NEW YORK STATE | Department of Health

KATHY HOCHUL
Governor

JAMES V. McDONALD, MD, MPH
Commissioner

JOHANNE E. MORNE, MS
Executive Deputy Commissioner

March 28, 2025

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 #25-0009
Non-Institutional Services

Dear Director McMillion:

The State requests approval of the enclosed amendment #25-0009 to the Title XIX (Medicaid) State Plan for non-institutional services to be effective January 1, 2025 (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 December 11, 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]

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: 25-0009

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
January 1, 2025

5. FEDERAL STATUTE/REGULATION CITATION
§ 1905(a)(9) Clinic Services

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 01/01/25-09/30/25 $ 226,337
b. FFY 10/01/25-09/30/26 $ 301,783

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.19-B Pages: 2(g)(1), 2(g)(2), 2(g)(3)

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 4.19-B Pages: 2(g)(1), 2(g)(2), 2(g)(3)

9. SUBJECT OF AMENDMENT
January 2025 APG Update - Freestanding Clinics

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
March 28, 2025

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

Appendix I
2025 Title XIX State Plan
First Quarter Amendment
Amended SPA Pages

New York
2(g)(1)

1905(a)(9) Clinic Services

APG Reimbursement Methodology – Freestanding Clinics

For the purposes of sections pertaining to the Ambulatory Patient Group, and excepted as otherwise noted, the term freestanding clinics will mean freestanding Diagnostic and Treatment Centers (D&TCs) and will include freestanding ambulatory surgery centers.

For dates of service beginning September 1, 2009, through December 31, ~~2024~~ 2025, for freestanding Diagnostic and Treatment Center (D&TC) and ambulatory surgery center services, the operating component of rates will be reimbursed using a methodology that is prospective and associated with resource utilization to ensure that ambulatory services are economically and efficiently provided. The methodology is based upon the Ambulatory Patient Group (APG) classification and reimbursement system. This methodology incorporates payments for the separate covered Medicaid benefits in accordance with the payment methods for these services. Reimbursement for the capital component of these rates will be made as an add-on to the operating component as described in the APG Rate Computation section.

The Ambulatory Patient Group patient classification system is designed to explain the amount and type of resources used in an ambulatory visit by grouping patients with similar clinical characteristics and similar resource use into a specific APG. Each procedure code associated with a patient visit is assigned to an APG using the grouping logic developed by 3M Health Information Systems (3M). When evaluation and management codes are coded, the APG grouping logic also uses the diagnosis code to make the APG assignment. Ultimately, the procedures and diagnoses coded for a patient visit will result in a list of APGs that correspond on a one-for-one basis with each procedure coded for the visit.

New York
2(g)(2)

1905(a)(9) Clinic Services

APG Reimbursement Methodology – Freestanding Clinics

The following links direct users to the various definitions and factors that comprise the APG reimbursement methodology, which can also be found in aggregate on the APG website at http://www.health.ny.gov/health_care/medicaid/rates/apg/index.htm. In addition, prior period information associated with these links is available upon request to the Department of Health.

Contact Information:
http://www.health.ny.gov/health_care/medicaid/rates/apg/index.htm Click on "Contacts."

3M APG Crosswalk*:
http://www.health.ny.gov/health_care/medicaid/rates/apg/index.htm Click on "3M Versions and Crosswalks," then on "3M APG Crosswalk" toward bottom of page, and finally on "Accept" at bottom of page.

APG Alternative Payment Fee Schedule; updated as of 01/01/24:
http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm Click on "Alternative Payment Fee Schedule."

APG Consolidation Logic; logic is from version ~~3.18.24.3 and 3.18.24.4~~ 3.18.25.1 and 3.18.25.2, updated as of ~~07/01/24 and 10/01/24~~ 01/01/25 and 04/01/25:
http://www.health.ny.gov/health_care/medicaid/rates/bundling/ Click on "~~2024~~ 2025"

APG 3M Definitions Manual; version 3.18 updated as of ~~07/01/24 and 10/01/24~~ 01/01/25 and 04/01/25: http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm Click on "3M Versions and Crosswalk."

APG Investments by Rate Period; updated as of 07/01/10:
http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm Click on "Investments by Rate Period."

APG Relative Weights; updated as of ~~07/01/24~~ 01/01/25:
http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm Click on "Weights, Proc Weights, and APG Fee Schedule Amounts."

Associated Ancillaries; updated as of 01/01/20:
http://www.health.ny.gov/health_care/medicaid/rates/apg/index.htm Click on "Ancillary Policy."

*Older 3M APG crosswalk versions available upon request.

New York
2(g)(3)

1905(a)(9) Clinic Services

Carve-outs; updated as of 10/01/12. The full list of carve-outs is contained in Never Pay APGs and Never Pay Procedures:
http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm Click on "Carve Outs."

Coding Improvement Factors (CIF); updated as of 04/01/12 and 07/01/12:
http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm Click on "CIFs by Rate Period."

If Stand Alone, Do Not Pay APGs; updated 01/01/15:
http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm Click on "If Stand Alone, Do Not Pay APGs."

If Stand Alone, Do Not Pay Procedures; updated 07/01/22:
http://www.health.state.ny.us/health_care/medicaid/rates/methodology/index.htm Click on "If Stand Alone, Do Not Pay Procedures."

Modifiers; updated as of ~~07/01/24~~ 06/01/25:
http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm Click on "Modifiers."

Never Pay APGs; updated as of 07/01/21:
http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm Click on "Never Pay APGs."

Never Pay Procedures; updated as of ~~01/01/24~~ 01/01/25:
http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm Click on "Never Pay Procedures."

No-Blend APGs; updated as of 01/01/20:
http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm Click on "No Blend APGs."

No-Blend Procedures; updated as of 01/01/11:
http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm Click on "No-Blend Procedures."

No Capital Add-on APGs: updated as of 01/01/20:
http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm Click on "No Capital Add-on APGs."

Appendix II
2025 Title XIX State Plan
First Quarter Amendment
Summary

SUMMARY
SPA #25-0009

This State Plan Amendment proposes for freestanding clinic and ambulatory surgery center services to extend the Ambulatory Patient Group (APG) reimbursement methodology until December 31, 2025, and reflect the recalculated weight and component updates that will become effective on or after January 1, 2025.

Appendix III
2025 Title XIX State Plan
First Quarter Amendment
Authorizing Provisions

SPA 25-0009

PHL §2807(2-a)(e):

(e) (i) notwithstanding any inconsistent provisions of this subdivision, the commissioner shall promulgate regulations establishing, subject to the approval of the state director of the budget, methodologies for determining rates of payment for the services described in this subdivision. Such regulations shall reflect utilization of the ambulatory patient group (APG) methodology, in which patients are grouped based on their diagnosis, the intensity of the services provided and the medical procedures performed, and with each APG assigned a weight reflecting the projected utilization of resources. Such regulations shall provide for the development of one or more base rates and the multiplication of such base rates by the assigned weight for each APG to establish the appropriate payment level for each such APG. Such regulations may also utilize bundling, packaging and discounting mechanisms.

If the commissioner determines that the use of the APG methodology is not, or is not yet, appropriate or practical for specified services, the commissioner may utilize existing payment methodologies for such services or may promulgate regulations, and may promulgate emergency regulations, establishing alternative payment methodologies for such services.

(ii) Notwithstanding this subdivision and any other contrary provision of law, the commissioner may incorporate within the payment methodology described in subparagraph (i) of this paragraph payment for services provided by facilities pursuant to licensure under the mental hygiene law, provided, however, that such APG payment methodology may be phased into effect in accordance with a schedule or schedules as jointly determined by the commissioner, the commissioner of mental health, the commissioner of alcoholism and substance abuse services, and the commissioner of mental retardation and developmental disabilities.

(iii) Regulations issued pursuant to this paragraph may incorporate quality related measures limiting or excluding reimbursement related to potentially preventable conditions and complications; provided however, such quality related measures shall not include any preventable conditions and complications not identified for Medicare nonpayment or limited payment.

Regulation: 10 NYCRR 86-8.11: https://regs.health.ny.gov/content/section-86-811-system-updating-and-incorporation-reference

PHL §2807(2-a)(f)(ii)(C):

(f)(i) The commissioner shall periodically measure the utilization and intensity of services provided to medical assistance recipients in ambulatory settings. Such analysis shall include, but not be limited to: measurement of the shift of surgical procedures from the inpatient hospital setting to the ambulatory setting including measurement of the impact of any such shift on quality of care and outcomes; changes in the utilization and intensity of services provided in the outpatient hospital department and in diagnostic and treatment centers; and the change in the utilization and intensity of services provided in the emergency department.

(ii) notwithstanding the provisions of paragraphs (a) and (b) of this subdivision, for periods on and after January first, two thousand nine, the following services provided by general hospital outpatient departments and diagnostic and treatment centers shall be reimbursed with rates of payment based entirely upon the ambulatory patient group methodology as described in paragraph (e) of this subdivision, provided, however, that the commissioner may utilize existing payment methodologies or may promulgate regulations establishing alternative payment methodologies for one or more of the services specified in this subparagraph, effective for periods on and after March first, two thousand nine:

(A) services provided in accordance with the provisions of paragraphs (q), (r), and (ll) of subdivision two of section three hundred sixty-five-a of the social services law; and

(B) all services, but only with regard to additional payment amounts, as determined in accordance with regulations issued in accordance with paragraph (e) of this subdivision, for the provision of such services during times outside the facility's normal hours of operation, as determined in accordance with criteria set forth in such regulations; and

(C) services provided by licensed social workers, licensed mental health counselors, and licensed marriage and family therapists, in accordance with licensing criteria set forth in applicable regulations; and

(D) individual psychotherapy services provided by licensed social workers, in accordance with licensing criteria set forth in applicable regulations, at diagnostic and treatment centers that provided, billed for, and received payment for these services between January first, two thousand seven and December thirty-first, two thousand seven;

(E) services provided to pregnant women pursuant to paragraph (s) of subdivision two of section three hundred sixty-five-a of the social services law and, for periods on and after January first, two thousand ten, all other services provided pursuant to such paragraph (s) and services provided pursuant to paragraph (t) of subdivision two of section three hundred sixty-five-a of the social services law;

(F) wheelchair evaluation services and eyeglass dispensing services; and

(G) immunization services, effective for services rendered on and after June tenth, two thousand nine.

Appendix IV
2025 Title XIX State Plan
First 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.

NOTICE OF PUBLIC HEARING
Environmental Facilities Corporation

SUMMARY: The Environmental Facilities Corporation ("EFC") will hold a public hearing on February 10, 2025. EFC will hold this hearing in person. At this public hearing, EFC will hear testimony on the proposed amendments to update and modernize the priority ranking system scoring criteria for projects receiving financial assistance from the Clean Water State Revolving Fund program. The Notice of Proposed Rule Making was published in the State Register on November 20, 2024. The public should note that this public hearing will be the only opportunity to offer oral comments to EFC for the proposed amendments. The deadline for the submission of written comments is 5 p.m. on February 18, 2025.

DATES: The public hearing will convene on February 10, 2025 at 5:30 p.m. The public hearing will end at 7:00 p.m. or at the conclusion of public testimony, whichever is earlier. The deadline for submitting written comments is 5:00 p.m. on February 18, 2025.

ADDRESSES: This public hearing will be conducted in person at 625 Broadway, Room 129B, Albany, NY 12207.

For further information contact: Derek Sellman, Deputy General Counsel, (518) 402-6924 or derek.sellman@efc.ny.gov. Interpreter services shall be made available to deaf persons, and translator services shall be made available to persons with limited English proficiency, at no charge for either service, upon written request. Requests should be received 10 calendar days before the meeting, but EFC will make every effort to fulfill requests received closer to the meeting date.

Information concerning the proposed amendments, including text of proposed rule, is available at EFC's website at https://efc.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 revise provisions of the Ambulatory Patient Group (APG) reimbursement methodology in accordance with the Public Health Law § 2807(2–a)(e). The following changes are proposed:

Non-Institutional Services

Effective on or after January 1, 2025, the Ambulatory Patient Group (APG) reimbursement methodology is revised to include recalculated weight and component updates in order to update reimbursement for APG payments.

The estimated annual aggregate increase in gross Medicaid expenditures as a result of this proposed amendment is $2 million.

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

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

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

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

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

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

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

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

PUBLIC NOTICE
Department of Health

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

The Department of Health proposes to amend the Title XIX (Medicaid) State Plan for non-institutional services to 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

The following is a clarification to the September 25, 2024, noticed provision to amend the total of encounters/services per member per day from three (3) to five (5), that Indian Health Services (IHS)/Tribal 638 facilities, including Tribal Federally Qualified Health Centers (TFQHCs), will be reimbursed 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. IHS/Tribal 638/TFQHC providers may offer an array of distinct, non-related services to a member during a single encounter. This change would allow IHS/Tribal 638/TFQHC providers the ability to be reimbursed the full alternative payment methodology (APM)/all-inclusive rate (AIR) for up to a total of five (5) 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.

With clarification, the estimated net aggregate increase in gross Medicaid expenditures as a result of this proposed amendment for state fiscal year 2024-2025 is $2.7 million.

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

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

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

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

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

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

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

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

PUBLIC NOTICE

Department of Health

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

The Department of Health proposes to amend the Title XIX (Medicaid) State Plan for institutional, non-institutional and long-term care services to comply with statutory provisions. The following changes are proposed:

Non-Institutional Services

Effective on or after January 1, 2025, 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 the period beginning January 1, 2025 through December 31, 2025, 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 the current 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 the period beginning January 1, 2025 through December 31, 2025, 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.

Institutional Services

Effective on or after January 1, 2025, 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 the period beginning January 1, 2025 through December 31, 2025, 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 the current 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 the period beginning January 1, 2025 through December 31, 2025, 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 amendment.

Long Term Care Services

Effective on or after January 1, 2025, this proposal continues additional payments to non-state government operated public residential health care facilities, including public residential health care facilities located in Nassau, Westchester, and Erie Counties, but not excluding public residential health care facilities operating by a town or city

Appendix V
2025 Title XIX State Plan
First Quarter Amendment
Responses to Standard Funding Questions

NON-INSTITUTIONAL SERVICES
State Plan Amendment #25-0009

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**
Normal Per Diem	General Fund; Special Revenue Funds; County Contribution	$556M	$1,251M

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 Medicaid 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.

C. Additional Resources for Non-Federal Share Funding:

County Contribution: In State Fiscal Year 2006, through enacted State legislation (Part C of Chapter 58 of the laws of 2005), New York State "capped" the amount localities contributed to the non-Federal share of providers claims. This was designed to relieve pressure on county property taxes and the NYC budget by limiting local contributions having New York State absorb all local program costs above this fixed statutory inflation rate (3% at the time).

However, in State Fiscal Year 2013 New York State provided additional relief to Localities by reducing local contributions annual growth from three precent to zero over a three-year period. Beginning in State Fiscal Year 2016, counties began paying a fixed cost in perpetuity as follows:

Entity	Annual Amount
New York City	$5.210B
Suffolk County	$243M
Nassau County	$231M
Westchester County	$215M
Erie County	$205M
Rest of State (53 Counties)	$1.260B
Total	**$7.364B**

By eliminating the growth in localities Medicaid costs, the State has statutorily capped total Statewide County Medicaid expenditures at 2015 levels. All additional county Medicaid costs are funded by the State through State funding as described above. DOH provides annual letters to counties providing weekly contributions. Contributions are deposited directly into State escrow account and used to offset 'total' State share Medicaid funding.

NOTE: The Local Contribution is not tied to a specific claim or service category and instead is a capped amount based on 2015 county spending levels as stated above.

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 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: 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 2025 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.