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State/Territory Name: New York

State Plan Amendment (SPA) #: 15-0048

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) CMS 179 Form/Summary Form (with 179-like data)
- 3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S3-14-28
Baltimore, Maryland 21244-1850



Financial Management Group

October 27, 2020

Donna Frescatore
Medicaid Director
NYS Department of Health
One Commerce Plaza
Suite 1211
Albany, NY 12210

Reference: TN 15-0048

Dear Ms. Frescatore:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 15-0048. This amendment proposes to eliminate the reduction to the statewide base price for inpatient services.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1923 and 1903(a) of the Social Security Act and the implementing Federal regulations at 42 CFR 447.

This is to inform you that Medicaid State plan amendment 15-0048 is approved effective April 1, 2015. The CMS-179 (HCFA-179) and the amended plan pages are attached.

If you have any additional questions or need further assistance, please contact Novena James-Hailey at (617) 565-1291 or Novena.JamesHailey@cms.hhs.gov.

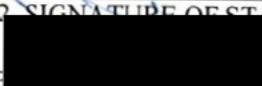
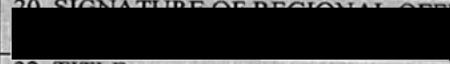
Sincerely,

A solid black rectangular box redacting the signature of the sender.

For

Rory Howe
Acting Director

Enclosures

1 TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL		1. TRANSMITTAL NUMBER: 15-0048	2. STATE New York
FOR: HEALTH CARE FINANCING ADMINISTRATION		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 (<i>Check One</i>): <input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (<i>Separate Transmittal for each amendment</i>)			
6. FEDERAL STATUTE/REGULATION CITATION: §1902(a) of the Social Security Act, and 42 CFR 447		7. FEDERAL BUDGET IMPACT: (<i>in thousands</i>) a. FFY 04/01/15-09/30/15 \$ 2,791.19 b. FFY 10/01/15-09/30/16 \$ 5,582.38	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-A: Page 106(a)		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (<i>If Applicable</i>): Attachment 4.19-A: Page 106(a)	
10. SUBJECT OF AMENDMENT: Eliminate Reduction to Statewide Base Price (FMAP = 50%)			
11. GOVERNOR'S REVIEW (<i>Check One</i>): <input checked="" type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input type="checkbox"/> OTHER, AS SPECIFIED: <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL			
12. SIGNATURE OF STATE AGENCY OFFICIAL: 		16. RETURN TO: New York State Department of Health Division of Finance and Rate Setting 99 Washington Ave – One Commerce Plaza Suite 1460 Albany, NY 12210	
13. NAME: John A. Helgerson			
14. TITLE: Medicaid Director Department of Health			
15. DATE SUBMITTED: JUN 26 2015			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED:		18. DATE APPROVED: 10/27/20	
PLAN APPROVED – ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: April 1, 2015		20. SIGNATURE OF REGIONAL OFFICIAL:  For	
21. TYPED NAME: Rory Howe		22. TITLE: Acting Director	
23. REMARKS:			

**New York
106(a)**

2. The SBP will be established based on the following process and mathematical sequence.
- a. Steps in the mathematical sequence:
 - i. Step 1: Develop, by facility, an average facility specific, all payer, cost neutral per discharge rate.
 - ii. Step 2: Convert the by facility per discharge rates developed in Step 1 to a price.
 - iii. Step 3: Adjust the price developed in Step 2 for budget neutrality.
 - b. For the period May 1, 2012 through March 31, 2013 and for state fiscal year periods on and after April 1, 2013 through March 31, 2015, the statewide base price will be adjusted such that total Medicaid payments are decreased for such period and for each such state fiscal year period by \$19,200,000.
 - c. Step 1: Develop an average facility specific, all payer, cost neutral per discharge rate. This rate represents the operating costs that will be paid by the statewide base price and is converted to a price in Step 2. The average per discharge rate developed in this process is represented as H in the chart in paragraph (2)(c)(iii).
 - i. Step 1 uses the following data on a facility specific basis and the mathematical process in the chart in paragraph (2)(c)(iii):
 1. Total allowable facility ICR costs in the base year, as defined in the Definitions section. These costs are represented as A in the chart.
 2. Total allowable facility specific costs in the ICR from the base year, as defined in the Definitions Section of this Attachment, that are associated with the rate add-ons as defined in the Add-Ons to the Acute Rate Per Discharge Section of this Attachment. These costs are represented as B in the chart.
 3. Total facility ICR discharges in the base year, as defined in the Definitions section. These discharges are represented as D in the chart.
 4. The wage equalization factor (WEF) for the base year, as defined in the Definitions section, and calculated based on the Wage Equalization Factor (WEF) section of this Attachment. This WEF factor is represented as F in the chart.
 5. A facility specific all payer CMI, as defined in the definitions section.
 - a. Uses the all payer acute claims of the base year, as defined in the Definitions Section of this Attachment.