NEW YORK STATE OF OPPORTUNITY. Department of Health

KATHY HOCHUL
Governor

MARY T. BASSETT, M.D., M.P.H.
Commissioner

KRISTIN M. PROUD
Acting Executive Deputy Commissioner

September 30, 2022

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 #22-0078
Inpatient Hospital Services

Dear Mr. McMillion:

The State requests approval of the enclosed amendment #22-0078 to the Title XIX (Medicaid) State Plan for inpatient hospital services to be effective July 1, 2022 (Appendix I). This amendment is being submitted based upon enacted legislation. A summary of the proposed amendment is contained in Appendix II.

This amendment is submitted pursuant to §1902(a) of the Social Security Act (42 USC 1396a(a)) and Title 42 of the Code of Federal Regulations (CFR), Part 447, Subpart C.

Notice of the changes in the methods and standards for setting payment rates for general hospital inpatient services was given in the New York State Register on June 29, 2022. A copy of pertinent sections of enacted legislation is enclosed for your information (Appendix III). 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: 22-0078

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: July 01, 2022

5. FEDERAL STATUTE/REGULATION CITATION: 1905(a)(16) Inpatient Psychiatric Hospital – PRTF / NY Mental Hygie

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 07/01/22-09/30/22 $ 1,875,000
b. FFY 10/01/22-09/30/23 $ 7,500,000

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachments 4.19-A Part III Pages: 3, 3(a), 4, 4.1

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: Attachments 4.19-A Part III Pages: 3, 3(a), 4, 4.1

9. SUBJECT OF AMENDMENT

RTF Methodology Updates

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: September 30, 2022

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
2022 Title XIX State Plan
Third Quarter Amendment
Amended SPA Pages

New York
3

1905(a)(16) Inpatient Psychiatric Hospital – PRTF

B. RESIDENTIAL TREATMENT FACILITIES FOR CHILDREN AND YOUTH

Medicaid rates for Residential Treatment Facilities for Children and Youth ("RTFs") are established prospectively, based upon actual costs and patient days as reported on cost reports for the fiscal year two years prior to the rate year. The RTF fiscal year and rate year are for the twelve months July 1 through June 30. Alternate Cost Reports ~~may~~ will be utilized to align with appealed rate periods until such time that the appealed information would be fully reflected in the facilities annual cost report. Actual patient days are subject to a maximum utilization of 96 percent and a minimum utilization of 90 percent. The minimum utilization requirements will be waived in full or in part by the Commissioner of the Office of Mental Health (OMH) if provider visit volume falls below 90% due to circumstances beyond provider control, including, but not limited to natural, environmental, and public health emergencies and if it is demonstrated to the satisfaction of the Commissioner that waiver is appropriate.

1. OPERATING COSTS

Allowable operating costs are subject to the review and approval of the ~~Office of Mental Health~~ OMH and effective on or after July 1, 2022, will exclude eligible outpatient medical, dental, vision, diagnostics/radiology, laboratory, occupational, physical and speech therapy, substance abuse treatment, neuropsychological/developmental testing and medical equipment which will be reimbursed using the Fee-for-Service Program administered by the New York Department of Health. The Fee-for-Service Program will be utilized for the purchase of the above eligible services commencing on the date the child is determined to be Medicaid eligible. The cost of those medical services provided to the child before the determination of Medicaid eligibility will be the responsibility of the RTF and considered an allowable cost in the development of the provider's reimbursement rate for inpatient stays. In determining the allowability of costs, the ~~Office of Mental Health~~ OMH reviews the categories of cost, described below, with consideration given to the special needs of the patient population to be served by the RTF. The categories of costs include:

(i) Clinical/Direct Care (C/DC). This category of costs includes salaries and fringe benefits for clinical and direct care staff.

(ii) Administration, Maintenance and Supports (AMS). This category of costs includes the costs associated with administration, maintenance and child support.

(iii) Purchased Health Services (PHS). This category of costs includes clinical services such as dental services, purchased on a contractual basis and not subject to the clinical standard if the services are not uniformly provided by all RTFs and thus not considered by the Commissioner in the establishment of the approved staffing levels.

On or after July 1, 2022, operating rates of payment will be adjusted by a length of stay (LOS) adjustment. The LOS adjustment will be a percentage increase or decrease in the operating component of the payment dependent on the duration of an individual recipient's care episode. The level and duration of rate payment increases for the early portions of a care episode and the level and duration of the payment rate decreases for extend portions of care episodes will be structure to achieve clinical goals and budget neutrality based on historical utilization data. Modifications will be made annually to adjust to changing utilization patterns and programmatic goals.

~~Allowable per diem operating costs in the category of C/DC are limited to the lesser of the reported costs or the amount derived from the number of clinical staff approved by the Commissioner multiplied by a standard salary and fringe benefit amount.~~

1905(a)(16) Inpatient Psychiatric Hospital – PRTF

Allowable per diem operating costs in the category of C/DC are limited to the lesser of the reported costs or the amount derived from the number of clinical staff approved by the Commissioner multiplied by a standard salary and fringe benefit amount.

Allowable per diem operating costs in the category of other than clinical care are limited to the lesser of the reported costs or a standard amount.

The standard amounts for the C/DC and AMS categories are computed as follows. For RTFs located in the New York City metropolitan statistical area and Nassau and Suffolk counties the standard is: the sum of 50 percent of the provider costs, 25 percent of the average per diem cost for all RTFs in this geographic area and ~~50~~ 25 percent of the average per diem cost for all RTFs in the state; increased by seven and one half percent. For RTFs located outside the New York City metropolitan statistical area and Nassau and Suffolk counties the standard is: the sum of 50 percent of the provider costs, 25 percent of the average per diem cost for all RTFs located outside the New York City metropolitan statistical area and Nassau and Suffolk Counties and ~~50~~ 25 percent of the average per diem cost for all RTFs in the state; increased by seven and one half percent.

On or after July 1, 2022, The State will increase the rates of payment to include necessary costs for additional staff, as approved by the OMH, which are not included in the historical cost reports utilized to develop the rates. The new costs will support additional staff being added to existing PRTFS who are necessary to meet updated programmatic needs and standards. The additional staff will include, but not be limited to, clinical, direct care, transition, intake, and permanency/family connections specialist. Cost adjustments for prospective staff will be based on OMH approved Staffing Plans and applicable Costs Report data, or Bureau of Labor Statistic Wage data when appropriate Cost Report data is not available. Costs will be trended to the to appropriate period and added to the applicable cost basis until such a time when the Department of Health has determined costs associated with the additional staff are reflected in the cost reports used for rate setting.

1905(a)(16) Inpatient Psychiatric Hospital – PRTF

Allowable operating costs as determined in the preceding paragraphs will be trended by the Medicare inflation factor.

Effective July 01, 2021 through March 31, 2022, operating rates of payment will be increased for a Cost of Living Adjustment (COLA), calculated to support a one percent (1.0%) annual aggregate payment to be paid out over the 9 month period between July 1, 2021 and March 31, 2022, and a one percent (1%) annual increase to be paid out over 12 months in subsequent years until such time as the COLA increase is reflected in the base period cost reports.

Effective on or after February 1, 2022, the C/DC rate component will be adjusted to include a twenty-five percent (25%) increase to include additional funds, not included in the base year, appropriate to maintain the required level of care. This increase will be included until such a time as the increase is reflected in the base period cost reports.

Effective April 01, 2022, through March 31, 2023, operating rates of payment will be increased for a Cost-of-Living Adjustment (COLA) to support a five point four percent (5.4%) increase until such time as the COLA increase is reflected in the base period cost reports.

Effective on or after July 01, 2022, rates of payment will receive a percentage increase. This increase will be included until such a time as the increase is reflected in the base period cost reports.

1905(a)(16) Inpatient Psychiatric Hospital – PRTF (Continued)

2. CAPITAL COSTS

To allowable operating costs are added allowable capital costs. Allowable capital costs are determined by the application of principles developed for determining reasonable cost payments under the Medicare program. Allowable capital costs include an allowance for depreciation and interest. To be allowable, capital expenditures which are subject to the Office of Mental Health's Prior Approval Review (PAR) procedures must be reviewed and approved by the Office of Mental Health. On or after July 01, 2022, the capital component of the rates will be adjusted once annually to account for actual billing over the rate period to compensate for the variation between allowable capital for the period and capital reimbursement actually received.

Transfer of Ownership

In establishing an appropriate allowance for depreciation and for interest on capital indebtedness and (if applicable) a return on equity capital with respect to an asset of a hospital which has undergone a change of ownership, that the valuation of the asset after such change of ownership will be the lesser of the allowable acquisition cost of such asset to the owner of record as of July 18, 1984 (or, in the case of an asset not in existence as of such date, the first owner of record of the asset after such date), or the acquisition cost of such asset to the new owner.

3. APPEALS

The Commissioner ~~may~~ will consider requests for rate revisions which are based on errors in the calculation of the rate or based on significant changes in costs resulting from changes in:

- Capital projects approved by the Commissioner in connection with OMH's PAR procedures.
- OMH approved changes in staffing plans submitted to DOH in a form as determined by the DOH.
- OMH approved changes in capacity approved by the Commissioner in connect with OMH's PAR procedures;
- Other rate revisions ~~may~~ will be based on requirements to meet accreditation standards of the Joint Commission on Accreditation of Hospitals, or other Federal or State mandated requirements resulting in increased costs.

Revised rates will utilize existing facility cost reports, adjusted as necessary. The rates of payment will be subject to total allowable costs, total allowable days, staffing standards as approved by the Commissioner, and a limitation on operating expenses as determined by the Commissioner. These rates must be certified by the Commissioners of OMH and DOH and approved by the Director of the Budget.

Appendix II
2022 Title XIX State Plan
Third Quarter Amendment
Summary

SUMMARY
SPA #22-0078

This State Plan Amendment proposes to respond to recent public criticism related to challenges involving maintaining required levels of staff, the Residential Treatment Facility (RTF) placement process and reimbursement levels. The Office of Mental Health is seeking to invest in staffing at RTFs to aid with the placement process and maintain beds for children who need placements by adjusting the RTF methodology to allow for more accurate representation of the needed resources and actual costs of service provision in these facilities.

Appendix III
2022 Title XIX State Plan
Third Quarter Amendment
Authorizing Provisions

SPA 22-0078

New York State Mental Hygiene Law §43.02: Rates of methods of payment for services at facilities subject to licensure or certification by the office of mental health, the office for people with developmental disabilities or the office alcoholism and substance abuse services

(a) Notwithstanding any inconsistent provision of law, payment made by government agencies pursuant to title eleven of article five of the social services law for services provided by any facility licensed by the office of mental health pursuant to article thirty-one of this chapter or certified by the office of alcoholism and substance abuse services pursuant to this chapter to provide inpatient chemical dependence services, as defined in section 1.03 of this chapter, shall be at rates or fees certified by the commissioner of the respective office and approved by the director of the division of the budget, provided, however, the commissioner of mental health shall annually certify such rates or fees which may vary for distinct geographical areas of the state and, provided, further, that rates or fees for service for inpatient psychiatric services or inpatient chemical dependence services, at hospitals otherwise licensed pursuant to article twenty-eight of the public health law shall be established in accordance with section two thousand eight hundred seven of the public health law and, provided, further, that rates or fees for services provided by any facility or program licensed, operated or approved by the office for people with developmental disabilities, shall be certified by the commissioner of health; provided, however, that such methodologies shall be subject to approval by the office for people with developmental disabilities and shall take into account the policies and goals of such office.

(b) Operators of facilities licensed by the office of mental health pursuant to article thirty-one of this chapter, licensed by the office for people with developmental disabilities pursuant to article sixteen of this chapter or certified by the office of alcoholism and substance abuse services pursuant to this chapter to provide inpatient chemical dependence services shall provide to the commissioner of the respective office such financial, statistical and program information as the commissioner may determine to be necessary. The commissioner of the appropriate office shall have the power to conduct on-site audits of books and records of such facilities.

(c) The commissioner of the office of mental health, the commissioner of the office for people with developmental disabilities and the commissioner of the office of alcoholism and substance abuse services shall adopt rules and regulations to effectuate the provisions of this section. Such rules and regulations shall include, but not be limited to, provisions relating to:

(i) the establishment of a uniform statewide system of reports and audits relating to the quality of care provided, facility utilization and costs of providing services; such a uniform statewide system may provide for appropriate variation in the application of the system to different classes or subclasses of facilities licensed by the office of mental health pursuant to article thirty-one of this chapter or licensed or operated by the office for people with developmental disabilities pursuant to article sixteen of this chapter, or certified by the office of alcoholism and substance abuse services pursuant to this chapter to provide inpatient chemical dependence services; and

(ii) methodologies used in the establishment of the schedules of rates or fees pursuant to this section provided, however, that the commissioner of health shall adopt rules and regulations including methodologies developed by him or her for services provided by any facility or program licensed, operated or approved by the office for people with developmental disabilities; provided,

however, that such rules and regulations shall be subject to the approval of the office for people with developmental disabilities and shall take into account the policies and goals of such office.

Appendix IV
2022 Title XIX State Plan
Third Quarter Amendment
Public Notice

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

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

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

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

PUBLIC NOTICE
Department of Health

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

The Department of Health proposes to amend the Title XIX (Medicaid) State Plan for institutional services. The following changes are proposed:

Institutional Services

Effective on or after July 1, 2022, Residential Treatment Facilities (RTF) rates will be adjusted to allow for more accurate representation of the needed resources and actual costs of service provision in these facilities via an update to the rate setting methodology. These updates will allow for preservation of needed capacity and better alignment of certain cost components reflected in the reimbursement methodology, including changes to preserve access, and removing certain outside medical costs that are currently included in the RTF per diem rate.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2022/2023 is $15,000,000.

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 international value equity investment management services for the International Equity Fund (the "Fund") investment option of the Plan. The objective of the Fund is to provide exposure to the broad international equity market. Qualified vendors that do not currently provide product capabilities to eVestment must submit product information to NEPC, LLC at the following e-mail address: bvertucci@nepc.com. Please complete the submission of product information no later than 4:30 P.M. Eastern Time on June 29, 2022.

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
Uniform Code Variance/Appeal Petitions

Pursuant to 19 NYCRR Part 1205, the variance and appeal petitions below have been received by the Department of State. Unless otherwise indicated, they involve requests for relief from provisions of the New York State Uniform Fire Prevention and Building Code. Persons wishing to review any petitions, provide comments, or receive actual notices of any subsequent proceeding may contact Brian Tollisen or Neil Collier, Building Standards and Codes, Department of State, One Commerce Plaza, 99 Washington Ave., Albany, NY 12231, (518) 474-4073 to make appropriate arrangements.

2022-0301 In the matter of David Vanderpoorten of the Facilities Department Cornell University, 639 Dryden Road, Humphreys Service Building, Ithaca, New York 14850 for a variance concerning a fire apparatus road width to Thurston Hall located at 130 Holister Drive, City of Ithaca, County of Tompkins, State of New York.

2022-0302 In the matter of David Kermizian of River's Edge Banquet Hall Kermizian LLC, 465 Christman Road, Cold Brook, New York 113324 for a variance concerning a required sprinkler system for River's Edge Banquet Hall to be located at 5675 State Route 28, Town of Newport, County of Herkimer, State of New York.

PUBLIC NOTICE
Department of State
Uniform Code Variance/Appeal Petitions

Pursuant to 19 NYCRR Part 1205, the variance and appeal petitions below have been received by the Department of State. Unless otherwise indicated, they involve requests for relief from provisions of the New York State Uniform Fire Prevention and Building Code. Persons wishing to review any petitions, provide comments, or receive actual notices of any subsequent proceeding may contact Brian Tollisen or Neil Collier, Building Standards and Codes, Department of State, One Commerce Plaza, 99 Washington Ave., Albany, NY 12231, (518) 474-4073 to make appropriate arrangements.

2022-0309 in the Matter of ADG Architecture and Design, P.C., Chris Carrano, 13 West 36th Street, 7th Floor, New York, NY 10018, for a variance concerning safety requirements, including protruding objects and headroom. Involved is a five story building located at 421 8th Avenue, New York, NY 10199, County of New York, State of New York.

2022-0310 in the Matter of Conor and Kellee Brennan, 28 Cowdin Lane, Chappaqua, NY 10514, for a variance concerning safety requirements, including ceiling height. Involved is a one family dwelling located at 28 Cowdin Lane, Chappaqua, NY 10514, County of Westchester, State of New York.

Appendix V
2022 Title XIX State Plan
Third Quarter Amendment
Responses to Standard Funding Questions

INSTITUTIONAL SERVICES
State Plan Amendment #22-0078

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-A 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 or is funded by an IGT transferred from the counties.

		4/1/22 – 3/31/23	
Payment Type	**Non-Federal Share Funding**	**Non-Federal**	**Gross**
Hospital Inpatient Normal Per Diem	General Fund; Special Revenue Funds; County Contribution	$2.199B	$4.398B
Residential Treatment Facilities Normal Per Diem	General Fund; County Contribution	$40M	$80M
Hospital Inpatient Supplemental	General Fund	$39M	$77M
Indigent Care Pool/Voluntary UPL $339M Guarantee	General Fund	$526M	$1.052B
Indigent Care Pool Adjustment	General Fund; IGT	$206M	$412M
Disproportionate Share Program	General Fund; IGT	$1.377B	$2.754B
State Public Inpatient UPL	General Fund	$8M	$16M
Non-State Government Inpatient UPL	IGT	$254M	$507M
Totals		**$4.648B**	**$9.297B**

1) **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.

   a) 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.

2) Special Revenue Funds:

a) 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 and 2807-s (surcharges), 2807-c (1 percent), and 2807-d-1 (1.6 percent). HCRA resources include:

- Surcharge on net patient service revenues for Inpatient 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.
- 1 percent assessment on General Hospital Inpatient Revenue.
- 1.6 percent Quality Contribution on Maternity and Newborn (IP) Services.

b) Health Facility Cash Assessment Program (HFCAP) Fund: Pursuant to New York State Public Health Law 2807-d, the total state assessment on each hospital's gross receipts received from all patient care services and other operating income, excluding gross receipts attributable to payments received pursuant to Title XVIII of the federal Social Security Act (Medicare), is 0.35 percent.

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.

3) 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:

County	Annual Amount
New York City	$4.882B
Suffolk	$216M
Nassau	$213M
Westchester	$199M
Erie	$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. Each deposit received is reviewed and compared to the amount each county is responsible to contribute to the Medicaid program to verify the county funds received are eligible for Medicaid expenses.

4) IGT Funding:

New York requests the transfer of the IGT amounts prior to the release of payments to the providers. Please note that counties have taxing authority and the State does not provide appropriations to the counties for IGTs. Distribution by provider in the table below will be completed upon approval of the UPL calculation.

Provider	County Transferring IGT Funds	4/1/22-3/31/23 IGT Amount
Jacobi Medical Center	New York City	$211M
Lincoln Medical & Mental Health Center	New York City	$175M
North Central Bronx Hospital	New York City	$23M
Coney Island Hospital	New York City	$18M
Kings County Hospital Center	New York City	$273M
Woodhull Medical and Mental Health Center	New York City	$73M
Bellevue Hospital Center	New York City	$343M
Harlem Hospital Center	New York City	$183M
Metropolitan Hospital Center	New York City	$135M
Henry J Carter Spec Hospital	New York City	($16M)
City Hospital Center at Elmhurst	New York City	$34M

Queens Hospital Center	New York City	$37M
Erie County Medical Center	Erie	$98M
Nassau County Medical Center	Nassau	$131M
Westchester County Medical Center	Westchester	$287M
Lewis County General Hospital	Lewis	$1M
Wyoming County Community Hospital	Wyoming	$1M
Non-State Government UPL	New York City	$507M
Total		**$2.516B**

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: Please see list of supplemental payments below:

	Private	State Government	Non-State Government	4/1/22-3/31/23 Total
Indigent Care Pool/Voluntary UPL $339M Guarantee	$912M	$8M	$133M	$1.052B
Indigent Care Pool Adjustment	$0	$86M	$326M	$412M
Disproportionate Share Program	$0	$1.071B	$1.684B	$2.754B
Vital Access Program	$77M	$0	$0	$77M
State Public Inpatient UPL	$0	$16M	$0	$16M
Non-State Government Inpatient UPL	$0	$0	$507M	$507M
Total	**$989M**	**$1.181B**	**$2.649B**	**$4.819B**

   The Medicaid payments under this State Plan Amendment are not supplemental payments.

4. **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 Residential Treatment Facilities (RTF) UPL calculation is payment-to-cost for private facilities (note: there are no state or non-state governmental RTFs). The Medicaid payments under this State Plan Amendment will be included in the 2022 RTF 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.