

**NEW YORK**  
state department of  
**HEALTH**

Nirav R. Shah, M.D., M.P.H.  
Commissioner

Sue Kelly  
Executive Deputy Commissioner

April 24, 2013

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

Re: SPA #13-11  
Inpatient Hospital Services

Dear Mr. Cooley:

The State requests approval of the enclosed amendment #13-11 to the Title XIX (Medicaid) State Plan for inpatient hospital services to be effective April 1, 2013 (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.

The State of New York pays for inpatient general hospital services using rates determined in accordance with methods and standards specified in an approved State Plan, following a public process, which complies with Social Security Act §1902(a)(13)(A).

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 27, 2013.

It is estimated that the changes represented by 2013 payment rates for inpatient general hospital services will have no noticeable short-term or long-term effect on the availability of services on a statewide or geographic area basis, the type of care furnished, or the extent of provider participation.

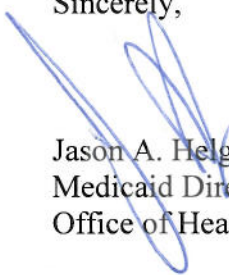
In accordance with 42 CFR §447.272(c), New York assures that its aggregate disproportionate share hospital payments do not exceed the disproportionate share hospital payment limit.

In accordance with §1923(g) of the Social Security Act, New York assures that it has calculated facility specific limits for disproportionate share payments for each disproportionate share hospital. New York assures that it will not make disproportionate share payments to a hospital in excess of the facility specific limits established for such hospital.

Copies of pertinent sections of enacted state statute 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 matter, please do not hesitate to contact John E. Ulberg, Jr., Medicaid Chief Financial Officer, Division of Finance and Rate Setting at (518) 474-6350.


Sincerely,



Jason A. Helgerson  
Medicaid Director  
Office of Health Insurance Programs

Enclosures

cc: Mr. Michael Melendez  
Mr. Tom Brady

|   |  |   |                             |
|---|--|---|-----------------------------|
| <b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</b><br><br><b>FOR: HEALTH CARE FINANCING ADMINISTRATION</b>  |  | 1. TRANSMITTAL NUMBER:<br><b>13-11</b>  | 2. STATE<br><b>New York</b> |
|   |  | 3. PROGRAM IDENTIFICATION: <b>TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)</b>   |                             |
| TO: REGIONAL ADMINISTRATOR<br>HEALTH CARE FINANCING ADMINISTRATION<br>DEPARTMENT OF HEALTH AND HUMAN SERVICES   |  | 4. PROPOSED EFFECTIVE DATE<br><b>April 1, 2013</b>  |                             |
| 5. TYPE OF PLAN MATERIAL ( <i>Check One</i> ):<br><br><input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT<br>COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT ( <i>Separate Transmittal for each amendment</i> ) |  |   |                             |
| 6. FEDERAL STATUTE/REGULATION CITATION:<br><b>Section 1902(a) of the Social Security Act &amp; 42 CFR 447</b>   |  | 7. FEDERAL BUDGET IMPACT:<br>a. FFY 04/01/13-09/30/13 \$ 217,900,000<br>b. FFY 10/01/13-09/30/14 \$ 267,000,000   |                             |
| 8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:<br><br><b>Attachment 4.19-A: Pages 153, 155</b>   |  | 9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT ( <i>If Applicable</i> ):<br><br><b>Attachment 4.19-A: Pages 153, 155</b>   |                             |
| 10. SUBJECT OF AMENDMENT:<br><b>DSH IGTs for County &amp; State Providers (FMAP = 50%)</b>  |  |   |                             |
| 11. GOVERNOR'S REVIEW ( <i>Check One</i> ):<br><input checked="" type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input type="checkbox"/> OTHER, AS SPECIFIED:<br><input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED<br><input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL |  |   |                             |
| 12. SIGNATURE OF STATE AGENCY OFFICIAL:<br>   |  | 16. RETURN TO:<br><b>New York State Department of Health<br/>Bureau of HCRA Operations &amp; Financial Analysis<br/>99 Washington Ave – One Commerce Plaza<br/>Suite 810<br/>Albany, NY 12210</b> |                             |
| 13. TYPED NAME: <b>Jason A. Helgerson</b>   |  |   |                             |
| 14. TITLE: <b>Medicaid Director<br/>Department of Health</b>  |  |   |                             |
| 15. DATE SUBMITTED: <b>April 24, 2013</b>   |  |   |                             |
| <b>FOR REGIONAL OFFICE USE ONLY</b>   |  |   |                             |
| 17. DATE RECEIVED:  |  | 18. DATE APPROVED:  |                             |
| <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:  |  |   |                             |

**Appendix I**  
**2013 Title XIX State Plan**  
**Second Quarter Amendment**  
**Hospital Inpatient Services**  
**Amended SPA Pages**

**New York  
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**Government General Hospital Additional Disproportionate Share Payments**

Government general hospital disproportionate share payments will be made to increase reimbursement to hospitals operated by the State of New York, the State University of New York. To be eligible, hospitals must be operating at the time the payments are made. The payments are subject to the payment limits established in this Attachment of this plan.

1. Government general hospitals operated by the State of New York or the State University of New York shall receive additional payments effective April 1, 1997 for the period April 1, 1997 through March 31, 1998, April 1, 1998 for the period April 1, 1998 through March 31, 1999, August 1, 1999 for the period April 1, 1999 through March 31, 2000, April 1, 2000 for the period April 1, 2000 through March 31, 2001, April 1, 2001 for the period April 1, 2001 through March 31, 2002, April 1, 2002 for the period April 1, 2002 through March 31, 2003, for the state fiscal year beginning April 1, 2005 through March 31, 2006, for the state fiscal year beginning April 1, 2006 through March 31, 2007 and April 1, 2007 through March 31, 2009, for the state fiscal years beginning April 1, 2009 through March 31, 2011, [and] for the state fiscal years beginning April 1, 2011 through March 31, 2013, and for the state fiscal years beginning April 1, 2013 through March 31, 2016, subject to the limits established pursuant to this Attachment. Such payments shall be established based on medical assistance and uninsured patient losses for 1996, 1997, 1998, 1999, 2000, 2001 and 2002 after considering all other medical assistance based initially for 1996 on 1994 reconciled data as further reconciled to actual reported 1996 reconciled data, for 1997 based initially on reported 1995 reconciled data as further reconciled to actual reported 1997 reconciled data, for 1998 based initially on reported 1995 reconciled data, as further reconciled to actual reported 1998 reconciled data, for 1999 based initially on reported 1995 reconciled data as further reconciled to actual reported 1999 reconciled data, for 2000 based initially on reported 1995 reconciled data, as further reconciled to actual reported 2000 reconciled data, for 2001 based initially on reported 1995 reconciled data, as further reconciled to actual reported 2001 reconciled data, for 2002 based initially on reported 2000 reconciled data as further reconciled to actual reported 2002 reconciled data, for the state fiscal year beginning on April 1, 2005, based initially on up to one hundred percent of reported 2000 reconciled data as further reconciled to up to one hundred percent of actual reported data for 2005, and for the state fiscal year beginning on April 1, 2006, based initially on up to one hundred percent of reported 2000 reconciled data as further reconciled to up to one hundred percent of actual reported data for 2006.

TN   #13-11  

Approval Date \_\_\_\_\_

Supersedes TN   #11-08  

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

**New York  
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2. Government general hospitals operated by a county, which does not include a city with a population of over one million, shall receive additional payments effective April 1, 1997 for the period April 1, 1997 through March 31, 1998, April 1, 1998 for the period April 1, 1998 through March 31, 1999, August 1, 1999 for the period April 1, 1999 through March 31, 2000, April 1, 2000 for the period April 1, 2000 through March 31, 2001, April 1, 2001 for the period April 1, 2001 through March 31, 2002, April 1, 2002 for the period April 1, 2002 through March 31, 2003, for the state fiscal year beginning April 1, 2005 through March 31, 2006, for the state fiscal year beginning April 1, 2006 through March 31, 2007, and April 1, 2007 through March 31, 2008, and for the state fiscal year beginning April 1, 2008 through March 31, 2009, for the state fiscal years beginning April 1, 2009 through March 31, 2011, [and] for the state fiscal years beginning April 1, 2011 through March 31, 2013, and for the state fiscal years beginning April 1, 2013 through March 31, 2016, subject to the limits established pursuant to this Attachment. Such payments shall be established based on medical assistance and uninsured patient losses for 1996, 1997, 1998, 1999, 2000, 2001 and 2002, after considering all other medical assistance based initially for 1996 on 1994 reconciled data as further reconciled to actual reported 1996 reconciled data, for 1997 based initially on reported 1995 reconciled data as further reconciled to actual reported 1997 reconciled data, for 1998 based initially on reported 1995 reconciled data, as further reconciled to actual reported 1998 reconciled data, for 1999 based initially on reported 1995 reconciled data as further reconciled to actual reported 1999 reconciled data, for 2000 based initially on reported 1995 reconciled data, as further reconciled to actual reported 2000 reconciled data, for 2001 based initially on reported 1995 reconciled data, as further reconciled to actual reported 2001 reconciled data, for 2002 based initially on reported 2000 reconciled data as further reconciled to actual reported 2002 reconciled data, for the state fiscal year beginning on April 1, 2005, based initially on up to one hundred percent of reported 2000 reconciled data as further reconciled to up to one hundred percent of actual reported data for 2005, and for the state fiscal year beginning on April 1, 2006, based initially on up to one hundred percent of reported 2000 reconciled data as further reconciled to up to one hundred percent of actual reported data for 2006.

TN   **#13-39**  \_\_\_\_\_

Approval Date \_\_\_\_\_

Supersedes TN   **#11-08**  \_\_\_\_\_

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

**Appendix II**  
**2013 Title XIX State Plan**  
**Second Quarter Amendment**  
**Hospital Inpatient Services**  
**Summary**

**SUMMARY**  
**SPA #13-11**

This State Plan Amendment proposes to extend additional medical assistance payments to State and County hospitals for the periods April 1, 2013 through March 31, 2016.



**Appendix III**  
**2013 Title XIX State Plan**  
**Second Quarter Amendment**  
**Hospital Inpatient Services**  
**Authorizing Provisions**

CHAPTER 56 OF THE LAWS OF 2013 - PART B

§ 2. Paragraph (a) of subdivision 1 of section 212 of chapter 474 of the laws of 1996, amending the education law and other laws relating to rates for residential healthcare facilities, as amended by section 2 of part D of chapter 59 of the laws of 2011, is amended to read as follows:

(a) Notwithstanding any inconsistent provision of law or regulation to the contrary, effective beginning August 1, 1996, for the period April 1, 1997 through March 31, 1998, April 1, 1998 for the period April 1, 1998 through March 31, 1999, August 1, 1999, for the period April 1, 1999 through March 31, 2000, April 1, 2000, for the period April 1, 2000 through March 31, 2001, April 1, 2001, for the period April 1, 2001 through March 31, 2002, April 1, 2002, for the period April 1, 2002 through March 31, 2003, and for the state fiscal year beginning April 1, 2005 through March 31, 2006, and for the state fiscal year beginning April 1, 2006 through March 31, 2007, and for the state fiscal year beginning April 1, 2007 through March 31, 2008, and for the state fiscal year beginning April 1, 2008 through March 31, 2009, and for the state fiscal year beginning April 1, 2009 through March 31, 2010, and for the state fiscal year beginning April 1, 2010 through March 31, ~~2013~~ 2016, the department of health is authorized to pay public general hospitals, as defined in subdivision 10 of section 2801 of the public health law, operated by the state of New York or by the state university of New York or by a county, which shall not include a city with a population of over one million, of the state of New York, and those public general hospitals located in the county of Westchester, the county of Erie or the county of Nassau, additional payments for inpatient hospital services as medical assistance payments pursuant to title 11 of article 5 of the social services law for patients eligible for federal financial participation under title XIX of the federal social security act in medical assistance pursuant to the federal laws and regulations governing disproportionate share payments to hospitals up to one hundred percent of each such public general hospital's medical assistance and uninsured patient losses after all other medical assistance, including disproportionate share payments to such public general hospital for 1996, 1997, 1998, and 1999, based initially for 1996 on reported 1994 reconciled data as further reconciled to actual reported 1996 reconciled data, and for 1997 based initially on reported 1995 reconciled data as further reconciled to actual reported 1997 reconciled data, for 1998 based initially on reported 1995 reconciled data as further reconciled to actual reported 1998 reconciled data, for 1999 based initially on reported 1995 reconciled data as further reconciled to actual reported 1999 reconciled data, for 2000 based initially on reported 1995 reconciled data as further reconciled to actual reported 2000 data, for 2001 based initially on reported 1995 reconciled data as further reconciled to actual reported 2001 data, for 2002 based initially on reported 2000 reconciled data as further reconciled to actual reported 2002 data, and for state fiscal years beginning on April 1, 2005, based initially on reported 2000 reconciled data as further reconciled to actual reported data for 2005, and for state fiscal years beginning on April 1, 2006, based initially on reported 2000 reconciled data as further reconciled to actual reported data for 2006, for state fiscal years beginning on and after April 1, 2007 through March 31, 2009, based initially on reported 2000 reconciled data as further reconciled to actual reported data for 2007 and 2008, respectively, for state fiscal years beginning

on and after April 1, 2009, based initially on reported 2007 reconciled data, adjusted for authorized Medicaid rate changes applicable to the state fiscal year, and as further reconciled to actual reported data for 2009, for state fiscal years beginning on and after April 1, 2010, based initially on reported reconciled data from the base year two years prior to the payment year, adjusted for authorized Medicaid rate changes applicable to the state fiscal year, and further reconciled to actual reported data from such payment year, and to actual reported data for each respective succeeding year. The payments may be added to rates of payment or made as aggregate payments to an eligible public general hospital.

**Appendix IV  
2013 Title XIX State Plan  
Second Quarter Amendment  
Hospital Inpatient Services  
Public Notice**

DAI will do business as Disability Rights New York (DRNY) and will operate all of the P&A/CAP programs authorized under federal law. DRNY will continue to serve existing clients and cases of the current P&A system or refer them to other sources of legal advocacy as appropriate, without disruption.

The Governor has, simultaneously with this public notice, provided notice to CQCAPD as the existing P&A and CAP; the State Rehabilitation Advisory Council; and the State Independent Living Council. Interested persons may wish to write to CQCAPD to obtain a copy of its response to that notice. Such requests should be sent to the address above.

Public comment on this redesignation will be accepted until April 5, 2013. Comments should be sent to the following:

Protection and Advocacy Redesignation  
The Capitol  
Albany, NY 12224  
Email: protectionandadvocacy@exec.ny.gov

A public hearing on the proposed redesignation will be held on April 9, 2013, at 1:00 p.m., Empire State Plaza, Meeting Rooms 3 and 4, Albany, New York.

For further information, contact: Protection and Advocacy Redesignation, The Capitol, Albany, New York 12224. Email: protectionandadvocacy@exec.ny.gov

**PUBLIC NOTICE**

Department of Health

The New York State Department of Health (DOH) is required by the provisions of the federal Beaches Environmental Assessment and Coastal Health (BEACH) Act to provide for public review and comment on the Department's beach monitoring and notification plan. The BEACH Act (Section 406(b) of the Clean Water Act) enacted a federal Environmental Protection Agency grant program available to states, such as New York, with coastal recreational waters. Coastal recreational waters include the Great Lakes and marine coastal waters that are designated for swimming, bathing, surfing, or similar water contact activities. The Act is not applicable to inland waters or waters upstream of the mouth of a river or stream having an unimpaired natural connection with the open sea.

The beach monitoring and public notification plan also includes information on the beach evaluation and classification process, including a list of waters to be monitored and beach ranking. Also included in this plan, is the sampling design and monitoring plan, including sampling location and sampling frequency. Lastly, the plan contains information on procedures for public notification and risk communication, including methods to notify the public of a swimming advisory or beach closure.

Any interested parties and/or agencies desiring to review and/or comment on the beach monitoring and notification plan for coastal recreational waters may do so by writing to: Timothy M. Shay, Section Chief, Department of Health, Center for Environmental Health, Bureau of Community Environmental Health and Food Protection, Empire State Plaza, Corning Tower Bldg., Rm. 1395, Albany, NY 12237, Fax (518) 402-7600

**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 inpatient, long term care, and non-institutional services and prescription drugs to comply with recently proposed statutory provisions. The following significant changes and clarifications are proposed:

**All Services**

- Effective on and after April 1, 2013, no annual trend factor will be applied pursuant to the provisions of Public Health Law § 2807-c(10)(c) to rates of payment for hospital inpatient services, residential health care facility inpatient services, adult day health care outpatient

services, hospital outpatient services and diagnostic and treatment care services, certified home health agencies, personal care services, adult day health care services provided to patients diagnosed with AIDS, personal care services provided in those local social services districts, including New York City, whose rates of payment for services is established by such social services districts pursuant to a rate-setting exemption granted by the Department, assisted living program services and hospice services. This includes the elimination of the trend factor effective for Medicaid rate periods April 1, 2013, and thereafter.

The annual decrease in gross Medicaid expenditures for state fiscal year 2013/14 is \$436.4 million.

- Continues, effective for dates of service April 1, 2013, through March 31, 2015, all non-exempt Medicaid payments as referenced below will be uniformly reduced by two percent.

The annual decrease in gross Medicaid expenditures for state fiscal year 2013/14 is \$714 million.

- The amount appropriated for Essential Community Provider Network and Vital Access Provider initiatives will be increased to \$182 million in state fiscal year 2013/14 and subsequently decreased to \$153 million in state fiscal year 2014/15. Included in this initiative is a \$30 million reallocation of nursing home financially disadvantaged funding to the vital access provider initiative.

The annual increase in gross Medicaid expenditures for state fiscal year 2013/14 is \$52 million.

- Consistent with Section 1202 of the Affordable Care Act, certain primary care providers (e.g., physicians, physician's assistants and nurse practitioners) will be reimbursed at the Medicare rate for Medicaid primary care services furnished in calendar years 2013 and 2014 in institutional and non-institutional settings, including nursing homes. This provision applies to evaluation and management (E&M) and vaccine administration services when delivered by a physician with a specialty designation of family medicine, general internal medicine, or pediatric medicine. The purpose of this provision is to encourage more physicians to participate in Medicaid, and thereby promote access to primary care services for current and new Medicaid beneficiaries to be served via coverage expansion in 2014.

It is estimated that the impact to the provider community will be a gross annual increase in state fiscal year 2013/14 of \$227.9 million. This includes the State eliminating the physician's portion of the two percent reduction that was enacted as part of the 2011-2012 State Fiscal Year consistent with the Federal Regulation.

**Institutional Services**

- For the state fiscal year beginning April 1, 2013 through March 31, 2014, continues specialty hospital adjustments for hospital inpatient services provided on and after April 1, 2013, 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. Payments to eligible public general hospitals may be added to rates of payment or made as aggregate payments.

- For state fiscal years beginning April 1, 2013 through March 31, 2016, additional medical assistance payments for inpatient hospital services may be made to public general hospitals operated by the State of New York or the State University of New York, or by a county which shall not include a city with a population over one million, and those public general hospitals located in the counties of Westchester, Erie, or Nassau, up to one hundred percent (100%) of each such public hospital's medical assistance and uninsured patient losses after all other medical assistance, including disproportionate share payments to such general hospitals. Payments may be added to rates of payment or made as aggregate payments. Payments will be based initially on reported reconciled data from the base year two years prior to the payment year adjusted for authorized Medicaid rate changes and further reconciled to actual reported data from such payment year.

- Extends current provisions for services April 1, 2013 through March 31, 2015, the reimbursable operating cost component for general hospital inpatient rates will be established with the 2006 final trend factor equal to the final Consumer Price Index (CPI) for all urban consumers less 0.25%.

# 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](http://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 Village of Geneseo

The Village of Geneseo is soliciting proposals for a full financial statement audit. The Village's annual operating budget amounts to \$5,036,673 and encompasses general, water and sewer funds. A trust and agency payroll account exists as well as several reserve and capital project funds. We would request that the court records are also audited in compliance with Section 2019-a of the Uniform Justice Court Act.

Please submit proposals to the Village of Geneseo, Marsha Merrick, Village Clerk/Treasurer, 119 Main St., Geneseo, NY 14454. Questions may be directed to 585-243-1177 or emailed to [village@geneseony.org](mailto:village@geneseony.org).

All proposals must be received no later than December 28, 2012. The goal is to review those proposals and select a firm in January 2013.

## 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, long term care, non-institutional and pharmacy services to comply with proposed and enacted statutory provisions. The following changes are proposed:

### General

- Consistent with Section 1202 of the Affordable Care Act, certain primary care providers (e.g., physicians, physician's assistants and nurse practitioners) will be reimbursed at the Medicare rate for Medicaid primary care services furnished in calendar years 2013 and 2014 in institutional and non-institutional settings. This provision applies to evaluation and management (E&M) and vaccine administration services when delivered by a physician with a specialty designation of family medicine, general internal

medicine, or pediatric medicine. The purpose of this provision is to encourage more physicians to participate in Medicaid, and thereby promote access to primary care services for current and new Medicaid beneficiaries to be served via coverage expansion in 2014. It is estimated that this provision will infuse \$11 billion into Medicaid primary care nationally and is 100 percent funded by the federal government through an enhanced federal financial participation (FFP) rate. The rate increase will significantly bolster the primary care delivery system, potentially increasing access for current and new Medicaid beneficiaries and reducing unnecessary visits to the emergency department.

The State is currently developing the impact to the provider community and will issue a clarification notice once such impact has been determined.

### Institutional Services

- For the period effective January 1, 2013 through December 31, 2015, indigent care pool payments will be made using an uninsured units methodology. Each hospital's uncompensated care need amount will be determined as follows:

- Inpatient units of service for the cost report period two years prior to the distribution year (excluding hospital-based residential health care facility (RHCF) and hospice) will be multiplied by the average applicable Medicaid inpatient rate in effect for January 1 of the distribution year;
- Outpatient units of service for the cost report period two years prior to the distribution year (excluding referred ambulatory and home health) will be multiplied by the average applicable Medicaid outpatient rate in effect for January 1 of the distribution year;
- Inpatient and outpatient uncompensated care amounts will then be summed and adjusted by a statewide adjustment factor and reduced by cash payments received from uninsured patients; and
- Uncompensated care nominal need will be based on a weighted blend of the net adjusted uncompensated care and the Medicaid inpatient utilization rate. The result will be used to proportionately allocate and make Medicaid disproportionate share hospital (DSH) payments in the following amounts:

\$139.4 million to major public general hospitals, including hospitals operated by public benefit corporations; and

\$994.9 million to general hospitals, other than major public general hospitals.

This initiative will be transitioned in over three years from the existing methodology to the uninsured units methodology.

There is no additional estimated annual change to gross Medicaid expenditures attributable to this initiative for state fiscal year 2013/14.

- For eligible public general hospitals effective beginning January 1, 2013 and subsequent calendar years, the Indigent Care Adjustment will be allocated proportionately based on each eligible hospital's Medicaid and uninsured losses to the total of such losses for eligible hospitals. The Medicaid and uninsured losses will be determined based on the latest available data reported to the Department of Health as required by the Commissioner on a specified date through the Data Collection Tool.

There is no additional estimated annual change to gross Medicaid expenditures attributable to this initiative for state fiscal year 2013/14.

- Extends effective beginning April 1, 2013 and for each state fiscal year thereafter, Intergovernmental Transfer Payments to eligible major public general hospitals run by counties and the State of New York.

There is no additional estimated annual change to gross Medicaid expenditures attributable to this initiative for state fiscal year 2013/14.

- Effective beginning April 1, 2013 and for state fiscal years thereafter, the supplemental upper payment limit payments made to general hospitals, other than major public general hospitals, increases to \$339 million annually.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2013/2014 is \$25 million.

#### Long Term Care Services

- Effective with the 2013 rate year, the Department of Health will implement quality measures and benchmarks and against those parameters make payments related to the implementation of a Quality Pool for non-specialty residential health care facilities (i.e., non-specialty nursing homes). The quality measures and benchmarks used to score and measure nursing home quality will include the following three categories.

1) Quality MDS Measures - will be calculated using data from MDS 3.0 data, New York State employee flu vaccination data, and the Centers for Medicare & Medicaid Services (CMS) 5-Star staffing measure;

2) Compliance Measures - will be calculated using data from the CMS' 5-Star Rating for health inspections, the timely filing of certified nursing home cost reports, and the timely filing of employee flu immunization data; and

3) Avoidable hospitalizations - will be calculated using MDS 3.0 data, and will be based upon a potentially preventable hospitalization quality indicator for short and long stay hospitalizations.

The scores will be based upon performance in the current year (as defined by the measures and the time period for which data is available) and improvements from the prior year. Certain nursing homes, including those which receive a survey outcome of immediate jeopardy, or substandard quality of care, a J, K, or L deficiency will be not be eligible for quality payments. Funding for the quality payments will be made from a redistribution of existing resources paid through the nursing home pricing methodology to non-specialty nursing homes, and as a result, the Quality Pool will not have an impact on annual gross Medicaid expenditures.

#### Non-Institutional Services

- Effective January 1, 2013, the State will be adding a new reimbursement methodology for providers who are participating in a Medicaid program integrating the delivery of physical and behavioral health services at a single clinic site.

The goal of this program is to improve the quality and coordination of care provided to individuals who have multiple physical and behavioral health needs. Presently, individuals with serious mental illness and/or addictions often receive regular care in specialized behavioral health settings. The specific clinic site in which these services are provided is licensed to provide such services by the Office of Mental Health (OMH) or the Office of Alcohol and Substance Abuse Services (OASAS) and is not licensed or authorized to provide physical/medical care under Article 28 of the Public Health Law. Patients receiving treatment in these clinics may therefore forgo primary care or, when they do receive physical/medical health care from an Article 28 Department of Health (DOH) certified clinic, the DOH certified clinic site is separate and distinct from the behavioral health clinic site. This leads to fragmented care, poorer health outcomes, and higher rates of emergency room and inpatient services. The goal of this program is to facilitate and promote the availability of both physical and behavioral health services at the site where that individual receives their regular care. For example, if an individual receives regular care in a mental health or substance abuse clinic, that clinic will now be authorized to provide both the physical/medical as well as behavioral health services required by that individual.

A number of steps will be undertaken by DOH, OMH and OASAS

to facilitate and streamline this health care delivery model. DOH, OMH and OASAS will work together to:

- Provide an efficient approval process to add new services to a site that is not licensed for those services;
- Establish a single set of administrative standards and survey process under which providers will operate and be monitored; and
- Provide single state agency oversight of compliance with administrative standards for providers offering multiple services at a single site.

To insure quality and coordination of care provided to people with multiple needs, DOH, OMH and OASAS will:

- Ensure appropriate compliance with applicable federal and State requirements for confidentiality of records;
- Work with providers to ensure optimal use of clinical resources jointly developed by OASAS and OMH that support evidence based approaches to integrated dual disorders treatment; and
- Provide an opportunity for optimal clinical care provided in a single setting creating cost efficiencies and promoting quality of care.

Providers eligible to participate in the program include those with two or more licenses at different physical locations, providers who have co-located clinics (i.e., two separately licensed clinics that operate in the same physical location) and providers who are licensed by one State agency but choose to provide an array of services that would fall under the license or certification of another State agency.

Participating providers will be paid through the Ambulatory Patient Group (APG) reimbursement methodology when offering integrated services at an authorized clinic site. Recognizing that integration of physical and behavioral services may result in lower clinic patient billing volume, OMH and OASAS providers will have their APG payment blend accelerated so that they will now receive a 100% calculated APG payment instead of a blended payment - 25% or 50% of existing payment for blend/75% or 50% of APG payment (Note: DOH clinics are already receiving 100% APG payment with no blend). Additionally, the overall APG calculated payment for all providers will be increased by 5%.

The DOH projects that the new payment methodology will be cost neutral.

- The Ambulatory Patient Group (APG) reimbursement methodology is revised to include recalculated weights that will become effective on or after January 1, 2013.

There is no estimated annual change to gross Medicaid expenditures attributable to this initiative in state fiscal year 2013/14.

- Effective January 1, 2013, Medicaid will provide reimbursement to hospital and diagnostic and treatment center physicians for providing home visits to chronically ill patients.

There is no additional estimated annual change to gross Medicaid expenditures attributable to this initiative for state fiscal year 2013/14.

#### Pharmacy

- The Department of Health proposes to remove coverage of benzodiazepines as well as barbiturates used in the treatment of epilepsy, cancer, or a chronic mental health disorder for dually eligible beneficiaries, effective January 1, 2013.

Section 175 of the Medicare Improvement for Patients and Providers Act of 2008 (MIPPA) amended section 1860D-2(e)(2)(A) of the Act to include barbiturates "used in the treatment of epilepsy, cancer, or a chronic mental health disorder" and benzodiazepines in Part D drug coverage, effective as of January 1, 2013. Currently, barbiturates and benzodiazepines are among the excluded drugs covered for all Medicaid beneficiaries.

Since the coverage of barbiturates under Part D is limited to the treatment of epilepsy, cancer or a chronic mental health disorders, New York State (NYS) proposes to continue to cover barbiturates for conditions other than the three covered by Part D. The coverage of benzodiazepines under Part D is inclusive of all indications, so NYS proposes to provide coverage for only non-dually eligible beneficiaries.

**Appendix V**  
**2013 Title XIX State Plan**  
**Second Quarter Amendment**  
**Hospital Inpatient Services**  
**Responses to Standard Funding Questions**



**APPENDIX V  
HOSPITAL SERVICES  
State Plan Amendment #13-11**

**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 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 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 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. 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:** Disproportionate Share Hospital (DSH) IGT payments being made in accordance with this plan amendment are not subject to the upper payment limit.

- 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:** DSH payments are required by federal and State law to not exceed the costs of providing inpatient and outpatient services to Medicaid and uninsured patients net of revenues received. The State assures that the payments being made pursuant to this SPA do not exceed this limitation.

All aggregate DSH payments to governmental providers are limited to the reasonable costs of providing services as measured by their projected annual DSH cap. If, upon reconciliation, a governmental provider is found to have received payment in excess of its reconciled annual DSH cap, the excess payment over the DSH cap is recouped and the corresponding Federal share of the excess payment is credited on the quarterly expenditure report.

#### **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 FMAs 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 will be forwarded to CMS. To date, no feedback has been received from any tribal representative in response to the proposed change in this SPA.