NEW YORK STATE | Department of Health

KATHY HOCHUL
Governor

JAMES V. McDONALD, MD, MPH
Commissioner

JOHANNE E. MORNE, MS
Executive Deputy Commissioner

December 30, 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 #25-0064
Non-Institutional Services

Dear Director McMillion:

The State requests approval of the enclosed amendment #25-0064 to the Title XIX (Medicaid) State Plan for non-institutional services to be effective October 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 September 24, 2025, and clarified on December 24, 2025, are 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: 25-0064

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, 2025

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

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 10/01/25-09/30/26 $ 0
b. FFY 10/01/26-09/30/27 $ 0

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

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*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

9. SUBJECT OF AMENDMENT
Drug Reimbursement

10. GOVERNOR'S REVIEW *(Check One)*
(●) GOVERNOR'S OFFICE REPORTED NO COMMENT
( ) COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
( ) NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
( ) OTHER, AS SPECIFIED:

11. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

12. TYPED NAME
Amir Bassiri

13. TITLE
Medicaid Director

14. DATE SUBMITTED
December 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
Fourth Quarter Amendment
Amended SPA Pages

New York

4(d)(1)

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

5. Payment for drugs dispensed by the pharmacy of a 340B covered entity as described in section 1927(a)(5)(B) of the Act, or a contract pharmacy under contract with a 340B covered entity as described in section 1927(a)(5)(B) of the Act, will be as follows:
   a. 340B purchased drugs – actual acquisition cost not to exceed the 340B ceiling price, plus the professional dispensing fee in Section 2;
   b. Non-340B purchased drugs, including drugs on a carve out list – in accordance with lower of logic in section 1 plus the professional dispensing fee in Section 2.
6. Payment for clotting factor dispensed by a pharmacy enrolled in the NYS Medicaid FFS Program is at the lower of: SMAC, as described below, not to exceed WAC, plus the professional dispensing fee in Section 2; or the billing pharmacy's usual and customary price charged to the general public.

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

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

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

New York
4(d)(2)

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

7. Practitioner administered or provided drugs billed separately under the medical benefit are reimbursed as follows:
   a. When administered or provided during an office visit, facility setting, or ordered ambulatory setting, drugs will be reimbursed at the lower of:
      i. National Average Drug Acquisition Cost (NADAC) or, in the event of no NADAC pricing available, Wholesale Acquisition Cost (WAC); or
      ii. the Federal Upper Limit (FUL); or
      iii. the State Maximum Acquisition Cost (SMAC); or
      iv. the actual cost of the drug to the practitioner.

      No professional dispensing fee is paid.

      Drugs purchased by covered entities at the prices authorized under Section 340B of the Public Health Services Act must be billed at their actual acquisition cost.

      Drugs on the carve-out list must be billed at the provider's usual and customary price.
   b. When administered in an outpatient setting to a patient of a disproportionate share hospital, clinic, or emergency department, payment may be made through either the Ambulatory Patient Group (APG) classification and reimbursement system, as referenced in this Attachment, or, if carved out of the APG system, in accordance with Section 7.a.

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

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

Appendix II
2025 Title XIX State Plan
Fourth Quarter Amendment
Summary

SUMMARY
SPA #25-0064

This State Plan Amendment proposes to modify the existing State Plan to reimburse select drugs identified on a carve-out list at the existing lower of methodology. Drugs on the carve-out list will be billed only at the usual and customary price.

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

SPA 25-0064

NYS Social Services Law §367-a(9)(a) and (9)(b)

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

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

(ii) Notwithstanding subparagraph (i) of this paragraph and paragraph (e) of this subdivision, for the Medicaid fee-for-service program, if a drug has been purchased from a manufacturer by a covered entity pursuant to section 340B of the federal public health service act (42 USCA § 256b), the actual amount paid by such covered entity. For purposes of this subparagraph, a "covered entity" is an entity that meets the requirements of paragraph four of subdivision (a) of such section that elects to participate in the program established by such section, and that causes claims for payment for drugs covered by this subparagraph to be submitted to the medical assistance program, either directly or through an authorized contract pharmacy. No medical assistance payments may be made to a covered entity or to an authorized contract pharmacy of a covered entity for drugs that are eligible for purchase under the section 340B program and are dispensed on an outpatient basis to patients of the covered entity, other than under the provisions of this subparagraph. Medical practitioners submitting claims for reimbursement of drugs purchased pursuant to section 340B of the public health service act shall notify the department that the claim is eligible for purchase under the 340B program, consistent with claiming instructions issued by the department to identify such claims.

(iii) In no event shall a medical practitioner be reimbursed at an amount that is lower than the state maximum acquisition cost, or for drugs that do not have a state maximum acquisition cost, the wholesale acquisition cost of the drug based on the package size.

(b) for drugs dispensed by pharmacies:

(i) (A) if the drug dispensed is a generic prescription drug, the lower of: (1) an amount equal to the national average drug acquisition cost set by the federal centers for medicare and medicaid services for the drug, if any, or if such amount if not available, the wholesale acquisition cost of the drug based on the package size dispensed from,

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

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

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

(iii) notwithstanding subparagraphs (i) and (ii) of this paragraph and paragraphs (d) and (e) of this subdivision, if the drug dispensed is a drug that has been purchased from a manufacturer by a covered entity pursuant to section 340B of the federal public health service act (42 USCA § 256b), the actual amount paid by such covered entity pursuant to such section, plus the reasonable administrative costs, as determined by the commissioner, incurred by the covered entity or by an authorized contract pharmacy in connection with the purchase and dispensing of such drug and the tracking of such transactions. For purposes of this subparagraph, a "covered entity" is an entity that meets the requirements of paragraph four of subsection (a) of such section, that elects to participate in the program established by such section, and that causes claims for payment for drugs covered by this subparagraph to be submitted to the medical assistance program, either directly or through an authorized contract pharmacy. No medical assistance payments may be made to a covered entity or to an authorized contract pharmacy of a covered entity for drugs that are eligible for purchase under the section 340B program and are dispensed on an outpatient basis to patients of the covered entity, other than under the provisions of this

subparagraph. Pharmacies submitting claims for reimbursement of drugs purchased pursuant to section 340B of the public health service act shall notify the department that the claim is eligible for purchase under the 340B program, consistent with claiming instructions issued by the department to identify such claims.

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

services that are not experimental or investigational; together with prescription drugs, which shall be limited to federal food and drug administration approved medications and subject to Medicaid program coverage requirements.

The estimated net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2025-2026 is $4.6 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 non-institutional services to comply with section 1927 of the Social Security Act and 42 CFR Part 10. The following changes are proposed:

Non-Institutional Services

Effective on or after October 1, 2025, this proposal would modify the existing State Plan by reimbursing select inpatient drugs identified on a carve out list at the existing lower of methodology, in accordance with New York Social Services Law 367-a(9). The carve out list will ensure supplemental and federal rebates are obtainable from any eligible claim for the drugs listed.

There is no estimated change to gross Medicaid expenditures as a result of this proposed amendment for state fiscal year 2025-2026. The estimated net aggregate decrease in gross Medicaid expenditures attributable to this proposed amendment for state fiscal year 2026-2027 is ($4 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.

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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 and non-institutional services to comply with Social Security Act section 1905(ee)(1) and SUPPORT ACT section 1006(b). The following changes are proposed:

Institutional Services

Effective on or after October 1, 2025, the Medication Assisted Treatment (MAT) benefit will continue to be a mandatory benefit to comply with federal statute by removing the September 30, 2025, discontinuation date.

This benefit transition does not impact current MAT benefits provided by either the Pharmacy or Medical benefit.

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

Non-Institutional Services

Effective on or after October 1, 2025, the Medication Assisted Treatment (MAT) benefit will continue to be a mandatory benefit to comply with federal statute by removing the September 30, 2025, discontinuation date.

This benefit transition does not impact current MAT benefits provided by either the Pharmacy or Medical benefit.

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

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

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

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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 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, 2026, 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 $704,372.

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

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Staten Island, New York 10301

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

PUBLIC NOTICE
Department of Health

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

The Department of Health proposes to amend the Title XIX (Medicaid) State Plan for non-institutional services to comply with section 1927 of the Social Security Act and 42 CFR Part 10. The following changes are proposed:

Non-Institutional Services

The following is a clarification to the September 24, 2025, noticed provision to reimburse select inpatient drugs identified on a carve out list at the existing lower of methodology.

With clarification, there is no estimated change to gross Medicaid expenditures as a result of this proposed amendment for state fiscal year 2026-2027.

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

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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 January 1, 2026, 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:

- The Wartburg Home

The aggregate payment amounts totaling up to $2,000,017 for the period January 1, 2026, through March 31, 2026.

The aggregate payment amounts totaling up to $408,928 for the period April 1, 2026, through March 31, 2027.

The aggregate payment amounts totaling up to $166,202 for the period April 1, 2027, through March 31, 2028.

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

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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

Office of General Services

Pursuant to Section 30-a of the Public Lands Law, the Office of General Services hereby gives notice to the following:

Notice is hereby given that the Department of Transportation has determined that:

Address: La Salle Arterial Highway, Section III
City of Niagara Falls, NY 14301
Niagara County

a +2,563 square foot portion of vacant land (part of Tax I.D. 158.08-1-5) on a +4,422-square foot parcel of vacant land, is surplus and no longer useful or necessary for state program purposes and has abandoned the property to the Commissioner of General Services for conveyance as Unappropriated State Land.

For further information, please contact: Frank Pallante, Office of General Services, Legal Services, 36th Fl., Corning Tower, Empire State Plaza, Albany, NY 12242, (518) 474-8831

PUBLIC NOTICE

Department of State

2025 State Energy Conservation Construction Code / 2025 New York State Uniform Fire Prevention and Building Code fossil fuel provisions (19 NYCRR Section 1240.6 and Subpart 1229-2)

Pursuant to the Order of the United States District Court for the Northern District of New York, dated November 18, 2025, Case 1:23-cv-01267-GTS-PJE (available online at: https://dos.ny.gov/notice-adoption and https://dos.ny.gov/system/files/documents/2025/11/mulhern-so-ordered-stipulation-11-18-25.pdf), the provisions of 19 NYCRR Section 1240.6 and Subpart 1229-2 (relating to the installation of fossil-fuel equipment and building systems in new buildings) are suspended, pending the final disposition of the Plaintiffs' appeal in the United States Court of Appeals (Case No. 25-2041) and the disposition of any petition for a writ of certiorari, if such writ is timely sought, consistent with the timing set forth in the Order of the Northern District of New York. If no writ of certiorari is timely sought, the suspension shall terminate 120-days after the issuance of the mandate of the Second Circuit. Should a writ of certiorari be timely sought by any party, and denied, then the suspension shall terminate on the 120th day after such denial. Should a writ of certiorari be timely sought by any party, and the petition for a writ of certiorari is granted, the suspension shall terminate on the 120th day following the sending down of the judgment of the United States Supreme Court.

Please be advised that the December 31, 2025, effective date remains unchanged for all other provisions of the 2025 State Energy Conservation Construction Code and 2025 New York State Uniform Fire Prevention and Building Code.

The Department of State will continue to monitor the case and will provide updates accordingly on its public website at https://dos.ny.gov/notice-adoption.

PUBLIC NOTICE

Department of State
F-2025-0578
Date of Issuance – December 24, 2025

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

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

In F-2025-0578, the applicant, Valley Stream Central High School District, is proposing to stabilize 800' of streambank by installing coir logs with growing medium with 1 row of riprap at low tide line with plantings placed between the stones; vegetated rock gabion baskets

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

NON-INSTITUTIONAL SERVICES
State Plan Amendment #25-0064

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**
Supplemental	General Fund	$3.8B	$11.4B

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.

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 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.