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

MAR 29 2018

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

Re: SPA #18-0012
Inpatient Hospital Services

Dear Mr. Cooley:

The State requests approval of the enclosed amendment #18-0012 to the Title XIX (Medicaid) State Plan for inpatient hospital services to be effective January 1, 2018 (Appendix I). This amendment is being submitted based upon state statute. 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 September 27, 2017.

Copies of pertinent sections of state statute are enclosed for your information (Appendix III). In addition, responses to the five standard funding questions and the standard access questions are also enclosed (Appendix V and 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: **18-0012**	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 **January 1, 2018**	

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 10/01/17-09/30/18 $ 3742.20** **b. FFY 10/01/18-09/30/19 $ 3793.17**
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: **Attachment 4.19-A: 1, 2, 2(a), 2(b), 2(c), 2(d), 2(e), 2(f), 2(g)**	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: **Attachment 4.19-A: 1, 2**

10. SUBJECT OF AMENDMENT:
OPWDD Specialty 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 & Rate Setting** **99 Washington Ave – One Commerce Plaza** **Suite 1432** **Albany, NY 12210**
13. TYPED NAME: **Jason A. Helgerson**	
14. TITLE: **Medicaid Director** **Department of Health**	
15. DATE SUBMITTED: MAR 29 2018	

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
1

1. Rates for existing specialty hospitals for services delivered [on and after] July 1, 2011 through December 31, 2018 will be determined in accordance with the following described methodology.

(a) "**Specialty hospital**" as used in this Part of this Attachment is the program and site for which OPWDD has issued an operating certificate to operate as a specialty hospital for persons with developmental disabilities. "**Provider**" as used in this Part of this Attachment is the corporation or other organization operating a specialty hospital.

(b) **Unit of service -** The unit of service will be a day.

(c) **Rates** will be as follows:

Rate period	Rate
07/01/2011-12/31/2014	$895.16
01/01/2015-03/31/2015	$898.93
04/01/2015-03/31/2016	$910.94
04/01/2016-12/31/2017	$912.73
01/01/2018-03/31/2018	$919.09
04/01/2018-12/31/2018	$939.32

(d) **Rate appeals** - A provider may appeal for an adjustment to its rate that would result in an annual increase of $5,000 or more in the provider's allowable costs and that is needed because of bed vacancies. A bed vacancy appeal may be requested when the occupancy rate of the specialty hospital is less than 100 percent. The appeal request must be made within one year of the close of the rate period in which the bed vacancies occurred or within six months of the notification to the provider of the rate amount, whichever is later. OPWDD will only grant the appeal if the provider has demonstrated that the vacancies were unavoidable. No amount granted on appeal will result in Medicaid payments exceeding the provider's specialty hospital costs of providing Medicaid services for the rate period.

New York
2

[(e) Additional Disproportionate Share Payment – Specialty Hospital

Disproportionate share hospital payments under this plan cannot exceed the State disproportionate share allotment calculated in accordance with section 1923(f) of the Social Security Act and cannot exceed the facility specific disproportionate share hospital payment limits at section 1923(g) of the Social Security Act.

Effective October 1, 2014, the State will make disproportionate share hospital (DSH) payments to privately operated specialty hospitals certified by the New York State Office for People With Developmental Disabilities (OPWDD). The annual total aggregate amount of the payment will be $10,000. Currently Terence Cardinal Cooke Health Care Center is the only privately operated specialty hospital certified by the New York State Office for People with Developmental Disabilities (OPWDD). Should additional hospitals qualify for this DSH payment, the total aggregate amount of payment will be distributed proportionately based on each hospital's relative percentage of Medicaid days to total Medicaid days of all hospitals eligible for a payment under this provision.]

2. Effective on and after October 1, 2017, rates for services delivered for newly certified Specialty Hospital providers and, effective on and after January 1, 2019 rates for existing Specialty Hospital providers reimbursed using the payment method as described in Part VII, Attachment 4.19-A, Section (1), will be governed by this section of Part VII, Attachment 4.19-A. The standards for rate development are in accordance with the following described methodology:

(a) Definitions (applicable to this section):

(i) **Allowable Capital Costs** – All necessary costs incurred to provide covered services to beneficiaries determined in accordance with the cost principles described in the Medicare Provider Reimbursement Manual (PRM-15). This will include allowable lease/rental and ancillary payments; depreciation of equipment, vehicles, leasehold improvements and real property; and bonding, principal, interest and financing expenditures associated with the purchase of equipment, vehicles and real property, and related expenditures and leasehold improvements, which have received prior approval by the Office for People With Developmental Disabilities (OPWDD).

(ii) **Allowable Operating Costs** – All necessary and proper costs which are appropriate in developing and maintaining the operation of a Specialty Hospital. Necessary and proper costs are costs which are common and accepted occurrences in the field of Specialty Hospitals. These costs will be determined in accordance with the cost principles described in the Medicare Provider Reimbursement Manual (PRM-15), which will include allowable Administration, OTPS, Clinical, Direct Care, Support, Fringe Benefits and Utilities.

New York
2(a)

(iii) **Base Period CFR** – The CFRs for the period July 1 to June 30 and January 1 to December 31 will be used to calculate rates. The base period CFR used for rate development will be two years prior to the rate period.

(iv) **Capital Costs** – Costs that are related to the acquisition and/or long term use of land, buildings, construction and equipment.

(v) **Certified Bed Capacity**– Represents the total bed capacity of the specialty hospital on the provider's operating certificate.

(vi) **Consolidated Fiscal Report (CFR)** – A reporting tool, with core schedules, submitted in accordance with Generally Accepted Accounting Principles and utilized by all New York State (NYS) government and non-government OPWDD providers to communicate their annual costs incurred as a result of operating OPWDD programs and services, along with related utilization and staffing statistics.

(vii) **Existing Providers** – A specialty hospital which opened prior to October 1, 2017.

(viii) **First rate period** – is the first twelve months of the rate cycle.

(ix) **Maximum Units of Service** – will be calculated by multiplying the certified bed capacity on the last day of the prior rate period by the number of total annual days in that rate period.

(x) **Newly Certified Providers** – A specialty hospital which opened on and after October 1, 2017.

(xi) **Occupancy Adjustment** – An adjustment to the provider's specialty hospital operating per day rate to account for days when Medicaid billing cannot occur.

(xii) **OPWDD** – NYS Office for People With Developmental Disabilities (OPWDD) is the NYS agency that is responsible for coordinating services for New Yorkers with developmental disabilities.

(xiii) **Provider** - The corporation or other organization operating a specialty hospital.

(xiv) **Provider Rate** – The provider-specific rate resulting from implementation of the reimbursement methodology. The provider rate is unique for each provider.

(xv) **Prior Rate Period** – is the twelve months prior to the current rate period.

New York
2(b)

(xvi) **Rate Cycle** – the rate cycle is a twenty-four month period that consists of two rate periods beginning on January 1st of each year.

(xvii) **Rate Period –** The time period for which rates are effective.

(xviii) **Specialty Hospital** - The program and site for which OPWDD has issued an operating certificate to operate as a specialty hospital for persons with developmental disabilities.

(xix) **Subsequent Rate Cycle** – the rate cycle after the initial rate cycle.

(xx) **Subsequent Rate Period** – is the second twelve months of the rate cycle.

(xxi) **Trend Factor** – is a percentage applied to all applicable operating costs that represent inflations in the costs of goods and services.

(xxii) **Unit of service -** The unit of service will be a day. The day of admission but not the day of discharge will be counted as a unit of service. Also, one unit of service will be counted if the individual is discharged on the same day he/she is admitted, providing there was an expectation that the admission would have at least a twenty-four hour duration.

New York
2(c)

(b) Specialty Hospital provider rates will be calculated as follows:

(i) Existing providers will continue to use the method as described in paragraph (1) of the Specialty Hospital Section through December 31, 2018.

(ii) Effective on and after January 1, 2019, specialty hospital provider rates for existing providers will be calculated as follows:

(1) A two-year prior base period CFR will be used for the development of rates.

(a) The base period CFR operating and capital cost (subject to PPA approval) used in the January 1, 2019 rate development will be the specialty hospital's applicable CFR for the period from July 1, 2017 to June 30, 2018 or January 1, 2017 to December 31, 2017.

(b) The base period CFR described in paragraph (2)(b)(ii)(1)(a) will continue to be used for two rate periods within the rate cycle that begins with the January 1, 2019 rate.

(2) The base period CFR cost data will be utilized in the rate development as follows:

(a) The allowable operating costs used in the provider rate development will reflect a trend factor and other rate adjustments based on the requirements as provided for in legislation unless the base period CFR operating costs are reflective of the trend factors and other rate adjustments based on the effective date of the adjustments.

(b) The allowable capital costs used in the provider rate development will be based on paragraphs (2)(b)(ii)(1)(a) and a capital schedule developed to provide supporting documentation of the capital rate development.

(i) OPWDD regulations under 14 NYCRR Subpart 635-6 establish standards and criteria that describes the capital acquisition and lease of real property assets which require approval by OPWDD. Any adjustments to the provider's property schedule developed in paragraph (2)(b)(ii)(2)(b) will require a prior property approval (PPA) completed by OPWDD.

(ii) A property cost verification (PCV) will be performed to reconcile the costs submitted on a PPA by requiring the provider to submit to NYS supporting documentation of actual costs. Actual costs will be verified by the Department within NYS that is reviewing the supporting documentation of such costs. A provider submitting such actual costs will certify that the reimbursement requested reflects allowable capital costs and that such costs were actually expended by the provider. Under no circumstances

New York
2(d)

will the amount included in the rate under this subparagraph exceed the amount authorized in the PPA process. A PCV will be performed on all PPAs prior to any capital costs being included in reimbursement rates.

(iii) Capital rates will be reviewed and adjusted for PCVs twice a year. The effective date of the rate adjustments will be on the January 1 or July 1 date that is subsequent to the PCV date, however, the adjustment will incorporate the capital change from the initial effective date of the capital change. This update may require NYS to annualize the PPA, which could include more than twelve months of costs in the first year.

(c) The base year costs will be updated to reflect an occupancy adjustment factor.

(i) For the first rate period of the rate cycle, this factor will be calculated by comparing the maximum units of service in relation to the actual billed days based on the latest available twelve months of experience.

(ii) For the subsequent rate period of the rate cycle, this factor will be updated by comparing the maximum units of service in relation to the actual billed days based on the latest available twelve months of experience.

(iii) The maximum occupancy adjustment factor will be five percent.

(d) The days used as the divisor for the per day provider rate calculation will be the maximum units of service in the rate period which will be calculated as defined in the Definitions Section. The divisor will be updated for each rate period.

(3) For subsequent rate cycles:

(i) The base period CFR for the operating provider rate component will be a two-year base period CFR as required in paragraph (2)(b)(ii)(1).

(ii) The base period CFR will be updated every two years.

(iii) The days used as the divisor will be the maximum units as stated in (2)(b)(ii)(2)(d) of this section.

New York
2(e)

(iii) For newly certified specialty hospital providers with no cost experience the specialty hospital provider rate will be calculated as follows:

(1) The effective date of the specialty hospital provider rate will be the date the hospital is approved for opening but will be no earlier than the effective date of paragraph (2) of this section.

(a) The operating component of the provider rate will be based on the specialty hospital's budgeted costs which were submitted by the specialty hospital and reviewed and approved by OPWDD.

(b) The budgeted operating component of the provider rate will reflect a trend factor and other rate adjustments as provided for in legislation unless the approved budgeted costs are reflective of the trend factor and other rate adjustments based on the effective date of the adjustments.

(c) No occupancy adjustment factor will be applied to the budgeted costs.

(d) The initial capital component of the provider rate will be based on the specialty hospital's budgeted costs which were submitted by the specialty hospital to OPWDD and received prior property approval (PPA) from OPWDD.

(i) NYS will perform a property cost verification (PCV) to reconcile the budgeted costs submitted on the PPA by requiring the provider to submit to NYS supporting documentation of actual costs. Actual costs will be verified by the Department within NYS that is reviewing the supporting documentation of such costs. A provider submitting such actual costs will certify that the reimbursement requested reflects allowable capital costs and that such costs were actually expended by the provider. Under no circumstances will the amount included in the rate under this subparagraph exceed the amount authorized in the approval process.

(ii) Estimated costs for a newly certified provider shall be submitted in lieu of actual costs for a period no greater than two years. If actual costs are not submitted to the Department within two years from the date of site certification, the amount of capital costs included in the rate shall be zero for each period in which actual costs are not submitted. The Department will retroactively adjust the capital component and will return Federal Financial Participation (FFP) to the Centers for Medicare and Medicaid Services (CMS) on the next quarterly expenditure report (CMS-64) following the two year period. Once the final cost reconciliation has

New York
2(f)

been received by the Department, the rate will be retroactively adjusted to include reconciled costs.

(iii) Any additional capital costs requested subsequent to the initial PPA for budgeted capital costs will require a new PPA. These costs will be reconciled in accordance with paragraph (2)(iii)(1)(d)(i). No additional costs will be included in reimbursement until the completion of the PCV for the additional costs.

(e) The days used as the divisor for the per day provider rate calculation will be the maximum units of service as defined in the Definitions Section. The divisor will be updated for each rate period.

(d) The budgeted operating per day provider rates will be revised to actual operating costs using the first full year of operations.

(i) At the time a provider's rates are based on actual CFR costs, their rates will be established in accordance with paragraph (2)(b)(ii) of this Section.

(ii) At the time the base year CFR costs are updated on a statewide basis and the base period CFR used statewide reflects a full year of operations for the newly certified provider, the specialty hospital provider rates will be updated to bring the newly certified specialty hospital to the same base period CFR that is used statewide.

New York
2(g)

3. Additional Disproportionate Share Payment – Specialty Hospital

Disproportionate share hospital payments under this plan cannot exceed the State disproportionate share allotment calculated in accordance with section 1923(f) of the Social Security Act and cannot exceed the facility specific disproportionate share hospital payment limits at section 1923(g) of the Social Security Act.

Effective October 1, 2014, the State will make disproportionate share hospital (DSH) payments to privately operated specialty hospitals certified by the New York State Office for People With Developmental Disabilities (OPWDD). The annual total aggregate amount of the payment will be $10,000. Currently Terence Cardinal Cooke Health Care Center is the only privately operated specialty hospital certified by the New York State Office for People with Developmental Disabilities (OPWDD). Should additional hospitals qualify for this DSH payment, the total aggregate amount of payment will be distributed proportionately based on each hospital's relative percentage of Medicaid days to total Medicaid days of all hospitals eligible for a payment under this provision. Effective on and after October 1, 2017, specialty hospital providers, whether reimbursed in accordance with Sections (1) or (2) of Attachment 4.19 Part VII, will be considered as qualifying for this DSH payment.

Appendix II
2017 Title XIX State Plan
Fourth Quarter Amendment
Summary

SUMMARY
SPA #18-0012

This State Plan Amendment proposes to revise the State Plan effective on or after January 1, 2018 such that newly certified providers will have a budget based rate and convert to a cost based rate after the first full year of costs is reflected in the cost report. Further, effective on or after January 1, 2019, the rate for the existing provider will be calculated using a cost-based methodology.

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

Authorizing Provisions – SPA 180012

Compilation of Codes, Rules and Regulations of the State of New York (NYCRR)
Title 14. Department of Mental Hygiene
Chapter XIV. Office for People with Developmental Disabilities
Part 680. Specialty Hospitals

A Specialty Hospital is governed by Title 14, Part 860 of the NYCRR.

- s 680.1 Background and intent. [Supplied below]
- s 680.2 Statutory authority. [Supplied below]
- s 680.3 Certification.
- s 680.4 Organization and administration.
- s 680.5 Admission criteria.
- s 680.6 Individual program planning and review.
- s 680.7 Specialty hospital services (see section 680.13 of this Part).
- s 680.8 Staffing.
- s 680.9 Utilization review.
- s 680.10 Individual rights and protection.
- s 680.11 Physical environment.
- s 680.12 Rate setting and financial reporting. [Sections (d) and (e) to be repealed and replaced to add rate methodology in State Plan Amendment 18-0012]
- s 680.13 Glossary.

14 NYCRR 680.1
Section 680.1. Background and intent

(a) Within the continuum of human services offered by OPWDD (see section 680.13 of this Part), the specialty hospital (see section 680.13) is designed as the most intensive provider of care for individuals with developmental disability and health care problems (see section 680.13) through an integrated combination of assessment services, active programming, continuing medical treatment, and residential arrangements.

(b) The specialty hospital serves as a transitional setting which has as its primary goal the prevention, amelioration or limitation of health care problems for individuals with developmental disabilities to enable the movement of such individuals to less restrictive environments.

(c) Because active programming, medical treatment and residence are combined in a single setting, the specialty hospital is considered as the most restrictive environment which offers 24-hour care to people with developmental disabilities whose health problems, rather than developmental disability *per se,* prevent placement in an alternative, less restrictive placement.

(d) Individuals admitted to a specialty hospital shall have a previously established diagnosis of developmental disability (see section 680.13) and shall require:

(1) active programming (see section 680.13) for their developmental disabilities; and

(2) individualized attention for more than three hours per day for health care problems.

(e) Services within a specialty hospital shall be oriented toward ameliorating the health care problem(s) preventing a client's movement to the least restrictive treatment alternative (see section 680.13). Therefore, health care problems preventing such movement shall be identified for individuals prior to their admission to a specialty hospital. Services focused on these identified problems shall be delivered with the frequency and intensity necessary to affect a rapid transition to less restrictive treatment alternatives. In general, comprehensive programming aimed toward a general increase in all aspects of individual functioning is not the primary emphasis of specialty hospitals.

Appendix IV
2017 Title XIX State Plan
Fourth 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 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 institutional services methods and standards for setting Medicaid payment rates for Office of People With Developmental Disabilities (OPWDD) Specialty Hospitals. The following changes are proposed:

Institutional Services

The following is a newly established methodology for the reimbursement of existing and newly certified OPWDD Specialty Hospitals.

All existing OPWDD Specialty Hospitals will continue the current fee-based methodology through December 31, 2018. Effective January 1, 2019, the rate for existing specialty hospital providers will follow the method for newly established OPWDD Specialty Hospitals, using a two-year cost-based methodology.

Effective on or after January 1, 2019, for existing specialty hospital providers, a cost-based rate will be developed. The base period CFR operating and capital costs used will be the specialty hospitals CFR for the period from July 1, 2016 to June 30, 2017 or January 1, 2017 to December 31, 2017. The base period CFR will continue to be used for two rate periods within a rate cycle that begins with the January 1, 2019 rate.

Effective on or after October 1, 2017, newly certified providers will be reimbursed a budget-based rate and convert to a cost-based rate after the first full year of costs is reflected in the Consolidated Fiscal Report (CFR) cost report. After a newly certified provider receives a cost-based rate, they will utilize the same two-year cost-based methodology as existing specialty hospital providers and will be rebased at the same time all specialty hospitals are rebased statewide.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2017/2018 is $7,200,000.

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. 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 1432, Albany, NY 12210, e-mail: spa_inquiries@health.ny.gov

PUBLIC NOTICE

Department of State
F-2017-0498
Date of Issuance – September 27, 2017

The New York State Department of State (DOS) is required by Federal regulations to provide timely public notice for the activities described below, which are subject to the consistency provisions of the Federal Coastal Zone Management Act of 1972, as amended.

The applicant has certified that the proposed activity complies with and will be conducted in a manner consistent with the approved New York State Coastal Management Program. The applicant's consistency certification and accompanying public information and data are available for inspection at the New York State Department of State offices located at One Commerce Plaza, 99 Washington Avenue, in Albany, New York.

In F-2017-0498, the Village of Piermont is proposing to construct a 720-square foot main floating dock and a 360-square foot floating finger dock at the northern end of the Piermont Pier, located at 200 Ferry

Road, Village of Piermont, Rockland County. The docks would be anchored with 18-inch diameter steel pilings and connected to the existing pier with a 30-foot long gangway. The purpose of the project is to improve year-round response times for the Village of Piermont Fire Department's emergency response vessels.

Any interested parties and/or agencies desiring to express their views concerning any of the above proposed activities may do so by filing their comments, in writing, no later than 4:30 p.m., 30 days from the date of publication of this notice, or, October 27, 2017.

Comments should be addressed to the Consistency Review Unit, Department of State, Office of Planning and Development, One Commerce Plaza, 99 Washington Ave., Albany, NY 12231, (518) 474-6000, Fax (518) 473-2464. Electronic submissions can be made by email at: CR@dos.ny.gov

This notice is promulgated in accordance with Title 15, Code of Federal Regulations, Part 930.

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

APPENDIX V
HOSPITAL SERVICES
State Plan Amendment #18-0012

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.,
2. 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.

3. 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 amendment 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.

4. 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.

5. 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 UPL has been approved and the margin has been paid. This service will not be in the 2017 UPL (hospital has not been built) and will be included in the appropriate UPL.

6. 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: The 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 18-0012

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 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 assure efficiency, economy and quality of care are not impacted in any way by the amendment. Second, all licensed hospitals currently participate in the New York State's Medicaid program and are located all across the state so that Medicaid recipients in any geographic area have access to services that are available to the general population in those communities. This amendment seeks to periodically update the weights to accurately pay providers for the service they performed.

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 providers must notify and receive approval from the Department's Office of Health Systems Management (OHSM) in order to discontinue services. This Office monitors and considers such requests in the context of access as they approve/deny changes in services. Finally, providers cannot discriminate based on source of payment.

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

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

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

   Response: This change was enacted by the State Legislature as part of the negotiation of the 2017-18 Budget. The impact of this change was weighed in the context of the overall Budget in the State. The legislative process provides opportunities for all stakeholders to lobby their concerns, objections, or support for various legislative initiatives. 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.