NEW YORK STATE | Department of Health

KATHY HOCHUL
Governor

JAMES V. McDONALD, MD, MPH
Commissioner

JOHANNE E. MORNE, MS
Executive Deputy Commissioner

December 31, 2024

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 #24-0074
Non-Institutional Services

Dear Director McMillion:

The State requests approval of the enclosed amendment #24-0074 to the Title XIX (Medicaid) State Plan for non-institutional services to be effective October 1, 2024 (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 September 25, 2024, 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]

Michael Ogborn
Deputy Medicaid Director
Office of Health Insurance Programs

Enclosures

DEPARTMENT OF HEALTH ANDHUMAN 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: 24 — 0074

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, 2024

5. FEDERAL STATUTE/REGULATION CITATION
§ 1905(a)(12) Prescribed Drugs, Dentures, and Prosthetic Devices; a

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 10/01/24-09/30/25 $ 0
b. FFY 10/01/25-09/30/26 $ 0

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.19-B Pages: 4(d), 4(d)(1), 4(d)(2)

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 4.19-B Pages: 4(d), 4(d)(1), 4(d)(2)

9. SUBJECT OF AMENDMENT
Drug Reimbursement

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
Michael Ogborn

13. TITLE
Deputy Medicaid Director

14. DATE SUBMITTED
December 31, 2024

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
2024 Title XIX State Plan
Fourth Quarter Amendment
Amended SPA Pages

New York
4(d)

1905(a)(12) Prescribed Drugs, Dentures, and Prosthetic Devices; and Eyeglasses
Outpatient Drug Reimbursement

1. Reimbursement for ~~Prescribed~~ Drugs (including specialty drugs) as outlined on the New York State Medicaid Pharmacy List of Reimbursable Drugs found on the state's website, dispensed by a retail pharmacy; an institutional or long term care pharmacy; an Indian Health Service, tribal or urban Indian pharmacy; or any other pharmacy enrolled in the NYS Medicaid FFS Program is as follows:

   a. Reimbursement for Brand Name Drugs is the lower of:

      i. National Average Drug Acquisition Cost (NADAC) or, in the event of no NADAC pricing available, Wholesale Acquisition Cost (WAC) ~~less 3.3%~~; plus, the professional dispensing fee in Section 2; or
      ii. the billing pharmacy's usual and customary price charged to the general public.

   b. Reimbursement for Generic Drugs is the lower of:

      i. NADAC or, in the event of no NADAC pricing available, WAC less 17.5%; plus, a professional dispensing fee; or
      ii. the Federal Upper Limit (FUL) plus the professional dispensing fee in Section 2; or
      iii. the State Maximum Acquisition Cost (SMAC) plus the professional dispensing fee in Section 2; or
      iv. the billing pharmacy's usual and customary price charged to the general public.

   c. Reimbursement for Nonprescription Drugs is the lower of:
      i. NADAC or, in the event of no NADAC pricing available, WAC; plus, if a covered outpatient drug, the professional dispensing fee in Section 2;
      ii. the FUL plus, if a covered outpatient drug, the professional dispensing fee in Section 2; or
      iii. the SMAC plus, if a covered outpatient drug, the professional dispensing fee in Section 2; or
      iv. the billing pharmacy's usual and customary price charged to the general public.

2. The professional dispensing fee for covered outpatient drugs, including 340B-purchased drugs, when dispensed by a retail pharmacy; an institutional or long term care pharmacy; an Indian Health Service, tribal or urban Indian pharmacy; or any other pharmacy enrolled in the NYS Medicaid FFS Program, is $10.18**.**

3. Payment for drugs dispensed by pharmacies that are acquired at a nominal price as referenced in 42 CFR § 447.502 is at actual acquisition cost plus the professional dispensing fee in Section 2.

4. Payment for drugs dispensed by pharmacies that are acquired via the Federal Supply Schedule is at actual acquisition cost plus the professional dispensing fee in Section 2.

New York

4(d)(1)

1905(a)(12) Prescribed Drugs, Dentures, and Prosthetic Devices; and Eyeglasses

~~c. Reimbursement for Nonprescription Drugs is the lower of:~~

~~i. NADAC or, in the event of no NADAC pricing available, WAC; plus, if a covered outpatient drug, the professional dispensing fee in Section 2;~~

~~ii. the FUL plus, if a covered outpatient drug, the professional dispensing fee in Section 2; or~~

~~iii. the SMAC plus, if a covered outpatient drug, the professional dispensing fee in Section 2; or~~

~~iv. the billing pharmacy's usual and customary price charged to the general public.~~

~~2. The professional dispensing fee for covered outpatient drugs, including 340B purchased drugs, when dispensed by a retail pharmacy; an institutional or long-term care pharmacy; an Indian Health Service, tribal or urban Indian pharmacy; or any other pharmacy enrolled in the NYS Medicaid FFS Program, is $10.00.~~

~~3. Payment for drugs dispensed by pharmacies that are acquired at a nominal price as referenced in 42 CFR § 447.502 is at actual acquisition cost plus the professional dispensing fee in Section 2.~~

~~4. Payment for drugs dispensed by pharmacies that are acquired via the Federal Supply Schedule is at actual acquisition cost plus the professional dispensing fee in Section 2.~~

5. Payment for drugs dispensed by the pharmacy of a 340B covered entity as described in section 1927(a)(5)(B) of the Act, or a contract pharmacy under contract with a 340B covered entity as described in section 1927(a)(5)(B) of the Act, ~~shall~~ will be as follows:
   a. 340B purchased drugs – actual acquisition cost not to exceed the 340B ceiling price, plus the professional dispensing fee in Section 2;
   b. Non-340B purchased drugs – in accordance with lower of logic in section 1 plus the professional dispensing fee in Section 2.

6. Payment for clotting factor dispensed by a pharmacy enrolled in the NYS Medicaid FFS Program is at the lower of: SMAC, as described below, not to exceed WAC, plus the professional dispensing fee in Section 2; or the billing pharmacy's usual and customary price charged to the general public.

   SMAC is established for clotting factor products using multiple clotting factor pricing resources including but not limited to wholesalers, drug file vendors such as First Data Bank, pharmaceutical manufacturers, and the Hemophilia Services Consortium, Inc. pricing. The Hemophilia Services Consortium, Inc. subcontracts with the New York Blood Center (both not-for-profit corporations) to negotiate with manufacturers and distributors to obtain the best volume discount for the Consortium's safety net hospital.

   The SMAC file is stored in a database where valid statistical calculations are used to evaluate and compare the various pricing benchmarks to develop the SMAC price. The SMAC file is updated monthly and applied to all clotting factor products.

   Payment for 340B-purchased clotting factor dispensed by a Hemophilia Treatment Center, whether the pharmacy is owned by the covered entity or has a contract pharmacy arrangement, ~~shall~~ will be in accordance with Section 5.a.

New York
4(d)(2)

1905(a)(12) Prescribed Drugs, Dentures, and Prosthetic Devices; and Eyeglasses

7. Practitioner ~~-administered~~ provided drugs billed separately under the medical benefit are reimbursed as follows:
   a. When administered or provided during an office visit, ~~payment is made at actual acquisition cost by invoice, not to exceed Medicare Part B price.~~ drugs will be reimbursed at the lower of:
      i. National Average Drug Acquisition Cost (NADAC) or, in the event of no NADAC pricing available, Wholesale Acquisition Cost (WAC); or
      ii. the Federal Upper Limit (FUL); or
      iii. the State Maximum Acquisition Cost (SMAC); or
      iv. the actual cost of the drug to the practitioner.

      No professional dispensing fee is paid.
   b. When administered by a practitioner in an ordered ambulatory setting, payment is at actual acquisition cost, not to exceed Medicare Part B price. Drugs purchased by covered entities at the prices authorized under Section 340B of the Public Health Services Act must be billed at their actual acquisition cost. No professional dispensing fee is paid.
   c. When administered in an outpatient setting to a patient of a disproportionate share hospital, clinic, or emergency department, payment may be made through either the Ambulatory Patient Group (APG) classification and reimbursement system, as referenced in page 1(b)(ii) of this Attachment, or, if carved out of the APG system, in accordance with Section 7.b.

      Reimbursement for drugs in the APG reimbursement are paid as follows:

      1. Practitioner-administered drugs assigned to an APG and paid through the APG drug band are reimbursed based on the weighted average, using Medicaid paid claims data. Payment for drugs purchased by covered entities at the prices authorized under Section 340B of the Public Health Services Act and paid through the APG drug band are paid at 75% of the drug's APG band payment amount.
      2. Practitioner-administered drugs assigned to an APG and paid through the APG Fee Schedule are paid in accordance with Section 7.b.

      No professional dispensing fee is paid.
   d. Federally Qualified Health Centers (FQHC) and Indian Health Services/Tribal/Urban Indian Clinic Facilities have the option of receiving their payment through the Federal Prospective (PPS) rate, or through the APG reimbursement methodology as an "alternative rate setting methodology". In the event the facility chooses to be reimbursed through the Federal PPS Rate, the rate is considered inclusive of any practitioner administered drugs. In the event the facility has opted for the APG reimbursement methodology, payment for drugs administered by a practitioner during a visit to the facility will be in accordance with Section 7.c. If a facility's Medicaid reimbursement under APGs is lower than what their payment would have been under the Federal PPS rate, the facility is entitled to receive a supplemental payment reflecting the difference between what they were paid under APGs and what they would have been paid using the PPS rate. No professional dispensing fee is paid.
8. Reimbursement for Investigational Drugs is not a covered service. The Department may consider Medicaid coverage on a case by case basis for life-threatening medical illnesses when no other treatment options are available. If/when approved by a Medical Director, reimbursement is at actual acquisition cost. When dispensed by a pharmacy enrolled in the NYS Medicaid FFS Program, reimbursement includes the professional dispensing fee in Section 2.

Appendix II
2024 Title XIX State Plan
Fourth Quarter Amendment
Summary

SUMMARY
SPA #24-0074

This State Plan Amendment proposes to amend pharmacy reimbursement for brand prescription drugs to wholesale acquisition cost, and physician provided drug reimbursement to a lower of methodology.

Appendix III
2024 Title XIX State Plan
Fourth Quarter Amendment
Authorizing Provisions

SPA 24-0074
Authorizing Provisions

Social Services Law, § 367-a(9)(a)(i)

9. Notwithstanding any inconsistent provision of law or regulation to the contrary, for those drugs which may not be dispensed without a prescription as required by section sixty-eight hundred ten of the education law and for which payment is authorized pursuant to paragraph (g) of subdivision two of section three hundred sixty-five-a of this title, and for those drugs that are available without a prescription as required by section sixty-eight hundred ten of the education law but are reimbursed as items of medical assistance pursuant to paragraph (a) of subdivision four of section three hundred sixty-five-a of this title, payments under this title shall be made at the following amounts:

(a) for drugs provided by medical practitioners and claimed separately by the practitioners the lower of:

(i) (1) an amount equal to the national average drug acquisition cost set by the federal centers for medicare and medicaid services for the drug, if any, or if such amount is not available, the wholesale acquisition cost of the drug based on the package size dispensed from, as reported by the prescription drug pricing service used by the department, (2) the federal upper limit, if any, established by the federal centers for medicare and medicaid services; (3) the state maximum acquisition cost, if any, established pursuant to paragraph (e) of this subdivision; or (4) the actual cost of the drug to the practitioner.

Social Services Law, § 367-a(9)(b)(ii)

(b) for drugs dispensed by pharmacies:

(i) (A) if the drug dispensed is a generic prescription drug, the lower of: (1) an amount equal to the national average drug acquisition cost set by the federal centers for medicare and medicaid services for the drug, if any, or if such amount if not available, the wholesale acquisition cost of the drug based on the package size dispensed from, as reported by the prescription drug pricing service used by the department, less seventeen and one-half percent thereof; (2) the federal upper limit, if any, established by the federal centers for medicare and medicaid services; (3) the state maximum acquisition cost, if any, established pursuant to paragraph (e) of this subdivision; or (4) the dispensing pharmacy's usual and customary price charged to the general public; (B) if the drug dispensed is available without a prescription as required by section sixty-eight hundred ten of the education law but is reimbursed as an item of medical assistance pursuant to paragraph (a) of subdivision four of section three hundred sixty-five-a of this title, the lower of (1) an amount equal to the national average drug

acquisition cost set by the federal centers for medicare and medicaid services for the drug, if any, or if such amount is not available, the wholesale acquisition cost of the drug based on the package size dispensed from, as reported by the prescription drug pricing service used by the department, (2) the federal upper limit, if any, established by the federal centers for medicare and medicaid services; (3) the state maximum acquisition cost if any, established pursuant to paragraph (e) of this subdivision; or (4) the dispensing pharmacy's usual and customary price charged to the general public;

(ii) if the drug dispensed is a brand-name prescription drug, the lower of:

(A) an amount equal to the national average drug acquisition cost set by the federal centers for medicare and medicaid services for the drug, if any, or if such amount is not available, the wholesale acquisition cost of the drug based on the package size dispensed from, as reported by the prescription drug pricing service used by the department; or (B) the dispensing pharmacy's usual and customary price charged to the general public; and

Appendix IV
2024 Title XIX State Plan
Fourth Quarter Amendment
Public Notice

For the New York City district, copies will be available at the following places:

New York County
250 Church Street
New York, New York 10018

Queens County, Queens Center
3220 Northern Boulevard
Long Island City, New York 11101

Kings County, Fulton Center
114 Willoughby Street
Brooklyn, New York 11201

Bronx County, Tremont Center
1916 Monterey Avenue
Bronx, New York 10457

Richmond County, Richmond Center
95 Central Avenue, St. George
Staten Island, New York 10301

For further information and to review and comment, please contact: Department of Health, Division of Finance and Rate Setting, 99 Washington Ave., One Commerce Plaza, Suite 1432, Albany, NY 12210, spa-inquiries@health.ny.gov

PUBLIC NOTICE

Department of Health

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

The Department of Health proposes to amend the Title XIX (Medicaid) State Plan for non-institutional services to outpatient clinics operated by a tribe or tribal organization and funded by the Indian Self-Determination Act (Public Law 93-638). The following changes are proposed:

Non-Institutional Services

Effective on or after October 1, 2024, the Department of Health will amend the New York Medicaid State Plan for Tribal 638 outpatient facilities to clarify that outpatient services provided by or through facilities of the Indian Health Services (IHS) which includes, at the option of the tribe, facilities operated by a tribe or tribal organization and funded by Title I or V of the Indian Self Determination and Education Assistance Act, also known as Tribal 638 facilities are paid at the most current applicable rates published in the Federal Register or Federal Register Notices by IHS.

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

Effective on or after October 1, 2024, New York State will reimburse Indian Health Service (IHS) /Tribal 638 facilities enrolled in New York State (NYS) Medicaid as a Tribal Federally Qualified Health Center (TFQHC) an alternative payment methodology (APM), which is equal to the federal all-inclusive rate (AIR) published annually in the Federal Register. TFQHCs will be reimbursed the full APM/AIR for eligible threshold visits rendered by qualified healthcare practitioners who are recognized/approved under the NYS Medicaid State Plan. This change will allow TFQHC's to be reimbursed the full APM/AIR for services provided to American Indians/Alaska Natives (AI's/AN's) either outside the four walls of the IHS/Tribal facility or for services provided to AI's/AN's "Through" the TFQHC under a written care coordination agreement.

IHS/Tribal 638 facilities, including TFQHCs, will be able to be reimbursed for up to a total of three (3) services per member per day for any combination of medical, behavioral health, dental, and ambulatory visits delivered face-to-face (either in person or via telehealth/telemedicine) as part of an eligible threshold visit. Eligible threshold visits are limited to Medicaid-covered services rendered by qualified healthcare practitioners who are recognized/approved under the NYS Medicaid State Plan. Tribal FQHC's may provide an array of distinct, non-related services to a member during a single encounter. This change would allow IHS/Tribal facilities the ability to be reimbursed the full APM/AIR for up to three (3) eligible threshold visits rendered face-to-face (either in person or via telehealth/telemedicine) when distinct, non-related services are provided to a member during a member encounter or when delivered as a part of a care coordination agreement per member per day.

The estimated net aggregate increase in gross Medicaid expenditures as a result of this proposed amendment for state fiscal year 2024-2025 is $2.6 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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3220 Northern Boulevard
Long Island City, New York 11101

Kings County, Fulton Center
114 Willoughby Street
Brooklyn, New York 11201

Bronx County, Tremont Center
1916 Monterey Avenue
Bronx, New York 10457

Richmond County, Richmond Center
95 Central Avenue, St. George
Staten Island, New York 10301

For further information and to review and comment, please contact: Department of Health, Division of Finance and Rate Setting, 99 Washington Ave., One Commerce Plaza, Suite 1432, Albany, NY 12210, spa-inquiries@health.ny.gov

PUBLIC NOTICE

Department of Health

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

The Department of Health proposes to amend the Title XIX (Medicaid) State Plan for non-institutional services to comply with NYS Social Services Law § 367-a, in Part I of Chapter 57 of the Laws of 2024. The following changes are proposed:

Non-Institutional Services

Effective on or after October 1, 2024, the Department proposes to amend pharmacy reimbursement for brand prescription drugs from wholesale acquisition cost minus 3.3 percent to wholesale acquisition cost in the reimbursement methodology. Additionally, the Department will amend the physician administered drug reimbursement for drugs provided and claimed separately by a medical practitioner from actual acquisition cost to the lower of:

- National Average Drug Acquisition Cost (NADAC) or, in the event of no NADAC pricing available, Wholesale Acquisition Cost (WAC); or
- the Federal Upper Limit (FUL); or
- the State Maximum Acquisition Cost (SMAC); or
- the actual cost of the drug to the practitioner.

The medical practitioner would never be reimbursed lower than either the SMAC or for drugs that do not have a SMAC, the wholesale acquisition cost of the drug based on package size.

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

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.

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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 long term care and non-institutional services to comply with the 2024-2025 enacted budget. The following changes are proposed:

Long Term Care Services

The following is a clarification to the June 26, 2024, noticed provision to provide a one-time increase in funding associated with reimbursement of residential health care facilities.

With clarification, the estimated net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2024-2025 is now $280.5 million.

Non-Institutional Services

The following is a clarification to the June 26, 2024, noticed provision to provide a one-time increase in funding associated with reimbursement of Adult Day Health Centers (ADHCs).

With clarification, the estimated net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2024-2025 is now $4.0 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:

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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
F-2024-0258
Date of Issuance – September 25, 2024

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

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

In F-2024-0258, the applicant, Suffolk County Department of Public Works, is proposing maintenance dredging of a 1,625' long x 40' wide and variable channel (133,500 sqft total) to a depth of 6' below mean low water. Approx 10,500 CY of material to be hydraulically dredged and placed via dredge pipeline into an existing upland disposal area west of Swan River. This project is located in Corey Creek, Town of Brookhaven, Suffolk County, south of Middle Road and west of Corey Avenue.

The applicant's consistency certification and supporting information are available for review at: https://dos.ny.gov/system/files/documents/2024/09/f-2024-0258.pdf or at https://dos.ny.gov/public-notices

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

- Great South Bay-East Significant Coastal Fish and Wildlife Habitat:

https://dos.ny.gov/system/files/documents/2020/03/great_south_bay_east.pdf

Original copies of public information and data submitted by the applicant 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.

Any interested parties and/or agencies desiring to express their views concerning any of the above proposed activities may do so by filing their comments, in writing, no later than 4:30 p.m., 15 days from the date of publication of this notice, or October 10, 2024.

Comments should be addressed to the Consistency Review Unit, Department of State, Office of Planning, Development and Community Infrastructure, One Commerce Plaza, 99 Washington Ave., Albany, NY 12231, (518) 474-6000, Fax (518) 473-2464. Electronic submissions can be made by email at: CR@dos.ny.gov

Appendix V
2024 Title XIX State Plan
Fourth Quarter Amendment
Responses to Standard Funding Questions

NON-INSTITUTIONAL SERVICES
State Plan Amendment #24-0074

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

2. **Section 1902(a)(2) provides that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan. Please describe how the state share of each type of Medicaid payment (normal per diem, supplemental, enhanced, other) is funded. Please describe whether the state share is from appropriations from the legislature to the Medicaid agency, through intergovernmental transfer agreements (IGTs), certified public expenditures (CPEs), provider taxes, or any other mechanism used by the state to provide state share. Note that, if the appropriation is not to the Medicaid agency, the source of the state share would necessarily be derived through either an IGT or CPE. In this case, please identify the agency to which the funds are appropriated. Please provide an estimate of total expenditure and State share amounts for each type of Medicaid payment. If any of the non-federal share is being provided using IGTs or CPEs, please fully describe the matching arrangement including when the state agency receives the transferred amounts from the local government entity transferring the funds. If CPEs are used, please describe the methodology used by the state to verify that the total expenditures being certified are eligible for Federal matching funds in accordance with 42 CFR 433.51(b). For any payment funded by CPEs or IGTs, please provide the following:**
   - **(i) a complete list of the names of entities transferring or certifying funds;**
   - **(ii) the operational nature of the entity (state, county, city, other);**

(iii) the total amounts transferred or certified by each entity;
(iv) clarify whether the certifying or transferring entity has general taxing authority: and,
(v) whether the certifying or transferring entity received appropriations (identify level of appropriations).

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

		4/1/24 – 3/31/25	
Payment Type	**Non-Federal Share Funding**	**Non-Federal**	**Gross**
Per Diem	General Fund	$3.4B	$10.2B

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

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

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

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 under this State Plan Amendment are not supplemental or enhanced payments.

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: This is not applicable, 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.