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**State/Territory Name: New York**

**State Plan Amendment (SPA) #: NY 18-0031**

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) CMS 179 Form
- 3) Approval SPA Page

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



**New York Regional Operations Group**

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September 18, 2019

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

RE: State Plan Amendment (SPA) 18-0031

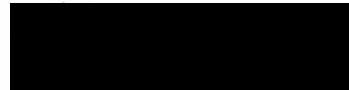
Dear Ms. Frescatore:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number 18-0031. This amendment continues supplemental payments to private hospitals for inpatient services, effective April 1, 2018.

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 implementing Federal regulations at 42 CFR 447 Subpart C. We have found that the proposed reimbursement methodology complies with applicable requirements and, therefore, have approved them with an effective date of April 1, 2018. We are enclosing the CMS-179 and the amended approved plan pages.



If you have any questions, please call Charlene Holzbaaur at (609) 882-4103 Extension 104.

Sincerely,



Kristin Fan  
Director

cc:  
R. Weaver  
R. Holligan  
T. Brady  
C. Holzbaaur

<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</b> <b>FOR: CENTERS FOR MEDICARE &amp; MEDICAID SERVICES</b>		<b>1. TRANSMITTAL NUMBER</b> <u>1 8</u> — <u>0 0 3 1</u>	<b>2. STATE</b> New York
<b>TO: REGIONAL ADMINISTRATOR</b> CENTERS FOR MEDICARE & MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES		<b>3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)</b> TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
<b>5. TYPE OF PLAN MATERIAL (Check One)</b> <input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT		<b>4. PROPOSED EFFECTIVE DATE</b> April 1, 2018	
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate transmittal for each amendment)			
<b>6. FEDERAL STATUTE/REGULATION CITATION</b> § 1902(a) of the Social Security Act and 42 CFR 447		<b>7. FEDERAL BUDGET IMPACT</b> a. FFY 04/01/18-09/30/18      \$ 44,311.92 b. FFY 10/01/18-09/30/19      \$ 44,311.92	
<b>8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT</b>  Attachment: 4.19-A: Page 161(1)		<b>9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable)</b>  Attachment: 4.19-A: Page 161(1)	
<b>10. SUBJECT OF AMENDMENT</b> 2018 Voluntary UPL Payments - Inpatient (FMAP=50%)			
<b>11. GOVERNOR'S REVIEW (Check One)</b> <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			
<b>12. SIGNATURE OF STATE AGENCY OFFICIAL</b> 		<b>16. RETURN TO</b> New York State Department of Health Division of Finance and Rate Setting 99 Washington Ave – One Commerce Plaza Suite 1432 Albany, NY 12210	
<b>13. TYPED NAME</b> Donna Frescatore			
<b>14. TITLE</b> Medicaid Director, Department of Health			
<b>15. DATE SUBMITTED</b> June 22, 2018			
FOR REGIONAL OFFICE USE ONLY			
<b>17. DATE RECEIVED</b>		<b>18. DATE APPROVED</b> SEP 18 2019	
PLAN APPROVED - ONE COPY ATTACHED			
<b>19. EFFECTIVE DATE OF APPROVED MATERIAL</b> APR 01 2018		<b>20. SIGNATURE OF REGIONAL OFFICIAL</b> 	
<b>21. TYPED NAME</b> Kristin Fan		<b>22. TITLE</b> Director, FMG	
<b>23. REMARKS</b>			

**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 \$235,500,000 for the period July 1, 2010 through March 31, 2011; \$314,000,000 for the period April 1, 2011 through March 31, 2012; \$281,778,852 for the period April 1, 2012 through March 31, 2013; \$298,860,732 for the period April 1, 2013 through March 31, 2014; and \$226,443,721 for the period April 1, 2014 through March 31, 2015; and \$264,916,150 for the period April 1, 2015 through March 31, 2016; and \$271,204,805 for the period of April 1, 2016 through March 31, 2017; and \$319,459,509 for the period of April 1, 2017 through March 31, 2018; and \$177,247,671 for the period of April 1, 2018 through March 31, 2019 subject to the requirements of 42 CFR 447.272 (upper payment limit) . Such payments are paid monthly to eligible voluntary sector owned or operated general hospitals, excluding government general hospitals.

Eligibility to receive such additional payments, and the allocation amount paid to each hospital, 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 payment will be made to a hospital described in (i) and (ii). Payment amounts will be reduced as necessary not to exceed the limitations described in (iii).
- (i) did not receive an Indigent Care Pool (ICP) payment;
- (ii) the hospital's facility specific projected disproportionate share hospital payment ceiling is zero; or,
- (iii) the annual payments amount to eligible hospitals exceeds the Medicaid customary charge limit at 42 CFR 447.271.
- (d) Any amounts calculated under paragraphs (a) and (b) but not paid to a hospital because of the requirements in paragraph (c) will be allocated proportionately to those eligible general hospitals that provide emergency room services and which would not be precluded by paragraph (c) from receiving such additional allocations.

TN #18-0031

Approval Date

SEP 18 2019

Supersedes TN #17-0039

Effective Date

APR 01 2018