Department of Health

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

SEP 2 9 2016

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

Re: SPA #16-0044
Inpatient Hospital Services

Dear Mr. Cooley:

The State requests approval of the enclosed amendment #16-0044 to the Title XIX (Medicaid) State Plan for inpatient hospital services to be effective September 1, 2016 (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.

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 August 10, 2016.

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

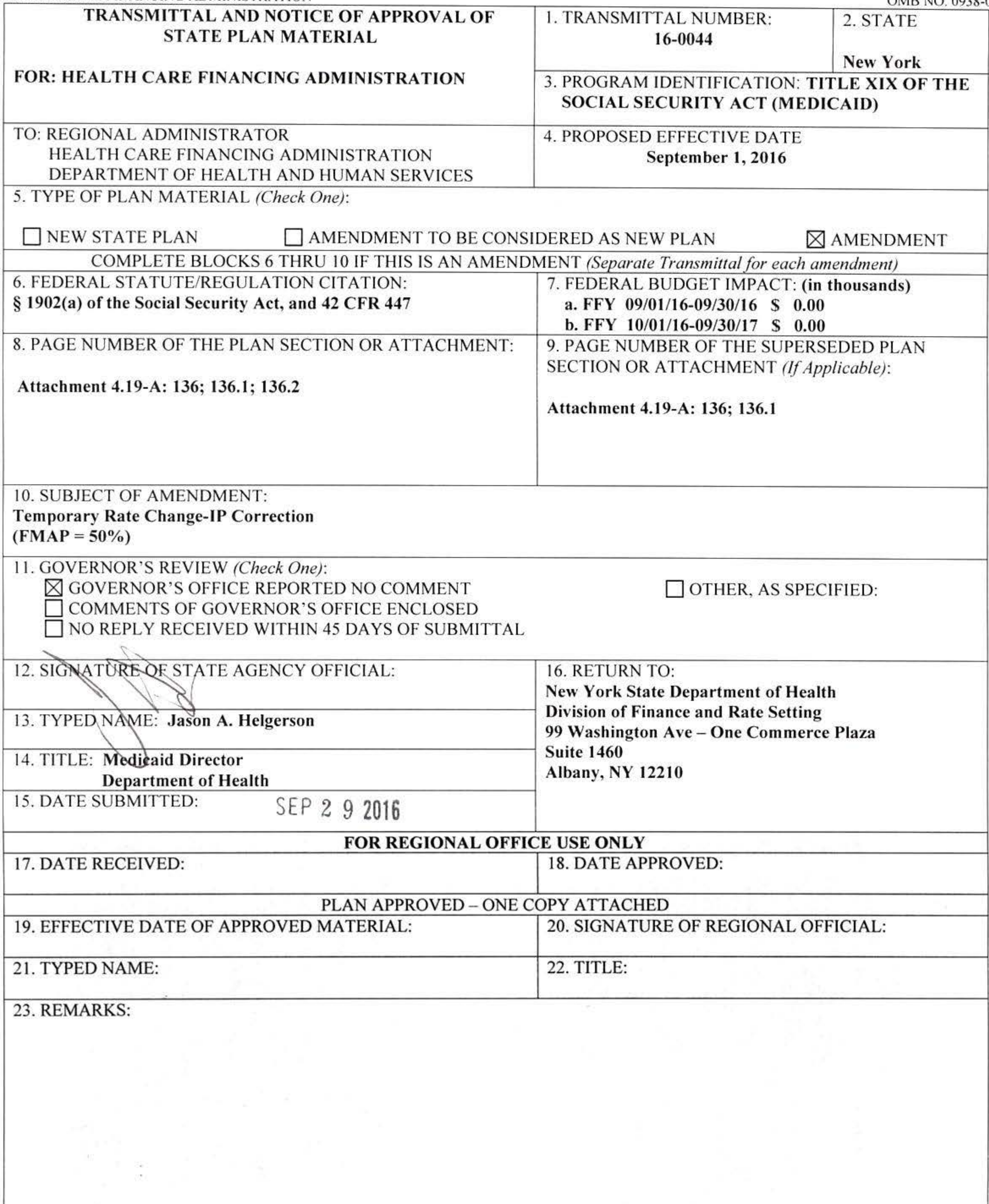
If you have any questions regarding this matter, please do not hesitate to contact John E. Ulberg, Jr., Medicaid Chief Financial Officer, Division of Finance and Rate Setting, Office of Health Insurance Programs at (518) 474-6350.

Sincerely,

Jason A. Helgerson
Medicaid Director
Office of Health Insurance Programs

Enclosures
cc: Mr. Michael Melendez
Mr. Tom Brady

FORM APPROVED
OMB NO. 0938-0193



TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: **16-0044**

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 **September 1, 2016**

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 09/01/16-09/30/16 $ 0.00
b. FFY 10/01/16-09/30/17 $ 0.00

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-A: 136; 136.1; 136.2

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-A: 136; 136.1

10. SUBJECT OF AMENDMENT:
Temporary Rate Change-IP Correction
(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:

13. TYPED NAME: **Jason A. Helgerson**

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

15. DATE SUBMITTED: SEP 2 9 2016

16. RETURN TO:
New York State Department of Health
Division of Finance and Rate Setting
99 Washington Ave – One Commerce Plaza
Suite 1460
Albany, NY 12210

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
2016 Title XIX State Plan
Third Quarter Amendment
Amended SPA Pages

Mergers, acquisitions, consolidations, restructurings and closures.

1. *Rates of Payment.* [As used in this Section, t]The terms merger, acquisition, [and] consolidation, and restructuring, for the purpose of calculating a combined reimbursement rate, [shall]will mean the combining of two or more general hospitals where such combination is a full asset merger or a full asset acquisition (hereinafter referred to as full asset merger) and is consistent with the public need, would create a new, more economical entity, reduce the costs of operation, result in the reduction of beds and/or improve service delivery and approved through the Department's Certificate of Need process. Payments for hospitals subject to a full asset merger[, acquisition or consolidation] for inpatient acute care services that are not otherwise exempt from DRG case-based rates of payment will be effective on the date the full asset merger transaction is effected and [shall]will be computed in accordance with this Section except as follows:

   a. The WEF used to adjust the statewide base price [shall]will be calculated by combining all components used in the calculation pursuant to the WEF Section for all hospitals subject to the full asset merger[, acquisition or consolidation].

   b. The direct GME payment per discharge added to the case payment rates of teaching hospitals [shall]will be calculated by dividing the total reported Medicaid direct GME costs for all teaching hospitals subject to the full asset merger[, acquisition, or consolidation] by the total reported Medicaid discharges reported by such hospitals in the applicable base period.

   c. The indirect GME payment per discharge added to the case payment rates of teaching hospitals [shall]will be calculated in accordance with the Add-ons to the Case Payment Rate Per Discharge Section, except the ratio of residents to beds used in the calculation [shall]will be based on the total residents and beds of all such hospitals subject to the full asset merger[, acquisition, or consolidation].

   d. The non-comparable payment per discharge added to the case payment rates [shall]will be calculated by dividing the total reported Medicaid costs for qualifying non-comparable cost categories for all hospitals subject to the full asset merger[, acquisition, or consolidation] by the total reported Medicaid discharges reported by such hospitals in the applicable base period.

1. A. Temporary rate change for full asset mergers and acquisitions.

a. For the period April 1, 2012 through August 31, 2016, the Commissioner may grant approval of a temporary change to rates calculated pursuant to this Section for hospitals that complete a merger, acquisition or consolidation provided such hospitals demonstrate through submission of a written proposal that the merger, acquisition or consolidation will result in an improvement to (i) cost effectiveness of service delivery, (ii) quality of care, and (iii) factors deemed appropriate by the Commissioner. Such written proposal shall be submitted to the Department sixty days prior to the requested effective date of the temporary rate change. The temporary rate change shall be in effect for no longer than such time as base year costs are updated for the development of these temporary rates or such time as statewide base year costs are updated for the development of rates, whichever is earlier, and shall consist of the various operating rate components of the surviving entity. At the end of the specified timeframe, the hospital will be reimbursed in accordance with the statewide methodology set forth in this Attachment. The Commissioner may establish, as a condition of receiving such a temporary rate change, benchmarks and goals to be achieved as a result of the ongoing consolidation efforts and may also require that the hospital submit such periodic reports concerning the achievement of such benchmarks and goals as the Commissioner deems necessary. Failure to achieve satisfactory progress, as determined by the Commissioner, in accomplishing such benchmarks and goals shall be a basis for ending the hospital's temporary rate change prior to the end of the specified timeframe.

b. The Commissioner shall withdraw approval of a temporary rate change for hospitals which (i) fail to demonstrate compliance with and continual improvement on the approved proposal or (ii) an update to the base year is made by the Department.

c. For the period beginning September 1, 2016 and thereafter, the Commissioner may grant approval of a temporary change to the non-capital components of rates calculated pursuant to this Section for hospitals that have undergone a full asset merger:

i. The "higher of" operating rate of all hospitals merged will be paid to all hospitals in the merged entity. The "higher of" is based on all components of a hospital's rate and not determined on an individual operating rate component basis.

ii. Facilities seeking a rate change under this section will submit an appeal and demonstrate that the additional resources provided by a temporary rate change will achieve one or more of the following:

(1) protect or enhance access to care;

(2) protect or enhance quality of care;

(3) improve the cost effectiveness of the delivery of health care services; or

(4) otherwise protect or enhance the health care delivery system, as determined by the Commissioner.

iii. The temporary rate change issued pursuant to this section will be effective as of the date the full asset merger transaction is effected and will be in effect for three years. At the expiration of the temporary rate change period, the facility will be reimbursed in accordance with the otherwise applicable rate-setting methodology as stated in this section and will be effective the first day of the month following the expiration of the three year period.

Appendix II
2016 Title XIX State Plan
Third Quarter Amendment
Summary

SUMMARY
SPA #16-0044

This State Plan Amendment proposes to update the Temporary Rate Change provisions for an acute rate adjustment for full asset mergers and acquisitions.

Appendix III
2016 Title XIX State Plan
Third Quarter Amendment
Authorizing Provisions

Effective Date: [07/03/2012]09/01/2016
Title: Section 86-1.31 – Mergers, acquisitions, [and] consolidations, restructurings and closures.

86-1.31 Mergers, acquisitions, [and] consolidations, restructurings and closures.

(a) *Rates of Payment.* As used in this section, subdivisions (a) and (b), the terms merger, acquisition, [and] consolidation, and restructuring [shall]will mean the combining of two or more general hospitals licensed under Article 28 of the Public Health Law, where such combination is a full asset merger or a full asset acquisition (hereinafter referred to as full asset merger) and is consistent with the public need, would create a new, more economical entity, reduce the costs of operation, result in the reduction of beds and/or improve service delivery. Payments for hospitals subject to a full asset merger[, acquisition or consolidation] for inpatient acute care services that are not otherwise exempt from DRG case-based rates of payment will be effective on the date the full asset merger transaction is effected and [shall]will be computed in accordance with this Subpart except as follows:

(1) The WEF used to adjust the statewide base price [shall]will be calculated by combining all components used in the calculation pursuant to section 86-1.19 of this Subpart for all hospitals subject to the full asset merger[, acquisition or consolidation].

(2) The direct GME payment per discharge added to the case payment rates of teaching hospitals [shall]will be calculated by dividing the total reported Medicaid direct GME costs for all teaching hospitals subject to the full asset merger[, acquisition, or consolidation] by the total reported Medicaid discharges reported by such hospitals in the applicable base period.

(3) The indirect GME payment per discharge added to the case payment rates of teaching hospitals [shall]will be calculated in accordance with section 86-1.20 of this Subpart, except the ratio of residents to beds used in the calculation [shall]will be based on the total residents and beds of all such hospitals subject to the full asset merger[, acquisition, or consolidation].

(4) The non-comparable payment per discharge added to the case payment rates [shall]will be calculated by dividing the total reported Medicaid costs for qualifying non-comparable cost categories for all hospitals subject to the full asset merger[, acquisition, or consolidation] by the total reported Medicaid discharges reported by such hospitals in the applicable base period.

(b) *Temporary Medicaid Rate Change for Full Asset Mergers.*

(1) The commissioner may grant approval of a temporary change to the non-capital components of rates calculated pursuant to this section for eligible general hospitals that have undergone a full asset merger as defined in subdivision (a) of this section.

(2) The "higher of" operating rate of all hospitals merged be paid to all hospitals merged. The "higher of" is based on all components of a hospital's rate and not determined on an individual operating rate component basis.

(3) Facilities seeking rate adjustments under this section will submit an appeal and demonstrate that the additional resources provided by a temporary rate change will achieve one or more of the following:

(i) protect or enhance access to care;

(ii) protect or enhance quality of care;

(iii) improve the cost effectiveness of the delivery of health care services; or

(iv) otherwise protect or enhance the health care delivery system, as determined by the commissioner.

(4) The temporary rate change issued pursuant to this section will be effective as of the date the full asset merger or acquisition transaction is effected and will be in effect for three years. At the expiration of the temporary rate change period, the facility will be reimbursed in accordance with the otherwise applicable rate-setting methodology as set forth in applicable statutes and subdivision (a) of this section and will be effective the first day of the month following the expiration of the three year period.

(5) A transfer of patients between divisions during the temporary rate change period will be reimbursed as provided in subdivision b(4) of section 86-1.21 of this Subpart.

(c)[(b)] *Vital Access Provider Program (VAP) for c[C]losures, mergers, acquisitions, consolidations and restructurings.*

(1) The commissioner may grant approval of a temporary adjustment to the non-capital components of rates calculated pursuant to this subpart for eligible general hospitals.

(2) Eligible facilities [shall]will include:

(i) facilities undergoing closure;

(ii) facilities impacted by the closure of other health care providers;

(iii) facilities subject to mergers, acquisitions, consolidations or restructuring; or

(iv) facilities impacted by the merger, acquisition, consolidation or restructuring of other health care providers.

(3) Upon notification from the Department that funds are available, qualifying facilities will submit an application to the commissioner, within the timeframe specified. Facilities seeking rate adjustments under this section [shall]will demonstrate through submission of a written proposal to the commissioner that the additional resources provided by a temporary rate adjustment will achieve one or more of the following:

(i) protect or enhance access to care;

(ii) protect or enhance quality of care;

(iii) improve the cost effectiveness of the delivery of health care services; or

(iv) otherwise protect or enhance the health care delivery system, as determined by the commissioner.

(4) (i) Such written proposal [shall]will be submitted to the commissioner at least sixty days prior to the requested effective date of the temporary rate adjustment and [shall]will include a proposed budget, timeline and [to achieve the] goals to be achieved by [of] the proposal. Any temporary rate adjustment issued pursuant to this section [shall]will be in effect for a specified period of time as determined by the commissioner, of up to three years. At the end of the specified timeframe, the facility [shall]will be reimbursed in accordance with the otherwise applicable rate-setting methodology as set forth in applicable statutes and this Subpart. The commissioner may establish, as a condition of receiving such a temporary rate adjustment, benchmarks and goals to be achieved in conformity with the facility's written proposal as approved by the commissioner and may also require that the facility submit such periodic reports concerning the achievement of such benchmarks and goals as the commissioner deems necessary. Failure to achieve satisfactory progress, as determined by the commissioner, in accomplishing such benchmarks and goals [shall]will be a basis for ending the facility's temporary rate adjustment prior to the end of the specified timeframe.

(ii) The commissioner may require that applications submitted pursuant to this section be submitted in response to and in accordance with a Request For Applications or a Request For Proposals issued by the commissioner.

Proposed

Appendix IV
2016 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.

NOTICE OF PUBLIC HEARING

Hudson River Park Trust

Public Review and Comment Period

Pursuant to the Hudson River Park Act, the Hudson River Park Trust ("Trust") hereby gives notice of a public hearing and public comment period regarding the following significant action under the Hudson River Park Act: the proposed transfer by sale of 200,000 sf of unused development rights from Pier 40 and associated actions.

Date and Time: August 24, 2016
To be held concurrently with the New York City Planning Commission's public hearing on the Special Hudson River Park District and 550 Washington Street. The City Planning Commission public meeting begins at 10:00 a.m. The public hearing on this matter is expected to begin at approximately 11:00 a.m.

Place: Spector Hall
22 Reade St.
New York, NY

Purpose: To allow the public an opportunity to review and comment on a proposed significant action within the Park pursuant to the Hudson River Park Act.

Pursuant to the Hudson River Park Act, Chapter 592 of the Laws of 1998 of the State of New York, as amended (the "Act"), the Trust is responsible for the planning, design, development, construction, operation and maintenance of the Hudson River Park and the improvements therein (collectively, the "Park"), which is located along West Street in the Borough of Manhattan, City and State of New York and includes Pier 40.

Pursuant to a 2013 amendment to the Act, the Trust is authorized:

"to transfer by sale any unused development rights as may be available for transfer to properties located up to one block east of the boundaries of the [P]ark along the west side of Manhattan, if and to the extent designated and permitted under local zoning ordinances provided however that revenues derived from the transfer of air rights from [P]ier 40 must be used in the first instance for the repair of [P]ier 40 infrastructure including piles and roof, after which any excess revenues may be used by the [T]rust for other uses permitted by this [A]ct."

Several land use actions related to a proposed private development at 550 Washington Street in the Borough of Manhattan, City and State of New York and having a tax lot designation as Block 596, Lot 1 (the "SJC Property") are currently being reviewed through New York City's Uniform Land Use Review Procedure ("ULURP") and the City Environmental Quality Review process. Among these is a Special Permit application that would allow the Trust to transfer 200,000 square feet of floor area from Pier 40 to 550 Washington Street if also approved subsequently by the Trust's Board of Directors (the "Transfer").

In connection with the Special Permit application, the Trust submitted a statement to the New York City Department of City Planning ("DCP") identifying infrastructure improvements to be made to the Park at Pier 40, and confirming the sufficiency of funding to complete such identified improvements as required by the Act. In addition, the Trust has also (1) negotiated a draft Purchase and Sale Agreement (the "PSA") with developer of the SJC Property for the Transfer pursuant to which the developer would pay the Trust $100,000,000, and (2) retained an independent appraiser to conduct an appraisal of the 200,000 square feet of unused development rights.

Copies of the proposed PSA, the Trust's statement to DCP regarding the identification of Pier 40 infrastructure improvements, and the appraisal can be found on the Trust's website at www.hudsonriverpark.org.

DCP, on behalf of the City Planning Commission as lead agency, has issued a Notice of Completion for a Draft Environmental Impact Statement ("DEIS") for the 550 Washington Street/Special Hudson River Park District Proposal. A copy of that document is available at www1.nyc.gov/site/planning/applicants/env-review/550-washington-street-hudson-river-park.page.

In addition to the public hearing, the public will have an opportunity to provide written comments to the Trust. Written and verbal comments will be accorded the same weight. The public comment period extends from July 20, 2016 to September 21, 2016. Comments may be sent by regular mail to Amy Jedlicka, Esq., Hudson River Park Trust, Pier 40, 2nd Floor, 353 West Street, New York, N.Y. 10014 or by email to Pier40Comments@hrpt.ny.gov. The public hearing is being held in compliance with the requirements of the Hudson River Park Act regarding significant actions.

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 institutional services to clarify current provisions. The following changes are proposed:

Institutional Services

The following is a clarification to the Temporary Rate Adjustment provisions for an acute rate adjustment for mergers and acquisitions and will be effective on or after September 1, 2016. The Temporary Rate Adjustment provisions will apply as follows:

- A full asset merger or acquisition is required.
- The temporary rate adjustment is for the operating components of the acute rate only.
- The "higher of" operating rates of all hospitals merged or acquired in the full asset merger will be paid to all hospitals merged or acquired. This "higher of" is determined on an aggregate acute rate basis and not on an acute operating rate component basis.
- Facilities seeking a temporary rate adjustment will submit an appeal and demonstrate that the additional resources provided by a temporary rate adjustment will achieve one or more of the following: 1) protect or enhance access to care; 2) protect or enhance quality of care; 3) improve the cost effectiveness of the delivery of health care services; and/or 4) otherwise protect or enhance the health care delivery system, as determined by the commissioner.
- The temporary rate adjustment will be effective as of the date the full asset merger or acquisition transaction is completed and will be in effect for three years from that date.
- At the expiration of the temporary rate adjustment period, the entity will receive a combined cost-based rate for the operating components of the acute rate of all the facilities in the merged entity based on applicable rate methodologies for mergers and acquisitions.

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

The public is invited to review and comment on this proposed State Plan Amendment (SPA). Copies of which will be available for public review on the Department's website at www.health.ny.gov/regulations/state_plans/status. In addition, approved SPA's beginning in 2011, are also available for viewing on this website.

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, Division of Finance and Rate Setting, 99 Washington Ave. – One Commerce Plaza, Suite 1460, Albany, NY 12210, spa_inquiries@health.ny.gov

PUBLIC NOTICE

Office of Parks, Recreation and Historic Preservation

Pursuant to Title 3, Article 49 of the Environmental Conservation Law, the Office of Parks, Recreation and Historic Preservation hereby gives public notice of the following:

Notice is hereby given, pursuant to Section 49-0305(9) of the Environmental Conservation Law, of the Office of Parks, Recreation and Historic Preservation's intent to acquire a Conservation Easement from The Scenic Hudson Land Trust, Inc. over certain lands located at Mott Farm Road, Town of Stony Point, in the County of Rockland and the State of New York.

For further information contact: Sandra Burnell, Real Estate Specialist 2, Real Property Bureau, Office of Parks, Recreation and Historic Preservation, Albany, NY 12238, (518) 408-1964, Sandra.Burnell@parks.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 June 30, 2016. 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.

Acevedo, Marilyn - Sleepy Hollow, NY
Baker, Lisa L - Plattsburgh, NY
Carr, Leilian K - Bronx, NY
Foster, Bruce J - Buffalo, NY
Frazer, Andrew R - Elmira, NY
Gorman, Timothy E - Syracuse, NY
Hallett, Dwayne L - Bemus Point, NY
Maples, Sean M - Little Genesee, NY
Newlove, Bryan - West Seneca, NY
Orlando, Tracey L - Hamburg, NY
Regan, Joseph G - Springville, NY
Rezabek, William J - Buffalo, NY
Simpson, Zachary K - La Fargeville, NY
Singleton, James A - Middletown, NY
Spooner, Cory D - Worcester, NY
Symonds, Rockwood E - Gansevoort, NY
Wilson, Arthur G - Ogdensburg, NY

Appendix V
2016 Title XIX State Plan
Third Quarter Amendment
Responses to Standard Funding Questions

APPENDIX V
HOSPITAL SERVICES
State Plan Amendment #16-0044

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 Medicaid General Fund Local Assistance Account, which is part of the Global Cap. The Global Cap is funded by General Fund and HCRA resources. In addition, there have been no changes to provider taxes by the State.

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 447.272, 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: The State and CMS are having ongoing discussions to resolve issues with the 2015 inpatient UPL, which the 2016 UPL is contingent upon.

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 State 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.