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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:

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,

[redacted]

For

Rory Howe
Acting Director

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

1TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL **FOR: HEALTH CARE FINANCING ADMINISTRATION**	1. TRANSMITTAL NUMBER: **15-0048**	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 $ 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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: **Attachment 4.19-A: Page 106(a)**

10. SUBJECT OF AMENDMENT:
Eliminate Reduction to Statewide Base Price (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 and Rate Setting** **99 Washington Ave – One Commerce Plaza** **Suite 1460** **Albany, NY 12210**
13. [redacted]**n 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: 10/27/20
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: April 1, 2015	20. SIGNATURE OF REGIONAL OFFICIAL: [redacted] For
21. TYPED NAME: Rory Howe	22. TITLE: Acting Director

23. REMARKS:

FORM HCFA-179 (07-92)

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.