NEW YORK
state department of
HEALTH

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

Sue Kelly
Executive Deputy Commissioner

SEP 30 2014

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

Re: SPA #14-029
Inpatient Hospital Services

Dear Mr. Cooley:

The State requests approval of the enclosed amendment #14-029 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 State regulations. 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 State regulations 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: **14-029**	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 $ 862,500** **b. FFY 10/01/14-09/30/15 $ 3,450,000**	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: **Attachment 4.19-A: Pages 117(d), 117(i), 117(k), 117(m)**	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: **Attachment 4.19-A: Pages 117(d), 117(i),117(k), 117(m)**	
10. SUBJECT OF AMENDMENT: **Hospital IP Psychiatric Exempt Rates (FMAP = 50%)**		
11. GOVERNOR'S REVIEW *(Check One)*: ☒ GOVERNOR'S OFFICE REPORTED NO COMMENT ☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED ☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL ☐ OTHER, AS SPECIFIED:		
12. SIGNATURE OF STATE AGENCY OFFICIAL:	16. RETURN TO: **New York State Department of Health** **Bureau of Federal Relations & Provider Assessments** **99 Washington Ave – One Commerce Plaza** **Suite 1430** **Albany, NY 12210**	
13. TYPED NAME: **Jason A. Helgerson**		
14. TITLE: **Medicaid Director** **Department of Health**		
15. DATE SUBMITTED: SEP 30 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:		

FORM HCFA-179 (07-92)

Appendix I
2014 Title XIX State Plan
Third Quarter Amendment
Amended SPA Pages

New York
117(d)

8. *Inpatient psychiatric services provided in general hospitals, or distinct units of general hospitals, specializing in such inpatient psychiatric services*, for patients admitted on and after October 20, 2010, will be reimbursed on a per diem basis as follows:

   a. Reimbursement will use the All Patient Refined Diagnostic Related Group (APR-DRG) patient classification system.

   b. The operating component of the rate will be a statewide price, calculated utilizing 2005 Medicaid fee-for-service (FFS) inpatient costs developed using the ratio of cost to charges approach to determine costs and a regression model to price out various components of the costs to determine cost significance in such components. The components include patient age, rural designation, comorbidities, length of stay, and presence of mental retardation. The costs of these components as developed in the regression model were excluded in developing the statewide price.

      i. The facility-specific old operating per diem rates were trended to 2010, and for each case, these rates were multiplied by the length of stay (LOS) to calculate the "old payment."

      ii. Facility-specific 2005 Direct Graduate Medical Education (DGME) costs were divided by 2005 patient days to calculate DGME per diem rates. These rates were then trended to 2010.

      iii. The 2010 payment rate for Electroconvulsive Therapy (ECT) was established as $281 (based on the ECT rate in effect for Medicare psychiatric patients during the first half of 2010). This rate was then adjusted by each facility's wage equalization factor (WEF).

      iv. For each case, the proper DGME payment (DGME rate multiplied by the LOS) and ECT payment (WEF-adjusted ECT rate times the number of ECT treatments) was subtracted from the "old payments" to derive the "old payments subject to risk adjustment."

      v. For each case, a payment adjustment factor was derived based on the regression model, including the LOS adjustment factor as defined by the new payment methodology.

      vi. The sum of the old payments subject to risk adjustment from step iv ([$502,341,057] $534,255,388), was divided by the sum of payment adjustment factors from step v ($831,319), which resulted in the statewide per diem rate of [$604.27] $642.66.

New York
117(i)

772	1	Alcohol & Drug Dependence w Rehab or Rehab/Detox Therapy, SOI-1	0.8373
772	2	Alcohol & Drug Dependence w Rehab or Rehab/Detox Therapy, SOI-2	0.8373
772	3	Alcohol & Drug Dependence w Rehab or Rehab/Detox Therapy, SOI-3	0.8373
772	4	Alcohol & Drug Dependence w Rehab or Rehab/Detox Therapy, SOI-4	0.8373
773	1	Opioid Abuse & Dependence, SOI-1	1.0204
773	2	Opioid Abuse & Dependence, SOI-2	1.0204
773	3	Opioid Abuse & Dependence, SOI-3	1.0361
773	4	Opioid Abuse & Dependence, SOI-4	1.0361
774	1	Cocaine Abuse & Dependence, SOI-1	0.9807
774	2	Cocaine Abuse & Dependence, SOI-2	1.0360
774	3	Cocaine Abuse & Dependence, SOI-3	1.0513
774	4	Cocaine Abuse & Dependence, SOI-4	1.0513
775	1	Alcohol Abuse & Dependence, SOI-1	1.0196
775	2	Alcohol Abuse & Dependence, SOI-2	1.0709
775	3	Alcohol Abuse & Dependence, SOI-3	1.0709
775	4	Alcohol Abuse & Dependence, SOI-4	1.0709
776	1	Other Drug Abuse & Dependence, SOI-1	0.9363
776	2	Other Drug Abuse & Dependence, SOI-2	1.0926
776	3	Other Drug Abuse & Dependence, SOI-3	1.0926
776	4	Other Drug Abuse & Dependence, SOI-4	1.0926

iii. A rural adjustment factor of 1.2309 will be applied to the operating per diem for those hospitals designated as rural hospitals. A rural facility is a general hospital with a service area which has an average population of less than 175 persons per square mile, or a general hospital with a service area which has an average population of less than 200 persons per square mile measured as population density by zip code. For dates of service beginning on or after July 1, 2014, rural designation will be applicable to hospitals located in an upstate region, as defined in subparagraph (l) of this section, and with population densities of 225 persons or fewer per square mile as determined based on the New York State 2010 Vital Statistics table of estimated population, land area, and population density. Accordingly, there are [22] 27 rural facilities that provide inpatient psychiatric services.

iv. An age adjustment payment factor of 1.0872 will be applied to the per diem operating component for adolescents ages 17 and under. For ages 18 and over, an adjustment payment factor of 1 will be applied.

New York
117(k)

ix. For dates of service beginning on or after July 1, 2014, a ten percent increase will be applied for hospitals located in an upstate region as defined in subdivision (l) of this section.

e. The first day of a patient's readmissions to the same hospital within 30 days of discharge will be treated as day four for purposes of the variable payment factor computed as aforementioned, with subsequent days treated in a conforming manner with the provisions.

f. Reimbursement for physician services will not be included in rates and such services may be billed on a fee-for-services basis pursuant to the Hospital Physician Billing Section in Attachment 4.19-B.

g. Reimbursement for electroconvulsive therapy will be established at a statewide fee of $281, as adjusted for each facility's WEF, for each treatment during a patient's stay.

h. New inpatient psychiatric exempt hospitals or units established pursuant to Article 28 of the Public Health Law will be reimbursed at the statewide price plus budgeted capital and Direct GME. Budgeted capital will be adjusted as described in this section and will be adjusted to actual costs in future years. Direct GME will be adjusted to actual costs based upon the first twelve months reporting following the calendar year after the opening of the new unit.

i. The base period costs and statistics used for inpatient psychiatric per diem rate setting operating cost components including the weights assigned to diagnostic related groups (DRG) designated as psychiatric DRGs for per diem reimbursement, will be updated no [less frequently than every four years and the new base period will be no more than four years prior to the first applicable rate period that utilized such new base period] earlier than April 1, 2015. The payment factors for rural designation, age, certain defined comorbidities, and the presence of mental retardation may also be updated to reflect more current data.

j. For rate periods through December 31, 2014, reimbursement will include transition payments of $25 million on an annualized basis, which will be distributed as follows:

New York
117(m)

i. Eligible hospitals will be those general hospitals which receive approval for certificate of need applications submitted to the Department of Health between April 1, 2010 and March 31, 2011 for adding new behavioral health inpatient beds in response to the decertification of other general hospital behavioral health inpatient beds in the same service area, or which the Commissioner of Health, in consultation with the Commissioner of Mental Health, has determined to have complied with Department of Health requests to adjust behavioral health service delivery in order to ensure access.

ii. Eligible hospitals will, as a condition of their receipt of the rate adjustments, submit to the Department of Health proposed budgets for the expenditure of the additional Medicaid payments for the purpose of providing inpatient behavioral health services to Medicaid eligible individuals. The budgets must be approved by the Department of Health, in consultation with the Office of Mental Health, prior to the rate adjustments being issued.

iii. Distributions will be made as add-ons to each eligible facility's inpatient Medicaid rate and will be allocated proportionally, utilizing the proportion of each approved hospital budget to the total amount of all approved hospital budgets. Distributions will be subsequently reconciled to ensure that actual aggregate expenditures are within available aggregate funding.

l. For purposes of this section, the downstate region of New York State will consist of the following counties of: Bronx, New York, Kings, Queens, Richmond, Nassau, Suffolk, Westchester, Rockland, Orange, Putnam and Dutchess; and the upstate region of New York State will consist of all other New York counties.

Appendix II
2014 Title XIX State Plan
Third Quarter Amendment
Summary

SUMMARY
SPA #14-029

This State Plan Amendment proposes to change rural status criteria for Article 28 exempt psychiatric hospitals and hospital exempt units, and provide upstate hospitals with a ten percent increase in statewide price, effective July 1, 2014.

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

SPA #14-029

Section 86-1.39 - Inpatient psychiatric services

86-1.39 Inpatient psychiatric services. Inpatient psychiatric services provided in general hospitals, or distinct units of general hospitals, specializing in such inpatient psychiatric services, with regard to patients admitted on and after October 20, 2010, shall be reimbursed on a per diem basis in accordance with the following, provided, however, that such rates applicable to inpatients otherwise subject to the provisions of public health law section 2807-c(1)(a-2)(i) shall be effective with regard to patients admitted on and after January 1, 2011:

(a) Such reimbursement shall be based on the All Patient Refined Diagnostic Related Group (APR-DRG) patient classification system as defined in section 86-1.15(a) of this Subpart.

(b) The operating component of the rate shall be based on a statewide price, utilizing 2005 Medicaid fee-for-service (FFS) inpatient costs adjusted for case mix and the Wage Equalization Factor (WEF) and excluding costs for Direct GME, Electroconvulsive Therapy, and capital costs.

(c) The capital cost components of rates computed pursuant to this section shall be computed on the basis of budgeted capital costs allocated to the hospital, or to the distinct unit of a hospital, in accordance with the provisions of section 86-1.25 of this Subpart divided by the hospital or distinct unit patient days and reconciled to actual total expenses.

(d) The non-operating component of the rate shall reflect 2005 Medicaid fee-for-service Direct GME costs.

(e) The statewide price shall be adjusted for each patient to reflect the following factors:

(1) a service intensity weight (SIW) associated with the case based on the grouper assigned APR-DRG, as described in subdivision (f) of this section, will be applied to the adjusted operating per diem;

(2) a rural adjustment factor of 1.2309 will be applied to the operating per diem for those hospitals designated as rural hospitals;

(i) for dates of service beginning on or after July 1, 2014, rural designation shall be applicable to hospitals located in an upstate region, as defined in subdivision (o) of this section, and with population densities of 225 persons or fewer per square mile as determined based on the New York State 2010 Vital Statistics table of estimated population, land area, and population density.

(3) an age adjustment payment factor of 1.0872 will be applied to the per diem operating component for adolescents ages 17 and under;

(4) a payment adjustment factor of 1.0599 will be applied to the operating component for the presence of a mental retardation diagnosis;

(5) the payment methodology shall include one co-morbidity factor per stay and if more than one co-morbidity is presented, the co-morbidity that reflects the highest payment factor shall be used to adjust the per diem operating component; and

(6) a variable payment factor will be applied to the operating per diem for each day of the stay, with the factor for days 1 through 4 established at 1.2, the factor for days 5 through 11 established at 1.0, the factor for days 12 through 22 established at 0.96 and the factor for stays longer than 22 days established at 0.92.

(7) for dates of service beginning on or after July 1, 2014, a ten percent increase will be applied for hospitals located in an upstate region as defined in subdivision (o) of this section.

(f) (1) The table of service intensity weights (SIW's) applicable to rates set pursuant to this section for each effective period is published on the New York State Department of Health website at http://www.health.ny.gov/nysdoh/hospital/drg/index.htm and reflects the cost weights assigned to each All Patient Refined (APR) diagnosis related group (DRG) patient classification category. The SIWs assigned to each DRG/APR indicates the relative cost variance of that DRG/APR classification from the average cost of all inpatients in all DRG/APRs. Such SIWs are developed using two years of Medicaid fee-for-service cost data as reported to the Statewide Planning and Research Cooperative System (SPARCS) for the years set forth in paragraph (2) of this subdivision. Costs associated with hospitals that do not have an ancillary charge structure and costs associated with statistical outliers shall be excluded from the SIW calculations.

(2) For rate periods on and after the effective date of this section the SIW shall be computed using SPARCS and reported cost data from the 2005 and 2006 calendar years, as submitted to the department by September 30, 2009.

(g) The table of co-morbidity factors applicable to the rate adjustments described in paragraph (5) of subdivision (e) of this section is published on the New York State Department of Health website at http://www.health.state.ny.us/.

(h) The first day of a patient's readmissions to the same hospital within thirty days of discharge will be treated as day four for purposes of the variable payment factor computed pursuant to paragraph (6) of subdivision (d) of this section, with subsequent days treated in a conforming manner with the provisions of such paragraph.

(i) Reimbursement for physician services shall not be included in rates set pursuant to this section and such services may be billed on a fee-for-services basis as otherwise provided by applicable provisions of law.

(j) Reimbursement for Electroconvulsive Therapy shall be established at a statewide fee of $281, as adjusted for each facility's WEF, for each treatment during a patient's stay.

(k) Reimbursement for days of alternative level of care for patients whose reimbursement is otherwise subject to this section shall be in accordance with section 86-1.22 of this Subpart.

(l) New inpatient psychiatric exempt hospitals or units established pursuant to article 28 of the public health law shall be reimbursed at the statewide price plus budgeted capital and Direct GME.

(m) For rate periods through December 31, 2014, reimbursement pursuant to this section shall include transition payments of up to twenty-five million dollars on an annualized basis, which shall be distributed in accordance with the following:

(1)(i) Fifty percent of such payments shall be allocated to facilities that experience a reduction in Medicaid operating revenue in excess of threshold percentage set forth in subparagraph (ii) of this paragraph as a result of the implementation of rates set pursuant to this section. Such payments shall be allocated proportionally, based on each eligible facility's relative Medicaid operating revenue loss in excess of the threshold, as determined by the commissioner.

(ii) The threshold percentage described in subparagraph (i) of this paragraph shall be 6.02%.

(2)(i) Fifty percent of such payments shall be allocated to facilities with regard to which it is determined by the commissioner that rates otherwise set pursuant to this section result in Medicaid revenue that is less than the facility's Medicaid costs by a threshold percentage in excess of the threshold percentage set forth in subparagraph (ii) of this paragraph. Such payments shall be allocated proportionally, based on the degree each facility Medicaid operating revenue shortfall exceeds such threshold percentage. For those facilities without available Medicaid fee-for-service cost data, computations pursuant to this paragraph shall be based on each such facility's total operating costs as determined by the commissioner.

(ii) The threshold percentage described in subparagraph (i) of this paragraph shall be 1.20%.

(n) For rate period after October 20, 2010 through March 31, 2011, reimbursement pursuant to this paragraph may include transition payments totaling, in aggregate, up to twelve million dollars and distributed to eligible hospitals in accordance with the following, provided, however, that if less than twelve million dollars is distributed in such rate period, then additional distributions of up to such twelve million dollars may be made in accordance with the provisions of this subdivision in subsequent rate periods:

(1) Eligible hospitals shall be those general hospitals which receive approval for certificate-of-need applications submitted to the Department of Health between April 1, 2010 and March 31, 2011 for adding new behavioral health beds to their certified bed capacity as a direct result of the decertification of other general hospital behavioral health inpatient beds in the same service area, or which the Commissioner of Health, in consultation with the Commissioner of Mental Health, has determined have complied with Department of Health requests to make other significant behavioral health service delivery adjustments in direct response to such decertification.

(2) Eligible hospitals shall, as a condition of their receipt of such rate adjustments, submit to the Department of Health proposed budgets for the expenditure of such additional Medicaid payments for the purpose of providing behavioral health services and such budgets must be

approved by the Department of Health, in consultation with the Office of Mental Health, prior to such rate adjustments being issued.

(3) Distributions made pursuant to this paragraph shall be made as add-ons to each eligible facility's inpatient Medicaid rate and shall be allocated proportionally, based on the proportion of each approved hospital budget to the total amount of all approved hospital budgets and such distributions shall be subsequently reconciled to ensure that actual aggregate expenditures are within available aggregate funding.

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

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

MISCELLANEOUS NOTICES/HEARINGS

Notice of Abandoned Property Received by the State Comptroller

Pursuant to provisions of the Abandoned Property Law and related laws, the Office of the State Comptroller receives unclaimed monies and other property deemed abandoned. A list of the names and last known addresses of the entitled owners of this abandoned property is maintained by the office in accordance with Section 1401 of the Abandoned Property Law. Interested parties may inquire if they appear on the Abandoned Property Listing by contacting the Office of Unclaimed Funds, Monday through Friday from 8:00 a.m. to 4:30 p.m., at:

1-800-221-9311
or visit our web site at:
www.osc.state.ny.us

Claims for abandoned property must be filed with the New York State Comptroller's Office of Unclaimed Funds as provided in Section 1406 of the Abandoned Property Law. For further information contact: Office of the State Comptroller, Office of Unclaimed Funds, 110 State St., Albany, NY 12236.

PUBLIC NOTICE
Department of Civil Service

PURSUANT to the Open Meetings Law, the New York State Civil Service Commission hereby gives public notice of the following:

Please take notice that the regular monthly meeting of the State Civil Service Commission for July 2014 will be conducted on July 8 and July 9 commencing at 10:00 a.m. This meeting will be conducted at NYS Media Services Center, Suite 146, South Concourse, Empire State Plaza, Albany, NY.

For further information, contact: Office of Commission Operations, Department of Civil Service, Empire State Plaza, Agency Bldg. 1, Albany, NY 12239, (518) 473-6598

PUBLIC NOTICE
Office of General Services

Pursuant to Section 33 of the Public Lands Law, the Office of General Services hereby gives notice to the following:

Notice is hereby given that the Office for People with Developmental Disabilities has determined 9 East Chestnut Street in the City of Kingston, Ulster County, New York State, improved with a two story residential building, with tax identifier Section 56.34, Block 10, Lot 17 as surplus and no longer useful or necessary for state program purposes, and has abandoned the property to the Commissioner of General Services for sale or other disposition as Unappropriated State land.

For further information, please contact: Thomas Pohl, Office of General Service, Legal Services, 41st Fl., Coming Tower, Empire State Plaza, Albany, NY 12242, (518) 474-8831, (518) 473-4973 fax

PUBLIC NOTICE
Department of Health

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

The Department of Health proposes to amend the Title XIX (Medicaid) State Plan for non-institutional services to revise provisions of the Ambulatory Patient Group (APG) reimbursement methodology on or after July 1, 2014. The following changes are proposed:

The Ambulatory Patient Group (APG) reimbursement methodology is revised to include recalculated weight and component updates that will become effective on or after July 1, 2014. In addition, the requirement to reweight the APG weights used in the APG payment method is being revised from the previous update of no less frequently than every two years to a reweight of no less frequently than every three years. The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for State Fiscal Year 2014/2015 is $1,572,729.

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 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:

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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.

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

APPENDIX V
HOSPITAL SERVICES
State Plan Amendment #14-029

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.