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

James G. Scott, Director
Division of Program Operations
Centers for Medicare & Medicaid Services
601 E. 12th St., Room 355
Kansas City, Missouri 64106

RE: SPA #24-0037
Non-Institutional Services

Dear Director Scott:

The State requests approval of the enclosed amendment #24-0037 to the Title XIX (Medicaid) State Plan for non-institutional services to be effective April 1, 2024 (Appendix I). This amendment is being submitted based on enacted legislation. A summary of the plan amendment is provided in Appendix II.

The State of New York reimburses these services through the use of rates that are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area as required by § 1902(a)(30) of the Social Security Act and 42 CFR § 447.204.

A copy of pertinent sections of enacted legislation is enclosed for your information (Appendix III). Copies of the public notices of this plan amendment, which were given in the New York State Register on March 27, 2024, and subsequently clarified on July 10, 2024, are also enclosed for your information (Appendix IV). In addition, responses to the five standard funding questions are also enclosed (Appendix V).

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

Sincerely,

[redacted]

Amir Bassiri
Medicaid Director
Office of Health Insurance Programs

Enclosures

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

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 24 — 0037

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
§ 1945 of the Social Security Act

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 04/01/24-09/30/24 $ 870,704
b. FFY 10/01/24-09/30/25 $ 1,741,409

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
MACPro Portal SPA

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
MACPro Portal SPA

9. SUBJECT OF AMENDMENT
Health Home Plus Rate for AOT and 2.84% COLA for Health Home Plus

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

NY - Submission Package - NY2024MS0004O - (NY-24-0037) - Health Homes

CMS-10434 OMB 0938-1188

Package Information

Package ID	NY2024MS0004O	**Submission Type**	O cial
Program Name	NYS Health Home Program	**State**	NY
SPA ID	NY-24-0037	**Region**	New York, NY
Version Number	1	**Package Status**	Pending

Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | NY2024MS0004O | NY-24-0037 | NYS Health Home Program

Package Header

Package ID	NY2024MS0004O	SPA ID	NY-24-0037
Submission Type	Official	Initial Submission Date	N/A
Approval Date	N/A	Effective Date	N/A
Superseded SPA ID	N/A		

State Information

State/Territory Name:	New York	Medicaid Agency Name:	Department of Health

Submission Component

- (•) State Plan Amendment
- (•) Medicaid
- ( ) CHIP

SPA ID and Effective Date

SPA ID NY-24-0037

Reviewable Unit	Proposed Effective Date	Superseded SPA ID
Health Homes Payment Methodologies	4/1/2024	NY-24-0023

Executive Summary

Summary Description Including Goals and Objectives

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

Under legislation S. 8007--C A. 9007—C, Article VII Part I, the 2024-25 enacted budget outlines a 2.84% Cost of Living Adjustment in eligible Health Home rates for those Health Home members that meet the risk and acuity criteria for Health Home Plus and to comply with S. 4003 – D the 2023-24 enacted budget outlines supplemental payments intended for services provided to eligible adults who meet risk and acuity criteria for Health Home Plus and receiving Assisted Outpatient Treatment (AOT) are now eligible for the supplemental payments.

Federal Budget Impact and Statute/Regulation Citation

Federal Budget Impact

	Federal Fiscal Year	Amount
First	2024	870,704
Second	2025	1,741,409

Federal Statute / Regulation Citation

1945 of the Social Security Act

Supporting documentation of budget impact is uploaded (optional).

Name	Date Created	
No items available		

Governor's Ofice Review

- (●) No comment
- ( ) Comments received
- ( ) No response within 45 days
- ( ) Other

Submission - Medicaid State Plan

MEDICAID | Medicaid State Plan | Health Homes | NY2024MS0004O | NY-24-0037 | NYS Health Home Program

CMS-10434 OMB 0938-1188

The submission includes the following:

- [ ] Administration
- [ ] Eligibility
- [ ] Benefits and Payments
  - [ ] Health Homes Program

Do not use "Create New Health Homes Program" to amend an existing Health Homes program. Instead, use "Amend existing Health Homes program," below.

- ○ Create new Health Homes program
- ◉ Amend existing Health Homes program
- ○ Terminate existing Health Homes program

NYS Health Home Program

Health Homes SPA - Reviewable Units

Only select Reviewable Units to include in the package which you intend to change.

*

	Reviewable Unit Name	Included in Another Submission Package	Source Type
☐	Health Homes Intro	◖	APPROVED
☐	Health Homes Geographic Limitations	(	APPROVED
☐	Health Homes Population and Enrollment Criteria	◖	APPROVED
☐	Health Homes Providers	◖	APPROVED
☐	Health Homes Service Delivery Systems	(	APPROVED
☐	Health Homes Payment Methodologies	◖	APPROVED
☐	Health Homes Services	(	APPROVED
☐	Health Homes Monitoring, Quality Measurement and Evaluation	(	APPROVED

1 – 8 of 8

- [ ] 1945A Health Home Program

Submission - Public Notice/Process

MEDICAID | Medicaid State Plan | Health Homes | NY2024MS0004O | NY-24-0037 | NYS Health Home Program

Package Header

Package ID NY2024MS0004O

SPA ID NY-24-0037

Submission Type Official

Initial Submission Date N/A

Approval Date N/A

Effective Date N/A

Superseded SPA ID N/A

Name of Health Homes Program

NYS Health Home Program

☐ Public notice was provided due to proposed changes in methods and standards for setting payment rates for services, pursuant to 42 CFR 447.205.

Upload copies of public notices and other documents used

Name	Date Created	
FPN HH+ AOT Rate	5/9/2024 1:11 PM EDT	

Submission - Tribal Input

MEDICAID | Medicaid State Plan | Health Homes | NY2024MS0004O | NY-24-0037 | NYS Health Home Program

Package Header

Package ID	NY2024MS0004O	SPA ID	NY-24-0037
Submission Type	Official	Initial Submission Date	N/A
Approval Date	N/A	Effective Date	N/A
Superseded SPA ID	N/A		

Name of Health Homes Program:

NYS Health Home Program

One or more Indian Health Programs or Urban Indian Organizations furnish health care services in this state

- ◯ Yes
- ◯ No

Submission - Other Comment

MEDICAID | Medicaid State Plan | Health Homes | NY2024MS0004O | NY-24-0037 | NYS Health Home Program

Package Header

Package ID NY2024MS0004O

SPA ID NY-24-0037

Submission Type Official

Initial Submission Date N/A

Approval Date N/A

Effective Date N/A

Superseded SPA ID N/A

SAMHSA Consultation

Name of Health Homes Program

NYS Health Home Program

Date of consultation
1/20/2014

☐ The State provides assurance that it has consulted and coordinated with the Substance Abuse and Mental Health Services Administration (SAMHSA) in addressing issues regarding the prevention and treatment of mental illness and substance abuse among eligible individuals with chronic conditions.

Health Homes Payment Methodologies

MEDICAID | Medicaid State Plan | Health Homes | NY2024MS0004O | NY-24-0037 | NYS Health Home Program

Package Header

Package ID	NY2024MS0004O	SPA ID	NY-24-0037
Submission Type	Official	Initial Submission Date	N/A
Approval Date	N/A	Effective Date	4/1/2024
Superseded SPA ID	NY-24-0023		

User-Entered

Payment Methodology

The State's Health Homes payment methodology will contain the following features

- [x] Fee for Service
  - [ ] Individual Rates Per Service
  - [x] Per Member, Per Month Rates
  - [x] Fee for Service Rates based on
    - [x] Severity of each individual's chronic conditions
    - [ ] Capabilities of the team of health care professionals, designated provider, or health team
    - [x] Other

      Describe below

      see text box below regarding rates
  - [ ] Comprehensive Methodology Included in the Plan
  - [ ] Incentive Payment Reimbursement

  Describe any variations in payment based on provider qualifications, individual care needs, or the intensity of the services provided: see text below
- [ ] PCCM (description included in Service Delivery section)
- [ ] Risk Based Managed Care (description included in Service Delivery section)
- [ ] Alternative models of payment, other than Fee for Service or PMPM payments (describe below)

Agency Rates

Describe the rates used

- ○ FFS Rates included in plan
- ○ Comprehensive methodology included in plan
- ◉ The agency rates are set as of the following date and are effective for services provided on or after that date

Effective Date

4/1/2024

Website where rates are displayed

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/billing/hh_rates_updated_may_2024.htm

Rate Development

Provide a comprehensive description in the SPA of the manner in which rates were set

1. In the SPA please provide the cost data and assumptions that were used to develop each of the rates;
2. Please identify the reimbursable unit(s) of service;
3. Please describe the minimum level of activities that the state agency requires for providers to receive payment per the defined unit;
4. Please describe the state's standards and process required for service documentation, and;
5. Please describe in the SPA the procedures for reviewing and rebasing the rates, including:
    - the frequency with which the state will review the rates, and
    - the factors that will be reviewed by the state in order to understand if the rates are economic and efficient and sufficient to ensure quality services.

Comprehensive Description

Provide a comprehensive description of the rate-setting policies the State will use to establish Health Homes provider reimbursement fee for service or PMPM rates. Explain how the methodology is consistent with the goals of efficiency, economy, and quality of care. Within your description, please explain: the reimbursable unit(s) of service, the cost assumptions and other relevant factors used to determine the payment amounts, the minimum level of activities that the State agency requires for providers to receive payment per the defined unit, and the State's standards and process required for service documentation.

Provider Type

NYS Medicaid providers eligible to become health homes include managed care plans; hospitals; medical, mental and chemical dependency treatment clinics; primary care practitioner practices; PCMHs; FQHCs; Targeted Case Management (TCM) providers; certified home health care agencies and any other Medicaid enrolled providers that meet health home provider standards.

Care Management Fee:

Health Homes meeting State and Federal standards will be paid a per member per month care management fee that is adjusted based on region and case mix method for adults, or the Child and Adolescent Needs and Strength Assessment of New York (CANS-NY) for children age 0 through 20). The total cost relating to a care manager (salary, fringe benefits, non-personal services, capital and administration costs) in conjunction with caseload assumptions were used to develop the Health Home rates. The state periodically reviews the Health Home payments in conjunction with Department of Labor salary data to ensure that the Health Home rates are sufficient to ensure quality services.

Effective May 1, 2018, the per member per month care management fee for adults will be based on region and case mix defined by populations as indicated below. Health Home rates for children will continue to be determined by an algorithm applied to the CANS-NY assessment. The risk adjusted payments will allow providers to receive a diverse population of patients and assign patients to various levels of care management intensity without having to meet preset standards for contact counts. Providers will be able to respond to and adjust the intensity and frequency of intervention based on patient's current condition and needs (from tracking to high touch). All rates will be published on the DOH website. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers. Rates for Health Home services to children are effective October 1, 2016 and apply to services furnished on and after October 1, 2016.

For dates of service beginning June 1, 2018 through December 31, 2018 , the per member per month care management fee for Health Homes that are, as of June 1, 2018, designated to serve children only, or designated to serve children in 43 counties and adults and children in one county, shall be adjusted to provide $4 million in payments to supplement care management fees. The supplemental payments shall be paid no later than March 31, 2019 and will be allocated proportionately among such Health Homes based on services provided between June 1, 2018 and December 1, 2018. The supplement shall be a lump sum payments.

Rates for Health Home services furnished to other populations are effective as noted below and apply to services furnished on and after such dates.

State Health Home Rates and Rate Codes Effective October 1, 2017 can be found at:
https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/hh_rates_eective_october_2017.xlsx

State Health Home Rates and Rate Codes Effective May 1, 2018 can be found at:
https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/hh_rates_eective_october_2017.xlsx

State Health Home Rates and Rate Codes Effective October 1, 2018 can be found at:
https://health.ny.gov/health_care/medicaid/program/medicaid_health_homes/billing/docs/hh_rates_effective_october_2018

.xlsx

State Health Home Rates and Rate Codes Effective July 1, 2020, can be found at: https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/billing/hh_rates_effective_july_2020.htm

Population Case Mix Definitions for Health Home Adult Rates

Health Home Plus/Care Management Rates include adults with active AOT order or expired AOT order within last year; adults stepping down from State PC and ACT; Health and Recovery Plan (HARP) members that meet high risk criteria (recent incarceration, homelessness, multiple hospital admissions, etc.); and members identified at the discretion of the Medicaid Managed Care Plan or state designated entity for adults not currently enrolled in a Medicaid Managed Care Plan.

Health Home High Risk/Need Care Management Rates, include adults that are HARP enrolled members not included in the Health Home Plus/Care Management; any adult member meeting high risk criteria based on the high, medium and low, Clinical and Functional Assessment; and members identified at the discretion of the Medicaid Managed Care Plan or state designated entity for adults not currently enrolled in a Medicaid Managed Care Plan.

Health Home Care Management Rates, include all other adults not meeting criteria for Health Home Services Adult Home Transition Rates, Health Home Plus/Care Management or High Risk /High Need Care Management Rates.

Health Home Services Adult Home Transition Rates apply to individuals, under the terms of a Stipulation and Order of Settlement between the U.S. Department of Justice and New York State, that are Adult Home Residents with serious mental illness (SMI) that are required to transition from Adult Homes located in New York City to the community.

Effective July 1, 2020, the PMPM for case finding will be reduced to $0 as indicated in the State Health Home Rates and Rate Codes posted to the State's website as indicated above.

A unit of service will be defined as a billable unit per service month. In order to be reimbursed for a billable unit of service per month health home providers must, at a minimum, provide one of the core health home services per month. The monthly payment will be paid via the active care management PMPM. Once a patient has consented to received services and been assigned a care manager and is enrolled in the health home program the active care management PMPM may be billed. Care managers must document all services provided to the member in the member's care plan.

Managed Care Considerations:

Similar to the NY patient centered Medical Home program, it is the intention of the State to coordinate and pay for health home services through health plans but at State set rates for the service. The State will address any existing care management resources in the current plan premium for health home enrollees under CMS guidelines (bring this resource out of the capitation and create federal matching for those resources under the health home payment). Plans will pay health home providers State set rates when providers are contracted to provide all health home services. In the case where the plan does a portion of the health home service (e.g. telephonic post discharge tracking) and downstream providers do a separate portion (e.g. face to face care management) the plan will then split the State generated PMPM proportional to the contracted effort.

The Medicaid/FHP Model Contract has been modified to include language similar to that outlined below which addresses any duplication of payment between the MCO capitation payments and health home payments. The delivery design and payment methodology will not result in any duplication of payment between Health Homes and managed care.

- The managed care plan is not required to provide services that would duplicate the CMS reimbursed Health Home services for members participating in the State's Health Home program.
- The managed care organization will be informed of members assigned to a Health Home or will assign its members to a Health Home for health home services. Plans may need to expand their networks to include additional State designated health home providers to ensure appropriate access.
- Plans will need to have signed contracts including clearly established responsibilities with the provider based health homes.
- The managed care plan will be required to inform either the individual's Health Home or the State of any inpatient admission or discharge of a Health Home member that the plan learns of through its inpatient admission initial authorization and concurrent review processes as soon as possible to promote appropriate follow-up and coordination of services.
- Plans will assist State designated Health Home providers in their network with coordinating access to data, as needed.
- Plans will, as appropriate, assist with the collection of required care management and patient experience of care data from State designated Health Home providers in its' network.

The State has a health home advisory committee of providers and managed care plans through which any issues with payment would be raised and addressed. Directions have been given to health plans to match health home payment to providers based on relative health home care management effort. Further information on specific construction on health home rates includes specific administration compensation to guide rate differential construct.

Targeted Case Management (TCM) Conversion Considerations:

The State envisions that eventually all targeted case management programs operating in New York will convert to or become part of health homes, and these providers will require time to meet State and Federal health home standards. The State will allow TCM providers that can meet health home standards to convert to health homes or join with larger health homes. TCM providers that convert to health homes will be governed under NYS Health Home Provider Qualification Standards, not TCM standards. The payment method will be designed to transition all existing TCM capacity from the current rates to the new Health Home payment structure. Effective January 1, 2015 TCM programs for adults will be paid

their existing TCM rates until November 30, 2016. Effective October 1, 2016 through September 30, 2018 TCM programs for children will be paid a transitional rate that is as financially equivalent as practicable to their current rate.

Health Home care management services may be provided to children that are eligible and enrolled in both the Early Intervention Program and Health Home, and will meet and fulfill the requirements of the ongoing service coordination required to be provided to children enrolled in the Early Intervention Program.

All payments will be made under the health home payment detailed above in the care management fee section if they convert to or become part of a health home. Effective October 1, 2017, the case finding PMPM will be paid under the provisions described in the care management fee section.

Children's Transitional Rates

Providers delivering Individualized Care Coordination (ICC) under the 1915c SED or Health Care Integration (HCI) under the 1915c B2H waivers, who shall provide Health Home Care Management services in accordance with this section effective on January 1, 2019, shall be eligible for a transition rate add-on for two years to enable providers to transition to Health Home rates. Health Home Care Management Services eligible for the transition rate add-on shall be limited to services provided to the number of children such providers served as of December 31, 2018. Services provided to a greater number of children than such providers served as of December 31, 2018 shall be reimbursed the Health Home rate without the add-on. The transition methodology is set forth in the transitional rate chart.

Children's Health Home Transition Rates

January 1, 2019 through June 30, 2019

Health Home	Add-On			Transitional Rate				
	Upstate	Downstate		Upstate	Downstate		Upstate	Downstate
1869: Low	$225.00	$240.00	7926: SED (L)	$948.00	$992.00	SED (L)	$1,173.00	$1,232.00
1870: Medium	$450.00	$479.00	7925: SED (M)	$723.00	$753.00	SED (M)	$1,173.00	$1,232.00
1871: High	$750.00	$799.00	7924: SED (H)	$423.00	$433.00	SED (H)	$1,173.00	$1,232.00

July 1, 2019 through December 31, 2019

Health Home	Add-On			Transitional Rate				
	Upstate	Downstate		Upstate	Downstate		Upstate	Downstate
1869: Low	$225.00	$240.00	7926: SED (L)	$711.00	$744.00	SED (L)	$936.00	$984.00
1870: Medium	$450.00	$479.00	7925: SED (M)	$542.00	$565.00	SED (M)	$992.00	$1,044.00
1871: High	$750.00	$799.00	7924: SED (H)	$317.00	$325.00	SED (H)	$1,067.00	$1,124.00

January 1, 2020 through June 30, 2020

Health Home	Add-On			Transitional Rate				
	Upstate	Downstate		Upstate	Downstate		Upstate	Downstate
1869: Low	$225.00	$240.00	7926: SED (L)	$474.00	$496.00	SED (L)	$699.00	$736.00
1870: Medium	$450.00	$479.00	7925: SED (M)	$362.00	$377.00	SED (M)	$812.00	$856.00
1871: High	$750.00	$799.00	7924: SED (H)	$212.00	$217.00	SED (H)	$962.00	$1,016.00

July1, 2020 through December 31, 2020

Health Home	Add-On			Transitional Rate				
	Upstate	Downstate		Upstate	Downstate		Upstate	Downstate
1869: Low	$225.00	$240.00	7926: SED (L)	$237.00	$248.00	SED (L)	$462.00	$488.00
1870: Medium	$450.00	$479.00	7925: SED (M)	$181.00	$188.00	SED (M)	$631.00	$667.00
1871: High	$750.00	$799.00	7924: SED (H)	$106.00	$108.00	SED (H)	$856.00	$907.00

January 1, 2019 through June 30, 2019

Health Home	Add-On			Transitional Rate				
	Upstate	Downstate		Upstate	Downstate		Upstate	Downstate
1869: Low	$225.00	$240.00	8002: B2H (L)	$925.00	$960.00	B2H (L)	$1,150.00	$1,200.00
1870: Medium	$450.00	$479.00	8001: B2H (M)	$700.00	$721.00	B2H (M)	$1,150.00	$1,200.00
1871: High	$750.00	$799.00	8000: B2H (H)	$400.00	$401.00	B2H (H)	$1,150.00	$1,200.00

July 1, 2019 through December 31, 2019

Health Home	Add-On			Transitional Rate				
	Upstate	Downstate		Upstate	Downstate		Upstate	Downstate
1869: Low	$225.00	$240.00	8002: B2H (L)	$694.00	$720.00	B2H (L)	$919.00	$960.00
1870: Medium	$450.00	$479.00	8001: B2H (M)	$525.00	$541.00	B2H (M)	$975.00	$1,020.00
1871: High	$750.00	$799.00	8000: B2H (H)	$300.00	$301.00	B2H (H)	$1,050.00	$1,100.00

January 1, 2020 through June 30, 2020

Health Home	Add-On			Transitional Rate				
	Upstate	Downstate		Upstate	Downstate		Upstate	Downstate
1869: Low	$225.00	$240.00	8002: B2H (L)	$463.00	$480.00	B2H (L)	$688.00	$720.00
1870: Medium	$450.00	$479.00	8001: B2H (M)	$350.00	$361.00	B2H (M)	$800.00	$840.00
1871: High	$750.00	$799.00	8000: B2H (H)	$200.00	$201.00	B2H (H)	$950.00	$1,000.00

July 1, 2020 through December 31, 2020

Health Home	Add-On			Transitional Rate				
	Upstate	Downstate		Upstate	Downstate		Upstate	Downstate
1869: Low	$225.00	$240.00	8002: B2H (L)	$231.00	$240.00	B2H (L)	$456.00	$480.00
1870: Medium	$450.00	$479.00	8001: B2H (M)	$175.00	$180.00	B2H (M)	$625.00	$659.00

1871: High	$750.00	$799.00	8000: B2H (H)	$100.00	$100.00	B2H (H)	$850.00	$899.00

Effective October,1, 2022, Children's Health Homes may receive an assessment fee to ensure that any child who may be eligible for Home and Community-Based Services (HCBS) under the Children's Waiver, demonstration or State Plan authority will be eligible
to receive a timely HCBS assessment under the Health Home program. The HH HCBS assessment fee will compensate the HH for the costs associated with conduct of:
· Evaluation and/or re-evaluation of HCBS level of care;
· Assessment and/or reassessment of the need for HCBS;
· Inclusion of all aspects of an HCBS Plan of Care in the HH's Comprehensive Care Plan.
This fee will be paid in addition to the PMPM calculated above and is contingent upon the Health Home completing a timely and
complete assessment.

Effective January 1, 2024, a per member per month (PMPM) care management fee was developed separately for the Health Homes Serving Children designated by the NYS designation process and providing High Fidelity Wraparound. The fee is based on modeling estimated enrollment, staff salaries, benefits, non-personnel costs, overhead, and administrative costs that is based on region under High Fidelity Wraparound based on the caseload assumptions. Separate projections and rates are developed for this population of most vulnerable children who meet the following conditions to be part of this service:

SED diagnosis as well as additional criteria, namely that the child or youth is:
-Between 6 and 21 years of age;
- Has a functional impairment in the home, school, or community as measured by the Children and Adolescent Needs and Strengths (CANS-NY);
- Is Health Home (HH) Enrolled/Eligible through SED or 2 MH diagnoses;
-Is involved with two or more systems;
- Has a history of service utilization with out-of-home residential or inpatient services, crisis and emergency services, intensive treatment programs or represent high needs populations.

Separate rates are developed for the children's High Fidelity Wraparound services for the Health Homes Serving Children. State Health Home Rates and Rate Codes Effective January 1, 2024 can be found at:
https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/billing/index.htm

Effective April 1, 2024, a supplemental per member per month (PMPM) care management fee was developed for the Health Homes Serving Adults designated by the NYS designation process and providing Health Home Plus Care Management to members who are receiving Health Home Plus Care Management due to an Assisted Outpatient Treatment (AOT) Order. Also rates are adjusted to reflect a 2.84% COLA for Health Home Plus members.

Rates are located at
https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/billing/hh_rates_updated_may_2024.htm

Health Homes Payment Methodologies

MEDICAID | Medicaid State Plan | Health Homes | NY2024MS0004O | NY-24-0037 | NYS Health Home Program

Package Header

Package ID	NY2024MS0004O	SPA ID	NY-24-0037
Submission Type	Official	Initial Submission Date	N/A
Approval Date	N/A	Effective Date	4/1/2024
Superseded SPA ID	NY-24-0023		
	User-Entered		

Assurances

☐ The State provides assurance that it will ensure non-duplication of payment for services similar to Health Homes services that are offered/covered under a different statutory authority, such as 1915(c) waivers or targeted case management.

Describe below how non-duplication of payment will be achieved: All rates are published on the DOH website. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers. All of the above payment policies have been developed to assure that there is no duplication of payment for health home services.

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/billing/hh_rates_updated_may_2024.htm

☐ The state has developed payment methodologies and rates that are consistent with section 1902(a)(30)(A).

☐ The State provides assurance that all governmental and private providers are reimbursed according to the same rate schedule, unless otherwise described above.

☐ The State provides assurance that it shall reimburse providers directly, except when there are employment or contractual arrangements consistent with section 1902(a)(32).

Optional Supporting Material Upload

Name	Date Created	
No items available		

PRA Disclosure Statement: Centers for Medicare & Medicaid Services (CMS) collects this mandatory information in accordance with (42 U.S.C. 1396a) and (42 CFR 430.12); which sets forth the authority for the submittal and collection of state plans and plan amendment information in a format defined by CMS for the purpose of improving the state application and federal review processes, improve federal program management of Medicaid programs and Children's Health Insurance Program, and to standardize Medicaid program data which covers basic requirements, and individualized content that reflects the characteristics of the particular state's program. The information will be used to monitor and analyze performance metrics related to the Medicaid and Children's Health Insurance Program in efforts to boost program integrity efforts, improve performance and accountability across the programs. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1188. The time required to complete this information collection is estimated to range from 1 hour to 80 hours per response (see below), including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850

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Appendix II
2024 Title XIX State Plan
Second Quarter Amendment
Summary

SUMMARY
SPA #24-0037

The Department of Health proposes to amend the Title XIX (Medicaid) State Plan Amendment for non-institutional services to comply with enacted statutory provisions.

Under legislation S. 8007--C A. 9007—C, Article VII Part I, the 2024-25 enacted budget outlines a 2.84% Cost of Living Adjustment in eligible Health Home rates for those Health Home members that meet the risk and acuity criteria for Health Home Plus and to comply with S. 4003 – D the 2023-24 enacted budget outlines supplemental payments intended for services provided to eligible adults who meet risk and acuity criteria for Health Home Plus and receiving Assisted Outpatient Treatment (AOT) are now eligible for the supplemental payments.

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

SPA 24-0037

Health and Mental Hygiene Article VII Bill | NYS FY 2024 Executive Budget

PART FF

Section 1. 1. Subject to available appropriations and approval of the director of the budget, the commissioners of the office of mental health, office for people with developmental disabilities, office of addiction services and supports, office of temporary and disability assistance, office of children and family services, and the state office for the aging (hereinafter "the commissioners") shall establish a state fiscal year 2024-2025 cost of living adjustment (COLA), effective April 1, 2024, for projecting for the effects of inflation upon rates of payments, contracts, or any other form of reimbursement for the programs and services listed in subdivision five of this section. The COLA established herein shall be applied to the appropriate portion of reimbursable costs or contract amounts. Where appropriate, transfers to the department of health (DOH) shall be made as reimbursement for the state share of medical assistance.

2. Notwithstanding any inconsistent provision of law, subject to the approval of the director of the budget and available appropriations therefore, for the period of April 1, 2024 through March 31, 2025, the commissioners shall provide funding to support a two and eight-tenths and four-hundredths percent (2.84%) cost of living adjustment under this section for all eligible programs and services as determined pursuant to subdivision five of this section.

3. Notwithstanding any inconsistent provision of law, and as approved by the director of the budget, the 2.84 percent cost of living adjustment (COLA) established herein shall be inclusive of all other cost of living type increases, inflation factors, or trend factors that are newly applied effective April 1, 2024. Except for the 2.84 percent cost of living adjustment (COLA) established herein, for the period commencing on April 1, 2024 and ending March 31, 2025 the commissioners shall not apply any other new cost of living adjustments for the purpose of establishing rates of payments, contracts or any other form of reimbursement. The phrase "all other cost of living type increases, inflation factors, or trend factors" as defined in this subdivision shall not include payments made pursuant to the American Rescue Plan Act or other federal relief programs related to the Coronavirus Disease 2019 (COVID-19) pandemic public health emergency. This subdivision shall not prevent the office

of children and family services from applying additional trend factors or staff retention factors to eligible programs and services under paragraph (v) of subdivision five of this section.

4. Each local government unit or direct contract provider receiving the cost of living adjustment established herein shall use such funding to provide a targeted salary increase of at least one and seven-tenths percent (1.7%) to eligible individuals in accordance with subdivision six of this section. Notwithstanding any inconsistent provision of law, the commissioners shall develop guidelines for local government units and direct contract providers on implementation of such targeted salary increase.

5. Eligible programs and services. (i) Programs and services funded, licensed, or certified by the office of mental health (OMH) eligible for the cost of living adjustment established herein, pending federal approval where applicable, include: office of mental health licensed outpatient programs, pursuant to parts 587 and 599 of title 14 CRR-NY of the office of mental health regulations including clinic, continuing day treatment, day treatment, intensive outpatient programs and partial hospitalization; outreach; crisis residence; crisis stabilization, crisis/respite beds; mobile crisis, part 590 comprehensive psychiatric emergency program services; crisis intervention; home based crisis intervention; family care; supported single room occupancy; supported housing; supported housing community services; treatment congregate; supported congregate; community residence - children and youth; treatment/apartment; supported apartment; community residence single room occupancy; on-site rehabilitation; employment programs; recreation; respite care; transportation; psychosocial club; assertive community treatment; case management; care coordination, including health home plus services; local government unit administration; monitoring and evaluation; children and youth vocational services; single point of access; school-based mental health program; family support children and youth; advocacy/support services; drop in centers; recovery centers; transition management services; bridger; home and community based waiver services; behavioral health waiver services authorized pursuant to the section 1115 MRT waiver; self-help programs; consumer service dollars; conference of local mental hygiene directors; multicultural initiative; ongoing integrated supported employment services; supported education; mentally ill/chemical abuse (MICA) network; personalized recovery oriented services; children and family treatment and support services; residential treatment facilities operating pursuant to part 584 of title 14-NYCRR; geriatric demonstration programs; community-based mental health family treatment and support; coordinated children's service initiative; homeless services; and promises zone.

(ii) Programs and services funded, licensed, or certified by the office for people with developmental disabilities (OPWDD) eligible for the cost of living adjustment

established herein, pending federal approval where applicable, include: local/unified services; chapter 620 services; voluntary operated community residential services; article 16 clinics; day treatment services; family support services; 100% day training; epilepsy services; traumatic brain injury services; hepatitis B services; independent practitioner services for individuals with intellectual and/or developmental disabilities; crisis services for individuals with intellectual and/or developmental disabilities; family care residential habilitation; supervised residential habilitation; supportive residential habilitation; respite; day habilitation; prevocational services; supported employment; community habilitation; intermediate care facility day and residential services; specialty hospital; pathways to employment; intensive behavioral services; community transition services; family education and training; fiscal intermediary; support broker; and personal resource accounts.

(iii) Programs and services funded, licensed, or certified by the office of addiction services and supports (OASAS) eligible for the cost of living adjustment established herein, pending federal approval where applicable, include: medically supervised withdrawal services - residential; medically supervised withdrawal services - outpatient; medically managed detoxification; medically monitored withdrawal; inpatient rehabilitation services; outpatient opioid treatment; residential opioid treatment; KEEP units outpatient; residential opioid treatment to abstinence; problem gambling treatment; medically supervised outpatient; outpatient rehabilitation; specialized services substance abuse programs; home and community based waiver services pursuant to subdivision 9 of section 366 of the social services law; children and family treatment and support services; continuum of care rental assistance case management; NY/NY III post-treatment housing; NY/NY III housing for persons at risk for homelessness; permanent supported housing; youth clubhouse; recovery community centers; recovery community organizing initiative; residential rehabilitation services for youth (RRSY); intensive residential; community residential; supportive living; residential services; job placement initiative; case management; family support navigator; local government unit administration; peer engagement; vocational rehabilitation; support services; HIV early intervention services; dual diagnosis coordinator; problem gambling resource centers; problem gambling prevention; prevention resource centers; primary prevention services; other prevention services; and community services.

(iv) Programs and services funded, licensed, or certified by the office of temporary and disability assistance (OTDA) eligible for the cost of living adjustment established herein, pending federal approval where applicable, include: nutrition outreach and education program (NOEP).

(v) Programs and services funded, licensed, or certified by the office of children and family services (OCFS) eligible for the cost of living adjustment established

herein, pending federal approval where applicable, include: programs for which the office of children and family services establishes maximum state aid rates pursuant to section 398-a of the social services law and section 4003 of the education law; emergency foster homes; foster family boarding homes and therapeutic foster homes; supervised settings as defined by subdivision twenty-two of section 371 of the social services law; adoptive parents receiving adoption subsidy pursuant to section 453 of the social services law; and congregate and scattered supportive housing programs and supportive services provided under the NY/NY III supportive housing agreement to young adults leaving or having recently left foster care.

(vi) Programs and services funded, licensed, or certified by the state office for the aging (SOFA) eligible for the cost of living adjustment established herein, pending federal approval where applicable, include: community services for the elderly; expanded in-home services for the elderly; and wellness in nutrition program.

6. Eligible individuals. Support staff, direct care staff, clinical staff, and non-executive administrative staff in programs and services listed in subdivision five of this section shall be eligible for the 1.7% targeted salary increase established pursuant to subdivision four of this section.

(a) For the office of mental health, office for people with developmental disabilities, and office of addiction services and supports, support staff shall mean individuals employed in consolidated fiscal report position title codes ranging from 100 to 199; direct care staff shall mean individuals employed in consolidated fiscal report position title codes ranging from 200 to 299; clinical staff shall mean individuals employed in consolidated fiscal report position title codes ranging from 300 to 399; and non-executive administrative staff shall mean individuals employed in consolidated fiscal report position title codes 400, 500 to 599, 605 to 699, and 703 to 799. Individuals employed in consolidated fiscal report position title codes 601 to 604, 701 and 702 shall be ineligible for the 1.7% targeted salary increase established herein.

(b) For the office of temporary and disability assistance, office of children and family services, and the state office for the aging, eligible support staff, direct care staff, clinical staff, and non-executive administrative staff titles shall be determined by each agency's commissioner.

7. Each local government unit or direct contract provider receiving funding for the cost of living adjustment established herein shall submit a written certification, in such form and at such time as each commissioner shall prescribe, attesting how such funding will be or was used to first promote the recruitment and retention of support staff, direct care staff, clinical staff, non-executive administrative staff, or respond to

other critical non-personal service costs prior to supporting any salary increases or other compensation for executive level job titles.

8. Notwithstanding any inconsistent provision of law to the contrary, agency commissioners shall be authorized to recoup funding from a local governmental unit or direct contract provider for the cost of living adjustment established herein determined to have been used in a manner inconsistent with the appropriation, or any other provision of this section. Such agency commissioners shall be authorized to employ any legal mechanism to recoup such funds, including an offset of other funds that are owed to such local governmental unit or direct contract provider.

§ 2. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2024.

fiscal year 2023-24, and (ii) appropriation for this item covering fiscal year 2023-24 set forth in chapter 53 of the laws of 2022 (26950) 3,553,637,000

For services and expenses of the medical assistance program including other long term care services.

Notwithstanding any provision of law to the contrary, the portion of this appropriation covering fiscal year 2023-24 shall supersede and replace any duplicative (i) reappropriation for this item covering fiscal year 2023-24, and (ii) appropriation for this item covering fiscal year 2023-24 set forth in chapter 53 of the laws of 2022 (26951) 11,598,028,000

For services and expenses of the medical assistance program including managed care services including regional planning activities of the finger lakes health systems agency, including statewide coordination and demonstration of best practices. The department shall make grants within amounts appropriated therefor, to assure high-quality and accessible primary care, to provide technical assistance to support financial and business planning for integrated systems of care, and to assist primary care providers in the adoption, implementation, and meaningful use of electronic health record technology.

Notwithstanding any provision of law to the contrary, the portion of this appropriation covering fiscal year 2023-24 shall supersede and replace any duplicative (i) reappropriation for this item covering fiscal year 2023-24, and (ii) appropriation for this item covering fiscal year 2023-24 set forth in chapter 53 of the laws of 2022 (26952) 11,861,596,000

For services and expenses for health homes including grants to health homes.

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

52 laws of 2022 (29548) 424,380,000

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

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 1460, 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 the 2023-24 enacted State budget. The following changes are proposed:

Non-Institutional Services

Effective on or after April 1, 2024, supplemental payments will be made to Health Home care managers who are employed by a State-designated Specialty Mental Health Care Management Agency and provide Health Home Plus services to adults receiving Assisted Outpatient Treatment.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget is $2.5 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 institutional, non-institutional and long-term care services to comply with Section 652 of Article 19 of the New York State Labor Law. The following changes are proposed:

All Services

The following is a clarification to the December 27, 2023 noticed provision to adjust Medicaid rates resulting from increases in New York State minimum wage and a decrease in wage parity. With clarification, this provision will only address minimum wage.

It is further clarified that the estimated net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal years 2024, 2025 and 2026 will now be $18 million, $85 million, and $132 million respectively.

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

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

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New York, New York 10018

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Brooklyn, New York 11201

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Bronx, New York 10457

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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 active Intermediate Fixed Income investment management services for the Stable Income Fund ("the Fund") investment option of the Plan. The Plan is seeking qualified vendors to manage a portfolio against the Barclays Intermediate Aggregate Index. The objective of the Fund is to provide an opportunity to invest in high quality fixed income securities with an emphasis on safety of principal and consistency of returns. To be considered, vendors must submit their product information to Segal Marco Advisors at the following e-mail address: nycdcp.procurement@segalmarco.com. Please complete the submission of product information no later than 4:30 P.M. Eastern Time on April 1, 2024.

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.

For publication in the July 10, 2024, edition of the New York State Register

Public Notice
NYS Department of Health

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

The Department of Health proposes to amend the Title XIX (Medicaid) State Plan for institutional, non-institutional and long-term care services pursuant to the enacted 2024-2025 executive budget. The following clarifications are proposed:

All Services

The following is a clarification to the March 27th, 2024 noticed proposal to adjust rates of payments statewide to reflect a 1.5 percent (1.5%) Cost of Living Adjustment. With clarification, this increase will now be 2.84 percent (2.84%) and relating to the following: Office of Mental Health (OMH), Office of Addiction Services and Supports (OASAS), and Office for People With Developmental Disabilities (OPWDD) State Plan Services: OMH Outpatient Services, OMH Clinic Services, OMH Rehabilitative Services, Comprehensive Psychiatric Emergency Program, including Extended Observation Beds, Children Family Treatment Support Services, Health Home Plus, Psychiatric Residential Treatment Facilities for Children and Youth, OASAS Outpatient Addiction Services, OASAS Freestanding (non-hospital) Inpatient Rehabilitation Services, OASAS Freestanding Inpatient Detox Services, OASAS Addiction Treatment Centers, OASAS Part 820 Residential Services, OASAS Residential Rehabilitation Services for Youth, Intermediate Care Facility (ICF/IDD), Day Treatment, Article 16 Clinic Services, Specialty Hospital, Independent Practitioner Services for Individual with Developmental Disabilities (IPSIDD), and OPWDD Crisis Services.

The estimated net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2024-2025 is $49.9 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
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New York, New York 10018

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

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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:

New York State Department of Health
Division of Finance and Rate Setting
99 Washington Ave
One Commerce Plaza
Suite 1432
Albany, New York 12210
spa_inquiries@health.ny.gov

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

NON-INSTITUTIONAL SERVICES
State Plan Amendment #24-0037

CMS Standard Funding Questions

The following questions are being asked and should be answered in relation to all payments made to all providers reimbursed pursuant to a methodology described in Attachment 4.19-B of the state plan.

1. **Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by States for services under the approved State plan. Do providers receive and retain the total Medicaid expenditures claimed by the State (includes normal per diem, supplemental, enhanced payments, other) or is any portion of the payments returned to the State, local governmental entity, or any other intermediary organization? If providers are required to return any portion of payments, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the amount or percentage of payments that are returned and the disposition and use of the funds once they are returned to the State (i.e., general fund, medical services account, etc.)**

   Response: Providers receive and retain 100 percent of total Medicaid expenditures claimed by the State and the State does not require any provider to return any portion of such payments to the State, local government entities, or any other intermediary organization.

2. **Section 1902(a)(2) provides that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan. Please describe how the state share of each type of Medicaid payment (normal per diem, supplemental, enhanced, other) is funded. Please describe whether the state share is from appropriations from the legislature to the Medicaid agency, through intergovernmental transfer agreements (IGTs), certified public expenditures (CPEs), provider taxes, or any other mechanism used by the state to provide state share. Note that, if the appropriation is not to the Medicaid agency, the source of the state share would necessarily be derived through either an IGT or CPE. In this case, please identify the agency to which the funds are appropriated. Please provide an estimate of total expenditure and State share amounts for each type of Medicaid payment. If any of the non-federal share is being provided using IGTs or CPEs, please fully describe the matching arrangement including when the state agency receives the transferred amounts from the local government entity transferring the funds. If CPEs are used, please describe the methodology used by the state to verify that the total expenditures being certified are eligible for Federal matching funds in accordance with 42 CFR 433.51(b). For any payment funded by CPEs or IGTs, please provide the following:**
   - **(i) a complete list of the names of entities transferring or certifying funds;**
   - **(ii) the operational nature of the entity (state, county, city, other);**

(iii) the total amounts transferred or certified by each entity;
(iv) clarify whether the certifying or transferring entity has general taxing authority: and,
(v) whether the certifying or transferring entity received appropriations (identify level of appropriations).

Response: The Non-Federal share Medicaid provider payment is funded by a combination of the following funds/funding sources through enacted appropriations authority to the Department of Health (DOH) for the New York State Medicaid program.

		4/1/24 – 3/31/25	
Payment Type	**Non-Federal Share Funding**	**Non-Federal**	**Gross**
Normal Per Diem	General Fund; County Contribution	$1,741,409	$3,482,409

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

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

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

B. Additional Resources for Non-Federal Share Funding:

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

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

Entity	Annual Amount
New York City	$5.210B
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.

3. **Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan. If supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to each provider type.**

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

4. **For clinic or outpatient hospital services please provide a detailed description of the methodology used by the state to estimate the upper payment limit (UPL) for each class of providers (state owned or operated, non-state government owned or operated, and privately owned or operated). Please provide a current (i.e., applicable to the current rate year) UPL demonstration. Under regulations at 42 CFR 447.272, States are prohibited from setting payment rates for Medicaid inpatient services that exceed a reasonable estimate of the amount that would be paid under Medicare payment principals.**

   Response: The Medicaid payments authorized under this State Plan Amendment do not impact the UPL demonstrations.

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

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

ACA Assurances:

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

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

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

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

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

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

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

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

Tribal Assurance:

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

IHCIA Section 2107(e)(I) of the Act was also amended to apply these requirements to the Children's Health Insurance Program CHIP. Consultation is required concerning Medicaid and CHIP matters having a direct impact on Indian health programs and Urban Indian organizations.

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

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