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 #24-0080
Non-institutional Services

Dear Director McMillion:

The State requests approval of the enclosed amendment #24-0080 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 18, 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 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: 24 — 0080

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)(2)(B), 1905(a)(2)(C)

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 10/01/24-09/30/25 $ 3,601,224
b. FFY 10/01/25-09/30/26 $ 1,435,548

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.19-B Page: 2(al)(1)

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 4.19-B Page: 2(al)(1)

9. SUBJECT OF AMENDMENT
Safety Net / VAP – Callen-Lorde & Oak Orchard

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

SPA 24-0080

Attachment A

Annotated Pages

Annotated Page: 2(al)(1)

New York
2(al)(1)

~~Federally Qualified Health Centers (FQHCs):~~

~~Provider Name~~	~~Gross Medicaid Rate Adjustment~~	~~Rate Period Effective~~
~~AHRC Health Care, Inc. (d/b/a ACCESS Community Health Center)~~	~~$74,937~~	~~01/01/2014 - 03/31/2014~~
	~~$299,749~~	~~04/01/2014 - 03/31/2015~~
	~~$160,152~~	~~04/01/2015 - 03/31/2016~~
~~Anthony L. Jordan Health Center~~	~~$40,268~~	~~01/01/2014 - 03/31/2014~~
	~~$161,073~~	~~04/01/2014 - 03/31/2015~~
	~~$81,295~~	~~04/01/2015 - 03/31/2016~~
~~Asian & Pacific Islander Coalition on HIV/AIDS, Inc. (d/b/a APICHA Community Health Center)~~	~~$67,633~~	~~01/01/14 - 03/31/2014~~
	~~$88,661~~	~~04/01/2014 - 03/31/2015~~
	~~$92,118~~	~~04/01/2015 - 03/31/2016~~
~~East Hill Family Medical Inc.~~	~~$35,217~~	~~01/01/2014 - 03/31/2014~~
~~Morris Heights Health Center, Inc.~~	~~$99,387~~	~~01/01/2014 - 03/31/2014~~
	~~$97,725~~	~~04/01/2014 - 03/31/2015~~
	~~$96,557~~	~~04/01/2015 - 03/31/2016~~
~~Mount Vernon Neighborhood Health Center Network~~	~~$38,713~~	~~01/01/2014 - 03/31/2014~~
	~~$41,170~~	~~04/01/2014 - 03/31/2015~~
	~~$43,000~~	~~04/01/2015 - 03/31/2016~~
~~The Floating Hospital~~	~~$29,476~~	~~01/01/2014 - 03/31/2014~~
	~~$29,476~~	~~04/01/2014 - 03/31/2015~~

Appendix I
2024 Title XIX State Plan
Fourth Quarter Amendment
Amended SPA Pages

New York
2(al)(1)

1905(a)(2)(B) Rural Health Clinic (RHC) Services and 1905(a)(2)(C) Federally Qualified Health Centers (FQHC)

Federally Qualified Health Centers (FQHCs):

Provider Name	Gross Medicaid Rate Adjustment	Rate Period Effective
Callen-Lorde Community Health Center	$4,367,716	10/01/24-03/31/25
	$2,699,711	04/01/25-03/31/26
	$1,563,973	04/01/26-03/31/27
Oak Orchard Community Health Center	$1,021,500	10/01/24-03/31/25
	$926,750	04/01/25-03/31/26
	$551,750	04/01/26-03/31/27

Appendix II
2024 Title XIX State Plan
Fourth Quarter Amendment
Summary

SUMMARY
SPA #24-0080

This State Plan Amendment proposes to assist Federally Qualified Health Centers (FQHCs) by providing a temporary rate adjustment because they are subject to or impacted by the closure, merger, consolidation, acquisition, or restructuring of a health care provider.

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

SPA 24-0080

Public Health Law

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

(b) Eligible providers shall include:

(i) providers undergoing closure;

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

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

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

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

(i) protect or enhance access to care;

(ii) protect or enhance quality of care;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(i) Eligible general hospitals shall include:

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

(B) a federally designated critical access hospital;

(C) a federally designated sole community hospital; or

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) applicant eligibility;

(2) each applicant's projected financial status;

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

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

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

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

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

(B) consultant fees;
(C) retirement of long term debt; or
(D) bankruptcy-related costs.

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

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

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

MISCELLANEOUS
NOTICES/HEARINGS

Notice of Abandoned Property Received by the State Comptroller

Pursuant to provisions of the Abandoned Property Law and related laws, the Office of the State Comptroller receives unclaimed monies and other property deemed abandoned. A list of the names and last known addresses of the entitled owners of this abandoned property is maintained by the office in accordance with Section 1401 of the Abandoned Property Law. Interested parties may inquire if they appear on the Abandoned Property Listing by contacting the Office of Unclaimed Funds, Monday through Friday from 8:00 a.m. to 4:30 p.m., at:

1-800-221-9311
or visit our web site at:
www.osc.state.ny.us

Claims for abandoned property must be filed with the New York State Comptroller's Office of Unclaimed Funds as provided in Section 1406 of the Abandoned Property Law. For further information contact: Office of the State Comptroller, Office of Unclaimed Funds, 110 State St., Albany, NY 12236.

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 as authorized by § 2826 of New York Public Health Law. The following changes are proposed:

Non-Institutional Services

Effective on or after October 1, 2024, temporary rate adjustments have been approved for services related to providers that are undergoing closure, merger, consolidation, acquisition or restructuring themselves or other health care providers. The temporary rate adjustments have been reviewed and approved for the following:

- Callen-Lorde Community Health Center with aggregate payment amounts totaling up to $4,367,716 for the period October 1, 2024 through March 31, 2025, $2,699,711 for the period of April 1, 2025 through March 31, 2026, and $1,563,973 for the period of April 1, 2026 through March 31, 2027.

- Oak Orchard Community Health Center, Inc with aggregate payment amounts totaling up to $1,021,500 for the period October 1, 2024 through March 31, 2025, $926,750 for the period of April 1, 2025 through March 31, 2026, and $551,750 for the period of April 1, 2026 through March 31, 2027.

The estimated net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget is $5,389,216 in 2024-2025. The Medicaid expenditures attributable to state fiscal year 2025-2026 and state fiscal year 2026-2027 are $3,626,461 and $2,115,723 respectively.

The public is invited to review and comment on this proposed State Plan Amendment, a copy of which will be available for public review on the Department's website at http://www.health.ny.gov/regulations/state_plans/status. Individuals without Internet access may view the State Plan Amendments at any local (county) social services district.

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

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

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

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

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

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

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

PUBLIC NOTICE

New York State and Local Retirement System
Unclaimed Amounts Payable to Beneficiaries

Pursuant to the Retirement and Social Security Law, the New York State and Local Retirement System hereby gives public notice of the amounts payable to beneficiaries.

The State Comptroller, pursuant to Sections 109(a) and 409(a) of the Retirement and Social Security Law has received, from the New York State and Local Retirement System, a listing of beneficiaries or estates having unclaimed amounts in the Retirement System. A list of names contained in this notice is on file and open to public inspection at the office of the New York State and Local Retirement System located at 110 State St., in the City of Albany, New York.

Set forth below are the names and last known city of record of the beneficiaries and estate appearing from the records of the New York State and Local Retirement System, entitled to the unclaimed benefits.

At the expiration of six months from the date of publication of this list of beneficiaries and estates, unless previously paid to the claimant, the amounts shall be deemed abandoned and place in the pension accumulation fund to be used for the purposes of said fund.

Any amounts so deemed abandoned and transferred to the pension accumulation fund, may be claimed by the executor or administrator of the estates or beneficiaries so designated to receive such amounts, by filing a claim with the State Comptroller. In the event such claim is properly made, the State Comptroller shall pay over to the estates or the person or persons making such claim, the amount without interest.

Beneficiary Name Beneficiary City
Adelaide Popely,Estate of West Sayville
Aird,Estate of Audrey J SPECULATOR
Alcorn,Jeffrey LAKEWOOD RCH
Ann R Ocker,Estate Of Port Washington
Annamarie Morra,Estate of Staten Island
Anne M Sisia,Estate Of Wappinger Falls
Archdeacon,Lorraine D BUFFALO
Ardis,Estate of Christine EAST MEADOW
Armstrong,Estate of James GREENWICH
Ashley,Jaden ROSEDALE
Austin,Estate of Mary S Salisbury
Bauer,Stephen Michael HAMBURG
Beirne,Dianne BUFFALO
Betty Jane VanVorst,Estate of NORTH CREEK
Beulah Reese,Estate Of Randolph
Bocca,Estate of Richard BAINBRIDGE
Booker,Conrad L LEWES
Borow,Benay STUART
Bowen,Tammy PALMETTO
Breeden,Lenny D SANBORN
Bretz,Catharine BALLSTON SPA
Bretz,Charmaine LENEXA
Britton,Estate of George POUGHKEEPSIE
Brown,Carolyn A BROOKLYN
Brown,Lewis PINE HILL
Brown,Tracy BIRMINGHAM
Brown,William D WOODSIDE
Bruer,Estate of Virginia SOUTHOLD
Bullock,Randy M BIRMINGHAM
Bump Sr,Estate of John R MEMPHIS
Burger Maxwell,Irene ATHENS
Burger,Colleen A ATHENS
Cabrera,Victoria KISSIMMEE
Carlon,Estate of Frank R Poughkeepsie
Carmichael,Kathleen M BALLSTON SPA
Carol Busse,Estate of SHIRLEY
Carolyn M Thall,Estate Of Ithaca
Caronia,Estate of Emily JUPITER
Carpenter Jr,John J BALLSTON SPA
Cecelia M Rover,Estate of SEA GIRT
Chaires,Susanne E SCHENECTADY
Chandler,Estate of William LELAND
CHOTKOWSKI,DENISE SCHENECTADY
Cody,Thomas Castlebar Co
Coleman,Estate of Rose P N PALM BEACH
Coumeri,Linda JACKSON
Courter III,Wygant MOSCOW MILLS
Coyle,Estate of John D PHILADELPHIA
Crosby,Estate of John G SCRANTON
Cuneo III,Victor E NORTHPORT
Cuneo,Michael E NORTHPORT
D'Auria,Dean TAPPAN
David,James ENDICOTT
Derr,Estate of Benjamin Carlisle
Di Rosa,James G N TONAWANDA
Di Rosa,John A N TONAWANDA
Di Rosa,Kevin D LONGMONT
Di Rosa,Mark D N TONAWANDA
Di Rosa,Michael J N TONAWANDA
Dibble,James P STERLING
Dibble,Shannon A BEALETON
Dietz,Michael BELVIDERE
Dietz,Robert F ISLIP
Donnelly,John F NEWARK VALLEY
Donnelly,Mark R PORT CRANE
Donnelly,Michael J CASTLE CREEK
Doty,Louise M CHESTER
Doty,Marian D MONROE
Doyle,Estate of Ethel Lake Mary
Edme,Evita HEMPSTEAD
Edwin J Vilim,Estate of WEST BABYLON
Eileen J ORourke,Estate of SMITHTOWN
Emma R Walsh,Estate of Oswego
Eric Dutton,Estate of Dexter
Family Trust 5/10/1990,Revocable Greenberg SKOKIE
Fear,Nicholas M SCHENECTADY
Ferry Jr,Neil TALLAHASSEE
Ferry,Michael TALLAHASSEE
Ferry,Thomas HUDSON FALLS
Finlayson,Aubree A CHAMPLAIN
Fitzgerald,Estate of Margaret Mary HIGHLAND
Franklin,Jeffrey L JAMESTOWN
French,Estate of Mittie PAVO
Fulton,David R CHESTNUT HILL
Gabel,Rose CROSS LKE TWP
Gademsky Jr,Estate of Leonard C NORTH TONAWANDA
Gardner,Marcus AMITYVILLE
Gehret,Estate of Carol J ELMIRA
Geiger,Estate of Verna SPRINGVILLE
Gene Hilliker,Estate of MATTITUCK
GERACI,KATHRYN E BUFFALO
Gipson,Estate of Irene N BUFFALO
Groshans,Estate of Mary BALLSTON SPA
Gross,Debra A GAINESVILLE
Gwen Devries,Estate of WARWICK
Hakes,Estate of Ruth E IRMO
Hamilton,Andre S FATE
Hamilton,Veronica G FRISCO
Hanna,Louis Lemuel NEW YORK
Hanna,Michaelyn Kai BROOKLYN
Hanna,Richard C KEW GARDENS
Hansley,Bruce Edward BROOKLYN
Hathorn,Kathy DALLAS
Head,Joseph R COLLEYVILLE
Healy,Estate of Barbara L CORAM
Helen Scott Lichtenberger,Estate Of VERO BEACH
Herrington,Estate of Ruth Monroe
Hevner,Juanita CORNING
Hevner,Randall W N FT MYERS
Hiller,Melanie GANSEVOORT
Homan Gordon,Estate of Shirley Superior
Horning,Michael M DRAPER
Horton,James P HORSEHEADS
Horton,Joseph M HORSEHEADS
Horton,Norma J HORSEHEADS
IFIL,Brooke Lynne J WHEATLEY HTS
Inga Solonevich,Estate of Roanoke

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

NON-INSTITUTIONAL SERVICES
State Plan Amendment #24-0080

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**
Vital Access Provider (VAP) Program	General Fund; Special Revenue Funds	$122.2M	$244.4M

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.

B. Special Revenue Funds:

1) 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:

   - Surcharge on net patient service revenues for specified provider types including Comprehensive Diagnostic and Treatment Centers and Ambulatory Surgery Centers.
     - The rate for commercial payors is 9.63 percent.
     - The rate for governmental payors, including Medicaid, is 7.04 percent.
     - Federal payors, including Medicare, are exempt from the surcharge.

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 $5.39 million for State Fiscal Year 2024-25.

Vital Access Provider (VAP) Program	Private	State Government	Non-State Government	4/1/24-3/31/25 Total
Supplemental	$5.39M	-	-	$5.39M

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 clinic UPL demonstration utilizes cost-to-payment methodology to estimate the upper payment limit for each class of providers. The Medicaid payments under this State Plan Amendment will be included in the 2024 clinic UPL when it is submitted to CMS.

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

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

ACA Assurances:

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

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

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

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

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

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

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

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

Tribal Assurance:

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

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

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

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