

July 8, 2026

Mr. Amir Bassiri
Medicaid Director, Deputy Commissioner
New York State Department of Health
State of New York, Department of Health
Empire State Plaza, Corning Tower, Room 1466
Albany, NY 12237

Dear Mr. Amir Bassiri:

In accordance with 42 CFR 438.6(c), the Centers for Medicare & Medicaid Services (CMS) has reviewed and is approving New York's submission of a proposal for a state directed payment (SDP) under Medicaid managed care plan contract(s). The proposal was received by CMS on March 13, 2026. The proposal has a control name of NY_Fee_IPH.OPH.BHI_Amend_20250401-20260331.

CMS has completed our review of the following Medicaid managed care SDP(s):

- Uniform increase for inpatient and outpatient services delivered by qualifying financially distressed hospitals for the rating period, April 1, 2025 through March 31, 2026, incorporated into the capitation rates through a separate payment term up to \$1,840,386,150.

This letter satisfies the regulatory requirement in 42 CFR 438.6(c)(2) for SDPs described in 42 CFR 438.6(c)(1). This letter pertains only to the actions identified above and does not apply to other actions currently under CMS's review. This letter does not constitute approval of any specific Medicaid financing mechanism used to support the non-federal share of expenditures associated with these actions. All relevant federal laws and regulations apply. CMS reserves its authority to enforce requirements in the Social Security Act and the applicable implementing regulations.

The state is required to submit contract action(s) and related capitation rates that include all SDPs, including those that do not require written prior approval as specified in 42 CFR 438.6(c)(2)(i). Additionally, all SDPs must be addressed in the applicable rate certifications. CMS recommends that states share this letter and the preprint(s) with the certifying actuary. Documentation of all SDPs must be included in the initial rate certification as outlined in Section I, Item 4, Subsection D, of the [Medicaid Managed Care Rate Development Guide](#). The state and its actuary must ensure all documentation outlined in the Medicaid Managed Care Rate Development Guide is included in the initial rate certification. Failure to provide all required documentation in the rate certification will cause delays in CMS review.

Approval of this SDP proposal for the applicable rating period does not preclude CMS from requesting additional materials from the state, revision to the SDP proposal design, or any other modifications to the proposal for this rating period or future rating periods, if CMS determines that such modifications are required for the state to meet relevant federal requirements.

CMS approval of this SDP preprint is conditioned on the state's continued compliance with Medicaid program integrity requirements, including 42 CFR 438 and 42 CFR 455. The state must ensure that the state and its managed care plans appropriately support program integrity activities, including the prevention, detection, investigation, referral, and resolution of fraud, waste, and abuse through appropriate staffing, oversight, controls, data, analytics, reporting, audits, and other actions. The state is responsible for monitoring all aspects of the managed care program, including the performance of every managed care plan related to program integrity as required in 42 CFR 438.66(b)(9). Any material changes to managed care plans' program integrity responsibilities must be clearly effectuated through the state's managed care contracts submitted to CMS for review and approval in accordance with 42 CFR 438.3(a).

Based on CMS's preliminary determination, this SDP proposal does not qualify for the temporary grandfathering period in section 71116(b) of the Working Families Tax Cut (WFTC) legislation (Public Law 119-21) because it was submitted after July 4, 2025. Rather, the preprint named NY_Fee_IPH.OPH.BHI_Renewal_20240401-20250331 submitted on June 11, 2024 with a total dollar amount of \$1,855,352,776 qualifies for the temporary grandfathering period in section 71116. CMS acknowledges that this determination is preliminary in nature and policies will be finalized as part of notice and comment rulemaking. CMS will enforce all federal requirements, including section 71116, and CMS's assessment may be revised if further information is identified that alters the initial assessment.

Until the phase down required by section 71116 begins, the total dollar amount of \$1,855,352,776 for the grandfathered SDP cannot increase and a state cannot increase this total dollar amount under any change or revision to the grandfathered SDP, including an amendment to the SDP, or subsequent renewal of this SDP for a future rating period. For rating periods beginning on or after January 1, 2028, grandfathered SDPs must comply with the specified phase down requirements.

CMS appreciates the information that New York has provided as part of the SFY 2026 rating period preprint review regarding the total payment rate analysis and average commercial rate calculations in accordance with 42 CFR 438.6(c)(2)(iii). CMS is approving this preprint with the condition that the state continue to work with CMS to further refine the total payment rate analysis and average commercial rate demonstration for the SFY 2027 rating period.

If you have any questions concerning this letter, please contact StateDirectedPayment@cms.hhs.gov.

Sincerely,

John Giles
Director, Managed Care Group
Center for Medicaid and CHIP Services

Section 438.6(c) Preprint

42 C.F.R. § 438.6(c) provides States with the flexibility to implement delivery system and provider payment initiatives under MCO, PIHP, or PAHP Medicaid managed care contracts (i.e., state directed payments). 42 C.F.R. § 438.6(c)(1) describes types of payment arrangements that States may use to direct expenditures under the managed care contract. Under 42 C.F.R. § 438.6(c)(2)(ii), contract arrangements that direct an MCO's, PIHP's, or PAHP's expenditures under paragraphs (c)(1)(i) through (c)(1)(ii) and (c)(1)(iii)(B) through (D) must have written approval from CMS prior to implementation and before approval of the corresponding managed care contract(s) and rate certification(s). This preprint implements the prior approval process and must be completed, submitted, and approved by CMS before implementing any of the specific payment arrangements described in 42 C.F.R. § 438.6(c)(1)(i) through (c)(1)(ii) and (c)(1)(iii)(B) through (D). Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules using State plan approved rates as defined in 42 C.F.R. § 438.6(a).

Submit all state directed payment preprints for prior approval to:
StateDirectedPayment@cms.hhs.gov.

SECTION I: DATE AND TIMING INFORMATION

1. Identify the State's managed care contract rating period(s) for which this payment arrangement will apply (for example, July 1, 2020 through June 30, 2021):
April 1, 2025 – March 31, 2026
2. Identify the State's requested start date for this payment arrangement (for example, January 1, 2021). *Note, this should be the start of the contract rating period unless this payment arrangement will begin during the rating period.* April 1, 2025
3. Identify the managed care program(s) to which this payment arrangement will apply:
Mainstream Medicaid Managed Care, HARP, and HIV/SNP
4. Identify the estimated **total dollar amount** (federal and non-federal dollars) of this state directed payment: \$1,840,386,150

a. Identify the estimated federal share of this state directed payment: \$1,141,039,413

b. Identify the estimated non-federal share of this state directed payment: \$699,346,737

Please note, the estimated total dollar amount and the estimated federal share should be described for the rating period in Question 1. If the State is seeking a multi-year approval (which is only an option for VBP/DSR payment arrangements (42 C.F.R. § 438.6(c)(1)(i)-(ii))), States should provide the estimates per rating period. For amendments, states should include the change from the total and federal share estimated in the previously approved preprint.

5. Is this the initial submission the State is seeking approval under 42 C.F.R. § 438.6(c) for this state directed payment arrangement? ☐ Yes ☒ No

6. If this is not the initial submission for this state directed payment, please indicate if:
- a. ☒ The State is seeking approval of an amendment to an already approved state directed payment.
 - b. ☐ The State is seeking approval for a renewal of a state directed payment for a new rating period.
 - i. If the State is seeking approval of a renewal, please indicate the rating periods for which previous approvals have been granted:
 - c. Please identify the types of changes in this state directed payment that differ from what was previously approved.
 - ☐ Payment Type Change
 - ☐ Provider Type Change
 - ☐ Quality Metric(s) / Benchmark(s) Change
 - ☒ Other; please describe:
Correction to a typo in the eligibility requirement described in 20b. - amending the three-year average to 2020, 2021 and 2022.
 - ☐ No changes from previously approved preprint other than rating period(s).
7. ☒ Please use the checkbox to provide an assurance that, in accordance with 42 C.F.R. § 438.6(c)(2)(ii)(F), the payment arrangement is not renewed automatically.

SECTION II: TYPE OF STATE DIRECTED PAYMENT

8. In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(A), describe in detail how the payment arrangement is based on the utilization and delivery of services for enrollees covered under the contract. The State should specifically discuss what must occur in order for the provider to receive the payment (e.g., utilization of services by managed care enrollees, meet or exceed a performance benchmark on provider quality metrics).

Contracted managed care organizations ("MCO") will provide enhanced payments for selected services provided by financially distressed private hospitals to Medicaid enrollees. MCO encounter data and hospital claims data will be used to directly link payments to utilization of services by Medicaid enrollees. Each service (acute inpatient, inpatient psychiatric, clinic, ambulatory surgery, and emergency department) has a separate uniform dollar increase per service unit.

At the beginning of each quarter, the State will pay each MCO a portion of the aggregate amount certified as a separate payment term in the managed care rate certification, separate from the monthly prospective base capitation rate paid to each MCO. The amount will be calculated by multiplying each MCO's projected qualifying hospital utilization by the per-unit add on described in Attachment A. Projected utilization will be based on prior claims experience. MCOs will pay an amount to each qualifying hospital based on the projected utilization. At the end of the rate year, the State and each MCO will reconcile to actual utilization.

- a. ☒ Please use the checkbox to provide an assurance that CMS has approved the federal authority for the Medicaid services linked to the services associated with the SDP (i.e., Medicaid State plan, 1115(a) demonstration, 1915(c) waiver, etc.).
- b. Please also provide a link to, or submit a copy of, the authority document(s) with initial submissions and at any time the authority document(s) has been renewed/revised/updated.

The New York Medicaid State plan and the Social Security Act make hospital services a mandatory Medicaid benefit. While New York contracts with Medicaid MCOs, per section 1115 (a) authority, to administer the State's Medicaid program, managed care organizations are similarly obligated - pursuant to the 1115 waiver and state and federal Medicaid managed care authorities - to cover hospital services, including the services described herein.

See

https://www.hcrapools.org/medicaid_state_plan/DOH_PDF_PROD/nys_medicaid_state_plan.pdf;
and <https://www.medicare.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/82656>

9. Please select the general type of state directed payment arrangement the State is seeking prior approval to implement. (Check all that apply and address the underlying questions for each category selected.)

- a. ☐ **VALUE-BASED PAYMENTS / DELIVERY SYSTEM REFORM:** In accordance with 42 C.F.R. § 438.6(c)(1)(i) and (ii), the State is requiring the MCO, PIHP, or PAHP to implement value-based purchasing models for provider reimbursement, such as alternative payment models (APMs), pay for performance arrangements, bundled payments, or other service payment models intended to recognize value or outcomes over volume of services; or the State is requiring the MCO, PIHP, or PAHP to participate in a multi-payer or Medicaid-specific delivery system reform or performance improvement initiative.

If checked, please answer all questions in Subsection IIA.

- b. ☒ **FEE SCHEDULE REQUIREMENTS:** In accordance with 42 C.F.R. § 438.6(c)(1)(iii)(B) through (D), the State is requiring the MCO, PIHP, or PAHP to adopt a minimum or maximum fee schedule for network providers that provide a particular service under the contract; or the State is requiring the MCO, PIHP, or PAHP to provide a uniform dollar or percentage increase for network providers that provide a particular service under the contract. **[Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules using State plan approved rates as defined in 42 C.F.R. § 438.6(a).]**

If checked, please answer all questions in Subsection IIB.

SUBSECTION IIA: VALUE-BASED PAYMENTS (VBP) / DELIVERY SYSTEM REFORM (DSR):

This section must be completed for all state directed payments that are VBP or DSR. This section does not need to be completed for state directed payments that are fee schedule requirements.

10. Please check the type of VBP/DSR State directed payment the State is seeking prior approval for. *Check all that apply; if none are checked, proceed to Section III.*

- ☐ Quality Payment/Pay for Performance (Category 2 APM, or similar)
- ☐ Bundled Payment/Episode-Based Payment (Category 3 APM, or similar)
- ☐ Population-Based Payment/Accountable Care Organization (Category 4 APM, or similar)
- ☐ Multi-Payer Delivery System Reform
- ☐ Medicaid-Specific Delivery System Reform
- ☐ Performance Improvement Initiative
- ☐ Other Value-Based Purchasing Model

11. Provide a brief summary or description of the required payment arrangement selected above and describe how the payment arrangement intends to recognize value or outcomes over volume of services. If “other” was checked above, identify the payment model. The State should specifically discuss what must occur in order for the provider to receive the payment (e.g., meet or exceed a performance benchmark on provider quality metrics).

12. In Table 1 below, identify the measure(s), baseline statistics, and targets that the State will tie to provider performance under this payment arrangement (provider performance measures). Please complete all boxes in the row. To the extent practicable, CMS encourages states to utilize existing, validated, and outcomes-based performance measures to evaluate the payment arrangement, and recommends States use the [CMS Adult and Child Core Set Measures](#) when applicable. If the state needs more space, please use Addendum Table 1.A and check this box: ☐

TABLE 1: Payment Arrangement Provider Performance Measures

Measure Name and NQF # (if applicable)	Measure Steward/ Developer ¹	Baseline ² Year	Baseline ² Statistic	Performance Measurement Period ³	Performance Target	Notes ⁴
<i>Example: Percent of High-Risk Residents with Pressure Ulcers – Long Stay</i>	<i>CMS</i>	<i>CY 2018</i>	<i>9.23%</i>	<i>Year 2</i>	<i>8%</i>	<i>Example notes</i>
a.						
b.						
c.						
d.						
e.						

1. Baseline data must be added after the first year of the payment arrangement

2. If state-developed, list State name for Steward/Developer.

3. If this is planned to be a multi-year payment arrangement, indicate which year(s) of the payment arrangement that performance on the measure will trigger payment.

4. If the State is using an established measure and will deviate from the measure steward’s measure specifications, please describe here. Additionally, if a state-specific measure will be used, please define the numerator and denominator here.

a. Please describe the methodology used to set the performance targets for each measure.

b. If multiple provider performance measures are involved in the payment arrangement, discuss if the provider must meet the performance target on each measure to receive payment or can providers receive a portion of the payment if they meet the performance target on some but not all measures?

c. For state-developed measures, please briefly describe how the measure was developed?

14. Is the State seeking a multi-year approval of the state directed payment arrangement?

☐ Yes ☐ No

- a. If this payment arrangement is designed to be a multi-year effort, denote the State's managed care contract rating period(s) the State is seeking approval for.
- b. If this payment arrangement is designed to be a multi-year effort and the State is **NOT** requesting a multi-year approval, describe how this application's payment arrangement fits into the larger multi-year effort and identify which year of the effort is addressed in this application.

15. Use the checkboxes below to make the following assurances:

- a. ☐ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(A), the state directed payment arrangement makes participation in the value-based purchasing initiative, delivery system reform, or performance improvement initiative available, using the same terms of performance, to the class or classes of providers (identified below) providing services under the contract related to the reform or improvement initiative.
- b. ☐ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(B), the payment arrangement makes use of a common set of performance measures across all of the payers and providers.
- c. ☐ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(C), the payment arrangement does not set the amount or frequency of the expenditures.
- d. ☐ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(D), the payment arrangement does not allow the State to recoup any unspent funds allocated for these arrangements from the MCO, PIHP, or PAHP.

SUBSECTION IIB: STATE DIRECTED FEE SCHEDULES:

This section must be completed for all state directed payments that are fee schedule requirements. This section does not need to be completed for state directed payments that are VBP or DSR.

16. Please check the type of state directed payment for which the State is seeking prior approval. Check all that apply; if none are checked, proceed to Section III.

- a. ☐ Minimum Fee Schedule for providers that provide a particular service under the contract *using rates other than State plan approved rates*¹ (42 C.F.R. § 438.6(c)(1)(iii)(B))
- b. ☐ Maximum Fee Schedule (42 C.F.R. § 438.6(c)(1)(iii)(D))
- c. ☒ Uniform Dollar or Percentage Increase (42 C.F.R. § 438.6(c)(1)(iii)(C))

¹ Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules that use State plan approved rates as defined in 42 C.F.R. § 438.6(a).

17. If the State is seeking prior approval of a fee schedule (options a or b in Question 16):

- a.** Check the basis for the fee schedule selected above.
 - i.** ☐ The State is proposing to use a fee schedule based on the **State-plan approved rates** as defined in 42 C.F.R. § 438.6(a). ²
 - ii.** ☐ The State is proposing to use a fee schedule based on the **Medicare or Medicare-equivalent rate**.
 - iii.** ☐ The State is proposing to use a fee schedule based on an **alternative fee schedule established by the State**.
 - 1.** If the State is proposing an alternative fee schedule, please describe the alternative fee schedule (e.g., 80% of Medicaid State-plan approved rate)
- b.** Explain how the state determined this fee schedule requirement to be reasonable and appropriate.

18. If using a maximum fee schedule (option b in Question 16), please answer the following additional questions:

- a.** ☐ Use the checkbox to provide the following assurance: In accordance with 42 C.F.R. § 438.6(c)(1)(iii)(C), the State has determined that the MCO, PIHP, or PAHP has retained the ability to reasonably manage risk and has discretion in accomplishing the goals of the contract.
- b.** Describe the process for plans and providers to request an exemption if they are under contract obligations that result in the need to pay more than the maximum fee schedule.
- c.** Indicate the number of exemptions to the requirement:
 - i.** Expected in this contract rating period (estimate)
 - ii.** Granted in past years of this payment arrangement
- d.** Describe how such exemptions will be considered in rate development.

² Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules that use State plan approved rates as defined in 42 C.F.R. § 438.6(a).

19. If the State is seeking prior approval for a uniform dollar or percentage increase (option c in Question 16), please address the following questions:

- a. Will the state require plans to pay a ☒ uniform dollar amount **or** a ☐ uniform percentage increase? (*Please select only one.*)
- b. What is the magnitude of the increase (e.g., \$4 per claim or 3% increase per claim?)
A uniform dollar increase (per discharge, per day or per visit) is set for each of the five services. (See Attachment A)
- c. Describe how will the uniform increase be paid out by plans (e.g., upon processing the initial claim, a retroactive adjustment done one month after the end of quarter for those claims incurred during that quarter).

As described previously in the response to Question 8, hospitals will receive quarterly lump-sum directed payments from managed care organizations (MCOs) as directed by NYDOH. After the end of the contract year, NYDOH will conduct a reconciliation process based on actual contract year utilization and will direct the MCOs to make payment adjustments.

- d. Describe how the increase was developed, including why the increase is reasonable and appropriate for network providers that provide a particular service under the contract

The uniform dollar increases are constructed to allow qualifying financially distressed hospitals to receive sufficient reimbursement to allow their continued ability to serve Medicaid and low-income patient populations and to continue their process of transformation in order to meet Medicaid managed care needs. The uniform dollar amount decreases based on factors that signal financial distress including operating margin and commercial utilization to account for degree of financial distress.

SECTION III: PROVIDER CLASS AND ASSESSMENT OF REASONABLENESS

20. In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(B), identify the class or classes of providers that will participate in this payment arrangement by answering the following questions:

- a. Please indicate which general class of providers would be affected by the state directed payment (check all that apply):

- ☒ inpatient hospital service
☒ outpatient hospital service
☐ professional services at an academic medical center
☐ primary care services
☐ specialty physician services
☐ nursing facility services
☐ HCBS/personal care services
☒ behavioral health inpatient services
☐ behavioral health outpatient services
☐ dental services
☐ Other:

- b. Please define the provider class(es) (if further narrowed from the general classes indicated above).

In state fiscal year 2026, eligible hospitals are (1) hospitals that are not designated by the state as rural, specialty hospitals that receive a specialty rate, or public, and (2) have at least 34% of inpatient patient days and 34% of outpatient visits attributable to Medicaid based on an average using data from 2020, 2021 and 2022 institutional cost reports. All non-rural, non-specialty private, and specialty hospitals that do not receive a specialty rate meeting these payor mix thresholds must be included in the provider class. The alternative fee schedule applies specifically to the following hospital inpatient and outpatient services: acute inpatient, inpatient psychiatric services, and outpatient clinic, emergency, and ambulatory surgery services. NOTE, outpatient services are limited to services provided by hospitals pursuant to Article 28, Section 3401 of the New York Public Health Law. Outpatient clinic services do not include Federally Qualified Health Center (FQHC) services or mental health services not provided under Article 28.

- c. Provide a justification for the provider class defined in Question 20b (e.g., the provider class is defined in the State Plan.) If the provider class is defined in the State Plan, please provide a link to or attach the applicable State Plan pages to the preprint submission. Provider classes cannot be defined to only include providers that provide intergovernmental transfers.

The New York State Department of Health has determined that each of these voluntary hospital facilities are safety net hospitals requiring Medicaid rate enhancement because of their high Medicaid and/or high combined Medicaid and Medicare payer mix, which results in an inability to maintain vital services without additional support. The vast majority of these hospitals have previously received State and Federal support through one or more State programs, including VBP-QIP, VAPAP, and VAP.

21. In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(B), describe how the payment arrangement directs expenditures equally, using the same terms of performance, for the class or classes of providers (identified above) providing the service under the contract.

All hospitals eligible for the directed payment authorized by this directed payment will receive uniform dollar increases calculated using the methodology as set forth in Attachment A. The State is directing plans to pay non-network providers and/or network providers under this payment arrangement; however, this does not apply to out of state providers.

22. For the services where payment is affected by the state directed payment, how will the state directed payment interact with the negotiated rate(s) between the plan and the provider? Will the state directed payment:

- a. ☐ Replace the negotiated rate(s) between the plan(s) and provider(s).
b. ☐ Limit but not replace the negotiated rate(s) between the plans(s) and provider(s).
c. ☒ Require a payment be made in addition to the negotiated rate(s) between the plan(s) and provider(s).

23. For payment arrangements that are intended to require plans to make a payment in addition to the negotiated rates (as noted in option c in Question 22), please provide an analysis in Table 2 showing the impact of the state directed payment on payment levels for each provider class. This provider payment analysis should be completed distinctly for each service type (e.g., inpatient hospital services, outpatient hospital services, etc.).

This should include an estimate of the base reimbursement rate the managed care plans pay to these providers as a percent of Medicare, or some other standardized measure, and the effect the increase from the state directed payment will have on total payment. *Ex: The average base payment level from plans to providers is 80% of Medicare and this SDP is expected to increase the total payment level from 80% to 100% of Medicare.*

If the state needs more space, please use Addendum 2.A and check this box: ☒

TABLE 2: Provider Payment Analysis

Provider Class(es)	Average Base Payment Level from Plans to Providers (absent the SDP)	Effect on Total Payment Level of State Directed Payment (SDP)	Effect on Total Payment Level of Other SDPs	Effect on Total Payment Level of Pass-Through Payments (PTPs)	Total Payment Level (after accounting for all SDPs and PTPs)
<i>Ex: Rural Inpatient Hospital Services</i>	<i>80%</i>	<i>20%</i>	<i>N/A</i>	<i>N/A</i>	<i>100%</i>
a. see attached					
b.					
c.					
d.					
e.					
f. I					
g.					

24. Please indicate if the data provided in Table 2 above is in terms of a percentage of:

- a. ☐ Medicare payment/cost
- b. ☐ State-plan approved rates as defined in 42 C.F.R. § 438.6(a) (*Please note, this rate cannot include supplemental payments.*)
- c. ☒ Other; Please define: **Average Commercial Rate**

25. Does the State also require plans to pay any other state directed payments for providers eligible for the provider class described in Question 20b? ☐ Yes ☒ No

If yes, please provide information requested under the column "Other State Directed Payments" in Table 2.

- 26.** Does the State also require plans to pay pass-through payments as defined in 42 C.F.R. § 438.6(a) to any of the providers eligible for any of the provider class(es) described in Question 20b? ☐ Yes ☒ No

If yes, please provide information requested under the column “Pass-Through Payments” in Table 2.

- 27.** Please describe the data sources and methodology used for the analysis provided in response to Question 23.

Commercial comparison rates per visit and per day were obtained through a survey of the eligible hospitals and institutional cost reports. On the inpatient side, the comparison is between the weighted average commercial rates per day and the Medicaid managed care rates per day, including the hospital-specific inpatient uniform add-on. Acute discharges were conservatively estimated to have 3 days per discharge. For outpatient services, the comparison is between the weighted average commercial rates per visit and the Medicaid managed care rates per visit, including the hospital-specific outpatient uniform add-on.

- 28.** Please describe the State's process for determining how the proposed state directed payment was appropriate and reasonable.

The uniform dollar increases are constructed to allow the qualifying financially distressed hospitals to receive sufficient reimbursement to allow their continued ability to serve Medicaid and low-income patient populations while also furthering their transition to Medicaid managed care and the provision of value based services. The uniform dollar amount decreases based on factors that signal financial distress including operating margin and commercial utilization to account for degree of financial distress. The resulting payment amounts remain less than average commercial rates for the eligible class of hospitals.

SECTION IV: INCORPORATION INTO MANAGED CARE CONTRACTS

- 29.** States must adequately describe the contractual obligation for the state directed payment in the state's contract with the managed care plan(s) in accordance with 42 C.F.R. § 438.6(c). Has the state already submitted all contract action(s) to implement this state directed payment? ☒ Yes ☐ No

a. If yes:

- i.** What is/are the state-assigned identifier(s) of the contract actions provided to CMS?

'24-'29 Medicaid Managed Care Model Contract.

- ii.** Please indicate where (page or section) the state directed payment is captured in the contract action(s).

Section 22.19 and Appendix V of the '24-'29 Medicaid Managed Care Model Contract contain the contract provisions for the CMS - approved State Directed Payments.

- b.** If no, please estimate when the state will be submitting the contract actions for review.

SECTION V: INCORPORATION INTO THE ACTUARIAL RATE CERTIFICATION

Note: Provide responses to the questions below for the first rating period if seeking approval for multi-year approval.

- 30.** Has/Have the actuarial rate certification(s) for the rating period for which this state directed payment applies been submitted to CMS? ☒ Yes ☐ No
- a.** If no, please estimate when the state will be submitting the actuarial rate certification(s) for review.
- b.** If yes, provide the following information in the table below for each of the actuarial rate certification review(s) that will include this state directed payment.

Table 3: Actuarial Rate Certification(s)

Control Name Provided by CMS (List each actuarial rate certification separately)	Date Submitted to CMS	Does the certification incorporate the SDP?	If so, indicate where the state directed payment is captured in the certification (page or section)
i. New York_HIV SNP_20250401-20260331_Certification_20250327	03/31/2025	No	
ii. New York_HARP_20250401-20260331_Certification_20250327	03/31/2025	No	
iii. New York_MMC_20250401-20260331_Certification_20250327	03/31/2025	No	
iv.			
v.			

Please note, states and actuaries should consult the most recent [Medicaid Managed Care Rate Development Guide](#) for how to document state directed payments in actuarial rate certification(s). The actuary's certification must contain all of the information outlined; if all required documentation is not included, review of the certification will likely be delayed.)

- c.** If not currently captured in the State's actuarial certification submitted to CMS, note that the regulations at 42 C.F.R. § 438.7(b)(6) requires that all state directed payments are documented in the State's actuarial rate certification(s). CMS will not be able to approve the related contract action(s) until the rate certification(s) has/have been amended to account for all state directed payments. Please provide an estimate of when the State plans to submit an amendment to capture this information.

The approved directed payment will be included in a revised rate certification.

31. Describe how the State will/has incorporated this state directed payment arrangement in the applicable actuarial rate certification(s) (please select one of the options below):

- a. ☐ An adjustment applied in the development of the monthly base capitation rates paid to plans.
- b. ☒ Separate payment term(s) which are captured in the applicable rate certification(s) but paid separately to the plans from the monthly base capitation rates paid to plans.
- c. ☐ Other, please describe:

32. States should incorporate state directed payment arrangements into actuarial rate certification(s) as an adjustment applied in the development of the monthly base capitation rates paid to plans as this approach is consistent with the rate development requirements described in 42 C.F.R. § 438.5 and consistent with the nature of risk-based managed care. For state directed payments that are incorporated in another manner, particularly through separate payment terms, provide additional justification as to why this is necessary and what precludes the state from incorporating as an adjustment applied in the development of the monthly base capitation rates paid to managed care plans.

Given the unique nature of the financially distressed hospitals and contracting MCOs, a separate payment term is appropriate to ensure adequate distribution of the uniform dollar increase for the financially distressed hospitals. Implementation of the uniform dollar increase as a separate payment term will result in administrative efficiencies for all parties involved in the directed payment arrangement. Without the use of a separate payment term, additional administrative burdens would exist and persist, and NYDOH is concerned that plans may have the counterproductive incentive to shift business away from the financially distressed hospitals.

33. ☒ In accordance with 42 C.F.R. § 438.6(c)(2)(i), the State assures that all expenditures for this payment arrangement under this section are developed in accordance with 42 C.F.R. § 438.4, the standards specified in 42 C.F.R. § 438.5, and generally accepted actuarial principles and practices.

SECTION VI: FUNDING FOR THE NON-FEDERAL SHARE

34. Describe the source of the non-federal share of the payment arrangement. Check all that apply:

- a. ☒ State general revenue
- b. ☐ Intergovernmental transfers (IGTs) from a State or local government entity
- c. ☐ Health Care-Related Provider tax(es) / assessment(s)
- d. ☐ Provider donation(s)
- e. ☐ Other, specify:

35. For any payment funded by **IGTs (option b in Question 34)**,

- a. Provide the following (respond to each column for all entities transferring funds). If the state needs more space, please use Addendum Table 4.A and check this box: ☐

Table 4: IGT Transferring Entities

Name of Entities transferring funds (enter each on a separate line)	Operational nature of the Transferring Entity (State, County, City, Other)	Total Amounts Transferred by This Entity	Does the Transferring Entity have General Taxing Authority? (Yes or No)	Did the Transferring Entity receive appropriations? If not, put N/A. If yes, identify the level of appropriations	Is the Transferring Entity eligible for payment under this state directed payment? (Yes or No)
i.					
ii.					
iii.					
iv.					
v.					
vi.					
vii.					
viii.					
ix.					
x.					

- b.** ☐ Use the checkbox to provide an assurance that no state directed payments made under this payment arrangement funded by IGTs are dependent on any agreement or arrangement for providers or related entities to donate money or services to a governmental entity.
- c.** Provide information or documentation regarding any written agreements that exist between the State and healthcare providers or amongst healthcare providers and/or related entities relating to the non-federal share of the payment arrangement. This should include any written agreements that may exist with healthcare providers to support and finance the non-federal share of the payment arrangement. Submit a copy of any written agreements described above.

36. For any state directed payments funded by provider taxes/assessments (option c in Question 34),

- a.** Provide the following (respond to each column for all entries). If there are more entries than space in the table, please provide an attachment with the information requested in the table.

Table 5: Health Care-Related Provider Tax/Assessment(s)

Name of the Health Care-Related Provider Tax / Assessment (enter each on a separate line)	Identify the permissible class for this tax / assessment	Is the tax / assessment broad-based?	Is the tax / assessment uniform?	Is the tax / assessment under the 6% indirect hold harmless limit?	If not under the 6% indirect hold harmless limit, does it pass the “75/75” test?	Does it contain a hold harmless arrangement that guarantees to return all or any portion of the tax payment to the tax payer?
i.						
ii.						
iii.						
iv.						
v.						

- b.** If the state has any waiver(s) of the broad-based and/or uniform requirements for any of the health care-related provider taxes/assessments, list the waiver(s) and its current status:

Table 6: Health Care-Related Provider Tax/Assessment Waivers

Name of the Health Care-Related Provider Tax/Assessment Waiver (enter each on a separate line)	Submission Date	Current Status (Under Review, Approved)	Approval Date
i.			
ii.			
iii.			
iv.			
v.			

37. For any state directed payments funded by **provider donations (option d in Question 34)**, please answer the following questions:

- a.** Is the donation bona-fide? ☐ Yes ☐ No
- b.** Does it contain a hold harmless arrangement to return all or any part of the donation to the donating entity, a related entity, or other provider furnishing the same health care items or services as the donating entity within the class?
☐ Yes ☐ No

38. ☒ **For all state directed payment arrangements**, use the checkbox to provide an assurance that in accordance with 42 C.F.R. § 438.6(c)(2)(ii)(E), the payment arrangement does not condition network provider participation on the network provider entering into or adhering to intergovernmental transfer agreements.

SECTION VII: QUALITY CRITERIA AND FRAMEWORK FOR ALL PAYMENT ARRANGEMENTS

39. ☒ Use the checkbox below to make the following assurance, “In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(C), the State expects this payment arrangement to advance at least one of the goals and objectives in the quality strategy required per 42 C.F.R. § 438.340.”
40. Consistent with 42 C.F.R. § 438.340(d), States must post the final quality strategy online beginning July 1, 2018. Please provide:
- a. A hyperlink to State’s most recent quality strategy: https://www.health.ny.gov/health_care/medicaid/data_rpts/docs/2024-09-05_chplus_quality_strategy_f
 - b. The effective date of quality strategy. December 11, 2024
41. If the State is currently updating the quality strategy, please submit a draft version, and provide:
- a. A target date for submission of the revised quality strategy (month and year):
 - b. Note any potential changes that might be made to the goals and objectives.

Note: The State should submit the final version to CMS as soon as it is finalized. To be in compliance with 42 C.F.R. § 438.340(c)(2) the quality strategy must be updated no less than once every 3-years.

- 42.** To obtain written approval of this payment arrangement, a State must demonstrate that each state directed payment arrangement expects to advance at least one of the goals and objectives in the quality strategy. In the Table 7 below, identify the goal(s) and objective(s), as they appear in the Quality Strategy (include page numbers), this payment arrangement is expected to advance. If additional rows are required, please attach.

Table 7: Payment Arrangement Quality Strategy Goals and Objectives

Goal(s)	Objective(s)	Quality strategy page
<i>Example: Improve care coordination for enrollees with behavioral health conditions</i>	<i>Example: Increase the number of managed care patients receiving follow-up behavior health counseling by 15%</i>	5
a. Prevent and Manage Chronic Diseases	Improve access to and quality of chronic disease management	18
b. Increase Access to Care	Reduce unnecessary ER visits and hospitalizations	18
c.		
d.		

- 43.** Describe how this payment arrangement is expected to advance the goal(s) and objective(s) identified in Table 7. If this is part of a multi-year effort, describe this both in terms of this year's payment arrangement and in terms of that of the multi-year payment arrangement.

The payment arrangement will advance the objectives of "Prevent and Manage Chronic Diseases" and "Increase Access to Care" by reimbursing hospitals who primarily serve Medicaid and uninsured populations, for the purposes of supporting critically needed health care and population health services and to ensure the continued maintenance and operation of such hospitals. The continued maintenance and operation of these hospitals will support the health care safety net at the system and State levels and ensure Medicaid members have access to complete care with the necessary health care providers.

44. Please complete the following questions regarding having an evaluation plan to measure the degree to which the payment arrangement advances at least one of the goals and objectives of the State's quality strategy. To the extent practicable, CMS encourages States to utilize existing, validated, and outcomes-based performance measures to evaluate the payment arrangement, and recommends States use the [CMS Adult and Child Core Set Measures](#), when applicable.

- a.** ☒ In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(D), use the checkbox to assure the State has an evaluation plan which measures the degree to which the payment arrangement advances at least one of the goals and objectives in the quality strategy required per 42 C.F.R. § 438.340, and that the evaluation conducted will be *specific* to this payment arrangement. *Note:* States have flexibility in how the evaluation is conducted and may leverage existing resources, such as their 1115 demonstration evaluation if this payment arrangement is tied to an 1115 demonstration or their External Quality Review validation activities, as long as those evaluation or validation activities are *specific* to this payment arrangement and its impacts on health care quality and outcomes.

- b.** Describe how and when the State will review progress on the advancement of the State's goal(s) and objective(s) in the quality strategy identified in Question 42. For each measure the State intends to use in the evaluation of this payment arrangement, provide in Table 8 below: 1) the baseline year, 2) the baseline statistics, and 3) the performance targets the State will use to track the impact of this payment arrangement on the State's goals and objectives. Please attach the State's evaluation plan for this payment arrangement.

TABLE 8: Evaluation Measures, Baseline and Performance Targets

Measure Name and NQF # (if applicable)	Baseline Year	Baseline Statistic	Performance Target	Notes ¹
<i>Example: Flu Vaccinations for Adults Ages 19 to 64 (FVA-AD); NQF # 0039</i>	<i>CY 2019</i>	<i>34%</i>	<i>Increase the percentage of adults 18–64 years of age who report receiving an influenza vaccination by 1 percentage point per year</i>	<i>Example notes</i>
i. Follow-Up After Hospitalization for Mental Illness (FUH) for members 6 years of age and older within 30 days (NQF # 0576)	CY2019	63%	Improve the percentage of follow-up care by 1 percentage point over baseline	
ii. Follow-up after Emergency Department (ED) visit for Mental Illness (FUM) for members 6 years of age and older within 30 days (NQF # 3489)	CY2019	65%	Increase the percentage of follow-up after ED visits for Mental Illness by 1 percentage point over baseline	
iii.				
iv.				

1. If the State will deviate from the measure specification, please describe here. If a State-specific measure will be used, please define the numerator and denominator here. Additionally, describe any planned data or measure stratifications (for example, age, race, or ethnicity) that will be used to evaluate the payment arrangement.

- c. If this is any year other than year 1 of a multi-year effort, describe (or attach) prior year(s) evaluation findings and the payment arrangement's impact on the goal(s) and objective(s) in the State's quality strategy. Evaluation findings must include 1) historical data; 2) prior year(s) results data; 3) a description of the evaluation methodology; and 4) baseline and performance target information from the prior year(s) preprint(s) where applicable. If full evaluation findings from prior year(s) are not available, provide partial year(s) findings and an anticipated date for when CMS may expect to receive the full evaluation findings.

Please see attached Evaluation Plan: NY_Evl Design_26

Directions

2. For payment arrangements that are intended to require plans to make a payment in addition to the negotiated rates (as noted in option c in Question 22 of the State Directed Payment preprint file), please use the rows in Table 2.A below to add provider classes to Table 2 and an analysis showing the impact of the SDP on payment levels for each additional provider class. States may also use Table 2.A in lieu of completing Table 2 in the preprint. Input data only in beige cells in columns B - G.

States should only submit the tables they populate to CMS; please do not submit the entire workbook unless the State inputs data into Tables 1.A - 8.A. For example, if the state only needs extra rows to complete Table 2. in the preprint, please delete Tabs 1.A and 3.A - 8.A. CMS requests States submit the addendum tables with the preprint in this Excel format; please do not merge and re-PDF the preprint.

TABLE 2.A: Provider Payment Analyses

Column1	Provider Class(es)	Average Base Payment Level from Plans to Providers (absent the SDP)	Effect on Total Payment Level of SDP	Effect on Total Payment Level of Other SDPs	Effect on Total Payment Level of Pass-Through Payments (PTPs)	Total Payment Level (after accounting for all SDPs and PTPs)
Data Format	Free text	Percent (#.#%)	Percent (#.#%)	Percent (#.#%) or N/A	Percent (#.#%) or N/A	Percent (#.#%)
Example	Rural Inpatient Hospital Services	80.0%	20.0%	N/A	N/A	100.0%
a	Inpatient Hospital Services - Acute - Tier 1	39.89%	29.42%	0.26%		69.57%
b	Inpatient Hospital Services - Acute - Tier 2	39.89%	38.78%	0.26%		78.93%
c	Inpatient Hospital Services - Acute - Tier 3	39.89%	44.14%	0.26%		84.29%
d	Inpatient Hospital Services - Psych - Tier 1	73.50%	9.12%	0.47%		83.09%
e	Inpatient Hospital Services - Psych - Tier 2	73.50%	11.40%	0.47%		85.37%
f	Inpatient Hospital Services - Psych - Tier 3	73.50%	13.68%	0.47%		87.65%
g	Outpatient Hospital Services - Clinic - Tier 1	32.37%	14.29%	0.00%		46.66%
h	Outpatient Hospital Services - Clinic - Tier 2	32.37%	28.58%	0.00%		60.95%
i	Outpatient Hospital Services - Clinic - Tier 3	32.37%	42.88%	0.00%		75.25%
j	Outpatient Hospital Services - Amb Surg - Tier 1	27.72%	11.06%	0.00%		38.78%
k	Outpatient Hospital Services - Amb Surg - Tier 2	27.72%	22.13%	0.00%		49.85%
l	Outpatient Hospital Services - Amb Surg - Tier 3	27.72%	33.19%	0.00%		60.91%
m	Outpatient Hospital Services - ED - Tier 1	22.94%	8.73%	0.00%		31.67%
n	Outpatient Hospital Services - ED - Tier 2	22.94%	17.45%	0.00%		40.39%
o	Outpatient Hospital Services - ED - Tier 3	22.94%	26.18%	0.00%		49.12%
p						
q						
r						
s						
t						
u						
v						
w						
x						
y						
z						
aa						
ab						
ac						
ad						
ae						
f						
ga						
gb						
gc						
gd						
ge						
h						
ia						
ib						
ic						
id						
ie						
if						
ig						
ih						
ii						
ij						
ik						
il						
im						
in						
io						
ip						
iq						
ir						
is						
it						
iu						
iv						
iw						
ix						
iy						
iz						
jaa						
jba						
jca						
jda						
jea						
jfa						
jga						
jha						
jia						
jja						
jka						
jla						
jma						
jna						
jpa						
jqa						
jra						
jsa						
jta						
jua						
jva						
jwa						
jxa						
jya						
jza						
kab						
kba						
kca						
kda						
kea						
kfa						
kga						
kha						
kia						
kja						
kla						
kma						
kna						
kpa						
kqa						
kra						
ksa						
kta						
kua						
kva						
kwa						
kxa						
kya						
kza						
lab						
lba						
lca						
lda						
lea						
lfa						
lga						
lha						
lia						
lja						
lma						
lna						
lpa						
lqa						
lra						
lsa						
lta						
lua						
lva						
lwa						
lxa						
lya						
lza						
ma						
mb						
mc						
md						
me						
mf						
mg						
mha						
mhb						
mhc						
mhd						
mea						
mfb						
mfc						
mfd						
meb						
mfb						
mfc						
mfd						
mea						
mfb						
mfc						
mfd						
meb						
mfb						
mfc						
mfd						
mea						
mfb						
mfc						
mfd						
meb						
mfb						
mfc						
mfd						
mea						
mfb						
mfc						
mfd						
meb						
mfb						
mfc						
mfd						
mea						
mfb						
mfc						
mfd						
meb						
mfb						
mfc						
mfd						
mea						
mfb						
mfc						
mfd						
meb						
mfb						
mfc						
mfd						
mea						
mfb						
mfc						
mfd						
meb						
mfb						
mfc						
mfd						
mea						
mfb						
mfc						
mfd						
meb						
mfb						
mfc						
mfd						
mea						
mfb						
mfc						
mfd						
meb						
mfb						
mfc						
mfd						
mea						
mfb						
mfc						
mfd						
meb						
mfb						
mfc						
mfd						
mea						
mfb						
mfc						
mfd						
meb						
mfb						
mfc						
mfd						
mea						
mfb						
mfc						
mfd						
meb						
mfb						
mfc						
mfd						
mea						
mfb						
mfc						
mfd						
meb						
mfb						
mfc						
mfd						
mea						
mfb						
mfc						
mfd						
meb						
mfb						
mfc						
mfd						
mea						
mfb						
mfc						
mfd						
meb						
mfb						
mfc						
mfd						
mea						
mfb						
mfc						
mfd						
meb						
mfb						
mfc						
mfd						
mea						
mfb						
mfc						
mfd						
meb						
mfb						
mfc						
mfd						
mea						
mfb						
mfc						
mfd						
meb						
mfb						
mfc						
mfd						
mea						
mfb						
mfc						
mfd						
meb						
mfb						
mfc						
mfd						
mea						
mfb						
mfc						
mfd						
meb						
mfb						
mfc						
mfd						
mea						
mfb						
mfc						
mfd						
meb						
mfb						
mfc						
mfd						
mea						
mfb						
mfc						
mfd						
meb						
mfb						
mfc						
mfd						
mea						
mfb						
mfc						
mfd						
meb						
mfb						
mfc						
mfd						
mea						
mfb						
mfc						
mfd						
meb						
mfb						
mfc						
mfd						
mea						
mfb						
mfc						

New York Directed Payment Evaluation Findings Template

As indicated in the preprint, states must “describe prior year(s) evaluation findings and the payment arrangement’s impact on the goal(s) and objective(s) in the states quality strategy” in “any year other than Year 1 of a multi-year effort.” By providing evaluation data for each year of the payment arrangement, the state will be able to understand the impact of the payment arrangement over time.

In the Year 2 preprint, the state must include evaluation findings. The state may choose to use the tables below to provide this information. The tables are optional, but encompass CMS’ expectations for what states include when sharing evaluation findings and describing directed payment arrangement evaluations.

Table 1. New York’s Evaluation Findings for Financially Distressed Hospital Preprint

Measure Name	Baseline Year	Baseline Statistic	Performance Target	Evaluation Data				
				Year 1	Year 2	Year 3	Year 4	Year 5
				2021-2022	2022-2023	2023-2024		
Follow-Up After Hospitalization for Mental Illness (FUH) for members 6 years of age and older within 30 days (NQF # 0576)	CY2019	63%	Improve the percentage of follow-up care by 1 percentage point over baseline	70%	70%	66%		
Follow-up after Emergency Department (ED) visit for	CY2019	65%	Increase the percentage of follow-up after ED visits for Mental	Measure Specification change	Measure Specification change	61%		

				Evaluation Data				
Measure Name	Baseline Year	Baseline Statistic	Performance Target	Year 1	Year 2	Year 3	Year 4	Year 5
				2021-2022	2022-2023	2023-2024		
Mental Illness (FUM) for members 6 years of age and older within 30 days (NQF # 3489)			Illness by 1 percentage point over baseline					

*Please include an asterisk next to any findings based on partial year data

Table 2. New York's Evaluation Plan for the Children's Health Home Preprint

<i>Prompt</i>	<i>State Response</i>
<i>Evaluation metrics</i>	
Please share the data source(s) and year(s) of data used to calculate the evaluation metrics.	Medicaid datawarehouse
Please confirm that the data used to calculate the evaluation metrics was limited to Medicaid Managed Care enrollees.	The data is limited to Medicaid Managed Care Enrollees.
Please confirm that the data used to calculate the evaluation metrics was limited to providers participating in the payment arrangement.	The data used to calculate the evaluation metrics is limited to providers participating in the payment arrangement.
<i>Evaluation methodology</i>	
Please identify the entity conducting the evaluation.	Internal state staff.
Please describe the analytic methods used to understand the impact of the payment arrangement. For example, comparison groups, pre-post study design, etc.	Pre-Post comparison
Please share any limitations of the state's evaluation plan.	Claim lag causes a delay in calculating measure results.
<i>Findings</i>	
Please share the state's assessment of the impact of this payment arrangement.	Year 3 results for Follow-up After Hospitalization for Mental Illness remains above the original performance target. Follow-up after Emergency Department Visits still remains below baseline and has not recovered post-COVID. There was a measure specification change that resulted in the baseline rate being recalculated for FUM and results for Year 1 and 2 have not been recalculated with the new specifications.
Please share any relevant context (e.g., changes to the managed care program, COVID-19) that may have impacted the evaluation results	

For all evaluation metrics that did not improve over baseline, please share any plans the state has to address declining performance.	The Department does not have plans to address declining performance in the Follow-up after Emergency Department Visits among the providers in this arrangement. The trend is consistent with overall Medicaid managed care performance results.
--	--