NEW YORK
state department of
HEALTH

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

Sue Kelly
Executive Deputy Commissioner

March 26, 2013

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

Re: SPA #13-13
Inpatient Hospital Services

Dear Mr. Cooley:

The State requests approval of the enclosed amendment #13-13 to the Title XIX (Medicaid) State Plan for inpatient hospital services to be effective January 1, 2013 (Appendix I). This amendment is being submitted based upon proposed 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 December 26, 2012.

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 proposed 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

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: **13-13**	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 **January 1, 2013**	

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 01/01/13-09/30/13 $ 579,862,500** **b. FFY 10/01/13-09/30/14 $ 773,150,000**
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: **Attachment 4.19-A: Contents Page; Pages 140, 152, 160, 161(a), 161(d), 161(e), 161(f), 161(g), 161(1)**	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: **Attachment 4.19-A: Contents Page; Pages 140, 152, 160, 161(a)**

10. SUBJECT OF AMENDMENT:
Indigent Care Adjustments & Indigent Care Pool (FMAP = 50%)

11. GOVERNOR'S REVIEW *(Check One)*:
☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:	16. RETURN TO: **New York State Department of Health** **Bureau of HCRA Oper & Financial Analysis** **99 Washington Ave – One Commerce Plaza** **Suite 810** **Albany, NY 12210**
13. TYPED NAME: **Jason A. Helgerson**	
14. TITLE: **Medicaid Director** **Department of Health**	
15. DATE SUBMITTED: March 26, 2013	

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
2013 Title XIX State Plan
First Quarter Amendment
Hospital Inpatient Services
Amended SPA Pages

New York
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Hospital Inpatient Reimbursement – Effective December 1, 2009

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Supplemental indigent care distributions.

Effective beginning January 1, 2013 the methodology described in this section is terminated. The new methodology is described in the Indigent Care Pool Reform section of this Attachment.

1. From funds in the pool for each year, except as otherwise provided for in this section, $27 million shall be reserved on an annual basis for the periods January 1, 2000 through May 1, 2009, to be distributed to each hospital based on each hospital's proportional annual reduction to their projected distribution from the New York State Health Care Reform Act Profession Education Pool, relative to the statewide annual reduction to said pool, as authorized by State law, up to the hospital specific disproportionate share (DSH) payment limits.

2. Effective May 1, 2009 through December 31, 2009:

   a. Each hospital eligible for supplemental indigent care distributions in 2008 shall receive 90% of its 2008 annual award amount as Medicaid DSH payment.

   b. $307 million shall be distributed to facilities designated by the Department as teaching hospitals as of December 31, 2008, to compensate such facilities for Medicaid and self-pay losses. The payment amounts apply consistently to all teaching hospitals, and are reasonably related to costs, based on Medicare GME payments as a proxy, and are pursuant to the following schedule of payments:

Commissioner shall use annual cost reports in accordance with the provisions of paragraph (5) to estimate Medicaid and self-pay costs in the projection methodology for a particular rate year. This shall be referred to as the "projection methodology". Subsequent to the receipt of a hospital's annual cost report having an end date in the applicable annual disproportionate share distribution period, or for certain state-operated general hospitals whose annual cost reports have an end date within the subsequent annual period, each hospital's disproportionate share limitation shall be reconciled to the actual rate year data. This shall be referred to as the "reconciliation methodology".

5. Projection methodology. Each hospital's projected disproportionate share limitation for each rate year shall be the sum of its inpatient and outpatient Medicaid and uninsured gains/(losses) as calculated using reported base year data and statistics from the year two years immediately preceding the rate year and as used for projection methodology purposes for that prior year. For the two thousand eleven calendar year, maximum disproportionate share payment distributions shall be determined initially based on each hospital's submission of a fully completed two thousand eight disproportionate share hospital data collection tool, and shall subsequently be revised to reflect each hospital's submission of a fully completed two thousand nine disproportionate share hospital data collection tool. For calendar years on or after January 1, 2012, inpatient and outpatient Medicaid and uninsured gains/(losses) based on data for the <u>most recent</u> calendar year <u>available</u> [2 years] prior to the DSH payment year submitted by hospitals as prescribed by the Commissioner shall be used to determine maximum disproportionate share payments. All such initial determinations shall subsequently be revised to reflect actual calendar year inpatient and outpatient Medicaid and uninsured gains/(losses) applicable to the DSH payment year.

6. Reconciliation methodology. The Commissioner shall revise the projected limitation based on actual audited and certified data reported to the Commissioner for such calendar year in accordance with the following and in accordance with final regulations issued by the federal Department of Health and Human Services implementing 42 USC §1396r-4. The Commissioner shall revise the projected limitations for each hospital within eight months from the date required reports are submitted to the Department, except if such reports are determined to be unacceptable by the Department. For hospitals which have submitted unacceptable reports, the Commissioner shall revise the projected limitations within eight months from the date acceptable reports have been resubmitted to the Department.

[a.]

Government General Hospital Indigent Care Adjustment.

For rate periods commencing January 1, 1997 and thereafter, each eligible government general hospital [shall] will receive an annual amount equal to the amount allocated to such government general hospitals as determined pursuant to this Attachment for the period January 1, 1996 through December 31, 1996. The adjustment may be made to rates of payment or as aggregate payments to an eligible government general hospital and is contingent upon all federal approvals necessary by federal law and rules for federal financial participation for medical assistance under Title XIX of the federal Social Security Act based upon the adjustment provided herein as a component of such payments being granted.

For calendar years effective January 1, 2013, and for each calendar year thereafter, eligible major government general hospitals will receive in aggregate $412,000,000 proportionately allocated 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 of Health on a specified date.

New York
161(a)

Medicaid disproportionate share payments.

Effective beginning January 1, 2013 the methodology described in this section is terminated. The new methodology is described in the Indigent Care Pool Reform section of this Attachment.

1. For the rate periods commencing January 1, 1991 and thereafter, Medicaid disproportionate share payments shall be made to hospitals to reimburse a portion or all of the costs associated with serving those patients unable or unwilling to pay for services rendered.

2. For rate periods commencing January 1, 1997 and thereafter, uncompensated care need shall mean losses from bad debts reduced to cost and the costs of charity care of a general hospital for inpatient services. The cost of services provided as an employment benefit or as a courtesy shall not be included.

3. For rate periods commencing January 1, 1997 and thereafter, targeted need shall be defined as the relationship of uncompensated care need to reported costs expressed as a percentage. Reported costs shall mean costs allocated as prescribed by the Commissioner to government general hospital inpatient services. Targeted need shall be determined based on base year data and statistics for the calendar year two years prior to the distribution period.

4. Nominal payment amount shall be defined as the sum of the dollars attributable to the application of an incrementally increasing proportion of reimbursement for percentage increases in targeted need according to the scale specified in this section.

5. For rate periods commencing January 1, 1997 and thereafter, targeted need share shall mean the relationship of each general hospital's nominal payment amount of uncompensated care need determined in accordance with the scale specified in this section to the nominal payment amounts of uncompensated care need for all eligible general hospitals applied to funds available for distribution pursuant to this section.

6. Major government general hospitals shall mean all State-operated general hospitals, all general hospitals operated by the New York City Health and Hospital Corporation and all other government general hospitals having annual inpatient operating costs in excess of $25 million.

7. Voluntary sector hospitals shall mean all voluntary non-profit, private proprietary and government general hospitals other than major government general hospitals.

8. For rate periods commencing January 1, 1997 and thereafter, uninsured care shall be defined as losses from bad debts reduced to cost and the costs of charity care of a general hospital for inpatient services, which are not eligible for payment in whole or in part by a governmental agency, insurer or other third-party payor on behalf of a patient, including payment made

New York
161(d)

Indigent Care Pool Reform – effective January 1, 2013

The provisions of this section will be effective for the period January 1, 2013 through December 31, 2015.

(a) Indigent Care Pool Reform Methodology. Each hospital's uncompensated care nominal need will be calculated in accordance with the following:

1. Inpatient Uncompensated Care. Inpatient units of services for all uninsured patients from the calendar year two years prior to the distribution year, excluding hospital-based residential health care facility (RHCF) and hospice services, will be multiplied by the applicable Medicaid inpatient rates in effect for January 1 of the distribution year.

2. Outpatient Uncompensated Care. Outpatient units of service for all uninsured patients from the calendar year two years prior to the distribution year, excluding referred ambulatory and home health services, will be multiplied by Medicaid outpatient rates that reflect the exclusive utilization of the ambulatory patient groups (APG) rate-setting methodology; however, for those services for which APG rates are not available the applicable Medicaid rate will be the outpatient rates in effect for January 1 of the distribution year.

3. Statewide Adjustment Factor (SWAF). A statewide adjustment factor will be calculated as the statewide aggregate sum of the inpatient uninsured units multiplied by the step-down cost per unit from the calendar year two years prior to the distribution year for each applicable inpatient service, excluding hospital-based RHCF and hospice services, and the statewide aggregate sum of the outpatient uninsured units of service multiplied by the step-down cost per unit from the calendar year two years prior to the distribution year for each applicable outpatient service, excluding referred ambulatory and home health services, divided by the statewide aggregate sum of the inpatient and outpatient uncompensated care.

4. Net Adjusted Uncompensated Care. The inpatient and outpatient uncompensated care amounts will be summed and multiplied by the SWAF, then reduced by the sum of all cash payments collected from uninsured patients as reported in the Institutional Cost Report for the calendar year two years prior to the distribution year to determine net adjusted uncompensated care.

5. Blended Nominal Need Factor. A "blended" nominal need factor will be calculated by first dividing net adjusted uncompensated care by the step-down costs for the calendar year two years prior to the distribution year and then multiplying the result by the sum of:

    a. 0.40; and
    b. the Medicaid inpatient utilization rate multiplied by 0.60.

    The Medicaid inpatient utilization rate for this purpose will be calculated based on discharge data from the calendar year two years prior to the distribution year and will include fee-for-service and managed care discharges for acute and exempt services.

6. Uncompensated Care Nominal Need. Step-down costs from the calendar year two years prior to the distribution year will be multiplied by the blended nominal need factor to determine uncompensated care nominal need which will be used to proportionally allocate the available indigent care pool funding described in paragraph (b).

(b) Indigent Care Pool. Indigent care pool distributions will be made to eligible hospitals in the following amounts:

1. Major Government General Hospital Pool Distributions. $139.4 million will be distributed as Medicaid disproportionate share hospital (DSH) payments to major government general hospitals, including the hospitals operated by public benefit corporations, on the basis of each hospital's relative share of uncompensated care nominal need to the aggregate uncompensated care nominal need for all major government general hospitals determined in accordance with the Indigent Care Pool Reform methodology described in paragraph (a) of this section. Major government general hospitals are defined as all State-operated general hospitals, all general hospitals operated by the New York City Health and Hospital Corporation, and all other government general hospitals having annual inpatient operating costs in excess of $50 million.

2. Voluntary General Hospital Pool Distributions. $994.9 million will be distributed as Medicaid disproportionate share hospital (DSH) payments to eligible voluntary general hospitals, other than major public general hospitals, on the basis of each hospital's relative share of uncompensated care nominal need to the aggregate uncompensated care nominal need for all eligible voluntary general hospitals as determined in accordance with the Indigent Care Pool Reform methodology described in paragraph (a) of this section. Voluntary general hospitals are defined as all voluntary non-profit, private proprietary, and government general hospitals other than major government general hospitals.

3. Transition Pool. A three-year transition pool utilizing a floor/ceiling model has been established to help hospitals avoid large funding swings. The transition pool funding will be generated through a redistribution of dollars from those hospitals which experience an increase in distributions using the new Indigent Care Reform methodology to those that experience a decrease. Transition amounts will be determined based on a comparison of the distributions for the applicable calendar year 2013 through 2015 to an average of the annual distributions for the three year period January 1, 2010 through December 31, 2012.

   A separate transition pool will be established for major government general hospitals and voluntary general hospitals. Individual hospital gains and losses in each pool will be capped by means of the following transition adjustments.

   a. Payment Floor. Distributions will be adjusted by a transition factor which establishes a payment floor to ensure that no hospital will experience a reduction in 2013 pool distributions that is greater than 2.5 percent less than the three-year average distributions.

      In calendar years 2014 and 2015 the transition factor establishing the payment floor will increase to 5.0 percent and 7.5 percent, respectively, for comparison to the three-year average distributions.

b. Payment Ceiling. Distributions will be adjusted by a factor which establishes a payment ceiling to ensure that hospitals which experience increases in payments, as compared to the average of their annual distributions for the three-year period January 1, 2010 through December 31, 2012, will have such increases limited in amounts sufficient to ensure full funding of the transition adjustments described in subparagraph (a).

c. Average Distributions. The three-year average distributions used for comparison were calculated in accordance with previous methodologies described in the Supplemental indigent care distributions section, the High Need Indigent Care Adjustment Pool section, and the Medicaid disproportionate share section, and, for voluntary hospitals, are net of the "pool cut" reductions described in paragraph (f) of the Medicaid disproportionate share section, but before the "Voluntary UPL" reductions described in paragraph (e) of the Medicaid disproportionate section.

5. Financial Assistance Compliance Pool. For calendar years 2014 and 2015, one percent of the DSH funds available for distribution to general hospitals will be set aside and distributed to such hospitals based on their level of compliance with the New York State Financial Aid Law.

6. DSH Payment Limits. The distributions in this section are subject to the provisions of the Disproportionate share limitations section.

New York
161(1)

Voluntary Supplemental Inpatient Payments

Effective for the period July 1, 2010 through March 31, 2011, additional inpatient hospital payments are authorized to voluntary sector hospitals, excluding government general hospitals, for inpatient hospital services after all other medical assistance payments, of $235.5M for the period July 1, 2010 through March 31, 2011 and $314M for the period April 1, 2011 through March 31, 2012 subject to the requirements of 42 CFR 447.272 (upper payment limit). Such payments may be added to rates of payment or made as aggregate payments to eligible voluntary sector owned or operated general hospitals, excluding government general hospitals.

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

(a) Thirty percent of such payments will be allocated to safety net hospitals based on each eligible hospital's proportionate share of all eligible safety net hospitals' Medicaid discharges for inpatient hospital services, including both Medicaid fee-for-service and managed care discharges for acute and exempt services;

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

(b) Seventy percent of such payments will be allocated to eligible general hospitals, which provide emergency room services, based on each such hospital's proportionate share of all eligible hospitals' Medicaid discharges for inpatient hospital services, including both Medicaid fee-for-service and managed care discharges for acute and exempt services;

(c) No eligible general hospital's annual payment amount will exceed the lower of the sum of the annual amounts due that hospital in accordance with the Medicaid Disproportionate Share Section, the Supplemental Indigent Care Distributions Section, and the High Need Indigent Care Adjustment Pool Section of this Attachment, or the hospital's facility specific projected disproportionate share hospital payment ceiling

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

SUMMARY
SPA #13-13

This State Plan Amendment proposes to 1) revise the methodology for the distribution of indigent care pool funds to general hospitals to be based on uninsured units for the three-year period January 1, 2013 through December 31, 2015, and 2) revise the methodology for the distribution of government general hospitals indigent care adjustments to be based on Medicaid and uninsured losses for calendar years beginning January 1, 2013.

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

SPA #13-13

PROPOSED LANGUAGE FROM EXECUTIVE BUDGET (S.2606-B/A.3006-B)

Section 1. Section 2807-k of the public health law is amended by adding a new subdivision 5-d to read as follows:

5-d. (a) Notwithstanding any inconsistent provision of this section, section twenty-eight hundred seven-w of this article or any other contrary provision of law, and subject to the availability of federal financial participation, for periods on and after January first, two thousand thirteen, through December thirty-first, two thousand fifteen, all funds available for distribution pursuant to this section, except for funds distributed pursuant to subparagraph (v) of paragraph (b) of subdivision five-b of this section, and all funds available for distribution pursuant to section twenty-eight hundred seven-w of this article, shall be reserved and set aside and distributed in accordance with the provisions of this subdivision.

(b) The commissioner shall promulgate regulations, and may promulgate emergency regulations, establishing methodologies for the distribution of funds as described in paragraph (a) of this subdivision and such regulations shall include, but not be limited to, the following:

(i) Such regulations shall establish methodologies for determining each facility's relative uncompensated care need amount based on uninsured inpatient and outpatient units of service from the cost reporting year two years prior to the distribution year, multiplied by the applicable medicaid rates in effect January first of the distribution year, as summed and adjusted by a statewide cost adjustment factor and reduced by the sum of all payment amounts collected from such uninsured patients, and as further adjusted by application of a nominal need computation that shall take into account each facility's medicaid inpatient share.

(ii) Annual distributions pursuant to such regulations for the two thousand thirteen through two thousand fifteen calendar years shall be in accord with the following:

(A) one hundred thirty-nine million four hundred thousand dollars shall be distributed as Medicaid Disproportionate Share Hospital ("DSH") payments to major public general hospitals; and

(B) nine hundred ninety-four million nine hundred thousand dollars as Medicaid DSH payments to eligible general hospitals, other than major public general hospitals.

(iii)(A) Such regulations shall establish transition adjustments to the distributions made pursuant to clauses (A) and (B) of subparagraph (ii) of this paragraph such that no facility experiences a reduction in indigent care pool payments pursuant to this subdivision that is greater than the percentages, as specified in such regulations, as compared to the average distribution that each such facility received for the three calendar years prior to two thousand thirteen pursuant to this section and section twenty-eight hundred seven-w of this article.

(B) Such regulations shall also establish adjustments limiting the increases in indigent care pool payments experienced by facilities pursuant to this subdivision by an amount that will be, as determined by the commissioner and in conjunction with such other funding as may be available for this purpose, sufficient to ensure full funding for the transition adjustment payments authorized by clause (A) of this subparagraph.

(iv) Such regulations shall reserve one percent of the funds available for distribution in the two thousand fourteen and two thousand fifteen

calendar years pursuant to this subdivision, subdivision fourteen-f of section twenty-eight hundred seven-c of this article, and sections two hundred eleven and two hundred twelve of chapter four hundred seventy-four of the laws of nineteen hundred ninety-six, in a "financial assistance compliance pool" and shall establish methodologies for the distribution of such pool funds to facilities based on their level of compliance, as determined by the commissioner, with the provisions of subdivision nine-a of this section.

§ 2. Subdivision 14-f of section 2807-c of the public health law, as amended by chapter 1 of the laws of 1999, is amended to read as follows:
14-f. Public general hospital indigent care adjustment. Notwithstanding any inconsistent provision of this section **and subject to the availability of federal financial participation**, payment for inpatient hospital services for persons eligible for payments made by state governmental agencies for the period January first, nineteen hundred ninety-seven through December thirty-first, nineteen hundred ninety-nine and periods on and after January first, two thousand applicable to patients eligible for federal financial participation under title XIX of the federal social security act in medical assistance provided pursuant to title eleven of article five of the social services law determined in accordance with this section shall include for eligible public general hospitals a public general hospital indigent care adjustment equal to the aggregate amount of the adjustments provided for such public general hospital for the period January first, nineteen hundred ninety-six through December thirty-first, nineteen hundred ninety-six pursuant to subdivisions fourteen-a and fourteen-d of this section on an annualized basis, [~~provided all federal approvals necessary by federal law and regulation for federal financial participation in payments made for beneficiaries eligible for medical assistance under title XIX of the federal social security act based upon the adjustment provided herein as a component of such payments are granted~~] **provided, however, that for periods on and after January first, two thousand thirteen an annual amount of four hundred twelve million dollars shall be allocated to eligible major public hospitals based on each hospital's proportionate share of medicaid and uninsured losses to total medicaid and uninsured losses for all eligible major public hospitals, net of any disproportionate share hospital payments received pursuant to sections twenty-eight hundred seven-k and twenty-eight hundred seven-w of this article**. The adjustment may be made to rates of payment or as aggregate payments to an eligible hospital.

PROPOSED

Appendix IV
2013 Title XIX State Plan
First Quarter Amendment
Hospital Inpatient Services
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

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.

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.

The estimated annual net aggregate decrease in gross Medicaid expenditures attributable to this initiative for state fiscal year 2013/2014 is ($1,983,863).

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

The public is invited to review and comment on this proposed State Plan Amendment.

For further information and to review and comment, please contact: Department of Health, Bureau of HCRA Operations & Financial Analysis, 99 Washington Ave. - One Commerce Plaza, Suite 810, Albany, NY 12210, (518) 474-1673, (518) 473-8825 (FAX), e-mail: spa_inquiries@health.state.ny.us

PUBLIC NOTICE

Office for People with Developmental Disabilities and Department of Health

Pursuant to 42 CFR Section 447.205, the New York State Office for People With Developmental Disabilities (OPWDD) and the New York State Department of Health hereby give notice of the following:

The State proposes to make the following changes effective February 1, 2013. The State will expand the applicability of the reporting and audit requirements in OPWDD regulations to cover Medicaid Service Coordination (MSC), Home and Community Based Services Waiver services (HCBS Waiver services), and clinic treatment facilities ("Article 16 clinics") provided under the auspices of OPWDD. Additionally, the State proposes to reduce the number of cost report filing deadline extensions from two thirty-day extensions to one thirty-day extension. The State proposes to change the penalty for failure to file a cost report on time from a 5 percent penalty imposed at the discretion of the State and levied against the operating portion of existing rates, prices or fees, to a 2 percent mandatory reduction in reimbursements.

Another proposed change will require OPWDD to give the provider written notice that it missed the cost report deadline or that it must submit a revised cost report. This notice will give the provider a final opportunity to submit the cost report or explain that it cannot submit it because of unforeseeable factors beyond its control. If the provider submits the cost report or shows that there were unforeseeable factors beyond its control that prevented it from submitting on time, it will avoid the penalty. However, the penalty will be imposed if the provider submits an explanation of the unforeseeable factors and OPWDD sets a new deadline for the cost report, but the provider misses this new deadline.

The State would also change the procedures in cases where it is the provider that discovers that a cost report is incomplete, inaccurate or incorrect, and where the provider makes this discovery before receiving its new base period rate, fee or price. The change will eliminate the requirement that the provider first give OPWDD notice and then follow up with a revised cost report within 30 days. Instead, the provider will simply submit a revised cost report. Also, the change will eliminate the penalty in this situation, but keep the provision that allows, rather than requires, that OPWDD revise the rate, fee or price based on the revised cost data, and then only if and when OPWDD receives the revised cost report.

Finally, the State is proposing to clarify that service-specific records of expenditures and revenues must be kept at the program or site level, that providers must maintain underlying records which formed the basis for or which support the cost, budget and other reports and data submitted to OPWDD, that reports and records that were not used to establish a rate, price or fee must be kept until the later of six years from the due date or date of submission, and that reports and records that were used to establish a rate, price or fee must be kept for six years after the rate, price or fee was set.

The State does not expect this change to result in any aggregate increases or decreases in Medicaid expenditures.

The reasons for the proposed changes are as follows. The State is proposing to expand the reporting and audit requirements to MSC, HCBS Waiver services and Article 16 clinics because the State's regulations governing financial reporting, record keeping and audit requirements were promulgated in 1998. Since then, OPWDD has developed new services and existing services have been substantially changed.

The State is proposing to reduce the number of cost report deadline extensions from two to one to bring regulations in line with actual OPWDD practices.

The State is proposing the changes on sanctions for providers which fail to meet the deadlines because the current discretionary penalty has not been imposed and as a result, late filers do exist. Not only does this disrupt the efficient flow of rate setting operations, but providers need to examine the financial results of their operations at least on an annual basis to measure, assess and react to the factors influencing their financial health and to forge budgets and define their fiscal direction. OPWDD wants to assure that the compilation and submission of financial data occurs on a timely basis.

The State is proposing to apply the percentage reduction to reimbursements because this will not require that prices, rates and/or fees be recalculated and reissued. In contrast, the current system of applying reductions to a rate, price or fee requires that the State recalculate and reissue rates.

The State is proposing that OPWDD give the provider notice that it missed the cost report deadline or that it must submit a revised cost report, and that the provider have a final opportunity to submit the cost report or explain why it cannot submit it, because this will be both a fair and effective way of ensuring that penalties are imposed only on those providers that are truly at fault.

The State is proposing to change the procedures when the provider discovers that a cost report is incomplete, inaccurate or incorrect to increase efficiency. The State is proposing to eliminate the penalty in this situation in the interests of fairness.

The State is proposing the clarifications to requirements for the records that providers must keep so that these requirements will be better understood and so that there will be adequate records for the State to exercise necessary oversight of Medicaid funding.

Outside New York City, a detailed description of the changes is available for public review at the following addresses:

Albany
Albany County Department of Mental Health

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

APPENDIX V
HOSPITAL SERVICES
State Plan Amendment #13-13

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 appropriations received by the State agency that oversees medical assistance (Medicaid), which is the Department of Health. The source of the appropriations is the Local Assistance Account under the General Fund/Aid to Localities and the Indigent Care Account under the HCRA Resources 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: The payments authorized by this SPA are not subject to the UPL limitations. Instead, they are subject to the federal regulations on DSH payments, which the State assures compliance with.

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 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.