



Department of Health

ANDREW M. CUOMO
Governor

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

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

SEP 04 2015

Mr. Michael Melendez
Associate Regional Administrator
Department of Health & Human Services
Centers for Medicare & Medicaid Services
New York Regional Office
Division of Medicaid and Children's Health Operations
26 Federal Plaza - Room 37-100 North
New York, New York 10278

RE: SPA #11-0026-C
Non-Institutional Services

Dear Mr. Melendez:

In consultation with CMS, the State has split SPA 11-0026 into four separate SPAs as follows:


- SPA 11-0026 relates to a Federally Qualified Health Center (Hudson River Healthcare);
- SPA 11-0026-A relates to hospital-based outpatient provider (Oswego Hospital);
- SPA 11-0026-B relates to a freestanding clinic (Medalliance Medical Health Services, Inc.); and
- SPA 11-0026-C relates to 2013 cost containment – non-institutional (CHHA A & G Only).

The State is resubmitting and requests approval of enclosed amendment #11-0026-C to the Title XIX (Medicaid) State Plan for non-institutional services to be effective April 1, 2012. This amendment is being resubmitted as requested by CMS.

SPA 11-0026 was approved on June 15, 2015; SPAs 11-0026-A and 11-0026-B will remain off-the-clock until all issues related to those particular amendments are resolved, at which time the State will re-submit those plans. Enclosed is the appropriate plan page, the RAI response and a revised CMS-179 form.

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

Sincerely,


Jason A. Helgeson
Medicaid Director
Office of Health Insurance Programs

Enclosures

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL**

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER:
#11-0026-C

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, 2012

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:
Section 1902(a) of the Social Security Act, and 42 CFR 447

7. FEDERAL BUDGET IMPACT:
a. FFY 04/01/12-09/30/12 \$ 0
b. FFY 10/01/12-09/30/13 \$ 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-B: 1(c)(ii)

9. PAGE NUMBER OF THE SUPERSEDED PLAN
SECTION OR ATTACHMENT (*If Applicable*):

Attachment 4.19-B: 1(c)(ii)

10. SUBJECT OF AMENDMENT: **Note: The cost savings associated with this SPA were included in approved SPA 13-0025.
2013 Cost Containment – Non-Institutional (CHHA A & G Only)
(FMAP = 50%)**

11. GOVERNOR'S REVIEW (*Check One*):

- GOVERNOR'S OFFICE REPORTED NO COMMENT OTHER, AS SPECIFIED:
 COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
 NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

12. SIGNATURE OF STATE AGENCY OFFICIAL:

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

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

15. DATE SUBMITTED: **March 20, 2012**

16. RETURN TO:

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

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED:

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:

22. TITLE:

23. REMARKS:

Appendix I
2015 Title XIX State Plan
Third Quarter Amendment
Amended SPA Pages

New York
1(c)(ii)

Freestanding Clinic Services (diagnostic and treatment facilities) Facilities Certified Under Article 28 of the State Public Health Law

Prospective, all inclusive rates calculated by Department of Health, based on the lower of the allowable average cost per visit or the group ceiling trended to the current year. For purposes of establishing rates of payment for diagnostic and treatment centers for services provided on or after April 1, 1995 through March 31, 1999, and on or after July 1, 1999 through March 31, 2000, and on and after April 1, 2000 through March 31 2003, on and after April 1, 2003 through March 31, 2011, on and after April 1, 2011 through March 31, 2013, and on and after April 1, 2013 through March 31, 2015, and on and after April 1, 2015 through March 31, 2017, the reimbursable base year administrative and general costs of a provider, excluding a provider reimbursed on an initial budget basis, [shall] will not exceed the statewide average of total reimbursable base year administrative and general costs of diagnostic and treatment centers. For the purposes of this provision, reimbursable base year administrative and general costs [shall] will mean those base year administrative and general costs remaining after application of all other efficiency standards, including, but not limited to, peer group cost ceilings or guidelines. The limitation on reimbursement for provider administrative and general expenses [shall] will be expressed as a percentage reduction of the operating cost component of the rate promulgated for each diagnostic and treatment center with base year administrative and general costs exceeding the average. Facilities offering similar types of services and having similar regional economic factors are grouped and ceilings are calculated on the cost experience of facilities within the group taking into account regional economic factors such as geographic location. Costs at or below these ceilings have been determined to be reasonable. The facility-specific impact of eliminating the statewide cap on administrative and general costs, for the period April 1, 1999 through June 30, 1999 [shall] will be included in rates of payment for facilities affected by such elimination for the period October 1, 1999 through December 31, 1999.

TN #11-0026-C

Approval Date _____

Supersedes TN #11-0021

Effective Date _____

**Appendix II
2015 Title XIX State Plan
Third Quarter Amendment
Summary**

SUMMARY
SPA #11-0026-C

This State Plan Amendment proposes to continue the cost sharing measure of the cap on administrative and general component of rates for certified home health agencies and freestanding diagnostic and treatment centers. This SPA is being submitted because the language was erroneously omitted from approved SPA 13-0025.

**Appendix III
2015 Title XIX State Plan
Third Quarter Amendment
Authorizing Provisions**

CHAPTER 56 OF THE LAWS OF 2013 - PART B

§ 15. Subdivision 5-a of section 246 of chapter 81 of the laws of 1995, amending the public health law and other laws relating to medical reimbursement and welfare reform, as amended by section 15 of part D of chapter 59 of the laws of 2011, is amended to read as follows:

5-a. Section sixty-four-a of this act shall be deemed to have been in full force and effect on and after April 1, 1995 through March 31, 1999 and on and after July 1, 1999 through March 31, 2000 and on and after April 1, 2000 through March 31, 2003 and on and after April 1, 2003 through March 31, 2007, and on and after April 1, 2007 through March 31, 2009, and on and after April 1, 2009 through March 31, 2011, and on and after April 1, 2011 through March 31, 2013, and on and after April 1, 2013 through March 31, 2015;

§ 16. Section 64-b of chapter 81 of the laws of 1995, amending the public health law and other laws relating to medical reimbursement and welfare reform, as amended by section 16 of part D of chapter 59 of the laws of 2011, is amended to read as follows:

§ 64-b. Notwithstanding any inconsistent provision of law, the provisions of subdivision 7 of section 3614 of the public health law, as amended, shall remain and be in full force and effect on April 1, 1995 through March 31, 1999 and on July 1, 1999 through March 31, 2000 and on and after April 1, 2000 through March 31, 2003 and on and after April 1, 2003 through March 31, 2007, and on and after April 1, 2007 through March 31, 2009, and on and after April 1, 2009 through March 31, 2011, and on and after April 1, 2011 through March 31, 2013, and on and after April 1, 2013 through March 31, 2015.

**Appendix IV
2015 Title XIX State Plan
Third Quarter Amendment
Public Notice**

- Continues, effective April 1, 2013 through March 31, 2015, budgeted capital inpatient costs of a general hospital applicable to the rate year shall be decreased to reflect the percentage amount by which the budgeted costs for capital related inpatient costs of the hospital for the base year two years prior to the rate year exceeded actual costs.

The annual decrease in gross Medicaid expenditures attributable to these initiatives for state fiscal year 2013/14 is \$114.5 million

- Effective April 1, 2013, rates of payments for general hospitals certified by the Office of Alcoholism and Substance Abuse Services who provide inpatient detoxification and withdrawal services and, for inpatient services provided for patients discharged on and after December 1, 2008, and who are determined to be in diagnosis-related groups as identified and published on the New York State Department of Health website will be made on a per diem basis. Such payments will be made in accordance with existing methodology previously noticed on June 10, 2009.

- The base period reported costs and statistics used for case based rate-setting operating cost components, including the weights assigned to diagnostic related groups, will be updated no less frequently than every four years and the new base period will 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 January 1, 2014.

- Effective January 1, 2014, the payment rates for hospital DRG exempt services may be adjusted periodically to reflect a more current cost and statistical base year including adjustments deemed necessary by the Commissioner.

- Effective January 1, 2014, hospital inpatient payment rates may be adjusted to include changes to the base year statistics and costs used to determine the direct and indirect graduate medical education components of the rates as a result of new teaching programs at new teaching hospitals and/or as a result of residents displace and transferred as a result of a teaching hospital closure.

- Continues, effective January 1, 2014, the current methodology established to incorporate quality related measures, including, but not limited to potentially preventable re-admissions (PPRs) and provide for rate adjustments or payment disallowances related to PPRs and other potentially preventable negative outcomes (PPNOs), shall be calculated in accordance with the existing methodology.

- Such methodology will be based on a risk adjusted comparison of the actual and the expected number of PPRs and other PPNOs in a given hospital and with benchmarks established by the Commissioner.

- Such rate adjustments or payment disallowances will result in an aggregate reduction in Medicaid payments of no less than \$51 million for the period April 1, 2013 through March 31, 2014.

- Such aggregate reductions shall be offset by Medicaid payment reductions occurring as a result of decreased PPRs during the period April 1, 2013 through March 31, 2014 and as a result of decreased PPNOs during the period April 1, 2013 through March 31, 2014. Such rate adjustments or payment disallowances will not apply to behavioral health PPRs or to readmissions that occur on or after 15 days following an initial admission.

Long Term Care Services

- Continues, effective for periods April 1, 2013 through March 31, 2015, the total reimbursable state assessment on each residential health care facility's gross receipts received from all patient care services and other operating income on a cash basis for inpatient or health-related services, including adult day service, but excluding gross receipts attributable to payments received pursuant to Title XVIII of the federal Social Security Act (Medicare), at six percent. The extent to which a facility is reimbursed for the additional cost of the assessment is dependent upon Medicaid volume of services.

The annual increase in gross Medicaid expenditures attributable to these initiatives for state fiscal year 2013/14 is \$420 million.

- Continues, effective April 1, 2013 through March 31, 2015, the provision that rates of payment for RHCFS shall not reflect trend factor projections or adjustments for the period April 1, 1996 through March 31, 1997.

- Extends current provisions to services April 1, 2013 through

March 31, 2015, the reimbursable operating cost component for RHCFS rates will be established with the final 2006 trend factor equal to the final Consumer Price Index (CPI) for all urban consumers less 0.25%.

- Continues, effective April 1, 2013 through March 31, 2015, long-term care Medicare maximization initiatives.

The annual decrease in gross Medicaid expenditures attributable to these initiatives for state fiscal year 2013/14 is \$117 million.

- Extends the provision, cost reports submitted by facilities for the 2002 calendar year or any subsequent year used to determine the operating component of the 2009 rate will be subject to audit through December 31, 2018. Facilities will therefore retain all fiscal and statistical records relevant to such cost reports. Any audit of the 2002 cost report, which is commenced on or before December 31, 2018, may be completed subsequent to that date and used for adjusting the Medicaid rates that are based on such costs.

- For state fiscal years beginning April 1, 2013, 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 \$300 million. The amount allocated to each eligible public RHCFS will be in accordance with the previously approved methodology, provided, however that, in consultation with impacted providers, of the funds allocated for distribution in state fiscal year beginning April 1, 2013, up to \$32 million may be allocated proportionally to those public residential health care facilities which were subject to retroactive reductions in payments made for state fiscal year periods beginning April 1, 2006. Payments to eligible RHCFS may be added to rates of payment or made as aggregate payments.

Non-institutional Services

- For state fiscal year beginning April 1, 2013 through March 31, 2014, continues hospital outpatient payment adjustments that increase the operating cost components of rates of payment for hospital outpatient and emergency departments 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 eligibility criteria remain unchanged. The amount to be paid will be up to \$287 million. Payments to eligible public general hospitals may be added to rates of payment or made as aggregate payments.

- Continues, effective April 1, 2013 through March 31, 2015, the provision that rates of payment for adult day health services shall not reflect trend factor projections or adjustments for the period April 1, 1996 through March 31, 1997.

- Extends current provisions to services April 1, 2013 through March 31, 2015, the reimbursable operating cost component for general hospital outpatient rates and adult day health care services provided by RHCFS rates will be established with the final 2006 trend factor equal to the final consumer price index (CPI) for all urban consumers less 0.25%.

- Extends current provisions for certified home health agency administrative and general cost reimbursement limits for the periods April 1, 2013 through March 31, 2015.

- Continues, effective April 1, 2013 through March 31, 2015, home health care Medicare maximization initiatives.

The annual decrease in gross Medicaid expenditures attributable to these initiatives for state fiscal year 2013/14 is \$17.8 million.

- The current authority to adjust Medicaid rates of payment for services provided by certified home health agencies (CHHAs) for such services provided to children under 18 years of age and for services provided to a special needs population of medically complex and fragile children, adolescents and young disabled adults by a CHHA, AIDS home care programs, and hospice programs for purposes of supporting recruitment and retention of non-supervisory health care workers or any worker with direct patient care responsibility has been extended for the period April 1, 2013 through March 31, 2014. Payments shall not exceed in the aggregate, \$100 million for such period, and shall be calculated in accordance with the previously approved methodology.

Appendix V
2015 Title XIX State Plan
Third Quarter Amendment
Responses to Standard Funding Questions

APPENDIX V
NON-INSTITUTIONAL SERVICES
State Plan Amendment #11-0026-C

CMS Standard Funding Questions

The following questions are being asked and should be answered in relation to all payments made to all providers reimbursed pursuant to a methodology described in Attachment 4.19-B of this SPA. For SPAs that provide for changes to payments for clinic or outpatient hospital services or for enhanced or supplemental payments to physician or other practitioners, the questions must be answered for all payments made under the state plan for such service.

- 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 payments, a complete listing of providers that return a portion of their payments, the amount or percentage of payments that are returned and the disposition and use of the funds once they are returned to the State (i.e., general fund, medical services account, etc.).**

Response: Providers do retain the payments made pursuant to this amendment. However, this requirement in no way prohibits the public provider, including county providers, from reimbursing the sponsoring local government for appropriate expenses incurred by the local government on behalf of the public provider. The State does not regulate the financial relationships that exist between public health care providers and their sponsoring governments, which are extremely varied and complex. Local governments may provide direct and/or indirect monetary subsidies to their public providers to cover on-going unreimbursed operational expenses and assure achievement of their mission as primary safety net providers. Examples of appropriate expenses may include payments to the local government which include reimbursement for debt service paid on a provider's behalf, reimbursement for Medicare Part B premiums paid for a provider's retirees, reimbursement for contractually required health benefit fund payments made on a provider's behalf, and payment for overhead expenses as allocated per federal Office of Management and Budget Circular A-87 regarding Cost Principles for State, Local, and Indian Tribal Governments. The existence of such transfers should in no way negate the legitimacy of these facilities' Medicaid payments or result in reduced Medicaid federal financial participation for the State. This position was further supported by CMS in review and approval of SPA 07-07C when an on-site audit of these transactions for New York City's Health and Hospitals Corporation was completed with satisfactory results.

2. **Section 1902(a)(2) provides that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan. Please describe how the state share of each type of Medicaid payment (normal per diem, supplemental, enhanced, other) is funded. Please describe whether the state share is from appropriations from the legislature to the Medicaid agency, through intergovernmental transfer agreements (IGTs), certified public expenditures (CPEs), provider taxes, or any other mechanism used by the state to provide state share. Note that, if the appropriation is not to the Medicaid agency, the source of the state share would necessarily be derived through either through 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 governmental 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 Local Assistance Account under the General Fund/Aid to Localities.

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. **For clinic or outpatient hospital services 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.

Response: The State has submitted the applicable hospital-based outpatient and clinic UPL demonstrations and are having ongoing conversations with CMS to resolve any remaining issues.

- 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 State Plan for freestanding diagnostic and treatment and ambulatory surgery center services or hospital outpatient services is based upon the Ambulatory Patient Group (APG) system with the exception of Federally Qualified Health Centers who have the option to opt into the APG system or remain on the Prospective Payment Methodology (PPS) as approved by CMS in SPA 01-03. We are unaware of any requirement under current federal law or regulation that limits individual providers' 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 SPA 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.