary. Failure to achieve satisfactory progress, as determined by the commissioner, in accomplishing such benchmarks and goals shall be a basis for ending the facility's temporary rate adjustment or grant prior to the end of the specified timeframe. (ii) The commissioner may require that applications submitted pursuant to this section be submitted in response to and in accordance with a Request For Applications or a Request For Proposals issued by the commissioner.

(e) Notwithstanding any law to the contrary, general hospitals defined as critical access hospitals pursuant to title XVIII of the federal social security act shall be allocated no less than seven million five hundred thousand dollars annually pursuant to this section. The department of health shall provide a report to the governor and legislature no later than June first, two thousand fifteen providing recommendations on how to ensure the financial stability of, and preserve patient access to, critical access hospitals, including an examination of permanent Medicaid rate methodology changes.

(e-1) Thirty days prior to executing an allocation or modification to an allocation made pursuant to this section, the commissioner shall provide written notice to the chair of the senate finance committee and the chair of the assembly ways and means committee with regards to the intent to distribute such funds. Such notice shall include, but not be limited to, information on the methodology used to distribute the funds, the facility specific allocations of the funds, any facility specific project descriptions or requirements for receiving such funds, the multi-year impacts of these allocations, and the availability of federal matching funds. The commissioner shall provide quarterly reports to the chair of the senate finance committee and the chair of the assembly ways and means committee on the distribution and disbursement of such funds. Within sixty days of the effectiveness of this subdivision, the commissioner shall provide a written report to the chair of the senate finance committee and the chair of the assembly ways and means committee on all awards made pursuant to this section prior to the effectiveness of this subdivision, including all information that is required to be included in the notice requirements of this subdivision.

(f) Notwithstanding any provision of law to the contrary, and subject to federal financial participation, no less than ten million dollars shall be allocated to providers described in this subdivision; provided, however that if federal financial participation is unavailable for any eligible provider, or for any potential investment under this subdivision then the non-federal share of payments pursuant to this subdivision may be made as state grants.

(i) Providers serving rural areas as such term is defined in section two thousand nine hundred fifty-one of this chapter, including but not limited to hospitals, residential health care facilities, diagnostic and treatment centers, ambulatory surgery centers and clinics shall be eligible for enhanced payments or reimbursement under a supplemental rate methodology for the purpose of promoting access and improving the quality of care.

(ii) Notwithstanding any provision of law to the contrary, and subject

to federal financial participation, essential community providers, which, for the purposes of this section, shall mean a provider that offers health services within a defined and isolated geographic region where such services would otherwise be unavailable to the population of such region, shall be eligible for enhanced payments or reimbursement under a supplemental rate methodology for the purpose of promoting access and improving quality of care. Eligible providers under this paragraph may include, but are not limited to, hospitals, residential health care facilities, diagnostic and treatment centers, ambulatory surgery centers and clinics.

(iii) In making such payments the commissioner may contemplate the extent to which any such provider receives assistance under subdivision (a) of this section and may require such provider to submit a written proposal demonstrating that the need for monies under this subdivision exceeds monies otherwise distributed pursuant to this section.

(iv) Payments under this subdivision may include, but not be limited to, temporary rate adjustments, lump sum Medicaid payments, supplemental rate methodologies and any other payments as determined by the commissioner.

(v) Payments under this subdivision shall be subject to approval by the director of the budget.

(vi) The commissioner may promulgate regulations to effectuate the provisions of this subdivision.

(vii) Thirty days prior to adopting or applying a methodology or procedure for making an allocation or modification to an allocation made pursuant to this subdivision, the commissioner shall provide written notice to the chairs of the senate finance committee, the assembly ways and means committee, and the senate and assembly health committees with regard to the intent to adopt or apply the methodology or procedure, including a detailed explanation of the methodology or procedure.

(viii) Thirty days prior to executing an allocation or modification to an allocation made pursuant to this subdivision, the commissioner shall provide written notice to the chairs of the senate finance committee, the assembly ways and means committee, and the senate and assembly health committees with regard to the intent to distribute such funds. Such notice shall include, but not be limited to, information on the methodology used to distribute the funds, the facility specific allocations of the funds, any facility specific project descriptions or requirements for receiving such funds, the multi-year impacts of these allocations, and the availability of federal matching funds. The commissioner shall provide quarterly reports to the chair of the senate finance committee and the chair of the assembly ways and means committee on the distribution and disbursement of such funds.

(g) Notwithstanding subdivision (a) of this section, and within amounts appropriated for such purposes as described herein, for the period of April first, two thousand fifteen through March thirty-first, two thousand sixteen, the commissioner may award a temporary adjustment to the non-capital components of rates, or make temporary lump-sum Medicaid payments to eligible general hospitals in severe financial distress to enable such facilities to maintain operations and vital services while such facilities establish long term solutions to achieve sustainable health services.

(i) Eligible general hospitals shall include:

(A) a public hospital, which for purposes of this subdivision, shall mean a general hospital operated by a county or municipality, but shall exclude any such hospital operated by a public benefit corporation;

(B) a federally designated critical access hospital;

(C) a federally designated sole community hospital; or

(D) a general hospital that is a safety net hospital, which for purposes of this subdivision shall mean:

(1) such hospital has at least thirty percent of its inpatient discharges made up of Medicaid eligible individuals, uninsured individuals or Medicaid dually eligible individuals and with at least thirty-five percent of its outpatient visits made up of Medicaid eligible individuals, uninsured individuals or Medicaid dually-eligible individuals; or

(2) such hospital serves at least thirty percent of the residents of a county or a multi-county area who are Medicaid eligible individuals, uninsured individuals or Medicaid dually-eligible individuals.

(ii) Eligible applicants must demonstrate that without such award, they will be in severe financial distress through March thirty-first, two thousand sixteen, as evidenced by:

(A) certification that such applicant has less than fifteen days cash and equivalents;

(B) such applicant has no assets that can be monetized other than those vital to operations; and

(C) such applicant has exhausted all efforts to obtain resources from corporate parents and affiliated entities to sustain operations.

(iii) Awards under this subdivision shall be made upon application to the department.

(A) Applications under this subdivision shall include a multi-year transformation plan that is aligned with the delivery system reform incentive payment ("DSRIP") program goals and objectives. Such plan shall be approved by the department and shall demonstrate a path towards long term sustainability and improved patient care.

(B) The department may authorize initial award payments to eligible applicants based solely on the criteria pursuant to paragraphs (i) and (ii) of this subdivision.

(C) Notwithstanding subparagraph (B) of this paragraph, the department may suspend or repeal an award if an eligible applicant fails to submit a multi-year transformation plan pursuant to subparagraph (A) of this paragraph that is acceptable to the department by no later than the thirtieth day of September two thousand fifteen.

(D) Applicants under this subdivision shall detail the extent to which the affected community has been engaged and consulted on potential projects of such application, as well as any outreach to stakeholders and health plans.

(E) The department shall review all applications under this subdivision, and determine:

(1) applicant eligibility;

(2) each applicant's projected financial status;

(3) each applicant's proposed use of funds to maintain critical services needed by its community; and

(4) the anticipated impact of the loss of such services.

(F) After review of all applications under this subdivision, and a determination of the aggregate amount of requested funds, the department shall make awards to eligible applicants; provided, however, that such awards may be in an amount lower than such requested funding, on a per applicant or aggregate basis.

(iv) Awards under this subdivision may not be used for:

(A) capital expenditures, including, but not limited to: construction, renovation and acquisition of capital equipment, including major medical equipment;

(B) consultant fees;

(C) retirement of long term debt; or

(D) bankruptcy-related costs.

(v) Payments made to awardees pursuant to this subdivision shall be made on a monthly basis. Such payments will be based on the applicant's actual monthly financial performance during such period and the reasonable cash amount necessary to sustain operations for the following month. The applicant's monthly financial performance shall be measured by such applicant's monthly financial and activity reports, which shall include, but not be limited to, actual revenue and expenses for the prior month, projected cash need for the current month, and projected cash need for the following month.

(vi) The department shall provide a report on a quarterly basis to the chairs of the senate finance, assembly ways and means, senate health and assembly health committees. Such reports shall be submitted no later than sixty days after the close of the quarter, and shall include for each award, the name of the applicant, the amount of the award, payments to date, and a description of the status of the multi-year transformation plan pursuant to paragraph (iii) of this subdivision.

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

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

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

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

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

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

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

Institutional Services

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Long Term Care Services

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

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

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

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

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

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

Eligibility

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

The estimated net aggregate increase in gross Medicaid expenditures as a result of the proposed amendment for State Fiscal Year 2023 is \$10 million.

The public is invited to review and comment on this proposed State Plan Amendment, a copy of which will be available for public review on the Department's website at http://www.health.ny.gov/regulations/state_plans/status. In addition, approved SPA's beginning in 2011 are also available for viewing on this website.

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

Appendix VI
2022 Title XIX State Plan
Second Quarter Amendment
Responses to Standard Access Questions

LONG-TERM SERVICES
State Plan Amendment #22-0049

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-D 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 payments, a complete listing of providers that return a portion of their payments, the amount or percentage of payments that are returned and the disposition and use of the funds once they are returned to the State (i.e., general fund, medical services account, etc.).**

Response: Providers do receive and retain the total Medicaid expenditures claimed by the State and the State does not require any provider to return any portion of such payments to the State, local government entities, or any other intermediary organization.

- 2. Section 1902(a)(2) provides that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan. Please describe how the state share of each type of Medicaid payment (normal per diem, supplemental, enhanced, other) is funded. Please describe whether the state share is from appropriations from the legislature to the Medicaid agency, through intergovernmental transfer agreements (IGTs), certified public expenditures (CPEs), provider taxes, or any other mechanism used by the state to provide state share. Note that, if the appropriation is not to the Medicaid agency, the source of the state share would necessarily be derived through either through 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 governmental entity transferring the funds. If CPEs are used, please describe the methodology used by the state to verify that the total expenditures being certified are eligible for Federal matching funds in accordance with 42 CFR 433.51(b). For any payment funded by CPEs or IGTs, please provide the following:**

- (i) a complete list of the names of entities transferring or certifying funds;
- (ii) the operational nature of the entity (state, county, city, other);
- (iii) the total amounts transferred or certified by each entity;
- (iv) clarify whether the certifying or transferring entity has general taxing authority: and,
- (v) whether the certifying or transferring entity received appropriations (identify level of appropriations).

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

		4/1/22 – 3/31/23	
Payment Type	Non-Federal Share Funding	Non-Federal	Gross
Supplemental	General Fund; Special Revenue Funds	\$15,000,000	\$30,000,000

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

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

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

2) Special Revenue Funds:

- a. Health Care Reform Act (HCRA) Resource Fund: as authorized in section 92-dd of New York State Finance Law and was established in 1996, pursuant to New York State Public Health Law 2807-j. HCRA resources include health care related surcharges, assessments on hospital revenues, and a "covered lives" assessment paid by insurance carriers pursuant to chapter 820 of the laws of 2021.
- b. Health Facility Cash Assessment Program (HFCAP) Fund: HFCAP requires New York State designated providers to pay an assessment on cash operating receipts on a monthly basis. The assessment includes Article 28

Residential Health Care Facilities, Article 28 General Hospitals, Article 36 Long Term Home Health Care Programs, Article 36 Certified Home Health Agencies and Personal Care Providers that possess a Title XIX (i.e. Medicaid) contract with a Local Social Services District for the delivery of personal care services pursuant to Section 367-i of the New York State Social Services Law.

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

- 3. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan. If supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to each provider type.**

Response: The Medicaid payments authorized under this State Plan Amendment are supplemental payments and total \$30 million for State Fiscal Year 2022-23.

- 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 nursing home UPL calculation is a payment-to-payment calculation for state government and private facilities. Non-state Governmental facilities undergo a payment-to-cost calculation. The State is in the process of completing the 2022 nursing home UPL as well as the Procedural Manual which describes the methodology for eligible providers and will be submitting both documents to CMS.

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

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

ACA Assurances:

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

MOE Period.

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

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

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

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

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

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

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

Tribal Assurance:

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

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

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

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