NEW YORK
state department of
HEALTH

Howard A. Zucker, M.D., J.D.
Acting Commissioner of Health

Sue Kelly
Executive Deputy Commissioner

SEP 3 0 2014

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

Re: SPA #14-021
Inpatient Hospital Services

Dear Mr. Cooley:

The State requests approval of the enclosed amendment #14-21 to the Title XIX (Medicaid) State Plan for inpatient hospital services to be effective July 1, 2014 (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 June 25, 2014.

It is estimated that the changes represented by 2014 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 are also enclosed (Appendix V).

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: **14-021**	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 **July 1, 2014**	

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: **§1902(a) of the Social Security Act, and 42 CFR 447**	7. FEDERAL BUDGET IMPACT: **(in thousands)** **a. FFY 07/01/14-09/30/14 $ 0** **b. FFY 10/01/14-09/30/15 $ 0**
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: **Attachment 4.19-A Pages: 103, 104, 105, 105(a), 106, 106(a), 107, 108, 109, 109(a), 110, 110(a), 110(b), 111, 111(a), 111(b), 111(c),112, 113, 114, 121, 123, 124, 125, 126, 127, 128, 129, 137, 138** **Attachment 4.19-A Part I New Pages: See Attachment B**	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: **Attachment 4.19-A Pages: 103, 104, 105, 105(a), 106, 107, 108, 109, 109(a), 110, 110(a), 111, 111(a), 111(b), 112, 113, 114, 121, 123, 124, 125, 126, 127, 128, 129, 137, 138** **Attachment 4.19-A Part I Deleted Pages: See Attachment A**

10. SUBJECT OF AMENDMENT:
Rebase Hospital Acute IP Rates to 2010
(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 Federal Relations & Provider Assessments** **99 Washington Ave – One Commerce Plaza** **Suite 1460** **Albany, NY 12210**
13. TYPED NAME: **Jason A. Helgerson**	
14. TITLE: **Medicaid Director** **Department of Health**	
15. DATE SUBMITTED: SEP 3 0 2014	

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
Third Quarter Amendment
Amended SPA Pages

Appendix II
2014 Title XIX State Plan
Third Quarter Amendment
Summary

SUMMARY
SPA #14-021

This State Plan Amendment proposes to update the cost base used for the non-comparable components of the acute hospital inpatient rates from the 2005 cost base to 2010, effective July 1, 2014. In addition, it proposes to adjust hospital inpatient payment rates as a result of displaced residents due to the closing of a teaching hospital.

Appendix III
2014 Title XIX State Plan
Third Quarter Amendment
Authorizing Provisions

Pursuant to the authority vested in the Commissioner of Health by sections 2807(c)(35), 2807(c)(4)(e-2), and 2807-k(5-b)(a)(ii) of the Public Health Law, Subpart 86-1 of Title 10 of the Official Compilation of Codes, Rules and Regulations of the State of New York, is hereby amended, effective upon filing with the Department of State, to read as follows:

Section 86-1.2 is amended to read as follows:

Section 86-1.2 Financial and statistical data required.

(a) Each medical facility shall complete and file with the department and/or its agent annual financial and statistical report forms supplied by the department and/or its agent. Medical facilities certified for title XVIII (Medicare) shall use the same fiscal year for title XIX (Medicaid) and title B (children's bureau programs) as is used for title XVIII. All other medical facilities must report their operations on a calendar-year basis. Facilities seeking a change in the fiscal year must submit a written application to the department at least 60 days prior to the end of the fiscal year being reported and must provide such documentation as required by the department, including any applicable approval received from the federal government with regard to the facility's Medicare fiscal year.

(b) Financial and statistical reports required by this Subpart shall be submitted to the department and/or its agent no later than 5 months following the close of the fiscal period, unless granted an extension by the department. Extensions of time for filing reports may be granted by the commissioner, and upon application received prior to the due date of the report only in those circumstances where the medical facility establishes, by documentary evidence, that the reports cannot be filed by the due date for reasons beyond the control of the facility.

(c) In the event a medical facility fails to file the required financial and statistical reports on or before the due dates, or as the same may be extended pursuant to subdivisions (b) or (e) of this section, or fails to comply with the provisions of subdivision (k) of this section, the commissioner shall reduce the [current] rate paid by state governmental agencies by two percent for the number of months the reports are outstanding. Months shall be counted [for a period] beginning on the first day of the calendar month following the original due date of the required reports and continuing until the last day of the calendar month in which the required reports are filed.

(d) In the event that any information or data which a facility has submitted to the department on required reports, budgets or appeals for rate revisions intended for use in establishing rates is inaccurate or incorrect, whether by reason of subsequent events or otherwise, such facility shall forthwith submit to the department a correction of such information or data which meets the same certification requirements as the document being corrected.

(e) If the financial and statistical reports required by this Subpart are determined by the department or its agent to be incomplete, inaccurate or incorrect, the facility will [have 30 days from date of receipt of]receive notification to provide the corrected or additional data by a specified date. Failure to file the corrected or additional data [within 30 days]by the specified due date, or within such period as extended by the commissioner, will result in application of

subdivision (c) of this section.

(f) Specific additional data related to the rate setting process may be requested by the commissioner. These data, which may include but are not limited to, those for use in a wage geographic differential survey, a peer grouping data survey, a medical supplies survey, a malpractice insurance survey, a graduate medical education survey and a quarterly utilization survey must be provided by the medical facility within 30 days from the date of receipt of notification to supply such information. The commissioner must supply to each facility, prior to the start of each rate period, a preliminary listing of the data that will be required. Failure to submit the additional data shall result in application of the provisions of subdivision (c) of this section, unless the medical facility can prove by documentary evidence that the data being requested is not available.

(g) General hospitals shall submit to the commissioner at least 120 days prior to the commencement of each [revenue cap]rate year, a schedule of anticipated capital-related inpatient expenses for the forthcoming year pursuant to the provisions of section 86-1.25 of this Subpart.

(h) General hospitals with exempt psychiatric units shall submit hospital data regarding patients in such units as required by the Office of Mental Health (see 14 NYCRR Part 580).

[(i) Each medical facility shall file with the department a complete copy of the U.S Department of the Treasury, Internal Revenue Service, Form 990, for that facility. The Form 990 shall be submitted to the department no later than 30 days following the annual filing with the Internal Revenue Service. Failure to submit the Form 990 shall result in application of the provisions of subdivision (c) of this section.]

[(j)](i) Generally accepted accounting principles. The completion of the financial and statistical report forms shall be in accordance with generally accepted accounting principles as applied to the medical facility, [unless the reporting instructions authorize specific variation in such principles]unless the department's instructions for the annual report set forth specific instructions contrary to those principles.

[(k)](j) Accountant's certification. With regard to institutional cost reports filed for report years prior to 2010, the institutional cost report shall be certified by an independent licensed public accountant or an independent certified public accountant. The minimum standard for the term independent shall be the standard used by the State Board of Public Accountancy.

(1) Certification by operator, officer or official. (1) The institutional cost report shall be certified by the operator of a proprietary medical facility, an officer of a voluntary medical facility, or the public official responsible for the operation of a public medical facility.

(2) The form of the certification required in paragraph (1) of this subdivision shall be as prescribed in the annual fiscal and statistical report forms provided by the commissioner.

Section 86-1.4 is amended to read as follows:

Section 86-1.4 Audits.

(a) All fiscal and statistical records and reports shall be subject to audit. All underlying books, records and documentation which formed the basis for the fiscal and statistical reports, filed by the medical facility with the department, shall b[h]e kept and maintained by the facility for a period of time not less than six years from the date of filing or the date upon which the fiscal and statistical records were to be filed, whichever is the later date. In this respect, any rate of payment certified or established by the State Commissioner of Health prior to audit shall be construed to represent a provisional rate until such audit is performed and completed, at which time such rate or adjusted rate will be construed to represent the audited rate.

(b) Subsequent to the filing of fiscal and statistical reports, field or desk audits will[may] be conducted of the records of medical facilities in a time, manner and place to be determined by the State Department of Health. [Alternatively or in addition the Department may, in its sole discretion, conduct desk audits of such fiscal and statistical reports.]

(c) The required fiscal and statistical reports shall be subject to audit for a period of six years from the date of their filing with the department or from the date when due, whichever is later. This limitation shall not apply to situations in which fraud may be involved, or where the provider or an agent thereof prevents or obstructs the commissioner from performing an audit pursuant to this section.

(d) Upon completion of the audit, the medical facility shall be afforded a closing conference. The medical facility may appear in person or by any one authorized in writing to act on behalf of the medical facility. The medical facility shall be afforded an opportunity at such conference to produce additional documentation in support of any modifications requested in the audit.

(e) The medical facility shall be provided with the audit report[and the rate computation sheet per audit]. The audit report shall be final unless within 30 days of receipt of the audit report, the medical facility initiates a bureau review of such final audit report by notifying the department[Division of Health Care financing] by registered or certified mail, detailing the specific items of the audit report with which the provider disagrees, and such other material as the provider wishes to submit in its behalf, and forwarding all material documentation in support of the medical facility's position.

(f) The medical facility shall be notified in writing of the determination of the controverted items of the final audit report, including a statement of the reasons for such adjustments and the appropriate citation to applicable law, regulation or policy. The audit findings as adjusted in accordance with the determination of the bureau review shall be final, except that the medical facility may, within 30 days of receipt of the determination of the bureau review, initiate a hearing to refute those items of the audit report adverse to the interests of the medical facility presenting a factual issue by serving on the commissioner, by certified or registered mail, a notice containing a statement of the legal authority and jurisdiction under which the hearing should be held, a reference to the particular sections of the statutes and rules involved and a statement of the controverted items of the audit report and bureau determination, together with copies of any documentation relied on by the medical facility in support of its position.

(1) Upon receipt of such notice the commissioner shall:

(i) designate a hearing officer to hear and recommend;

(ii) establish a time and place for such hearing;

(iii) notify the medical facility of the time and place of such hearing at least 15 days prior thereto; and

(iv) include in a notice of hearing those issues of the audit report which are controverted in the notice served on the commissioner by the medical facility.

(2) The issues and documentation presented by the medical facility at such hearing shall be limited to the factual issues and documentation presented at the bureau review.

(3) The audit report shall be presumptive evidence of its content. The burden of proof at any such hearing shall be upon the medical facility to prove by substantial evidence that the items therein contained are incorrect.

(4) The hearing shall be conducted in conformity with section 12-a of the Public Health Law and the State Administrative Procedure Act.

(5) At the conclusion of the hearing the medical facility may submit memoranda on any legal issues which it deems relevant to the proceeding. Such memoranda shall become part of the official record of the hearing.

(g) Rate revisions resulting from the procedure set forth in this section shall be made retroactive to the period or periods during which the rates based on the periods audited were established. Any resulting overpayment or underpayment shall be satisfied by either retroactive adjustment of the provisional rate paid, based on the period audited, or prospective adjustment of the current certified rate at the discretion of the State Commissioner of Health.

(h) Notwithstanding the provisions of this section, the commissioner may promulgate rate revisions based on audits completed by another State agency. Unless otherwise indicated, such audits shall not be considered final and shall not preclude conduct of a complete audit by the State Department of Health or its agent.

(i) (1) Effective for institutional cost reports filed for report periods ending on and after December 31, 2010, the Department shall establish a fee schedule for the purpose of funding audit activities authorized pursuant to this section. Such fee schedule shall be published on the New York State Department of Health website at: http://www.health.state.ny.us. The amount of such fees shall be proportional to the amount of the total costs reported by each facility, provided, however, that minimum and maximum fee levels may be established.

(2) Additional fee obligations shall be established for facilities filing more than two institutional

costs reports for a reporting period. The Department may, upon written application submitted prior to the submission of such additional institutional cost reports, waive or reduce such additional fees based on a showing of financial hardship or a showing that the additional submission is necessitated by Department error or other factors beyond the facility's control. Such a waiver must be in writing.

(3) Fees shall be submitted at the time of the submission of the institutional costs reports. A failure to pay such fees may be deemed by the Department as constituting the non-filing of the institutional cost report and subject the facility to the rate reduction authorized pursuant to section 86-1.2(c) of this Subpart. Failure to pay the additional fee associated with the filing of additional institutional cost reports as described in paragraph (2) of this subdivision shall result in the non-utilization of such revised cost reports by the Department. Delinquent fees may be collected by the Department in accordance with the provisions of paragraph (h) of subdivision 18 of section 2807-c of the Public Health law.

Section 86-1.11 is amended to read as follows:

Section 86-1.11 Termination of service. The [Division of Health Care Financing in the]department shall be notified immediately of the deletion of any previously offered service or of the withholding of services from patients paid for by government agencies. Such notification shall include a statement indicating the date of the deletion or the withholding of such service and the cost impact on the medical facility of such action. Any overpayments by reason of such deletion of previously offered service shall bear interest and be subject to penalties both in the manner provided in section 86-1.4(f) of this Subpart.

Section 86-1.15 is amended to read as follows:

Section 86-1.15 Definitions. As used in this Subpart, the following definitions shall apply:

(a) *Diagnosis related groups (DRGs)* shall mean the All-Patient-Refined (APR) classification system which utilizes diagnostic related groups with assigned weights that incorporate differing levels of severity of a patient's condition [and the associated risk of mortality,] and reflects such factors as the patient's medical diagnosis, severity level, sex, age, and procedures performed.

(b) *DRG case-based payment per discharge* shall mean the payment to be received by a hospital for all inpatient services, except for physician services, rendered to each patient based on the DRG to which that patient has been assigned, as determined by multiplying the statewide base price by the applicable service intensity weight (SIW) and facility-specific wage equalization factor (WEF) and as further adjusted for teaching hospitals by the inclusion of reimbursement for direct and indirect graduate medical education (GME) costs and for all hospitals, the inclusion of non-comparable costs.

(c) *Service intensity weights (SIWs)* are the cost weights established such that the SIW for any given DRG indicates the relative cost of the average cost of the patient in the DRG as compared to the average cost of all patients in all DRGs. Weights are developed using cost data from

Medicaid fee-for-service, Medicaid managed care and commercial payors as reported to the Statewide Planning and Research Cooperative System (SPARCS).

(d) *Case mix index (CMI)* shall mean the relative costliness of a hospital's case mix relative to the case mix of all other hospitals as reflected in the weighted aggregate SIW for the hospital.

(e) *Reimbursable operating costs* shall mean reported operating costs which relate to the cost of providing inpatient hospital services to Medicaid patients, adjusted for inflation between the base period, as defined in subdivision (t) of this section,[used to determine the statewide base price] and the rate period in accordance with trend factors determined pursuant to the applicable provisions of section 2807-c(10) of the Public Health Law, but excluding the following costs:

(1) ALC costs;

(2) Exempt unit costs;

(3) Transfer costs; and

(4) High-cost outlier costs.

(f) *Graduate medical education (GME).* (1) *Direct GME costs* shall mean the reimbursable salaries, fringe benefits, non-salary costs and allocated overhead teaching costs for residents, fellows, and supervising physicians trended to the rate year by the applicable provisions of section 2807-c(10) of the Public Health Law. Only the costs reported for Interns and Residents Services Salary and Fringes, Interns and Residents Services Other Program Costs and Supervising Physician Teaching will be included in the direct GME cost development.

(2) *Indirect GME costs* shall mean an estimate of the costs associated with additional ancillary intensiveness of medical care, more aggressive treatment regimens, and increased availability of state-of-the-art testing technologies resulting from the training of residents and fellows.

(g) *High-cost outlier costs* for payment purposes shall mean 100 percent of the hospital's charges converted to cost, using the hospital's most recent [ratio of cost-to-charges]charge converter, as defined in subdivision (q) of this section, that exceed the DRG specific high-cost thresholds calculated pursuant to section 86-1.21 of this Subpart.

(h) *Alternate level of care (ALC) services* shall mean those services provided by a hospital to a patient for whom it has been determined that inpatient hospital services are not medically necessary, but that post-hospital extended care services are medically necessary, consistent with utilization review standards, and are being provided by the hospital and are not otherwise available.

(i) *Exempt hospitals and units* shall mean those hospitals and units that are paid per diem rates of payment pursuant to the provisions of section 86-1.23 of this Subpart, rather than receiving per discharge case-based rates of payment.

(j) *The wage equalization factor (WEF)* shall mean the mechanism to equalize hospital salary and fringe benefit costs to account for the differences in the price of labor among hospitals and groups of hospitals.

(k) *Statewide Base Price* shall mean the numeric value calculated pursuant to section 86-1.16 of this Subpart which shall be used to calculate DRG case-based payments per discharge as defined in subdivision (b) of this section.

(l) *Non-comparable adjustments* shall mean those base year costs, as defined in subdivision (t) of this section, that are passed through the statewide base price calculation and applied to the case-based rate of payment as an add-on payment. The following shall be considered non-comparable adjustments:

(1) Medicaid costs associated with ambulance services operated by a facility and reported as inpatient costs in the institutional cost report; and

(2) Medicaid costs associated with hospital-based physicians at hospitals designated under the Medicare program as meeting the criteria set forth in section 1861(b)(7) of the federal Social Security Act; and

(3) Medicaid costs associated with schools of nursing operated by the facility and reported as inpatient costs in the Institutional Cost Report.

(m) *Transfers.* For purposes of transfer per diem payments, a transfer patient shall mean a patient who is not discharged as defined in this section, is not transferred among two or more divisions of merged or consolidated facilities, is not assigned to a DRG specifically identified as a DRG for transferred patients only, and meets one of the following conditions:

(1) is transferred from an acute care facility reimbursed under the DRG case-based payment system to another acute care facility reimbursed under this system; or

(2) is transferred to an out-of-state acute care facility; or

(3) is a neonate who is being transferred to an exempt hospital for neonatal services.

(n) *Discharges*, as used in this Subpart, shall mean those inpatients whose admission to the facility occurred on or after December 1, 2009, and:

(1) the patient is released from the facility to a non-acute[nonacute] care setting;

(2) the patient dies in the facility; or

(3) the patient is transferred to a facility or unit that is exempt from the case-based payment system, except when the patient is a newborn transferred to an exempt hospital for neonatal services and thus classified as a transfer patient pursuant to this section; or

(4) the patient is a neonate being released from a hospital providing neonatal specialty services back to the community hospital of birth for weight gain.

(o) *Arithmetic Inlier Length of Stay (ALOS)* shall mean the arithmetic average of the number of days a patient is in the hospital per admission as calculated by counting the number of days from and including the day of admission up to, but not including the day of discharge. The ALOS shall be calculated for each DRG on a statewide basis.

(p) *Hospital*, as used in this Subpart, shall mean "general hospital" as defined in section 2801(10) of the Public Health Law.

(q) *Charge converter* shall mean the ratio of cost to charges using total inpatient costs and total inpatient charges as reported by the hospital in its annual institutional cost reports submitted to the department.

(r) *IPRO* shall mean the Island Peer Review Organization, Inc., a New York not-for-profit corporation providing health related services.

(s) *Medicaid*, for the purposes of this subpart, shall mean Medicaid Fee-for-Service and Medicaid Managed Care for the period beginning October 1, 2010.

(t) *Base period*, for the purposes of this Subpart, shall mean the period as determined pursuant to the applicable provisions of section 2807-c (35) (c) of the Public Health Law and applies to DRG case-based payment per discharge, based on the following:

(1) (i) For periods beginning on December 1, 2009 through June 30, 2014, the "base period" shall be the 2005 calendar year and the data and statistics shall be those reported by each facility pursuant to sections 86-1.2 and reported to the department prior to July 1, 2009.

(ii) For those hospitals operated by the New York City Health and Hospitals Corporation, the base period shall be for the period which ended June 30, 2005, and for those hospitals operated by New York State, excluding the hospitals operated by the State University of New York, the base period shall be the 12-month period which ended March 31, 2006.

(2) (i) For periods beginning on or after July 1, 2014, the "base period" shall be the 2010 calendar year and the data and statistics shall be the audited costs reported by each facility to the department pursuant to sections 86-1.2 and 86-1.4 of this Subpart.

(ii) For those hospitals operated by New York City Health and Hospital Corporation, the base period shall be for the period ended June 30, 2010, and for those hospitals operated by New York State excluding the hospitals operated by the State University of New York, the base period shall be the 12-month period which ended March 31, 2011.

(u) *Divisor for add-ons to the case payment rates per discharge*, as used in this Subpart, shall mean the discharges used in the development of the add-ons pursuant to section 86-1.20 of this Subpart.

(1) For periods beginning on December 1, 2009 through June 30, 2014, the discharges used as the divisor shall be the 2007 calendar year reported to the department prior to July 1, 2009.

(2) For periods beginning on or after July 1, 2014, the discharges used as the divisor shall be the 2011 calendar year reported to the department prior to August 1, 2013.

(v) The year discharges, as used in this Subpart, shall mean the latest calendar year utilized pursuant to section 1.18(d) of this Subpart.

Section 86-1.16 is amended to read as follows:

Section 86-1.16 Statewide base price.

(a) (1) For periods on and after December 1, 2009, a statewide base price per discharge shall be established based on targeted statewide Medicaid inpatient hospital acute operating expenditures. Medicaid shall be as defined in section 86-1.15(s) of this Subpart.[and case-mix and wage neutral reimbursable Medicaid acute operating costs derived from the base period in subdivision (b) of this section, and as adjusted for inflation between the base period and the rate period in accordance with trend factors determined pursuant to applicable provisions of section 2807-c(10) of the Public Health Law, but]

(2) The Medicaid inpatient hospital operating expenditures utilized to derive the statewide base price shall be developed by calculating total targeted Medicaid acute operating payments as identified in subdivision (a)(1) of this section, for acute discharges, identified in subdivision (c) of this section, and excluding the payments [costs] related to graduate medical education,[exempt units,] patient transfers, high-cost outliers,[alternate level of care,] and non-comparables. [Such trended operating costs shall then be divided by Medicaid inpatient discharges in the base period identified in subdivision (b) of this section to establish the average statewide base price per discharge for the applicable rate period.]

(b) (1) For periods beginning on and after July 1, 2014, base year operating cost data, as defined in section 86-1.15(t) of this Subpart, shall be utilized to calculate an operating cost neutral statewide price. [For periods on and after December 1, 2009, the "base period" shall be the 2005 calendar year and "operating costs" shall be those reported by each facility to the department prior to July 1, 2009].

[(1) For those hospitals operated by the New York City Health and Hospitals Corporation, the base period shall be for the period which ended June 30, 2005, and for those hospitals operated by New York State, excluding the hospitals operated by the State University of New York, the base period shall be the 12-month period which ended March 31, 2006.]

(2) To maintain budget neutrality to the targeted statewide Medicaid inpatient hospital acute operating expenditures, pursuant to subdivision (a)(1) of this section, a "budget neutrality factor" shall be applied to the operating cost neutral statewide price, graduate medical education add-ons and non-comparable cost add-ons utilized in the Medicaid payments for acute discharges.

(c)(1)[(2)] Discharges [as defined in section 86-1.15(n) of this Subpart,] used for direct graduate medical education adjustments for this section shall be as defined in sections 86-1.15(n) and 86-1.15(v) of this Subpart [based on reported 2007 data].

(2)[(3)] Discharges, as defined in [subdivision (n) of] section 86-1.15(n) of this Subpart, but excluding the factors set forth in paragraph (3) of such subdivision (n), as used for non-comparable adjustments for this section shall be as defined in section 86-1.15(v) of this Subpart [based on reported 2007 data].

(d)[(c)] (1) For the period effective July 1, 2011 through March 31, 2012, the statewide base price shall be adjusted such that total Medicaid payments are decreased by $24,200,000.

(2) For the period May 1, 2012 through March 31, 2013 and for state fiscal year periods on and after April 1, 2013, the statewide base price shall be adjusted such that total Medicaid payments are decreased for such period and for each such state fiscal year period by $19,200,000.

(e) High-cost outlier payments, from hospitals with ancillary and routine charges schedules, shall be excluded from the statewide base price and shall equal 100 percent of the excess costs above the high cost outlier threshold. The thresholds shall be developed using acute Medicaid operating costs derived from the discharges pursuant to section 86-1.15(v) of this Subpart. For discharges on or after July 1, 2014, the high cost thresholds shall be scaled to maintain budget neutrality to estimated outlier payments pursuant to subdivision (b)(2) of this section. For purposes of determining budget neutrality, the Medicaid discharges to be applied to the high-cost outlier thresholds shall be pursuant to section 86-1.15(v) of this Subpart.

(f) Transfer case payments shall be excluded from the statewide base price by excluding the transfer discharges pursuant section 86-1.15(v) of this Subpart except for those transfer cases that are assigned to a DRG specifically identified as a DRG for transferred patients only.

Section 86-1.17 is REPEALED

Section 86-1.18 is amended to read as follows:

Section 86-1.18 Service Intensity Weights (SIW) and average length-of-stay (LOS).

(a) The table of SIWs and statewide average LOS for each effective period is published on the New York State Department of Health website at: http://www.health.state.ny.us/ and reflects the cost weights and LOS assigned to each All-Patient Refined (APR) diagnosis related group (DRG) patient classification category. The SIWs assigned to each APR/DRG indicates the relative cost variance of that APR/DRG classification from the average cost of all inpatients in all APR/DRGs. Such SIWs are developed using three years of Medicaid fee-for-service cost data, Medicaid managed care data and commercial third party payor data as reported to the Statewide Planning and Research Cooperative System (SPARCS) for the years set forth in subdivision (b) of this section. Costs associated with hospitals that do not have an ancillary charge structure or associated with hospitals and services exempt from the case payment methodology, and costs associated with statistical outliers are excluded from the SIW

calculations.

(b) For periods on and after December 1, 2009, the SIW and statewide average LOS table shall be computed using SPARCS and reported cost data from the 2005, 2006 and 2007 calendar years as submitted to the department by September 30, 2009.

(c) For periods on and after January 1, 2011, the SIW and statewide average LOS table shall be computed using SPARCS and reported cost data from the 2006, 2007 and 2008 calendar years as submitted to the department by June 30, 2010.

(d) For each calendar year thereafter, the SIW and statewide average LOS table shall be updated by dropping the earliest year of SPARCS data and including the next subsequent calendar year data as submitted to the department by September 30 of the year prior to the rate year.

(e) For the period beginning January 1, 2014 through [April]June 30[1], 2014, [but no later than July 1, 2014,] the SIWs and statewide average LOS calculated for the 2013 calendar year will be utilized by the Department.

(f) For the period beginning January 1, 2015 through December 31, 2015, the SIWs and statewide average LOS calculated and utilized for discharges on or after July 1, 2014 through December 31, 2014 will be utilized by the Department.

Section 86-1.19 is amended to read as follows:

Section 86-1.19 Wage Equalization Factor (WEF).

(a) The statewide base price per discharge shall be adjusted by a facility-specific wage equalization factor (WEF) to reflect differences in labor costs between hospitals. Such WEF adjustment shall be used to adjust for the level of wage and fringe benefit costs for each hospital in accordance with the following:

(1) The WEF shall be based on each hospital's occupational mix and wages for registered nurses, licensed practical nurses, surgical technologists, nursing aides, orderlies, attendants and medical assistants as reported and approved by the federal Medicare program, and the hospital's proportion of salaries and fringe benefit costs to total operating costs as reported to the Institutional Cost Report. The WEF shall be computed as follows:

(i) For discharges beginning December 1, 2009, [F]for each occupation described in this paragraph, a statewide average salary shall be calculated by dividing the statewide sum of hospitals' total dollars paid by the statewide sum of hospitals' hours paid. For discharges beginning on and after July 1, 2014 the statewide average salary shall be calculated utilizing an average of three years data by dividing the statewide sum of three years of hospitals' total dollars paid by the statewide sum of three years of hospitals' hours paid. The three years utilized for this calculation shall be the base year pursuant to 86.15(t) and two years prior to the base year; and

(ii) For discharges beginning December 1, 2009, [F]for each hospital an actual weighted average salary shall be calculated by dividing the total dollars paid for such occupations by the total hours paid for such occupations. For discharges beginning on and after July 1, 2014, each hospital's actual weighted average salary shall be calculated by dividing the sum of three years total dollars paid for such occupations by the sum of three years total hours paid for such occupations. The three years utilized for each hospital shall be the three years as identified in subdivision (1)(i) of this section; and

(iii) An initial WEF shall be calculated for each hospital by dividing the hospital-specific actual weighted average salary as calculated pursuant to subparagraph (ii) of this paragraph by the statewide average salary calculated pursuant to subparagraph (i) of this paragraph; and

(iv) The final WEF shall be calculated using the following formula:

(1 / ((Labor Share/initial WEF) + Non-Labor Share))

where "Labor Share" is calculated by dividing the hospital's total salary cost plus the hospital's total fringe benefits by the hospital's total operating costs as reported in the institutional cost report for the [same calendar year used to calculate the statewide] base [price] period as defined in section 86-1.15(t) of this Subpart. The "Non-Labor Share" equals total operating costs less the "Labor Share" of costs.

(2) A hospital may submit updated occupational service data as approved by the federal Department of Health and Human Services prior to January 1 of a rate year for use in calculating the WEF in accordance with this section.

(3) For those hospitals that are in bankruptcy proceedings in the base year and that have subrogated their labor contracts, the commissioner shall use the higher of the hospital-specific or regional average WEF calculated pursuant to this section. These regions will be consistent with those used in the development of the exempt unit cost ceilings.

Section 86-1.20 is amended to read as follows:

Section 86-1.20 Add-ons to the case payment rate per discharge. Rates of payment computed pursuant to this Subpart shall be further adjusted in accordance with the following:

(a) (1)For periods beginning on December 1, 2009 through June 30, 2014, the costs and discharges used in this section shall be total inpatient costs.

(2) For periods beginning on or after July 1, 2014, the costs and discharges used in this section shall be total acute inpatient costs.

(b) For rates beginning on and after July 1, 2014, the Medicaid costs, as used in this section, shall be calculated based on a percentage ratio of Medicaid acute days to Total acute days using base year days as defined in section 86-1.15(t) of this Subpart. For the purpose of this section, Medicaid is defined pursuant to section 86-1.15(s) of this Subpart.

(2) For rates beginning on and after July 1, 2014, all add-on operating cost components of the acute per discharge rate, as identified in this section, shall be reduced by the "Budget Neutrality Factor" pursuant to section 1.16(b)(2) of this Subpart.

[(b)](c)(1) An indirect GME payment per discharge shall be added to the case payment rates of teaching general hospitals after the application of SIW and WEF adjustments to the budget neutral statewide base price, pursuant to section 1.16(b)(2) of this Subpart, and shall 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 subdivision (g) of this section[for the period ended June 30, 2005 as contained in the survey document submitted by the hospital to the department as of June 30, 2009] and the staffed beds for the general hospital reported in the base year as defined in section 86-1.15(t) of this Subpart[2005 institutional cost report and submitted to the department no later than June 30, 2009,] but excluding exempt unit beds and nursery bassinettes.

(2) Indirect GME costs are those costs defined in section 86-1.15(f)(2) of this Subpart, derived from the [same] base period as defined in section 86-1.15(t) of this Subpart[used to calculate the statewide base price for the applicable rate period] and trended forward to such rate period in accordance with applicable provisions of section 2807-c(10) of the Public Health Law, and shall be excluded from computation of the statewide base price. The amount of such exclusion shall be determined by multiplying the total reported Medicaid costs less reported direct GME costs by the following formula:

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

where "r" equals the ratio of residents and fellows to beds as determined in accordance with paragraph (1) of this subdivision.

[(a)] (d) A direct graduate medical education (GME) payment per discharge shall be added to the case payment rates of teaching general hospitals after the application of SIW, [and]WEF and IME adjustments to the budget neutral statewide base price, pursuant to section 1.16(b)(2) of this Subpart, and shall be calculated for each hospital by dividing the facility's total reported Medicaid direct GME costs, pursuant to subdivisions (a) and (b) of this section, by its total reported Medicaid discharges [pursuant to section 86-1.16(b)(2) of this Subpart]. Direct GME costs shall be those costs defined in section 86-1.15(f)(1) of this Subpart, derived from the [same] base period as defined in section 86-1.15(t) of this Subpart[used to calculate the statewide base price for the applicable rate period] and trended forward to such rate period in accordance with applicable provisions of section 2807-c(10) of the Public Health Law, and shall be excluded from the cost included in the statewide base price. Medicaid discharges shall be as defined in sections 86-1.15(n) and 86-1.15(u) of this Subpart and shall include the factors set forth in paragraph (3) of Section 86-1.15(n) of this Subpart.

[(c)](e) A non-comparable payment per discharge shall be added to case payment rates after the application of SIW, [and]WEF and IME adjustments to the budget neutral statewide base price, pursuant to section 1.16(b)(2) of this Subpart, and shall be calculated for each hospital by

dividing the facility's total reported Medicaid costs for qualifying non-comparable cost categories by its total reported Medicaid discharges pursuant to [section 86-1.16(b)(2) of this Subpart]subdivisions (a) and (b) of this section. Non-comparable hospital costs are those costs defined in section 86-1.15(l) of this Subpart, derived from the [same] base period as defined in section 86-1.15(t) of this Subpart[used to calculate the statewide base price for the applicable rate period] and trended forward to such rate period in accordance with applicable provisions of section 2807-c(10) of the Public Health Law, and shall be excluded from the cost included in the statewide base price. Medicaid discharges shall be as defined in sections 86-1.15(n) and 86-1.15(u) of this Subpart.

(f) At the time non-comparable base year costs are updated pursuant to Section 2807-c(35)(c), cost transfers between affiliated facilities, for non-comparable costs as defined in section 1.15(l) of this Subpart for other than DME or IME, due to the transfer of an entire service for organizational restructuring, may be adjusted in the payment rate. The non-comparable costs shall be eliminated from the rate for the hospital closing the service and included in the rate for the receiving hospital. The costs transferred and utilized in the receiving hospital's rate shall be the base year costs of the facility closing the service as defined in section 86-1.15(t) of this Subpart. No revisions to the costs will be allowed.

(g) Hospitals shall furnish to the department such reports and information as may be required by the department to access the cost, quality and health system needs for medical education. Such reports and information shall include, but not be limited to, the Indirect Medical Education Survey.

(1) For rates beginning on December 1, 2009 through June 30, 2014, the ratio of residents and fellows to beds shall be based on the medical education statistics for the hospital for the period ended June 30, 2005 as contained in the survey document submitted by the hospital to the department as of June 30, 2009.

(2) For rates beginning on and after July 1, 2014, the ratio of residents and fellows to beds shall be based on the medical education statistics for the hospital for the period ended June 30, 2010 as contained in the survey document submitted by the hospital to the department as of June 30, 2013.

Section 86-1.21 is amended to read as follows:

Section 86-1.21 Outlier and transfer cases rates of payment

(a)(1) High cost outlier rates of payment shall be calculated by reducing total billed patient charges, as approved by IPRO, to cost[, as determined based on the hospital's ratio of cost to charges]by applying the hospital's charge converter as defined in section 1.15(q) of this Subpart. Such calculation shall use the most recent data available as subsequently updated to reflect the data from the year in which the discharge occurred, and shall equal 100 percent of the excess costs above the high cost outlier threshold. The high cost outlier threshold shall be developed for each DRG using acute Medicaid operating costs which are derived from the discharges pursuant to section 86-1.15(v) of this Subpart, then subsequently adjusted by the hospital specific wage

equalization factor (WEF). For discharges beginning on or after July 1, 2014, the high cost thresholds shall be scaled to maintain budget neutrality to estimated outlier payments pursuant to subdivision (b)(2) of this section.[High cost outlier thresholds shall be developed for each individual DRG and adjusted by hospital-specific wage equalization factors (WEF) and increased by the Consumer Price Index from the base period used to determine the statewide base price and the rate period.]

(2) A non-public, not-for-profit general hospital which has not established an ancillary and routine charges schedule shall be eligible to receive high-cost outlier payments equal to the average of high-cost outlier payments received by comparable hospitals, as determined using the following criteria:

(i) downstate hospitals;

(ii) hospitals with a Medicaid fee for service case mix greater than 1.75;

(iii) hospitals with Medicaid fee for service revenue greater than $30 million of total revenue; and

(iv) hospitals with a proportion of Medicaid fee for service outlier to inlier cases greater than 3.0 percent.

(b) Rates of payment to non-exempt hospitals for inpatients who are transferred to another non-exempt hospital shall be calculated on the basis of a per diem rate for each day of the patient's stay in the transferring hospital, subject to the exceptions set forth in paragraphs (1), (2) and (3) of this subdivision. The total payment to the transferring facility shall not exceed the amount that would have been paid if the patient had been discharged. The per diem rate shall be determined by dividing the DRG case-based payment per discharge as defined in section 86-1.15(b) of this Subpart by the arithmetic inlier length of stay (ALOS) for that DRG, as defined in section 86-1.15(o) of this Subpart, and multiplying by the transfer case's actual length of stay and by the transfer adjustment factor of 120 percent. In transfer cases where the [arithmetic inlier] ALOS for the DRG is equal to one, the transfer adjustment factor shall not be applied.

(1) Transfers among more than two hospitals that are not part of a merged facility shall be reimbursed as follows:

(i) the facility which discharges the patient shall receive the full DRG payment; and

(ii) all other facilities in which the patient has received care shall receive a per diem rate unless the patient is in a transfer DRG.

(2) A transferring facility shall be paid the full DRG rate for those patients in DRGs specifically identified as transfer DRGs.

(3) Transfers among non-exempt hospitals or divisions that are part of a merged [or consolidated] facility shall be reimbursed as if the hospital that first admitted the patient had also discharged the patient.

(4) Services provided to neonates discharged from a hospital providing neonatal specialty services to a hospital reimbursed under the case payment system for purposes of weight gain shall be reimbursed and assigned to the applicable APR-DRG upon admission or readmission.

Section 86-1.22 is amended to read as follows:

Section 86-1.22 Alternate level of care payments.

(a) (1) For rates beginning on December 1, 2009 through June 30, 2014, h[H]ospitals shall be reimbursed for ALC days at the appropriate 1987 group average operating cost component of rates of payment for hospital-based residential health care facilities established pursuant to Subpart 86-2 of this Part trended to the rate year. [The determination of the group average operating rate for hospital-based residential health care facilities shall be based on the combination of residential health care facilities as follows:]

[(1) The downstate group consisting of residential health care facilities located in the five boroughs of New York City and Nassau, Suffolk, Westchester and Rockland Counties.]

(2) For rates beginning on July 1, 2014, hospitals shall be reimbursed for ALC days at the appropriate 2013 group average operating cost component of rates of payment for hospital-based residential health care facilities established pursuant to Subpart 86-2 of this Part trended to the rate year. [The upstate group consisting of all other residential health care facilities in the state.]

(b) (1) For rates beginning on December 1, 2009 through June 30, 2014, the determination of the group average operating rate for hospital-based residential health care facilities shall be based on the combination of residential health care facilities as follows:

(i) The downstate group shall consist of residential health care facilities located in the New York counties of Bronx, New York, Kings, Queens, Richmond, Nassau, Suffolk, Westchester and Rockland.

(ii) The upstate group shall consist of all residential health care facilities in the state other than those included in the downstate group.

(2) For rates beginning July 1, 2014, the determination of the group average operating rate for hospital-based residential health care facilities shall be based on the combination of residential health care facilities as follows:

(i) The downstate group shall consist of residential health care facilities located in the the New York counties of Bronx, New York, Kings, Queens, Richmond, Nassau, Suffolk, Westchester, Rockland, Orange, Putnam and Dutchess.

(ii) The upstate group shall consist of all residential health care facilities in the state other than those included in the downstate group.

(c)[(b)] Hospitals that convert medical/surgical beds to residential health care beds shall be reimbursed for services provided in the converted beds in accordance with Subpart 86-2 of this Part.

Section 86-1.25 has been amended to read as follows:

Section 86-1.25 Capital expense reimbursement

(a) The allowable costs of fixed capital (including but not limited to depreciation, rentals and interest on capital debt), and major movable equipment shall be reimbursed based on budgeted data and shall be reconciled to total actual expense for the rate year and shall be determined and computed in accordance with the provisions of subdivisions (f), (g), and (h) of this section.

(b) General hospitals shall submit a schedule of anticipated inpatient capital-related expenses for the forthcoming year to the commissioner at least 120 days prior to the beginning of the rate year.

(c) The following principles shall apply to budgets for inpatient capital-related expenses:

(1) The basis for determining capital-related inpatient expenses shall be the lesser of actual cost or the final amount specifically approved for construction of the capital asset.

(2) Any capital-related inpatient expense generated by a capital expenditure which requires or required approval pursuant to article 28 of the Public Health Law, must have received such approval for the capital-related expense to be included in the rate calculation.

(3) The submitted budget may include the capital-related inpatient expense of all existing capital assets, as well as estimates of capital-related inpatient expenses for capital assets to be acquired or placed in use prior to the commencement of the rate year.

(4) Any capital-related expense generated by a capital expenditure acquired or placed in use during a rate year shall be carried forward to the subsequent rate year, provided all required approvals have been obtained. In instances where such approvals have been obtained or where approval is not required and such assets are acquired or placed in use during a rate year, the budget may include estimates for capital-related expenses relating to these assets.

(d) Allocation of budgeted capital costs. In each rate year budgeted capital costs shall be allocated to exempt units and hospitals (including certified substance abuse detoxification services) to DRG case payment rates based on reported capital traceback statistics for the two years prior to the rate year.

(e) Payment for budgeted allocated capital costs.

(1) Capital per diems for exempt units and hospitals shall be calculated by dividing the budgeted capital costs allocated to such rates in paragraph (d) of this section by the exempt unit days, reconciled to rate year days and actual rate year exempt unit or hospital-approved capital expense.

(2) Capital payments for DRG case rates shall be determined by dividing the budgeted capital allocated to such rates in paragraph (d) of this section by the hospital's budgeted non-exempt unit discharges, reconciled to rate year discharges and actual rate year non-exempt unit or hospital-approved capital expense.

(3) Capital payments for transferred patients shall be determined by dividing the budgeted capital allocated to the DRG case payment rates by the budgeted nonexempt hospital's unit days, reconciled to rate year days and actual rate year nonexempt unit or hospital approved capital expense.

(f) Depreciation.

(1) Reported depreciation based on historical cost is recognized as a proper element of cost. Useful lives shall be the higher of the reported useful life or those useful lives from the Estimated Useful Lives of Depreciable Hospital Assets, American Hospital Association, consistent with title XVIII provisions. Copies of this publication are available from the American Hospital Association, [One North Franklin]155 N. Wacker Drive, Chicago, IL 60606[-3421], and a copy is available for inspection and copying at the offices of the records access officer of the Department of Health, Corning Tower, Empire State Plaza, Albany, NY 12237.

(2) In the computation of rates for voluntary facilities, depreciation shall be included on a straight line method on plant and nonmovable equipment. Depreciation on movable equipment may be computed on a straight line method or accelerated under a double declining balance or sum-of-the-years' digit method. Depreciation shall be funded unless the commissioner determines, upon application by the facility, and after inviting written comments from interested parties, that the requested waiver of the requirements for funding is a matter of public interest and necessity. In instances where funding is required, such fund may be used only for capital expenditures with approval as required for the amortization of capital indebtedness. Funding for plant and fixed equipment shall mean that the transfer of monies to the funded accounts shall occur by the end of the fiscal period in which the depreciation is recorded. Board-designated funds and the accrual of liabilities to the funded depreciation accounts (due to/from accounts) shall not be recognized as funding of depreciation. Deposits to the funded depreciation accounts must remain in such accounts to be considered as valid funding transactions unless expended for the purpose for which it was funded.

(3) In the computation of rates for public facilities, depreciation is to be included on a straight-line method on plant and nonmovable equipment. Depreciation on movable equipment may be computed on a straight-line method or accelerated under a double declining balance or sum-of-the-years' digits method.

(4) Medical facilities financed by mortgage loans pursuant to the Nursing Home Companies Law

or the Hospital Mortgage Loan Construction Law shall conform to the requirements of this Subpart. In lieu of depreciation and interest, on the loan-financed portion of the facilities, the commissioner shall allow level debt service on the mortgage loan, for all loans approved for financing prior to January 1, 1990, together with such required fixed charges, sinking funds and reserves as may be determined by the commissioner as necessary to assure repayment of the mortgage indebtedness. For loans approved for financing on or after January 1, 1990, medical facilities shall receive reimbursement in the form of interest and depreciation in accordance with the remainder of this Subpart.

[(5) Article IX-C corporations may elect to include in their reimbursement rates depreciation computed by a method other than that used in paragraphs (2) and (3) of this subdivision, subject to approval by the commissioner.]

[(6)](5) With respect to outpatient facilities, capital cost reimbursement may include an amount for rent, provided the following conditions are met:

(i) the lease is reviewed and approved by the department or any other appropriate State agency;

(ii) the space rented is in a multi-purpose, multi-use building not specifically constructed for the purpose of housing an outpatient facility;

(iii) the rental, if the lease is a sublease, is the same or less than comparable leases in the geographic area;

(iv) the applicant has no interest, direct or indirect, beneficial or of record, in the ownership of the building or any overlease; and

(v) the rental per square foot, in the judgment of the department, is the same as or is comparable to other rentals in the building in which the outpatient service is to be located, and the rental per square foot is comparable to the rental of similar space in other comparable buildings in the area when such comparisons can be made.

(g) Interest.

(1) Necessary interest on both current and capital indebtedness is an allowable cost for all medical facilities.

(2) To be considered as an allowable cost, interest shall be incurred to satisfy a financial need, and at a rate not in excess of what a prudent borrower would have had to pay in the money market at the time the loan was made, [and exclude costs and fees] Fees incurred as a result of an interest rate swap agreement are not reimbursable. Also, the interest shall be paid to a lender not related through control, ownership, affiliation or personal relationship to the borrower, except in instances where the prior approval of the commissioner has been obtained. Financial need for capital indebtedness relating to a specific project shall exist when all available restricted funds designated for capital acquisition of that type have been considered for equity purposes.

(3) Interest expense shall be reduced by investment income with the exception of income from funded depreciation, qualified pension funds, trusteed malpractice insurance funds, or in instances where income from gifts or grants is restricted by donors. Interest on funds borrowed from a donor restricted fund or funded depreciation is an allowable expense. Investment income shall be defined as the aggregate net amount realized from dividends, interest, rental income, interest earned on temporary investment of withholding taxes, as well as all gains and losses. If the aggregate net amount realized is a loss, the loss shall not be allowable. Rate year investment income shall reduce rate year interest expense allowed for reimbursement as follows:

(i) for all medical facilities, investment income shall first be used to reduce operating interest expense for that year;

(ii) any remaining amount of investment income, after application of paragraph (i), shall be used to reduce capital interest expense reimbursed that year for medical facilities; and

(iii) any remaining amount of investment income after application of paragraph (ii) shall not be considered in the determination of allowable costs.

(4) Interest on current indebtedness shall be treated and reported as an operating, administrative expense.

(5) Interest on capital indebtedness is an allowable cost if the debt generating the interest is approved by the commissioner, incurred for authorized purposes, and the principal of the debt does not exceed either the approval of the commissioner or the cost of the authorized purposes. Capital indebtedness shall mean all debt obligations of a facility that are:

(i) evidenced by a mortgage note or bond and secured by a mortgage on the land, building or nonmovable equipment; a note payable secured by the nonmovable equipment of a facility; a capital lease;

(ii) incurred for the purpose of financing the acquisition, construction or renovation of land, building or nonmovable equipment;

(iii) found by the commissioner to be reasonable, necessary and in the public interest with respect to the facility. Interest related to refinancing indebtedness shall be considered an allowable cost only to the extent that it is payable with respect to an amount equal to the unpaid principal of the indebtedness then being refinanced. However, interest incurred on refinanced debt in excess of the previously unpaid balance of the refinanced indebtedness will be allowable on acceptable demonstration to the commissioner that such refinancing will result in a debt service savings over the life of the indebtedness; or

(iv) incurred for the purpose of advance refunding of debt. Gains and losses resulting from the advanced refunding of debt shall be treated and reported as a deferred charge or asset. This deferred charge or asset is to be amortized on a straight-line basis over the period to the scheduled maturity date of the refunding debt.

(6) Where a public finance authority has established a mortgage rate of interest such that sufficient cash flows exist to retire the mortgage prior to the stated maturity, the amount of the mortgage to be forgiven, at the time of such forgiveness, shall be capitalized as a deferred asset and amortized over the remaining mortgage life, as a reduction to the facility's capital expense.

(7) Voluntary facilities shall report mortgage obligations financed by public finance authorities for their benefit and which they are responsible to repay, as liabilities in the general fund, when such mortgage obligations are incurred.

(h) Sales, leases and realty transactions.

(1) If a medical facility is sold or leased or is the subject of any other realty transaction before a rate for the facility has been determined and certified by the commissioner, the capital cost component of such rate shall be determined in accordance with the provisions of this section.

(2) If a medical facility is sold or leased or is the subject of any other realty transaction after a rate for the facility has been determined and certified by the commissioner, the capital cost component of such rate shall be considered to be continuing with the same force and effect as though such sale, lease or other realty transaction had not occurred. This subdivision shall not be construed as limiting the powers and rights of the commissioner to change rate computations generally or specifically when based upon previous error, deceit or any other misrepresentation or misstatement that has led the commissioner to determine and certify a rate which he would otherwise not have determined or certified. Further, this subdivision shall not be construed as limiting the powers and rights of the commissioner to reduce rates when one or more of the original property right aspects related to such a facility is terminated.

(3) An arms length lease purchase agreement with a nonrelated lessor involving plant facilities or equipment which meets any one of the four following conditions, establishes the lease as a virtual purchase.

(i) The lease transfers title of the facilities or equipment to the lessee during the lease term.

(ii) The lease contains a bargain purchase option.

(iii) The lease term is at least 75 percent of the useful life of the facilities or equipment. This provision is not applicable if the lease begins in the last 25 percent of the useful life of the facilities or equipment.

(iv) The present value of the minimum lease payments (payments to be made during the lease term including bargain purchase option, guaranteed residual value and penalties for failure to renew) equals at least 90 percent of the fair market value of the leased property. This provision is not applicable if the lease begins in the last 25 percent of the useful life of the facilities or equipment. Present value is computed using the lessee's incremental borrowing rate, unless the interest rate implicit in the lease is known and is less than the lessee's incremental borrowing rate, in which case the interest rate implicit in the lease is used.

(4) If a lease is established as a virtual purchase under subdivision (d) of this section, the rental charge may be included in capital-related costs to the extent that it does not exceed the amount that the provider would have included in capital-related costs if it had legal title to the asset (the cost of ownership). The cost of ownership shall be limited to depreciation and interest. Further, the amounts to be included in capital-related costs are determined as follows:

(i) The difference between the amount of rent paid and the amount of rent allowed as capital-related costs is considered a deferred charge and is capitalized as part of the historical cost of the asset when the asset is purchased.

(ii) If an asset is returned to the owner instead of being purchased, the deferred charge may be included in capital-related costs in the year the asset is returned.

(iii) If the term of the lease is extended for an additional period of time at a reduced lease cost and the option to purchase still exists, the deferred charge may be included in capital-related costs to the extent of increasing the reduced rental to an amount not in excess of the cost of ownership.

(iv) If the term of the lease is extended for an additional period of time at a reduced lease cost and the option to purchase no longer exists, the deferred charge may be included in capital-related costs to the extent of increasing the reduced rental to a fair rental value.

(v) If the lessee becomes the owner of the leased asset (either by operation of the lease or by other means), the amount considered as depreciation for the purpose of having computed the limitation on rental charges under subdivision (e) of this section, must be used in calculating the limitation on adjustments for the purpose of determining any gain or loss upon disposal of an asset.

(vi) In the aggregate, the amount of rental or lease costs included in capital-related costs may not exceed the amount of the costs of ownership that the provider could have included in capital-related costs had the provider legal title to the asset.

(5) If a facility enters into a sale and leaseback agreement involving plant facilities or equipment, the amounts to be included in capital-related costs both on an annual basis and over the useful life of the asset shall not exceed the costs of ownership which shall be limited to depreciation and interest, and shall be determined as follows:

(i) If the annual rental or lease costs in the early years of the lease are less than the annual costs of ownership, but in the later years of the lease the annual rental or lease costs are more than the annual costs of ownership, in the years that the annual rental or lease costs are more than the annual costs of ownership, the facility may include in capital-related costs annually the actual amount of rental or lease costs, except that in any given year, the amount included in capital related costs is limited to an amount which would not cause the aggregate rental or lease costs included up to that year in capital-related costs to exceed the costs of ownership that would have been included in capital-related costs up to that year if the provider had retained legal title to the asset.

(ii) If the annual rental or lease costs in the early years of the lease exceed the annual costs of ownership, but in the later years of the lease the annual rental or lease costs are less than the annual costs of ownership, the facility may carry forward amounts of rental or lease costs that were not included in capital-related costs in the early years of the lease due to the costs of ownership limitation, and include these amounts in capital-related costs in the years of the lease when the annual rental or lease costs are less than the annual costs of ownership, provided, however, in any given year the amount of actual annual rental or lease costs plus the amount carried forward to that year may not exceed the amount of the costs of ownership for that year.

(iii) In the aggregate, the amount of rental or lease costs included in capital-related costs may not exceed the amount of the costs of ownership that the provider could have included in capital-related costs if the provider had retained legal title to the asset.

(iv) If a facility enters into a sale and leaseback agreement involving land, the incurred rental for the cost of land may not be included in allowable costs.

Section 86-1.32 has been amended to read as follows:

Section 86-1.32 - Administrative rate appeals

(a) Administrative rate appeals of rates of payment issued pursuant to this Subpart must be submitted to the department in writing within [120]60 days of the date such rates are issued by the department to the facility. Challenges to the rate setting methodology, as set forth in applicable statutes and regulations, shall not constitute valid administrative rate appeals and shall not be processed as validly filed rate appeals. [r]Rate appeals must set forth in detail the basis for [such] the appeal and be accompanied by any relevant supporting documentation. Appeals that lack appropriate documentation will not be considered as validly filed administrative rate appeals. Thereafter the department shall respond to [such] validly filed administrative rate appeals in writing and shall either affirm the original rates, revise such rates or request additional information. A failure to respond to the department's request for additional information within 30 days shall be deemed to constitute the withdrawal, with prejudice, of the facility's rate appeal, provided, however, that the department may extend that time period upon a request by the facility and for good cause shown. Upon its receipt of the requested additional information the department shall issue a written determination of such rate appeal.

(b) The department's written determination of a facility's rate appeal shall be deemed final unless the facility submits a written request for further consideration of the rate appeal within 30 days of the date the department issued such written determination, provided, however, that if such written determination advises the facility that its [rate appeal] submission is being [denied] rejected on the ground that [the appeal] it constitutes a challenge to the rate[-]setting methodology [set forth in this Subpart] and does not constitute a validly filed administrative rate appeal, such denial shall be deemed to be the department's final administrative determination [with regard to such appeal] and there shall be no further administrative review available. The department shall otherwise respond in writing to such further appeal and either affirm or revise its original rate appeal determination and this response by the department shall be deemed its

final administrative determination with regard to such rate appeal.

[(c) Rate appeals which are rejected or precluded on the grounds of being untimely may be considered in connection with subsequent audits conducted pursuant to section 86-1.4 of this Subpart.]

[(d)](c) The department shall consider only those rate appeals that reflect one or more of the following:

(1) Mathematical or clerical errors [in the financial and/or statistical data originally submitted by the medical facility, including information reported to the New York State Statewide Planning and Research Cooperate System (SPARCS) in accordance with section 400.18 of this Title, or mathematical or clerical errors] made by the department. [Revised data submitted by a facility must meet the same certification requirements as the original data and the department may require verification of revised SPARCS data by an independent review agent at the cost of the facility]; and

[(2) Any errors regarding a medical facility's capital cost reimbursement; and]

[(3)](2) Beginning on or after January 1, 2014, [D]direct medical education (DME) and indirect medical education (IME) costs, as defined in section 86-1.15(f)(1) and (f)(2) of this Subpart, for hospitals where the teaching status has changed from non-teaching to teaching.

(i) The effective date of the initial rate adjustment will be the later of the first of the month following 60 days from the department's receipt of the written notification with documentation requesting a rate adjustment or July 1st of the program year; and

(3) Beginning on or after July 1, 2014, direct and indirect medical education costs, as defined in section 86-1.15(f)(1) and 86-1.15(f)(2) of this Subpart, for displaced residents due to the closing of a teaching hospital.

(i) The effective date of the initial rate adjustment will be the later of the first of the month following the department's receipt of the written notification with documentation requesting a rate adjustment or the date the hospital has taken in the displaced residents.

(d) The budgeted capital cost schedule, submitted pursuant to section 86-1.25(b) of this Subpart, may be revised only during the rate notice period referred to as the "hotline" period that the applicable schedule is required; and

(e) The department may refuse to accept or consider a rate appeal from a facility that:

(1) is providing an unacceptable level of care as determined after review by the State Hospital Review and Planning Council; or

(2) is operated by the same management that operates a facility with regard to which a determination of an unacceptable level of care has been made in accordance with paragraph (1)

of this subdivision; or

(3) has been determined by the department as being operated by a person or persons not properly established or licensed pursuant the Public Health Law; or

(4) is delinquent in the payment of a fine or penalty imposed on the facility pursuant to the Public Health Law.

Section 86-1.33 has been amended to read as follows:

Section 86-1.33 Out-of-state providers
(a) For discharges occurring on and after December 1, 2009, rates of payment for inpatient hospital services provided by out-of-state providers in accordance with the prior approval requirements set forth in section 365-a(4)(d) of the Social Services Law shall be as follows:

(1) (i)The weighted average of inpatient rates, including a teaching adjustment where applicable, in effect for similar services for hospitals located in the downstate region of New York State shall apply with regard to services provided by out-of-state providers located in the New Jersey counties of Sussex, Passaic, Bergin, Hudson, Essex, Union, Middlesex and Monmouth, in the Pennsylvania county of Pike, and in the Connecticut counties of Fairfield and Litchfield.

(ii) For rates effective beginning [January 1]March 13, 2014, the weighted average of inpatient rates, including a teaching adjustment where applicable, in effect for similar services for hospitals located in the downstate region of New York State shall also apply with regard to services provided by out-of-state providers located in cities where the city's population census is 500,000 or greater based on the U. S. Department of Commerce, United States Census Bureau; and

(2) The weighted average of inpatient rates, including a teaching adjustment where applicable, in effect for similar services for hospitals located in the upstate region of New York State shall apply with regard to all other out-of-state providers.

(3) High cost outlier rates of payment shall be calculated in accordance with 86-1.21 with the exception of the wage equalization factor (WEF) being based upon the weighted average of the upstate or downstate region.

(4) The weighted average of the capital component of the inpatient rates in effect for similar services for hospitals located in New York State shall apply with regard to services provided by out-of-state providers.

(b) Notwithstanding any inconsistent provision of this section, in the event the department determines that an out-of-state provider is providing services that are not available within New York State, the department may negotiate payment rates and conditions with such provider; provided however, such payments shall not exceed the provider's usual and customary charges for such services.

(c) For purposes of this section, the downstate region of New York State shall consist of the New York counties of Bronx, New York, Kings, Queens, Richmond, Nassau, Suffolk, Westchester, Rockland, Orange, Putnam and Dutchess. The upstate region of New York State shall consist of all other New York counties.

Section 86-1.38 has been amended to read as follows:

Section 86-1.38 Transition [pool for 2010-2013 period.]

(a) Subject to the availability of federal financial participation, the commissioner may, for rate periods effective on and after October 20, 2010 through March 31, 2014, increase inpatient Medicaid fee-for-service rates subject to this Subpart for the following periods and in the following amounts:

(1) for the period October 20, 2010 through March 31, 2011, up to thirty-seven million five hundred thousand dollars;

(2) for the period April 1, 2011 through March 31, 2012, up to seventy-five million dollars;

(3) for the period April 1, 2012 through March 31, 2013, up to fifty million dollars;

(4) for the period April 1, 2013 through March 31, 2014, up to twenty-five million dollars.

(b) The distributions authorized pursuant to subdivision (a) of this section shall be made available through a reduction, as determined by the commissioner, in the state-wide base price as otherwise computed in accordance with this Subpart.

(c) Hospitals eligible for distributions pursuant to subdivision (a) of this section shall be public and non-public general hospitals with Medicaid inpatient discharges equal to or greater than seventeen and one-half percent as reported for the 2007 period.

(d) Funds allocated pursuant to subdivision (a) of this section shall be allocated to eligible hospitals pursuant to a formula, as determined by the commissioner, such that, to the extent of funds available, no hospital's reduction in total Medicaid fee-for-service inpatient revenue for the corresponding rate periods, as a result of the application of otherwise applicable rate-setting methodologies in effect for such periods, exceeds a percentage reduction as determined by the commissioner.

(e) Hospitals receiving funds pursuant to subdivision (a) of this section that did not previously receive funds to facilitate improvements in hospital operations and finances beginning on December 1, 2009, shall, as a condition for eligibility for such funds, adopt a resolution of the Board of Directors of each such hospital setting forth its current financial condition, including ongoing board oversight, and shall, after two years, issue a report as adopted by each such Board of Directors setting forth what progress has been achieved regarding such improvement, provided, however, if such report fails to set forth adequate progress, as determined by the Commissioner, the Commissioner will deem such facility ineligible for further distributions

pursuant to this section and will redistribute such further distributions to other eligible facilities in accordance with the provisions of this section. The Commissioner shall be provided with copies of all such resolutions and reports.

(f) Subject to the availability of federal financial participation, for discharges beginning on and after July 1, 2014, a transition factor will be applied to the operating budget neutral statewide price, pursuant to section 1.16(b)(2) of this Subpart and all budget neutral add-on operating cost components of the acute case per discharge rate, pursuant to section 1.20(b)(2) of this Subpart.

(g) Hospital estimated losses, due to the implementation of the updated base period pursuant to section 1.15(t)(2), and associated policy updates, will be limited as follows:

(1) for the period July 1, 2014 through December 31, 2015, hospital specific estimated losses will be limited to 2% of the hospital's current revenues;

(2) for the period January 1, 2016 through December 31, 2016, the limitation on estimated losses will be increased to 2.5% of the hospital's current revenues;

(3) for the period January 1, 2017 through December 31, 2017, the limitation on estimated losses will be increased to 3.5% of the hospital's current revenues.

(h) The transition limitation on estimated losses shall be funded:

(1) utilizing sixty percent of the current estimated revenues, valued at forty-two million dollars, for hospitals that have closed since January 1, 2011;

(2) a cap on a hospital's estimated gain due to the implementation of the updated base period pursuant to section 1.15(t)(2), and associated policy updates, shall be applied as necessary each year in order to achieve budget neutrality pursuant to section 1.16(a)(1) of this Subpart.

(i) The cap on a hospital's estimated gain shall be adjusted to exclude the portion of the gain related to an increase in the teaching resident count. The increase in resident count shall be determined by comparing the medical education statistics supplied to the Department of Health pursuant to sections 1.20(g)(1) and 1.20(g)(2) of this Subpart.

(i) All public and non-public general hospitals shall be subject to the transition factor.

(j) The transition factor will not be subject to reconciliation.

Appendix IV
2014 Title XIX State Plan
Third Quarter Amendment
Public Notice

(Medicaid) State Plan for psychiatric inpatient hospital services. The following changes are proposed:

Institutional Services

• For per diem rates of payment for Article 28 exempt psychiatric hospitals and hospital exempt units, effective for days of services associated with admissions occurring on or after July 1, 2014, the rural status will be applicable only to hospitals located in a county that has been designated as an upstate county with population densities of 225 persons or fewer per square mile. The population densities will be determined based on the New York State 2010 Vital Statistics table of estimated population, land area and population density by county per the Department of Health's public website.

• The case mix neutral psychiatric statewide per diem base price, effective for days of services associated with admissions occurring on or after July 1, 2014, will be increased by 10% for hospitals in a county that has been designated as an upstate county.

The estimated annual change to gross Medicaid expenditures as a result of the proposed amendment is $6,900,000.

The public is invited to review and comment on this proposed State Plan Amendment. Copies of which will be available for public review on the Department's website at http://www.health.ny.gov/regulations/state_plans/status.

Copies of the proposed State Plan Amendments will be on file in each local (county) social services district and available for public review.

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

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

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

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

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

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

For further information and to review and comment, please contact: Department of Health, Bureau of Federal Relations & Provider Assessments, 99 Washington Ave. – One Commerce Plaza, Suite 1430, Albany, NY 12210, (518) 474-1673, (518) 473-8825 (FAX), e-mail: spa_inquiries@health.state.ny.us

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 acute inpatient hospital services to comply with proposed regulatory provisions. The following changes are proposed:

Institutional Services

• The case based general hospital acute inpatient rebasing rate initiative will be implemented effective for discharges on or after July 1, 2014 with the following updates to the acute rate development:

- The rebased acute rates will reflect an update to the 2005 Institutional Cost Report (ICR), as reported by each facility to the department, which was utilized in the acute rates effective for discharges beginning on December 1, 2009, to the audited 2010 ICR for the operating components of the rates.

- Medicaid costs used in the rate development will be calculated based on a ratio of 2010 total Medicaid acute days (fee-for-service and managed care) to 2010 total acute days.

- The 2011 Medicaid fee-for-service paid claims and Medicaid managed care encounter claims will be used as the divisor for the non-comparable operating cost components of the rate.

- The costs used for the direct medical education (DME) component of the rates will be based on the audited 2010 ICR and only the costs reported for cost center 013 (I&R Services – Salary & Fringes), cost center 033 (I&R Services – Other Program Costs), and cost center 014 (Supervising Physician – Teaching) will be included in the DME cost development for the rates.

- The indirect medical education (IME) percentage will be based on the resident count provided to the Department of Health in the July 2010 IME Survey in addition to the 2010 provider ICR data.

- The ambulance non-comparable cost will be included only for providers stating they provide ambulance services per the 2010 Ambulance Survey completed by providers and submitted to the Department of Health during July, 2013.

- The provider specific wage equalization factor will be calculated using a 3 year average (2008 through 2010 data) of provider specific Medicare occupational-mix adjusted wages and hours in addition to the 2010 provider ICR data to determine the labor share.

- The case mix neutral statewide price and all non-comparable add-on operating cost components of the rate will be adjusted for a budget neutrality factor to equitably reduce all rate payment components to maintain budget neutrality to current expenditures.

- A transition factor will be applied to the case mix neutral statewide price and all non-comparable add-on operating cost components of the rate to limit losses and gains due to the implementation of the audited 2010 cost base and associated policy changes. For the period July 1, 2014 through December 31, 2015, provider specific losses will be limited to 2% of the provider's current expenditures. For the period January 1, 2016 through December 31, 2016, the limitation on losses will be increased to 2.5%. For the period January 1, 2017 through December 31, 2017, the limitation on losses will be increased to 3.5%. To fund the transition floor, 60% of the current estimated expenditures for hospitals that have closed since January 1, 2011 shall be applied. In addition, a cap on gains will be applied as necessary each year in order to achieve budget neutrality. The cap on a provider's gain, for the transition calculation, will be adjusted to exclude the portion of the gain related to an increase in the teaching resident count from 2005 to 2010. The transition factor will not be subject to reconciliation.

- Potentially Preventable Negative Outcomes (PPNO) factor will be calculated based on the PPNO cost reduction included in the April 1, 2014 rate.

- Through the administrative rate appeal process, providers may apply for a rate adjustment for direct and indirect medical education for accepting displaced teaching residents due to the closure of a teaching hospital after the base period.

• The alternate level of care (ALC) rate effective for days of service on July 1, 2014 and thereafter will be updated to reflect the January 1, 2013 skilled nursing home rate and implemented budget neutral on a statewide basis. The downstate region for receiving the downstate ALC rate will be expanded to include Dutchess, Orange and Putnam counties.

• For discharges on or after July 1, 2014, the acute hospital inpatient claims will be processed with the rates as calculated with the provisions above and will use the following:

- 2014 APR DRG grouper (Version 31);

- 2014 Service Intensity Weights (SIWs) and average length of stay;

- 2014 cost outlier thresholds scaled to maintain budget neutrality to estimated outlier payments using the 2013 thresholds.

There is no additional estimated annual change to gross Medicaid expenditures as a result of the proposed amendments.

The public is invited to review and comment on this proposed State Plan Amendment. Copies of which will be available for public review on the Department's website at http://www.health.ny.gov/regulations/state_plans/status.

Copies of the proposed State Plan Amendments will be on file in each local (county) social services district and available for public review.

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

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

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

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

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

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

For further information and to review and comment, please contact: Department of Health, Bureau of Federal Relations & Provider Assessments, 99 Washington Ave. – One Commerce Plaza, Suite 1430, Albany, NY 12210, (518) 474-1673, (518) 473-8825 (FAX), e-mail: spa_inquiries@health.state.ny.us

PUBLIC NOTICE

Office of Mental Health

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

The Office of Mental Health proposes to amend the Title XIX (Medicaid) State Plan for Residential Treatment Facilities for Children and Youth to reflect no trend factor applied to allowable costs effective July 1, 2014.

The public is invited to review and comment on this proposed State Plan Amendment. Copies of which will be available for public review on the Department's website at http://www.health.ny.gov/regulations/state_plans/status.

Copies of the proposed State Plan Amendments will be on file in each local (county) social services district and available for public review.

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

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

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

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

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

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

For further information and to review and comment, please contact: Office of Mental Health, Robert E. Blaauw, Director, Community Budget and Financial Management Group, 44 Holland Ave., 7th Fl., Albany, NY 12229, (518) 474-5968, (518) 486-6767 (FAX), e-mail: Bob.Blaauw@OMH.NY.GOV

PUBLIC NOTICE

New York State and Local Retirement System

Pursuant to Retirement and Social Security Law, the New York State and Local Employees' Retirement System hereby gives public notice of the following:

The persons whose names and last known addresses are set forth below appear from records of the above named Retirement System to be entitled to accumulated contributions held by said retirement system whose membership terminated pursuant to Section 517-a of the Retirement and Social Security Law on or before May 10, 2013. This notice is published pursuant to Section 109 of the Retirement and Social Security Law of the State of New York. A list of the names contained in this notice is on file and open to public inspection at the office of the New York State and Local Retirement System located at the 110 State St., in the City of Albany, New York. At the expiration of six months from the date of the publication of this notice. The accumulated contributions of the persons so listed shall be deemed abandoned and shall be placed in the pension accumulation fund to be used for the purpose of said fund. Any accumulated contributions so deemed abandoned and transferred to the pension accumulation fund may be claimed by the persons who made such accumulated contributions or, in the event of his death, by his estate or such person as he shall have nominated to receive such accumulated contributions, by filing a claim with the State Comptroller in such form and in such a manner as may be prescribed by him, seeking the return of such abandoned contributions. In the event such claim is properly made the State Comptroller shall pay over to the person or persons or estate making the claim such amount of such accumulated contributions without interest.

Bloomfield, Gregory T - Staten Island, NY

Mc Field, John L - Brooklyn, NY

Minnies, Robin L - Stony Point, NY

For further information contact: Mary Ellen Kutey, New York State Retirement Systems, 110 State St., Albany, NY 12244, (518) 474-3502

PUBLIC NOTICE

New York State and Local Retirement System

Pursuant to Retirement and Social Security Law, the New York State and Local Employees' Retirement System hereby gives public notice of the following:

The persons whose names and last known addresses are set forth below appear from records of the above named Retirement System to be entitled to accumulated contributions held by said retirement system whose membership terminated pursuant to Section 613 of the Retirement and Social Security Law on or before May 10, 2013. This notice is published pursuant to Section 109 of the Retirement and Social Security Law of the State of New York. A list of the names contained in this notice is On file and open to public inspection at the office of the New York State and Local Retirement System located at the 110 State St., in the City of Albany, New York. At the expiration of six months from the date of the publication of this notice. The accumulated contributions of the persons so listed shall be deemed abandoned and shall be placed in the pension accumulation fund to be used for the purpose of said fund. Any accumulated contributions so deemed abandoned and transferred to the pension accumulation fund may be claimed by the persons who made such accumulated contribu-

Appendix V
2014 Title XIX State Plan
Third Quarter Amendment
Responses to Standard Funding Questions

APPENDIX V
HOSPITAL SERVICES
State Plan Amendment #14-021

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 and CMS will engage in discussions to develop a strategic plan to complete the inpatient UPL demonstration for 2014 and submit it as soon as practicable.

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.