NEW YORK STATE OF OPPORTUNITY. Department of Health

KATHY HOCHUL
Governor

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

JOHANNE E. MORNE, M.S.
Acting Executive Deputy Commissioner

December 28, 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 #23-0097
Long Term Care Facility Services

Dear Mr. McMillion:

The State requests approval of the enclosed amendment #23-0097 to the Title XIX (Medicaid) State Plan for long term care facility services to be effective October 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 September 27, 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: 23-0097

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
October 1, 2023

5. FEDERAL STATUTE/REGULATION CITATION
§ 1905(a)(15) ICF/IID

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 10/01/23-09/30/24 $ 957,052
b. FFY 10/01/24-09/30/25 $ 319,017

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.19 D part II Pages: 6, 8, 9, 10, 14, 15, 16, 18, 19, 20, 21, 22, 22(a), 23, 24

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 4.19 D part II Pages: 6, 8, 9, 10, 14, 15, 16, 18, 19, 20, 21, 22, 22(a), 23, 24

9. SUBJECT OF AMENDMENT
LTC ICF/IDD Updates to Methodology

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 December 28, 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

Annotated Pages

23-0097

Attachment 4.19-D Part II Page: 23

~~(12) Transition to New Methodology~~

~~i. The reimbursement methodology described in this Attachment will be phased-in over a three-year period, with a year for purposes of the transition period meaning a 12-month period from July 1st to the following June 30th, and with full implementation in the beginning of the fourth year. During this transition period, the base operating rate will transition to the target rate as determined by the reimbursement methodology described in this Attachment, according to the phase-in schedule outlined below. The base operating rate will remain fixed and the target rate, as determined by the reimbursement methodology in this Attachment, will be updated to reflect rebasing of cost data, trend factors and/or other appropriate adjustments.~~

	~~Phase-in Percentage~~	
~~Transition Year~~	~~Base Operating Rate~~	~~New Methodology~~
~~Year 1 (July 1, 2014 – June 30, 2015)~~	~~75%~~	~~25%~~
~~Year 2 (July 1, 2015 – June 30, 2016)~~	~~50%~~	~~50%~~
~~Year 3 (July 1, 2016 - June 30, 2017)~~	~~25%~~	~~75%~~
~~Year 4 (July 1, 2017 – June 30, 2018)~~	~~0%~~	~~100%~~

~~ii. Providers will have the opportunity to apply for additional funding in order to help individuals maintain access to services during the current financial transformation, as well as assist providers in achieving the larger transformation agenda of deinstitutionalization. In order for a provider to receive additional funding the following criteria must be met:~~

~~(a) Provider must submit a completed application to OPWDD.~~

~~(b) Provider must be in a fiscal deficit.~~

~~(c) Provider must be in compliance with CFR submission requirements.~~

~~iii. DOH and OPWDD will utilize the January 1, 2013 through December 31, 2013 CFR for non-New York City providers and the July 1, 2013 through June 30, 2014 CFR for New York City providers to determine the provider's three year deficit for rate periods July 1, 2014 through June 30, 2015; July 1, 2015 through June 30, 2016; and July 1, 2016 through June 30, 2017.~~

~~iv. Providers will be reimbursed 60% of the total deficit over three years beginning with the period July 1, 2014 through June 30, 2015.~~

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

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1905(a)(15) ICF/IID

Rates for ICF/IID services delivered by Non-Government and Voluntary ICFs/IID on and after July 1, 2014, will be determined in accordance with this section.

(1) Definitions (applicable to this section):

Active Treatment (AT) – Habilitation services provided for residents of an ICF/IID who are under the age of 21, in all areas of life and at any location. The ICF/IID can arrange for and reimburse other providers (schools or otherwise) to carry out some of the AT called for in the facility's plan of care for an individual. The purpose of AT provided during normal school hours must be habilitation, not educational.

Allowable Agency Administration – For Non-State Government and Voluntary Providers, from the CFR for the base year, divide the Agency Administration Allocation (from CFR1 Line 65) by the Total Operating Costs (from CFR1 Line 64) to determine the agency administration percentage. Effective on or after October 1, 2020, a screen on allowable agency administration costs of 15 percent will be applied to the product of the agency administration percentage multiplied by Total Operating Costs, and the result is the amount permitted for Agency Administration and used within the methodology.

Allowable Operating Costs – All necessary and proper costs which are appropriate and helpful in developing and maintaining the operation of ICFs/IID. Necessary and proper costs are costs which are common and accepted occurrences in the field of ICFs/IID. These costs will be determined in accordance with the cost principles described in the Medicare Provider Reimbursement Manual (HIM-15). This will include allowable program administration, direct care, support, clinical, fringe benefits, and indirect personal service/non-personal service. Effective on or after October 1, 2023, allowable operating costs may exclude workforce bonus payments authorized by state law and/or otherwise approved by the federal government including, but not limited to, supplemental payments to address critical workforce shortages stemming from the COVID-19 emergency.

Allowable Capital Costs – Are all necessary and proper capital costs that are appropriate and helpful in developing and maintaining the provision of ICF/IID services to beneficiaries determined in accordance with the cost principles described in the Medicare Provider Reimbursement Manual (HIM-15) except as further defined below. This will include, where appropriate, allowable lease/rental and ancillary costs; amortization of leasehold improvements and depreciation of real property; financing expenditures associated with the purchase of real property and related expenditures, and leasehold improvements.

Capital costs of depreciation, and lease/rental of equipment and vehicles (annual lease, depreciation, and interest) will be included in the operating components of the provider's rate.

Base Year Consolidated Fiscal Report (CFR) – For Non-Government and Voluntary Providers, the CFR from which the initial target rate will be calculated. Such period will be January 1, 2011, through December 31, 2011, for providers reporting on a calendar year basis and July 1, 2010, through June 30, 2011, for providers reporting on a fiscal year basis. For subsequent periods, the base year CFR will mean the CFR used to update the methodology.

~~**Base Operating Rate** – Reimbursement amount calculated by dividing annual reimbursement by applicable annual units of service, both in effect on June 30, 2014.~~

Budget Neutrality Adjustment – Factor applied to the end of the methodology to ensure the total annual target reimbursement operating ~~adjust the proposed amount so that it~~ is equivalent to the total annual operating base reimbursement ~~amount of dollars~~. The factors can be found on: https://www.health.ny.gov/health_care/medicaid/rates/mental_hygiene/

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1905(a)(15) ICF/IID

Provider – A Non-government or Voluntary agency that has been issued a Medicaid provider agreement for an ICF/IID. A provider may operate multiple ICFs/IID.

Provider Assessment – An assessment in the amount of 5.5% uniformly imposed on the residential portion of gross Medicaid revenue on all providers of ICF/IID services.

Rate Cycle – The rate cycle is a 24-month period, beginning on July 1st, that consists of two rate periods.

Rate Period – The annual time period of July 1st through June 30th that rates are effective.

Rate Sheet Capacity – The number of ICF/IID individuals for whom a provider is certified or approved by OPWDD as of two months prior to the ~~last day of the previous~~ rate period.

Regions

i. **Department of Health (DOH) Regions** – Regions as defined by DOH are, assigned to providers based upon the geographic location of the provider's headquarters as reported on the consolidated fiscal report. Such regions are as follows:

(a) **Downstate:** 5 boroughs of New York City, Nassau, Suffolk and Westchester;

(b) **Hudson Valley:** Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster;

(c) **Upstate Metro:** Albany, Erie, Fulton, Genesee, Madison, Monroe, Montgomery, Niagara, Onondaga, Orleans, Rensselaer, Saratoga, Schenectady, Warren, Washington, Wyoming; and

(d) **Upstate Non-Metro:** Any counties not listed in paragraphs (a), (b) or (c) of this section.

ii. **Specialized Populations Funding OPWDD Developmental Disabilities Regional Office (DDRO) Regions**

(a) **Downstate DDRO Regions:** Brooklyn, Bernard Fineson, Hudson Valley, Long Island, Metro, Staten Island and Taconic (Dutchess and Putnam counties only);

(b) **Upstate DDRO Regions:** Broome, Capital District, Central, Finger Lakes, Sunmount, Taconic and Western.

iii. **In-House Day Programming OPWDD DDRO Regions**

(a) Region 1: Brooklyn, Bernard Fineson, Metro and Staten Island

(b) Region 2: Long Island, Hudson Valley (Rockland and Westchester Counties), Taconic (Putnam County)

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(c) Region 3: Broome, Capital District, Central, Finger Lakes, Sunmount, Western, Hudson Valley (Sullivan, Orange Counties), Taconic (Greene, Columbia, Ulster and Dutchess Counties)

Reimbursable Cost – The final allowable costs of the rate period after all audit and/or adjustments are made.

Specialized Populations Funding – An all-inclusive fee payment for ICF/IID paid to voluntary ICF/IID providers that serve individuals who left an institutional setting ~~or who have aged out of a New York State residential school setting between November 1, 2011, and March 31, 2013. Special Populations Funding is time limited~~. Reimbursement for this Special Population will be from the Special Population Fee Table below for ICFs/IID.

Standard Academic Curricula -The subjects comprising a course of study in an educational institution.

Subsequent Rate Period – The corresponding 12-month rate periods that follow the Initial Rate Period.

~~**Target Rate –** The final rate in effect at the end of the transition period for each provider.~~

Therapy Day – A therapy day is a day when the individual is away from the ICF/IID and is not receiving services from paid Residential Habilitation staff and the absence is for the purpose of a visiting with family or friends, or a vacation. The therapy day must be described in the person's plan of care to be eligible for payment and the person may not receive another Medicaid-funded residential, in-patient service or day service on that day. Effective October 1, 2020, or after, a provider is limited to being paid 96 Therapy days per rate year per person and all Therapy days will be reimbursed at a rate of 50 percent of the provider's established rate.

~~**Transition Period –** The three-year period which the reimbursement methodology will be phased-in, with a year for purposes of the transition period meaning a twelve-month period from July 1st to the following June 30th, and with full implementation in the beginning of the fourth year.~~

Wage Equalization Factor (WEF) – The sum of the provider average direct care hourly wage multiplied by .75 and the applicable regional average direct care hourly wage, multiplied by .25.

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1905(a)(15) ICF/IID

(2) Rates for Providers of ICF/IID Services

i. There will be one provider-wide rate for each provider (with some components to be paid separately, as set forth in paragraph (4)) ,except that rate for ICF/IID services provided to individuals identified as special populations by OPWDD. Adjustments may be made to the rate resulting from any final audit findings or reviews.

ii. Rates will be computed based on a full 12-month base year CFR, adjusted in accordance with the methodology as delineated in this section. The rate will include operating cost components and capital cost components. Such base year may be updated in accordance with subsequent rate section, paragraph ~~p)~~(8).

iii. **Components of Rates for ICF/IID Services**

(a) **Operating Component -** The operating component will be calculated using allowable costs identified in the consolidated fiscal reports. The operating component will be inclusive of the following components:

1. **Regional average direct care wage -** The quotient of base year salaried direct care dollars for each provider in a DOH region, totaled for all such providers in such region, for all residential habilitation-supervised individualized residential alternative (IRA); residential habilitation-supportive IRA; day habilitation services; and ICF/IID, divided by base year salaried direct care hours for each provider in a DOH region, totaled for all such providers in such region, for all residential habilitation- supervised IRA; residential habilitation-supportive IRA; day habilitation services; and ICF/IID services.

2. **Regional average employee-related component -** The sum of the annual change in vacation leave accruals and total fringe benefits for the base year for each provider of a DOH region, totaled for all such providers in such region, with the sum to be divided by base year salaried direct care dollars for each provider of a DOH region, totaled for all such providers in such region, and then multiplied by the applicable regional average direct care wage.

3. **Regional average program support component -** The sum of transportation related-participant; staff travel; participant incidentals; expensed adaptive equipment; sub-contract raw materials; participant wages-non-contract; participant wages-contract; participant fringe benefits; staff development; supplies and materials-non-household; other-OTPS; lease/rental vehicle; depreciation-vehicle; interest-vehicle; other-equipment; other than to/from transportation allocation; salaried support dollars (excluding housekeeping and maintenance staff); and salaried program administration dollars for the base year for each provider of a DOH region, totaled by all such providers in such region. Such sum is divided by the total base year salaried direct care dollars for all providers in a DOH region and multiplied by the applicable regional average direct care wage.

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26. **Statewide budget neutrality adjustment factor for operating dollars -** ~~The quotient of the operating portion of all provider rates in accordance with the State Plan in effect on June 30, 2014, divided by the provider operating revenue for all providers.~~ Factor applied to the end of the methodology to ensure the total annual target reimbursement is equivalent to the total annual base reimbursement.

27. **Total provider operating revenue – adjusted -** The product of the provider operating revenue and the statewide budget neutrality adjustment factor for operating dollars.

28. **Final daily operating rate** – This rate is determined by dividing the total provider operating revenue – adjusted by the applicable provider rate sheet capacity for the initial period and such quotient to be further divided by 365.

29. **Occupancy Adjustment**.

~~(i) For the initial rate period of July 1, 2014, through June 30, 2015; Providers will be paid 75% of the operating component for up to an annual total of 90 days per bed for days when there is a vacancy.~~

(ii) For the rate periods beginning July 1, 2015, providers will receive an occupancy adjustment to the operating component of their rate for vacancy days. The occupancy adjustment percentage is calculated by dividing the sum of the agency's rate period medical leave days, service days, ~~and the~~ therapy days, and days indicated on a submitted non-billable day survey by 100% of the agency's certified capacity. The certified capacity is calculated taking into account capacity changes throughout the year, multiplied by 100% of the year's days. This adjustment will begin on July 1, 2015, and be recalculated on an annual basis based on the most recent 12 months' experience.

(ii~~i~~) For the period beginning October 1, 2020, or after, the occupancy will no longer be calculated and applied to the provider's rate. The occupancy adjustment will be zero percent.

(3) Alternative Operating Component. For providers that did not submit a cost report or submitted a cost report that was incomplete for the base year, the final daily operating rate will be a regional daily operating rate. This rate will be the sum of:

i. The result of the appropriate regional average direct care hourly rate and the applicable regional average direct care hours, which is the quotient of base year salaried and contracted direct care hours for each provider of a DOH region, totaled for all providers in such region, divided by the rate sheet capacities, pro-rated for partial year sites for the base year for each provider of a DOH region, totaled for all providers in such region; and

ii. The result of the applicable regional average clinical hourly wage and the applicable regional average clinical hours, which is the quotient of base year salaried and contracted clinical hours for each provider of a DOH region, totaled for all providers in

such region, divided by the rate sheet capacities, pro-rated for partial year sites for the base year for each provider of a DOH region, totaled for all providers in such region; and

iii. The applicable regional average facility revenue, which is the quotient of the sum of food; repairs and maintenance; utilities; expensed equipment; household supplies; telephone; lease/rental equipment; depreciation; insurance – property and casualty; housekeeping and maintenance staff; and program administration property for the base year divided by the rate sheet capacities, pro-rated for partial year sites for the base year for each provider of a DOH region, totaled for all providers in such region.

iv. This sum is then multiplied by the statewide budget neutrality adjustment factor for operating dollars and divided by 365.

(a) This rate will be in effect until such time that the provider has submitted a cost report for a base year which will be used in the calculation of a subsequent rate period.

(b) For cost reporting periods beginning July 1, 2015, and thereafter, providers are required to file an annual Consolidated Fiscal Report (CFR) to the State by June 1st for providers reporting on the January 1st through December 31st period or December 1st for providers reporting on the July 1st through June 30th period. If the completed CFR is not submitted by either June 1st for providers reporting on the January 1st through December 31st period or December 1st for providers reporting on the July 1st through June 30th period, a 2 percent penalty on the provider's OPWDD Medicaid reimbursement will be imposed effective on the due date of the CFR. However, OPWDD will not impose such a penalty if it determines that there were unforeseeable circumstances beyond the provider's control (such as a natural disaster, or other circumstance as determined by the OPWDD commissioner) that prevented the provider from filing the cost report by the due date.

~~If a provider fails to file a complete and compliant CFR by the first day of the second month following the imposition of the 2 percent penalty, the State must provide timely notice to the delinquent provider that Federal Financial Participation (FFP) will end on the first day of the eighth month following the imposition of the 2 percent penalty; and the State will not claim FFP for any Waiver service provided by the provider with a date of service after the first day of the eighth month.~~

1905(a)(15) ICF/IID

(4) Day Program Services Component. There is a day program services component for individuals who participate in either in-house day programming or day services, or active treatment.

i. **In-house day programming <u>(paid separately to the In-House day programming provider)</u>** are equal to the sum of the provider in-house day programming amount in accordance with the State Plan in effect on June 30, 2014, plus the product of the units of service for the day services providers as was used in the calculation of the rate in effect on June 30, 2014, and the day service provider's rate in effect on July 1, 2014. A fee schedule follows:

IN-HOUSE DAY PROGRAMMING	
OPWDD DDRO Region	Daily Fee
1	$111.02
2	$124.89
3	$103.39

ii. **Day Services <u>(paid separately to the Day Services provider)</u>-** Effective January 1, 2015, the new day services calculation will be equal to the reimbursement of the applicable day habilitation and/or prevocational service, less capital, as delineated in the supplemental language of the 1915c Wavier.

iii. **Active Treatment (AT) Add-on** is equal to the AT fees, as shown below, multiplied by school days attended, less time spent by children in actual standard educational curricula.

ACTIVE TREATMENT Effective 7/1/14	
OPWDD DDRO Region	Daily Fee
Downstate	$192.98
Upstate	$179.00

DOH will require a signed attestation annually from Children's Residential Program (CRP) providers documenting the percentage of time spent by an individual in AT versus standard educational curricula.

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(a) Reimbursement rates will include actual straight-line depreciation, interest expense, financing expenses, and lease cost established using generally accepted accounting principles, comply with CMS Publication – 15 (Medicare cost and cost allocation principles) and establish useful lives using the American Hospital Association (AHA) Estimated Useful Lives of Depreciable Hospital Assets Revised 2008 Edition.

(b) OPWDD will never approve lease or acquisition costs in excess of the lower of fair market value (as determined by an independent appraisal) or the provider's actual cost. However, OPWDD may limit the approved costs to a lower amount based on a review of the reasonableness of the transaction and price and a comparison of costs to those of similar facilities with the same characteristics. For example, if a provider purchases or leases a property in an area in which real estate costs are considerably higher than those in the surrounding areas, and an equally suitable property in the surrounding area was available to the provider for purchase or lease at a lower cost, OPWDD may limit the allowable costs to those of properties in the surrounding area.

(c) In no case will the total capital reimbursement associated with the capital asset exceed the total acquisition, renovation and financing cost associated with a capital asset.

(d) The State will identify each asset, by provider, and provide a schedule of these assets identifying: total actual cost, reimbursable cost, and useful life, determined by the prior property approval, total financing cost, allowable depreciation and allowable interest for the remaining useful life as determined by the prior approval, and the allowable reimbursement for each year of the remaining useful lives.

(e) Notification to Providers. Each provider will receive supporting documentation detailing all real property to be included in the capital component of the provider's reimbursement rate.

iii. The rate will include applicable annual interest, depreciation and/or amortization of the approved appraised costs of an acquisition, or fair market value of a lease, and property associated with ICF/IID facilities; the useful life will be 25 years. Such costs will be included in the rate upon or after submission and approval of the Final Expenditure Report and completion of the property cost verification.

Estimated costs will be submitted in lieu of actual costs for new providers for a period no greater than two years. If actual costs are not submitted to the State within two years from the date of site certification, the amount of capital costs included in the rate will be zero for each period in which actual costs are not submitted. DOH will retroactively adjust the capital component; and will return FFP to CMS on the next quarterly expenditure

report (CMS-64) following the two-year period. Once the final cost reconciliation has been received by the Department of Health, the rate will be retroactively adjusted to include reconciled costs.

DOH will verify and reconcile the costs submitted on a PPA by requiring the provider to submit to the State supporting documentation of actual costs. Actual costs will be verified by the State reviewing the supporting documentation of such costs. A provider submitting such actual costs will certify that the reimbursement requested reflects allowable capital costs and that such costs were actually expended by such provider. Under no circumstances will the amount included in the rate under this subparagraph exceed the amount authorized in the approval process. Capital costs will be amortized over a 25 year period for acquisition of properties or the life of the lease for leased sites. Capital improvements will be depreciated over the life of the asset, or the revised useful life of the asset as a result of the capital improvements, whichever is greater. The amortization of interest will not exceed the life of the loan taken. Amortization or depreciation will begin upon certification by the provider of such costs. Start-up costs will be amortized over a one year period beginning with certification of the site. If new providers actual costs are not submitted to the State within two years from the date of site certification, the amount of capital costs included in the rate will be zero for each period in which actual costs are not submitted. The Department will retroactively adjust capital reimbursement based on the actual cost verification process as described.

iv. DOH will semi-annually update Capital reimbursement for all providers in January and July ~~twice a year, January for providers filing a CFR on a calendar year and July for providers filing a CFR on a fiscal year cycle~~. Also, DOH will update capital to include all new and approved PPA's twice a year. The ~~second~~ update may require the Department to annualize the PPA, which could include more than 12 months of costs in the first year.

v. **CFR Reporting for Capital Assets**

(a) Expenses relating to Equipment are reported in two sections of CFR-1. Expensed equipment is included under the Other Than Personal Services (OTPS) section of CFR-1 and is included in the operating portion of the rate reimbursement (Lines 27 & 28). Depreciable equipment expenses are included under the Equipment section of CFR-1 and all items in this section are included in the operating portion of the rate reimbursement (Lines 42-47).

(b) Capital expenses related to real property are included under the Property section of the CFR-1 (Lines 49-62). With the exception of Insurance-Property or Casualty, which is reported on CFR-1, Line 55, Lines 49-62 are not included in the rates. Alternatively, providers are reimbursed for Capital in accordance with the capital schedule (iii as identified above) and the Insurance-Property or Casualty reported on CFR-1, Line 55.

1905(a)(15) ICF/IID

(c) All expenses reported on CFR-1 are to be reported in accordance with Appendix X – Adjustments to Reported Costs, dated January 1, 2014, which details expenses that are considered to be non-allowable. CFR instructions for reporting depreciation and amortization are included in Appendix O of the January 1, 2014 CFR Manual, which can be found at:

http://www.oms.nysed.gov/rsu/Manuals_Forms/Manuals/CFRManual/home.html

~~(d) **Capital Schedule.** Beginning with the cost reporting periods ending December 31, 2014 (calendar year filers), and July 31, 2015 (fiscal year filers), any provider required to file a CFR will submit to OPWDD, as part of the annual cost report, a Capital Schedule.~~

~~This schedule will specifically identify the differences, by capital reimbursement item, between the amounts reported on the certified cost report, and the reimbursable items, including depreciation, interest and lease cost from the schedule of approved reimbursable costs.~~

~~The provider's independent auditor will apply procedures to verify the accuracy and completeness of the capital schedule.~~

(6) Tax Assessment. The provider assessment on ICF/IID services rendered to Medicaid recipients will be considered an allowable cost and reimbursed through residential Medicaid service rates of payment. The amount of 5.5% assessment uniformly imposed on all ICF/IDD residential services of all such providers will be included in the rate.

(7) Total Per Diem. This will be the sum of products of paragraphs (2)(iii)(a)(28), (2)(iii)(a)(29), (4), (5) and (6) of this Section.

(8) Computation of Subsequent Rate Period- Beginning one year after the initial period, the methodology will rebase the costs used in the methodology described in paragraph (2) of this Section using the 1/1 – 12/31 and 7/1 – 6/30 CFR one and one half, and two years prior to the rate period, respectively. Thereafter, the Department will rebase within five ~~four~~ years of the previous rebase utilizing the base year CFR. For years in which the Department of Health does not update the base year, the Department will update property as described in paragraph (5) of this Section.

1905(a)(15) ICF/IID

(9) a. Computation of Subsequent Rate Period for CRPs – Effective July 1, 2015

Corp ID	Corp Name	CRP Operating Fee
11440	Devereux Foundation in New York	$392.62
22270	SCO Family of Services	$413.70
40640	U C P Handicapped Persons of Utica	$400.81
86050	Maryhaven Center of Hope, Inc.	$347.65
22460	Developmental Disabilities Institute	$488.22
26050	UCPA of Greater Suffolk, Inc.	$479.06
20600	Heartshare Human Services of New York	$363.60
21160	Birch Family Services, Inc.	$465.20
43850	Brookville Center for Children's Services, Inc.	$577.33
22630	UCP of Ulster County	$258.32
22620	The Center for Discovery, Inc.	$525.45
21620	NY Easter Seals Society, Inc.	$422.89

i. Total capital will be an add-on and reimbursed as computed in paragraph (5) of this Section.

ii. Tax Assessment will be an add-on and reimbursed as computed in paragraph (6) of this Section.

b. **Computation of Subsequent Rate Period for CRPs – Effective October 1, 2023**

i. Operating components of the CRP rates will be reimbursed as computed in paragraph (2)iii.(a) of this section, with the exception that computations for CRP rates will be based on 100% of provider specific costs and will not utilize regional averages or a wage equalization factor.
ii. Total capital will be an add-on and reimbursed as computed in paragraph (5) of this Section.
iii. Tax Assessment will be an add-on and reimbursed as computed in paragraph (6) of this Section.

(10) Reporting Requirements

i. Providers will report costs and maintain financial and statistical records in accordance with the Financial and Audit Requirements of the New York State OPWDD.

ii. Generally Accepted Accounting Principles (GAAP). The completion of the financial and statistical report forms are in accordance with generally accepted accounting principles as applied to the provider unless the reporting instructions authorized specific variation in such principles. The State will identify provider cost and providers will submit cost data in accordance with GAAP.

1905(a)(15) ICF/IID

iii. For cost reporting periods beginning July 1, 2015, and thereafter, providers are required to file an annual Consolidated Fiscal Report (CFR) to the State by June 1st for providers reporting on the January 1st through December 31st period or December 1st for providers reporting on the July 1st through June 30th period. If the completed CFR is not submitted by either June 1st for providers reporting on the January 1st through December 31st period or December 1st for providers reporting on the July 1st through June 30th period, a 2 percent penalty on the provider's OPWDD Medicaid reimbursement will be imposed effective on the due date of the CFR. However, OPWDD will not impose such a penalty if it determines that there were unforeseeable circumstances beyond the provider's control (such as a natural disaster, or other circumstance as determined by the OPWDD commissioner) that prevented the provider from filing the cost report by the due date.

~~If a provider fails to file a complete and compliant CFR by the first day of the second month following the imposition of the 2 percent penalty, the State must provide timely notice to the delinquent provider that Federal Financial Participation (FFP) will end on the first day of the eighth month following the imposition of the 2 percent penalty; and the State will not claim FFP for any Waiver service provided by the provider with a date of service after the first day of the eighth month.~~

(11) Trend Factors and Increases to Compensation

i. **Trend Factors**

~~a. The trend factor used will be the applicable years from the Medical Care Services Index for the period April to April of each year from www.BLS.gov/cpi; Table 1 Consumer Price Index for All Urban Consumers (CPI-U); U.S. city average, by expenditure category and commodity and service group.~~

~~b. Generally, actual index values will be used for all intervening years between the base period and the rate period. However, because the index value for the last year immediately preceding the current rate period will not be available when the current rate is calculated, an average of the previous five years actual known indexes will be calculated and used as a proxy for that one year.~~

New York
22(a)

1905(a)(15) ICF/IID

~~c. A compounded trend factor will be calculated in order to bring base period costs to the appropriate rate.~~

a. ~~d.~~ The applicable trend factor effective July 01, 2021, through March 31, 2022, will be calculated as follows. Operating rates of payment will be increased for a Cost of Living Adjustment (COLA), calculated to support a one percent (1.0%) annual aggregate payment to be paid out over the 9 month period between July 1, 2021 and March 31, 2022, and a one percent (1%) annual increase to be paid out over 12 months in subsequent years until such time as the COLA increase is reflected in the base period cost reports.

b. ~~e.~~ The applicable trend factor effective April 01, 2022, through March 31, 2023, will be calculated as follows. Operating rates of payment will be increased for a Cost-of-Living Adjustment (COLA) to support a five-point four percent (5.4%) increase until such time as the COLA increase is reflected in the base period cost reports.

c. ~~f.~~ The applicable trend factor effective April 01, 2023, through March 31, 2024, will be calculated as follows. Operating rates of payment will be increased for a Cost-of-Living Adjustment (COLA) to support a four percent (4.0%) increase until such time as the COLA increase is reflected in the base period cost reports.

New York
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1905(a)(15) ICF/IID

e. Minimum Wage Adjustment – Effective January 1, 2024, and every January 1 thereafter until the minimum wage reaches the state statutorily described per hour wage as shown below, a minimum wage add-on will be developed and applied to all ICF/IID rates.

Minimum Wage Region	1-Jan-24	1-Jan-25	1-Jan-26
New York City	$16.00	$16.50	$17.00
Nassau, Suffolk & Westchester	$16.00	$16.50	$17.00
Remainder of State	$15.00	$15.50	$16.00

The minimum wage adjustment will be developed and implemented as follows:

1. Minimum wage costs will mean the additional costs incurred beginning January 1, 2024, and thereafter, as a result of New York State statutory increases to minimum wage.

2. The annual facility specific minimum wage add-on for 2024 and subsequent years will be developed and calculated based on the facilities consolidated fiscal report (CFR) wage data for the applicable base year. Once the costs are included in the CFR utilized in a base year, such reimbursement will be excluded from the add-on.

f. These rates may be adjusted to incorporate funding to reflect Cost of Living Adjustments (COLA), compensation increases, or any other adjustments authorized pursuant to NYS law.

New York
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1905(a)(15) ICF/IID

(123) Rate Corrections

i. Arithmetic or calculation errors will be adjusted accordingly in instances that would result in an annual change of $5,000 or more in a provider's annual reimbursement for ICFs/IID.

ii. In order to request a rate correction in accordance with paragraph i. of this section, the provider must send to the Department of Health its request by certified mail, return receipt requested, or via email within ninety days of the provider receiving the rate computation or within 90 days of the first day of the rate period in question, whichever is later.

(134) Specialized Populations Funding

i. Notwithstanding any other provisions of this Attachment, rates for individuals identified by OPWDD as qualifying for specialized populations funding will be as follows:

ii. For individuals initially identified as qualifying for specialized populations funding, a fee schedule can be found using the link below:

https://www.health.ny.gov/health_care/medicaid/rates/mental_hygiene/~~2014rates.htm~~

iii. The tax assessment as described in paragraph (6) will be applied to these rates.

(145) Changes in Ownership and Control

i. The following will be effective beginning August 1, 2017. Where a non-state governmental provider or voluntary provider ceases to operate an ICF/IID due to:

(a) a limitation, suspension, revocation or surrender of that provider's operating certificate;
(b) bankruptcy or other financial or operational distress; or
(c) dissolution of the provider under State Law;

and there arises an emergency situation of a loss of services to individuals, OPWDD will transfer operation of the affected provider's ICF/IID services to another non-governmental provider or voluntary provider at a temporarily enhanced reimbursement rate as described below.

In those emergency situations, the voluntary provider assuming the transferred services will be reimbursed at a rate which is the higher of the two providers' rates (hereafter "higher of rate"). The higher of rate will be in effect until a full year's costs of providing services to the individual(s) impacted by the transfer of services is reflected in the assuming provider's base year CFR. If the assuming provider does not currently operate an ICF/IID but qualifies for the higher of rate, the rate will be the higher of the affected provider's rate or the regional average rate for the ICF/IID services.

ii. In situations where a non-state governmental provider or voluntary provider ceases to operate an ICF/IID due to circumstances other than those specified in paragraphs (145)(i)(a), (145)(i)(b), (145)(i)(c) or there is no emergency situation of a loss of services to individuals, any provider assuming the operation of those services will not be eligible for a temporarily enhanced reimbursement rate. The assuming provider will use their rate as calculated for all of the individuals for which they are taking over services. If the assuming provider does not currently operate an ICF/IID, the assuming provider will receive the affected provider's rate for the ICF/IID services.

Appendix II
2023 Title XIX State Plan
Fourth Quarter Amendment
Summary

SUMMARY
SPA #23-0097

This State Plan Amendment proposes to make necessary updates to the Intermediate Care Facility (ICF/IDD) rate methodology including updates to align to the recent OPWDD Comprehensive Waiver Amendment.

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

SPA 23-0097

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

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

(a) Notwithstanding any inconsistent provision of law, payment made by government agencies pursuant to title eleven of article five of the social services law for services provided by any facility licensed by the office of mental health pursuant to article thirty-one of this chapter or certified by the office of alcoholism and substance abuse services pursuant to this chapter to provide inpatient chemical dependence services, as defined in section 1.03 of this chapter, shall be at rates or fees certified by the commissioner of the respective office and approved by the director of the division of the budget, provided, however, the commissioner of mental health shall annually certify such rates or fees which may vary for distinct geographical areas of the state and, provided, further, that rates or fees for service for inpatient psychiatric services or inpatient chemical dependence services, at hospitals otherwise licensed pursuant to article twenty-eight of the public health law shall be established in accordance with section two thousand eight hundred seven of the public health law and, provided, further, that rates or fees for services provided by any facility or program licensed, operated or approved by the office for people with developmental disabilities, shall be certified by the commissioner of health; provided, however, that such methodologies shall be subject to approval by the office for people with developmental disabilities and shall take into account the policies and goals of such office.

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

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

(i) the establishment of a uniform statewide system of reports and audits relating to the quality of care provided, facility utilization and costs of providing services; such

a uniform statewide system may provide for appropriate variation in the application of the system to different classes or subclasses of facilities licensed by the office of mental health pursuant to article thirty-one of this chapter or licensed or operated by the office for people with developmental disabilities pursuant to article sixteen of this chapter, or certified by the office of alcoholism and substance abuse services pursuant to this chapter to provide inpatient chemical dependence services; and

(ii) methodologies used in the establishment of the schedules of rates or fees pursuant to this section provided, however, that the commissioner of health shall adopt rules and regulations including methodologies developed by him or her for services provided by any facility or program licensed, operated or approved by the office for people with developmental disabilities; provided, however, that such rules and regulations shall be subject to the approval of the office for people with developmental disabilities and shall take into account the policies and goals of such office.

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DEPARTMENT OF MENTAL HYGIENE

OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES

AID TO LOCALITIES 2023-24

For payment according to the following schedule:

	APPROPRIATIONS	REAPPROPRIATIONS
General Fund	4,993,192,000	3,171,637,000
All Funds	4,993,192,000	3,171,637,000

SCHEDULE

COMMUNITY SERVICES PROGRAM 4,993,192,000

General Fund
Local Assistance Account - 10000

For services and expenses of the community services program, net of disallowances, for community programs for people with developmental disabilities pursuant to article 41 of the mental hygiene law, and/or chapter 620 of the laws of 1974, chapter 660 of the laws of 1977, chapter 412 of the laws of 1981, chapter 27 of the laws of 1987, chapter 729 of the laws of 1989, chapter 329 of the laws of 1993 and other provisions of the mental hygiene law. Notwithstanding any inconsistent provision of law, the following appropriation shall be net of prior and/or current year refunds, rebates, reimbursements, and credits.

Notwithstanding any other provision of law, advances and reimbursement made pursuant to subdivision (d) of section 41.15 and section 41.18 of the mental hygiene law shall be allocated pursuant to a plan and in a manner prescribed by the agency head and approved by the director of the budget. The moneys hereby appropriated are available to reimburse or advance localities and voluntary non-profit agencies for expenditures made during local fiscal periods commencing January 1, 2023, April 1, 2023 or July 1, 2023, and for advances for the 3 month period beginning January 1, 2024.

Notwithstanding the provisions of article 41 of the mental hygiene law or any other

inconsistent provision of law, rule or regulation, the commissioner, pursuant to such contract and in the manner provided therein, may pay all or a portion of the expenses incurred by such voluntary agencies arising out of loans which are funded from the proceeds of bonds and notes issued by the dormitory authority of the state of New York.

Notwithstanding any other provision of law, the money hereby appropriated may be transferred to state operations and/or any appropriation of the office for people with developmental disabilities with the approval of the director of the budget.

Notwithstanding any inconsistent provision of law, moneys from this appropriation may be used for state aid of up to 100 percent of the net deficit costs of day training programs and family support services.

Notwithstanding the provisions of section 16.23 of the mental hygiene law and any other inconsistent provision of law, with relation to the operation of certified family care homes, including family care homes sponsored by voluntary not-for-profit agencies, moneys from this appropriation may be used for payments to purchase general services including but not limited to respite providers, up to a maximum of 14 days, at rates to be established by the commissioner and approved by the director of the budget in consideration of factors including, but not limited to, geographic area and number of clients cared for in the home and for payment in an amount determined by the commissioner for the personal needs of each client residing in the family care home.

Notwithstanding the provisions of subdivision 12 of section 8 of the state finance law and any other inconsistent provision of law, moneys from this appropriation may be used for expenses of family care homes including payments to operators of certified family care homes for damages caused by clients to personal and real property in accordance with standards established by the commissioner and approved by the director of the budget.

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DEPARTMENT OF MENTAL HYGIENE

OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES

AID TO LOCALITIES 2023-24

Notwithstanding any inconsistent provision of law, moneys from this appropriation may be used for appropriate day program services and residential services including, but not limited to, direct housing subsidies to individuals, start-up expenses for family care providers, environmental modifications, adaptive technologies, appraisals, property options, feasibility studies and preoperational expenses.

Notwithstanding any inconsistent provision of law except pursuant to a chapter of the laws of 2023 authorizing a 4.0 percent cost of living adjustment, for the period commencing on April 1, 2023 and ending March 31, 2024 the commissioner shall not apply any other cost of living adjustment for the purpose of establishing rates of payments, contracts or any other form of reimbursement.

Notwithstanding section 6908 of the education law and any other provision of law, rule or regulation to the contrary, direct support staff in programs certified or approved by the office for people with developmental disabilities, including the home and community based services waiver programs that the office for people with developmental disabilities is authorized to administer with federal approval pursuant to subdivision (c) of section 1915 of the federal social security act, are authorized to provide such tasks as OPWDD may specify when performed under the supervision, training and periodic inspection of a registered professional nurse and in accordance with an authorized practitioner's ordered care.

Notwithstanding any other provision of law to the contrary, and consistent with section 33.07 of the mental hygiene law, the directors of facilities licensed but not operated by the office for people with developmental disabilities who act as federally-appointed representative payees and who assume management responsibility over the funds of a resident may continue to use such funds for the cost of the

resident's care and treatment, consistent with federal law and regulations.

Funds appropriated herein shall be available in accordance with the following:

Notwithstanding any inconsistent provision of law, the director of the budget is authorized to make suballocations from this appropriation to the department of health medical assistance program.

Notwithstanding any inconsistent provision of law, and pursuant to criteria established by the commissioner of the office for people with developmental disabilities and approved by the director of the budget, expenditures may be made from this appropriation for residential facilities which are pending recertification as intermediate care facilities for people with developmental disabilities.

Notwithstanding the provisions of section 41.36 of the mental hygiene law and any other inconsistent provision of law, moneys from this appropriation may be used for payment up to $250 per year per client, at such times and in such manner as determined by the commissioner on the basis of financial need for the personal needs of each client residing in voluntary-operated community residences and voluntary-operated community residential alternatives, including individualized residential alternatives under the home and community based services waiver. The commissioner shall, subject to the approval of the director of the budget, alter existing advance payment schedules for voluntary-operated community residences established pursuant to section 41.36 of the mental hygiene law.

Notwithstanding any inconsistent provision of law, moneys from this appropriation may be used for the operation of clinics licensed pursuant to article 16 of the mental hygiene law including, but not limited to, supportive and habilitative services consistent with the home and community based services waiver.

Notwithstanding sections 112 and 163 of the state finance law and section 142 of the economic development law, or any other

inconsistent provision of law, funds appropriated to the department of health in accordance with a schedule based upon approved Medicaid claims for eligible home and community-based services, or other approved services as defined in section nine thousand eight hundred and seventeen of the American rescue plan act of 2021, from April 1, 2021 through March 31, 2024 and made available by the department of health via sub-allocation or transfer of up to $740,000,000 may be allocated and distributed by the commissioner of the office for people with developmental disabilities, subject to approval of the director of the budget, without a competitive bid or request for proposal process for the services and expenses of qualified applicants. All awards will be granted utilizing criteria established by the commissioner of the office for people with developmental disabilities to strengthen and enhance home and community-based services consistent with the American rescue plan act of 2021.

For the state share of medical assistance services expenses incurred by the department of health for the provision of medical assistance services to people with developmental disabilities (37835) 4,246,079,000

For additional state share medical assistance services expenses incurred by the department of health for the provision of medical assistance services to people with developmental disabilities, related to the development of new service opportunities for individuals with disabilities that are currently living at home and whose caregivers are unable to continue caring for them (37818) 2,000,000

For services and expenses of the office for people with developmental disabilities to implement a chapter of the laws of 2023, to provide funding for a cost of living adjustment for the purpose of establishing rates of payments, contracts or any other form of reimbursement for the period April 1, 2023 through March 31, 2024. Notwithstanding any other provision of law to the contrary, and subject to the approval of

law, a sum not to exceed $21,710,000 for the fiscal year ending March 31, 2024. Notwithstanding any other provision of law, and subject to the approval of the New York state director of the budget, the board of directors of the state of New York mortgage agency shall authorize the transfer to the housing trust fund corporation, for the purposes of reimbursing any costs associated with rural rental assistance program contracts authorized by this section, a total sum not to exceed $21,710,000, such transfer to be made from (i) the special account of the mortgage insurance fund created pursuant to section 2429-b of the public authorities law, in an amount not to exceed the actual excess balance in the special account of the mortgage insurance fund, as determined and certified by the state of New York mortgage agency for the fiscal year 2022-2023 in accordance with section 2429-b of the public authorities law, if any, and/or (ii) provided that the reserves in the project pool insurance account of the mortgage insurance fund created pursuant to section 2429-b of the public authorities law are sufficient to attain and maintain the credit rating, as determined by the state of New York mortgage agency, required to accomplish the purposes of such account, the project pool insurance account of the mortgage insurance fund, such transfer shall be made as soon as practicable but no later than June 30, 2023.

§ 4. Notwithstanding any other provision of law, the homeless housing and assistance corporation may provide, for purposes of the New York state supportive housing program, the solutions to end homelessness program or the operational support for AIDS housing program, or to qualified grantees under such programs, in accordance with the requirements of such programs, a sum not to exceed $50,781,000 for the fiscal year ending March 31, 2024. The homeless housing and assistance corporation may enter into an agreement with the office of temporary and disability assistance to administer such sum in accordance with the requirements of such programs. Notwithstanding any other provision of law, and subject to the approval of the New York state director of the budget, the board of directors of the state of New York mortgage agency shall authorize the transfer to the homeless housing and assistance corporation, a total sum not to exceed $50,781,000, such transfer to be made from (i) the special account of the mortgage insurance fund created pursuant to section 2429-b of the public authorities law, in an amount not to exceed the actual excess balance in the special account of the mortgage insurance fund, as determined and certified by the state of New York mortgage agency for the fiscal year 2022-2023 in accordance with section 2429-b of the public authorities law, if any, and/or (ii) provided that the reserves in the project pool insurance account of the mortgage insurance fund created pursuant to section 2429-b of the public authorities law are sufficient to attain and maintain the credit rating as determined by the state of New York mortgage agency, required to accomplish the purposes of such account, the project pool insurance account of the mortgage insurance fund, such transfer shall be made as soon as practicable but no later than March 31, 2024.

§ 5. This act shall take effect immediately.

PART R

Intentionally Omitted

PART S

Section 1. Paragraph (c) of subdivision 1 of section 652 of the labor law, as added by section 1 of part K of chapter 54 of the laws of 2016, is amended to read as follows:

(c) Remainder of state. Every employer shall pay to each of its employees for each hour worked outside of the city of New York and the counties of Nassau, Suffolk, and Westchester, a wage of not less than:

$9.70 on and after December 31, 2016,

$10.40 on and after December 31, 2017,

$11.10 on and after December 31, 2018,

$11.80 on and after December 31, 2019,

$12.50 on and after December 31, 2020,

and on each following December thirty-first **up to and until December 31, 2022**, a wage published by the commissioner on or before October first, based on the then current minimum wage increased by a percentage determined by the director of the budget in consultation with the commissioner, with the result rounded to the nearest five cents, totaling no more than fifteen dollars, where the percentage increase shall be based on indices including, but not limited to, (i) the rate of inflation for the most recent twelve month period ending June of that year based on the consumer price index for all urban consumers on a national and seasonally unadjusted basis (CPI-U), or a successor index as calculated by the United States department of labor, (ii) the rate of state personal income growth for the prior calendar year, or a successor index, published by the bureau of economic analysis of the United States department of commerce, or (iii) wage growth; or, if greater, such other wage as may be established by federal law pursuant to 29 U.S.C. section 206 or its successors or such other wage as may be established in accordance with the provisions of this article.

§ 2. Section 652 of the labor law is amended by adding two new subdivisions 1-a and 1-b to read as follows:

1-a. Annual minimum wage from January 1, 2024 to December 31, 2026.

(a) New York city. Notwithstanding subdivision one of this section, every employer regardless of size shall pay to each of its employees for each hour worked in the city of New York a wage of not less than:

$16.00 on and after January 1, 2024,

$16.50 on and after January 1, 2025,

$17.00 on and after January 1, 2026, or, if greater, such other wage as may be established by federal law pursuant to 29 U.S.C. section 206 or its successors or such other wage as may be established in accordance with the provisions of this article.

(b) Remainder of downstate. Notwithstanding subdivision one of this section, every employer shall pay to each of its employees for each hour worked in the counties of Nassau, Suffolk, and Westchester, a wage of not less than:

$16.00 on and after January 1, 2024,

$16.50 on and after January 1, 2025,

$17.00 on and after January 1, 2026, or, if greater, such other wage as may be established by federal law pursuant to 29 U.S.C. section 206 or its successors or such other wage as may be established in accordance with the provisions of this article.

(c) Remainder of state. Notwithstanding subdivision one of this section, every employer shall pay to each of its employees for each hour worked outside the city of New York and the counties of Nassau, Suffolk, and Westchester, a wage of not less than:

$15.00 on and after January 1, 2024,

$15.50 on and after January 1, 2025,

$16.00 on and after January 1, 2026, or, if greater, such other wage as may be established by federal law pursuant to 29 U.S.C. section 206 or its successors or such other wage as may be established in accordance with the provisions of this article.

1-b. Annual minimum wage increase beginning on January first, two thousand twenty-seven. (a) New York city. On and after January first, two thousand twenty-seven, every employer regardless of size shall pay to each of its employees for each hour worked in the city of New York, a wage of not less than the adjusted minimum wage rate established annually by the commissioner. Such adjusted minimum wage rate shall be determined by increasing the then current year's minimum wage rate by the rate of change in the average of the three most recent consecutive twelve-month periods between the first of August and the thirty-first of July, each over their preceding twelve-month periods published by the United States department of labor non-seasonally adjusted consumer price index for northeast region urban wage earners and clerical workers (CPI-W) or any successor index as calculated by the United States department of labor, with the result rounded to the nearest five cents.

(b) Remainder of downstate. On and after January first, two thousand twenty-seven, every employer shall pay to each of its employees for each hour worked in the counties of Nassau, Suffolk, and Westchester, a wage of not less than the adjusted minimum wage rate established annually by the commissioner. Such adjusted minimum wage rate shall be determined by increasing the then current year's minimum wage rate by the rate of change in the average of the three most recent consecutive twelve-month periods between the first of August and the thirty-first of July, each over their preceding twelve-month periods published by the United States department of labor non-seasonally adjusted consumer price index for the northeast region urban wage earners and clerical workers (CPI-W) or any successor index as calculated by the United States department of labor, with the result rounded to the nearest five cents.

(c) Remainder of state. On and after January first, two thousand twenty-seven, every employer shall pay to each of its employees for each hour worked outside of the city of New York and the counties of Nassau, Suffolk, and Westchester a wage of not less than the adjusted minimum wage rate established annually by the commissioner. Such adjusted minimum wage rate shall be determined by increasing the then current year's minimum wage rate by the rate of change in the average of the three most recent consecutive twelve-month periods between the first of August and the thirty-first of July, each over their preceding twelve-month periods published by the United States department of labor non-seasonally adjusted consumer price index for northeast region urban wage earners and clerical workers (CPI-W) or any successor index as calculated by the United States department of labor, with the result rounded to the nearest five cents.

(d) Exceptions. Effective January first, two thousand twenty-seven and thereafter, notwithstanding paragraphs (a), (b) and (c) of this subdivision, there shall be no increase in the minimum wage in the state for the following year if any of the following conditions are met, provided, however, that such exception shall be limited to no more than two consecutive years:

(i) the rate of change in the average of the most recent period of the first of August to the thirty-first of July over the preceding period of the first of August to the thirty-first of July published by the United States department of labor non-seasonally adjusted consumer price index for the northeast region urban wage earners and clerical workers

(CPI-W), or any successor index as calculated by the United States department of labor, is negative;

(ii) the three-month moving average of the seasonally adjusted New York state unemployment rate as determined by the U-3 measure of labor underutilization for the most recent period ending the thirty-first of July as calculated by the United States department of labor rises by one-half percentage point or more relative to its low during the previous twelve months; or

(iii) seasonally adjusted, total non-farm employment for New York state in July, calculated by the United States department of labor, decreased from the seasonally adjusted, total non-farm employment for New York state in April, and seasonally adjusted, total non-farm employment for New York state in July, calculated by the United States department of labor, decreased from the seasonally adjusted, total non-farm employment for New York state in January.

(e) The commissioner shall publish the adjusted minimum wage rates no later than the first of October of each year to take effect on the following first day of January.

§ 3. Subdivisions 2, 4 and 5 of section 652 of the labor law, subdivision 2 as amended by chapter 38 of the laws of 1990, the opening paragraph of subdivision 2 as amended by section 6 of part II of chapter 58 of the laws of 2020, and subdivisions 4 and 5 as amended by section 2 of part K of chapter 54 of the laws of 2016, are amended to read as follows:

2. Existing wage orders. The minimum wage orders in effect on the effective date of this act shall remain in full force and effect, except as modified in accordance with the provisions of this article; provided, however, that the minimum wage order for farm workers codified at part one hundred ninety of title twelve of the New York code of rules and regulations in effect on January first, two thousand twenty shall be deemed to be a wage order established and adopted under this article and shall remain in full force and effect except as modified in accordance with the provisions of this article or article nineteen-A of this chapter.

Such minimum wage orders shall be modified by the commissioner to increase all monetary amounts specified therein in the same proportion as the increase in the hourly minimum wage as provided in [~~subdivision~~] subdivisions one, one-a, and one-b of this section, including the amounts specified in such minimum wage orders as allowances for gratuities, and when furnished by the employer to its employees, for meals, lodging, apparel and other such items, services and facilities. All amounts so modified shall be rounded off to the nearest five cents. The modified orders shall be promulgated by the commissioner without a public hearing, and without reference to a wage board, and shall become effective on the effective date of such increases in the minimum wage except as otherwise provided in this subdivision, notwithstanding any other provision of this article.

4. Notwithstanding subdivisions one, one-a, one-b, and two of this section, the wage for an employee who is a food service worker receiving tips shall be a cash wage of at least two-thirds of the minimum wage rates set forth in subdivision one of this section, rounded to the nearest five cents or seven dollars and fifty cents, whichever is higher, provided that the tips of such an employee, when added to such cash wage, are equal to or exceed the minimum wage in effect pursuant to [~~subdivision~~] subdivisions one, one-a, and one-b of this section and

provided further that no other cash wage is established pursuant to section six hundred fifty-three of this article.

5. Notwithstanding subdivisions one, one-a, one-b, and two of this section, meal and lodging allowances for a food service worker receiving a cash wage pursuant to subdivision four of this section shall not increase more than two-thirds of the increase required by subdivision two of this section as applied to state wage orders in effect pursuant to [~~subdivision~~] subdivisions one, one-a, and one-b of this section.

§ 4. This act shall take effect immediately.

PART T

Intentionally Omitted

PART U

Section 1. Subdivision 2 of section 410-u of the social services law, as amended by section 1 of part L of chapter 56 of the laws of 2022, is amended to read as follows:

2. The state block grant for child care shall be divided into two parts pursuant to a plan developed by the department and approved by the director of the budget. One part shall be retained by the state to provide child care on a statewide basis to special groups and for activities to increase the availability and/or quality of child care programs, including, but not limited to, the start-up of child care programs, the operation of child care resource and referral programs, training activities, the regulation and monitoring of child care programs, the development of computerized data systems, and consumer education, provided however, that child care resource and referral programs funded under title five-B of article six of this chapter shall meet additional performance standards developed by the department of social services including but not limited to: increasing the number of child care placements for persons who are at or below [~~two hundred percent of the state income standard, or three hundred percent of the state income standard effective August first, two thousand twenty-two, provided such persons are at or below~~] eighty-five percent of the state median income, with emphasis on placements supporting local efforts in meeting federal and state work participation requirements, increasing technical assistance to all modalities of legal child care to persons who are at or below [~~two hundred percent of the state income standard, or three hundred percent of the state income standard effective August first, two thousand twenty two, provided such persons are at or below~~] eighty-five percent of the state median income, including the provision of training to assist providers in meeting child care standards or regulatory requirements, and creating new child care opportunities, and assisting social services districts in assessing and responding to child care needs for persons at or below [~~two hundred percent of the state income standard, or three hundred percent of the state income standard effective August first, two thousand twenty two, provided such persons are at or below~~] eighty-five percent of the state median income. The department shall have the authority to withhold funds from those agencies which do not meet performance standards. Agencies whose funds are withheld may have funds restored upon achieving performance standards. The other part shall be allocated to social services districts to

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

PUBLIC NOTICE
Department of Health

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

The Department of Health proposes to amend the Title XIX (Medicaid) State Plan for long term care services to comply with Social Services Law, Section 363-a and Public Health Law, Section 201(1)(v). The following changes are proposed:

Long Term Care Services

Effective on or after October 1, 2023, the Department of Health will make necessary updates to the Intermediate Care Facility (ICF/IDD) rate methodology including but not limited to amending the language pertaining to rebasing, budget neutrality, trends, and other changes to align to the recent updates within the OPWDD Comprehensive Waiver Amendment.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative is $2.5 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 consistent with the New York State enacted budget. The following changes are proposed:

Non-Institutional Services

Effective on or after October 1, 2023, the Department of Health will adjust Medicaid rates of payment by 1.86% statewide for those Mental Health Outpatient Treatment and Rehabilitative Services (MHOTRS) providers licensed by the Office of Mental Health who participate in the OMH Quality Improvement initiative. The existing quality improvement initiative program will be expanded to include hospital-based MHOTRS providers and the quality program will be enhanced to support expansion of access to mental health services and improved patient outcomes.

The estimated net aggregate increase in gross fee-for-service Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2024 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. 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

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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 the enacted New York State budget. The following changes are proposed:

Non-Institutional Services

Effective on or after October 1, 2023, the Department of Health will adjust rates statewide to reflect the impact of New York State Minimum Wage increases for the following services: Assertive Community Treatment, Partial Hospitalization, Mental Health Outpatient Treatment and Rehabilitative Services, Day Treatment Services for Children, Continuing Day Treatment, Personalized Recovery Oriented Services, and Comprehensive Psychiatric Emergency Program (CPEP) Services.

The estimated net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2023-2024 is $81,000.

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

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

LONG-TERM SERVICES
State Plan Amendment #23-0097

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.

		4/1/23 – 3/31/24	
Payment Type	**Non-Federal Share Funding**	**Non-Federal**	**Gross**
Nursing Homes Normal Per Diem	General Fund; Special Revenue Funds; County Contribution	$3.545B	$7.089B
Intermediate Care Facilities Normal Per Diem	General Fund; County Contribution	$438M	$877M
Nursing Homes Supplemental	General Fund	$159M	$318M
Intermediate Care Facilities Supplemental	General Fund	$0	$0
Nursing Homes UPL	IGT	$92M	$184M
Totals		**$4.234B**	**$8.468B**

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	$5.200B
Suffolk County	$226M
Nassau County	$217M
Westchester County	$204M

Erie County	$194M
Rest of State (53 Counties)	$1.187B
Total	**$7.228B**

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	4/1/23-3/31/24 IGT Amount
A Holly Patterson Extended Care Facility	Nassau County	$8M
Albany County Nursing Home	Albany County	$3M
Chemung County Health Center	Chemung County	$2M
Clinton County Nursing Home	Clinton County	$1M
Coler Rehabilitation & Nursing Care Center	New York City	$8M
Dr. Susan Smith Mckinney Nursing and Rehab Center	Kings County	$4M
Glendale Home	Schenectady County	$3M
Henry J. Carter Nursing Home	New York City	$3M
Lewis County General Hospital-Nursing Home Unit	Lewis County	$2M
Livingston County Center for Nursing and Rehabilitation	Livingston County	$5M
Monroe Community Hospital-Nursing Home Unit	Monroe County	$9M
New Gouverneur Hospital-Nursing Home Unit	New York City	$3M
Sea View Hospital Rehabilitation Center and Home	Richmond County	$5M
Sullivan County Adult Care Center	Sullivan County	$2M
Terrace View Long Term Care	Erie County	$7M
The Pines Healthcare & Rehab Centers Machias Camp	Cattaraugus County	$2M
The Pines Healthcare & Rehab Centers Olean Camp	Cattaraugus County	$2M
The Valley View Center for Nursing Care and Rehab	Orange County	$7M
Van Rensselaer Manor	Rensselaer County	$6M

Wayne County Nursing Home	Wayne County	$3M
Willow Point Rehabilitation & Nursing Center	Broome County	$4M
Wyoming County Community Hospital-NH Unit	Wyoming County	$3M
Total		**$92M**

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	4/1/23-3/31/24 Gross Total
Advanced Training Initiative	$43M	$0	$3M	$46M
Cinergy	$30M	$0	$0	$30M
1% Supplemental Payment	$130M	$1M	$9M	$140M
Enhanced ATI (VAP Workforce)	$102M	$0	$0	$102M
Nursing Home UPL	$0	$0	$184M	$184M
Total	**$306M**	**$1M**	**$196M**	**$502M**

   The Medicaid payments under this State Plan Amendment are not supplemental payments.

4. **Please provide a detailed description of the methodology used by the state to estimate the upper payment limit (UPL) for each class of providers (State owned or operated, non-state government owned or operated, and privately owned or operated). Please provide a current (i.e. applicable to the current rate year) UPL demonstration. Under regulations at 42 CFR 447.272, States are prohibited from setting payment rates for Medicaid inpatient services that exceed a reasonable estimate of the amount that would be paid under Medicare payment principals.**

   Response: The Intermediate Care Facilities (ICFs) UPL calculation is a payment-to-reasonable cost proxy calculation for state government and private facilities (note: there are no non-state governmental ICFs). The Medicaid payments under this State Plan Amendment will be included in the 2023 ICF UPL when it is submitted to CMS.

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

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

ACA Assurances:

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

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

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

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

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

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

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

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

Tribal Assurance:

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

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

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

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