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

SEP 2 8 2018

Re: SPA #18-0057
Inpatient Hospital Services

Dear Mr. Cooley:

The State requests approval of the enclosed amendment #18-0057 to the Title XIX (Medicaid) State Plan for inpatient hospital services to be effective July 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.

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 **June 27, 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,

[redacted]

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: **18-0057**	2. STATE **New York**
	3. PROGRAM IDENTIFICATION: **TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)**	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE **July 1, 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 07/01/18-09/30/18 $ 0** **b. FFY 10/01/18-09/30/19 $ 0**
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: **Attachment 4.19-A Pages: 105, 105(a), 106, 108, 110, 110(a), 111, 111(a), 112, 114**	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: **Attachment 4.19-A Pages: 105, 105(a), 106, 108, 110, 110(a), 111, 111(a), 112, 114**

10. SUBJECT OF AMENDMENT:
Rebase Hospital Acute IP Rates to 2015
(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. SIGNATU[redacted]	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: **Donna Frescatore**	
14. TITLE: **Medicaid Director** **Department of Health**	
15. DATE SUBMITTED: SEP 2 8 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
Third Quarter Amendment
Amended SPA Pages

b. Medicaid costs associated with schools of nursing operated by the facility and reported as inpatient costs in the ICR; and

c. Medicaid costs associated with hospital-based physicians at hospitals designated under the Medicare program as meeting the criteria set forth in §1861(b)(7) of the federal Social Security Act.

13. *Transfers,* For purposes of transfer per diem payments, a transfer patient will mean a patient who is not discharged as defined in this Section, is not transferred among two or more divisions of merged or consolidated facilities as defined in the Mergers, Acquisitions, Consolidations, Restructurings and Closure Section, is not assigned to a DRG specifically identified as a DRG for transferred patients only, and meets one of the following conditions:

a. is transferred from an acute care facility reimbursed under the DRG case-based payment system to another acute care facility reimbursed under this system; or

b. is transferred to an out-of-state acute care facility; or

c. is a neonate who is being transferred to an exempt hospital for neonatal services.

14. *Discharges*, as used in this Section, will mean those inpatients whose discharge from the facility occurred on and after July 1, [2014]2018, and:

a. the patient is released from the facility to a non-acute care setting; or

b. the patient dies in the facility; or

c. the patient is transferred to a facility or unit that is exempt from the case-based payment system, except when the patient is a newborn transferred to an exempt hospital for neonatal services and thus classified as a transfer patient pursuant to this Section; or

d. the patient is a neonate being released from a hospital providing neonatal specialty services back to the community hospital of birth for weight gain.

15. *Average [Inlier] Length of Stay (ALOS)* will mean the arithmetic average of the number of days a patient is in the hospital per admission as calculated by counting the number of days from and including the day of admission up to, but not including, the day of discharge. The ALOS will be calculated for each DRG on a statewide basis.

16. *General hospital*, as used in this Section, will mean a hospital engaged in providing medical or medical and surgical services primarily to inpatients by or under the supervision of a physician on a twenty-four hour basis with provisions for admission or treatment of persons in need of emergency care and with an organized medical staff and nursing service, including facilities providing services relating to particular diseases, injuries, conditions, or deformities.

New York
105(a)

17. *Charge converter* will mean the ratio of cost to charges using total inpatient costs and total inpatient charges as reported by the hospital in its annual institutional cost reports submitted to the Department.

18. *IPRO* will mean the Island Peer Review Organization, Inc., a New York not-for-profit corporation providing health related services.

19. *Medicaid,* for the Medicaid Acute Rate, will mean Medicaid Fee-for-Service (FFS) and Medicaid Managed Care (MC). Acute rates are developed using the FFS claims data and the MC encounter data using the methodologies described in this Attachment.

20. *Base year* will mean the period as determined pursuant to the applicable provisions of this Attachment and applies to the DRG case-based payment per discharge, based on the following:

    a. For periods beginning on and after July 1, [2014]2018, the base year will be the [2010]2015 calendar year and the data and statistics will be the audited costs reported by each facility to the Department pursuant to the Financial and Statistical Data Required and Audits Sections.

    b. [For those hospitals operated by New York City Health and Hospitals Corporation (NYC H+H), the base year will be for the 12 months ended June 30, 2010, for those hospitals operated by New York State, excluding the hospitals operated by the State University of New York (SUNY), the base year will be the 12-month period which ended March 31, 2011.] For hospitals with a fiscal filing period that is other than a calendar year, the base year will be the 12-month period which ended between June 30, 2015 and May 31, 2016.

21. *Divisor for add-ons to the acute rates per discharge*, as used in this Section, will mean the discharges used in the development of the add-ons pursuant to the Add-Ons to the Acute Rate Per Discharge Section of this Attachment.

    a. For the period beginning on and after July 1, [2014]2018, the discharges used as the divisor will be the [2011]2015 [calendar] base year reported to the Department prior to [August 1, 2013] April 25, 2017.

22. *The year discharges* will mean the latest calendar year utilized pursuant to the Service Intensity Weights (SIWs) and Average Length of Stay (ALOS) Section of this Section.

    a. For the period beginning on and after July 1, [2014]2018, the latest calendar year will be [2011]2014.

23. *Goal Seek* is the process of finding the correct input when only the output is known.

    a. Wikipedia definition states, "In computing, goal seeking is the ability to calculate backward to obtain an input that would result in a given output. This can also be called "what-if analysis" or "back-solving."

Service Intensity Weights (SIW) and Average Length-of-Stay (ALOS).

1. The table of SIWs and statewide ALOS effective on and after July 1, [2014]2018 is published on the New York State Department of Health website at:

   http://www.health.ny.gov/facilities/hospital/reimbursement/apr-drg/weights/

   and reflects the cost weights and ALOS assigned to each All-Patient Refined (APR) diagnosis related group (DRG) patient classification category. The SIWs assigned to each APR-DRG indicates the relative cost variance of that APR-DRG classification from the average cost of all inpatients in all APR-DRGs. Such SIWs are developed using three years of Medicaid fee-for-service cost data, Medicaid managed care data and commercial third party payor data as reported to the Statewide Planning and Research Cooperative System (SPARCS) for the years set forth in paragraph (3) of this section. Costs associated with hospitals that do not have an ancillary charge structure or associated with hospitals and services exempt from the case payment methodology, and costs associated with statistical outliers are excluded from the SIW calculations.

2. For periods beginning on and after July 1, [2014]2018, the SIWs and statewide ALOS table will be computed using SPARCS and reported cost data from the [2009, 2010, and 2011]2012, 2013 and 2014 calendar years as submitted to the Department.

3. The DRG classification system used in rates, as defined in paragraph (1) of the Definitions Section of this Attachment, will be as follows:

   a. Effective July 1, [2014]2018 through December 31, 2014, Version [31]34 of the APR-DRG classification system will be used.

   [b. Effective January 1, 2015 through September 30, 2015, Version 32 of the APR-DRG classification system will be used.]

   [c. Effective beginning on and after October 1, 2015, Version 33 of the APR-DRG classification system will be used.]

New York
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Add-Ons to the Acute Rate Per Discharge.

Rates of payment computed pursuant to this Attachment will include operating cost add-on payments to the statewide base price payment as follows:

1. The base period used for the add-on development will be as defined in the Definitions Section.
2. The costs and discharges used in the development of the add-ons will be total acute inpatient costs and discharges.

[3. Medicaid costs will be calculated based on a percentage ratio of Medicaid acute days to Total acute days using the base year days, as defined in the Definitions Section. For the purpose of this Section, Medicaid is as defined in the Definitions Section.]

[4]3. All add-on components of the acute operating per discharge rate will be reduced by the Budget Neutrality Factor pursuant to the Statewide Base Price Section of this Attachment.

[5]4. A direct graduate medical education (DGME) payment per discharge will be added to the acute rates of teaching general hospitals after the application of SIW, WEF, and Indirect Graduate Medical Education (IME) adjustments to the statewide base price. The DGME will be calculated for each hospital by dividing the facility's total reported [Medicaid] DGME costs by its total reported [Medicaid] discharges pursuant to paragraphs (1) through (3) of this Section. DGME costs will be those costs defined in the Definitions Section and trended forward to such rate period in accordance with applicable provisions of this Attachment

[6]5. a. An indirect GME payment per discharge will be added to the acute rates of teaching general hospitals after the application of SIW and WEF adjustments to the statewide base price and will be calculated by multiplying such rates by the indirect teaching cost percentage determined by the following formula:

$$(1 - (1 / (1 + 1.03(((1 + r) ^0.0405) - 1))))$$

where "r" equals the ratio of residents and fellows to beds based on the medical education statistics for the hospital based on paragraph (7) of this Section and the staffed beds for the general hospital reported in the base period, as defined in the Definitions Section, but excluding exempt unit beds and nursery bassinettes.

b. Indirect GME costs are those costs defined in the Definitions Section, derived from the base year, as also defined in the Definitions Section, and trended forward to such rate period in accordance with applicable provisions of this Attachment.

7. [Hospitals will furnish to the Department such reports and information as will be required by the Department to access the cost, quality, and health system needs for medical education. Such reports and information will include, but not be limited to, the Indirect Medical Education Survey.]For rates beginning on and after July 1, 2018, the ratio of residents and fellows to bed will be based on the medical education statistics as reported on Exhibit 3 of the Hospital Institutional Cost report for the base year, as defined in the Definitions Section.

   [a. The Indirect Medical Education Survey is completed annually by hospitals and collects the actual interns and residents in a program year.

      i. For rates beginning on and after July 1, 2014, the ratio of residents and fellows to bed will be based on the medical education statistics for the hospital for the period ended June 30, 2011 as contained in the Indirect Medical Education survey document submitted by the hospital to the Department as of June 30, 2013.]

8. A non-comparable payment per discharge will be added to acute rates after the application of SIW, WEF, and IME adjustments to the statewide base price and the addition of the DGME payment and will be calculated for each hospital by dividing the facility's total reported [Medicaid] costs, pursuant to paragraphs (1) through (3) of this Section, for qualifying non-comparable cost categories by its total reported [Medicaid] discharges pursuant to the Definitions Section. Non-comparable hospital costs are those costs defined in the Definitions Section, derived from the base year, as also defined in the Definitions Section, and trended forward to such rate period in accordance with applicable provisions of this Attachment.

9. At the time non-comparable base year costs are updated in accordance with applicable provisions of this Section, cost transfers between affiliated facilities, for non-comparable costs as defined in the Definitions Section for other than DME or IME, due to the transfer of an entire service for organizational restructuring, will be adjusted in the payment rate. The non-comparable costs will be eliminated from the rate for the hospital closing the service and included in the rate for the receiving hospital. The costs transferred and utilized in the receiving hospital's rate will be the base year costs of the facility closing the service as defined in the Definitions Section. No revisions to the costs will be allowed.

10. The add-ons described in this section will be adjusted to reflect [potentially preventable negative outcomes (PPNOs) in accordance with the Potentially Preventable Negative Outcomes (PPNO) Section of this Attachment and] the transition factor per paragraph (1)(a)(ii) of the Transition Section of this Attachment.

New York
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1. Transition

a. For discharges beginning on July 1, [2014]2018 through December 31, [2017]2021, a transition factor will be applied as follows:

i. The factor will be applied to the operating statewide base price as stated in paragraph (5) of the Statewide Base Price Section of this Attachment.

ii. The factor will be applied to all add-on operating cost components of the acute case per discharge rate as stated in paragraph (10) of the Add-ons to the Case Payment Rate per Discharge Section of this Attachment.

b. Hospital estimated losses and gains for the transition development will be calculated by comparing the estimated revenue, by provider, based on the newly developed rate using the updated base year and associated policy updates in comparison to the last rate developed with the previous base year and policy.

c. Hospital estimated losses which are due to the implementation of the updated base year pursuant to the Definitions Section of this Attachment and associated policy updates, will be limited as follows:

i. for the period July 1, [2014]2018 through December 31, [2015]2018, hospital specific estimated losses will be limited to[2]1% of the hospital's current revenues;

ii. for the period January 1, [2016]2019 through December 31, [2016]2019, the limitation on estimated losses will be increased to 2[.5]% of the hospital's current revenues;

iii. for the period January 1, [2017]2020 through December 31, [2017]2020, the limitation on estimated losses will be increased to 3[.5]% of the hospital's current revenues.

iv. for the period January 1, 2021 through December 31, 2021, the limitation on estimated losses will be increased to 4% of the hospital's current revenues.

d. The transition limitation on estimated losses, defined in paragraph (1)(b) of this section, shall be funded as follows:

i. Utilizing [sixty percent of the historical estimated revenues, valued at forty-two]two million four-hundred thousand dollars[,] for hospitals that have closed since January 1, [2011]2014;

ii. A cap on a hospital's estimated gain, as described in paragraph (1)(b) of this Section, shall be applied as necessary each year in order to achieve budget neutrality pursuant to the Statewide Base Price Section of this Attachment. This will be accomplished as follows:

New York
111(a)

[1. A hospital's estimated gain shall be adjusted to exclude the portion of the gain related to an increase in the teaching resident count. The increase in resident count shall be determined by comparing the medical education statistics supplied to the Department of Health pursuant to the Add-ons to the Case Payment Rate per Discharge Section of this Attachment.]

[2]1. The cap on the [adjusted] estimated gain is derived through the "Goal Seek" programming in Microsoft excel, as defined in the Definitions Section, to determine the percentage necessary to hold payments budget neutral to the target total Medicaid operating payments, per the Statewide Base Price Section of this Attachment, with the limit on the losses.

[3]2. For the period July 1, [2014]2018 through December 31, [2015]2018, the cap on gains is [3.4308]3.5633%. When the cap on losses is revised, based on paragraph (c) of this section, the cap on gains will be increased.

e. The facility specific transition factor is determined by dividing the dollars associated with the total transition adjustment from gains or losses by the total facility specific projected revenue based on the newly developed rates using the updated base year and associated policy updates.

i. The total projected facility specific revenue excludes revenue from cost outlier cases since the transition factor does not apply to cost outlier payments.

f. The transition factor will not be subject to reconciliation.

New York
114

Alternate Level of Care Payments (ALC).

1. For rates beginning on and after July 1, [2014]2018, hospitals will be reimbursed for ALC days at the appropriate 2013 group average operating cost component of rates of payment for hospital-based residential health care facilities established pursuant to Attachment 4.19-D, trended to the rate year.

   The determination of the group average operating rate for hospital-based residential health care facilities specified in this paragraph will be based on the combination of residential health care facilities as follows:

   a. The downstate group will consist of residential health care facilities located in the New York counties of Bronx, New York, Kings, Queens, Richmond, Nassau, Suffolk, Westchester, Rockland, Orange, Putnam, and Dutchess.

   b. The upstate group will consist of all other residential health care facilities in the State.

2. Hospitals that convert medical/surgical beds to residential health care beds will be reimbursed for services provided in the converted beds in accordance with Attachment 4.19-D.

New York
112

Outlier Rates of Payment.

1. High cost outlier rates of payment will be calculated by converting 100% of the total billed patient charges, as approved by IPRO, to cost by applying the hospital's charge converter as defined in the Definitions Section. Such calculation will use the most recent charge converter available as subsequently updated to reflect the data from the year in which the discharge occurred, and will equal the excess costs above the high cost outlier threshold.

   i. For payment, the high cost outlier threshold will be adjusted by the hospital specific wage equalization factor (WEF), as defined in the Definitions Section of this Attachment, prior to determining the excess costs above the high cost outlier threshold as stated in paragraph (1)(a) of this Section.

2. The high cost outlier threshold will be developed for each Diagnosis Related Group (DRG) using acute Medicaid operating costs which are derived from the year discharges used in the Statewide Base Price Section and defined in the Definitions Section of this Attachment. The high cost thresholds will be scaled to maintain budget neutrality[,] to targeted outlier payments developed pursuant to the Statewide Base Price Section.

   i. The high cost outlier thresholds will be updated at the time the Service Intensity Weights (SIWs) are updated in accordance with the SIW and ALOS Section.

   ii. Cost outlier thresholds for each base APR-DRG effective on and after July 1, [2014]2018, have been posted to the Department of Health's public website at the following:

   http://www.health.ny.gov/facilities/hospital/reimbursement/apr-drg/tresholds/

New York
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Statewide Base Price

1. For periods on and after July 1, [2014]2018, a statewide base price (SBP) will be established for operating
cost payments and will be used in the calculation of the payment of a Medicaid acute claim as follows:

	RATE ELEMENT	STATE PLAN SECTION
	Operating cost neutral statewide base price per discharge	Statewide Base Price
x	(1+ Budget neutrality factor)	Statewide Base Price
x	(1 + Trend factor)	Trend Factor
x	Institution-specific wage equalization factor (WEF) adjustment	Wage Equalization Factor (WEF)
x	(1 + Transition adjustment factor)	Transition
x	(1 + Potentially Preventable negative outcome reduction factor)	Potentially Preventable Negative Outcomes (PPNOs)
x	APR-DRG weight with severity level	Service Intensity Weights (SIW) and Average Length-of-Stay (ALOS)
=	FFS adjusted statewide base price per discharge	
+	IME per discharge add-on	Add-Ons to the Acute Rate Per Discharge
+	DGME per discharge add-on	Add-Ons to the Acute Rate Per Discharge
+	Capital per discharge add-on	Capital expense reimbursement for DRG case-based rates of payment
+	Non-comparable cost per discharge add-on	Add-Ons to the Acute Rate Per Discharge
=	Medicaid FFS rate per discharge	

a. The rate elements included in the chart are developed as described within the sections of this Attachment.

Appendix II
2018 Title XIX State Plan
Third Quarter Amendment
Summary

SUMMARY
SPA #18-0057

This State Plan Amendment proposes to update effective July 1, 2018 the cost base used for the non-comparable components of the acute hospital inpatient rates from the 2010 cost base to 2015, the acute rate statewide base price and the service intensity weights.

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

Public Health Law 2807-c(35)(c):

(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.

Appendix IV
2018 Title XIX State Plan
Third Quarter Amendment
Public Notice

MISCELLANEOUS NOTICES/HEARINGS

Notice of Abandoned Property Received by the State Comptroller

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

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

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

PUBLIC NOTICE

Office of General Services

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

Notice is hereby given that the Office for People with Developmental Disabilities has determined that 733 Euclid Avenue, City of Syracuse, Onondaga County, New York State, improved with a 2,648 ± square foot dwelling situated on a 0.12 ± acre lot, as surplus and no longer useful or necessary for state program purposes, and has abandoned the property to the Commissioner of General Services for sale or other disposition as Unappropriated State land.

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

PUBLIC NOTICE

Department of Health

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

The Department of Health proposes to amend the Title XIX (Medicaid) State Plan for acute inpatient hospital services to comply with proposed regulatory provisions. The following changes are proposed:

Institutional Services

• The case based general hospital acute inpatient rebasing rate initiative will be implemented effective for discharges on or after July 1, 2018 with the following updates to the acute rate development:

- The rebased acute rates will reflect an update to the 2010 Institutional Cost Report (ICR), as reported by each facility to the department, which was utilized in the acute rates effective for discharges beginning on July 1, 2014, to the audited 2015 ICR for the operating components of the rates.

- Medicaid costs used in the rate development will be calculated based on a ratio of 2015 total Medicaid acute days (fee-for-service and managed care) to 2015 total acute days.

- The 2014 Medicaid fee-for-service paid claims and Medicaid managed care encounter claims will be used as the divisor for the non-comparable operating cost components of the rate.

- The costs used for the direct medical education (DME) component of the rates will be based on the audited 2015 ICR and only the costs reported for cost center 013 (I&R Services – Salary & Fringes), cost center 033 (I&R Services – Other Program Costs), and cost center 014 (Supervising Physician – Teaching) will be included in the DME cost development for the rates.

- The indirect medical education (IME) percentage will be based on the resident count provided to the Department of Health in the audited 2015 ICR, Exhibit 3, in addition to the 2015 provider ICR data.

- The ambulance non-comparable cost will be included only for providers stating they provide ambulance services per the 2010 Ambulance Survey completed by providers and submitted to the Department of Health during July, 2013.

- The provider specific wage equalization factor will be calculated using a 3-year average (2016 through 2018 data) of provider specific Medicare occupational-mix adjusted wages and hours in addition to the 2015 provider ICR data to determine the labor share.

- The case mix neutral statewide price and all non-comparable add-on operating cost components of the rate will be adjusted for a budget neutrality factor to equitably reduce all rate payment components to maintain budget neutrality to current expenditures.

- A transition factor, if applicable, will be applied to the case mix neutral statewide price and all non-comparable add-on operating cost components of the rate to limit losses and gains due to the implementation of the audited 2015 cost base and associated policy changes. The transition factor, if applied, will not be subject to reconciliation.

• The alternate level of care (ALC) rate effective for days of service on July 1, 2018 and thereafter will be updated to reflect the January 1, 2018 skilled nursing home rate and implemented budget neutral on a statewide basis.

• For discharges on or after July 1, 2018, the acute hospital inpatient claims will be processed with the rates as calculated with the provisions above and will use the following:

- 2018 APR DRG grouper (Version 34);

- 2018 Service Intensity Weights (SIWs) and average length of stay;

- 2018 cost outlier thresholds scaled to maintain budget neutrality to estimated outlier payments using the 2018 thresholds.

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. Copies of which will be available for public review on the Department's website at http://www.health.ny.gov/regulations/state_plans/status.

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

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

New York County

250 Church Street
New York, New York 10018

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

Kings County, Fulton Center
114 Willoughby Street
Brooklyn, New York 11201

Bronx County, Tremont Center
1916 Monterey Avenue
Bronx, New York 10457

Richmond County, Richmond Center
95 Central Avenue, St. George
Staten Island, New York 10301

For further information and to review and comment, please contact: Department of Health, Bureau of Federal Relations and Provider Assessments, 99 Washington Ave., One Commerce Plaza, Suite 1430, Albany, NY 12210, (518) 474-1673, (518) 473-8825 (FAX), e-mail: spa_inquiries@health.state.ny.us

PUBLIC NOTICE

Department of Health

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

The Department of Health proposes to amend the Title XIX (Medicaid) State Plan for institutional services to comply with enacted statutory provisions. The following changes are proposed:

Institutional Services

Effective on or after July 1, 2018, the Department of Health will adjust rates of reimbursement for inpatient psychiatric services provided in general hospitals, or distinct units of general hospitals to reimburse hospitals for providing these services to individuals aged 17 and under to better meet community children's mental health needs. The Department of Health will increase the age adjustment factor for these services to these individuals from 1.0872 to 1.3597.

The estimated annual aggregate increase in gross Medicaid expenditures attributable to the increase of the age adjustment factor is $10,000,000. Funds for this increase are contained in the State budget beginning in state fiscal year 2018/2019.

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 Health

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

The Department of Health proposes to amend the Title XIX (Medicaid) State Plan for institutional services at non-profit Residential Treatment Facilities for Children and Youth to comply with an OMH policy objective. The following changes are proposed:

Institutional Services

The amendment will reflect an adjustment to the minimum utilization range, used in the Residential Treatment Facility reimbursement methodology, from 93 percent to 90 percent, effective on or after July 1, 2018.

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 $436,285, with an annualized value of $581,714.

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

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

APPENDIX V
HOSPITAL SERVICES
State Plan Amendment #18-0057

CMS Standard Funding Questions (NIRT Standard Funding Questions)

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

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

   Response: Providers do retain the payments made pursuant to this amendment. However, this requirement in no way prohibits the public provider, including county providers, from reimbursing the sponsoring local government for appropriate expenses incurred by the local government on behalf of the public provider. The State does not regulate the financial relationships that exist between public health care providers and their sponsoring governments, which are extremely varied and complex. Local governments may provide direct and/or indirect monetary subsidies to their public providers to cover on-going unreimbursed operational expenses and assure achievement of their mission as primary safety net providers. Examples of appropriate expenses may include payments to the local government which include reimbursement for debt service paid on a provider's behalf, reimbursement for Medicare Part B premiums paid for a provider's retirees, reimbursement for contractually required health benefit fund payments made on a provider's behalf, and payment for overhead expenses as allocated per federal Office of Management and Budget Circular 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 budget 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 additional provider taxes levied and no existing taxes have been modified.

3. **Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan. If supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to each provider type.**

Response: The payments authorized for this provision are not supplemental or enhanced payments.

4. **Please provide a detailed description of the methodology used by the state to estimate the upper payment limit (UPL) for each class of providers (State**

owned or operated, non-state government owned or operated, and privately owned or operated). Please provide a current (i.e. applicable to the current rate year) UPL demonstration. Under regulations at 42 CFR 447.272, States are prohibited from setting payment rates for Medicaid inpatient services that exceed a reasonable estimate of the amount that would be paid under Medicare payment principals.

Response: State staff are working to finalize the 2018 UPL demonstration.

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 17-65, 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.