NEW YORK STATE | Department of Health

KATHY HOCHUL
Governor

JAMES V. McDONALD, MD, MPH
Commissioner

JOHANNE E. MORNE, MS
Executive Deputy Commissioner

June 30, 2026

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 #26-0030
Non-Institutional Services

Dear Director McMillion:

The State requests approval of the enclosed amendment #26-0030 to the Title XIX (Medicaid) State Plan for non-institutional services to be effective April 1, 2026 (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 March 25, 2026, 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: 2 6 — 0 0 3 0

2. STATE: N Y

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
April 1, 2026

5. FEDERAL STATUTE/REGULATION CITATION
§ 1905(a)(24) Personal care services

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 04/01/26-09/30/26 $ (3,750,000)
b. FFY 10/01/26-09/30/27 $ (7,500,000)

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.19-B Pages: 6(a)(1), 6(a)(1)(i)

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 4.19-B Pages: 6(a)(1), 6(a)(1)(i)

9. SUBJECT OF AMENDMENT
Personal Care Reimbursement Methodology

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, 2026

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
2026 Title XIX State Plan
Second Quarter Amendment
Amended SPA Pages

New York
6(a)(1)

1905(a)(24) Personal ~~C~~care ~~S~~services

For personal care services provided pursuant to a contract between a social services district and a voluntary, proprietary or public personal care services provider, payment ~~is made~~ for direct care services is based on reported allowable costs not to exceed, or fall below, one standard deviation of the mean for the applicable geographic group. The administrative portion of the rate will not exceed 15 percent of the total rate. Personal care services providers' payments for nursing assessment and nursing supervision services will be a fee determined by the Commissioner of Health. All personal care services provider payments are at the lower of the provider's charge to the general public for personal care services or a rate the Department establishes for the provider, subject to the approval of the Director of the Division of the Budget, in accordance with a cost-based methodology. Under the cost-based methodology, the Department determines a provider's rate based upon the provider's reported allowable costs, as adjusted by annual trend factors provided, however, for services on and after April 1, 2008, the Commissioner of Health will apply a trend factor projection equal to 65% of the otherwise applicable trend factor for calendar year 2008, as calculated in accordance with the general trend factor methodology contained on page 1(c)(i) in this Attachment.

For rates of payment effective for personal care services provided on and after January 1, 2009 through March 31, 2009, the otherwise applicable final trend factor attributable to the 2008 calendar year period will be adjusted such that any increase to the average trend factor for the period April 1, 2008 through December 31, 2008 will be reduced, on an annualized basis, by 1.3%. However, no retroactive adjustment to such trend factor will be made for the period April 1, 2008 through December 31, 2008. Effective on and after April 1, 2009, the otherwise applicable final trend factor attributable to the 2008 calendar year period will be zero.

For rates of payment effective for personal care services provided on and after January 1, 2009 through March 31, 2009, a trend factor equal to the otherwise applicable trend factor attributable to the period January 1, 2009 through December 31, 2009, less 1% will be applied. Effective on and after April 1, 2009 the otherwise applicable trend factor attributable to the 2009 calendar year period will be zero.

For rates of payment effective for services provided on and after January 1, 2010 through March 31, 2010, the otherwise applicable final trend factor attributable to the 2010 calendar year period will be zero.

For rates of payment effective for personal care services provided on and after April 1, 2010, the otherwise applicable trend factor attributable to the 2010 calendar year period will be zero.

For rates of payment effective for personal care services provided on and after April 1, 2011, the otherwise applicable trend factors attributable to the 2011 through 2014 calendar year periods will be no greater than zero. For such rates effective for the period January 1, 2015 through March 31, 2015 and for the period April 23, 2015 through December 31, 2015 otherwise applicable trend factors attributable to the 2015 calendar year period will be no greater than zero. For rates of payment effective for services provided on and after January 1, 2016 through March 31, 2017 and for the period April 1, 2017 through December 31, 2017, the otherwise applicable final trend factor attributable to the 2016 and 2017 calendar year periods will be zero. For rates of payment effective for services provided on and after January 1, 2018 through March 31, 2019 and for the period April 1, 2019 through December 31, 2019, the otherwise applicable final trend factor attributable to the 2018 and 2019 calendar year periods will be zero. For rates of payment effective for services provided on and after January 1, 2020, the otherwise applicable trend factor will be zero.

For nursing services rates, the Commissioner of Health may apply a trend factor, subject to the approval of the Director of the Division of the Budget.

1905(a)(24) Personal care services

The provider's rate for direct care includes payment for the provider's reported allowable trended costs only in an amount that does not exceed, or fall below, one standard deviation of the mean for ~~the ceilings for allowable costs that the Department has established for all providers in~~ the applicable geographic group to which the provider belongs. The rate includes adjustments for worker recruitment and retention, background and fingerprinting, and minimum wage growth ~~an adjustment for profit, for proprietary providers, or surplus, for voluntary providers~~. The provider's reported allowable administrative expenses cannot exceed 15 percent of the total rate. Nursing supervision and nursing assessment services will be paid a fee, as established by the Commissioner of Health.

Appendix II
2026 Title XIX State Plan
Second Quarter Amendment
Summary

SUMMARY
SPA #26-0030

This State Plan Amendment proposes to update the personal care reimbursement methodology to a regional standard deviation approach where rates cannot be above or fall below one standard deviation. Allowable administrative costs will be capped at 15 percent of the total rate. Nursing supervision and nursing assessment rates will be a set fee, established by the Commissioner of Health.

Appendix III
2026 Title XIX State Plan
Second Quarter Amendment
Authorizing Provisions

SPA 26-0030

Social Services § 363. Declaration of objects. Medical assistance for needy persons is hereby declared to be a matter of public concern and a necessity in promoting the public health and welfare and for promoting the state's goal of making available to everyone, regardless of race, age, national origin or economic standing, uniform, high-quality medical care. In furtherance of such goal, a comprehensive program of medical assistance for needy persons is hereby established to operate in a manner which will assure a uniform high standard of medical assistance throughout the state. In carrying out this program every effort shall be made to promote maximum public awareness of the availability of, and procedure for obtaining, such assistance, and to facilitate the application for, and the provision of such medical assistance.

Social Services § 365. Responsibility for assistance. 1. Subject to supervision by the department: (a) each public welfare district shall furnish medical assistance to the persons eligible therefor who reside in its territory, except to persons for whom another public welfare district would be responsible under the provisions of paragraphs (b), (c), (d) or (g) of subdivision five of section sixty-two and other provisions of this chapter, and except to persons for whom provision is made hereinafter in subdivision two. Temporary absence, within or without the state, of such persons from such territory shall not effect their eligibility for such assistance; (b) each public welfare district shall also be responsible for furnishing medical assistance to eligible persons found in its territory, who are temporarily in the state; (c) each public welfare district, in any case in which the appropriate medical care and services are not available within such district, shall make appropriate arrangements, including the provision of transportation, for obtaining such medical care and services outside such district; (d) each public welfare district may furnish all or any part of the medical assistance required to be furnished pursuant to this title, either directly or by contract or agreement.

Appendix IV
2026 Title XIX State Plan
Second Quarter Amendment
Public Notice

MISCELLANEOUS NOTICES/HEARINGS

Notice of Abandoned Property Received by the State Comptroller

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

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

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

PUBLIC NOTICE

Department of Health

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

The Department of Health proposes to amend the Title XIX (Medicaid) State Plan for all services to comply with the 2026-2027 proposed executive budget. The following changes are proposed:

All Services

Effective on or after April 1, 2026, the Department of Health will adjust Medicaid rates statewide to reflect a 1.7% percent Targeted Inflationary Increase for the following Office of Mental Health (OMH), Office of Addiction Services and Supports (OASAS), and Office for People With Developmental Disabilities (OPWDD) State Plan Services: OMH Outpatient Services, OMH Clinic Services, OMH Rehabilitative Services, Comprehensive Psychiatric Emergency Program, including Extended Observation Beds, Children and Family Treatment and Support Services, Health Home Plus, Psychiatric Residential Treatment Facilities for Children and Youth, OASAS Part 822 Outpatient Addiction Services, OASAS Part 818 Substance Use Disorder Residential Rehabilitation Services (freestanding), OASAS Part 816 Residential Medically Supervised Withdrawal and Stabilization Services (freestanding), OASAS Part 820 Residential Services, OASAS Part 817 Substance Use Disorder Residential Rehabilitation Services for Youth, Intermediate Care Facility (ICF/IDD), Day Treatment, Article 16 Clinic Services, Specialty Hospital, Independent Practitioner Services for Individual with Developmental Disabilities (IPSIDD), and OPWDD Crisis Services.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative is $24.9 million.

Non-Institutional Services

Effective on or after April 1, 2026, the Department of Health will adjust Medicaid rates statewide to account for increased labor costs resulting from statutorily required increases in New York State minimum wage for the following Office of Mental Health (OMH) State Plan Services: OMH Outpatient Services, OMH Clinic Services, and OMH Rehabilitative Services.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative is $85,000.

Effective on or after April 1, 2026, the State will invest up to $60 million in diagnostic and treatment centers, including Federally Qualified Health Centers and Rural Health Clinics, licensed under Article 28 of the Public Health Law, by an aggregate amount up to $60 million per year.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative is up to $60 million.

Effective on April 1, 2026, for the 2026 rate year and thereafter, the reimbursement methodology for personal care services will be revised. Personal care direct services rates will be based on reported allowable costs not to exceed, or fall below, one standard deviation of the mean for the applicable geographic group. The administrative portion of the rate will not exceed 15 percent of the total rate. Providers' payments for nursing services will be a fee.

The estimated annual net aggregate decrease in gross Medicaid expenditures attributable to this initiative is ($15 million).

Effective on or after April 1, 2026 through March 31, 2027, the State will invest up to $1.5 billion in hospital outpatient services when combined with investments in hospital inpatient and residential health care facility services. The State will invest up to $1.0 billion, collectively, in each state fiscal year thereafter.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative is up to $1.5 billion.

Effective on or after April 1, 2026, the State will provide Medicaid reimbursement to freestanding birth centers, including midwifery birth centers and birth centers licensed as diagnostic and treatment centers. The Ambulatory Patient Group (APG) payment methodology will be utilized to reimburse services provided in freestanding birth centers. A separate payment will also be made to the healthcare professionals providing services in freestanding birth centers.

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

Institutional Services

Effective on or after April 1, 2026, this proposal continues the indigent care pool payments made to general hospitals, subject to all provisions of PHL 2807-k.

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

Effective on or after April 1, 2026, the proposed amendment to the State Plan will allow Title XIX (Medicaid) reimbursement to general hospitals, as defined in Subdivision 10 of Section 2801 of the Public Health Law, for provision of inpatient acute care that is provided off-site, pursuant to the conditions set forth in proposed Subdivision 15 of Section 2803 of the Public Health Law (see Proposed Executive Budget, Health and Mental Hygiene, Part K, Section 6). Reimbursement rates will match those provided for inpatient acute care services provided on-site in licensed general hospital settings.

Under the proposed law, the Commissioner of Health of the State of New York may allow general hospitals to provide off-site acute care medical services that are (a) not home care services or professional services as defined in Subdivisions 1 and 2 of Section 3602 of the

Public Health Law; (b) provided by a medical professional, including a physician, registered nurse, nurse practitioner, or physician assistant, to a patient with a preexisting clinical relationship with the general hospital or with the health care professional providing the service; and (c) provided to a patient for whom a medical professional has determined is appropriate to receive acute medical services at their residence. To participate, the general hospital must also have appropriate discharge planning in place to coordinate discharge to a home care agency where medically necessary and consented to by the patient after the patient's acute care episode ends, consistent with all applicable federal, state, and local laws.

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

Effective on or after April 1, 2026 through March 31, 2027, the State will invest up to $1.5 billion in hospital inpatient services when combined with investments in hospital outpatient and residential health care facility services. The State will invest up to $1.0 billion, collectively, in each state fiscal year thereafter.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative is up to $1.5 billion.

Long Term Care

Effective on or after April 1, 2026, this proposal would end-date the previously enacted 10% reduction to nursing home capital reimbursement. The 10% reduction will not continue going forward.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative is $58 million.

Effective on or after April 1, 2026 through March 31, 2027, the State will invest up to $1.5 billion in residential health care facility services when combined with investments in hospital inpatient and hospital outpatient services. The State will invest up to $1.0 billion, collectively, in each state fiscal year thereafter.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative is up to $1.5 billion.

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

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

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

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

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

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

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

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

PUBLIC NOTICE

New York City Deferred Compensation Plan

The New York City Deferred Compensation Plan (the "Plan") is seeking qualified vendors to provide US small-cap equity core investment management services for the Small Cap Equity Fund ("the Fund") investment option of the Plan. The objective of the Fund is to provide long term growth of capital by investing primarily in the stocks of smaller rapidly growing companies. To be considered, vendors must submit their product information to Segal Marco Advisors at the following e-mail address: nycdcp.procurement@segalmarco.com. Please complete the submission of product information no later than 4:30 P.M. Eastern Time on April 2, 2026.

Consistent with the policies expressed by the City, proposals from certified minority-owned and/or women-owned businesses or proposals that include partnering arrangements with certified minority-owned and/or women-owned firms are encouraged. Additionally, proposals from small and New York City-based businesses are also encouraged.

PUBLIC NOTICE

New York City Deferred Compensation Plan

The New York City Deferred Compensation Plan (the "Plan") is seeking qualified vendors to provide liquidity support services, including maintenance of daily liquidity, for the Stable Income Fund ("the Fund") investment option of the Plan. The objective of the Fund is to provide an opportunity to invest in high quality fixed income securities with an emphasis on safety of principal and consistency of returns. To be considered, vendors must submit their product information to Segal Marco Advisors at the following e-mail address: nycdcp.procurement@segalmarco.com. Please complete the submission of product information no later than 4:30 P.M. Eastern Time on April 2, 2026.

Consistent with the policies expressed by the City, proposals from certified minority-owned and/or women-owned businesses or proposals that include partnering arrangements with certified minority-owned and/or women-owned firms are encouraged. Additionally, proposals from small and New York City-based businesses are also encouraged.

PUBLIC NOTICE

Department of State
F-2026-0002
Date of Issuance – March 25, 2026

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-2026-0002, the applicant, Joseph Milito, PHH Bank, is proposing to install an approx. 200' long rock revetment along the toe of the bluff, including 10' and 12' returns, and place erosion control matting with approx. 1,400 cubic yards of clean sand backfill to be planted with indigenous species to revegetate the bluff face. This project is located at 10 Richards Path, Village of St. James, Suffolk County, Long Island Sound.

The applicant's consistency certification and supporting information are available for review at:

https://dos.ny.gov/f-2026-0002 or at https://dos.ny.gov/public-notices

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

- Town of Smithtown Local Waterfront Revitalization Program:

  https://dos.ny.gov/location/town-smithtown-local-waterfront-revitalization-program
- Villages of Head of the Harbor and Nissequogue Local Waterfront Revitalization Program:

Appendix V
2026 Title XIX State Plan
Second Quarter Amendment
Responses to Standard Funding Questions

NON-INSTITUTIONAL SERVICES
State Plan Amendment #26-0030

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.

		4/1/26 – 3/31/27	
Payment Type	**Non-Federal Share Funding**	**Non-Federal**	**Gross**
Normal Per Diem	General Fund; County Contribution	$199.6M	$399.2

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
2026 Title XIX State Plan
Second Quarter Amendment
Responses to Standard Access Questions

APPENDIX VI
LONG TERM CARE SERVICES
State Plan Amendment 26-0030

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-D of the state plan.

1. **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)?**

   Response: This amendment seeks to update the personal care reimbursement methodology by eliminating outdated direct care ceilings and replacing the ceilings with a standard deviation approach, which will more readily reflect changing fiscal climates in provider rates. Additionally, providers' direct care rates cannot fall below one standard deviation, which creates a minimum rate, safeguarding providers. The savings are generated by capping allowable administrative costs at 15 percent of the total rate. This ensures that direct care is the focus of Medicaid reimbursement, and it aligns Fee-for-Service (FFS) reimbursement with Managed Care's methodology. Nursing supervision and nursing assessment rates will be a set fee, established by the Commissioner of Health, preventing large variability in the nursing rates. The projected savings are just under 4 percent of total annual spending on FFS personal care services in New York State.

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. Certain classes of providers must notify and receive approval from the Department's Office of Primary Care and Health Systems Management in order to discontinue services. This office monitors and considers such requests in the context of access as they approve/deny changes in services. Finally, providers cannot discriminate based on source of payment.

   For providers that are not subject to an approval process, the State will continue to monitor 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.

Finally, the State ensures that there is sufficient provider capacity for Medicaid Managed Care plans as part of its process to approve managed care rates and plans. Should access to services be compromised, the State would be alerted and would take appropriate action to ensure retention of access to such services.

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: This change was proposed in the Governor's Executive Budget for State Fiscal Year 2027, and enacted by the State Legislature as part of the negotiation of the State Fiscal Year 2027 Budget. The impact of this change was weighed in the context of the overall Budget in the State. The legislative process provides opportunities for all stakeholders to lobby their concerns, objections, or support for various legislative initiatives.

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: Should any essential community provider experience Medicaid or other revenue issues that would prevent access to needed community services, per usual practice, the State would meet with them to explore the situation and discuss possible solutions, if necessary.

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: Over the course of the past three years, the State has undertaken a massive reform initiative to better align reimbursement with care. When fully implemented, the initiative will invest over $600 million in the State's ambulatory care system (outpatient, ambulatory surgery, emergency department, clinic and physicians) to incentivize care in the most appropriate setting. The State has also increased its physician reimbursement schedule to resemble Medicare payments for similar services, thus ensuring continued access for Medicaid beneficiaries. While some of these initiatives are outside the scope of the State Plan, they represent some of the measures the State is taking to ensure quality care for the State's most vulnerable population.