NEW YORK STATE OF OPPORTUNITY. Department of Health

KATHY HOCHUL
Governor

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

KRISTIN M. PROUD
Acting Executive Deputy Commissioner

September 7, 2022

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

RE: SPA #22-0069
Non-Institutional Services

Dear Mr. McMillion:

The State requests approval of the enclosed amendment #22-0069 to the Title XIX (Medicaid) State Plan for non-institutional services to be effective July 1, 2022 (Appendix I). This amendment is being submitted based on enacted legislation. A summary of the plan amendment is provided in Appendix II.

The State of New York reimburses these services through the use of rates that are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area as required by § 1902(a)(30) of the Social Security Act and 42 CFR § 447.204.

A copy of pertinent sections of enacted legislation is enclosed for your information (Appendix III). A copy of the public notice of this plan amendment, which was given in the New York State Register on March 30, 2022, is also enclosed for your information (Appendix IV). In addition, responses to the five standard funding questions are also enclosed (Appendix V).

If you have any questions regarding this State Plan Amendment submission, please do not hesitate to contact Regina Deyette, Medicaid State Plan Coordinator, Division of Finance and Rate Setting, Office of Health Insurance Programs at (518) 473-3658.

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: 22-0069

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
July 1, 2022

5. FEDERAL STATUTE/REGULATION CITATION
§ 1905(a)(30) Other Medical Care

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 07/01/22-09/30/22 $ 150,475,000
b. FFY 10/01/22-09/30/23 $ 300,955,000

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.19-B: Pages: A(9)

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*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

9. SUBJECT OF AMENDMENT
Worker Bonuses - Non-Institutional

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
September 7, 2022

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

FOR CMS USE ONLY

16. DATE RECEIVED

17. DATE APPROVED

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL

19. SIGNATURE OF APPROVING OFFICIAL

20. TYPED NAME OF APPROVING OFFICIAL

21. TITLE OF APPROVING OFFICIAL

22. REMARKS

Instructions on Back

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

New York
A (9)

1905(a)(30) Other Medical Care

Health Care and Mental Hygiene Worker Bonuses

1. Effective July 1, 2022, through September 30, 2024, the Department of Health is providing additional supplemental payments, known as the "health care and mental hygiene bonuses," to qualified Medicaid enrolled providers that are defined as Employers in accordance with Social Services Law §367-w for payment of recruitment and retention bonuses to eligible employees. Employees eligible for the bonus payment must have worked:

    a. As front-line health care and mental hygiene practitioners, technicians, assistants or aides and other health care support workers that work under an eligible title listed in or determined in accordance with Social Services Law §367-w(2)(a);
    b. For a qualified employer as defined in Social Services Law §367-w;
    c. During the identified vesting period(s) for at least an average of 20 hours per week;
    d. In a position that received an annualized salary, excluding bonuses and overtime, of one hundred twenty-five thousand dollars or less;
    e. For a consecutive six-month period between October 1, 2021, and March 31, 2024, in accordance with a schedule issued by the Department of Health; and
    f. Are not suspended or excluded from the medical assistance program during the vesting period and at the time an employer submits a claim.

    Employees eligible pursuant to the above will receive a bonus for no more than two vesting periods per employer; and the total amount of bonus payments paid to any single qualified employee will not exceed $3,000.00. Employers will receive an amount to cover the bonus payment obligation in accordance with 367-w and to account for employer liabilities to pay Federal Insurance Contributions Act (FICA), Social Security, and Medicare Tax in an amount equal to 7.65 percent of the bonus payment obligation.

Appendix II
2022 Title XIX State Plan
Third Quarter Amendment
Summary

SUMMARY
SPA #22-0069

This State Plan Amendment proposes to provide worker bonuses to New York State's health care and mental hygiene workers effective on or after July 1, 2022.

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

SPA 22-0069

Chapter 56 of the Laws of 2022, Part ZZ:

PART ZZ

Section 1. The social services law is amended by adding a new section 367-w to read as follows:

§ 367-w. Health care and mental hygiene worker bonuses. 1. Purpose and intent. New York's essential front line health care and mental hygiene workers have seen us through a once-in-a-century public health crisis and turned our state into a model for battling and beating COVID-19. To attract talented people into the profession at a time of such significant strain while also retaining those who have been working so tirelessly these past two years, we must recognize the efforts of our health care and mental hygiene workforce and reward them financially for their service.

To do that, the commissioner of health is hereby directed to seek federal approvals as applicable, and, subject to federal financial participation, to support with federal and state funding bonuses to be made available during the state fiscal year of 2023 to recruit, retain, and reward health care and mental hygiene workers.

2. Definitions. As used in this section, the term:

(a) "Employee" means certain front line health care and mental hygiene practitioners, technicians, assistants and aides that provide hands on health or care services to individuals, without regard to whether the person works full-time, part-time, on a salaried, hourly, or temporary basis, or as an independent contractor, that received an annualized base salary of one hundred twenty-five thousand dollars or less, to include:

(i) Physician assistants, dental hygienists, dental assistants, psychiatric aides, pharmacists, pharmacy technicians, physical therapists, physical therapy assistants, physical therapy aides, occupational therapists, occupational therapy assistants, occupational therapy aides, speech-language pathologists, respiratory therapists, exercise physiologists, recreational therapists, all other therapists, orthotists, prosthetists, clinical laboratory technologists and technicians, diagnostic medical sonographers, nuclear medicine technologists, radiologic technologists, magnetic resonance imaging technologists, ophthalmic medical technicians, radiation therapists, dietetic technicians, cardiovascular technologists and technicians, certified first responders, emergency medical technicians, advanced emergency medical technicians, paramedics, surgical technologists, all other health technologists and technicians, orderlies, medical assistants, phlebotomists, all other health care support workers, nurse anesthetists, nurse midwives, nurse practitioners, registered nurses, nursing assistants, and licensed practical and licensed vocational nurses;

(ii) to the extent not already included in subparagraph (i) of this paragraph, staff who perform functions as described in the consolidated fiscal report (CFR) manual with respect to the following title codes:

Mental Hygiene Worker;
Residence/Site Worker;
Counselor (OMH);
Manager (OMH);
Senior Counselor (OMH);
Supervisor (OMH);
Developmental Disabilities Specialist QIDP - Direct Care (OPWDD);

Certified Recovery Peer Advocate;
Peer Professional - Non-CRPA (OASAS Only);
Job Coach/Employment Specialist (OMH and OPWDD);
Peer Specialist (OMH);
Counselor - Alcoholism and Substance Abuse (CASAC);
Counseling Aide/Assistant - Alcoholism and Substance Abuse;
Other Direct Care Staff;
Case Manager;
Counselor - Rehabilitation;
Developmental Disabilities Specialist/Habilitation Specialist QIDP - Clinical (OPWDD);
Emergency Medical Technician;
Intensive Case Manager (OMH);
Intensive Case Manager/Coordinator (OMH);
Nurse - Licensed Practical;
Nurse - Registered;
Psychologist (Licensed);
Psychologist (Master's Level)/Behavioral Specialist;
Psychology Worker/Other Behavioral Worker;
Social Worker - Licensed (LMSW, LCSW);
Social Worker - Master's Level (MSW);
Licensed Mental Health Counselor (OASAS, OMH, OCFS);
Licensed Psychoanalyst (OMH);
Therapist - Recreation;
Therapist - Activity/Creative Arts;
Therapist - Occupational;
Dietician/Nutritionist;
Therapy Assistant/Activity Assistant;
Nurse's Aide/Medical Aide;
Behavior Intervention Specialist 1 (OPWDD);
Behavior Intervention Specialist 2 (OPWDD);
Clinical Coordinator;
Intake/Screening;
Pharmacist;
Marriage and Family Counselor/Therapist;
Residential Treatment Facility (RTF) Transition Coordinator (OMH);
Crisis Prevention Specialist (OMH);
Early Recognition Specialist (OMH);

Other Clinical Staff/Assistants;
Nurse Practitioner/Nursing Supervisor;
Therapist - Physical;
Therapist - Speech;
Program or Site Director; and
Assistant Program or Assistant Site Director; and
(iii) such titles as determined by the commissioner, or relevant agency commissioner as applicable, and approved by the director of the budget.

(b) "Employer" means a provider enrolled in the medical assistance program under this title that employs at least one employee and that bills for services under the state plan or a home and community based services waiver authorized pursuant to subdivision (c) of section nineteen hundred fifteen of the federal social security act, or that has a provider agreement to bill for services provided or arranged through a managed care provider under section three hundred sixty-four-j of this title or a managed long term care plan under section forty-four hundred three-f of the public health law, to include:

(i) providers and facilities licensed, certified or otherwise authorized under articles twenty-eight, thirty, thirty-six or forty of the public health law, articles sixteen, thirty-one, thirty-two or thirty-six of the mental hygiene law, article seven of this chapter, fiscal intermediaries under section three hundred sixty-five-f of this title, pharmacies registered under section six thousand eight hundred eight of the education law, or school based health centers;

(ii) programs that participate in the medical assistance program and are funded by the office of mental health, the office of addiction services and supports, or the office for people with developmental disabilities; and

(iii) other provider types determined by the commissioner and approved by the director of the budget;

(iv) provided, however, that unless the provider is subject to a certificate of need process as a condition of state licensure or approval, such provider shall not be an employer under this section unless at least twenty percent of the provider's patients or persons served are eligible for services under this title and title XIX of the federal social security act.

(c) Notwithstanding the definition of employer in paragraph (b) of this subdivision, and without regard to the availability of federal financial participation, "employer" shall also include an institution of higher education, a public or nonpublic school, a charter school, an approved preschool program for students with disabilities, a school district or boards of cooperative educational services, programs funded by the office of mental health, programs funded by the office of addiction services and supports, programs funded by the office for people with developmental disabilities, programs funded by the office for the aging, a health district as defined in section two of the public health law, or a municipal corporation, where such program or entity employs at least one employee. Such employers shall be required to enroll in the system designated by the commissioner, or relevant agency commissioners, in consultation with the director of the budget, for the purpose of claiming bonus payments under this section. Such system or process for claiming bonus payments may be different from the system and process used under subdivision three of this section.

(d) "Vesting period" shall mean a series of six-month periods between the dates of October first, two thousand twenty-one and March thirty-

first, two thousand twenty-four for which employees that are continuously employed by an employer during such six-month periods, in accordance with a schedule issued by the commissioner or relevant agency commissioner as applicable, may become eligible for a bonus pursuant to subdivision four of this section.

(e) "Base salary" shall mean, for the purposes of this section, the employee's gross wages with the employer during the vesting period, excluding any bonuses or overtime pay.

(f) "Municipal corporation" means a county outside the city of New York, a city, including the city of New York, a town, a village, or a school district.

3. Tracking and submission of claims for bonuses. (a) The commissioner, in consultation with the commissioner of labor and the Medicaid inspector general, and subject to any necessary approvals by the federal centers for Medicare and Medicaid services, shall develop such forms and procedures as may be needed to identify the number of hours employees worked and to provide reimbursement to employers for the purposes of funding employee bonuses in accordance with hours worked during the

vesting period.

(b) Using the forms and processes developed by the commissioner under this subdivision, employers shall, for a period of time specified by the commissioner:

(i) track the number of hours that employees work during the vesting period and, as applicable, the number of patients served by the employer who are eligible for services under this title; and

(ii) submit claims for reimbursement of employee bonus payments. In filling out the information required to submit such claims, employers shall use information obtained from tracking required pursuant to paragraph (a) of this subdivision and provide such other information as may be prescribed by the commissioner. In determining an employee's annualized base salary, the employer shall use information based on payroll records.

(c) Employers shall be responsible for determining whether an employee is eligible under this section and shall maintain and make available upon request all records, data and information the employer relied upon in making the determination that an employee was eligible, in accordance with paragraph (d) of this subdivision.

(d) Employers shall maintain contemporaneous records for all tracking and claims related information and documents required to substantiate claims submitted under this section for a period of no less than six years. Employers shall furnish such records and information, upon request, to the commissioner, the Medicaid inspector general, the commissioner of labor, the secretary of the United States Department of Health and Human Services, and the deputy attorney general for Medicaid fraud control.

4. Payment of worker bonuses. (a) Upon issuance of a vesting schedule by the commissioner, or relevant agency commissioner as applicable, employers shall be required to pay bonuses to employees pursuant to such schedule based on the number of hours worked during the vesting period. The schedule shall provide for total payments not to exceed three thousand dollars per employee in accordance with the following:

(i) employees who have worked an average of at least twenty but less than thirty hours per week over the course of a vesting period would receive a five hundred dollar bonus for the vesting period;

(ii) employees who have worked an average of at least thirty but less than thirty-five hours per week over the course of a vesting period would receive a one thousand dollar bonus for such vesting period;

(iii) employees who have worked an average of at least thirty-five hours per week over the course of a vesting period would receive a one thousand five hundred dollar bonus for such vesting period.

(iv) full-time employees who are exempt from overtime compensation as established in the labor commissioner's minimum wage orders or otherwise provided by New York state law or regulation over the course of a vesting period would receive a one thousand five hundred dollar bonus for such vesting period.

(b) Notwithstanding paragraph (a) of this subdivision, the commissioner may through regulation specify an alternative number of vesting periods, provided that total payments do not exceed three thousand dollars per employee.

(c) Employees shall be eligible for bonuses for no more than two vesting periods per employer, in an amount equal to but not greater than three thousand dollars per employee across all employers.

(d) Upon completion of a vesting period with an employer, an employee shall be entitled to receive the bonus and the employer shall be

required to pay the bonus no later than the date specified under this subdivision, provided however that prior to such date the employee does not terminate, through action or inaction, the employment relationship with the employer, in accordance with any employment agreement, including a collectively bargained agreement, if any, between the employee and employer.

(e) Any bonus due and payable to an employee under this section shall be made by the employer no later than thirty days after the bonus is paid to the employer.

(f) an employer shall be required to submit a claim for a bonus to the department no later than thirty days after an employee's eligibility for a bonus vests, in accordance with and upon issuance of the schedule issued by the commissioner or relevant agency commissioner.

(g) No portion of any dollars received from claims under subparagraph (ii) of paragraph (b) of subdivision three of this section for employee bonuses shall be returned to any person other than the employee to whom the bonus is due or used to reduce the total compensation an employer is obligated to pay to an employee under section thirty-six hundred fourteen-c of the public health law, section six hundred fifty-two of the labor law, or any other provisions of law or regulations, or pursuant to any collectively bargained agreement.

(h) No portion of any bonus available pursuant to this subdivision shall be payable to a person who has been suspended or excluded under the medical assistance program during the vesting period and at the time an employer submits a claim under this section.

(i) The use of any accruals or other leave, including but not limited to sick, vacation, or time used under the family medical leave act, shall be credited towards and included in the calculation of the average number of hours worked per week over the course of the vesting period.

5. Audits, investigations and reviews. (a) The Medicaid inspector general shall, in coordination with the commissioner, conduct audits, investigations and reviews of employers required to submit claims under this section. Such claims, inappropriately paid, under this section shall constitute overpayments as that term is defined under the regulations governing the medical assistance program. The Medicaid inspector general may recover such overpayments to employers as it would an over-

payment under the medical assistance program, impose sanctions up to and including exclusion from the medical assistance program, impose penalties, and take any other action authorized by law where:

(i) an employer claims a bonus not due to an employee or a bonus amount in excess of the correct bonus amount due to an employee;

(ii) an employer claims, receives and fails to pay any part of the bonus due to a designated employee;

(iii) an employer fails to claim a bonus due to an employee.

(b) Any employer identified in paragraph (a) of this subdivision who fails to identify, claim and pay any bonus for more than ten percent of its employees eligible for the bonus shall also be subject to additional penalties under subdivision four of section one hundred forty-five-b of this article.

(c) Any employer who fails to pay any part of the bonus payment to a designated employee shall remain liable to pay such bonus to that employee, regardless of any recovery, sanction or penalty the Medicaid inspector general may impose.

(d) In all instances recovery of inappropriate bonus payments shall be recovered from the employer. The employer shall not have the right to recover any inappropriately paid bonus from the employee.

(e) Where the Medicaid inspector general sanctions an employer for violations under this section, they may also sanction any affiliates as defined under the regulations governing the medical assistance program.

6. Rules and regulations. The commissioner, in consultation with the Medicaid inspector general as it relates to subdivision five of this section, may promulgate rules, to implement this section pursuant to emergency regulation; provided, however, that this provision shall not be construed as requiring the commissioner to issue regulations to implement this section.

§ 2. Subparagraphs (iv) and (v) of paragraph (a) of subdivision 4 of section 145-b of the social services law, as amended by section 1 of part QQ of chapter 56 of the laws of 2020, are amended to read as follows:

(iv) such person arranges or contracts, by employment, agreement, or otherwise, with an individual or entity that the person knows or should know is suspended or excluded from the medical assistance program at the time such arrangement or contract regarding activities related to the medical assistance program is made[~~.~~]**;**

(v) **such person had an obligation to identify, claim, and pay a bonus under subdivision three of section three hundred sixty-seven-w of this article and such person failed to identify, claim and pay such bonus.**

(vi) For purposes of this paragraph, "person" as used in subparagraph (i) **of this paragraph** does not include recipients of the medical assistance program; and "person" as used in subparagraphs (ii) [~~--~~]**, (iii) and** (iv) **of this paragraph**, is as defined in paragraph (e) of subdivision [~~**(6)**~~] **six** of section three hundred sixty-three-d of this [~~**chapter**~~] **article; and "person" as used in subparagraph (v) of this paragraph includes employers as defined in section three hundred sixty-seven-w of this article**.

§ 3. Paragraph (c) of subdivision 4 of section 145-b of the social services law is amended by adding a new subparagraph (iii) to read as follows:

(iii) For subparagraph (v) of paragraph (a) of this subdivision, a monetary penalty shall be imposed for conduct described in subparagraphs (i), (ii) and (iii) of paragraph (a) of subdivision five of section three hundred sixty-seven-w of this article and shall not exceed one

thousand dollars per failure to identify, claim and pay a bonus for each employee.

§ 4. Health care and mental hygiene worker bonuses for state employees. 1. An employee who is employed by a state operated facility, an institutional or direct-care setting operated by the executive branch of the State of New York or a public hospital operated by the state university of New York and who is deemed substantially equivalent to the definition of employee pursuant to paragraph (a) of subdivision 2 of section 367-w of the social services law as determined by the commissioner of health, in consultation with the chancellor of the state university of New York, the commissioner of the department of civil service, the director of the office of employee relations, and the commissioners of other state agencies, as applicable, and approved by the director of the budget, shall be eligible for the health care and mental hygiene worker bonus. Notwithstanding the definition of base salary pursuant to paragraph (e) of subdivision 2 of section 367-w, such bonus shall only be paid to employees that receive an annualized base salary of one hundred twenty-five thousand dollars or less.

2. Employees shall be eligible for health care and mental hygiene worker bonuses in an amount up to but not exceeding three thousand

dollars per employee. The payment of bonuses shall be paid based on the total number of hours worked during two vesting periods based on the employee's start date with the employer. No employee's first vesting period may begin later than March thirty-first, two thousand twenty-three, and in total both vesting periods may not exceed one year in duration. For each vesting period, payments shall be in accordance with the following:

(a) employees who have worked an average of at least twenty but less than thirty hours per week over the course of a vesting period shall receive a five hundred dollar bonus for the vesting period;

(b) employees who have worked an average of at least thirty but less than thirty-seven and one half hours per week over the course of a vesting period shall receive a one thousand dollar bonus for such vesting period; and

(c) employees who have worked an average of at least thirty-seven and one half hours per week over the course of a vesting period shall receive a one thousand five hundred dollar bonus for such vesting period.

§ 5. An employee under this act shall be limited to a bonus of three thousand dollars per employee without regard to which section or sections such employee may be eligible or whether the employee is eligible to receive a bonus from more than one employer.

§ 6. Notwithstanding any provision of law to the contrary, any bonus payment paid pursuant to this act, to the extent includible in gross income for federal income tax purposes, shall not be subject to state or local income tax.

§ 7. Bonuses under this act shall not be considered income for purposes of public benefits or other public assistance.

§ 8. Paragraph (a) of subdivision 8 of section 131-a of the social services law is amended by adding a new subparagraph (x) to read as follows:

(x) all of the income of a head of household or any person in the household, who is receiving such aid or for whom an application for such aid has been made, which is derived from the health care and mental hygiene worker bonuses under section three hundred sixty-seven-w of this

article or under the chapter of the laws of two thousand twenty-two which added this subparagraph.

§ 9. The department of health shall request any necessary waiver or waivers from the centers for medicare and medicaid services to ensure that the payments required by this act shall not be included in the calculation of federal disproportionate share payments as determined by 42 CFR § 412.106, or in the calculation of the upper payment limit as determined by 42 CFR § 447.272 and 42 CFR § 447.321, for any applicable employer types that receive disproportionate share payments, upper payment limit supplemental payments, or similar supplemental payments where the centers for medicare and medicaid services has a waiver or similar process for the exclusion of the payments required by this act from such calculations.

§ 10. This act shall take effect immediately.

Appendix IV
2022 Title XIX State Plan
Third 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 institutional, non-institutional and long-term care services to comply with statutory provisions. The following changes are proposed:

All Services

Effective on or after April 1, 2022, the Department of Health will adjust rates statewide to reflect a 5.4% percent Cost of Living Adjustment for the following Office of Mental Health (OMH), Office of Addiction Services and Supports (OASAS), and Office for People With Developmental Disabilities (OPWDD) State Plan Services: OMH Outpatient Services, OMH Clinic Services, OMH Rehabilitative Services, Children Family Treatment Support Services, Health Home Plus, Residential Treatment Facilities for Children and Youth, OASAS outpatient addiction services, OASAS freestanding (non-hospital) inpatient rehabilitation services, OASAS freestanding inpatient detox services, OASAS addiction treatment centers, OASAS Part 820 residential services, OASAS residential rehabilitation services for youth, Intermediate Care Facility (ICF/IDD), Day Treatment, Article 16 Clinic services, Specialty Hospital, Health Home Services Provided by Care Coordination Organizations, Independent Practitioner Services for Individual with Developmental Disabilities (IPSIDD), and OPWDD Crisis Services.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to the April 1, 2022, 5.4% percent Cost of Living Adjustment contained in the budget for State Fiscal Year 2023 is $109.9 million.

Effective on or after April 1, 2022, Health care and mental hygiene worker bonuses will be provided to New York's essential front line health care and mental hygiene workers. These bonuses are intended to attract talented people into the profession and retain people who have been working during the COVID-19 Pandemic by rewarding them financially for their service.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for State Fiscal Year 2023 is $1.85 billion.

Effective for dates of service on or after April 1, 2022, through March 31, 2024, all Medicaid rate-based claims will receive a 1% operating increase. Payments exempted from this increase, are as follows:

- Payments not subject to federal financial participation;
- Payments that would violate federal law including, but not limited to, hospital disproportionate share payments that would be in excess of federal statutory caps;
- Payments made by other state agencies including, but not limited to, those made pursuant to articles 16, 31 and 32 of the mental hygiene laws;
- Payments the state is obligated to make pursuant to court orders or judgments;
- Payments for which the non-federal share does not reflect any state funding; and
- At the discretion of the Commissioner of Health and the Director of the Budget, payments with regard to which it is determined that application of increases pursuant to this section would result, by operation of federal law, in a lower federal medical assistance percentage applicable to such payments.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for State Fiscal Year 2023 is $165 million.

Effective for dates of service on or after April 1, 2022, the 1.5% uniform reduction for all non-exempt Department of Health state funds Medicaid payments will be restored.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for State Fiscal Year 2023 is $280 million.

Non-Institutional Services

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

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

For state fiscal year beginning April 1, 2022, through March 31, 2023, this proposal continues hospital outpatient payment adjustments that increase the operating cost components of rates of payment for hospital outpatient and emergency departments on and after April 1, 2011, for public general hospitals other than those operated by the State of New York or the State University of New York, which are located in a city with a population of over one million. The amount to be paid will be up to $287 million annually based on criteria and methodology set by the Commissioner of Health, which the Commissioner may periodically set through a memorandum of understanding with the New York City Health and Hospitals Corporation. Such adjustments shall be paid by means of one or more estimated payments. Payments may be added to rates of payment or made as aggregate payments.

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

For state fiscal year beginning April 1, 2022, through March 31, 2023, this proposal continues payment of up to $5.4 million in additional annual Medicaid payments to county operated free-standing clinics, not including facilities operated by the New York City Health and Hospitals Corporation, for services provided by such DTC and those provided by a county operated freestanding mental health or substance abuse DTC. Distributions shall be based on each eligible facility's proportionate share of the sum of all DTC and clinic visits for all eligible facilities receiving payments for the base year two years prior to the rate year. The proportionate share payments may be added to rates of payment or made as aggregate payments to eligible facilities.

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

Effective April 1, 2022, and each state fiscal year thereafter, this amendment proposes to revise the final payment component of the calculation to account for claim runout. The current authority to make supplemental payments for services provided by physicians, nurse practitioners and physician assistants will continue.

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

Effective on or after April 1, 2022, payments in quarter-hour units for the following harm reduction services for people who actively use drugs provided at New York State Commissioner of Health waivered comprehensive harm reduction programs (community-based organizations) will be revised. The intention is to combat the opioid overdose crisis and reduce health care costs for people who use drugs. Harm reduction services improve population health and have been shown to reduce health care costs by preventing disease transmission (HIV, HBV, and HCV), injection site infections, emergency department and inpatient care from drug overdose, injury, and death. Comprehensive harm reduction programs are effective at engaging high-risk populations and serving as a bridge for entry into drug treatment and other health and social services.

Regional monthly rates will be established for New York City and the rest of the state and are based on the expected direct service costs in each region. Billable activities encompass those components of harm reduction attributable to direct client service, such as brief assessment and treatment planning, harm reduction counseling, linkage and navigation, medication management and treatment adherence counseling, psychoeducation support groups. Direct and indirect costs are budgeted as part of the rate. No funds shall be used to carry out the purchase or distribution of sterile needles or syringes for the hypodermic injection of any illegal drug.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for State Fiscal Year 2023 is $34.6 million.

Effective on or after April 1, 2022, this notice proposes to establish Medical Assistance coverage and rates of payment for crisis intervention services to stabilize and treat mental health and substance use disorder conditions, provided by mobile crisis teams and residential crisis settings for adults, as well as crisis stabilization centers for adults and children.

More specifically, crisis intervention services provided by multidisciplinary mobile crisis teams in accordance with Section 9813 of the American Rescue Plan Act provide an array of crisis intervention services, including telephonic triage for both adults and children, mobile crisis response, and mobile or telephonic follow-up services, in a variety of settings in the community.

Crisis intervention services provided in crisis stabilization centers will provide urgently needed immediate evaluation, treatment, and support services, including coordination with other mental health and substance use services, for children and adults experiencing or at risk of a mental health or substance use disorder crisis.

Crisis intervention services will also be provided in residential crisis settings, which are short-term, voluntary, non-IMD, sub-acute settings, and address a spectrum of acuity levels in which an individual may present in a mental health or substance use disorder crisis. Services stabilize crisis symptoms and restore functionality to enable transition back to the community and to prevent or reduce future psychiatric crises.

The estimated annual net aggregate increase in gross Medicaid expenditures related to this State Plan Amendment for State Fiscal Year 2023 is $16M and for State Fiscal Year 2024 is $44.5 million.

Effective on or after April 1, 2022, and for each State Fiscal Year thereafter, the State proposes to revise the method of distributing the funding for the Clinic Safety Net (CSN) distribution for comprehensive diagnostic and treatment centers that are other than Federally Qualified Health Centers (referred to as the non-FQHC CSN distribution).

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

Effective on or after April 1, 2022, the State proposes to enter into outcomes-based contract arrangements with drug manufacturers for drugs provided to Medicaid beneficiaries through supplemental rebate agreements.

The estimated annual net aggregate decrease in gross Medicaid expenditures attributable to this initiative contained in the budget for State Fiscal Year 2023 is ($5 million).

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

Contingent upon CMS approval of the Spending Plan submitted by the state, established rates will be enhanced for state-plan approved private duty nursing (PDN) services for members 23 years of age and older by an additional 30 percent for the medically fragile training and experience and 45 percent for the private duty nursing directory starting April 1, 2022.

The estimated annual net aggregate increase in gross Medicaid expenditures as a result of the proposed amendments for PDN services for State Fiscal Year 2023 is $38.9 million.

Effective on or after April 1, 2022, pursuant to the Centers for Medicare and Medicaid Services, Medicaid coverage must include routine patient costs for items and services furnished in connection with participation by beneficiaries in qualifying clinical trials. The Department will submit a State Plan Amendment for Medicaid to formalize federal approval of existing coverage in accordance with the requirements. Routine patient costs and qualifying clinical trials are defined in Section 1905(a)30 and Section 1905(gg) of the Social Security Act (the Act), respectively. This includes clinical trials in any clinical phase of development that is conducted in relation to the prevention, detection, or treatment of any serious or life-threatening disease or condition and is described in any of clauses (i)-(iii) of section 1905(gg) of the Act. Routine patient costs do not include any investigational item or service that is the subject of the qualifying clinical trial and is not otherwise covered outside of the clinical trial under the state plan, waiver, or demonstration project.

There is no estimated annual change to gross Medicaid expenditures as a result of this proposed amendment, since these benefits are already covered under long-standing NYS Medicaid policy.

Effective on or after April 1, 2022, pursuant to the Centers for Medicare and Medicaid Services, Alternative Benefit Plans (ABP) coverage must include routine patient costs for items and services furnished in connection with participation by beneficiaries in qualifying clinical trials. The Department will submit a State Plan Amendment for ABP to formalize federal approval of existing coverage in accordance with the requirements. Routine patient costs and qualifying clinical trials are defined in Section 1905(a)30 and Section 1905(gg) of the Social Security Act (the Act), respectively. This includes clinical trials in any clinical phase of development that is conducted in relation to the prevention, detection, or treatment of any serious or life-threatening disease or condition and is described in any of clauses (i)-(iii) of section 1905(gg) of the Act. Routine patient costs do not include any investigational item or service that is the subject of the qualifying clinical trial and is not otherwise covered outside of the clinical trial under the state plan, waiver, or demonstration project.

There is no estimated annual change to gross Medicaid expenditures as a result of this proposed amendment, since these benefits are already covered under long-standing NYS Medicaid policy.

Effective April 1, 2022, the Medicaid Program is proposing to incentivize ABA provider enrollment and participation by increasing Medicaid reimbursement amounts, aligning fees with those paid by the Child Health Plus program. ‘‘Applied behavior analysis’’ or ‘‘ABA’’ is the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior. ABA services are provided to individuals who have a diagnosis of autism spectrum or related disorder. As of August 1, 2021, Medicaid began accepting enrollment of Licensed Behavior Analysts as independent practitioners to provide ABA to Medicaid members under age 21 with a diagnosis of Autism Spectrum Disorder or Rhett’s Syndrome. However, Medicaid Managed Care Plans (MMC) and ABA providers indicated that the Medicaid reimbursement rate is below rates paid by CHP and commercial plans. Subsequently, very few ABA providers have been willing to enroll as Medicaid managed care and/or fee-for-service providers.

The estimated annual net aggregate increase in gross Medicaid expenditures as a result of the proposed amendment for State Fiscal Year 2023 is $73.2 million.

Effective on or after April 1, 2022, this proposal to amend the State Plan to align with Subdivision 2 of section 365-a of the social services law, that authorizes clinical social workers, licensed pursuant to Article 154 of the Education law, to bill Medicaid directly for their services within their scope of practice, effective April 1, 2022.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for State Fiscal Year 2023 is $24.2 million.

Effective on or after April 1, 2022, this proposal to amend the State Plan to align with Subdivision 2 of section 365-a of the social services law, that authorizes licensed mental health counselors and marriage and family therapists, licensed pursuant to Article 163 of the Education law, to bill Medicaid directly for their services within their scope of practice, effective April 1, 2022.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for State Fiscal Year 2023 is $4.2 million.

Effective on or after July 1, 2022, Medicaid reimbursement rates for non-facility physician services will be updated to 70% of current Medicare rates. This update will apply to Evaluation & Management (E&M) and Medicine procedure codes. Most Medicaid physician reimbursement rates have not been updated since 2009 and New York Medicaid is currently reimbursing physicians, on average, at 45% of Medicare for E&M codes and 58% of Medicare for Medicine codes. Updating the Medicaid physician fee schedule is intended to increase the use of primary care and preventative services and reduced utilization of costlier downstream care.

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

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

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

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

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

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

Institutional Services

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

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

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

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

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

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

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

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

Effective on or after April 1, 2022, additional medical assistance, known as, Intergovernmental Transfer (IGT) payments, for inpatient hospital services may be made to public general hospitals operated by the State of New York or the State University of New York, or by a county which shall not include a city with a population over one million, and those public general hospitals located in the counties of Westchester, Erie, or Nassau, up to one hundred percent (100%) of each such public hospital's medical assistance, and uninsured patient losses after all other medical assistance, including disproportionate share hospital (DSH) payments to such public general hospitals. Payments will be made by means of one or more estimated distributions initially based on the latest DSH audit results, which shall later be reconciled to such payment year's actual DSH audit uncompensated care costs. Payments may be added to rates of payment or made as aggregate payments. Such payments will continue April 1, 2022, through March 31, 2025.

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

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

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

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

Long Term Care Services

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

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

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

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

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

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

Eligibility

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

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

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

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

each local (county) social services district and available for public review.

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 State
Notice of Review of Request for
Brownfield Opportunity Area
Conformance Determination
Project: Alvista Rise
Location: 147-25 94th Avenue
Jamaica Brownfield Opportunity Area
City of New York, Queens County

In accordance with General Municipal Law, Article 18 - C, Section 970-r, the Secretary of State designated the Jamaica Brownfield Opportunity Area, in the Bronx, on April 15, 2015. The designation of the Jamaica Brownfield Opportunity Area was supported by a Nomination or a comprehensive planning tool that identifies strategies to revitalize the area which is affected by one or more known or suspected brownfield sites.

Pursuant to New York State Tax Law, Article 1, Section 21, the eligible taxpayer(s) of a project site located in a designated Brownfield Opportunity Area may apply for an increase in the allowable tangible property tax credit component of the brownfield redevelopment tax credit if the Secretary of State determines that the project conforms to the goals and priorities established in the Nomination for a designated Brownfield Opportunity Area.

On October 5, 2021, J2 Owner LLC submitted a request for the Secretary of State to determine whether the project Alvista Rise, located at 147-25 94th Avenue, Queens, NY, which will be located within the designated Jamaica Brownfield Opportunity Area, conform to the goals and priorities identified in the Nomination that was prepared for the designated Jamaica Brownfield Opportunity Area.

The public is permitted and encouraged to review and provide comments on the request for conformance. For this purpose, the full application for a conformance determination is available online at: https://dos.ny.gov/system/files/documents/2022/03/application_147-25_94th-avenue_jamaica.pdf

Comments must be submitted no later than April 30th, 2022, either by mail to: Kevin Garrett, Department of State, Office of Planning and Development, 123 William St., #20-163, New York, NY 10038, or by email to: kevin.garrett@dos.ny.gov

PUBLIC NOTICE

Department of State
Notice of Review of Request for
Brownfield Opportunity Area
Conformance Determination
Project: The Arches
Location: Port Morris Harlem Riverfront
Brownfield Opportunity Area
City of New York, Bronx County

In accordance with General Municipal Law, Article 18 - C, Section 970-r, the Secretary of State designated the Port Morris Harlem Riverfront Brownfield Opportunity Area, in the Bronx, on April 9, 2015. The designation of the Port Morris Harlem Riverfront Brownfield Opportunity Area was supported by a Nomination or a comprehensive planning tool that identifies strategies to revitalize the area which is affected by one or more known or suspected brownfield sites.

Pursuant to New York State Tax Law, Article 1, Section 21, the eligible taxpayer(s) of a project site located in a designated Brownfield Opportunity Area may apply for an increase in the allowable tangible property tax credit component of the brownfield redevelopment tax credit if the Secretary of State determines that the project conforms to the goals and priorities established in the Nomination for a designated Brownfield Opportunity Area.

On July 30, 2021, Deegan 135 Realty LLC submitted a request for the Secretary of State to determine whether The Arches Project, which will be located within the designated Port Morris Harlem Riverfront Brownfield Opportunity Area, conform to the goals and priorities identified in the Nomination that was prepared for the designated Port Morris Harlem Riverfront Brownfield Opportunity Area.

The public is permitted and encouraged to review and provide comments on the request for conformance. For this purpose, the full application for a conformance determination is available online at: https://dos.ny.gov/system/files/documents/2022/03/2021-07-30-final-boa-conformance-application-with-attachments-for-deegan-135-realty-llc.pdf

Comments must be submitted no later than March 30th, 2022, either by mail to: Kevin Garrett, Department of State, Office of Planning and Development, 123 William St., #20-163, New York, NY 10038, or by email to: kevin.garrett@dos.ny.gov

PUBLIC NOTICE

Department of State
F-2022-0058, F-2022-0130 through F-2022-0140
Date of Issuance – March 30, 2022

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

The applicant has certified that the proposed activities comply with and will be conducted in a manner consistent with the federally approved New York State Coastal Management Program (NYSCMP). The applicant's consistency certification and accompanying public information and data are available for inspection at the New York State Department of State offices located at One Commerce Plaza, 99 Washington Avenue, in Albany, New York.

In F-2022-0058, F-2022-0130, F-2022-0131, F-2022-0132, F-2022-0133, F-2022-0134, F-2022-0135, F-2022-0136, F-2022-0137, F-2022-0138, F-2022-0139, and F-2022-0140, the consultant, Andrew Baird at First Coastal Corp., is proposing a living shoreline along twelve contiguous properties. The shoreline design will contain the following parts: a 12' wide emergent rock sill ranging from 40' to 65' long consisting of approx. 110 cubic yards of stone per property to be placed 58 feet seaward of the rock core dune; 94 cubic yards of clean sand fill landward of rock sill per property; 750 square feet of spartina planting 12″ O.C. per property; a rock-core dune of 45 cubic yards of toe stone and fill stone per property for 6 of the homes; additional 18″

Appendix V
2022 Title XIX State Plan
Third Quarter Amendment
Responses to Standard Funding Questions

NON-INSTITUTIONAL SERVICES
State Plan Amendment #22-0069

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-B of the state plan.

1. **Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by States for services under the approved State plan. Do providers receive and retain the total Medicaid expenditures claimed by the State (includes normal per diem, supplemental, enhanced payments, other) or is any portion of the payments returned to the State, local governmental entity, or any other intermediary organization? If providers are required to return any portion of payments, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the amount or percentage of payments that are returned and the disposition and use of the funds once they are returned to the State (i.e., general fund, medical services account, etc.)**

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

2. **Section 1902(a)(2) provides that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan. Please describe how the state share of each type of Medicaid payment (normal per diem, supplemental, enhanced, other) is funded. Please describe whether the state share is from appropriations from the legislature to the Medicaid agency, through intergovernmental transfer agreements (IGTs), certified public expenditures (CPEs), provider taxes, or any other mechanism used by the state to provide state share. Note that, if the appropriation is not to the Medicaid agency, the source of the state share would necessarily be derived through either an IGT or CPE. In this case, please identify the agency to which the funds are appropriated. Please provide an estimate of total expenditure and State share amounts for each type of Medicaid payment. If any of the non-federal share is being provided using IGTs or CPEs, please fully describe the matching arrangement including when the state agency receives the transferred amounts from the local government entity transferring the funds. If CPEs are used, please describe the methodology used by the state to verify that the total expenditures being certified are eligible for Federal matching funds in accordance with 42 CFR**

433.51(b). For any payment funded by CPEs or IGTs, please provide the following:

(i) a complete list of the names of entities transferring or certifying funds;

(ii) the operational nature of the entity (state, county, city, other);

(iii) the total amounts transferred or certified by each entity;

(iv) clarify whether the certifying or transferring entity has general taxing authority; and,

(v) whether the certifying or transferring entity received appropriations (identify level of appropriations).

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

		4/1/22 – 3/31/23	
Payment Type	**Non-Federal Share Funding**	**Non-Federal**	**Gross**
Supplemental	General Fund; Special Revenue Funds	$451,432,000	$902,865,000

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

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

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

2) Special Revenue Funds:

a. Health Care Reform Act (HCRA) Resource Fund: as authorized in section 92-dd of New York State Finance Law and was established in 1996, pursuant to New York State Public Health Law 2807-j. HCRA resources include health care related surcharges, assessments on hospital revenues, and a "covered lives" assessment paid by insurance carriers pursuant to chapter 820 of the laws of 2021.

b. Health Facility Cash Assessment Program (HFCAP) Fund: HFCAP requires New York State designated providers to pay an assessment on cash operating receipts on a monthly basis. The assessment includes Article 28 Residential Health Care Facilities, Article 28 General Hospitals, Article 36 Long Term Home Health Care Programs, Article 36 Certified Home Health Agencies and Personal Care Providers that possess a Title XIX (i.e. Medicaid) contract with a Local Social Services District for the delivery of personal care services pursuant to Section 367-i of the New York State Social Services Law.

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

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

   Response: The Medicaid payments authorized under this State Plan Amendment are supplemental payments and total $902,865,000 for State Fiscal Year 2022-23.

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

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

5. **Does any governmental provider receive payments that in the aggregate (normal per diem, supplemental, enhanced, other) exceed their reasonable costs of providing services? If payments exceed the cost of**

services, do you recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report?

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

ACA Assurances:

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

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

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

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

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

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

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

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

Tribal Assurance:

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

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

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

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