NEW YORK STATE OF OPPORTUNITY. Department of Health

KATHY HOCHUL
Governor

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

MEGAN E. BALDWIN
Acting Executive Deputy Commissioner

June 29, 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 #23-0063
Long Term Care Facility Services

Dear Mr. McMillion:

The State requests approval of the enclosed amendment #23-0063 to the Title XIX (Medicaid) State Plan for long term care facility services to be effective April 1, 2023 (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 29, 2023, 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.

Sincerely,

[redacted]

Amir Bassiri
Medicaid Director
Office of Health Insurance Programs

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

# TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

**FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES**

1. TRANSMITTAL NUMBER: 23-0063

2. STATE: NY

3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT: (●) XIX ( ) XXI

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

4. PROPOSED EFFECTIVE DATE
April 1, 2023

5. FEDERAL STATUTE/REGULATION CITATION
§ 1905(a)(4)(A) Nursing Facility Services

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 04/01/23-09/30/23 $ 125,000,000
b. FFY 10/01/23-03/31/24 $ 125,000,000

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.19-D Part I: Page 47(x)(2)(b)

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 4.19-D Part I: Page 47(x)(2)(b)

9. SUBJECT OF AMENDMENT
2023 Nursing Home UPL

*10.* GOVERNOR'S REVIEW *(Check One)*
(●) GOVERNOR'S OFFICE REPORTED NO COMMENT
( ) COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
( ) NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
( ) OTHER, AS SPECIFIED:

11. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

12. TYPED NAME
Amir Bassiri

13. TITLE
Medicaid Director

14. DATE SUBMITTED
June 29, 2023

15. RETURN TO
New York State Department of Health
Division of Finance and Rate Setting
99 Washington Ave – One Commerce Plaza
Suite 1432
Albany, NY 12210

***FOR CMS USE ONLY***

16. DATE RECEIVED

17. DATE APPROVED

***PLAN APPROVED - ONE COPY ATTACHED***

18. EFFECTIVE DATE OF APPROVED MATERIAL

19. SIGNATURE OF APPROVING OFFICIAL

20. TYPED NAME OF APPROVING OFFICIAL

21. TITLE OF APPROVING OFFICIAL

22. REMARKS



***Instructions on Back***

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

**New York**
**47(x)(2)(b)**

**1905(a)(4)(A) Nursing Facility Services**

For the period April 1, 1997, through March 31, 1999, proportionate share payments in an annual aggregate amount of $631.1 million will be made under the medical assistance program to non-state public operated residential health care facilities, excluding public residential health care facilities operated by a town or city within a county. For the period April 1, 1999, through March 31, 2000, proportionate share payments in an annual aggregate amount of $982 million will be made under the medical assistance program to non-state operated public residential health care facilities, excluding public residential health care facilities operated by a town or city within a county. For annual state fiscal year periods commencing April 1, 2000 and ending March 31, 2005, and April 1, 2005, through March 31, 2009, proportionate share payments in an annual aggregate amount of up to $991.5 million and $150.0 million, respectively, for state fiscal year April 1, 2009 through March 31, 2010, $167 million, and for state fiscals years commencing April 1, 2010 through March 31, 2011, $189 million in an annual aggregate amount , and for the period April 1, 2011 through March 31, 2012 an aggregate amount of $172.5 million and for state fiscal years commencing April 1, 2012 through March 31, 2013, an aggregate amount of $293,147,494, and for the period April 1, 2013 through March 31, 2014, $246,522,355, and for the period April 1, 2014 through March 31, 2015, $305,254,832, and for the period April 1, 2015 through March 31, 2016, $255,208,911, for the period April 1, 2016 through March 31, 2017, $198,758,133 in an annual aggregate amount, and for the period April 1, 2017 through March 31, 2018, the aggregate amount of $167,600,071, will be paid semi-annually in September and March, and for the period April 1, 2018 through March 31, 2019, the aggregate amount of $225,104,113, will be paid semi-annually in September and March, and for the period April 1, 2019 through March 31, 2020, the aggregate amount of $196,055,358 will be paid semi-annually in September and March, and for the period April 1, 2020 through March 31, 2021, the aggregate amount of $112,885,261 will be paid semi-annually in September and March, and for the period April 1, 2021 through March 31, 2022, the aggregate amount of $110,086,302 will be paid semi-annually in September and March, and for the period April 1, 2022 through March 31, 2023, the aggregate amount of $500,000,000 will be paid semi-annually in September and March, and for the period April 1, 2023 through March 31, 2024, the aggregate amount of $500,000,000 will be paid semi-annually in September and March, which will be made under the medical assistance program to non-state operated public residential health care facilities, including public residential health care facilities located in the counties of Erie, Nassau and Westchester, but excluding public residential health care facilities operated by a town or city within a county.

The amount allocated to each eligible public residential health care facility for the period April 1, 1997, through March 31, 1998, will be calculated as the result of $631.1 million multiplied by the ratio of their 1995 Medicaid days relative to the sum of 1995 Medicaid days for all eligible public residential health care facilities. The amount allocated to each eligible public residential health care facility for the period April 1, 1998, through March 31, 1999, will be calculated as the result of $631.1 million multiplied by the ratio of their 1996 Medicaid days relative to the sum of 1996 Medicaid days for all eligible public residential health care facilities. The amount allocated to each public residential health care facility for the period April 1, 1999, through March 31, 2000, will be calculated as the result of $982 million multiplied by the ratio of their 1997 Medicaid days relative to the sum of 1997 Medicaid days for all eligible public residential health care facilities. The amount allocated to each public residential health care facility for annual state fiscal year periods commencing April 1, 2000 and ending March 31, 2005, and for annual state fiscal year periods commencing April 1, 2005 through March 31, 2009, and for state fiscal years commencing April 1, 2009 through March 31, 2011; April 1, 2011 through March 31, 2012; April 1, 2012 through March 31, 2013; April 1, 2013 through March 31, 2014; and April 1, 2014 through March 31, 2015; April 1, 2015 through March 31, 2016; April 1, 2016 through March 31, 2017; April 1, 2017 through March 31, 2018; and April 1, 2018 through March 31, 2019; and April 1, 2019 through March 31, 2020; and April 1, 2020 through March 31, 2021, and April 1, 2021 through March 31, 2022, and April 1, 2022 through March 31, 2023, and April 1, 2023 through March 31, 2024 will be calculated as the result of the respective annual aggregate amount multiplied by the ratio of their Medicaid days relative to the sum of Medicaid days for all eligible public residential health care facilities for the calendar year period two years prior provided, however, that an additional amount of $26,531,995 for the April 1, 2013 through March 2014 period will be distributed to those public residential health care facilities in the list which follows.

# Appendix II
# 2023 Title XIX State Plan
# Second Quarter Amendment
# Summary

**SUMMARY**
**SPA #23-0063**

This State Plan Amendment proposes to revise the State Plan to provide additional payments to non-state government public residential health care facilities in aggregate amounts of up to $500 million.

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

**SPA 23-0063**

PHL 2808, subdivision 12, paragraph (e-1)

(e-1) Notwithstanding any inconsistent provision of law or regulation, the commissioner shall provide, in addition to payments established pursuant to this article prior to application of this section, additional payments under the medical assistance program pursuant to title eleven of article five of the social services law for non-state operated public residential health care facilities, including public residential health care facilities located in the county of Nassau, the county of Westchester and the county of Erie, but excluding public residential health care facilities operated by a town or city within a county, in aggregate annual amounts of up to one hundred fifty million dollars in additional payments for the state fiscal year beginning April first, two thousand six and for the state fiscal year beginning April first, two thousand seven and for the state fiscal year beginning April first, two thousand eight and of up to three hundred million dollars in such aggregate annual additional payments for the state fiscal year beginning April first, two thousand nine, and for the state fiscal year beginning April first, two thousand ten and for the state fiscal year beginning April first, two thousand eleven, and for the state fiscal years beginning April first, two thousand twelve and April first, two thousand thirteen, and of up to five hundred million dollars in such aggregate annual additional payments for the state fiscal years beginning April first, two thousand fourteen, April first, two thousand fifteen and April first, two thousand sixteen and of up to five hundred million dollars in such aggregate annual additional payments for the state fiscal years beginning April first, two thousand seventeen, April first, two thousand eighteen, and April first, two thousand nineteen, and of up to five hundred million dollars in such aggregate annual additional payments for the state fiscal years beginning April first, two thousand twenty, April first, two thousand twenty-one, and April first, two thousand twenty-two, and of up to five hundred million dollars in such aggregate annual additional payments for the state fiscal years beginning April first, two thousand twenty-three, April first, two thousand twenty-four, and April first, two thousand twenty-five. The amount allocated to each eligible public residential health care facility for this period shall be computed in accordance with the provisions of paragraph (f) of this subdivision, provided, however, that patient days shall be utilized for such computation reflecting actual reported data for two thousand three and each representative succeeding year as applicable, and provided further, however, that, in consultation with impacted providers, of the funds allocated for distribution in the state fiscal year beginning April first, two thousand thirteen, up to thirty-two million dollars may be allocated in accordance with paragraph (f-1) of this subdivision.

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

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 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 estimated change to gross Medicaid expenditures as a result of this proposed amendment.

Effective for dates of service on or after April 1, 2023, the Department of Health will 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.

The estimated net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2023-2024 is $186.5 million.

Effective on or after April 1, 2023, and each state fiscal year (SFY) thereafter, this proposal would reduce the size of the voluntary hospital Indigent Care Pool by an additional $85.4 million (gross). This reduction would be additive to the $150 million (gross) reduction implemented in the FY 2021 Enacted Budget, for a total reduction of $235.4 million. Similar to the previous $150 million reduction, the $85.4 million reduction would only apply to voluntary hospitals whose public payor (Medicare and Medicaid) mix is less than the statewide average. Additionally, hospitals qualifying as Enhanced Safety Net Hospitals under PHL 2807-c would be exempt from this reduction.

The estimated net aggregate decrease in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2023-2024 is ($85.4 million).

Effective for the period January 1, 2023, through December 31, 2025, indigent care pool payments will be made using an uninsured unit's methodology. Each hospital's uncompensated care need amount will be determined as follows:

- Inpatient units of service for the cost report period two years prior to the distribution year (excluding hospital-based residential health care facility (RHCF) and hospice) will be multiplied by the average applicable Medicaid inpatient rate in effect for January 1 of the distribution year;
- Outpatient units of service for the cost report period two years prior to the distribution year (excluding referred ambulatory and home health) will be multiplied by the average applicable Medicaid outpatient rate in effect for January 1 of the distribution year (exclusive of the public goods surcharge);
- Inpatient and outpatient uncompensated care amounts will then be summed and adjusted by a statewide adjustment factor and reduced by cash payments received from uninsured patients; and
- Uncompensated care nominal need will be based on a weighted blend of the net adjusted uncompensated care and the Medicaid inpatient utilization rate. The result will be used to proportionally allocate and make Medicaid disproportionate share hospital (DSH) payments in the following amounts:
- $139.4 million to major public general hospitals, including hospitals operated by public benefit corporations; and
- $884.5 million to general hospitals, other than major public general hospitals.

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

Long Term Care Services

Effective on or after April 1, 2023, 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 not excluding public residential health care facilities operating 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 for 2021 and each representative succeeding year as applicable. 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 or after April 1, 2023, the Department of Health will adjust rates for Nursing Home (NH) 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 $314 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. 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

### 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 non-institutional services to comply with SSL 365-a (2)(jj). The following changes are proposed:

Non-Institutional Services

Effective on or after April 1, 2023, Medicaid will reimburse for services provided by certified dietitians and nutritionists to eligible populations.

The estimated net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2023/2024 is $520,000.

Effective on or after April 1, 2023, Medicaid will reimburse for the services of Community Health Workers for services rendered to eligible populations. A Community Health Worker is a public health worker that reflects the community served (through lived experience that may include, but is not limited to pregnancy and birth, housing status, mental health conditions or substance use, shared race, ethnicity, language, or community of residence), and functions as a liaison between healthcare systems, social services, and community-based

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

**LONG-TERM SERVICES**
**State Plan Amendment #23-0063**

**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 (except for OPWDD's ICF/DD) 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.

   OPWDD's ICF/DD facilities are subject to a 5.5% Medicaid-reimbursable tax on gross receipts that are not kept by the provider but remitted to the state general fund for both voluntary and State-operated ICF/DDs. This assessment is authorized by Public Law 102-234, Section 43.04 of the New York State Mental Hygiene Law, Federal Medicaid regulations at 42 CFR 433.68. OPWDD recoups the assessment from the ICF/DD Medicaid payment before the payment is sent to the voluntary provider. For State operated ICF/DDs, the legislature appropriates an amount for payment of the assessment. Aside from the assessments, providers receive and retain all the Medicaid payments for ICF/DD services.

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 (normal per diem and supplemental) 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** |
| Nursing Homes Normal Per Diem | General Fund; Special Revenue Funds; County Contribution | $3.215B | $6.429B |
| Intermediate Care Facilities Normal Per Diem | General Fund; County Contribution | $409M | $818M |
| Nursing Homes Supplemental | General Fund | $279M | $558M |
| Intermediate Care Facilities Supplemental | General Fund | $33M | $65M |
| Nursing Homes UPL | IGT | $148M | $296M |
| **Totals** | | **$4.083B** | **$8.166B** |

A. **General Fund:** Revenue resources for the State's General Fund includes taxes (e.g., income, sales, etc.), and miscellaneous fees (including audit recoveries and provider assessments). 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.

2) Intermediate Care Facilities (ICF) Provider Service Assessment: Pursuant to New York State Mental Hygiene Law 43.04, a provider's gross receipts received on a cash basis for all services rendered at all ICFs is assessed at 5.5 percent. This assessment is deposited directly into the State's General Fund.

**B. Special Revenue Funds:**

Health Facility Cash Assessment Program (HFCAP) Fund: Pursuant to New York State Public Health Law 2807-d and Section 90 of Part H of Chapter 59 of the Laws of 2011, the total state assessment on each residential health care facility's gross receipts received from all patient care services and other operating income on a cash basis for residential health care facilities, including adult day service, but excluding, gross receipts attributable to payments received pursuant to Title XVIII of the federal Social Security Act (Medicare), is 6.8 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 the 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 |
|---|---|---|
| A Holly Patterson Extended Care Facility | Nassau County | $14M |
| Albany County Nursing Home | Albany County | $5M |
| Chemung County Health Center | Chemung County | $4M |
| Clinton County Nursing Home | Clinton County | $2M |
| Coler Rehabilitation & Nursing Care Center | New York City | $12M |
| Dr. Susan Smith Mckinney Nursing and Rehab Center | Kings County | $7M |
| Glendale Home | Schenectady County | $5M |
| Henry J. Carter Nursing Home | New York City | $5M |
| Lewis County General Hospital-Nursing Home Unit | Lewis County | $4M |
| Livingston County Center for Nursing and Rehabilitation | Livingston County | $7M |
| Monroe Community Hospital-Nursing Home Unit | Monroe County | $16M |
| New Gouverneur Hospital-Nursing Home Unit | New York City | $5M |
| Sea View Hospital Rehabilitation Center and Home | Richmond County | $8M |
| Sullivan County Adult Care Center | Sullivan County | $2M |
| Terrace View Long Term Care | Erie County | $11M |
| The Pines Healthcare & Rehab Centers Machias Camp | Cattaraugus County | $3M |
| The Pines Healthcare & Rehab Centers Olean Camp | Cattaraugus County | $3M |
| The Valley View Center for Nursing Care and Rehab | Orange County | $11M |
| Van Rensselaer Manor | Rensselaer County | $10M |

| | | |
|---|---|---|
| Wayne County Nursing Home | Wayne County | $4M |
| Willow Point Rehabilitation & Nursing Center | Broome County | $6M |
| Wyoming County Community Hospital-NH Unit | Wyoming County | $4M |
| **Total** | | **$148M** |

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:** Below is a list of nursing home and ICF supplemental payments:

| Payment Type | Private | State Government | Non-State Government | 4/1/22-3/31/23 Gross Total |
|---|---|---|---|---|
| Nursing Home Reforms | $187M | $0 | $0 | $187M |
| 2% Supplemental Payment | $130M | $1M | $9M | $140M |
| 1.5% ATB Restoration | $88M | $0.6M | $5M | $94M |
| Workforce Vital Access Program | $51M | $0 | $0 | $51M |
| Advanced Training Initiative | $43M | $0 | $3M | $46M |
| Cinergy | $30M | $0 | $0 | $30M |
| Vital Access Program | $7M | $0 | $0 | $7M |
| Bridgeview Settlement | $2M | $0 | $0 | $2M |
| Nursing Home Quality Pool | ($1.2M) | $0.4M | $0.8M | $0 |
| Nursing Home UPL | $0 | $0 | $295M | $295M |
| ICF Worker Bonus | $65M | $0 | $0 | $65M |
| **Total** | **$603M** | **$2M** | **$313M** | **$918M** |

   The Medicaid payments authorized under this State Plan Amendment are supplemental payments. Please note that the dollar amount currently listed in the plan page is a placeholder and will be updated once the calculation is completed.

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 2023 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.