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State/Territory Name: **NEW YORK**

State Plan Amendment (SPA) #: **15-0028**

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
New York Regional Office
26 Federal Plaza, Room 37-100
New York, NY 10278

DIVISION OF MEDICAID AND CHILDREN'S HEALTH OPERATIONS

DMCHO: JH:SPA-NY-15-0028-Approval

March 31, 2017

Jason Helgerson
State Medicaid Director
Office of Health Insurance Programs
New York State Department of Health
Corning Tower (OCP 1211)
Empire State Plaza
Albany, New York 12237

Dear Mr. Helgerson:

This is to notify you that New York State Plan Amendment (SPA) #15-0028 has been approved for adoption into the State Medicaid Plan with an effective date of April 1, 2015. This State Plan Amendment proposes to continue for periods April 1, 2015 through March 31, 2017, the previously enacted cost containment measures:

- The cap on the administrative and general component of rates for certified home health agencies;
- Continues to appropriately allocate capital costs for outpatient and emergency department rates; and,
- Continues home health care maximization initiatives.

Enclosed are copies of SPA #15-0028 and the HCFA-179 form, as approved.

If you have any questions or wish to discuss this SPA further, please contact Shing Jew at (212) 616-2426 or Joanne Hounsell at (212) 616-2446.

Sincerely,

[redacted]

Michael Melendez, LMSW
Associate Regional Administrator
Division of Medicaid and Children's Health Operations

Enclosures: HCFA-179 Form
State Plan Pages

cc:
J. Ulberg
R. Deyette
M. Levesque
R. Weaver
J. Guhl
N. McKnight
M. Varon
S. Jew
J. Hounsell
M. Lopez
R. Holligan

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: **15-0028**	2. STATE **New York**
	3. PROGRAM IDENTIFICATION: **TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)**	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE **April 1, 2015**	

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: **§ 1902(a) of the Social Security Act, and 42 CFR 447**	7. FEDERAL BUDGET IMPACT: **(in thousands)** **a. FFY 04/01/15-09/30/15 $ ~~(27,453.80)~~** (26,937.20) **b. FFY 10/01/15-09/30/16 $ ~~(54,907.60)~~** (53,874.40)
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: **Attachment 4.19-B: Pages 1(b), 4(2), 4(a)(iii), 4(a)(iii)(A), 4(a)(iv), 4(a)(iv)(1), 4(a)(iv)(2), 4(a)(v)**	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: **Attachment 4.19-B: Pages 1(b), 4(2), 4(a)(iii), 4(a)(iii)(A), 4(a)(iv), 4(a)(iv)(1), 4(a)(iv)(2), 4(a)(v)**

10. SUBJECT OF AMENDMENT:
2015 Non-Intuitional Cost Containment Extenders
(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: [redacted]	16. RETURN TO: **New York State Department of Health** **Division of Finance & Rate Setting** **99 Washington Ave – One Commerce Plaza** **Suite 1432** **Albany, NY 12210**
13. TYPED NAME: **Jason A. Helgerson**	
14. TITLE: **Medicaid Director** **Department of Health**	
15. DATE SUBMITTED: JUN 2 6 2015	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:	18. DATE APPROVED: MARCH 31, 2017
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: APRIL 01, 2015	20. SIGNATURE OF REGIONAL OFFICIAL: [redacted]
21. TYPED NAME: MICHAEL MELENDEZ	22. TITLE: ASSOCIATE REGIONAL ADMINISTRATOR DIVISION OF MEDICAID & CHILDREN'S HEALTH

23. REMARKS:
pen - ink change made to box 7 per request by New York State on e-mail dated 1/25/2017

FORM HCFA-179 (07-92)

New York
1(b)

(two year trend movement) on a per visit basis, except that commencing April 1, 1995 through March 31, 1999 and on and after July 1, 1999 through March 31, 2000 and on and after April 1, 2000 through March 31, 2003, and on and after April 1, 2003 through March 31, 2009, and on and after April 1, 2009 through March 31, 2011, and on and after April 1, 2011 through March 31, 2013, and on and after April 1, 2013 through March 31, 2015, and on and after April 1, 2015 through March 31, 2017, for rates of payment for patients eligible for payments made by state governmental agencies, the capital cost per visit components [shall] will be adjusted by the Commissioner to exclude such expenses related to 1) forty-four percent of the costs of major moveable equipment and 2) staff housing. A return on equity is recognized in those instances where the hospital is organized under the auspices of proprietary sponsorship. MMTP services may be reimbursed on a uniform fixed weekly fee per enrolled patient basis. Renal dialysis services are reimbursed on the lower of a facility's actual cost or statewide ceiling of $150.00 per procedure. Payment rates for renal dialysis services are adjusted to reflect utilization patterns for CAPD, CCPD, hemodialysis and extended peritoneal dialysis services. Effective October 1, 1995, the rate for primary care clinic services provided in primary care hospitals, [shall] will be a per visit rate based on allowable reportable operating costs subject to a cap on operating costs of $67.50 per visit. For dates of service beginning on December 1, 2008 through March 31, 2010, primary care clinic and renal dialysis services [shall] will be reimbursed using the Ambulatory Patient Group classification and reimbursement system. Allowable reportable capital costs will be reimbursed on a per visit basis not subject to a ceiling on reimbursement, provided however that for the period October 1, 1995 through March 31, 1999 and on and after July 1, 1999 through March 31, 2000 and on and after April 1, 2000 through March 31, 2003, and on and after April 1, 2003 through March 31, 2009, and on and after April 1, 2009 through March 31, 2011, and on and after April 1, 2011 through March 31, 2013, and on and after April 1, 2013 through March 31, 2015, and on and after April 1, 2015 through March 31, 2017, the capital cost per visit components [shall] will be adjusted by the Commissioner to exclude such expenses related to 1) forty-four percent of the cost of major movable equipment and 2) staff housing. A return on equity is recognized in those instances where the hospital is organized under the auspices of proprietary sponsorship.

Effective October 1, 1995, the rate for emergency services provided in primary care hospitals, [shall] will be a per visit rate based upon allowable reportable operating costs and limited to a cap on operating costs of $95 per visit provided however, that for the period January 1, 2007 through December 31, 2007 the maximum payment for the operating component [shall] will be $125 per visit; and during the period January 1, 2008 through December 31, 2008, the maximum payment for the operating cost component [shall] will be $140 per visit; and during the period January 1, 2009 through March 31, 2010 emergency department services [shall] will be reimbursed through the Ambulatory Patient Group (APG) classification and reimbursement system. Allowable reportable capital costs will be reimbursed on a per visit basis not subject to a ceiling on reimbursement, provided however, that for the period of October 1, 1995 through March 31, 1999 and on and after July 1, 1999 through March 31, 2000, and on and after April 1, 2000 through March 31, 2003, and on and after April 1, 2003 through March 31, 2009, and on and after April 1, 2009 through March 31, 2011, and on and after April 1, 2011 through March 31, 2013, and on and after April 1, 2013 through March 31, 2015, and on and after April 1, 2015 through March 31, 2017, the capital costs per visit components [shall] will be adjusted by the Commissioner to exclude such expenses related to 1) forty-four percent of the cost of major movable equipment and 2) staff housing. A return on equity is recognized in those instances where the hospital is organized under the auspices of proprietary sponsorship.

New York
4(2)

Providers are grouped geographically into upstate/downstate and by sponsorship, public/voluntary. Ceilings are calculated using the group cost experience. For purposes of establishing rates of payment by governmental agencies for certified home health agencies for the period April 1, 1995 through December 31, 1995, and for rate periods beginning on or after January 1, 1996 through March 31, 1999, and on July 1, 1999 through March 31, 2000, and on and after April 1, 2000 through March 31, 2003, and on and after April 1, 2003 through March 31, 2009, and on and after April 1, 2009 through March 31, 2011, and on and after April 1, 2011 through March 31, 2013, and on and after April 1, 2013 through March 31, 2015, and on and after April 1, 2015 through March 31, 2017, the reimbursable base year administrative and general costs of a provider of services, excluding a provider of services reimbursed on an initial budget basis, and a new provider, excluding changes in ownership or changes in name, who begins operations in the year prior to the year which is used as base year in determining rates of payment, [shall] will not exceed the statewide average of total reimbursable base year administrative and general costs of such providers of services. In the 1996, 1997, 1998, 1999, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, and 2009, rate periods respectively the amount of such reduction in certified home health agency rates of payments made during the twelve month period running from April 1, of the year prior to the respective rate period through March 31, of such respective rate period [shall] will be adjusted in the respective rate period on a pro-rate basis, if it is determined upon post-audit review by June 15, of the respective rate period and reconciliation, that the savings for the state share, excluding the federal and local government shares, of medical assistance payments is in excess of one million five hundred thousand dollars or is less than one million five hundred thousand dollars for payments made on or before March 31, of the applicable twelve month period to reflect the amount by which such savings are in excess of or lower than one million five hundred thousand dollars. The amount of such reduction in certified home health agency rates of payment made during the period July 1, 1999 through March 31, 2000, [shall] will be adjusted in the 2000 rate period on a pro-rate basis, if it is determined upon post-audit review by June 15, 2000 and reconciliation, that the savings for the state share, excluding the federal and local government shares, of medical assistance payments is in excess of one million one hundred twenty-five thousand dollars or is less than one million one hundred twenty-five thousand dollars for payments made on or before March 31, 2000, to reflect the amount by which such savings are in excess of or lower than one million one hundred twenty-five thousand dollars.

New York
4(a)(iii)

Effective for the period August 1, 1996 through November 30, 2009, certified home health agencies (CHHAs) [shall] will be required to increase their Medicare revenues relative to their Medicaid revenues measured from a base period (calendar year 1995) to a target period (the 1996 target period is August 1, 1996 through March 31, 1997, the 1997 target period is January 1, 1997 through November 30, 1997, the 1998 target period [shall] will mean January 1, 1998 through November 30, 1998, the 1999 target period [shall] will mean January 1, 1999 through November 30, 1999, the 2000 target period [shall] will mean January 1, 2000 through November 30, 2000, the 2001 target period [shall] will mean January 1, 2001 through November 30, 2001, the 2002 target period [shall] will mean January 1, 2002 through November 30, 2002, the 2003 target period [shall] will mean January 1, 2003 through November 30, 2003, the 2004 target period [shall] will mean January 1, 2004 through November 30, 2004, the 2005 target period [shall] will mean January 1, 2005 through November 30, 2005, the 2006 target period [shall] will mean January 1, 2006 through November 30, 2006, the 2007 target period [shall] will mean January 1, 2007 through November 30, 2007, the 2008 target period [shall] will mean January 1, 2008 through November 30, 2008, and the 2009 target period [shall] will mean January 1, 2009 through November 30, 2009, and the 2010 target period [shall] will mean January 1, 2010 through November 30, 2010, and the 2011 target period [shall] will mean January 1, 2011 through November 30, 2011, and the 2012 target period [shall] will mean January 1, 2012 through November 30, 2012 and the 2013 target period [shall] will mean January 1, 2013 through November 30, 2013, and the 2014 target period will mean January 1, 2014 through November 30, 2014, and the 2015 target period will mean January 1, 2015 through November 30, 2015, and the 2016 target will mean January 1, 2016 through November 30, 2016, and the 2017 target period will mean January 1, 2017 through November 30, 2017, or receive a reduction in their Medicaid payments. For this purpose, regions [shall] will consist of a downstate region comprised of Kings, New York, Richmond, Queens, Bronx, Nassau and Suffolk counties and an upstate region comprised of all other New York State counties. A certified home health agency [shall] will be located in the same county utilized by the Commissioner of Health for the establishment of rates pursuant to Article 36 of the Public Health Law. Regional group [shall] will mean all those CHHAs located within a region. Medicaid revenue percentage [shall] will mean CHHA revenues attributable to services provided to persons eligible for payments pursuant to Title 11 of Article 5 of the Social Services law divided by such revenues plus CHHA revenues attributable to services provided to beneficiaries of Title XVIII of the Federal Social Security Act (Medicare).

New York
4(a)(iii)(A)

Prior to February 1, 1997, for each regional group, 1996 Medicaid revenue percentage for the period commencing August 1, 1996, to the last date for which such data is available and reasonably accurate [shall] will be calculated. Prior to February 1, 1998, prior to February 1, 1999, prior to February 1, 2000, prior to February 1, 2001, prior to February 1, 2002, prior to February 1, 2003, prior to February 1, 2004, prior to February 1, 2005, prior to February 1, 2006, prior to February 1, 2007, prior to February 1, 2008, prior to February 1, 2009, prior to February 1, 2010, prior to February 1, 2011, prior to February 1, 2012, [and] prior to February 1, 2013, prior to February 1, 2014, [and] prior to February 1, 2015, prior to February 1, 2016, and prior to February 1, 2017, for each regional group, the Commissioner of Health [shall] will calculate the prior years Medicaid revenue percentages for the period beginning January 1 through November 30 of such prior year. By September 15, 1996, for each regional group, the base period Medicaid revenue percentage [shall] will be calculated.

For each regional group, the 1996 target Medicaid revenue percentage [shall] will be calculated by subtracting the 1996 Medicaid revenue reduction percentages from the base period Medicaid revenue percentages. The 1996 Medicaid revenue reduction percentage, taking into account regional and program differences in utilization of Medicaid and Medicare services, for the following regional groups [shall] will be equal to:

one and one-tenth percentage points for CHHAs located within the downstate region; and,

six-tenths of one percentage point for CHHAs located within the upstate region.

New York
4(a)(iv)

For 1997, 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, [and] 2015, 2016, and 2017, for each regional group, the target Medicaid revenue percentage for the respective year [shall] will be calculated by subtracting the respective year's Medicaid revenue reduction percentage from the base period Medicaid revenue percentage. The Medicaid revenue reduction percentages for 1997, 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, [and] 2015, 2016, and 2017 taking into account regional and program differences in utilization of Medicaid and Medicare services, for the following regional groups [shall] will be equal to:

one and one-tenth percentage points for CHHAs located within the downstate region; and,

six-tenths of one percentage point for CHHAs located within the upstage region.

For each regional group, the 1999 target Medicaid revenue percentage [shall] will be calculated by subtracting the 1999 Medicaid revenue reduction percentage from the base period Medicaid revenue percentage. The 1999 Medicaid revenue reduction percentages, taking into account regional and program differences in utilization of Medicaid and Medicare services, for the following regional groups [shall] will be equal to:

eight hundred twenty-five thousandths (.825) of one percentage point for CHHAs located within the downstate region;

forty-five hundredths (.45) of one percentage point for CHHAs located within the upstate region;

For each regional group, if the 1996 Medicaid revenue percentage is not equal to or less than the 1996 target Medicaid revenue percentage, a 1996 reduction factor [shall] will be calculated by comparing the 1996 Medicaid revenue percentage to the 1996 target Medicaid revenue percentage to determine the amount of the shortfall and dividing such shortfall by the 1996 Medicaid revenue reduction percentage. These amounts, expressed as a percentage, [shall] will not exceed one hundred percent. If the 1996 Medicaid revenue percentage is equal to or less than 1996 target Medicaid revenue percentage, the 1996 reduction factor [shall] will be zero. For each regional group, the 1996 reduction factor [shall] will be multiplied by the following amounts to determine each regional group's applicable 1996 state share reduction amount.

two million three hundred ninety thousand dollars ($2,390,000) for CHHAs located within the downstate region;

seven hundred fifty thousand dollars ($750,000) for CHHAs located within the upstate region.

New York
4(a)(iv)(1)

For each regional group reduction, if the 1996 reduction factor [shall] will be zero, there [shall] will be no 1996 state share reduction amount.

For 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, [and] 2015, 2016, and 2017, for each regional group, if the Medicaid revenue percentage for the respective year is not equal to or less than the target Medicaid revenue percentage for such respective year, the Commissioner of Health [shall] will compare such respective year's Medicaid revenue percentage to such respective year's target Medicaid revenue percentage to determine the amount of the shortfall which, when divided by the respective year's Medicaid revenue reduction percentage, [shall] will be called the reduction factor for such respective year. These amounts, expressed as a percentage, [shall] will not exceed one hundred percent. If the Medicaid revenue percentage for a particular year is equal to or less than the target Medicaid revenue percentage for that year, the reduction factor for that year [shall] will be zero.

For 1997, 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, [and] 2015, 2016, and 2017, for each regional group, the reduction factor for the respective year [shall] will be multiplied by the following amounts to determine each regional group's applicable state share reduction amount for such respective year.

New York
4(a)(iv)(2)

two million three hundred ninety thousand dollars ($2,390,000) for CHHAs located within the downstate region;

seven hundred fifty thousand dollars ($750,000) for CHHAs located within the upstate region;

For each regional group reduction, if the reduction factor for a particular year is zero, there [shall] will be no state share reduction amount for such year.

For each regional group, the 1999 reduction factor [shall] will be multiplied by the following amounts to determine each regional group's applicable 1999 state share reduction amount:

one million seven hundred ninety-two thousand five hundred dollars ($1,792,500) for CHHAs located within the downstate region;

five hundred sixty-two thousand five hundred dollars ($562,500) for CHHAs located within the upstate region;

For each regional group reduction, if the 1999 reduction factor is zero, there [shall] will be no 1999 state share reduction amount.

For each regional group, the 1996 state share reduction amount [shall] will be allocated among CHHAs on the basis of the extent of each CHHA's failure to achieve the 1996 target Medicaid revenue percentage, calculated on a provider specific basis utilizing revenues for this purpose, expressed as a proportion of the total of each CHHA's failure to achieve the 1996 target Medicaid revenue percentage within the applicable regional group. This proportion [shall] will be multiplied by the applicable 1996 state share reduction amount. This amount [shall] will be called the 1996 provider specific state share reduction amount.

The 1996 provider specific state share reduction amount [shall] will be due to the state from each CHHA and may be recouped by the State by March 31, 1997, in a lump sum amount or amounts from payments due to the CHHA pursuant to Title 11 of Article 5 of the Social Services Law.

For 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, [and] 2015, 2016, and 2017, for each regional group, the state share reduction amount for the respective year [shall] will be allocated among CHHAs on the basis of the extent of each CHHA's failure to achieve the target Medicaid revenue percentage for the applicable year, calculated on a provider specific basis utilizing revenues for this purpose, expressed as a proportion of the total of each CHHA's failure to achieve the target Medicaid revenue percentage for the applicable year within the applicable regional group. This proportion [shall] will be multiplied by the applicable year's state share reduction amount for the applicable regional group. This amount [shall] will be called the provider specific state share reduction amount for the applicable year.

New York
4(a)(v)

The provider specific state share reduction amount for 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, [and] 2015, 2016, and 2017, respectively, [shall] will be due to the state from each CHHA and the amount due for each respective year may be recouped by the state by March 31 of the following year in a lump sum amount or amounts from payments due to the CHHA pursuant to Title 11 of Article 5 of the Social Services Law.

CHHAs [shall] will submit such data and information at such times as the Commissioner of Health may require. The Commissioner of Health may use data available from third party payors.

On or about June 1, 1997, for each regional group, the Commissioner of Health [shall] will calculate for the period of August 1, 1996 through March 31, 1997, a Medicaid revenue percentage, a reduction factor, a state share reduction amount, and a provider specific state share reduction amount in accordance with the methodology provided herein for calculating such amounts for the 1996 target period. The provider specific state share reduction amount calculated [shall] will be compared to the 1996 provider specific state share reduction amount. Any amount in excess of the 1996 provider specific state share reduction amount [shall] will be due to the state from each CHHA and may be recouped. If the amount is less than the 1996 provider specific state share reduction amount, the difference [shall] will be refunded to the CHHA by the state no later than July 15, 1997. CHHAs [shall] will submit data for the period August 1, 1996 through March 31, 1997, to the Commissioner of Health by April 15, 1997.

If a CHHA fails to submit data and information as required, such CHHA [shall] will be presumed to have no decrease in Medicaid revenue percentage between the base period and the applicable target period for purposes of the calculations described herein and the Commissioner of Health [shall] will reduce the current rate paid to such CHHA by state governmental agencies pursuant to Article 36 of the Public Health Law by one percent for the period beginning on the first day of the calendar month following the applicable due date as established by the Commissioner of Health and continuing until the last day of the calendar month in which the required data and information are submitted.

Notwithstanding any inconsistent provision set forth herein, the annual percentage reductions as set forth above, [shall] will be prorated by the Commissioner of Health for the period April 1, 2007 through March 31, 2009.