DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Center for Medicaid, CHIP, and Survey & Certification

JUN 2 2 2011

Jason A. Helgerson
State Medicaid Director
Deputy Commissioner
Office of Health Insurance Programs
NYS Department of Health
Empire State Plaza
Corning Tower, Room 1466
Albany, NY 12237
RE: TN 10-33-A

Dear Mr. Helgerson:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 10-33-A. Effective October 20, 2010, this amendment establishes a second temporary supplemental payment to assist certain hospitals transition to the inpatient reimbursement reforms instituted on December 1, 2009. Effective January 1, 2011, it also revises the DRG service intensity weights and average lengths of stay used to compute acute inpatient hospital reimbursement.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903(a), and 1923 of the Social Security Act and the regulations at 42 CFR 447 Subpart C. This is to inform you that New York 10-33-A is approved as stated above and I have enclosed the HCFA-179 and the approved plan pages.

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

Sincerely,

[redacted]

Cindy Mann
Director, CMCS

Enclosures

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: **10-33-A**	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 **October 20, 2010**	

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 **10/20/10-09/30/11 $0** b. FFY **10/01/11-09/30/12 $0**
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: **Attachment 4.19-A: Pages 106(a), 108, 111,111(a), 111(b)**	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: **Attachment 4.19-A: Pages 108, 111**

10. SUBJECT OF AMENDMENT:
Inpatient Transition II Pool and service intensity weights
(FMAP = 61.59% based on effective date)

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:

[redacted]GENCY OFFICIAL:	16. RETURN TO: **New York State Department of Health** **Corning Tower** **Empire State Plaza** **Albany, New York 12237**
13. TYPED NAME: **Jason A. Helgerson**	
14. TITLE: **Medicaid Director & Deputy Commissio er Department of Health**	
15. DATE SUBMITTED: June 16, 2011	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:	18. DATE APPROVED: 06-22-11
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: OCT 20 2010	20 [redacted]
21. TYPED NAME: William Lasowski	22. TITLE: Deputy Director, CMCS

23. REMARKS:

FORM HCFA-179 (07-92)

4. To establish the Transition II Pool, effective October 20, 2010, the statewide base price will be reduced such that the level of total Medicaid payments shall be decreased for the periods specified on the 'Transition II Pool' section by the corresponding Transition II fund amounts.

Service Intensity Weights (SIW) and average length-of-stay (LOS).

1. The table of SIWs and statewide average LOS for each effective period is published on the New York State Department of Health website at: http://www.health.ny.gov/nysdoh/hospital/drg/index.htm and reflects the cost weights and LOS assigned to each All-Patient Refined (APR) diagnosis related group (DRG) patient classification category. The SIWs assigned to each APR-DRG indicates the relative cost variance of that APR-DRG classification from the average cost of all inpatients in all APR-DRGs. Such SIWs are developed using three years of Medicaid fee-for-service cost data, Medicaid managed care data and commercial third party payor data as reported to the Statewide Planning and Research Cooperative System (SPARCS) for the years set forth in paragraph (2) below. Costs associated with hospitals that do not have an ancillary charge structure or associated with hospitals and services exempt from the case payment methodology, and costs associated with statistical outliers are excluded from the SIW calculations.

2. For periods on and after December 1, 2009 through December 31, 2010, the SIW and statewide average LOS table shall be computed using SPARCS and reported cost data from the 2005, 2006 and 2007 calendar years as submitted to the Department by September 30, 2009.

3. For periods on and after January 1, 2011 through December 31, 2011, the SIW and statewide average LOS table shall be computed using SPARCS and reported cost data from the 2006, 2007 and 2008 calendar years as submitted to the department by June 30, 2010.

4. For the rate periods on and after December 1, 2009, additional adjustments to the inpatient rates of payment for eligible general hospitals to facilitate improvements in hospital operations and finances will be made, in accordance with the following:

a. General hospitals eligible for distributions pursuant to this section shall be those nongovernmental hospitals with total Medicaid discharges equal to or greater than seventeen and one-half percent for 2007, and a total reduction in Medicaid inpatient revenue, as a result of the application of otherwise applicable rate-setting methodologies in effect for the period December 1, 2009 through March 31, 2010, in excess of 9.7%.

b. For the period December 1, 2009 through March 31, 2010, $33.5 million dollars shall be allocated, [to eligible hospitals such that no hospital's reduction in Medicaid inpatient revenue, as a result of the hospital acute care rate methodology changes that are effective December 1, 2009, exceeds 9.7%.] The allocation amount for each eligible hospital shall equal the amount of inpatient Medicaid revenue for that hospital that existed using the Medicaid reimbursement provisions in effect immediately prior to the revisions instituted on December 1, 2009, multiplied by that hospital's percentage of reduced Medicaid revenue that is in excess of the threshold set forth in paragraph (a)(ii).

c. For periods on or after April 1, 2010, funds distributed pursuant to this section shall be allocated to eligible hospitals based on a proportion of the eligible hospital's allocation of the funds distributed for the period December 1, 2009 through March 31, 2010, to the total funds distributed for that period applied to the appropriate funds available for the applicable periods below:

   i. for the period April 1, 2010 through March 31, 2011, $75 million;
   ii. for the period April 1, 2011 through March 31, 2012, $50 million; and
   iii. for the period April 1, 2012 through March 31, 2013, $25 million.

d. Payments made pursuant to this section shall be added to rates of payments and not be subject to retroactive adjustment or reconciliation. The amount per discharge to be added to the rates shall be established by dividing the total allocated funds in accordance with paragraph (b) and (c) by the hospital's total reported Medicaid discharges in the applicable base period.

e. Each hospital receiving funds pursuant to this section shall, as a condition for eligibility for such funds, adopt a resolution of the Board of Directors of each such hospital setting forth its current financial condition, including ongoing board oversight, and shall, after two years, issue a report as adopted by each such Board of Directors setting forth what progress has been achieved regarding such improvement, provided, however, if such report fails to set forth adequate progress, as determined by the Commissioner, the Commissioner will deem such facility ineligible for further distributions pursuant to this section and will redistribute such further distributions to other eligible facilities in accordance with the provisions of this section. The Commissioner shall be provided with copies of all such resolutions and reports.

5. *Transition II Pool.* For the rate periods on and after October 20, 2010 additional adjustments to the inpatient rates of payment for eligible general hospitals to facilitate improvements in hospital operations and finances will be made in accordance with the following:

   a. Hospitals eligible for distributions pursuant to this section shall be those governmental and nongovernmental general hospitals with:

      i. total Medicaid inpatient discharges equal to or greater than 17.5% for the 2007 period; and
      ii. total reduction in Medicaid inpatient revenue, as a result of the application of otherwise applicable rate-setting methodologies in effect for the period October 20, 2010 through March 31, 2011, in excess of 10.2%.

   b. For the period October 20, 2010 through March 31, 2011, total funding equaling $37.5 million shall be allocated. The allocation amount for each eligible hospital shall equal the amount of inpatient Medicaid revenue for that hospital that existed using the Medicaid reimbursement provisions in effect immediately prior to the revisions instituted on December 1, 2009, multiplied by that hospital's percentage of reduced Medicaid revenue that is in excess of the threshold set forth in paragraph (a)(ii).

   c. For the periods on and after April 1, 2011, funds distributed pursuant to this section shall be allocated to eligible hospitals based on a proportion of the eligible hospital's allocation of the funds distributed for the period October 20, 2010 through March 31, 2011, to the total funds distributed for that period applied to the appropriate funds for the applicable periods below:

      i. for the period April 1, 2011 through March 31, 2012, $75 million;
      ii. for the period April 1, 2012 through March 31, 2013, $50 million; and
      iii. for the period April 1, 2013 through March 31, 2014, $25 million.

   d. The distributions authorized pursuant to this section shall be made available through a commensurate reduction in the statewide base price for the October 20, 2010 through March 31, 2011, and each applicable period thereafter, as otherwise computed in accordance with the Statewide Base Price Section.

e. Payments made pursuant to this section shall be added to rates of payments and not be subject to retroactive adjustment or reconciliation. The amount per discharge to be added on to the rates for the period October 20, 2010 through March 31, 2011 shall be established by dividing the total funds allocated in accordance with paragraph (b) by six months of the hospital's total reported Medicaid discharges in accordance with paragraph (3)(b) in the 'Statewide Base Price' section of this Attachment. For the periods on and after April 1, 2011 the amount per discharge to be added on to the rates shall be established by dividing the total funds allocated in accordance with paragraph (c) by the hospital's total reported Medicaid discharges in accordance with paragraph (3)(b) in the 'Statewide Base Price' section of this Attachment

f. Hospitals receiving funds pursuant to this section that did not previously receive funds to facilitate improvements in hospital operations and finances beginning on December 1, 2009, shall, as a condition for eligibility for such funds, adopt and submit a restructuring plan that includes both an assessment of the hospital's current financial position and the plan to restructure and improve its financial operations. The plan must also provide for ongoing Board oversight of plan implementation, along with measurable objectives. Two years following receipt of funds, the Board of Directors must issue a report setting forth what progress has been made toward accomplishing the goals of the restructuring plan. The Commissioner shall be provided with copies of all such resolutions and reports. If such report fails to set forth adequate progress toward the goals of the hospital's restructuring plan as determined by the Commissioner, the Commissioner will deem such facility ineligible for further distributions and will redistribute such further distributions to other eligible facilities in accordance with the provisions of this section.

g. Unallocated funds awarded to hospitals deemed ineligible by the Commissioner, as a result of paragraph (f) of this section, shall be redistributed to all remaining eligible hospitals using the proportion of each eligible hospitals' allocation of the funds distributed for the period October 20, 2010 through March 31, 2011, to the total funds distributed for that period.