NEW YORK
state department of
HEALTH

Nirav R. Shah, M.D., M.P.H.
Commissioner

Sue Kelly
Executive Deputy Commissioner

June 24, 2013

National Institutional Reimbursement Team
Attention: Mark Cooley
CMS, CMCS
7500 Security Boulevard, M/S S3-14-28
Baltimore, MD 21244-1850

Re: SPA #13-41
Inpatient Hospital Services

Dear Mr. Cooley:

The State requests approval of the enclosed amendment #13-41 to the Title XIX (Medicaid) State Plan for inpatient hospital services to be effective April 1, 2013 (Appendix I). This amendment is being submitted based upon enacted legislation. A summary of the proposed amendment is contained in Appendix II.

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

The State of New York pays for inpatient general hospital services using rates determined in accordance with methods and standards specified in an approved State Plan, following a public process, which complies with Social Security Act §1902(a)(13)(A).

Notice of the changes in the methods and standards for setting payment rates for general hospital inpatient services were given in the New York State Register on March 28, 2012 and March 27, 2013.

It is estimated that the changes represented by 2013 payment rates for inpatient general hospital services will have no noticeable short-term or long-term effect on the availability of services on a statewide or geographic area basis, the type of care furnished, or the extent of provider participation.

In accordance with 42 CFR §447.272(c), New York assures that its aggregate disproportionate share hospital payments do not exceed the disproportionate share hospital payment limit.

In accordance with §1923(g) of the Social Security Act, New York assures that it has calculated facility specific limits for disproportionate share payments for each disproportionate

share hospital. New York assures that it will not make disproportionate share payments to a hospital in excess of the facility specific limits established for such hospital.

Copies of pertinent sections of enacted State statute are enclosed for your information (Appendix III). In addition, responses to the five standard funding questions and the standard access questions are also enclosed (Appendix V and VII, respectively).

If you have any questions regarding this matter, please do not hesitate to contact John E. Ulberg, Jr., Medicaid Chief Financial Officer, Division of Finance and Rate Setting at (518) 474-6350.

Sincerely,

Jason A. Helgerson
Medicaid Director
Office of Health Insurance Programs

Enclosures

cc: Mr. Michael Melendez
Mr. Tom Brady

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: **13-41**	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 **April 1, 2013**	

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 1902(a) of the Social Security Act, and 42 CFR 447**	7. FEDERAL BUDGET IMPACT: **a. FFY 04/01/13-09/30/13 $ ($8,550,000)** **b. FFY 10/01/13-03/31/14 $ ($8,550,000)**
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: **Attachment 4.19-A: Pages 120(a)(ii), 120(a)(iv), 120(b), 120(b)(i), 120(b)(i)(1)**	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: **Attachment 4.19-A: Pages 120(a)(ii), 120(a)(iv), 120(b), 120(b)(i), 120(b)(i)(1)**

10. SUBJECT OF AMENDMENT:
Potentially Preventable Negative Outcomes & Health Care Acquired Conditions (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:	16. RETURN TO: **New York State Department of Health** **Bureau of HCRA Operations & Financial Analysis** **99 Washington Ave – One Commerce Plaza** **Suite 810** **Albany, NY 12210**
13. TYPED NAME: **Jason A. Helgerson**	
14. TITLE: **Medicaid Director** **Department of Health**	
15. DATE SUBMITTED: June 24, 2013	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:	18. DATE APPROVED:
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL:	20. SIGNATURE OF REGIONAL OFFICIAL:
21. TYPED NAME:	22. TITLE:

23. REMARKS:

Appendix I
2014 Title XIX State Plan
First Quarter Amendment
Hospital Inpatient Services
Amended SPA Pages

New York
120(a)(iv)

PPC Adjustment Factor.

1. Effective for the period July 1, 2011 through March 31, [2012] 2014, rate adjustments for each hospital will be calculated using 2009 Medicaid claims data for discharges that occurred between January 1, 2009 and December 31, 2009.
2. The hospital-specific coefficient is multiplied by the total number of non-behavioral health Medicaid discharges to compute the PPC penalty. The PPC penalty is then multiplied by the hospital's wage equalization factor (WEF) and, for teaching hospitals, the indirect graduate medical education (IME) factor.
3. The Medicaid case payment rate for the applicable rate period shall be used to compute the total Medicaid operating payments for all non-behavioral health Medicaid discharges in each hospital.
4. For each hospital, a PPC adjustment factor will be computed as the ratio of the hospital's PPC penalty and the hospital's total Medicaid operating payments for all non-behavioral health Medicaid discharges in each hospital as determined pursuant to this section.

Adjustment for Hospitals With Unreliable Present On Admission (POA) Data.

Each hospital will be evaluated on five criteria for the reliability of the POA indicator in Medicaid discharge data. POA data was evaluated using 2009 Statewide Planning and Research Cooperative System (SPARCS) data. Two levels of POA quality will be established for each of the criteria, "red" and "grey" zones. The criteria and levels will be as follows:

1. The percent of pre-existing diagnoses that are coded as not present on admission: "red" will be greater than or equal to 7.5%, "grey" will be greater than or equal to 5%, but less than 7.5%.
2. Excluding pre-existing and exempt diagnoses, the percent of remaining diagnoses coded as uncertain: "red" will be greater than or equal to 10%, "grey" will be greater than or equal to 5%, but less than 10%.
3. Excluding pre-existing, exempt, and perinatal diagnoses, a high percentage of remaining diagnoses coded as present on admission: "red" will be greater than or equal to 96%, "grey" will be greater than or equal to 93%, but less than 96%.
4. Excluding pre-existing, exempt, and perinatal diagnoses, a low percentage of remaining diagnoses coded as present on admission: "red" will be less than or equal to 70%, "grey" will be greater than or equal to 70%, but less than 77%; and

New York
120(a)(ii)

Potentially Preventable Negative Outcomes (PPNOs)

Potentially Preventable Complications (PPC)

For discharges occurring on and after July 1, 2011 through March 31, [2012] 2014, Medicaid rates of payment to hospitals that have higher than expected Medicaid payments related to potentially preventable complications, based on the criteria set forth in the Complication Criteria section, as determined by a risk adjusted comparison of the actual and expected Medicaid payments per case for each hospital as described by the Methodology section, will be reduced in accordance with the PPC Adjustment Factor section. Such rate adjustments will result in an aggregate reduction in Medicaid payments of $[31,257,000] 20,500,000.

Definitions. As used in this Section, the following definitions shall apply:

1. **Potentially Preventable Complications** shall mean harmful events or negative outcomes that develop after hospital admission and may result from processes of care and treatment rather than from natural progression of the underlying illness, as defined under version 28 of the Potentially Preventable Complication grouping logic software developed and published by 3M Health Information Systems, Inc. (3M). The software identifies 1,450 ICD-9-CM diagnosis codes as a PPC diagnoses. Each ICD-9-CM code designated as a PPC diagnosis was assigned to one of 64 mutually exclusive complication groups called PPCs. A list of such PPCs are available on the following Department of Health website link:

   www.health.ny.gov/health_care/medicaid/quality/ppo/complications

2. **Hospital** shall mean a general hospital as defined pursuant to the Hospital Inpatient Reimbursement – Effective December 1, 2009 section, excluding, effective July 1, 2011, those hospitals exempt from the APR-DRG reimbursement methodology and critical access hospitals.
3. **Observed case** shall mean all non-Medicare acute care cases.
4. **PPC Coefficient** shall mean a dollar amount, the result of an indirect standardization, equal to the statewide average incremental Medicaid payment attributable to each of the 64 PPCs.
5. **Adjusted Admission APR-DRG** shall be defined as the assigned hospital admission APR-DRG SOI for each observed case using version 28 of the APR-DRG grouper and results from 3M's PPC grouping logic software. The software results identify each PPC per admission, which has been adjusted to reassign all secondary diagnosis, not identified as a PPC or the direct cause of a PPC, as present on admission.

New York
120(b)

Potentially Preventable Hospital Readmissions (PPR)

For discharges occurring on and after July 1, 2010 through March 31, [2012] 2014, Medicaid rates of payment to hospitals that have an excess number of readmissions based on the criteria set forth in the Readmission Criteria Section, as determined by a risk adjusted comparison of the actual and expected number of readmissions in a hospital as described by the Methodology Section, shall be reduced in accordance with the Payment Calculation Section. Such rate adjustments shall result in an aggregate reduction in Medicaid payments of $27.8 million for the period July 1, 2010 through March 31, 2011; [and] $12 million for the period April 1, 2011 through March 31, 2012; and $13.7 million for the period April 1, 2012 through March 31,2013 and $13.7 million for the period April 1, 2013 through March 31, 2014.

Definitions. As used in this Section, the following definitions shall apply:

1. **Potentially Preventable Readmissions (PPR)** shall mean a readmission to a hospital that follows a prior admission from a hospital within 14 days, and that is clinically-related to the prior hospital admission, as defined under the PPR grouping logic software developed and published by 3M Health Information Systems, Inc. (3M), version 26.1 for the period July 1, 2010 through [June 30]March 31, 2011; [and] version 28 for the period [July]April 1, 2011 through March 31, 2012; and version 29 for the period April 1, 2012 through March 31, 2014.
2. **Hospital** shall mean a general hospital as defined pursuant to the Hospital Inpatient Reimbursement – Effective December 1, 2009 Section, excluding, effective July 1, 2011, those hospitals exempt from the APR-DRG reimbursement methodology and critical access hospitals.
3. **Expected Potentially Preventable Readmissions**, for the period July 1, 2010 through June 30, 2011, are derived using a logistic regression analysis that produces a predicted probability (a number ranging from zero to one) that a hospital admission would be followed by at least one PPR. The total number of expected PPRs shall equal the sum of the expected probabilities of a PPR for all admissions at each hospital. Effective for the period July 1, 2011, through March 31, [2012] 2014, the Expected Potentially Preventable Readmissions shall be derived using [2009] SPARCS Medicaid data, updated annually, through an indirect standardization. A statewide PPR rate, the number of at-risk admissions followed by at least one PPR divided by the total number of at-risk admissions, for every APR-DRG severity of illness (SOI) combination will be multiplied by the number of at-risk admissions in that APR-DRG SOI at each hospital. The sum of all APR-DRG SOI combinations will be the Expected PPRs.
4. **Observed Rate of Readmission** shall mean the number of admissions in each hospital that were actually followed by at least one PPR divided by the total number of admissions.

New York
120(b)(i)

5. **Expected Rate of Readmission** shall mean a risk adjusted rate for each hospital that accounts for the severity of illness, APR-DRG, and age of patients at the time of discharge preceding the readmission. It shall equal the number of expected PPRs divided by the total number of at risk hospital admissions at that hospital.
6. **Excess Rate of Readmission** shall mean the difference between the observed rate of readmission and the expected rate of readmission for each hospital.
7. **Behavioral Health**, for the period July 1, 2010 through June 30, 2011, shall mean an admission that includes a primary or secondary diagnosis of a major mental health related condition. Effective for the period July 1, 2011 through March 31, [2012] 2014, Behavioral Health shall mean an admission that is assigned to a Major Diagnostic Category of 19-Mental Diseases and Disorders or 20-Alcohol/Drug Use and Alcohol/Drug Induced Organic Mental Disorders.
8. **Average Hospital Specific Payment** shall equal the Medicaid operating payment, using the applicable Medicaid rates for such period, of the total number of PPRs identified for each hospital divided by the total number of PPRs identified for each hospital.

Readmission Criteria.

1. A readmission is a return hospitalization following a prior discharge that meets all of the following criteria:
    a. The readmission could reasonably have been prevented by the provision of appropriate care consistent with accepted standards in the prior discharge or during the post discharge follow-up period.
    b. The readmission is for a condition or procedure related to the care during the prior discharge or the care during the period immediately following the prior discharge and including, but not limited to:
        i. the same or closely related condition or procedure as the prior discharge;
        ii. an infection or other complication of care;
        iii. a condition or procedure indicative of a failed surgical intervention; or
        iv. an acute decompensation of a coexisting chronic disease.
    c. The readmission is back to the same or to any other hospital.
2. Readmissions, for the purposes of determining PPRs, excludes the following circumstances:

New York
120(b)(ii)

a. The original discharge was a patient initiated discharge and was Against Medical Advice (AMA) and the circumstances of such discharge and readmission are documented in the patient's medical record.

b. For the period July 1, 2010 through June 30, 2011, the original discharge was for the purpose of securing treatment of a major or metastatic malignancy, multiple trauma, burns, neonatal and obstetrical admissions. Effective for the period July 1, 2011 through March 31, [2012] 2014, the original discharge was for the purpose of securing treatments of the admissions listed on the following Department of Health website link:

www.health.ny.gov/health_care/medicaid/quality/ppo/outcomes

c. The readmission was a planned readmission that occurred on or after 15 days following an initial admission.

d. For readmissions occurring during the period up through March 31, 2012, the readmissions involve a discharge determined to be behavioral health related.

Methodology.

1. For the period July 1, 2010 through June 30, 2011, rate adjustments for each hospital shall be calculated using 2007 Medicaid paid claims data for discharges that occurred between January 1, 2007 and December 31, 2007. Effective for the period July 1, 2011 through March 31, [2012] 2014, rate adjustments for each hospital will be calculated using 2009 Medicaid claims data for discharges that occurred between January 1, 2009 and December 31, 2009.

2. The expected rate of readmission shall be reduced by:

   (a) 24% for periods prior to September 30, 2010;

   (b) 38.5% for the period October 1, 2010 through December 31, 2010;

   (c) 33.3% for the period January 1, 2011 through June 30, 2011.

   (d) 11.4% for periods on and after July 1, 2011.

3. The excess rate of readmission is multiplied by the total number of at risk hospital admissions at each hospital to determine the total number of risk adjusted excess readmissions.

4. In the event the observed rate of readmission for a hospital is lower than the expected rate of readmission, after the expected rate of readmission has been reduced by the applicable percentage in accordance with this section, the risk adjusted excess readmissions shall be set at zero.

Appendix II
2014 Title XIX State Plan
First Quarter Amendment
Hospital Inpatient Services
Summary

SUMMARY
SPA #13-41

This State Plan Amendment proposes to continue, through March 31, 2014, the potentially preventable readmission (PPRs) methodology, which established quality related measures pertaining to potentially preventable conditions and complications of care acquired in the hospital effective July 1, 2011. In addition, this amendment also proposes to continue to deny additional Medicaid payments for costs incurred for hospital acquired conditions (HACs) effective on or after July 1, 2011, which was the result of the Federal Regulation, CMS-2400-F, finalized on June 1, 2011.

Appendix III
2014 Title XIX State Plan
First Quarter Amendment
Hospital Inpatient Services
Authorizing Provisions

CHAPTER 56 OF THE LAWS OF 2013 - PART B

§ 7. Subparagraph (v) of paragraph (b) of subdivision 35 of section 2807-c of the public health law, as amended by section 2 of part G of chapter 56 of the laws of 2012, is amended to read as follows:

(v) such regulations shall incorporate quality related measures, including, but not limited to, potentially preventable re-admissions (PPRs) and provide for rate adjustments or payment disallowances related to PPRs and other potentially preventable negative outcomes (PPNOs), which shall be calculated in accordance with methodologies as determined by the commissioner, provided, however, that such methodologies shall be based on a comparison of the actual and risk adjusted expected number of PPRs and other PPNOs in a given hospital and with benchmarks established by the commissioner and provided further that such rate adjustments or payment disallowances shall result in an aggregate reduction in Medicaid payments of no less than thirty-five million dollars for the period July first, two thousand ten through March thirty-first, two thousand eleven and no less than fifty-one million dollars for annual periods beginning April first, two thousand eleven through March thirty-first, two thousand [~~thirteen~~] fourteen, provided further that such aggregate reductions shall be offset by Medicaid payment reductions occurring as a result of decreased PPRs during the period July first, two thousand ten through March thirty-first, two thousand eleven and the period April first, two thousand eleven through March thirty-first, two thousand [~~thirteen~~] fourteen and as a result of decreased PPNOs during the period April first, two thousand eleven through March thirty-first, two thousand [~~thirteen~~] fourteen; and provided further that for the period July first, two thousand ten through March thirty-first, two thousand [~~thirteen~~] fourteen, such rate adjustments or payment disallowances shall not apply to behavioral health PPRs; or to readmissions that occur on or after fifteen days following an initial admission. By no later than July first, two thousand eleven the commissioner shall enter into consultations with representatives of the health care facilities subject to this section regarding potential prospective revisions to applicable methodologies and benchmarks set forth in regulations issued pursuant to this subparagraph;

Appendix IV
2014 Title XIX State Plan
First Quarter Amendment
Hospital Inpatient Services
Public Notice

DAI will do business as Disability Rights New York (DRNY) andwill operate all of the P&A/CAP programs authorized under federal law. DRNY will continue to serve existing clients and cases of the current P&A system or refer them to other sources of legal advocacy as appropriate, without disruption.

The Governor has, simultaneously with this public notice, provided notice to CQCAPD as the existing P&A and CAP; the State Rehabilitation Advisory Council; and the State Independent Living Council. Interested persons may wish to write to CQCAPD to obtain a copy of its response to that notice. Such requests should be sent to the address above.

Public comment on this redesignation will be accepted until April 5, 2013. Comments should be sent to the following:

Protection and Advocacy Redesignation
The Capitol
Albany, NY 12224
Email: protectionandadvocacy@exec.ny.gov

A public hearing on the proposed redesignation will be held on April 9, 2013, at 1:00 p.m., Empire State Plaza, Meeting Rooms 3 and 4, Albany, New York.

For further information, contact: Protection and Advocacy Redesignation, The Capitol, Albany, New York 12224, Email: protectionandadvocacy@exec.ny.gov

PUBLIC NOTICE

Department of Health

The New York State Department of Health (DOH) is required by the provisions of the federal Beaches Environmental Assessment and Coastal Health (BEACH) Act to provide for public review and comment on the Department's beach monitoring and notification plan. The BEACH Act (Section 406(b) of the Clean Water Act) enacted a federal Environmental Protection Agency grant program available to states, such as New York, with coastal recreational waters. Coastal recreational waters include the Great Lakes and marine coastal waters that are designated for swimming, bathing, surfing, or similar water contact activities. The Act is not applicable to inland waters or waters upstream of the mouth of a river or stream having an unimpaired natural connection with the open sea.

The beach monitoring and public notification plan also includes information on the beach evaluation and classification process, including a list of waters to be monitored and beach ranking. Also included in this plan, is the sampling design and monitoring plan, including sampling location and sampling frequency. Lastly, the plan contains information on procedures for public notification and risk communication, including methods to notify the public of a swimming advisory or beach closure.

Any interested parties and/or agencies desiring to review and/or comment on the beach monitoring and notification plan for coastal recreational waters may do so by writing to: Timothy M. Shay, Section Chief, Department of Health, Center for Environmental Health, Bureau of Community Environmental Health and Food Protection, Empire State Plaza, Corning Tower Bldg., Rm. 1395, Albany, NY 12237, Fax (518) 402-7600

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 inpatient, long term care, and non-institutional services and prescription drugs to comply with recently proposed statutory provisions. The following significant changes and clarifications are proposed:

All Services

• Effective on and after April 1, 2013, no annual trend factor will be applied pursuant to the provisions of Public Health Law § 2807-c(10)(c) to rates of payment for hospital inpatient services, residential health care facility inpatient services, adult day health care outpatient services, hospital outpatient services and diagnostic and treatment care services, certified home health agencies, personal care services, adult day health care services provided to patients diagnosed with AIDS, personal care services provided in those local social services districts, including New York City, whose rates of payment for services is established by such social services districts pursuant to a rate-setting exemption granted by the Department, assisted living program services and hospice services. This includes the elimination of the trend factor effective for Medicaid rate periods April 1, 2013, and thereafter.

The annual decrease in gross Medicaid expenditures for state fiscal year 2013/14 is $436.4 million.

• Continues, effective for dates of service April 1, 2013, through March 31, 2015, all non-exempt Medicaid payments as referenced below will be uniformly reduced by two percent.

The annual decrease in gross Medicaid expenditures for state fiscal year 2013/14 is $714 million.

• The amount appropriated for Essential Community Provider Network and Vital Access Provider initiatives will be increased to $182 million in state fiscal year 2013/14 and subsequently decreased to $153 million in state fiscal year 2014/15. Included in this initiative is a $30 million reallocation of nursing home financially disadvantaged funding to the vital access provider initiative.

The annual increase in gross Medicaid expenditures for state fiscal year 2013/14 is $52 million.

• Consistent with Section 1202 of the Affordable Care Act, certain primary care providers (e.g., physicians, physician's assistants and nurse practitioners) will be reimbursed at the Medicare rate for Medicaid primary care services furnished in calendar years 2013 and 2014 in institutional and non-institutional settings, including nursing homes. This provision applies to evaluation and management (E&M) and vaccine administration services when delivered by a physician with a specialty designation of family medicine, general internal medicine, or pediatric medicine. The purpose of this provision is to encourage more physicians to participate in Medicaid, and thereby promote access to primary care services for current and new Medicaid beneficiaries to be served via coverage expansion in 2014.

It is estimated that the impact to the provider community will be a gross annual increase in state fiscal year 2013/14 of $227.9 million. This includes the State eliminating the physician's portion of the two percent reduction that was enacted as part of the 2011-2012 State Fiscal Year consistent with the Federal Regulation.

Institutional Services

• For the state fiscal year beginning April 1, 2013 through March 31, 2014, continues specialty hospital adjustments for hospital inpatient services provided on and after April 1, 2013, to public general hospitals, other than those operated by the State of New York or the State University of New York, located in a city with a population of over one million and receiving reimbursement of up to $1.08 billion annually. Payments to eligible public general hospitals may be added to rates of payment or made as aggregate payments.

• For state fiscal years beginning April 1, 2013 through March 31, 2016, additional medical assistance payments for inpatient hospital services may be made to public general hospitals operated by the State of New York or the State University of New York, or by a county which shall not include a city with a population over one million, and those public general hospitals located in the counties of Westchester, Erie, or Nassau, up to one hundred percent (100%) of each such public hospital's medical assistance and uninsured patient losses after all other medical assistance, including disproportionate share payments to such general hospitals. Payments may be added to rates of payment or made as aggregate payments. Payments will be based initially on reported reconciled data from the base year two years prior to the payment year adjusted for authorized Medicaid rate changes and further reconciled to actual reported data from such payment year.

• Extends current provisions for services April 1, 2013 through March 31, 2015, the reimbursable operating cost component for general hospital inpatient rates will be established with the 2006 final trend factor equal to the final Consumer Price Index (CPI) for all urban consumers less 0.25%.

• Continues, effective April 1, 2013 through March 31, 2015, budgeted capital inpatient costs of a general hospital applicable to the rate year shall be decreased to reflect the percentage amount by which the budgeted costs for capital related inpatient costs of the hospital for the base year two years prior to the rate year exceeded actual costs.

The annual decrease in gross Medicaid expenditures attributable to these initiatives for state fiscal year 2013/14 is $114.5 million.

• Effective April 1, 2013, rates of payments for general hospitals certified by the Office of Alcoholism and Substance Abuse Services who provide inpatient detoxification and withdrawal services and, for inpatient services provided for patients discharged on and after December 1, 2008, and who are determined to be in diagnosis-related groups as identified and published on the New York State Department of Health website will be made on a per diem basis. Such payments will be made in accordance with existing methodology previously noticed on June 10, 2009.

• The base period reported costs and statistics used for case based rate-setting operating cost components, including the weights assigned to diagnostic related groups, will be updated no less frequently than every four years and the new base period will be no more than four years prior to the first applicable rate period that utilizes such new base period provided, however, that the first updated base period shall begin on January 1, 2014.

• Effective January 1, 2014, the payment rates for hospital DRG exempt services may be adjusted periodically to reflect a more current cost and statistical base year including adjustments deemed necessary by the Commissioner.

• Effective January 1, 2014, hospital inpatient payment rates may be adjusted to include changes to the base year statistics and costs used to determine the direct and indirect graduate medical education components of the rates as a result of new teaching programs at new teaching hospitals and/or as a result of residents displace and transferred as a result of a teaching hospital closure.

• Continues, effective January 1, 2014, the current methodology established to incorporate quality related measures, including, but not limited to potentially preventable re-admissions (PPRs) and provide for rate adjustments or payment disallowances related to PPRs and other potentially preventable negative outcomes (PPNOs), shall be calculated in accordance with the existing methodology.

- Such methodology will be based on a risk adjusted comparison of the actual and the expected number of PPRs and other PPNOs in a given hospital and with benchmarks established by the Commissioner.

- Such rate adjustments or payment disallowances will result in an aggregate reduction in Medicaid payments of no less than $51 million for the period April 1, 2013 through March 31, 2014.

- Such aggregate reductions shall be offset by Medicaid payment reductions occurring as a result of decreased PPRs during the period April 1, 2013 through March 31, 2014 and as a result of decreased PPNOs during the period April 1, 2013 through March 31, 2014. Such rate adjustments or payment disallowances will not apply to behavioral health PPRs or to readmissions that occur on or after 15 days following an initial admission.

Long Term Care Services

• Continues, effective for periods April 1, 2013 through March 31, 2015, the total reimbursable state assessment on each residential health care facility's gross receipts received from all patient care services and other operating income on a cash basis for inpatient or health-related services, including adult day service, but excluding gross receipts attributable to payments received pursuant to Title XVIII of the federal Social Security Act (Medicare), at six percent. The extent to which a facility is reimbursed for the additional cost of the assessment is dependent upon Medicaid volume of services.

The annual increase in gross Medicaid expenditures attributable to these initiatives for state fiscal year 2013/14 is $420 million.

• Continues, effective April 1, 2013 through March 31, 2015, the provision that rates of payment for RHCFs shall not reflect trend factor projections or adjustments for the period April 1, 1996 through March 31, 1997.

• Extends current provisions to services April 1, 2013 through March 31, 2015, the reimbursable operating cost component for RHCFs rates will be established with the final 2006 trend factor equal to the final Consumer Price Index (CPI) for all urban consumers less 0.25%.

Continues, effective April 1, 2013 through March 31, 2015, long-term care Medicare maximization initiatives.

The annual decrease in gross Medicaid expenditures attributable to these initiatives for state fiscal year 2013/14 is $117 million.

• Extends the provision, cost reports submitted by facilities for the 2002 calendar year or any subsequent year used to determine the operating component of the 2009 rate will be subject to audit through December 31, 2018. Facilities will therefore retain all fiscal and statistical records relevant to such cost reports. Any audit of the 2002 cost report, which is commenced on or before December 31, 2018, may be completed subsequent to that date and used for adjusting the Medicaid rates that are based on such costs.

• For state fiscal years beginning April 1, 2013, continues additional payments to non-state government operated public residential health care facilities, including public residential health care facilities located in Nassau, Westchester, and Erie counties, but excluding public residential health care facilities operated by a town or city within a county, in aggregate amounts of up to $300 million. The amount allocated to each eligible public RHCF will be in accordance with the previously approved methodology, provided, however that, in consultation with impacted providers, of the funds allocated for distribution in state fiscal year beginning April 1, 2013, up to $32 million may be allocated proportionally to those public residential health care facilities which were subject to retroactive reductions in payments made for state fiscal year periods beginning April 1, 2006. Payments to eligible RHCF's may be added to rates of payment or made as aggregate payments.

Non-institutional Services

• For state fiscal year beginning April 1, 2013 through March 31, 2014, continues hospital outpatient payment adjustments that increase the operating cost components of rates of payment for hospital outpatient and emergency departments for public general hospitals other than those operated by the State of new York or the State University of New York, which are located in a city with a population of over one million. The eligibility criteria remain unchanged. The amount to be paid will be up to $287 million. Payments to eligible public general hospitals may be added to rates of payment or made as aggregate payments.

• Continues, effective April 1, 2013 through March 31, 2015, the provision that rates of payment for adult day health services shall not reflect trend factor projections or adjustments for the period April 1, 1996 through March 31, 1997.

• Extends current provisions to services April 1, 2013 through March 31, 2015, the reimbursable operating cost component for general hospital outpatient rates and adult day health care services provided by RHCFs rates will be established with the final 2006 trend factor equal to the final consumer price index (CPI) for all urban consumers less 0.25%.

• Extends current provisions for certified home health agency administrative and general cost reimbursement limits for the periods April 1, 2013 through March 31, 2015.

• Continues, effective April 1, 2013 through March 31, 2015, home health care Medicare maximization initiatives.

The annual decrease in gross Medicaid expenditures attributable to these initiatives for state fiscal year 2013/14 is $17.8 million.

• The current authority to adjust Medicaid rates of payment for services provided by certified home health agencies (CHHAs) for such services provided to children under 18 years of age and for services provided to a special needs population of medically complex and fragile children, adolescents and young disabled adults by a CHHA, AIDS home care programs, and hospice programs for purposes of supporting recruitment and retention of non-supervisory health care workers or any worker with direct patient care responsibility has been extended for the period April 1, 2013 through March 31, 2014. Payments shall not exceed in the aggregate, $100 million for such period, and shall be calculated in accordance with the previously approved methodology.

tives for state fiscal year 2012/13 is $100 million, including the redirection of the hospital inpatient Phase II funding.

- Continues Ambulatory Patient Group (APG) rates of payment for Medicaid services for outpatient hospital services, general hospital emergency services, ambulatory surgical services, for dates of service on and after April 1, 2012, and for diagnostic and treatment center services, for dates of services on and after July 1, 2012, except those payments made on behalf of persons enrolled in Medicaid HMO or Family Health Plus.
- For state fiscal year beginning April 1, 2012 and forward provide Medicaid reimbursement to hospitals for inpatient and ambulatory care services, and to free standing diagnostic and treatment centers through modification of APG payments, for the provision of interpretation services for patients with limited English proficiency (LEP) and communication services for people who are deaf and hard of hearing. The increase in gross Medicaid expenditures for state fiscal year 2012/13 is $2.70 million.

Institutional Services

- For the state fiscal year beginning April 1, 2012 through March 31, 2013, continues specialty hospital adjustments for hospital inpatient services provided on and after April 1, 2012, to public general hospitals, other than those operated by the State of New York or the State University of New York, located in a city with a population of over one million and receiving reimbursement of up to $1.08 billion annually. Payments to eligible public general hospitals may be added to rates of payment or made as aggregate payments.
- Effective April 1, 2012, the Commissioner of Health shall incorporate quality related measures including, potentially preventable re-admissions (PPRs) and other potentially preventable negative outcomes (PPNOs) and provide for rate adjustments or payment disallowances related to same. Such rate adjustments or payment disallowances will be calculated in accordance with methodologies, as determined by the Commissioner of Health, and based on a comparison of the actual and risk adjusted expected number of PPRs and other PPNOs in a given hospital and with benchmarks established by the Commissioner. Such adjustments or disallowances for PPRs and other PPNOs will result in an aggregate reduction in Medicaid payments of no less than $51 million annually for periods beginning April 1, 2012 through March 31, 2013, provided that such aggregate reductions shall be offset by Medicaid payment reductions occurring as a result of decreased PPRs for the periods April 1, 2012 through March 31, 2013, and as a result of decreased PPRs and PPNOs for the period April 1, 2012 through March 31, 2013. Such rate adjustments or payment disallowances shall not apply to behavioral health PPRs or to readmissions that occur on or after 15 days following an initial admission. The annual decrease in gross Medicaid expenditures for state fiscal year 2012/13 is $51 million.

Long Term Care Services

- Effective April 1, 2012, for rate periods on and after April 1, 2012, for services provided to residential health care facility residents 21 years of age and older, the Commissioner of Health shall promulgate regulations, which may be emergency regulations, establishing reimbursement rates for reserved bed days, provided, however, that such regulations shall achieve an aggregate annualized reduction in reimbursement for such reserved bed days of no less than $40 million, as determined by the Commissioner.
  - If federal financial participation is not available for rate adjustments, or regulations promulgated thereunder, then, for such rate periods, Medicaid rates for inpatient services shall not include any factor or payment amount for such reserved bed days with regard to residents 21 years of age or older. In addition, for such rate periods upward revisions to Medicaid rates shall be provided, however, such upward revisions shall not in the aggregate, as determined by the Commissioner, exceed, on an annual basis, an amount equal to current annual Medicaid payments for reserved bed days, less than $40 million.
- To clarify the previously noticed provisions of March 30, 2011, December 28, 2011 and March 14, 2012, related to Certified Home Health Agencies (CHHA) episodic pricing, Medicaid payments for services provided by CHHAs will be effective May 1, 2012.
- The current authority to adjust Medicaid rates of payment for personal care services, provided in local social services districts which include a city with a population of over one million persons and distributed in accordance with memorandums of understanding entered into between the State and such local districts for purpose of supporting recruitment and retention of personal care service workers has been extended for the period April 1, 2012 through March 31, 2014. Payments for the periods April 1, 2012 through March 31, 2013; and April 1, 2013 through March 31, 2014, shall not exceed, in the aggregate, $340 million for each applicable period.
- The current authority to adjust Medicaid rates of payment for personal care services provided in local social services districts which shall not include a city with a population of over one million persons, for purpose of supporting recruitment and retention of personal care service workers has been extended for the period April 1, 2012 through March 31, 2014. Payments for the period April 1, 2012 through March 31, 2013; and April 1, 2013 through March 31, 2014, shall be up to $28.5 million for each applicable period.
- The current authority to adjust Medicaid rates of payment for certified home health agencies, AIDS home care programs, and hospice programs for purposes of supporting recruitment and retention of non-supervisory health care workers or any worker with direct patient care responsibility has been extended for the period April 1, 2012 through March 31, 2014. Payments shall not exceed in the aggregate, $100 million for each of the following periods: April 1, 2012 through March 31, 2013; and April 1, 2013 through March 31, 2014, and shall be calculated in accordance with the previously approved methodology. Such adjustments to rates of payment shall be allocated proportionally based on each certified home health agency's, AIDS home care and hospice programs' home health aide or other direct care services total annual hours of service provided to Medicaid patients, as reported in each such agency's most recently available cost report as submitted to the Department. Payments made shall not be subject to subsequent adjustment or reconciliation.

Non-institutional Services

- For State fiscal years beginning April 1, 2012 through March 31, 2013, continues hospital outpatient payment adjustments that increase the operating cost components of rates of payment for hospital outpatient and emergency departments for public general hospitals other than those operated by the State of New York or the State University of New York, which are located in a city with a population of over one million. The eligibility criteria remain unchanged. Payments to eligible public general hospitals may be added to rates of payment or made as aggregate payments. The increase in Medicaid expenditures for state fiscal year 2012/13 is $287 million.
- The Ambulatory Patient Group (APG) reimbursement methodology is revised to include recalculated weights that will become effective on or after April 1, 2012. There is no estimated annual change to gross Medicaid expenditures as a result of this proposal.
- Effective on or after April 1, 2012, adults, age 21 and older, with a diagnosis of diabetes mellitus may obtain podiatry services from podiatrists in private practice. The decrease in gross Medicaid expenditures for state fiscal year 2012/13 is $4.40 million.
- Effective on or after April 1, 2012, lactation counseling services for pregnant and postpartum women will be provided when such services are ordered by a physician, registered physician's assistant, registered nurse practitioner, or licensed midwife and provided by a certified lactation consultant, as determined by the Commissioner of Health. The decrease in gross Medicaid expenditures for state fiscal year 2012/13 is $8.40 million.

Appendix V
2014 Title XIX State Plan
First Quarter Amendment
Hospital Inpatient Services
Responses to Standard Funding Questions

APPENDIX V
HOSPITAL SERVICES
State Plan Amendment #13-41

CMS Standard Funding Questions (NIRT Standard Funding Questions)

The following questions are being asked and should be answered in relation to all payments made to all providers under Attachment 4.19-A of your 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 do retain the payments made pursuant to this amendment. However, this requirement in no way prohibits the public provider, including county providers, from reimbursing the sponsoring local government for appropriate expenses incurred by the local government on behalf of the public provider. The State does not regulate the financial relationships that exist between public health care providers and their sponsoring governments, which are extremely varied and complex. Local governments may provide direct and/or indirect monetary subsidies to their public providers to cover on-going unreimbursed operational expenses and assure achievement of their mission as primary safety net providers. Examples of appropriate expenses may include payments to the local government which include reimbursement for debt service paid on a provider's behalf, reimbursement for Medicare Part B premiums paid for a provider's retirees, reimbursement for contractually required health benefit fund payments made on a provider's behalf, and payment for overhead expenses as allocated per federal Office of Management and Budget Circular A-87 regarding Cost Principles for State, Local, and Indian Tribal Governments. The existence of such transfers should in no way negate the legitimacy of these facilities' Medicaid payments or result in reduced Medicaid federal financial participation for the State. This position was further supported by CMS in review and approval of SPA 07-07C when an on-site audit of these transactions for New York City's Health and Hospitals Corporation was completed with satisfactory results.

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: Payments made to service providers under the provisions of this SPA are funded through a general appropriation received by the State agency that oversees medical assistance (Medicaid), which is the Department of Health. The source of the appropriation is the Local Assistance Account under the General Fund/Aid to Localities.

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 payments authorized for this provision are not supplemental or enhanced payments.

4. **Please provide a detailed description of the methodology used by the state to estimate the upper payment limit (UPL) for each class of providers (State owned or operated, non-state government owned or operated, and privately owned or operated). Please provide a current (i.e. applicable to the current rate year) UPL demonstration. Under regulations at 42 CFR 4447.272, 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: Based on guidance from CMS, the State will submit the current inpatient UPL demonstration by June 30, 2013.

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: The rate methodology included in the approved State Plan for institutional services is prospective payment. We are unaware of any requirement under current federal law or regulation that limits individual provider payments to their actual costs.

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: This SPA does comply 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 11-06, 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.

Appendix VI
2014 Title XIX State Plan
First Quarter Amendment
Hospital Inpatient Services
Responses to Standard Access Questions

APPENDIX VI
INPATIENT SERVICES
State Plan Amendment #13-41

CMS Standard Access Questions

The following questions have been asked by CMS and are answered by the State in relation to all payments made to all providers under Attachment 4.19-A of the state plan.

1. **Specifically, how did the State determine that the Medicaid provider payments that will result from the change in this amendment are sufficient to comply with the requirements of 1902(a)(30)?**

   Response: This amendment seeks to update several components used in the potentially preventable readmission (PPRs) methodology that established quality related measures pertaining to potentially preventable conditions and complications of care acquired in the hospital to be effective July 1, 2011. This plan will continue incentives for healthcare improvement by linking payment to quality measures as a way to focus quality improvement efforts to assist in the design of a safer health care delivery system. Further, this amendment builds off a former approved policy of PPRs. The additional savings is minimal, given the total amount of expenditures for inpatient services. Therefore, the State feels it is compliant with the requirements of 1902(a)(30).

2. **How does the State intend to monitor the impact of the new rates and implement a remedy should rates be insufficient to guarantee required access levels?**

   Response: The State has various ways to ensure that access levels in the Medicaid program are retained and is currently not aware of any access issues, particularly since there is excess bed capacity for both hospitals and nursing homes. Additionally, hospital and nursing home providers must notify and receive approval from the Department's Office of Health Systems Management (OHSM) in order to discontinue services. This Office monitors and considers such requests in the context of access as they approve/deny changes in services. Finally, providers cannot discriminate based on source of payment.

   For providers that are not subject to an approval process, the State will continue to monitor provider complaint hotlines to identify geographic areas of concern and/or service type needs. If Medicaid beneficiaries begin to encounter access issues, the Department would expect to see a marked increase in complaints. These complaints will be identified and analyzed in light of the changes proposed in this State Plan Amendment.

   Finally, the State ensures that there is sufficient provider capacity for Medicaid Managed Care plans as part of its process to approve managed care rates and plans.

Should sufficient access to services be compromised, the State would be alerted and would take appropriate action to ensure retention of access to such services.

3. **How were providers, advocates and beneficiaries engaged in the discussion around rate modifications? What were their concerns and how did the State address these concerns?**

   Response: This change was enacted by the State Legislature as part of the negotiation of the 2013-14 Budget. The impact of this change was weighed in the context of the overall Budget in the State. The legislative process provides opportunities for all stakeholders to lobby their concerns, objections, or support for various legislative initiatives.

4. **What action(s) does the State plan to implement after the rate change takes place to counter any decrease to access if the rate decrease is found to prevent sufficient access to care?**

   Response: Should any essential community provider experience Medicaid or other revenue issues that would prevent access to needed community services, per usual practice, the State would meet with them to explore the situation and discuss possible solutions, if necessary.

5. **Is the State modifying anything else in the State Plan which will counterbalance any impact on access that may be caused by the decrease in rates (e.g. increasing scope of services that other provider types may provide or providing care in other settings)?**

   Response: Over the course of the past three years, the State has undertaken a massive reform initiative to better align reimbursement with care. When fully implemented, the initiative will invest over $600 million in the State's ambulatory care system (outpatient, ambulatory surgery, emergency department, clinic and physicians) to incentivize care in the most appropriate setting. The State has also increased its physician reimbursement schedule to resemble Medicare payments for similar services, thus ensuring continued access for Medicaid beneficiaries. Further, the State is implementing initiatives that will award $600 million annually, over five years, to providers who promote efficiency and quality care through the Federal-State Health Reform Partnership(F-SHRP)/ NYS Healthcare Efficiency and Affordability Law (HEAL). While some of these initiatives are outside the scope of the State Plan, they represent some of the measures the State is taking to ensure quality care for the State's most vulnerable population.