NEW YORK STATE OF OPPORTUNITY. Department of Health

ANDREW M. CUOMO
Governor

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

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

DEC 15 2017

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

Re: SPA #17-0067
Inpatient Hospital Services

Dear Mr. Cooley:

The State requests approval of the enclosed amendment #17-0067 to the Title XIX (Medicaid) State Plan for inpatient hospital services to be effective December 1, 2017 (Appendix I). This amendment is being submitted based upon enacted State 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.

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 November 22, 2017.

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: HEALTH CARE FINANCING ADMINISTRATION	1. TRANSMITTAL NUMBER: **17-0067**	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 **December 1, 2017**	

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

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

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

6. FEDERAL STATUTE/REGULATION CITATION: **§ 1902(a) of the Social Security Act, and 42 CFR 447**	7. FEDERAL BUDGET IMPACT: **(in thousands)** **a. FFY 12/01/17-09/30/18 $ 295.87** **b. FFY 10/01/18-09/30/19 $ 304.85**
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: **Attachment 4.19-A: Page 136(b.2)**	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: **Attachment 4.19-A: Page 136(b.2)**

10. SUBJECT OF AMENDMENT:
Safety Net/VAP-St. Joseph's Hospital
(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** **Division of Finance and Rate Setting** **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: DEC 1 5 2017	

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
2017 Title XIX State Plan
Fourth Quarter Amendment
Amended SPA Pages

New York
136(b.2)

Hospitals (Continued):

Provider Name	Gross Medicaid Rate Adjustment	Rate Period Effective
Oswego Hospital	$250,000	02/01/2015-03/31/2015
	$1,000,000	04/01/2015-03/31/2016
	$1,000,000	04/01/2016–03/31/2017
	$750,000	04/01/2017-06/30/2017
St. Joseph's Hospital	$1,553,578	09/11/2014 – 03/31/2015
	$1,773,128	04/01/2015 – 03/31/2016
	$1,710,279	04/01/2016 – 03/31/2017
	$ 301,744	12/01/2017 – 03/31/2018
	$ 618,290	04/01/2018 – 03/31/2019
	$ 590,069	04/01/2019 – 03/31/2020
	$ 289,897	04/01/2020 – 03/31/2021

Appendix II
2017 Title XIX State Plan
Fourth Quarter Amendment
Summary

SUMMARY
SPA #17-0067

This State Plan Amendment proposes to revise the State Plan to modify the temporary rate adjustment for additional hospitals which are subject to or impacted by the closure, merger, acquisition, consolidation or restructuring of a health care provider. The additional provider for which approval is being requested is St. Joseph's Hospital.

Appendix III
2017 Title XIX State Plan
Fourth Quarter Amendment
Authorizing Provisions

SPA 17-0067

Public Health Law
Section 2807-c.

35. Notwithstanding any inconsistent provision of this section, or any other contrary provision of law and subject to the availability of federal financial participation, rates of payment by governmental agencies for general hospital inpatient services with regard to discharges occurring on and after December first, two thousand nine shall be in accordance with the following:

(a) For periods on and after December first, two thousand nine the operating cost component of such rates of payments shall reflect the use of two thousand five operating costs as reported by each facility to the department prior to July first, two thousand nine and as otherwise computed in accordance with the provisions of this subdivision;

(b) The commissioner shall promulgate regulations, and may promulgate emergency regulations, establishing methodologies for the computation of general hospital inpatient rates and such regulations shall include, but not be limited to, the following:

(i) The computation of a case-mix neutral statewide base price, applicable to each rate period, but excluding adjustments for graduate medical education costs, high cost outlier costs, costs related to patient transfers, and other non-comparable costs as determined by the commissioner, such statewide base prices may be periodically adjusted to reflect changes in provider coding patterns and case-mix and such other factors as may be determined by the commissioner;

(ii) Only those two thousand five base year costs which relate to the cost of services provided to Medicaid inpatients, as determined by the applicable ratio of costs to charges methodology, shall be utilized for rate-setting purposes, provided, however, that the commissioner may utilize updated Medicaid inpatient related base year costs and statistics as necessary to adjust inpatient rates in accordance with clause (C) of subparagraph (x) of this paragraph;

(iii) Such rates shall reflect the application of hospital specific wage equalization factors reflecting differences in wage rates;

(iv) Such rates shall reflect the utilization of the all patient refined (APR) case mix methodology, utilizing diagnostic related groups with assigned weights that incorporate differing levels of severity of patient condition and the associated risk of mortality, and as may be periodically updated by the commissioner;

(v) such regulations shall incorporate quality related measures, including, but not limited to, potentially preventable re-admissions (PPRs) and provide for rate adjustments or payment disallowances related to PPRs and other potentially preventable negative outcomes (PPNOs), which shall be calculated in accordance with methodologies as determined by the commissioner, provided, however, that such methodologies shall be based on a comparison of the actual and risk adjusted expected number of PPRs and other PPNOs in a given hospital and with benchmarks established by the commissioner and provided further that such rate adjustments or payment disallowances shall result in an aggregate reduction in Medicaid payments of no less than thirty-five million dollars for the period July first, two thousand ten through March thirty-first, two thousand eleven and no less than fifty-one million dollars for annual periods beginning April first, two thousand eleven through March thirty-first, two thousand fifteen, provided further that such aggregate reductions shall

be offset by Medicaid payment reductions occurring as a result of decreased PPRs during the period July first, two thousand ten through March thirty-first, two thousand eleven and the period April first, two thousand eleven through March thirty-first, two thousand fifteen and as a result of decreased PPNOs during the period April first, two thousand eleven through March thirty-first, two thousand fifteen; and provided further that for the period July first, two thousand ten through March thirty-first, two thousand fifteen, such rate adjustments or payment disallowances shall not apply to behavioral health PPRs; or to readmissions that occur on or after fifteen days following an initial admission. By no later than July first, two thousand eleven the commissioner shall enter into consultations with representatives of the health care facilities subject to this section regarding potential prospective revisions to applicable methodologies and benchmarks set forth in regulations issued pursuant to this subparagraph;

(vi) Such regulations shall address adjustments based on the costs of high cost outlier patients;

(vii) Such rates shall continue to reflect trend factor adjustments as otherwise provided in paragraph (c) of subdivision ten of this section;

(viii) Such rates shall not include any adjustments pursuant to subdivision nine of this section;

(ix) Rates for non-public, not for profit general hospitals which have not, as of the effective date of this subdivision, published an ancillary charges schedule as provided in paragraph (j) of subdivision one of section twenty-eight hundred three of this article shall have their inlier payments increased by an amount equal to the average of cost outlier payments for comparable hospitals or by a methodology that uses a statewide or regional ratio of cost to charges applied to statewide or regional comparable charges for those cases determined by the commissioner;

(x) Such regulations shall provide for administrative rate appeals, but only with regard to: (A) the correction of computational errors or omissions of data, including with regard to the hospital specific computations pertaining to graduate medical education, wage equalization factor adjustments, (B) capital cost reimbursement, and, (C) changes to the base year statistics and costs used to determine the direct and indirect graduate medical education components of the rates as a result of new teaching programs at new teaching hospitals and/or as a result of residents displaced and transferred as a result of teaching hospital closures;

(xi) Rates for teaching general hospitals shall include reimbursement for direct and indirect graduate medical education as defined and calculated pursuant to such regulations. In addition, such regulations shall specify the reports and information required by the commissioner to assess the cost, quality and health system needs for medical education provided;

(xii) Such regulations may incorporate quality related measures pertaining to the inappropriate use of certain medical procedures, including, but not limited to, cesarean deliveries, coronary artery bypass grafts and percutaneous coronary interventions;

(xiii) Such regulations may impose a fee on general hospital sufficient to cover the costs of auditing the institutional cost reports submitted by general hospitals, which shall be deposited in the Health Care Reform Act (HCRA) resources account.

(c) The base period reported costs and statistics used for rate-setting for operating cost components, including the weights assigned to diagnostic related groups, shall be updated no less

frequently than every four years and the new base period shall be no more than four years prior to the first applicable rate period that utilizes such new base period provided, however, that the first updated base period shall begin on or after April first, two thousand fourteen, but no later than July first, two thousand fourteen.

(d) Capital cost reimbursement for general hospitals otherwise subject to the provisions of this subdivision shall remain subject to the provisions of subdivision eight of this section.

(e) The provisions of this subdivision shall not apply to those general hospitals or distinct units of general hospitals whose inpatient reimbursement does not, as of November thirtieth, two thousand nine, reflect case based payment per diagnosis-related group or whose inpatient reimbursement is, for periods on and after July first, two thousand nine, governed by the provisions of paragraphs (e-1) or (e-2) of subdivision four of this section.

(f) Notwithstanding section one hundred twelve or one hundred sixty-three of the state finance law or any other law, rule or regulation to the contrary, the commissioner may contract with a vendor for consideration to develop the specifications for the diagnosis-related groups methodology as provided for in regulations promulgated pursuant to paragraph (b) of this subdivision if the commissioner certifies to the comptroller that such contract is in the best interest of the health of the people of the state. Notwithstanding that such specifications shall be available pursuant to article six of the public officers law, such contract may provide that the specifications for such adjusted or additional diagnosis-related groups provided by the vendor shall be subject to copyright protection pursuant to federal copyright law.

(g) Notwithstanding any inconsistent provision of this subdivision or any other contrary provision of law, the commissioner may, for rate periods on and after December first, two thousand nine and subject to the availability of federal financial participation, make additional adjustments to the inpatient rates of payment of eligible general hospitals, to facilitate improvements in hospital operations and finances, in accordance with the following:

(i) General hospitals eligible for distributions pursuant to this paragraph shall be those non public hospitals with Medicaid discharges equal to or greater than seventeen and one-half percent for two thousand seven.

(ii) Funds distributed pursuant to this paragraph shall be allocated to eligible hospitals pursuant to a formula such that, to the extent of funds available, no hospital's reduction in Medicaid inpatient revenue as a result of the application of the provisions of paragraphs (a) and (b) of this subdivision exceeds a percentage reduction as determined by the commissioner.

(iii) Funding pursuant to this paragraph shall be available for the following periods and in the following amounts:

(A) for the period December first, two thousand nine through March thirty-first, two thousand ten, up to thirty-three million five hundred thousand dollars;

(B) for the period April first, two thousand ten through March thirty-first, two thousand eleven, up to seventy-five million dollars, provided, however, that, notwithstanding subparagraph (ii) of this paragraph, no facility shall receive an amount pursuant to this clause that is less than such facility received pursuant to clause (A) of this subparagraph;

(C) for the period April first, two thousand eleven through March

thirty-first, two thousand twelve, up to fifty million dollars;

(D) for the period April first, two thousand twelve through March thirty-first, two thousand thirteen, up to twenty-five million dollars.

(iv) Payments made pursuant to this paragraph shall be added to rates of payments and not be subject to retroactive adjustment or reconciliation.

(v) Each hospital receiving funds pursuant to this paragraph 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 and a plan for reforming and improving such 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 is not issued and adopted by each such board of directors, or if such report fails to set forth adequate progress, as determined by the commissioner, the commissioner may deem such facility ineligible for further distributions pursuant to this paragraph and may redistribute such further distributions to other eligible facilities in accordance with the provisions of this paragraph. The commissioner shall be provided with copies of all such resolutions and reports.

(h) Inpatient rate adjustments made pursuant to paragraphs (a) through (f) of this subdivision after application of adjustments authorized pursuant to subdivision thirty-three of this section shall result in a net statewide decrease in aggregate Medicaid payments of no less than seventy-five million dollars for the period December first, two thousand nine through March thirty-first, two thousand ten, and no less than two hundred twenty-five million dollars for the period April first, two thousand ten through March thirty-first, two thousand eleven and each state fiscal year thereafter, provided, however, that such reductions shall be in addition to the reductions required pursuant to subparagraph (ii) of paragraph (a) of subdivision thirty-three of this section.

(i) (i) Notwithstanding any inconsistent provision of this subdivision or any other contrary provision of law and subject to the availability of federal financial participation, for the period July first, two thousand ten through March thirty-first, two thousand eleven, and each state fiscal year period thereafter, the commissioner shall make additional inpatient hospital payments up to the aggregate upper payment limit for inpatient hospital services after all other medical assistance payments, but not to exceed two hundred thirty-five million five hundred thousand dollars for the period July first, two thousand ten through March thirty-first, two thousand eleven, three hundred fourteen million dollars for each state fiscal year beginning April first, two thousand eleven, through March thirty-first, two thousand thirteen, and no less than three hundred thirty-nine million dollars for each state fiscal year thereafter, to general hospitals, other than major public general hospitals, providing emergency room services and including safety net hospitals, which shall, for the purpose of this paragraph, be defined as having either: a Medicaid share of total inpatient hospital discharges of at least thirty-five percent, including both fee-for-service and managed care discharges for acute and exempt services; or a Medicaid share of total discharges of at least thirty percent, including both fee-for-service and managed care discharges for acute and exempt services, and also providing obstetrical services. Eligibility to receive such additional payments shall be based on data from the period two years prior to the rate year, as reported on the institutional cost report submitted to the department as of October first of the prior rate

year. Such payments shall be made as medical assistance payments for fee-for-service inpatient hospital services pursuant to title eleven of article five of the social services law for patients eligible for federal financial participation under title XIX of the federal social security act and in accordance with the following:

(A) Thirty percent of such payments shall be allocated to safety net hospitals based on each eligible hospital's proportionate share of all eligible safety net hospitals' Medicaid discharges for inpatient hospital services, including both Medicaid fee-for-service and managed care discharges for acute and exempt services, based on data from the period two years prior to the rate year, as reported on the institutional cost report submitted to the department as of October first of the prior rate year;

(B) Seventy percent of such payments shall be allocated to eligible general hospitals based on each such hospital's proportionate share of all eligible hospitals' Medicaid discharges for inpatient hospital services, including both Medicaid fee-for-service and managed care discharges for acute and exempt services, based on data from the period two years prior to the rate year, as reported on the institutional cost report submitted to the department as of October first of the prior rate year;

(C) No eligible general hospital's annual payment amount pursuant to this paragraph shall exceed the lower of the sum of the annual amounts due that hospital pursuant to section twenty-eight hundred seven-k and section twenty-eight hundred seven-w of this article; or the hospital's facility specific projected disproportionate share hospital payment ceiling established pursuant to federal law, provided, however, that payment amounts to eligible hospitals pursuant to clauses (A) and (B) of this subparagraph in excess of the lower of such sum or payment ceiling shall be reallocated to eligible hospitals that do not have excess payment amounts. Such reallocations shall be proportional to each such hospital's aggregate payment amount pursuant to clauses (A) and (B) of this subparagraph to the total of all payment amounts for such eligible hospitals;

(D) Subject to the availability of federal financial participation, the payment methodology set forth in this subparagraph may be further revised by the commissioner on an annual basis pursuant to regulations issued pursuant to this subdivision for periods on and after April first, two thousand eleven; and

(E) Subject to the availability of federal financial participation and in conformance with all applicable federal statutes and regulations, such payments shall be made as upper payment limit payments and, further, such payments shall be made as aggregate monthly payments to eligible general hospitals.

(ii) In the event that the commissioner determines that federal financial participation will not be available for aggregate payments made in accordance with clause (E) of subparagraph (i) of this paragraph, payments pursuant to this paragraph shall be included as rate add-ons to medical assistance inpatient rates of payment established pursuant to this subdivision based on data from the period two years prior to the rate year, as reported on the institutional cost report submitted to the department as of October first of the prior rate year, provided, however, that if such payments are made as rate add-ons, the commissioner shall establish a procedure to reconcile payment amounts to reflect changes in medical assistance utilization from the period two years prior to the rate year and the actual rate year based on data as reported on each hospital's annual institutional cost report for the

respective rate year, as submitted to the department as of October first of the year following the rate year.

(iii) Notwithstanding any other law, rule or regulation to the contrary, projections of each general hospital's disproportionate share limitations as computed by the commissioner pursuant to applicable regulations shall be adjusted to reflect any additional revenue received or anticipated to be received by each such general hospital pursuant to this paragraph.

(j) Notwithstanding any contrary provision of law, with regard to inpatient and outpatient Medicaid rates of payment for general hospital services, the commissioner may make such adjustments to such rates and to the methodology for computing such rates as is necessary to achieve no aggregate, net increase or decrease in overall Medicaid expenditures related to the implementation of the International Classification of Diseases Version 10 (ICD-10) coding system on or about October first, two thousand fourteen, as compared to such aggregate expenditures from the twelve-month period immediately prior to such implementation.

Appendix IV
2017 Title XIX State Plan
Fourth Quarter Amendment
Public Notice

have an impact on Indians. Indian nation leaders and health clinic administrators and Urban Indian Organization leaders and health department administrators will now receive tribal consultation via electronic mail (e-mail). This will include a copy of the Federal Public Notice, draft plan pages, along with a cover letter offering the availability of State staff to meet with respective Indian leaders in person upon requests made within two weeks of the date of notification.

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, a copy of which will be available for public review on the Department's website at http://www.health.ny.gov/regulations/state_plans/status. Individuals without Internet access may view the State Plan Amendments at any local (county) social services district.

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 1432, Albany, NY 12210, spa_inquiries@health.ny.gov

PUBLIC NOTICE

Office of Mental Health and Department of Health

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

The Office of Mental Health and the Department of Health propose to amend the Title XIX (Medicaid) State Plan for institutional services related to temporary rate adjustments to Article 28 Hospitals that are undergoing a closure, merger, consolidation, acquisition or restructuring of themselves or other health care providers. These payments are currently authorized by 2807-c (35) of the New York Public Health Law. The following changes are proposed:

Additional temporary rate adjustments have been reviewed and approved for the following hospitals:

• Arnot Health, Inc / St. Joseph's Hospital

The aggregate payment amounts total up to $301,744 for the period December 1, 2017 through March 31, 2018.

The aggregate payment amounts total up to $618,290 for the period April 1, 2018 through March 31, 2019.

The aggregate payment amounts total up to $590,069 for the period April 1, 2019 through March 31, 2020.

The aggregate payment amounts total up to $289,897 for the period April 1, 2020 through March 31, 2021.

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 of Health'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 also 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

Department of State
Notice of Review for the City of Buffalo
Draft Local Waterfront Revitalization Program

In accordance with the New York State Waterfront Revitalization of Coastal Areas and Inland Waterways Act and the New York State Coastal Management Program, the City of Buffalo, located within Erie County, has prepared a Draft Local Waterfront Revitalization Program (LWRP). The LWRP is a comprehensive management program for the City's waterfront resources along Lake Erie, the Niagara River, the Buffalo River, Scajaquada Creek and Cazenovia Creek.

To approve the City of Buffalo LWRP, pursuant to Article 42 of the NYS Executive Law, it is required that potentially affected State, federal and local agencies be consulted to assure that the program does not conflict with any existing policies and programs.

The Draft LWRP was accepted by the New York State Department of State as complete and is now available for review by potentially affected State, federal and local agencies, and the public. Comments on the Draft LWRP are due by February 20, 2018. For this purpose, the City of Buffalo Draft LWRP is available online at: http://www.dos.ny.gov/opd/programs/WFRevitalization/LWRP_draft.html.

At the close of the required review period, the Department of State will coordinate responses to all comments received with the City of Buffalo, and modifications to the Draft LWRP will be made as needed. Following adoption of the LWRP by the City and its subsequent approval by the Secretary of State, pursuant to 15 CFR 923.84(b), the New York State Department of State will request incorporation of the City of Buffalo LWRP into the State's Coastal Management Program by NOAA's Office for Coastal Management as a Routine Program Change.

Comments on the City of Buffalo Draft LWRP are welcome and should be submitted in writing by February 20, 2018 to: Renee Parsons, Department of State, Office of Planning, Development & Community Infrastructure, 99 Washington Ave., Suite 1010, Albany, NY 12231-0001, (518) 474-6000.

Appendix V
2017 Title XIX State Plan
Fourth Quarter Amendment
Responses to Standard Funding Questions

APPENDIX V
HOSPITAL SERVICES
State Plan Amendment #17-0067

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 the 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 2 CFR 200 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. There have been no new provider taxes and no existing taxes have been modified as a result of this State Plan Amendment.

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 add-on services payments made to those providers listed who will receive temporary rate adjustments to be paid quarterly.

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 2017 Inpatient UPL has been approved.

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.

Appendix VI
2017 Title XIX State Plan
Fourth Quarter Amendment
Responses to Standard Access Questions

APPENDIX VI
INPATIENT SERVICES
State Plan Amendment 17-0067

CMS Standard Access Questions

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

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

   Response: First, hospitals are required to the meet licensure and certification requirements to ensure providers are qualified to deliver services to Medicaid patients. These requirements as well as other methods and procedures the state has in place to ensure efficiency, economy and quality of care are not impacted in any way by this amendment. Second, all licensed hospitals currently participate in New York State's Medicaid program and are located across the state so Medicaid recipients in any geographic area have access to services that are available to the general population in those communities. Continuing the policy to maintain a trend factor no greater than zero is intended to hold rates constant, not reduce them. While this one element in the state's methods and procedures for setting payment rates will control costs, any savings attributed to it will be reinvested in Medicaid hospital payments under other provisions of the state's methodology resulting in overall hospital payments being set at the maximum permitted by the Federal Medicaid Upper Payment limit requirements.

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

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

   For providers that are not subject to an approval process, the State will continue to monitor provider complaint hotlines to identify geographic areas of

concern and/or service type needs. If Medicaid beneficiaries begin to encounter access issues, the Department would expect to see a marked increase in complaints. These complaints will be identified and analyzed in light of the changes proposed in this State Plan Amendment.

Finally, the State ensures that there is sufficient provider capacity for Medicaid Managed Care plans as part of its process to approve managed care rates and plans. Should sufficient access to services be compromised, the State would be alerted and would take appropriate action to ensure retention of access to such services.

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

   Response: Funding was enacted by the State Legislature as part of the negotiation of the final Budget. The legislative process provides opportunities for all stakeholders to lobby their concerns, objections, or support for various legislative initiatives. In addition, NY published notice in the state register of the proposed policy and did not receive any comments

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

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

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

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

Affordability Law (HEAL). Further, the New York State Budget provides for a Quality Pool for hospital inpatient services for up to $57.8M for SFY 2017/2018 which will be paid through the Medicaid Managed Care Health Plan rates. The State Budget also provides for a $20M investment in Critical Access Hospitals, as well as a $20M investment in Enhanced Safety Net facilities. DOH is also in the process of implementing the Delivery System Reform Incentive Payment (DSRIP) program whereby up to $6.42 billion is being reinvested in the Medicaid program over a five-year period. The State also offers a number of other programs to hospitals such as the Vital Access Provider (VAP) program and the Vital Access Provider Assurance Program (VAPAP) to help sustain key health care services. While some of these initiatives are outside the scope of the State Plan, they represent some of the measures the State is taking to ensure quality care for the State's most vulnerable population.