NEW YORK STATE | Department of Health

KATHY HOCHUL
Governor

JAMES V. McDONALD, MD, MPH
Commissioner

JOHANNE E. MORNE, MS
Executive Deputy Commissioner

June 30, 2025

Courtney Miller
Director
CMS/Center for Medicaid & CHIP Services
Medicaid & CHIP Operations Group
601 E. 12th St., Room 355
Kansas City, Missouri 64106

RE: SPA #25-0004
Non-Institutional Services

Dear Director Miller:

The State requests approval of the enclosed amendment #25-0004 to the Title XIX (Medicaid) State Plan for non-institutional services to be effective May 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 April 30, 2025, is also enclosed for your information (Appendix IV). In addition, responses to the five standard funding questions and the standard access questions are also enclosed (Appendix V and VI, respectively).

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: 25-0004

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
May 01, 2025

5. FEDERAL STATUTE/REGULATION CITATION
§ 1905(a)(3) Other laboratory and X-ray services

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 05/01/25-09/30/25 $ (364,910)
b. FFY 10/01/25-09/30/26 $ (875,784)

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 3.1-A Supplemental Page: 2(a)(ii)(d)
Attachment 3.1-B Supplemental Page: 2(a)(ii)(d)
Attachment 4.19-B Page: 4(a)(i)(6.1)

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*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

9. SUBJECT OF AMENDMENT
Portable Radiology

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
June 30, 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

Instructions on Back

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

New York
2(a)(ii)(d)

1905(a)(3) Other laboratory and X-ray services

Portable x-ray

Portable x-ray involves screening and diagnostic radiology provided by a Medicaid-enrolled portable x-ray provider under the general supervision of a physician, delivered to patients in long term care settings or community-based settings, including patients who are home-bound. Portable x-ray procedures are limited to skeletal films involving the extremities, pelvis, vertebral column, or skull; and chest or abdominal films that do not involve the use of contrast media. Portable x-ray providers are eligible for reimbursement for transportation and set-up when providing a billable x-ray service. EKG's are allowed as a covered service but not independent of an x-ray or eligible for transportation reimbursement.

New York
2(a)(ii)(d)

1905(a)(3) Other laboratory and X-ray services

Portable x-ray

Portable x-ray involves screening and diagnostic radiology provided by a Medicaid-enrolled portable x-ray provider under the general supervision of a physician, delivered to patients in long term care settings or community-based settings, including patients who are home-bound. Portable x-ray procedures are limited to skeletal films involving the extremities, pelvis, vertebral column, or skull; and chest or abdominal films that do not involve the use of contrast media. Portable x-ray providers are eligible for reimbursement for transportation and set-up when providing a billable x-ray service. EKG's are allowed as a covered service but not independent of an x-ray or eligible for transportation reimbursement.

New York
4(a)(i)(6.1)

1905(a)(3) Other laboratory and X-ray services

Portable X-Ray

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of portable x-ray. The agency's fee schedule rate was last updated on April 1, 2025, and is effective for services provided on or after that date. Fee schedules are updated in January and April annually, and periodically during the year for time-sensitive changes (ex. COVID-19 codes).

All rates are published on the agency's eMedNY website found at the following link:

https://www.emedny.org/ProviderManuals/index.aspx.

Appendix II
2025 Title XIX State Plan
Second Quarter Amendment
Summary

SUMMARY
SPA #25-0004

This State Plan Amendment proposes to define and allow for Portable X-Ray services, including reimbursement for set up and transportation, in long term care settings or for individuals who are homebound in residential settings. Allowable services must be provided under the general supervision of a physician.

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

SPA 25-0004

§365-a(2)(i) of the Social Services Law authorizes medical assistance coverage of:
(i) laboratory and x-ray services;

SECTION 365-A
Character and adequacy of assistance
Social Services (SOS) CHAPTER 55, ARTICLE 5, TITLE 11
§ 365-a. Character and adequacy of assistance. The amount, nature and manner of providing medical assistance for needy persons shall be determined by the public welfare official with the advice of a physician
and in accordance with the local medical plan, this title, and the regulations of the department.

1. "Benchmark coverage" shall mean payment of part or all of the cost of medically necessary medical, dental, and remedial care, services, and
supplies described in subdivision two of this section, and to the extent
not included therein, any essential benefits as defined in 42 U.S.C. 18022(b), with the exception of institutional long term care services; such care, services and supplies shall be provided consistent with the managed care program described in section three hundred sixty-four-j of this title.

2. "Standard coverage" shall mean payment of part or all of the cost of medically necessary medical, dental and remedial care, services and supplies, as authorized in this title or the regulations of the department, which are necessary to prevent, diagnose, correct or cure conditions in the person that cause acute suffering, endanger life, result in illness or infirmity, interfere with such person's capacity for normal activity, or threaten some significant handicap and which are
furnished an eligible person in accordance with this title and the regulations of the department. Such care, services and supplies shall include the following medical care, services and supplies, together with
such medical care, services and supplies provided for in subdivisions three, four and five of this section, and such medical care, services and supplies as are authorized in the regulations of the department:

(a) services of qualified physicians, dentists, nurses, and private duty nursing services shall be further subject to the provisions of section three hundred sixty-seven-o of this chapter, optometrists, and other related professional personnel;

(b) care, treatment, maintenance and nursing services in hospitals, nursing homes that qualify as providers in the medicare program pursuant
to title XVIII of the federal social security act, infirmaries or other eligible medical institutions, and health-related care and services in intermediate care facilities, while operated in compliance with applicable provisions of this chapter, the public health law, the mental
hygiene law and other laws, including any provision thereof requiring

an
operating certificate or license, or where such facilities are not conveniently accessible, in hospitals located without the state; provided, however, that care, treatment, maintenance and nursing services in nursing homes or in intermediate care facilities, including those operated by the state department of mental hygiene or any other state department or agency, shall, for persons who are receiving or who are eligible for medical assistance under provisions of subparagraph four of paragraph (a) of subdivision one of section three hundred sixty-six of this chapter, be limited to such periods of time as may be determined necessary in accordance with a utilization review procedure established by the state commissioner of health providing for a review of medical necessity, in the case of skilled nursing care, every thirty days for the first ninety days and every ninety days thereafter, and in the case of care in an intermediate care facility, at least every six months, or more frequently if indicated at the time of the last review, consistent with federal utilization review requirements; provided, further, that in-patient care, services and supplies in a general hospital shall not exceed such standards as the commissioner of health shall promulgate but in no case greater than twenty days per spell of illness during which all or any part of the cost of such care, services and supplies are claimed as an item of medical assistance, unless it shall have been determined in accordance with procedures and criteria established by such commissioner that a further identifiable period of in-patient general hospital care is required for particular patients to preserve life or to prevent substantial risks of continuing disability; provided further, that in-patient care, services and supplies in a general hospital shall, in the case of a person admitted to such a facility on a Friday or Saturday, be deemed to include only those in-patient days beginning with and following the Sunday after such date of admission, unless such care, services and supplies are furnished for an actual medical emergency or pre-operative care for surgery as provided in paragraph (d) of subdivision five of this section, or are furnished because of the necessity of emergency or urgent surgery for the alleviation of severe pain or the necessity for immediate diagnosis or treatment of conditions which threaten disability or death if not promptly diagnosed or treated; provided, however, in-patient days of a general hospital admission beginning on a Friday or a Saturday shall be included commencing with the day of admission in a general hospital which the commissioner or his designee has found to be rendering and which continues to render full service on a seven day a week basis which
determination shall be made after taking into consideration such factors
as the routine availability of operating room services, diagnostic services and consultants, laboratory services, radiological services, pharmacy services, staff patterns consistent with full services and such
other factors as the commissioner or his designee deems necessary and appropriate; provided, further, that in-patient care, services and supplies in a general hospital shall not include care, services and supplies furnished to patients for certain uncomplicated procedures which may be performed on an out-patient basis in accordance with regulations of the commissioner of health, unless the person or body designated by such commissioner determines that the medical condition of
the individual patient requires that the procedure be performed on an

in-patient basis;

(c) out-patient hospital or clinic services in facilities operated in compliance with applicable provisions of this chapter, the public health law, the mental hygiene law and other laws, including any provisions thereof requiring an operating certificate or license, including facilities authorized by the appropriate licensing authority to provide integrated mental health services, and/or alcoholism and substance abuse services, and/or physical health services, and/or services to persons with developmental disabilities, when such services are provided at a single location or service site, or where such facilities are not conveniently accessible, in any hospital located within the state and care and services in a day treatment program operated by the department of mental hygiene or by a voluntary agency under an agreement with such department in that part of a public institution operated and approved pursuant to law as an intermediate care facility for persons with developmental disabilities; and provided, that the commissioners of health, mental health, alcoholism and substance abuse services and the office for people with developmental disabilities may issue regulations, including emergency regulations promulgated prior to October first, two thousand fifteen that are required to facilitate the establishment of integrated services clinics. Any such regulations promulgated under this paragraph shall be described in the annual report required pursuant to section forty-five-c of part A of chapter fifty-six of the laws of two thousand thirteen;

(d) home health services provided in a recipient's home and prescribed by a physician including services of a nurse provided on a part-time or intermittent basis rendered by an approved home health agency or if no such agency is available, by a registered nurse, licensed to practice in this state, acting under the written orders of a physician and home health aide service by an individual or shared aide provided by an approved home health agency when such services are determined to be cost effective and appropriate to meet the recipient's needs for assistance subject to the provisions of section three hundred sixty-seven-j and section three hundred sixty-seven-o of this title;

(e) (i) personal care services, including personal emergency response services, shared aide and an individual aide, subject to the provisions of subparagraphs (ii), (iii), (iv), (v) and (vi) of this paragraph, furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for individuals with intellectual disabilities, or institution for mental disease, as determined to meet the recipient's needs for assistance when cost effective and appropriate, and when prescribed by a qualified independent physician selected or approved by the department of health, in accordance with the recipient's plan of treatment and provided by individuals who are qualified to provide such services, who are supervised by a registered nurse and who are not members of the recipient's family, and furnished in the recipient's home or other location;

(ii) the commissioner is authorized to adopt standards, pursuant to emergency regulation, for the provision, management and assessment of services available under this paragraph for individuals whose need for such services exceeds a specified level to be determined by the commissioner, and who with the provision of such services is capable of safely remaining in the community in accordance with the standards set forth in Olmstead v. LC by Zimring, 527 US 581 (1999) and consider whether an individual is capable of safely remaining in the community;

(iii) the commissioner shall provide assistance to persons receiving services under this paragraph who are transitioning to receiving care from a managed long term care plan certified pursuant to section forty-four hundred three-f of the public health law, consistent with subdivision thirty-one of section three hundred sixty-four-j of this title;

(iv) personal care services available pursuant to this paragraph shall not exceed eight hours per week for individuals whose needs are limited to nutritional and environmental support functions;

(v) subject to the availability of federal financial participation, personal care services other than personal emergency response services available pursuant to this paragraph shall be available only to individuals assessed as needing at least limited assistance with physical maneuvering with more than two activities of daily living, or for individuals with a dementia or Alzheimer's diagnosis, assessed as needing at least supervision with more than one activity of daily living, as defined and determined by using an evidenced based validated assessment instrument approved by the commissioner and in accordance with regulations of the department and any applicable state and federal laws by an independent assessor. The provisions of this subparagraph shall only apply to individuals who receive an initial authorization for
such services on or after October first, two thousand twenty;

(vi) In establishing any standards for the provision, management or assessment of personal care services the state shall meet the standards set forth in Olmstead v. LC by Zimring, 527 US 581 (1999) and consider whether an individual is capable of safely remaining in the community;

(f) preventive, prophylactic and other routine dental care, services and supplies;

(g) sickroom supplies, eyeglasses, prosthetic appliances and dental prosthetic appliances furnished in accordance with the regulations of the department; provided further that: (i) the commissioner of health is
authorized to implement a preferred diabetic supply program wherein the department of health will receive enhanced rebates from preferred manufacturers of glucometers and test strips, and may subject non-preferred manufacturers' glucometers and test strips to prior authorization under section two hundred seventy-three of the public health law; (ii) enteral formula therapy and nutritional supplements are
limited to coverage only for nasogastric, jejunostomy, or gastrostomy tube feeding, for treatment of an inborn metabolic disorder, or to

address growth and development problems in children, or, subject to standards established by the commissioner, for persons with a diagnosis of HIV infection, AIDS or HIV-related illness or other diseases and conditions; (iii) prescription footwear and inserts are limited to coverage only when used as an integral part of a lower limb orthotic appliance, as part of a diabetic treatment plan, or to address growth and development problems in children; (iv) compression and support stockings are limited to coverage only for pregnancy or treatment of venous stasis ulcers; and (v) the commissioner of health is authorized to implement an incontinence supply utilization management program to reduce costs without limiting access through the existing provider network, including but not limited to single or multiple source contracts or, a preferred incontinence supply program wherein the department of health will receive enhanced rebates from preferred manufacturers of incontinence supplies, and may subject non-preferred manufacturers' incontinence supplies to prior approval pursuant to regulations of the department, provided any necessary approvals under federal law have been obtained to receive federal financial participation in the costs of incontinence supplies provided pursuant to
this subparagraph;

(g-1) drugs provided on an in-patient basis, those drugs contained on the list established by regulation of the commissioner of health pursuant to subdivision four of this section, and those drugs which may not be dispensed without a prescription as required by section sixty-eight hundred ten of the education law and which the commissioner of health shall determine to be reimbursable based upon such factors as the availability of such drugs or alternatives at low cost if purchased by a medicaid recipient, or the essential nature of such drugs as described by such commissioner in regulations, provided, however, that such drugs, exclusive of long-term maintenance drugs, shall be dispensed
in quantities no greater than a thirty day supply or one hundred doses, whichever is greater; provided further that the commissioner of health is authorized to require prior authorization for any refill of a prescription when more than a ten day supply of the previously dispensed
amount should remain were the product used as normally indicated, or in the case of a controlled substance, as defined in section thirty-three hundred two of the public health law, when more than a seven day supply of the previously dispensed amount should remain were the product used as normally indicated; provided further that the commissioner of health is authorized to require prior authorization of prescriptions of opioid analgesics in excess of four prescriptions in a thirty-day period in accordance with section two hundred seventy-three of the public health law; medical assistance shall not include any drug provided on other than an in-patient basis for which a recipient is charged or a claim is made in the case of a prescription drug, in excess of the maximum reimbursable amounts to be established by department regulations in accordance with standards established by the secretary of the United States department of health and human services, or, in the case of a drug not requiring a prescription, in excess of the maximum reimbursable
amount established by the commissioner of health pursuant to paragraph (a) of subdivision four of this section;

(h) speech therapy, and when provided at the direction of a physician or nurse practitioner, physical therapy including related rehabilitative
services and occupational therapy;

(i) laboratory and x-ray services; and

Appendix IV
2025 Title XIX State Plan
Second Quarter Amendment
Public Notice

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 comply with SSL § 365-a(2)(i). The following changes are proposed:

Non-Institutional Services

Effective on or after May 1, 2025, portable radiology providers can transport radiology equipment and deliver radiology services in the setting where a home-bound individual is located, including a long-term care setting, residential setting, or private home or dwelling of a patient. Expansion of the program to home-bound individuals is a cost-effective option that also provides patients an alternative mode of receiving care.

Coverage requirements and regulations will be updated consistent with Federal Regulation (42 CFR Part 486 Subpart C - Conditions for Coverage: Portable X-Ray Services), which provide that portable radiology providers be either the employee of a supervising physician; or require the supervising physician to certify annually that they periodically check the procedural manuals and observe the operator's performance, that they have verified that equipment and personnel meet applicable Federal, State, and local licensure and registration requirements and that safe operating procedures are used.

The estimated net aggregate decrease in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2025-2026 is ($1.6 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

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

Long Term Care Services

Effective on or after May 1, 2025, 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 Nursing Home:

• Highpointe On Michigan Health Care Facility with payment amounts totaling up to $40,001,679 for the period May 1, 2025, through June 30, 2025.

The estimated net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for SFY 2025-2026 is $40,001,679.

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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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

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

NON-INSTITUTIONAL SERVICES
State Plan Amendment #25-0004

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.

		4/1/25 – 3/31/26	
Payment Type	**Non-Federal Share Funding**	**Non-Federal**	**Gross**
Normal Per Diem	General Fund; County Contribution	$9.2M	$4.6M

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. 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	$5.378B
Suffolk County	$256M
Nassau County	$241M
Westchester County	$223M
Erie County	$216M
Rest of State (53 Counties)	$1.320B
Total	**$7.634B**

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 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.

Appendix VI
2025 Title XIX State Plan
Second Quarter Amendment
Responses to Standard Access Questions

APPENDIX VI
NON-INSTITUTIONAL SERVICES
State Plan Amendment # 25-0004

CMS Standard Access Questions

The following questions have been asked by CMS and are answered by the State in relation to all payments made to all providers under Attachment 4.19-B of the state plan.

Specifically, how did the State determine that the Medicaid provider payments that will result from the change in this amendment are sufficient to comply with the requirements of 1902(a)(30)?

1. **Response:** Portable radiology providers are required to meet licensure and certification requirements to ensure providers are qualified to deliver services to Medicaid patients. The radiology services paid to portable radiology providers will be consistent with the technical component of the Radiology Fee Schedule which was benchmarked to 80% of Medicare rates as part of the 2023-24 NYS budget initiative. The reimbursement for portable radiology is consistent with Medicare and other State programs. Additionally, NYS Medicaid has met with the NYS Chapter of American Portable Diagnostics Association to understand the challenges and proposed solutions which were incorporated into the State Plan Amendment to assure continued quality of care.

2. **How does the State intend to monitor the impact of the new rates and implement a remedy should rates be insufficient to guarantee required access levels?**

   Response: The State has various ways to ensure that access levels in the Medicaid program are retained and is currently not aware of any access issues. The State monitors and considers requests in the context of access as they approve/deny changes in services.

   The State will continue to monitor for provider complaint hotlines to identify geographic areas of concern and/or service type needs. If Medicaid beneficiaries begin to encounter access issues, the Department would expect to see a marked increase in complaints. These complaints will be identified and analyzed in light of the changes proposed in this State Plan Amendment. The Department will also remain in communication with the NYS Chapter of American Portable Diagnostics Association who will keep the State abreast of any issues or challenges regarding the proposed changes.

3. **How were providers, advocates and beneficiaries engaged in the discussion around rate modifications? What were their concerns and how did the State address these concerns?**

Response: The State met with the advocacy group to discuss their overall concerns of the Portable Radiology program which is currently a Demonstration Project. These collaborative meetings and the review of other successful state portable radiology programs resulted in the proposal to amend regulation to 18 NYCRR §505.17 and this State Plan Amendment.

In addition, the legislative process provides opportunities for all stakeholders to lobby their concerns, objections, or support for various legislative initiatives. The New York State Department of Health will also issue a Published Notice in the State Register requesting comment of the proposed regulatory amendment.

4. **What action(s) does the State plan to implement after the rate change takes place to counter any decrease to access if the rate decrease is found to prevent sufficient access to care?**

   Response: Not applicable to this SPA, this is not a rate decrease.

5. **Is the State modifying anything else in the State Plan which will counterbalance any impact on access that may be caused by the decrease in rates (e.g. increasing scope of services that other provider types may provide or providing care in other settings)?**

   Response: Not applicable to this SPA, this is not a rate decrease.