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

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

JUN 2 2 2018

Re: SPA #18-0031
Inpatient Hospital Services

Dear Mr. Cooley:

The State requests approval of the enclosed amendment #18-0031 to the Title XIX (Medicaid) State Plan for inpatient hospital services to be effective April 1, 2018 (Appendix I). This amendment is being submitted based upon enacted legislation. A summary of the proposed amendment is contained in Appendix II.

This amendment is submitted pursuant to §1902(a) of the Social Security Act (42 USC 1396a(a)) and Title 42 of the Code of Federal Regulations (CFR), Part 447, Subpart C.

In accordance with 42 CFR §447.272(c), New York assures that its aggregate disproportionate share hospital payments do not exceed the disproportionate share hospital payment limit.

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 March 28, 2018.

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

If you have any questions regarding this State Plan Amendment submission, please do not hesitate to contact Regina Deyette, Medicaid State Plan Coordinator, Division of Finance and Rate Setting, Office of Health Insurance Programs at (518) 473-3658.

Sincerely,

Donna Frescatore

Donna Frescatore
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: **18-0031**	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 **April 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 04/01/18-09/30/18 $79,865.88** **b. FFY 10/01/18-09/30/19 $79,865.88**
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: **Attachment 4.19-A: Page 161(1)**	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: **Attachment 4.19-A: Page 161(1)**

10. SUBJECT OF AMENDMENT:
2018 Voluntary UPL Payments
(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: Donna Frescatore	16. RETURN TO: **New York State Department of Health** **Division of Finance and Rate Setting** **99 Washington Ave – One Commerce Plaza** **Suite 1432** **Albany, NY 12210**
13. TYPED NAME: **Donna Frescatore**	
14. TITLE: **Medicaid Director** **Department of Health**	
15. DATE SUBMITTED: JUN 2 2 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
2018 Title XIX State Plan
Second Quarter Amendment
Amended SPA Pages

New York
161(1)

Voluntary Supplemental Inpatient Payments

Effective for the period July 1, 2010 through March 31, 2011, additional inpatient hospital payments are authorized to voluntary sector hospitals, excluding government general hospitals, for inpatient hospital services after all other medical assistance payments, of $235,500,000 for the period July 1, 2010 through March 31, 2011; $314,000,000 for the period April 1, 2011 through March 31, 2012; $281,778,852 for the period April 1, 2012 through March 31, 2013; $298,860,732 for the period April 1, 2013 through March 31, 2014; and $226,443,721 for the period April 1, 2014 through March 31, 2015; and $264,916,150 for the period April 1, 2015 through March 31, 2016; and $271,204,805 for the period of April 1, 2016 through March 31, 2017; and $319,459,509 for the period of April 1, 2017 through March 31, 2018; and $362,865,600 for the period of April 1, 2018 through March 31, 2019 subject to the requirements of 42 CFR 447.272 (upper payment limit) . Such payments are paid monthly to eligible voluntary sector owned or operated general hospitals, excluding government general hospitals.

Eligibility to receive such additional payments, and the allocation amount paid to each hospital, will be based on data from the period two years prior to the rate year, as reported on the Institutional Cost Report (ICR) submitted to the Department as of October 1 of the prior rate year.

(a) Thirty percent of such payments will 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;

(i) Safety net hospitals are defined as non-government owned or operated hospitals which provide emergency room services having either: a Medicaid share of total inpatient hospital discharges of at least 35%, including both fee-for-service and managed care discharges for acute and exempt services; or a Medicaid share of total discharges of at least 30%, including both fee-for-service and managed care discharges for acute and exempt services, and also providing obstetrical services.

(b) Seventy percent of such payments will be allocated to eligible general hospitals, which provide emergency room services, 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;

(c) No payment will be made to a hospital described in (i) and (ii). Payment amounts will be reduced as necessary not to exceed the limitations described in (iii).

(i) did not receive an Indigent Care Pool (ICP) payment;
(ii) the hospital's facility specific projected disproportionate share hospital payment ceiling is zero; or,
(iii) the annual payments amount to eligible hospitals exceeds the Medicaid customary charge limit at 42 CFR 447.271.

(d) Any amounts calculated under paragraphs (a) and (b) but not paid to a hospital because of the requirements in paragraph (c) will be allocated proportionately to those eligible general hospitals that provide emergency room services and which would not be precluded by paragraph (c) from receiving such additional allocations.

Appendix II
2018 Title XIX State Plan
Second Quarter Amendment
Summary

SUMMARY
SPA #18-0031

This State Plan Amendment proposes to extend supplemental upper payment limit distributions for inpatient hospital services to voluntary sector hospitals excluding government general hospitals, not to exceed in aggregate $339M annually in combination with the outpatient voluntary hospital UPL SPA for the period April 1, 2018 through March 31, 2019.

Appendix III
2018 Title XIX State Plan
Second Quarter Amendment
Authorizing Provisions

18-0031

Pub Health §2807-c(35)(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:

Appendix IV
2018 Title XIX State Plan
Second 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

Division of Criminal Justice Services
Law Enforcement Agency Accreditation Council

Pursuant to Public Officers Law § 104, the Division of Criminal Justice Services gives notice of a rescheduled meeting of the Law Enforcement Agency Accreditation Council to be held on:

Date: Monday, April 2, 2018
Time: 1:00 p.m.
Place: Division of Criminal Justice Services
Alfred E. Smith Office Bldg.
80 S. Swan St.
CrimeStat Rm. (Rm. 118)
Albany, NY 12210

Identification and sign-in are required at this location. *For further information, or if you need a reasonable accommodation to attend this meeting, please contact*: Division of Criminal Justice Services, Office of Public Safety, Alfred E. Smith Office Bldg., 80 S. Swan St., Albany, NY 12210, (518) 457-2667

Live Webcast will be available as soon as the meeting commences at: http://www.criminaljustice.ny.gov/pio/openmeetings.htm

PUBLIC NOTICE

Division of Criminal Justice Services
Municipal Police Training Council

Pursuant to Public Officers Law § 104, the Division of Criminal Justice Services gives notice of a rescheduled meeting of the Municipal Police Training Council to be held on:

Date: Friday, March 30, 2018 (tentative)
Time: 9:30 a.m.
Place: Division of Criminal Justice Services
Alfred E. Smith Office Bldg.
80 S. Swan St.
CrimeStat Rm. (Rm. 118)
Albany, NY 12210

Identification and sign-in are required at this location. *For further information, or if you need a reasonable accommodation to attend this meeting, please contact*: Division of Criminal Justice Services, Office of Public Safety, Alfred E. Smith Office Bldg., 80 S. Swan St., Albany, NY 12210, (518) 457-2667

Live Webcast will be available as soon as the meeting commences at: http://www.criminaljustice.ny.gov/pio/openmeetings.htm

PUBLIC NOTICE

Department of Health

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

The Department of Health proposes to amend the Title XIX (Medicaid) State Plan for non-institutional, institutional and long-term care services to comply with proposed statutory provisions. The following changes are proposed:

Non-Institutional Services

Effective on or after April 1, 2018, this initiative proposes to eliminate the supplemental medical assistance payments of $6 million annually made to providers of emergency medical transportation.

The estimated annual net aggregate decrease in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2018/2019 is $6 million.

Effective on or after April 1, 2018, the professional dispensing fee for brand name, generic, and OTC covered outpatient drugs will be updated to $10.08, to align with current costs.

The estimated annual aggregate increase in gross Medicaid expenditures attributable to this initiative for state fiscal year 2018/2019 is $795,531.

Effective on and after October 1, 2018, Medicaid will cover ABAs. ABAs are State Education Department (SED) licensed practitioners who provide intensive treatment for persons diagnosed with autism spectrum disorder using applied behavioral analysis treatment modalities. These services and practitioners are currently covered by Early Intervention (EI), Child Health Plus (CHIP), and all major commercial payers. The Medicaid Program does not currently recognize or reimburse ABA's, which results in a break in coverage for those children who age out of the EI program.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2018/2019 is $12.1 million.

Effective on and after July 1, 2018, the physical therapy cap under both fee-for-service and mainstream managed care will be increased from 20 visits to 40 visits per member in a 12-month period. The following populations are exempt from the 40-visit limitation: children (0-21 years of age); individuals with developmental disabilities; Medicare/Medicaid dually eligible individuals when the service is

covered by Medicare; and individuals with a traumatic brain injury. Revision of the physical therapy cap will provide members an opportunity to obtain additional rehabilitation therapy to treat low back pain as well as other physical conditions which will help reduce the need for opioid treatment.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2018/2019 is $4.6 million.

Effective on and after April 1, 2018, Medicaid will begin covering Centers for Disease Control (CDC) certified National Diabetes Prevention Program (NDPP). The NDPP is a CDC recognized educational and support program designed to assist at-risk individuals from developing Type 2 diabetes. The program focuses on lifestyle interventions and the long-term effects of diet and exercise. These intense interventions demonstrate a greater influence on the reduction in diabetes risk, return to normoglycemia, and weight loss than less intense programs.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2018/2019 is $1.03 million.

Effective on or after April 1, 2018, the Early Intervention Program reimbursement methodology for the targeted case management (service coordination) services will be revised from an hourly rate billed in fifteen-minute units to two separate categories of fixed rates for initial case management services and one per member per month fixed rate for ongoing case management services. These rates are being revised to create administrative efficiencies for billing providers and adjust for administrative activities assumed by providers in direct billing to third party payers through a state fiscal agent established April 1, 2013. These revisions will make the State Plan content and format consistent with Medicaid requirements for case management.

Initial service coordination services not followed by an Individualized Family Service Plan meeting will have a minimum base of two hours with no cap; those followed by an Individualized Family Service Plan meeting will have a minimum base of three hours with no cap. Ongoing service coordination services will have a minimum base of 1.25 hours per month. Rates for case management will be set prospectively and will cover labor, administrative overhead, general operating and capital costs, and regional cost differences.

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

Effective on or after April 1, 2018, this proposal is to establish a ten percent rate increase to the Hospice Residence rates, set a benchmark rate and include specialty rates in the weighted average rate calculation. The proposal would increase Medicaid Hospice Residence rates to help cover current costs and avoid closure of Hospice Residence programs.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2018/2019 is $1.7 million.

Effective on or after April 1, 2018, continues the supplemental upper payment limit payments made to general hospitals, other than major public general hospitals under non-institutional services of $339 million annually.

For state fiscal year beginning April 1, 2018 through March 31, 2019, continues hospital outpatient payment adjustments that increase the operating cost components of rates of payment for hospital outpatient and emergency departments on and after April 1, 2011, for public general hospitals other than those operated by the State of New York or the State University of New York, which are located in a city with a population of over one million. The amount to be paid will be up to $287 million annually based on criteria and methodology set by the Commissioner of Health, which the Commissioner may periodically set through a memorandum of understanding with the New York City Health and Hospitals Corporation. Such adjustments shall be paid by means of one or more estimated payments. Payments may be added to rates of payment or made as aggregate payments.

For the state fiscal year beginning April 1, 2018 through March 31, 2019, continues upon the election of the social services district in which an eligible diagnostic and treatment center (DTC) is physically located, up to $12.6 million in additional annual Medicaid payments may be paid to public DTCs operated by the New York City Health and Hospitals Corporation. Such payments will be based on each DTC's proportionate share of the sum of all clinic visits for all facilities eligible for an adjustment for the base year two years prior to the rate year. The proportionate share payments may be added to rates of payment or made as aggregate payments to eligible DTCs.

For the state fiscal year beginning April 1, 2018 through March 31, 2019, continues up to $5.4 million in additional annual Medicaid payments may be paid to county operated free-standing clinics, not including facilities operated by the New York City Health and Hospitals Corporation, for services provided by such DTC and those provided by a county operated freestanding mental health or substance abuse DTC. Distributions shall be based on each eligible facility's proportionate share of the sum of all DTC and clinic visits for all eligible facilities receiving payments for the base year two years prior to the rate year. The proportionate share payments may be added to rates of payment or made as aggregate payments to eligible facilities.

Effective on or after April 1, 2018, The Department of Health proposes to amend the Public Health Law § 3001, create new Public Health Law § § 2805-z and 3001-a, and amend the Social Services Law § 365-a to permit health care providers to collaborate on community paramedicine programs that allow emergency medical personnel to provide care within their certification, training and experience in residential settings.

The annual increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2018/2019 is $2.3 million.

Institutional Services

Effective on or after April 1, 2018, the commissioner shall convene a temporary workgroup comprised of representatives of hospitals and residential nursing facilities, as well as representatives from the department, to develop recommendations for streamlining the capital reimbursement methodology to achieve a one-percent reduction in capital expenditures to hospitals and residential nursing facilities, including associated specialty and adult day health care units. Pending the development of the workgroup's recommendations and the implementation of any such recommendations accepted by the commissioner, the commissioner shall be authorized to reduce the overall amount of capital reimbursement as necessary to achieve a one-percent reduction in capital expenditures beginning with State fiscal year 2018/2019.

The annual decrease in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2018/2019 is $13.4 million.

Effective on or after April 1, 2018, continues the supplemental upper payment limit payments made to general hospitals, other than major public general hospitals under institutional services of $339 million annually.

For the state fiscal year beginning April 1, 2018 through March 31, 2019, continues specialty hospital adjustments for hospital inpatient services provided on and after April 1, 2012, to public general hospitals, other than those operated by the State of New York or the State University of New York, located in a city with a population of over one million and receiving reimbursement of up to $1.08 billion annually based on criteria and methodology set by the Commissioner of Health, which the Commissioner may periodically set through a memorandum of understanding with the New York City Health and Hospitals Corporation. Such adjustments shall be paid by means of one or more estimated payments. Payments to eligible public general hospitals may be added to rates of payment or made as aggregate payments.

Effective on or after April 1, 2018, payments to hospitals that meet the criteria as an enhanced safety net hospital, the criteria is as follows: In any of the previous three calendar years has had not less than fifty percent of the patients it treats receive Medicaid or are medically uninsured; not less than forty percent of its inpatient discharges are covered by Medicaid; twenty-five percent or less of its discharged patients are commercially insured; not less than three percent of the

patients it provides services to are attributed to the care of uninsured patients; provides care to uninsured patients in its emergency room, hospital based clinics and community based clinics, including the provision of important community services, such as dental care and prenatal care.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative is $20 million.

Effective on or after April 1, 2018, payments to Critical Access Hospitals, Safety Net Hospitals, and Sole Community Hospitals will be based on criteria as determined by the Commissioner of Health.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2018/2019 is $40 million.

Long Term Care Services

Effective on or after April 1, 2018, continues additional payments to non-state government operated public residential health care facilities, including public residential health care facilities located in Nassau, Westchester, and Erie counties, but excluding public residential health care facilities operated by a town or city within a county, in aggregate amounts of up to $500 million. The amount allocated to each eligible public RHCF will be in accordance with the previously approved methodology, provided, however that patient days shall be utilized for such computation reflecting actual reported data for 2016 and each representative succeeding year as applicable. Payments to eligible RHCF's may be added to rates of payment or made as aggregate payments.

The overall combined estimated annual net aggregate increase in gross Medicaid expenditures attributable to the extension of all upper payment limit (UPL) payments for state fiscal year 2018/2019 in $2.5 billion.

Effective on or after April 1, 2018, the Commissioner shall convene with New York State Nursing Home Associations and other industry experts alongside representatives from the New York State Health Department, to revise the current Case Mix collection process in an effort to promote a higher degree of accuracy in the case mix data which would result in a reduction of audit findings. Pending the development and implementation of the revised process, the commissioner shall be authorized to reduce the overall amount of case mix reimbursement as is necessary to achieve savings.

The estimated annual net aggregate decrease in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2018/2019 is $15 million.

Effective on or after April 1, 2018 this proposes legislation to authorize the department to conduct a study of Home and Community Based Services in rural areas of the state. This study will include a review and analysis of factors including but not limited to transportation costs, costs of direct care personnel including home health aides, personal care attendants and other direct service personnel, and opportunities for telehealth and/ or technological advances to improve efficiencies.

The Legislation would also authorize the department to provide a targeted, Medicaid rate enhancement if supported by the study, for fee for service personal care.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2018/2019 is $3 million.

The following is a clarification for the partial restoration of the two percent annual uniform reduction of Medicaid payments which was originally noticed on March 26, 2014. Effective on or after April 1, 2018, supplemental payments will be made to all RHCF Nursing Homes for the value of SFY 2014/15, 2015/16, 2016/17 and 2017/18 beginning SFY 2018/19 and will be paid out at $70 million each year over four years. Additional supplemental payments will be made each year beginning in SFY 2018/19 in the amount of $70 million.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2018/2019 is $140,000,000.

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. 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, or e-mail: spa_inquiries@health.ny.gov

PUBLIC NOTICE

Department of Health

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

The Department of Health proposes to amend the Title XIX (Medicaid) State Plan for institutional care related to temporary rate adjustments to providers that are undergoing closure, merger, consolidation, acquisition or restructuring themselves or other health care providers. These payments are authorized by § 2826 of the New York Public Health Law. The following changes are proposed:

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

- Strong Memorial Hospital

The aggregate payment amounts total up to $4,163,227 for the period April 1, 2018 through March 31, 2019.

The aggregate payment amounts total up to $4,594,780 for the period April 1, 2019 through March 31, 2020.

The aggregate payment amounts total up to $4,370,030 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's website at http://www.health.ny.gov/regulations/state_plans/status.

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

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

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

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

Appendix V
2018 Title XIX State Plan
Second Quarter Amendment
Responses to Standard Funding Questions

APPENDIX V
HOSPITAL SERVICES
State Plan Amendment #18-0031

CMS Standard Funding Questions (NIRT Standard Funding Questions)

The following questions are being asked and should be answered in relation to all payments made to all providers under Attachment 4.19-A of your state plan.

1. **Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by States for services under the approved State plan. Do providers receive and retain the total Medicaid expenditures claimed by the State (includes normal per diem, supplemental, enhanced payments, other) or is any portion of the payments returned to the State, local governmental entity, or any other intermediary organization? If providers are required to return any portion of payments, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the amount or percentage of payments that are returned and the disposition and use of the funds once they are returned to the State (i.e., general fund, medical services account, etc.)**

   Response: Providers do retain the payments made pursuant to this amendment. Private providers do not return to the State any amount or percentage of the payment. 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 are no new provider taxes and no modifications to existing taxes have been made.

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 Medicaid payments authorized for this provision are supplemental payments. The amount of the IP UPL supplemental payment for voluntary hospitals for the period April 1, 2018 through March 31, 2019 is $339M.

4. **Please provide a detailed description of the methodology used by the state to estimate the upper payment limit (UPL) for each class of providers (State owned or operated, non-state government owned or operated, and privately owned or operated). Please provide a current (i.e. applicable to the current rate year) UPL demonstration. Under regulations at 42 CFR 4447.272, States are prohibited from setting payment rates for Medicaid inpatient services that exceed a reasonable estimate of the amount that would be paid under Medicare payment principals.**

   Response: For Exempt units, a cost based method is used. A ratio of cost to charges is multiplied by MDW charges to reach a Medicare equivalent amount. Acute claims use a payment based/Medicare DRG method. Claims are grouped and priced to a Medicare equivalent payment. Each methodology is compared against MDW Medicaid payments to reach the margin. SPA fiscal impacts that were not reflected in the base rates are then accounted for in the room analysis portion of the calculation to reach a final margin.

   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 a 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 17-0065, 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.