NEW YORK STATE OF OPPORTUNITY. Department of Health

KATHY HOCHUL
Governor

JAMES V. McDONALD, M.D., M.P.H.
Acting Commissioner

MEGAN E. BALDWIN
Acting Executive Deputy Commissioner

May 19, 2023

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 #23-0039
Non-Institutional Services

Dear Mr. McMillion:

The State requests approval of the enclosed amendment #23-0039 to the Title XIX (Medicaid) State Plan for non-institutional services to be effective April 1, 2023 (Appendix I). This amendment is being submitted based on proposed budget appropriation. 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 the proposed budget appropriation 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 29, 2023, is also enclosed for your information (Appendix IV). In addition, responses to the five standard funding questions are also enclosed (Appendix V).

If you have any questions regarding this State Plan Amendment submission, please do not hesitate to contact Regina Deyette, Medicaid State Plan Coordinator, Division of Finance and Rate Setting, Office of Health Insurance Programs at (518) 473-3658.

Sincerely,

[redacted]

Amir Bassiri
Medicaid Director
Office of Health Insurance Programs

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 23-0039

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
April 1, 2023

5. FEDERAL STATUTE/REGULATION CITATION
§ 1905(a)(2)(B) and 1905(a)(2)(C)

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 04/01/23-09/30/23 $ 67,524,732
b. FFY 10/01/23-09/30/24 $ 135,049,464

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

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*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

9. SUBJECT OF AMENDMENT
FQHC APM

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
May 19, 2023

15. RETURN TO
New York State Department of Health
Division of Finance and Rate Setting
99 Washington Ave – One Commerce Plaza
Suite 1432
Albany, NY 12210

FOR CMS USE ONLY

16. DATE RECEIVED

17. DATE APPROVED

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL

19. SIGNATURE OF APPROVING OFFICIAL

20. TYPED NAME OF APPROVING OFFICIAL

21. TITLE OF APPROVING OFFICIAL

22. REMARKS

Appendix I
2023 Title XIX State Plan
Second Quarter Amendment
Amended SPA Pages

New York
2(c)(iv)(f)

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

APM: Payment in Addition to Pre-existing PPS Rate

Effective April 1, 2023, eligible Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) will be designated as eligible by the Department to receive the additional payment under this section in order to preserve and improve beneficiary access to care and avoid loss of services in areas of concern.

The Department will routinely review eligible providers under this section and obtain information as it deems necessary to evaluate and determine need and effectiveness of previous payments.

For eligible providers, the annual amount of the additional payment that will be paid each state fiscal year, which runs April 1st through March 31st, on or before June 30th will be listed in the table which follows and will not be subject to subsequent adjustment or reconciliation. Furthermore, the FQHC/RHC payments made pursuant to this section are considered an alternative payment methodology (APM) and will be made in addition to the FQHC/RHC Prospective Payment System (PPS) rate. The APM will be agreed to by the Department of Health and the FQHC/RHC and will result in payment to the FQHC/RHC of an amount that is at least equal to the PPS rate. FQHCs/RHCs that do not choose an APM will be paid at their PPS per visit rate.

Additional payments have been approved for the following providers for the amounts listed:

Provider Name	Gross APM Payment Amount
Anthony L Jordan Health Ctr	$6,515,434.43
Apicha Comm Hlth Ctr	$9,800,000.00
Beacon Christian	$50,000.00
Beacon Christian Community Health Center	$100,000.00
Bed Stuy Family Hlth Ctr	$2,268,696.78
Betances Health Center	$4,112,760.34
Brooklyn Plaza Medical Ctr	$1,269,587.58
Brownsville Multi-Srv Fam H C	$6,020,157.32
Care For Homeless, Inc.	$1,077,951.00
Comm Hlth Ctr Buffalo Inc	$2,255,800.00
Community Health Center Of Richmond, Inc.	$165,000.00
Community Health Initiatives Inc	$424,823.00
Community Health Project	$16,833,184.55

New York
2(c)(iv)(g)

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

Providers (continued)

Provider Name	Gross APM Payment Amount
Community Healthcare Network	$4,900,059.42
Cornerstone Family Healthcare	$3,807,391.81
Cumberland Dtc	$2,247,276.86
Damian Family Care Center	$12,047,724.11
East Harlem Council Hum Serv	$2,380,215.86
East Hill Family Medical	$399,946.08
East New York Dtc	$3,231,301.64
Ehs, Inc. D/B/A Evergreen Health Services	$15,251,688.05
Ezras Choilim Hlth Ctr Inc	$1,132,228.17
Finger Lakes Migrant Hlth	$863,409.74
Floating Hospital	$1,100,000.00
Gouverneur Dtc	$5,598,364.58
Harmony Healthcare of Long Island	$500,000.00
Heritage Health Care	$3,100,000.00
His Branches	$173,130.00
Housing Works East New York	$10,805,223.00
Hudson Headwaters Hlth Network	$7,198,392.39
Jericho Road Community Hlth Ctr	$5,230,204.31
Joseph P Addabbo Family Hlth	$5,759,415.57
Lasante Health Center, Inc	$584,736.43
Long Island Select Healthcare	$3,889,256.51
L'Refauh Med & Rehab Ctr.,Inc	$2,404,086.96
Martin Luther King Hlth Ctr	$6,292,863.53
Morris Heights Health Center	$8,114,863.90
Morrisania Dtc	$1,886,219.55
Mt Vernon Neigh Hlth Ctr Inc	$313,500.00
Northern Oswego Cnty Hlth Svc	$4,012,949.00
Northwest Buffalo Comm H C	$4,945,114.91
Oak Orchard Comm Hlth Ctr Inc	$2,559,330.00
Oda Primary Health Care Center	$2,365,531.36
Open Door Family Medical Center, Inc.	$3,150,473.99

New York
2(c)(iv)(h)

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

Providers (continued)

Provider Name	Gross APM Payment Amount
P R O M E S A	$1,740,748.91
Premium Health Inc	$1,500,000.00
Rambam Family Health Center	$330,000.00
Refuah Health Center Inc	$5,922,198.93
Renaissance Health Care Network	$1,166,977.53
Schenectady Family Hlth Svc	$2,765,458.17
Segundo Ruiz Belvis Dtc	$959,252.54
Settlement Health	$1,016,650.60
Southern Tier Community Health Center Network	$50,000.00
Sun River Health, Inc	$16,165,930.92
Syracuse Comm Health Ctr Inc	$2,975,869.92
The Chautauqua Center	$2,333,954.35
The Institute For Family Health	$11,654,474.56
Trillium Health, Inc	$9,764,541.94
Union Community	$2,889,188.86
Upper Room Aids Ministry	$5,569,424.71
Upstate Family Health Center Inc	$2,654,774.00
Urban Health Plan Inc	$7,651,721.15
VIP Community Services	$2,408,659.95
Whitney M Young Health Center	$5,386,500.00
William F Ryan Comm Hlth Ctr	$8,054,307.96

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

For services provided on or after January 1, 2001, until such time as the new methodology is implemented, facilities ~~shall~~ will be paid via the methodology in place as of December 31, 2000. The difference between the two methodologies ~~shall~~ will be calculated and the sum ~~shall~~ will be paid, on a per visit basis, in the fiscal year immediately following implementation of this new methodology.

~~For services provided on or after January 1, 2001 by FQHC's participating in managed care, supplemental payments will be made to these FQHC's that will be equal to 100% of the difference between the facilities reasonable cost per visit rate and the amount per visit reimbursed by the managed care plan.~~

The reimbursement methodology that the Department of Health will use for FQHCs located out-of-state will be the currently approved FQHC rate of the provider's home state.

Supplemental Payment (Wrap) Program

For services provided by Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) participating in Medicaid managed care, supplemental payments will be made to these FQHCs/RHCs that will be equal to 100% of the difference between the facility's reasonable cost per visit rate and the amount per visit reimbursed by the Medicaid managed care health plan.

The Supplemental Payment (Wrap) Program utilizes data submitted on an annual basis by FQHCs/RHCs via the Managed Care Visit and Revenue (MCVR) report which provides calendar year managed care cost experience for the FQHCs/RHCs. This information is used to calculate an average managed care payment received by FQHCs/RHCs which is then compared to the blended Medicaid FQHC/RHC fee-for-service prospective payment system (PPS), group psychotherapy and individual offsite rates. The difference between the average amount received by the FQHCs/RHCs from the Medicaid managed care health plans and the amount that fee-for-service would have paid is the prospective per-visit Wrap rate amount. Using this methodology, a unique Wrap rate is calculated for each FQHC/RHC.

For newly established FQHCs/RHCs that do not have managed care experience, the Department of Health will use the regional managed care per-visit average rate to calculate the initial Wrap rate. This rate will remain in effect until the newly established FQHC/RHC has twelve months of experience to complete the MCVR report.

Additionally, annual audits of the underlying data used in the MCVR report will occur to ensure the accuracy of the rates being paid to FQHCs/RHCs. Audits may result in retroactive changes to wrap rates if FQHC/RHC reported cost data is modified.

Appendix II
2023 Title XIX State Plan
Second Quarter Amendment
Summary

SUMMARY
SPA #23-0039

This State Plan Amendment proposes to establish an Alternative Payment Methodology (APM) for Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) and to clarify the reimbursement methodology for the Supplemental Payment Wrap Program.

Appendix III
2023 Title XIX State Plan
Second Quarter Amendment
Authorizing Provisions

assistance program including hospital inpatient services and general hospitals that are safety-net providers that evince severe financial distress, pursuant to criteria determined by the commissioner, shall be eligible for awards for amounts appropriated herein, to enable such providers to maintain operations and vital services while establishing long term solutions to achieve sustainable health services.

Notwithstanding any inconsistent provision of law, rule or regulation to the contrary, for the period on and after April 1, 2023 subject to the approval of the commissioner of health and the director of budget, Medicaid payments made for the operating component of hospital inpatient services shall be subject to a uniform rate increase of five percent in addition to the current uniform rate increase of one percent, subject to federal financial participation.

Notwithstanding any provision of law to the contrary, the portion of this appropriation covering fiscal year 2023-24 shall supersede and replace any duplicative (i) reappropriation for this item covering fiscal year 2023-24, and (ii) appropriation for this item covering fiscal year 2023-24 set forth in chapter 53 of the laws of 2022 (26947) 1,607,598,000

For services and expenses of the medical assistance program including hospital outpatient and emergency room services.

Notwithstanding any provision of law to the contrary, the portion of this appropriation covering fiscal year 2023-24 shall supersede and replace any duplicative (i) reappropriation for this item covering fiscal year 2023-24, and (ii) appropriation for this item covering fiscal year 2023-24 set forth in chapter 53 of the laws of 2022 (26948) 568,442,000

For services and expenses of the medical assistance program including clinic services.

Notwithstanding any provision of law to the contrary, the portion of this appropriation covering fiscal year 2023-24 shall supersede and replace any duplicative (i) reappropriation for this item covering fiscal year 2023-24, and (ii) appropriation for this item covering fiscal year 2023-24 set forth in chapter 53 of the laws of 2022 (26949) 1,065,908,000

For services and expenses of the medical assistance program including nursing home services.

Notwithstanding any inconsistent provision of law, rule or regulation to the contrary, for the period on and after

Appendix IV
2023 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 institutional, non-institutional and long-term care services to comply with statutory provisions. The following changes are proposed:

All Services

Effective on or after April 1, 2023, the Department of Health will adjust rates statewide to reflect a 2.5% percent Cost of Living Adjustment 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, Children Family Treatment Support Services, Health Home Plus, Psychiatric Residential Treatment Facilities for Children and Youth, OASAS Outpatient Addiction Services, OASAS Freestanding (non-hospital) Inpatient Rehabilitation Services, OASAS Freestanding Inpatient Detox Services, OASAS Addiction Treatment Centers, OASAS Part 820 Residential Services, OASAS Residential Rehabilitation Services for Youth, Intermediate Care Facility (ICF/IDD), Day Treatment, Article 16 Clinic Services, Specialty Hospital, Health Home Services Provided by Care Coordination Organizations, Independent Practitioner Services for Individual with Developmental Disabilities (IPSIDD), and OPWDD Crisis Services.

The estimated net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2023-2024 is $53.6 million.

Non-Institutional Services

Effective on and after April 1, 2023, the New York State Department of Health proposes to amend the State Plan to allow for reimbursement of Medicaid covered services provided by pharmacists within their lawful scope of practice, including pharmacist prescribing oral contraceptives and smoking cessation products.

The estimated net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2023-2024 is $1.6 million. In the out years the net aggregate in gross Medicaid expenditure for smoking cessation products will be a savings.

Effective on or after April 1, 2024, this proposal would eliminate Prescriber Prevails which applies to the Medicaid fee-for-service pharmacy program. Doing so would reduce inappropriate prescribing, remove barriers that limit the State's ability to manage pharmacy programs, and minimize the inappropriate influence of pharmaceutical manufacturers in the prior authorization process.

The estimated net aggregate decrease in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2024-2025 is ($99 million).

Effective on or after April 1, 2023, the Department will remove copayments for over the counter (OTC) products and limit OTC products to those that are medically necessary. Clinically critical products such as aspirin and vitamins and minerals used for deficiencies will continue to be covered, as will less expensive OTC products that are in Preferred Drug Program (PDP) drug classes.

The estimated net aggregate decrease in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2023-2024 is ($17.4 million).

Effective on and after April 1, 2023, the New York State Department of Health proposes to amend the State Plan to modify the specific drug class language for excluded drugs, to alternatively use current publicly available Department resources for coverage transparency.

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

Effective on or after April 1, 2023, this proposal continues the supplemental upper payment limit payments made to general hospitals, other than major public general hospitals under non-institutional services of $339 million annually.

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

For state fiscal year beginning April 1, 2023, through March 31, 2024, this proposal continues hospital outpatient payment adjustments that increase the operating cost components of rates of payment for hospital outpatient and emergency departments on and after April 1, 2011, for public general hospitals other than those operated by the State of New York or the State University of New York, which are located in a city with a population of over one million. The amount to be paid will be up to $287 million annually based on criteria and methodology set by the Commissioner of Health, which the Commissioner may periodically set through a memorandum of understanding with the New York City Health and Hospitals Corporation. Such adjustments shall be paid by means of one or more estimated payments. Payments may be added to rates of payment or made as aggregate payments.

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

For state fiscal year beginning April 1, 2023, through March 31, 2024, this proposal continues payment of up to $5.4 million in additional annual Medicaid payments to county operated free-standing clinics, not including facilities operated by the New York City Health

and Hospitals Corporation, for services provided by such DTC and those provided by a county operated freestanding mental health or substance abuse DTC. Distributions shall be based on each eligible facility's proportionate share of the sum of all DTC and clinic visits for all eligible facilities receiving payments for the base year two years prior to the rate year. The proportionate share payments may be added to rates of payment or made as aggregate payments to eligible facilities.

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

Effective April 1, 2023, and each state fiscal year thereafter, this amendment proposes to revise the calculation to extract data later on in the calendar year for the applicable dates of service. The current authority to make supplemental payments for services provided by physicians, nurse practitioners and physician assistants will continue.

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

Effective on or after April 1, 2023, the Department of Health will adjust rates for Assisted Living Program (ALP) providers by a 5% across the board increase to the most recently active Operating rate in effect on March 31, 2023, for each provider.

The estimated net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2023-2024 is $18 million.

Effective on or after April 1, 2023, the Department of Health will adjust rates for Adult Day Health Care providers by a 5% across the board increase to the most recently active Operating rate in effect on March 31, 2023, for each provider.

The estimated net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2023-2024 is $838,000.

Effective on and after April 1, 2023, this notice provides for a temporary rate adjustment with an aggregate payment totaling no less than $7.5 million annually for Critical Access Hospitals (CAHs), for the periods April 1, 2023, through March 31, 2024, and April 1, 2024, through March 31, 2025. Funding will be allocated to financially distressed hospitals with plans to reconfigure operations by improving financial management, improving quality of care and service delivery and/or improving operational efficiency and cost effectiveness.

The estimated net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2023-2024 is $7.5 million and contained in the budget for state fiscal year 2024-2025 is $7.5 million.

Effective on and after April 1, 2023, this notice provides for a temporary rate adjustment with an aggregate payment amount totaling no less than $10 million annually, for Essential Community Providers (ECPs) for the periods April 1, 2023, through March 31, 2024, and April 1, 2024, through March 31, 2025. Funding will be allocated to financially distressed hospitals with plans to reconfigure operations by improving financial management, improving quality of care and service delivery and/or improving operational efficiency and cost effectiveness.

The estimated net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2023-2024 is $10 million and contained in the budget for state fiscal year 2024-2025 $10 million.

Effective on or after April 1, 2023, this notice proposes to establish Medical Assistance coverage and rates of payment for rehabilitative services for individuals residing in OMH-licensed residential settings who have been diagnosed with an eating disorder, in order to provide appropriate care and treatment to adults and children with eating disorders.

The estimated net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2023-2024 is $4 million.

Effective on or after May 1, 2023, the NYS Medicaid Program proposes to reimburse enrolled ambulance services for administration of vaccinations performed by Emergency Medical Technicians (EMT) / Paramedics employed by the ambulance service. This proposal is intended to ensure ongoing access to vaccinations after the end of the federal COVID-19 Public Health Emergency.

The estimated net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2023-24 is $35,000.

Effective March 11, 2021 and ending on the last day of the first calendar quarter that begins one year after the last day of the emergency period described in section 1135(g)(1)(B) of the Social Security Act, the Medicaid program assures coverage of COVID-19 vaccines and administration of the vaccines, COVID-19 treatment, including specialized equipment and therapies (including preventive therapies), and COVID-19 testing consistent with the Centers for Disease Control and Prevention (CDC) recommendations.

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

Effective December 1, 2021 and ending on the last day of the first calendar quarter that begins one year after the last day of the emergency period described in section 1135(g)(1)(B) of the Social Security Act, the Medicaid program proposes to reimburse providers for medically necessary COVID-19 vaccine counseling for children under 21 at a fee of $25.00 per session.

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

Effective on or after April 1, 2023, the Department of Health will adjust rates statewide to reflect up to a twenty-five percent rate increase for all services provided by School-based Mental Health Outpatient Treatment and Rehabilitative Service (SBMH MHOTRS) programs licensed by the Office of Mental Health.

The estimated net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2023-2024 is $9.2 million.

Effective on or after April 1, 2023, Medicaid will increase the APG Base Rates by ten percent for School Based Health Centers (SBHC).

The estimated net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2023-2024 is $2.8 million.

Effective on or after April 1, 2023, a Supplemental Payment Program will be established to reimburse eligible Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs) and Diagnostic and Treatment Centers (DTCs) for potential loss of funding associated with the 340B Drug Pricing Program due to State policy change. Additionally, this Amendment clarifies the reimbursement methodology for the Supplemental Payment Wrap Program for FQHCs and RHCs which provides supplemental payments that are equal to 100% of the difference between the facility's reasonable cost per visit rate and the amount per visit reimbursed by the Medicaid managed care health plan.

The estimated net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2023-2024 is $250 million.

Institutional Services

Effective on or after April 1, 2023, this proposal continues the supplemental upper payment limit payments made to general hospitals, other than major public general hospitals under institutional services of $339 million annually.

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

For state fiscal year beginning April 1, 2023 through March 31, 2024, this proposal continues adjustments for hospital inpatient services provided on and after April 1, 2012, to public general hospitals, other than those operated by the State of New York or the State University of New York, located in a city with a population of over one million and receiving reimbursement of up to $1.08 billion annually based on criteria and methodology set by the Commissioner of Health, which the Commissioner may periodically set through a memorandum of understanding with the New York City Health and Hospitals Corporation. Such adjustments will be paid by means of one or more estimated payments. Payments to eligible public general hospitals may be added to rates of payment or made as aggregate payments.

Appendix V
2023 Title XIX State Plan
Second Quarter Amendment
Responses to Standard Funding Questions

NON-INSTITUTIONAL SERVICES
State Plan Amendment #23-0039

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.

Hospital OPD		**4/1/22 – 3/31/23**	
Payment Type	**Non-Federal Share Funding**	**Non-Federal**	**Gross**
Normal Per Diem	General Fund; Special Revenue Funds; County Contribution	$257M	$513M

Freestanding Clinic		**4/1/22 – 3/31/23**	
Payment Type	**Non-Federal Share Funding**	**Non-Federal**	**Gross**
Normal Per Diem	General Fund; Special Revenue Funds; County Contribution	$184M	$368M

A. **General Fund:** Revenue resources for the State's General Fund includes taxes (e.g., income, sales, etc.), and miscellaneous fees (including audit recoveries). Medicaid expenditures from the State's General Fund are authorized from Department of Health Medicaid.

1) New York State Audit Recoveries: The Department of Health collaborates with the Office of the Medical Inspector General (OMIG) and the Office of the Attorney General (AG) in recovering improperly expended Medicaid funds. OMIG conducts and coordinates the investigation, detection, audit, and review of Medicaid providers and recipients to ensure they are complying with all applicable laws and regulation. OMIG recovers any improper payments through cash collections and voided claim recoveries. Cash collections are deposited into the State's General Fund to offset Medicaid costs.

   In addition to cash collections, OMIG finds inappropriately billed claims within provider claims. To correct an error, OMIG and DOH process the current accurate claim, and reduce this claim by the inappropriate claim value to recoup the previous overclaim and decrease state spending.

B. Special Revenue Funds:

1) Health Care Reform Act (HCRA) Resource Fund: as authorized in section 92-dd of New York State Finance Law and was established in 1996, pursuant to New York State Public Health Law 2807-j. HCRA resources include:

   - Surcharge on net patient service revenues for specified provider types including Comprehensive Diagnostic and Treatment Centers, Ambulatory Surgery Centers, and Outpatient Hospital Services.

- The rate for commercial payors is 9.63 percent.
- The rate for governmental payors, including Medicaid, is 7.04 percent.
- Federal payors, including Medicare, are exempt from the surcharge.

2) Health Facility Cash Assessment Program (HFCAP) Fund: Pursuant to New York State Public Health Law 2807-d HFCAP requires New York State designated providers to pay an assessment on cash operating receipts on a monthly basis. The assessment is 0.35% for Article 28 General Hospitals.

   NOTE: New York's Health Care taxes are either broad based and uniform (as in all HFCAP assessments except for the Personal Care Provider Cash Assessment) or have a specific exemption known as the "D'Amato provision (Federal PHL section 105-33 4722 (c)" which allows the HCRA surcharges to exist in their current format. The single tax which has been determined by the State to be an impermissible provider tax is the HFCAP charge on Personal Care Providers. The State does not claim any Federal dollars for the surcharge collected in this manner in order to comply with all Federal provider tax rules.

C. Additional Resources for Non-Federal Share Funding:

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

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

Entity	Annual Amount
New York City	$4.882B
Suffolk County	$216M
Nassau County	$213M
Westchester County	$199M
Erie County	$185M
Rest of State (53 Counties)	$979M
Total	**$6.835B**

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 authorized under this State Plan Amendment are supplemental payments. The value of these supplemental payments is $250 million gross.

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 outpatient UPL demonstration utilizes a cost-to-payment methodology to estimate the upper payment limit for each class of providers. The Medicaid payments under this State Plan Amendment will be included in the 2023 outpatient UPL when it is submitted to CMS.

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

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

ACA Assurances:

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

MOE Period.

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

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

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

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

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

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

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

Tribal Assurance:

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

IHCIA Section 2107(e)(I) of the Act was also amended to apply these requirements to the Children's Health Insurance Program CHIP. Consultation is

required concerning Medicaid and CHIP matters having a direct impact on Indian health programs and Urban Indian organizations.

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

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