DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Financial Management Group

April 28, 2021

Donna Frescatore
Medicaid Director
NYS Department of Health
One Commerce Plaza
Suite 1211
Albany, NY 12210

Reference: TN 17-0011

Dear Ms. Frescatore:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number 17-0011. Effective January 1, 2017, this amendment revises reimbursement for inpatient hospital services. Specifically, it proposes to provide additional payments to specialty, critical access and physical medical rehabilitation hospitals to account for increases in the minimum wage (MW).

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1923 and 1903(a) of the Social Security Act and the implementing Federal regulations at 42 CFR 447 Subpart C.

This letter is to inform you that Medicaid State Plan Amendment NY-17-0011 is approved effective January 1, 2017. The CMS-179 (HCFA-179) and the plan pages are attached.

If you have any additional questions or need further assistance, please contact Novena James-Hailey at 617-565-1291 or Novena.JamesHailey@cms.hhs.gov.

Sincerely,

[redacted]

For
Rory Howe
Acting Director

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: **17-0011**

2. STATE: **New York**

3. PROGRAM IDENTIFICATION: **TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)**

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
January 1, 2017

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
Section ~~1905(r)(5)~~ of the Social Security Act and 42 CFR 447
1902(a)

7. FEDERAL BUDGET IMPACT: **(in thousands)**
a. FFY 01/01/17-09/30/17 ~~$ 11.64~~ $11.71
b. FFY 10/01/17-09/30/18 ~~$ 25.98~~ $28.58
c. ~~FFY 10/01/18-09/30/19 $ 65.12~~
d. ~~FFY 10/01/19-09/30/20 $ 159.76~~
e. ~~FFY 10/01/20-09/30/21 $ 318.98~~

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-A: Pages ~~105(a), 110(b), 115.2, 116, 117, 117(b), 117(e)~~ 105(b), 105(c), 105(d), 110, 110(b), 115.2, 116, 117, 117(a), 117(b)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-A: Pages ~~105(a), 110(b), 115.2, 116, 117, 117(b), 117(e)~~ 110, 115.2, 116, 117, 117(a), 117(b)

10. SUBJECT OF AMENDMENT: Specialty, Critical Access and Physical Medical Rehabilitation Rates
Minimum Wage – Hospital Inpatient Acute ~~and Exempt Unit Hospital and Exempt Unit Inpatient Rates~~ (FMAP = 50%)

11. 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:

12. SIGNATURE OF STATE AGENCY OFFICIAL:
[redacted]

13. TYPED NAME:

14. TITLE: **Medicaid Director**
Department of Health

15. DATE SUBMITTED: NOV 18 2016

16. RETURN TO:
New York State Department of Health
Bureau of Federal Relations & Provider Assessments
99 Washington Ave – One Commerce Plaza
Suite 1432
Albany, NY 12210

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: November 16, 2016

18. DATE APPROVED: 4/28/21

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
January 1, 2017

20. SIGNATURE OF REGIONAL OFFICIAL:
For

21. TYPED NAME:
Rory Howe

22. TITLE:
Deputy Director, Financial Management Group

23. REMARKS:
Pen and ink changes in blocks 6, 7, 8, 9 and 10 per state request in 4/6/2021 RAI response.

FORM HCFA-179 (07-92)

New York
105(b)

24. *Minimum wage costs* will mean the additional costs incurred by a hospital beginning January 1, 2017, and thereafter, as a result of New York state statutory increases to minimum wage. The following regions' minimum wage will be increased on and after the stated periods as follows:

	December 31, 2016	December 31, 2017	December 31, 2018	December 31, 2019	December 31, 2020	December 31, 2021
New York City	$11.00	$13.00	$15.00	$15.00	$15.00	$15.00
Nassau, Suffolk, & Westchester counties	$10.00	$11.00	$12.00	$13.00	$14.00	$15.00
Remainder of the State	$9.70	$10.40	$11.10	$11.80	$12.50	$12.50

a. For purposes of reimbursement the minimum wage in effect on January 1, 2017 and January 1st of each year thereafter, will be utilized in the calculation of the additional costs due to minimum wage increases.

b. Minimum wage costs will be developed using collected survey data submitted and attested to by the hospital. If a hospital fails to submit a survey, the hospital's minimum wage costs will default to an average wage calculation based on the latest available institutional cost report (ICR) data.

i. Minimum wage cost development based on survey data collected.

1. Survey data will be collected for hospital specific wage data.

2. Hospitals will report by specified wage bands, the total count of FTEs and total hours paid of employees earning less than the statutory minimum wage applicable for the region.

3. Hospitals will report an average fringe benefit percentage of the reported employees.

4. The minimum wage costs are calculated by multiplying the total hours paid by the difference between the statutory minimum wage and the midpoint of each wage band where the hospital has reported total hours paid. To this result, the hospital's average fringe benefit percentage is applied and added to the costs resulting in total minimum wage costs.

ii. Minimum wage cost development based on the latest available institutional cost report (ICR) data.

1. If a hospital failed to submit a minimum wage survey the calculation for minimum wage costs will default to the use of hospital personnel wage data as reported in the ICR.

2. Minimum wage costs will be developed by identifying average hourly wages (exclusive of overtime) of employees in occupational titles where the reported average hourly wage is below the regional statutory minimum wage.

3. The total payroll hours (exclusive of overtime) of the titles identified are then multiplied by the regional statutory minimum wage resulting in a projected payroll (exclusive of overtime). The actual payroll as reported in the ICR is then subtracted from the projected payroll resulting in the expected wage costs.

4. An average fringe benefit percentage is calculated based on a ratio of fringe benefit costs to total wage costs from the ICR. The fringe benefit percentage is applied to the increased wage costs and added resulting in the minimum wage costs.

iii. The total minimum wage costs are included in the calculation of a minimum wage add-on component as described in the Add-Ons to the Acute Rate per Discharge Section.

iv. Minimum Wage Reconciliation - After the end of each calendar year, the Department of Health will survey providers to obtain the following information for the purpose of reconciling annual minimum wage reimbursement. The state will release the survey by the end of March and providers will have two weeks to complete the survey or request an extension if a provider determines it is unable to complete the survey within that time. Approval of extensions, and the time of the extension, is at the discretion of the state. If the survey is not submitted within the two weeks or within the extension time frame, should one be granted, the provider's funding for the calendar year covered by the survey will be recouped.

1. The total annual minimum wage costs incorporated into the inpatient Medicaid rates of payment as a minimum wage add-on for the period. (Supporting documentation detailing the calculation based on the original survey will be supplied by the Department of Health.)

2. The total amount the provider was obligated to pay to bring salaries up to the minimum wage, including fringes for the calendar year. (This information will be completed by the provider.)

3. The State agency will review providers' submissions for accuracy and reasonableness, following which it will process associated payments and recoupments via rate adjustments as quickly as practical thereafter.

4. The agency's Chief Executive Officer or Chief Financial Officer must sign an Attestation verifying the data that is supplied in the survey.

c. In the subsequent year, the Department will survey hospitals utilizing the methodology employed in year one. Once the minimum wage costs are in the base year for rate development, the additional minimum wages costs previously added will be removed.

New York
110

Add-Ons to the Acute Rate Per Discharge.

Rates of payment computed pursuant to this Attachment will include operating cost add-on payments to the statewide base price payment as follows:

1. The base period used for the add-on development will be as defined in the Definitions Section.
2. The costs and discharges used in the development of the add-ons will be total acute inpatient costs and discharges.
3. Medicaid costs will be calculated based on a percentage ratio of Medicaid acute days to Total acute days using the base year days, as defined in the Definitions Section. For the purpose of this Section, Medicaid is as defined in the Definitions Section.
4. All add-on components of the acute operating per discharge rate will be reduced by the Budget Neutrality Factor pursuant to the Statewide Base Price Section of this Attachment.

    a. For rates beginning on and after January 1, 2017, the hospital specific minimum wage payment per discharge, as identified in paragraph (11) of this Section, will be not be subject to a reduction by the "Budget Neutrality Factor" pursuant to the Statewide Base Price Section of this Attachment and will continue until minimum wage costs have been included within the development of the Statewide Base price.

5. A direct graduate medical education (DGME) payment per discharge will be added to the acute rates of teaching general hospitals after the application of SIW, WEF, and Indirect Graduate Medical Education (IME) adjustments to the statewide base price. The DGME will be calculated for each hospital by dividing the facility's total reported Medicaid DGME costs by its total reported Medicaid discharges pursuant to paragraphs (1) through (3) of this Section. DGME costs will be those costs defined in the Definitions Section and trended forward to such rate period in accordance with applicable provisions of this Attachment, and shall be excluded from the cost included in the statewide base price.

6. a. An indirect GME payment per discharge will be added to the acute rates of teaching general hospitals after the application of SIW and WEF adjustments to the statewide base price and will be calculated by multiplying such rates by the indirect teaching cost percentage determined by the following formula:

$$(1 - (1 / (1 + 1.03(((1 + r) ^0.0405) - 1))))$$

where "r" equals the ratio of residents and fellows to beds based on the medical education statistics for the hospital based on paragraph (7) of this Section and the staffed beds for the general hospital reported in the base period, as defined in the Definitions Section, but excluding exempt unit beds and nursery bassinettes.

New York
110(b)

a. For rates beginning on and after January 1, 2017, the hospital specific minimum wage payment per discharge, as identified in paragraph (11) of this Section, will be not be subject to the PPNO and transition adjustments.

11. For rates beginning January 1, 2017, a hospital specific minimum wage payment per discharge will be calculated based on minimum wage costs as defined in paragraph 24 of the Definitions Section and will be added to the acute rate per discharge.

a. A per discharge add-on to the rates will be developed by dividing hospital specific total minimum wage costs by total acute discharges as reported in the latest available institutional cost report.

(3) A hospital without an initial full year of pediatric ventilator service cost and statistics experience will have their physical medical rehabilitation rate, which includes the pediatric ventilator service, calculated as above in 1(b)(iii)(2). Except rather than data from 1(b)(iii)1(b) the costs and statistics used for the pediatric ventilator service will be based on budgeted CON approved costs. The budgeted costs will be subject to review and limitation based on a comparison to other hospitals and nursing homes providing the service.

(a) Budgeted base year costs will be replaced with actual audited costs at the time a full year of actual audited costs are available using data in 1(b)(iii)(1)(b).

(b) The pediatric ventilator service rate developed from actual audited costs will be subject to the same review and limitation based on a comparison to other hospitals and nursing homes providing the service that was initially completed for budgeted costs.

iv. For days of service beginning January 1, 2017, a hospital specific minimum wage payment per day will be calculated based on minimum wage costs as defined in 24 of the Definitions Section and will be added to the physical medical rehabilitation rate. The add-on shall apply only to medical rehabilitation hospitals which do not receive an acute rate per discharge.

a. A per day add-on to the rates will be developed by dividing total hospital specific minimum wage costs by total physical medical rehabilitation days as reported in the latest available institutional cost report.

2. *Chemical dependency rehabilitation inpatient services* shall qualify for reimbursement pursuant to this paragraph for periods on and after December 1, 2009, only if such services are provided in a hospital specializing in such services or in a distinct unit within a general hospital designated for such services and only if:

a. The services provided in such hospital or unit are limited to chemical dependency rehabilitation care and do not include chemical dependency related inpatient detoxification and/or withdrawal services; or

b. Such hospital or unit is licensed to provide such services pursuant to both the Public Health Law and the Mental Hygiene Law and meets the applicable alcohol and/or substance abuse rehabilitation standards set forth in regulations;

i. Any such unit within a hospital must be in a designated area and consist of designated beds providing only chemical dependency rehabilitation inpatient services with adequate adjoining supporting spaces and assigned personnel qualified by training and/or by experience to provide such services and in accordance with any applicable criteria regarding the provision of such services issued by the New York State Office of Alcohol and Substance Abuse Services.

ii. For days of service occurring on and after December 1, 2009, the operating component of rates of payment for inpatient services for facilities subject to this subdivision shall be a per diem amount reflecting the facility's reported 2005 operating costs as submitted to the Department prior to July 1, 2009, not including reported direct medical education costs, and held to a ceiling of 110% of the average of such costs in the region in which the facility is located, as described in paragraph (9) of this section. Such rates shall reflect trend adjustments in accordance with the applicable provisions of this Attachment.

3. *Critical access hospitals.*

a. Rural hospitals shall qualify for inpatient reimbursement as critical access hospitals for periods on and after December 1, 2009, only if such hospitals are designated as critical access hospitals in accordance with the provisions of Title XVIII (Medicare) of the federal Social Security Act.

b. For days of service occurring on and after December 1, 2009, the operating component of rates of payment for inpatient services for facilities subject to this subdivision shall be a per diem amount reflecting the facility's reported 2005 operating costs as submitted to the Department prior to July 1, 2009, and held to a ceiling of 110% of the average of such costs for all such designated hospitals statewide. Such rates shall reflect trend factor adjustments in accordance with the applicable provisions of this Attachment.

c. For days of service beginning January 1, 2017, a hospital specific minimum wage payment per day will be calculated based on minimum wage costs as defined in 24 of the Definitions Section and will be added to the critical access hospital rate.

i. A per day add-on to the rates will be developed by dividing total hospital specific minimum wage costs by total critical access days as reported in the latest available institutional cost report.

4. *Cancer hospitals.*

a. Hospitals shall qualify for inpatient reimbursement as cancer hospitals for periods on and after December 1, 2009, only if such hospitals were, as of December 31, 2008, designated as comprehensive cancer hospitals in accordance with the provisions of Title XVIII (Medicare) of the federal Social Security Act.

b. For days of service occurring on and after December 1, 2009, the operating component of rates of payment for inpatient services for facilities subject to this Section shall be a per diem amount reflecting the facility's reported 2005 operating costs as submitted to the Department prior to July 1, 2009. Such rates shall reflect trend factor adjustments in accordance with the applicable provisions of this Attachment.

c. For days of service beginning January 1, 2017, a hospital specific minimum wage payment per day will be calculated based on minimum wage costs as defined in 24 of the Definitions Section and will be added to the cancer hospital rate.

i. A per day add-on to the rates will be developed by dividing total hospital specific minimum wage costs by total cancer hospital days as reported in the latest available institutional cost report.

5. *Specialty long term acute care hospital.*
   a. Hospitals shall qualify for inpatient reimbursement as specialty long term acute care hospitals for periods on and after December 1, 2009, only if such hospitals were, as of December 31, 2008, designated as specialty long term acute care hospitals in accordance with the provisions of Title XVIII (Medicare) of the federal Social Security Act.

   b. For days of service occurring on and after December 1, 2009, the operating component of rates of payment for inpatient services for facilities subject to this Section shall be a per diem amount reflecting the facility's reported 2005 operating costs as submitted to the Department prior to July 1, 2009. Such rates shall reflect trend factor adjustments in accordance with the applicable provisions of this Attachment.

   c. For days of service beginning January 1, 2017, a hospital specific minimum wage payment per day will be calculated based on minimum wage costs as defined in 24 of the Definitions Section and will be added to the specialty long term care hospital rate.

      i. A per day add-on to the rates will be developed by dividing total hospital specific minimum wage costs by total specialty long term care days as reported in the latest available institutional cost report.

6. *Acute care children's hospitals*. Hospitals shall qualify for inpatient reimbursement as acute care children's hospitals for periods on and after December 1, 2009, only if:
   a. Such hospitals were, as of December 31, 2008, designated as acute care children's hospitals in accordance with the provisions of Title XVIII (Medicare) of the federal Social Security Act; and
   b. Such hospitals filed a discrete 2007 institutional cost report reflecting reported Medicaid discharges of greater than 50 percent of total discharges.

      i. For days of service occurring on and after December 1, 2009, the operating component of rates of payment for inpatient services for facilities subject to this subdivision shall be a per diem amount reflecting the facility's reported 2007 operating costs as submitted to the Department prior to July 1, 2009. Such rates shall reflect trend factor adjustments in accordance with the applicable provisions of this Attachment.

      ii. For days of service beginning January 1, 2017, a hospital specific minimum wage payment per day will be calculated based on minimum wage costs as defined in 24 of the Definitions Section and will be added to the acute care children's hospital rate.

[7. *Substance abuse detoxification inpatient services.* For patients discharged on and after December 1, 2008, rates of payment for general hospitals which are certified by the Office of Alcoholism and Substance Abuse Services (OASAS) to provide services to patients determined to be in the diagnostic category of substance abuse will be made on a per diem basis. This includes inpatient detoxification, withdrawal, and observation services:
   a. MDC 20, DRGs 743 through 751 effective December 1, 2008 through March 31, 2013.
   b. MDC 20, APR-DRGs 770 through 776 effective April 1, 2013. APR-DRGs are more fully described in the Definitions section and the Service Intensity Weights (SIW) and Average Length-of-Stay section of this Attachment.]

New York
117(a)

(1) A per day add-on to the rates will be developed by dividing total hospital specific minimum wage costs by total acute care children's hospital days as reported in the latest available institutional cost report.

7. *Substance abuse detoxification inpatient services.* For patients discharged on and after December 1, 2008, rates of payment for general hospitals which are certified by the Office of Alcoholism and Substance Abuse Services (OASAS) to provide services to patients determined to be in the diagnostic category of substance abuse will be made on a per diem basis. This includes inpatient detoxification, withdrawal, and observation services:

a. MDC 20, DRGs 743 through 751 effective December 1, 2008 through March 31, 2013.

b. MDC 20, APR-DRGs 770 through 776 effective April 1, 2013. APR-DRGs are more fully described in the Definitions section and the Service Intensity Weights (SIW) and Average Length-of-Stay section of this Attachment.

Medically managed detoxification services are for patients who are acutely ill from alcohol and or substance related addictions or dependence, including the need or risk for the need of medical management of severe withdrawal, and/or are at risk of acute physical or psychiatric co-morbid conditions. Medically supervised withdrawal services are for patients at a mild or moderate level of withdrawal, or are at risk for such, as well as patients with sub-acute physical or psychiatric complications related to alcohol and/or substance related dependence, are intoxicated, or have mild withdrawal with a situational crisis, or are unable to abstain yet have no past withdrawal complications.

The per diem rates for inpatient detoxification, withdrawal, and observation services will be determined as follows:

a. The operating cost component of the per diem rates will be computed using 2006 costs and statistics as reported to the Department by general hospitals prior to 2008, adjusted for inflation. The inflation factor will be calculated in accordance with the trend factor methodology described in this Attachment. The average operating cost per diem for the region in which the hospital is located will be calculated using costs incurred for patients requiring detoxification services. The operating cost component of the per diem rates will be transitioned to 2006 as follows:

1. For the period December 1, 2008 through March 31, 2009, 75% of the operating cost component will reflect the operating cost component of rates effective for December 31, 2007, adjusted for inflation, and 25% will reflect 2006 operating costs in accordance with paragraphs (b) through (f).

2. For April 1, 2009 through March 31, 2010, 37.5% of the operating cost component will reflect the December 31, 2007 operating cost component, adjusted for inflation, and 62.5% will reflect 2006 operating costs in accordance with paragraphs (b) through (f).

[3. For periods on and after April 1, 2010, 100% of the operating cost component will reflect 2006 operating costs in accordance with paragraphs (b) through (f).]

New York
117(b)

3. For periods on and after April 1, 2010, 100% of the operating cost component will reflect 2006 operating costs in accordance with paragraphs (b) through (f).

b. For purposes of establishing the average operating cost per diem by region for medically managed detoxification and medically supervised withdrawal services, the regions of the state are defined as follows:

1. New York City – Bronx, New York, Kings and Richmond Counties;
2. Long Island – Nassau and Suffolk Counties;
3. Northern Metropolitan – Columbia, Delaware, Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster and Westchester Counties;
4. Northeast - Albany, Clinton, Essex, Fulton, Greene, Hamilton, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Warren and Washington Counties;
5. Utica/Watertown – Franklin, Herkimer, Lewis, Oswego, Otsego, St. Lawrence, Jefferson, Chenango, Madison and Oneida Counties;
6. Central – Broome, Cayuga, Chemung, Cortland, Onondaga, Schuyler, Seneca, Steuben, Tioga, and Tompkins Counties;
7. Rochester – Monroe, Ontario, Livingston, Wayne and Yates Counties; and
8. Western – Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans and Wyoming Counties.

c. For each of the regions, the 2006 operating costs incurred by general hospitals in such region for providing care to inpatients requiring detoxification services , as defined by OASAS, and reported in the 2006 ICR submitted to the Department prior to 2008, are adjusted by a length of stay (LOS) factor. This LOS factor reflects the loss of revenue due to the reduction of payments for services over the 5th day of stay. The total adjusted operating costs for each region, divided by the total regional days, is the average operating cost per diem for the region.

d. The per diem rates for inpatients requiring medically managed detoxification services will reflect 100% of the average operating cost per diem for the region in which the hospital is located, adjusted for inflation, for the first 5 days of service. However, such payments will be reduced by 50% for services provided on the 6th through 10th day of service. No payments will be made for any services provided on and after the 11th day.

e. Per diem rates for inpatients requiring medically supervised withdrawal services, will reflect 100% of the average operating cost per diem for the region in which the hospital is located, adjusted for inflation, for the period January 1, 2009 through December 31, 2009. For periods on and after January 1, 2010, the per diem rates for withdrawal services will reflect 75% of the average operating cost per diem for the region, adjusted for inflation, and will be reduced by 50% for care provided on the 6th through 10th day of service. No payments will be made for any services provided on and after the 11th day.