NEW YORK STATE OF OPPORTUNITY. Department of Health

KATHY HOCHUL
Governor

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

JOHANNE E. MORNE, M.S.
Executive Deputy Commissioner

June 28, 2024

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 #24-0035
Long Term Care Facility Services

Dear Director McMillion:

The State requests approval of the enclosed amendment #24-0035 to the Title XIX (Medicaid) State Plan for long term care facility services to be effective April 1, 2024 (Appendix I). This amendment is being submitted based on enacted legislation. A summary of the proposed amendment is provided 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, Part 447, Subpart C, (42 CFR §447).

A copy of the pertinent section of enacted legislation is enclosed for your information (Appendix III). A copy of the public notice of this proposed amendment, which is given in the New York State Register on March 27, 2024, 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 ANDHUMAN 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: 24 — 0035

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, 2024

5. FEDERAL STATUTE/REGULATION CITATION
§ 1905(4)(a) Nursing Facility Services

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 04/01/24-09/30/24 $ 7,500,000
b. FFY 10/01/24-03/31/25 $ 7,500,000

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.19-D Part I: Pages 47(aa)(5), 47(aa)(5.1), 47(aa)(6), 47(aa)(6.1), 47(aa)(6.1.a), 47(aa)(6.2), 47(aa)(7), 47(aa)(7.1.a), 47(aa)(8), 47(aa)(8.1), 47(aa)(9), 47(aa)(9.2), 47(aa)(9.3), 47(aa)(10), 47(aa)(10.1)

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 4.19-D Part I: Pages 47(aa)(5), 47(aa)(5.1), 47(aa)(6), 47(aa)(6.1), 47(aa)(6.1.a), 47(aa)(6.2), 47(aa)(7), 47(aa)(7.1.a), 47(aa)(8), 47(aa)(8.1), 47(aa)(9), 47(aa)(9.2), 47(aa)(9.3), 47(aa)(10), 47(aa)(10.1)

9. SUBJECT OF AMENDMENT
Safety Net/VAP-Cinergy

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 28, 2024

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**
**2024 Title XIX State Plan**
**Second Quarter Amendment**
**Amended SPA Pages**

**1905(4)(a) Nursing Facility Services**

**Nursing Homes (continued):**

| Provider Name | Gross Medicaid Rate Adjustment | Rate Period Effective |
|---|---|---|
| Amsterdam Nursing Home Corp (Amsterdam House)* | ~~$847,377~~ | ~~04/01/2021 – 03/31/2022~~ |
| | ~~($11,859)~~ | ~~10/01/2021 – 03/31/2022~~ |
| | $799,375 | 04/01/2022 – 03/31/2023 |
| | $759,406 | 07/01/2023 – 03/31/2024 |
| | $736,624 | 04/01/2024 – 03/31/2025 |
| | | |
| Andrus on Hudson* | $500,000 | 04/01/2024 – 03/31/2025 |
| | | |
| Bronx-Lebanon Special Care Center* | ~~$521,445~~ | ~~04/01/2021 – 03/31/2022~~ |
| | ~~($9,201)~~ | ~~10/01/2021 – 03/31/2022~~ |
| | $551,640 | 04/01/2022 – 03/31/2023 |
| | $522,747 | 07/01/2023 – 03/31/2024 |
| | $507,065 | 04/01/2024 – 03/31/2025 |
| | | |

*Denotes provider is part of CINERGY Collaborative.

**1905(4)(a) Nursing Facility Services**

**Nursing Homes (continued):**

| Provider Name | Gross Medicaid Rate Adjustment | Rate Period Effective |
|---|---|---|
| Brooklyn United Methodist Church Home* | ~~$384,919~~ | ~~04/01/2021 – 03/31/2022~~ |
| | ~~$8,741~~ | ~~10/01/2021 – 03/31/2022~~ |
| | $369,825 | 04/01/2022 – 03/31/2023 |
| | $394,421 | 07/01/2023 – 03/31/2024 |
| | $382,588 | 04/01/2024 – 03/31/2025 |
| | | |
| ~~Buena Vida Continuing Care & Rehab Ctr~~ | ~~$642,147~~ | ~~04/01/2021 – 03/31/2022~~ |
| | ~~($321,073)~~ | ~~10/01/2021 – 03/31/2022~~ |
| | | |
| Carmel Richmond and Healthcare and Rehabilitation Center* | ~~$632,161~~ | ~~04/01/2021 – 03/31/2022~~ |
| | ~~($8,847)~~ | ~~10/01/2021 – 03/31/2022~~ |
| | $615,961 | 04/01/2022 – 03/31/2023 |
| | $636,012 | 07/01/2023 – 03/31/2024 |
| | $663,522 | 04/01/2024 – 03/31/2025 |
| | | |
| ~~Center For Nursing & Rehabilitation Inc~~ | ~~$746,693~~ | ~~04/01/2021 – 03/31/2022~~ |
| | ~~($373,347)~~ | ~~10/01/2021 – 03/31/2022~~ |
| | | |
| Chapin Home for the Aging* | ~~$487,868~~ | ~~04/01/2020 – 03/31/2021~~ |
| | ~~$487,868~~ | ~~04/01/2021 – 03/31/2022~~ |
| | ~~($6,828)~~ | ~~10/01/2021 – 03/31/2022~~ |
| | $460,231 | 04/01/2022 – 03/31/2023 |
| | $437,219 | 07/01/2023 - 03/31/2024 |
| | $424,103 | 04/01/2024 – 03/31/2025 |
| | | |

*Denotes provider is part of the CINERGY Collaborative

New York
47(aa)(6)

**1905(4)(a) Nursing Facility Services**

**Nursing Homes (continued):**

| Provider Name | Gross Medicaid Rate Adjustment | Rate Period Effective |
|---|---|---|
| Cobble Hill Health Center* | ~~$400,000~~ | ~~04/01/2021 – 03/31/2022~~ |
| | ~~$120,596~~ | ~~10/01/2021 – 03/31/2022~~ |
| | $495,826 | 04/01/2022 – 03/31/2023 |
| | $527,480 | 07/01/2023 – 03/31/2024 |
| | $550,296 | 04/01/2024 – 03/31/2025 |
| | | |
| Concord Nursing Home* | ~~$250,000~~ | ~~04/01/2021 – 03/31/2022~~ |
| | ~~$190,447~~ | ~~10/01/2021 – 03/31/2022~~ |
| | $371,870 | 04/01/2022 – 03/31/2023 |
| | $395,610 | 07/01/2023 - 03/31/2024 |
| | $383,742 | 04/01/2024 – 03/31/2025 |
| | | |
| Eger Health Care and Rehabilitation Center* | ~~$968,289~~ | ~~04/01/2021 – 03/31/2022~~ |
| | ~~($11,517)~~ | ~~10/01/2021 – 03/31/2022~~ |
| | $914,404 | 04/01/2022 – 03/31/2023 |
| | $909,294 | 07/01/2023 – 03/31/2024 |
| | $882,015 | 04/01/2024 – 03/31/2025 |
| | | |

*Denotes provider is part of CINERGY Collaborative.

New York
47(aa)(6.1)

**1905(4)(a) Nursing Facility Services**

**Nursing Homes (continued):**

| Provider Name | Gross Medicaid Rate Adjustment | Rate Period Effective |
|---|---|---|
| Elizabeth Seton Pediatric Center* | ~~$613,670~~ | ~~04/01/2021 – 03/31/2022~~ |
| | ~~$2,085,707~~ | ~~10/01/2021 – 03/31/2022~~ |
| | $ 747,671 | 04/01/2022 – 03/31/2023 |
| | $795,402 | 07/01/2023 – 03/31/2024 |
| | $829,807 | 04/01/2024 – 03/31/2025 |
| | | |
| Ferncliff Nursing Home Co Inc.* | ~~$681,294~~ | ~~04/01/2021 – 03/31/2022~~ |
| | ~~$36,050~~ | ~~10/01/2021 – 03/31/2022~~ |
| | $747,118 | 04/01/2022 – 03/31/2023 |
| | $794,814 | 07/01/2023 – 03/31/2024 |
| | $788,695 | 04/01/2024 – 03/31/2025 |
| | | |
| Fort Hudson Nursing Center | ~~$1,129,968~~ | ~~01/01/2022 – 03/31/2022~~ |
| | $118,982 | 04/01/2022 – 06/30/2022 |
| | $118,982 | 07/01/2022 – 09/30/2022 |
| | $118,983 | 10/01/2022 – 12/31/2022 |
| | $118,983 | 01/01/2023 – 03/31/2023 |
| | $137,943 | 04/01/2023 – 06/30/2023 |
| | $137,943 | 07/01/2023 – 09/30/2023 |
| | $137,943 | 10/01/2023 – 12/31/2023 |
| | $137,943 | 01/01/2024 – 03/31/2024 |
| | | |

*Denotes provider is part of CINERGY Collaborative.

New York
47(aa)(6.1.a)

**1905(4)(a) Nursing Facility Services**

**Nursing Homes (continued):**

| Provider Name | Gross Medicaid Rate Adjustment | Rate Period Effective |
|---|---|---|
| Good Samaritan Nursing Home* | ~~$371,698~~ | ~~04/01/2020 – 03/31/2021~~ |
| | ~~$371,698~~ | ~~04/01/2021 – 03/31/2022~~ |
| | ~~$304~~ | ~~10/01/2021 – 03/31/2022~~ |
| | $353,258 | 04/01/2022 – 03/31/2023 |
| | $364,063 | 07/01/2023 – 03/31/2024 |
| | $353,141 | 04/01/2024 – 03/31/2025 |
| | | |
| Greenfield Health and Rehabilitation Center | ~~$695,000~~ | ~~01/01/2022 – 03/31/2022~~ |
| | $411,875 | 04/01/2022 – 06/30/2022 |
| | $411,875 | 07/01/2022 – 09/30/2022 |
| | $411,875 | 10/01/2022 – 12/31/2022 |
| | $411,875 | 01/01/2023 – 03/31/2023 |
| | $155,000 | 04/01/2023 – 06/30/2023 |
| | $155,000 | 07/01/2023 – 09/30/2023 |
| | $155,000 | 10/01/2023 – 12/31/2023 |
| | $155,000 | 01/01/2024 – 03/31/2024 |
| | | |
| Gurwin Jewish Nursing and Rehabilitation Center* | ~~$1,110,754~~ | ~~04/01/2021 – 03/31/2022~~ |
| | ~~$288,490~~ | ~~10/01/2021 – 03/31/2022~~ |
| | $1,351,867 | 04/01/2022 – 03/31/2023 |
| | $1,438,170 | 07/01/2023 – 03/31/2024 |
| | $1,395,025 | 04/01/2024 – 03/31/2025 |
| | | |
| Hebrew Home for the Aged at Riverdale* | ~~$1,875,731~~ | ~~04/01/2021 – 03/31/2022~~ |
| | ~~$382,779~~ | ~~10/01/2021 – 03/31/2022~~ |
| | $1,971,361 | 04/01/2022 – 03/31/2023 |
| | $1,883,465 | 07/01/2023 – 03/31/2024 |
| | $1,826,961 | 04/01/2024 – 03/31/2025 |
| | | |

*Denotes provider is part of CINERGY Collaborative.

New York
47(aa)(6.2)

**1905(4)(a) Nursing Facility Services**

**Nursing Homes (continued):**

| Provider Name | Gross Medicaid Rate Adjustment | Rate Period Effective |
|---|---|---|
| ~~Incarnation Children's Center~~ | ~~$224,255~~ | ~~10/01/2021 – 03/31/2022~~ |
| | | |
| Isabella Geriatric Center Inc* | ~~$1,633,648~~ | ~~04/01/2021 – 03/31/2022~~ |
| | ~~$397,615~~ | ~~10/01/2021 – 03/31/2022~~ |
| | $1,749,498 | 04/01/2022 – 03/31/2023 |
| | $1,662,023 | 07/01/2023 – 03/31/2024 |
| | $1,612,162 | 04/01/2024 – 03/31/2025 |
| | | |
| Island Nursing and Rehab Center* | $495,250 | 04/01/2021 – 03/31/2022 |
| | $11,248 | 10/01/2021 – 03/31/2022 |
| | $475,830 | 04/01/2022 – 03/31/2023 |
| | $452,039 | 07/01/2023 – 03/31/2024 |
| | $438,478 | 04/01/2024 – 03/31/2025 |
| | | |

*Denotes provider is part of CINERGY Collaborative.

**New York**
**47(aa)(7)**

**1905(4)(a) Nursing Facility Services**

**Nursing Homes (continued):**

| Provider Name | Gross Medicaid Rate Adjustment | Rate Period Effective |
|---|---|---|
| ~~Island Nursing and Rehab~~ | ~~$4,200,000~~ | ~~04/01/2020 – 03/31/2021~~ |
| | ~~$4,275,000~~ | ~~04/01/2021 – 03/31/2022~~ |
| | | |
| Jamaica Hospital Nursing Home Co Inc* | ~~$505,965~~ | ~~04/01/2021 – 03/31/2022~~ |
| | ~~($6,017)~~ | ~~10/01/2021 – 03/31/2022~~ |
| | $479,225 | 04/01/2022 – 03/31/2023 |
| | $453,918 | 07/01/2023 – 03/31/2024 |
| | $473,552 | 04/01/2024 – 03/31/2025 |
| | | |
| ~~Jefferson's Ferry~~ | ~~$324,023~~ | ~~04/01/2020 – 03/31/2021~~ |
| | ~~$324,023~~ | ~~04/01/2021 – 03/31/2022~~ |
| | ~~$37,788~~ | ~~10/01/2021 – 03/31/2022~~ |
| | | |

*Denotes provider is part of CINERGY Collaborative.

**New York**
**47(aa)(7.1.a)**

**1905(4)(a) Nursing Facility Services**

**Nursing Homes (continued):**

| Provider Name | Gross Medicaid Rate Adjustment | Rate Period Effective |
|---|---|---|
| Mary Manning Walsh Nursing Home Co Inc* | ~~$861,601~~ | ~~04/01/2021 – 03/31/2022~~ |
| | ~~($12,059)~~ | ~~10/01/2021 – 03/31/2022~~ |
| | $895,415 | 04/01/2022 – 03/31/2023 |
| | $948,383 | 07/01/2023 – 03/31/2024 |
| | $919,932 | 04/01/2024 – 03/31/2025 |
| | | |
| Menorah Home And Hospital For Rehabilitation and Nursing* | ~~$800,433~~ | ~~04/01/2021 – 03/31/2022~~ |
| | ~~($9,519)~~ | ~~10/01/2021 – 03/31/2022~~ |
| | $755,890 | 04/01/2022 – 03/31/2023 |
| | $745,518 | 07/01/2023 – 03/31/2024 |
| | $777,765 | 04/01/2024 – 03/31/2025 |
| | | |
| Methodist Home for Nursing and Rehabilitation* | ~~$291,832~~ | ~~04/01/2021 – 03/31/2022~~ |
| | $275,592 | 04/01/2022 – 03/31/2023 |
| | $293,921 | 07/01/2023 – 03/31/2024 |
| | $285,104 | 04/01/2024 – 03/31/2025 |
| | | |

*Denotes provider is part of CINERGY Collaborative.

**New York**
**47(aa)(8)**

**1905(4)(a) Nursing Facility Services**

**Nursing Homes (continued):**

| Provider Name | Gross Medicaid Rate Adjustment | Rate Period Effective |
|---|---|---|
| Parker Jewish Institute For Health Care and Rehabilitation* | ~~$1,276,548~~ | ~~04/01/2021 – 03/31/2022~~ |
| | ~~$334,605~~ | ~~10/01/2021 – 03/31/2022~~ |
| | $1,555,295 | 04/01/2022 – 03/31/2023 |
| | $1,654,585 | 07/01/2023 – 03/31/2024 |
| | $1,726,153 | 04/01/2024 – 03/31/2025 |
| | | |

*Denotes provider is part of CINERGY Collaborative.

**New York**
**47(aa)(8.1)**

**1905(4)(a) Nursing Facility Services**

**Nursing Homes (continued):**

| Provider Name | Gross Medicaid Rate Adjustment | Rate Period Effective |
|---|---|---|
| Providence Rest* | ~~$458,838~~ | ~~04/01/2021 – 03/31/2022~~ |
| | ~~$6,393~~ | ~~10/01/2021 – 03/31/2022~~ |
| | $493,614 | 04/01/2022 – 03/31/2023 |
| | $525,127 | 07/01/2023 – 03/31/2024 |
| | $509,373 | 04/01/2024 – 03/31/2025 |
| | | |
| Rebekah Rehabilitation & Extended Care Center Inc* | ~~$282,288~~ | ~~04/01/2021 – 03/31/2022~~ |
| | ~~$73,992~~ | ~~10/01/2021 – 03/31/2022~~ |
| | $343,928 | 04/01/2022 – 03/31/2023 |
| | $331,686 | 07/01/2023 – 03/31/2024 |
| | $346,033 | 04/01/2024 – 03/31/2025 |
| | | |
| Rutland Nursing Home* | ~~$1,289,994~~ | ~~04/01/2021 – 03/31/2022~~ |
| | ~~($18,055)~~ | ~~10/01/2021 – 03/31/2022~~ |
| | $1,216,918 | 04/01/2022 – 03/31/2023 |
| | $19,155,100 | 03/01/2023 - 03/31/2023 |
| | $19,496,200 | 04/01/2023 – 03/31/2024 |
| | $19,344,300 | 04/01/2024 – 03/31/2025 |
| | $1,131,920 | 04/01/2024 – 03/31/2025 |
| | | |
| Saints Joachim & Anne Nursing and Rehabilitation Center* | ~~$426,310~~ | ~~04/01/2021 – 03/31/2022~~ |
| | ~~($5,070)~~ | ~~10/01/2021 – 03/31/2022~~ |
| | $402,586 | 04/01/2022 – 03/31/2023 |
| | $382,456 | 07/01/2023 – 03/31/2024 |
| | $370,983 | 04/01/2024 – 03/31/2025 |
| | | |

*Denotes provider is part of CINERGY Collaborative.

**New York**
**47(aa)(9)**

**1905(4)(a) Nursing Facility Services**

**Nursing Homes (continued):**

| Provider Name | Gross Medicaid Rate Adjustment | Rate Period Effective |
|---|---|---|
| Sarah Neuman Center for Healthcare* | ~~$773,173~~ | ~~04/01/2021 – 03/31/2022~~ |
| | ~~$3,393~~ | ~~10/01/2021 – 03/31/2022~~ |
| | $827,832 | 04/01/2022 – 03/31/2023 |
| | $842,992 | 07/01/2023 – 03/31/2024 |
| | $823,570 | 04/01/2024 – 03/31/2025 |
| | | |
| Schaffer Extended Care System* | ~~$291,907~~ | ~~04/01/2021 – 03/31/2022~~ |
| | ~~($3,471)~~ | ~~10/01/2021 – 03/31/2022~~ |
| | $308,810 | 04/01/2022 - 03/31/2023 |
| | $292,636 | 07/01/2023 – 03/31/2024 |
| | $305,294 | 04/01/2024 – 03/31/2025 |
| | | |
| Shulman and Schachne Institute for Nursing* | $ 1,204,270 | 04/01/2022 – 03/31/2023 |
| | $10,844,900 | 03/01/2023 – 03/31/2023 |
| | $10,503,800 | 04/01/2023 – 03/31/2024 |
| | $ 1,136,170 | 07/01/2023 – 03/31/2024 |
| | $10,655,700 | 04/01/2024 – 03/31/2025 |
| | $ 1,185,314 | 04/01/2024 – 03/31/2025 |
| | | |

*Denotes provider is part of CINERGY Collaborative.

**New York**
**47(aa)(9.2)**

**1905(4)(a) Nursing Facility Services**

**Nursing Homes (continued):**

| Provider Name | Gross Medicaid Rate Adjustment | Rate Period Effective |
|---|---|---|
| ~~Schulman and Schachne Institute for Nursing and Rehabilitation*~~ | ~~$1,225,719~~ | ~~04/01/2020 – 03/31/2021~~ |
| | ~~$1,225,719~~ | ~~04/01/2021 – 03/31/2022~~ |
| | ~~($14,577)~~ | ~~10/01/2021 – 03/31/2022~~ |
| | ~~$1,204,270~~ | ~~04/01/2022 – 03/31/2023~~ |
| | ~~$1,136,170~~ | ~~07/01/2023 – 03/31/2024~~ |
| | | |
| Silvercrest* | ~~$833,785~~ | ~~04/01/2021 – 03/31/2022~~ |
| | ~~($11,670)~~ | ~~10/01/2021 – 03/31/2022~~ |
| | $798,351 | 04/01/2022 – 03/31/2023 |
| | $770,721 | 07/01/2023 – 03/31/2024 |
| | $804,058 | 04/01/2024 – 03/31/2025 |
| | | |
| St Cabrini Nursing Home* | $748,048 | 04/01/2021 – 03/31/2022 |
| | $10,327 | 10/01/2021 – 03/31/2022 |
| | $788,645 | 04/01/2022 – 03/31/2023 |
| | $761,351 | 07/01/2023 – 03/31/2024 |
| | $794,283 | 04/01/2024 – 03/31/2025 |
| | | |

*Denotes provider is part of CINERGY Collaborative.

**New York**
**47(aa)(9.3)**

**1905(4)(a) Nursing Facility Services**

**Nursing Homes (continued):**

| Provider Name | Gross Medicaid Rate Adjustment | Rate Period Effective |
|---|---|---|
| St Johnland Nursing Center* | $400,000 | 04/01/2021 – 03/31/2022 |
| | $120,596 | 10/01/2021 – 03/31/2022 |
| | $495,826 | 04/01/2022 – 03/31/2023 |
| | $527,480 | 07/01/2023 – 03/31/2024 |
| | $550,296 | 04/01/2024 – 03/31/2025 |
| | | |
| St. Mary's Hospital for Children Inc.* | ~~$1,053,645~~ | ~~04/01/2021 – 03/31/2022~~ |
| | ~~($9,241)~~ | ~~10/01/2021 – 03/31/2022~~ |
| | $1,052,354 | 04/01/2022 – 03/31/2023 |
| | $1,114,606 | 07/01/2023 – 03/31/2024 |
| | $1,162,818 | 04/01/2024 – 03/31/2025 |
| | | |
| St. Patrick's Home* | ~~$920,596~~ | ~~10/01/2021 – 03/31/2022~~ |
| | $486,674 | 04/01/2022 – 03/31/2023 |
| | $459,153 | 07/01/2023 – 03/31/2024 |
| | $477,509 | 04/01/2024 – 03/31/2025 |
| | | |
| St Vincent Depaul Residence* | ~~$276,263~~ | ~~04/01/2021 – 09/30/2021~~ |
| | ~~$276,263~~ | ~~04/01/2021 – 03/31/2022~~ |
| | ~~$72,414~~ | ~~10/01/2021 – 03/31/2022~~ |
| | ~~$3,681,188~~ | ~~01/01/2022 – 03/31/2022~~ |
| | $384,746 | 04/01/2022 – 06/30/2022 |
| | $384,746 | 07/01/2022 – 09/30/2022 |
| | $384,747 | 10/01/2022 – 12/31/2022 |
| | $384,747 | 01/01/2023 – 03/31/2023 |
| | $336,588 | 04/01/2022 – 03/31/2023 |
| | $337,197 | 07/01/2023 – 03/31/2024 |
| | $351,782 | 04/01/2024 – 03/31/2025 |
| | | |

*Denotes provider is part of CINERGY Collaborative.

**New York**
**47(aa)(10)**

**1905(4)(a) Nursing Facility Services**

**Nursing Homes (continued):**

| Provider Name | Gross Medicaid Rate Adjustment | Rate Period Effective |
|---|---|---|
| Terence Cardinal Cooke Health Care Ctr* | ~~$1,449,586~~ | ~~04/01/2021 – 03/31/2022~~ |
| | ~~$147,364~~ | ~~10/01/2021 – 03/31/2022~~ |
| | $1,452,702 | 04/01/2022 – 03/31/2023 |
| | $1,380,067 | 07/01/2023 – 03/31/2024 |
| | $1,439,761 | 04/01/2024 – 03/31/2025 |
| | | |
| The Jewish Home Hospital* | ~~$1,248,092~~ | ~~04/01/2021 – 03/31/2022~~ |
| | ~~$271,207~~ | ~~10/01/2021 – 03/31/2022~~ |
| | $1,451,106 | 04/01/2022 – 03/31/2023 |
| | $1,572,645 | 07/01/2023 – 03/31/2024 |
| | $1,525,466 | 04/01/2024 – 03/31/2025 |
| | | |
| The Wartburg Home* | ~~$671,170~~ | ~~04/01/2021 – 03/31/2022~~ |
| | ~~$159,719~~ | ~~10/01/2021 – 03/31/2022~~ |
| | $769,740 | 04/01/2022 – 03/31/2023 |
| | $736,907 | 07/01/2023 – 03/31/2024 |
| | $714,800 | 04/01/2024 – 03/31/2025 |
| | | |
| ~~Trustees Eastern Star Hall and Home~~ | ~~$ 869,050~~ | ~~01/01/2022 – 03/31/2022~~ |
| | | |
| United Hebrew Geriatric Center* | ~~$762,452~~ | ~~04/01/2021 – 03/31/2022~~ |
| | ~~($9,068)~~ | ~~10/01/2021 – 03/31/2022~~ |
| | $776,512 | 04/01/2022 – 03/31/2023 |
| | $749,638 | 07/01/2023 – 03/31/2024 |
| | $782,063 | 04/01/2024 – 03/31/2025 |

*Denotes provider is part of CINERGY Collaborative.

**New York**
**47(aa)(10.1)**

**1905(4)(a) Nursing Facility Services**

**Nursing Homes (continued):**

| Provider Name | Gross Medicaid Rate Adjustment | Rate Period Effective |
|---|---|---|
| VillageCare Rehabilitation and Nursing Center | ~~$621,763~~ | ~~04/01/2021 – 03/31/2022~~ |
| | ~~$14,120~~ | ~~10/01/2021 – 03/31/2022~~ |
| | $597,382 | 04/01/2022 – 03/31/2023 |
| | $567,513 | 07/01/2023 – 03/31/2024 |
| | | |
| St. Mary's Center* | $259,009 | 04/01/2022 – 03/31/2023 |
| | $276,235 | 07/01/2023 – 03/31/2024 |
| | $267,948 | 04/01/2024 – 03/31/2025 |
| | | |

*Denotes provider is part of CINERGY Collaborative.

# Appendix II
# 2024 Title XIX State Plan
# Second Quarter Amendment
# Summary

**SUMMARY**
**SPA #24-0035**

This State Plan Amendment proposes to provide temporary rate adjustments to long term care providers that are undergoing closure, merger, consolidation, acquisition or restructuring themselves or other health care providers. These payments are authorized by current State statutory and regulatory provisions, and will be reviewed and approved by the CINERGY Collaborative.

# Appendix III
# 2024 Title XIX State Plan
# Second Quarter Amendment
# Authorizing Provisions

**SPA 24-0035**

Public Health (PBH) CHAPTER 45, ARTICLE 28

§ 2826. Temporary adjustment to reimbursement rates. (a) Notwithstanding any provision of law to the contrary, within funds appropriated and subject to the availability of federal financial participation, the commissioner may grant approval of a temporary adjustment to the non-capital components of rates, or make temporary lump-sum Medicaid payments, to eligible general hospitals, skilled nursing facilities, clinics and home care providers, provided however, that should federal financial participation not be available for any eligible provider, then payments pursuant to this subdivision may be made as grants and shall not be deemed to be medical assistance payments.

(b) Eligible providers shall include:

(i) providers undergoing closure;

(ii) providers impacted by the closure of other health care providers;

(iii) providers subject to mergers, acquisitions, consolidations or restructuring; or

(iv) providers impacted by the merger, acquisition, consolidation or restructuring of other health care providers.

(c) Providers seeking temporary rate adjustments under this section shall demonstrate through submission of a written proposal to the commissioner that the additional resources provided by a temporary rate adjustment will achieve one or more of the following:

(i) protect or enhance access to care;

(ii) protect or enhance quality of care;

(iii) improve the cost effectiveness of the delivery of health care services; or

(iv) otherwise protect or enhance the health care delivery system, as determined by the commissioner.

(c-1) The commissioner, under applications submitted to the department pursuant to subdivision (d) of this section, shall consider criteria that includes, but is not limited to:

(i) Such applicant's financial condition as evidenced by operating margins, negative fund balance or negative equity position;

(ii) The extent to which such applicant fulfills or will fulfill an unmet health care need for acute inpatient, outpatient, primary or residential health care services in a community;

(iii) The extent to which such application will involve savings to the Medicaid program;

(iv) The quality of the application as evidenced by such application's long term solutions for such applicant to achieve sustainable health care services, improving the quality of patient care, and/or transforming the delivery of health care services to meet community needs;

(v) The extent to which such applicant is geographically isolated in relation to other providers; or

(vi) The extent to which such applicant provides services to an underserved area in relation to other providers.

(d) (i) Such written proposal shall be submitted to the commissioner at least sixty days prior to the requested effective date of the temporary rate adjustment, and shall include a proposed budget to achieve the goals of the proposal. Any Medicaid payment issued pursuant to this section shall be in effect for a specified period of time as determined by the commissioner, of up to three years. At the end of the specified timeframe such payments or adjustments to the non-capital component of rates shall cease, and the provider shall be reimbursed in accordance with the otherwise applicable rate-setting methodology as set forth in applicable statutes and regulations. The commissioner may establish, as a condition of receiving such temporary rate adjustments or grants, benchmarks and goals to be achieved in conformity with the provider's written proposal as approved by the commissioner and may also require that the facility submit such periodic reports concerning the achievement of such benchmarks and goals as the commissioner deems necessary. Failure to achieve satisfactory progress, as determined by the commissioner, in accomplishing such benchmarks and goals shall be a basis for ending the facility's temporary rate adjustment or grant prior to the end of the specified timeframe. (ii) The commissioner may require that applications submitted pursuant to this section be submitted in response to and in accordance with a Request For Applications or a Request For Proposals issued by the commissioner.

(e) Notwithstanding any law to the contrary, general hospitals defined as critical access hospitals pursuant to title XVIII of the federal social security act shall be allocated no less than seven million five hundred thousand dollars annually pursuant to this section. The department of health shall provide a report to the governor and legislature no later than June first, two thousand fifteen providing recommendations on how to ensure the financial stability of, and preserve patient access to, critical access hospitals, including an examination of permanent Medicaid rate methodology changes.

(e-1) Thirty days prior to executing an allocation or modification to an allocation made pursuant to this section, the commissioner shall provide written notice to the chair of the senate finance committee and the chair of the assembly ways and means committee with regards to the intent to distribute such funds. Such notice shall include, but not be limited to, information on the methodology used to distribute the funds, the facility specific allocations of the funds, any facility specific project descriptions or requirements for receiving such funds, the multi-year impacts of these allocations, and the availability of federal

matching funds. The commissioner shall provide quarterly reports to the chair of the senate finance committee and the chair of the assembly ways and means committee on the distribution and disbursement of such funds. Within sixty days of the effectiveness of this subdivision, the commissioner shall provide a written report to the chair of the senate finance committee and the chair of the assembly ways and means committee on all awards made pursuant to this section prior to the effectiveness of this subdivision, including all information that is required to be included in the notice requirements of this subdivision.

(f) Notwithstanding any provision of law to the contrary, and subject to federal financial participation, no less than ten million dollars shall be allocated to providers described in this subdivision; provided, however that if federal financial participation is unavailable for any eligible provider, or for any potential investment under this subdivision then the non-federal share of payments pursuant to this subdivision may be made as state grants.

(i) Providers serving rural areas as such term is defined in section two thousand nine hundred fifty-one of this chapter, including but not limited to hospitals, residential health care facilities, diagnostic and treatment centers, ambulatory surgery centers and clinics shall be eligible for enhanced payments or reimbursement under a supplemental rate methodology for the purpose of promoting access and improving the quality of care.

(ii) Notwithstanding any provision of law to the contrary, and subject to federal financial participation, essential community providers, which, for the purposes of this section, shall mean a provider that offers health services within a defined and isolated geographic region where such services would otherwise be unavailable to the population of such region, shall be eligible for enhanced payments or reimbursement under a supplemental rate methodology for the purpose of promoting access and improving quality of care. Eligible providers under this paragraph may include, but are not limited to, hospitals, residential health care facilities, diagnostic and treatment centers, ambulatory surgery centers and clinics.

(iii) In making such payments the commissioner may contemplate the extent to which any such provider receives assistance under subdivision (a) of this section and may require such provider to submit a written proposal demonstrating that the need for monies under this subdivision exceeds monies otherwise distributed pursuant to this section.

(iv) Payments under this subdivision may include, but not be limited to, temporary rate adjustments, lump sum Medicaid payments, supplemental rate methodologies and any other payments as determined by the commissioner.

(v) Payments under this subdivision shall be subject to approval by the director of the budget.

(vi) The commissioner may promulgate regulations to effectuate the provisions of this subdivision.

(vii) Thirty days prior to adopting or applying a methodology or procedure for making an allocation or modification to an allocation made

pursuant to this subdivision, the commissioner shall provide written notice to the chairs of the senate finance committee, the assembly ways and means committee, and the senate and assembly health committees with regard to the intent to adopt or apply the methodology or procedure, including a detailed explanation of the methodology or procedure.

(viii) Thirty days prior to executing an allocation or modification to an allocation made pursuant to this subdivision, the commissioner shall provide written notice to the chairs of the senate finance committee, the assembly ways and means committee, and the senate and assembly health committees with regard to the intent to distribute such funds. Such notice shall include, but not be limited to, information on the methodology used to distribute the funds, the facility specific allocations of the funds, any facility specific project descriptions or requirements for receiving such funds, the multi-year impacts of these allocations, and the availability of federal matching funds. The commissioner shall provide quarterly reports to the chair of the senate finance committee and the chair of the assembly ways and means committee on the distribution and disbursement of such funds.

(g) Notwithstanding subdivision (a) of this section, and within amounts appropriated for such purposes as described herein, the commissioner may award a temporary adjustment to the non-capital components of rates, or make temporary lump-sum Medicaid payments to eligible facilities with serious financial instability and requiring extraordinary financial assistance to enable such facilities to maintain operations and vital services while such facilities establish long term solutions to achieve sustainable health services. Provided, however, the commissioner is authorized to make such a temporary adjustment or make such temporary lump sum payment only pursuant to criteria, an application, and an evaluation process acceptable to the commissioner in consultation with the director of the division of the budget. The department shall publish on its website the criteria, application, and evaluation process and notification of any award recipients.

(i) Eligible facilities shall include:

(A) a public hospital, which for purposes of this subdivision, shall mean a general hospital operated by a county, municipality or a public benefit corporation;

(B) a federally designated critical access hospital;

(C) a federally designated sole community hospital;

(D) a residential health care facility;

(E) a general hospital that is a safety net hospital, which for purpose of this subdivision shall mean:

(1) such hospital has at least thirty percent of its inpatient discharges made up of Medicaid eligible individuals, uninsured individuals or Medicaid dually eligible individuals and with at least thirty-five percent of its outpatient visits made up of Medicaid eligible individuals, uninsured individuals or Medicaid dually-eligible individuals; or

(2) such hospital serves at least thirty percent of the residents of a county or a multi-county area who are Medicaid eligible individuals, uninsured individuals or Medicaid dually-eligible individuals; or

(3) such hospital that, in the discretion of the commissioner, serves a significant population of Medicaid eligible individuals, uninsured individuals or Medicaid dually-eligible individuals; or

(F) an independent practice association or accountable care organization authorized under applicable regulations that participate in managed care provider network arrangements with any of the provider types in subparagraphs (A) through (F) of this paragraph; or an entity that was formed as a preferred provider system pursuant to the delivery system reform incentive payment (DSRIP) program and collaborated with an independent practice association that received VBP innovator status from the department for purposes of meeting DSRIP goals, and which preferred provider system remains operational as an integrated care system.

(ii) Eligible applicants must demonstrate that without such award, they will be in serious financial instability, as evidenced by:

(A) certification that such applicant has less than fifteen days cash and equivalents;

(B) such applicant has no assets that can be monetized other than those vital to operations; and

(C) such applicant has exhausted all efforts to obtain resources from corporate parents and affiliated entities to sustain operations.

(iii) Awards under this subdivision shall be made upon application to the department.

(A) Eligible applicants shall submit a completed application to the department.

(B) The department may authorize initial award payments to eligible applicants based solely on the criteria pursuant to paragraphs (i) and (ii) of this subdivision.

(C) Notwithstanding subparagraph (B) of this paragraph, the department may suspend or repeal an award if an eligible applicant fails to submit a multi-year transformation plan pursuant to subparagraph (A) of this paragraph that is acceptable to the department by no later than the thirtieth day of September two thousand fifteen.

(D) Applicants under this subdivision shall detail the extent to which the affected community has been engaged and consulted on potential projects of such application, as well as any outreach to stakeholders and health plans.

(E) The department shall review all applications under this subdivision, and determine:

(1) applicant eligibility;

(2) each applicant's projected financial status;

(3) criteria or requirements upon which an award of funds shall be conditioned, such as a transformation plan, savings plan or quality improvement plan. In the event the department requires an applicant to enter into an agreement or contract with a vendor or contractor, the department shall approve the selected vendor or contractor but shall not specify the vendor or contractor that the applicant must utilize; and

(4) the anticipated impact of the loss of such services.

(F) After review of all applications under this subdivision, and a determination of the aggregate amount of requested funds, the department may make awards to eligible applicants; provided, however, that such awards may be in an amount lower than such requested funding, on a per applicant or aggregate basis.

(iv) Awards under this subdivision may not be used for:

(A) capital expenditures, including, but not limited to: construction, renovation and acquisition of capital equipment, including major medical equipment; or

(B) bankruptcy-related costs.

(v) Payments made to awardees pursuant to this subdivision that are made on a monthly basis will be based on the applicant's actual monthly financial performance during such period and the reasonable cash amount necessary to sustain operations for the following month. The applicant's monthly financial performance shall be measured by such applicant's monthly financial and activity reports, which shall include, but not be limited to, actual revenue and expenses for the prior month, projected cash need for the current month, and projected cash need for the following month.

(vi) The department shall provide a report on a quarterly basis to the chairs of the senate finance, assembly ways and means, senate health and assembly health committees. Such reports shall be submitted no later than sixty days after the close of the quarter, and shall include for each award, the name of the applicant, the amount of the award, payments to date, and a description of the status of the multi-year transformation plan pursuant to paragraph (iii) of this subdivision.

**Appendix IV**
**2024 Title XIX State Plan**
**Second Quarter Amendment**
**Public Notice**

The estimated net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2024-2025 is $18 million.

Effective on April 1, 2024, conflicts of interest between Consumer Directed Personal Assistance Program (CDPAP) CDPAP Fiscal Intermediaries (FIs) and Licensed Home Care Service Agencies (LHCSAs) will be eliminated.

Effective on October 1, 2024, consumer self-direction will be required in the CDPAP program, and proposed regulation authority relating to quality-of-care standards and labor protections for the CDPAP and Personal Care programs shall take effect.

Effective on or after January 1, 2025, FI procurement will be repealed and replaced with an authorization process.

Effective on or after April 1, 2025, conflicts of interest between CDPAP Fis, Managed Long-term Care Plans (MLTCs), and Health Maintenance Organizations will be eliminated.

The estimated net aggregate decrease in gross Medicaid expenditures attributable to these initiatives contained in the budget for state fiscal year 2025 is ($200 million) and for state fiscal year 2026 is ($400 million).

Long Term Care Services

Effective on or after April 1, 2024, the case mix adjustment from the operating component of the rates for skilled nursing facilities shall remain unchanged from the July 2023 rates during the development and until full implementation of a new case mix methodology in accordance with Federal acuity data.

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

Effective on or after April 1, 2024 and each SFY thereafter, the Department proposes to reduce funding associated with residential health care facilities' capital reimbursement by 10 percent.

The estimated net aggregate decrease in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2024-2025 is ($57 million).

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

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

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

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

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

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

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

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

## PUBLIC NOTICE

### Department of Health

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

The Department of Health proposes to amend the Title XIX (Medicaid) State Plan for Long Term Care Services as authorized by § 2826 of New York Public Health Law. The following changes are proposed:

Long Term Care Service

Effective on or after April 1, 2024, the Department of Health proposes to amend the Title XIX (Medicaid) State Plan for long term care services related to temporary rate adjustments to long term care providers that are undergoing closure, merger, consolidation, acquisition or restructuring themselves or other health care providers. These payments are authorized by current State statutory and regulatory provisions. The temporary rate adjustments will be reviewed and approved by the CINERGY Collaborative.

The estimated net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2024-2025 is $30 million.

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

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

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

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

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

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

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

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

## PUBLIC NOTICE

### Department of Health

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

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

Non-Institutional Services

Effective on or after April 1, 2024, this amendment proposes to revise the payment eligibility criteria, for Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs), that are eligible for the Alternative Payment Methodology (APM) which provides for an additional payment annually to preserve and improve beneficiary

# Appendix V
# 2024 Title XIX State Plan
# Second Quarter Amendment
# Responses to Standard Funding Questions

**LONG-TERM SERVICES**
**State Plan Amendment #24-0035**

**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-D 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 payments, a complete listing of providers that return a portion of their payments, 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 (except for OPWDD's ICF/DD) 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.

   OPWDD's ICF/DD facilities are subject to a 5.5% Medicaid-reimbursable tax on gross receipts that are not kept by the provider but remitted to the state general fund for both voluntary and State-operated ICF/DDs. This assessment is authorized by Public Law 102-234, Section 43.04 of the New York State Mental Hygiene Law, Federal Medicaid regulations at 42 CFR 433.68. OPWDD recoups the assessment from the ICF/DD Medicaid payment before the payment is sent to the voluntary provider. For State operated ICF/DDs, the legislature appropriates an amount for payment of the assessment. Aside from the assessments, providers receive and retain all the Medicaid payments for ICF/DD services.

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 through 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 governmental 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 (normal per diem and supplemental) 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.

| | | 4/1/24 – 3/31/25 | |
|---|---|---|---|
| **Payment Type** | **Non-Federal Share Funding** | **Non-Federal** | **Gross** |
| Nursing Homes Normal Per Diem | General Fund; Special Revenue Funds; County Contribution | $3.667B | $7.334B |
| Intermediate Care Facilities Normal Per Diem | General Fund; County Contribution | $398M | $797M |
| Nursing Homes Supplemental | General Fund | $169M | $338M |
| Intermediate Care Facilities Supplemental | General Fund | $0 | $0 |
| Nursing Homes UPL | IGT | $106M | $213M |
| **Totals** | | **$4.341B** | **$8.682B** |

A. **General Fund:** Revenue resources for the State's General Fund includes taxes (e.g., income, sales, etc.), and miscellaneous fees (including audit recoveries and provider assessments). 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.

2) Intermediate Care Facilities (ICF) Provider Service Assessment: Pursuant to New York State Mental Hygiene Law 43.04, a provider's gross receipts received on a cash basis for all services rendered at all ICFs is assessed at 5.5 percent. This assessment is deposited directly into the State's General Fund.

**B. Special Revenue Funds:**

Health Facility Cash Assessment Program (HFCAP) Fund: Pursuant to New York State Public Health Law 2807-d and Section 90 of Part H of Chapter 59 of the Laws of 2011, the total state assessment on each residential health care facility's gross receipts received from all patient care services and other operating income on a cash basis for residential health care facilities, including adult day service, but excluding, gross receipts attributable to payments received pursuant to Title XVIII of the federal Social Security Act (Medicare), is 6.8 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.

**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 | $5.210B |
| Suffolk County | $243M |
| Nassau County | $231M |
| Westchester County | $215M |

| | |
|---|---|
| Erie County | $205M |
| Rest of State (53 Counties) | $1.260B |
| **Total** | **$7.364B** |

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.

**D. IGT Funding:**

New York State requests the transfer of the IGT amounts from entities prior to the release of payments to the providers. The entities transferring IGT amounts are all units of government, and the nonfederal share is derived from state or local tax revenue funded accounts only. The providers keep and retain Medicaid payments. Please note that entities have taxing authority, and the State does not provide appropriations to the entities for IGTs.

| Provider | Entity Transferring IGT Funds | 4/1/24-3/31/25 IGT Amount |
|---|---|---|
| A Holly Patterson Extended Care Facility | Nassau County | $9M |
| Albany County Nursing Home | Albany County | $5M |
| Chemung County Health Center | Chemung County | $3M |
| Clinton County Nursing Home | Clinton County | $2M |
| Coler Rehabilitation & Nursing Care Center | New York City | $8M |
| Dr. Susan Smith Mckinney Nursing and Rehab Center | Kings County | $6M |
| Glendale Home | Schenectady County | $4M |
| Henry J. Carter Nursing Home | New York City | $3M |
| Lewis County General Hospital-Nursing Home Unit | Lewis County | $3M |
| Livingston County Center for Nursing and Rehabilitation | Livingston County | $4M |
| Monroe Community Hospital-Nursing Home Unit | Monroe County | $10M |
| New Gouverneur Hospital-Nursing Home Unit | New York City | $4M |
| Sea View Hospital Rehabilitation Center and Home | Richmond County | $5M |
| Sullivan County Adult Care Center | Sullivan County | $2M |
| Terrace View Long Term Care | Erie County | $7M |
| The Pines Healthcare & Rehab Centers Machias Camp | Cattaraugus County | $2M |
| The Pines Healthcare & Rehab Centers Olean Camp | Cattaraugus County | $2M |
| The Valley View Center for Nursing Care and Rehab | Orange County | $7M |
| Van Rensselaer Manor | Rensselaer County | $8M |

| | | |
|---|---|---|
| Wayne County Nursing Home | Wayne County | $4M |
| Willow Point Rehabilitation & Nursing Center | Broome County | $5M |
| Wyoming County Community Hospital-NH Unit | Wyoming County | $3M |
| **Total** | | **$106M** |

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:** Below is a list of nursing home and ICF supplemental payments:

| Payment Type | Private | State Government | Non-State Government | 4/1/24-3/31/25 Gross Total |
|---|---|---|---|---|
| Advanced Training Initiative | $43M | $0 | $3M | $46M |
| Cinergy | $30M | $0 | $0 | $30M |
| 1% Supplemental Payment | $130M | $1M | $9M | $140M |
| Enhanced ATI (VAP Workforce) | $96M | $0 | $6M | $102M |
| Nursing Home UPL | $0 | $0 | $213M | $213M |
| **Total** | **$300M** | **$1M** | **$230M** | **$531M** |

   The Medicaid payments authorized under this State Plan Amendment are supplemental payments and total $30 million for State Fiscal Year 2024-25.

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 nursing home UPL calculation is a payment-to-payment calculation for state government and private facilities. Non-state Governmental facilities undergo a payment-to-cost calculation. The Medicaid payments under this State Plan Amendment will be included in the 2024 nursing home UPL submitted 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.