

MAR 27 2013

Jason A. Helgeson  
State Medicaid Director  
Deputy Commissioner  
Office of Health Insurance Programs  
NYS Department of Health  
Empire State Plaza  
Corning Tower, Room 1466  
Albany, NY 12237

RE: TN 12-028

Dear Mr. Helgeson:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 12-028. Effective September 1, 2012, this amendment proposes to provide reimbursement for the extra costs of inpatient hospital services that require language assistance for patients with limited English proficiency or communication services for patients who are hard of hearing or deaf.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2) 1902(a)(13), 1902(a)(30) and 1923 of the Social Security Act and the regulations at 42 CFR 447 Subpart C. This is to inform you that New York 12-028 is approved effective September 1, 2012 and have enclosed the HCFA-179 and the approved plan pages.

If you have any questions, please contact Tom Brady at 518-396-3810 or Rob Weaver at 410-786-5914.

Sincerely,

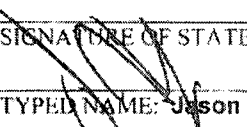
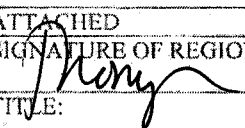
A handwritten signature in black ink, which appears to read "Cindy Mann". The signature is written in a cursive, flowing style.

Cindy Mann

Director

Center for Medicaid and CHIP Services

Enclosures

<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</b>		1. TRANSMITTAL NUMBER: <b>12-28</b>	2. STATE <b>New York</b>
<b>FOR: HEALTH CARE FINANCING ADMINISTRATION</b>		3. PROGRAM IDENTIFICATION: <b>TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)</b>	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE <b>September 1, 2012</b>	
5. TYPE OF PLAN MATERIAL ( <i>Check One</i> ): <input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT			
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT ( <i>Separate Transmittal for each amendment</i> )			
6. FEDERAL STATUTE/REGULATION CITATION: <b>Section 1902(a) of the Social Security Act, and 42 CFR 447</b>		7. FEDERAL BUDGET IMPACT: a. FFY 09/01/12 – 09/30/12 \$ 8,978 b. FFY 10/01/12 – 09/30/13 \$107,734	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: <b>Attachment 4.19-A: Contents, Page 165</b>		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT ( <i>If Applicable</i> ): <b>Attachment 4.19-A: Contents, Page 165</b>	
10. SUBJECT OF AMENDMENT: <b>Inpatient Language Assistance (FMAP = 50%)</b>			
11. GOVERNOR'S REVIEW ( <i>Check One</i> ): <input checked="" type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input type="checkbox"/> OTHER, AS SPECIFIED: <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL			
12. SIGNATURE OF STATE AGENCY OFFICIAL: 		16. RETURN TO: <b>New York State Department of Health Bureau of HCRA Oper &amp; Financial Analysis 99 Washington Ave – One Commerce Plaza Suite 810 Albany, NY 12210</b>	
13. TYPED NAME: <b>Jason A. Helgerson</b>			
14. TITLE: <b>Medicaid Director &amp; Deputy Commissioner Department of Health</b>			
15. DATE SUBMITTED: <b>September 28, 2012</b>			
<b>FOR REGIONAL OFFICE USE ONLY</b>			
17. DATE RECEIVED:		18. DATE APPROVED: <b>MAR 27 2013</b>	
<b>PLAN APPROVED – ONE COPY ATTACHED</b>			
19. EFFECTIVE DATE OF APPROVED MATERIAL:		20. SIGNATURE OF REGIONAL OFFICIAL: 	
21. TYPED NAME:		22. TITLE:	
23. REMARKS:			

New York  
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**Reimbursement for language assistance services in hospital inpatient settings:**

Effective for hospital inpatient services provided on and after September 1, 2012, a Medicaid rate of payment for language interpretation services provided to patients with limited English proficiency (LEP) and communication services provided for patients who are deaf and hard of hearing will be established as follows:

- (1) Payment will be established on a per unit basis, with the unit of payment based on the number of minutes of language assistance services provided.
- (2) A maximum of two billable units of language assistance services will be allowable per patient per day with the billable units defined as follows:
  - i) 1<sup>st</sup> billable unit – for encounters providing one to 22 minutes of language assistance service.
  - ii) 2<sup>nd</sup> billable unit – for encounters providing additional minutes (23+) beyond the initial 22 minutes of language assistance services during the given patient day.
- (3) The rate of payment will be established at \$11.00 per unit of language assistance services, with a maximum payment per inpatient day of care of \$22.00. Such payment will be available on an “as provided only” basis via a separate and discretely billed rate, and will supplement the applicable DRG or exempt unit per diem payment for the given inpatient stay to account for the additional costs of inpatient services involving language assistance services.
- (4) To be reimbursable, the language assistance services must be provided by an independent third party, a dedicated hospital employee or a third party vendor (e.g., telephonic interpretation service) whose sole function is to provide interpretation services for individuals with LEP and communication services for patients who are deaf and hard of hearing.

TN #12-28

Approval Date MAR 27 2013

Supersedes TN # NEW

Effective Date \_\_\_\_\_