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State/Territory Name: New York

State Plan Amendment (SPA) #: NY-18-0057

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

August 24, 2023
Amir Bassiri
State Medicaid Director
New York State Department of Health
99 Washington Ave
One Commerce Plaza, Suite 1432
Albany, NY 12210

RE: State Plan Amendment (SPA) NY-18-0057

Dear Director Bassiri:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State Plan submitted under transmittal number (TN) 18-0057. This State Plan Amendment updates, effective July 1, 2018, the cost base used for the non-comparable components of the acute hospital inpatient rates from the 2010 cost base to 2015, the acute rate statewide base price and the service intensity weights.

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.

This is to inform you that Medicaid State Plan Amendment NY-18-0057 is approved effective July 1, 2018. The CMS-179 and the amended plan pages are attached.

If you have any questions or need further assistance, please contact James Francis at 857-357-6378 or via email at James.Francis@cms.hhs.gov.

Sincerely,

[redacted]

Rory Howe
Director

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: **18-0057**	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 **July 1, 2018**	

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~~ 1905(a)(1) Inpatient Hospital Services	7. FEDERAL BUDGET IMPACT: **(in thousands)** **a. FFY 07/01/18-09/30/18 $ 0** **b. FFY 10/01/18-09/30/19 $ 0**
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: ~~Attachment 4.19-A Pages: 105, 105(a), 106, 108, 110, 110(a), 111, 111(a), 112, 114~~ Attachment 4.19-A Part I Pages: 103, 105, 105(a), 106, 108, 110, 110(a), 111, 111(a), 112, 114	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: ~~Attachment 4.19-A Pages: 105, 105(a), 106, 108, 110, 110(a), 111, 111(a), 112, 114~~ Attachment 4.19-A Part I Pages 103, 105, 105(a), 106, 108, 110, 110(a), 111, 111(a), 112, 114

10. SUBJECT OF AMENDMENT:
Rebase Hospital Acute IP Rates to 2015
(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. SIGNA [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: **Donna Frescatore**	
14. TITLE: **Medicaid Director** **Department of Health**	
15. DATE SUBMITTED: SEP 2 8 2018	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: September 28, 2018	18. DATE APPROVED: August 24, 2023
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: July 1, 2018	[redacted]
21. TYPED NAME: Rory Howe	22. TITLE: Director, Financial Management Group

23. REMARKS:
Pen and Ink changes:
Box 6: Federal Statute/Regulation Citation:1905(a)(1) Inpatient Hospital Services

Box 8: Page Number of the Plan Section or Attachment:
Attachment: 4.19-A Part I: Pages 103, 105, 105(a), 106, 108, 110, 110(a), 111, 111(a), 112, 114

Box 9: Page Number of the Superseded Plan Section or Attachment
Attachment: 4.19-A Part I: Pages 103, 105, 105(a), 106, 108, 110, 110(a), 111, 111(a), 112, 114

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Hospital Acute Inpatient Reimbursement – July 1, 2018

Definitions. As used in this Section, the following definitions will apply:

1. *Diagnosis related groups (DRGs)* will mean the 3M Corporation All-Patient-Refined (APR) classification system, which utilizes diagnostic related groups with assigned weights that incorporate differing levels of severity of a patient's condition and the associated risk of mortality, and reflects such factors as the patient's medical diagnosis, severity level, sex, age, and procedures performed.

2. *Acute Rate DRG case-based payment per discharge (herein after referred to as Acute Rate)* will mean the payment to be received by a hospital for inpatient services, except for physician services (unless allowed under paragraph 12(c) of this Section), rendered to each patient based on the DRG to which that patient has been assigned, as determined by multiplying the statewide base price by the applicable service intensity weight (SIW) and facility-specific wage equalization factor (WEF) and as further adjusted for teaching hospitals by the inclusion of reimbursement for direct and indirect graduate medical education (GME) costs and for all hospitals, the inclusion of non-comparable costs.

3. *Service intensity weights (SIWs)* are the cost weights established such that the SIW for any given DRG indicates the relative cost of the average cost of the patient in the DRG as compared to the average cost of all patients in all DRGs. Weights are developed using cost data from Medicaid fee-for-service, Medicaid managed care and commercial payors as reported to the Statewide Planning and Research Cooperative System (SPARCS) and will be updated no less frequently than every four years.

4. *Case mix index (CMI)* will mean the relative costliness of a hospital's case mix relative to the case mix of all other hospitals as reflected in the weighted aggregate SIW for the hospital.

   a. All payer CMI is developed using acute claims reported to the Statewide Planning and Research Cooperative System (SPARCS) which provides data for all payer sources.
   b. Medicaid fee-for-service CMI is developed based on Medicaid fee-for-service acute claims submission to New York State.
   c. Medicaid managed care CMI is developed based on Medicaid managed care acute claims submission to New York State.

5. *Reimbursable operating costs* will mean reported operating costs which relate to the cost of providing inpatient hospital services to Medicaid patients, trended for inflation between the base period, as defined in this Section, and the rate period in accordance with trend factors determined pursuant to the applicable provisions of this Attachment, but excluding the following costs:

   a. ALC costs;
   b. Exempt unit costs;
   c. Transfer costs; and
   d. High-cost outlier costs.

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b. Medicaid costs associated with schools of nursing operated by the facility and reported as inpatient costs in the ICR; and

c. Medicaid costs associated with hospital-based physicians at hospitals designated under the Medicare program as meeting the criteria set forth in §1861(b)(7) of the federal Social Security Act also referred to as Teaching Election Amendment (TEA) costs.

13. *Transfers,* For purposes of transfer per diem payments, a transfer patient will mean a patient who is not discharged as defined in this Section, is not transferred among two or more divisions of merged or consolidated facilities as defined in the Mergers, Acquisitions, Consolidations, Restructurings and Closure Section, is not assigned to a DRG specifically identified as a DRG for transferred patients only, and meets one of the following conditions:

    a. is transferred from an acute care facility reimbursed under the DRG case-based payment system to another acute care facility reimbursed under this system; or

    b. is transferred to an out-of-state acute care facility; or

    c. is a neonate who is being transferred to an exempt hospital for neonatal services.

14. *Discharges*, as used in this Section, will mean those inpatients whose discharge from the facility occurred on and after July 1, 2018, and:

    a. the patient is released from the facility to a non-acute care setting; or

    b. the patient dies in the facility; or

    c. the patient is transferred to a facility or unit that is exempt from the case-based payment system, except when the patient is a newborn transferred to an exempt hospital for neonatal services and thus classified as a transfer patient pursuant to this Section; or

    d. the patient is a neonate being released from a hospital providing neonatal specialty services back to the community hospital of birth for weight gain.

15. *Average Length of Stay (ALOS)* will mean the arithmetic average of the number of days a patient is in the hospital per admission as calculated by counting the number of days from and including the day of admission up to, but not including, the day of discharge. The ALOS will be calculated for each DRG on a statewide basis and will be rounded to the closest whole number.

16. *General hospital*, as used in this Section, will mean a hospital engaged in providing medical or medical and surgical services primarily to inpatients by or under the supervision of a physician on a twenty-four hour basis with provisions for admission or treatment of persons in need of emergency care and with an organized medical staff and nursing service, including facilities providing services relating to particular diseases, injuries, conditions, or deformities.

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17. *Charge converter* will mean the ratio of cost to charges using total inpatient costs and total inpatient charges as reported by the hospital in its annual institutional cost reports submitted to the Department.

18. *IPRO* will mean the Island Peer Review Organization, Inc., a New York not-for-profit corporation providing health related services.

19. *Medicaid,* when used to describe the calculation of the Medicaid Acute Rate in this section, will mean Medicaid Fee-for-Service (FFS) and Medicaid Managed Care (MC). Acute rates are developed using the FFS claims data and the MC encounter data using the methodologies described in this Attachment.

20. *Base year* will mean the period as determined pursuant to the applicable provisions of this Attachment and applies to the DRG case-based payment per discharge, based on the following:

    a. For periods beginning on and after July 1, 2018, the base year will be the 2015 calendar year and the data and statistics will be the audited costs reported by each facility to the Department pursuant to the Financial and Statistical Data Required and Audits Sections.

    b. For hospitals with a fiscal filing period that is other than a calendar year, the 2015 base year will be the 12-month period which ended between June 30, 2015 and May 31, 2016.

    c. The base year used for rate-setting for operating cost components will be updated no less frequently than every four years and the new base period will be no more than four years prior to the first applicable rate period that utilizes such new base year provided.

21. *Divisor for add-ons to the acute rates per discharge*, as used in this Section, will mean the discharges used in the development of the add-ons pursuant to the Add-Ons to the Acute Rate Per Discharge Section of this Attachment.

    a. For the period beginning on and after July 1, 2018, the discharges used as the divisor will be the 2015 base year reported to the Department prior to April 25, 2017.

22. *The year discharges* will mean the latest calendar year utilized pursuant to the Service Intensity Weights (SIWs) and Average Length of Stay (ALOS) Section of this Section.

    a. For the period beginning on and after July 1, 2018, the latest calendar year will be 2014.

23. *Goal Seek* is the process of finding the correct input when only the output is known.

    a. Wikipedia definition states, "In computing, goal seeking is the ability to calculate backward to obtain an input that would result in a given output. This can also be called "what-if analysis" or "back-solving."

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Statewide Base Price

1. For periods on and after July 1, 2018, a statewide base price (SBP) will be established for operating cost payments and will be used in the calculation of the payment of a Medicaid acute claim as follows:

	RATE ELEMENT	STATE PLAN SECTION
	Operating cost neutral statewide base price per discharge	Statewide Base Price
x	(1+ Budget neutrality factor)	Statewide Base Price
x	(1 + Trend factor)	Trend Factor
x	Institution-specific wage equalization factor (WEF) adjustment	Wage Equalization Factor (WEF)
x	(1 + Transition adjustment factor)	Transition
x	APR-DRG weight with severity level	Service Intensity Weights (SIW) and Average Length-of-Stay (ALOS)
=	FFS adjusted statewide base price per discharge	
+	IME per discharge add-on	Add-Ons to the Acute Rate Per Discharge
+	DGME per discharge add-on	Add-Ons to the Acute Rate Per Discharge
+	Capital per discharge add-on	Capital expense reimbursement for DRG case-based rates of payment
+	Non-comparable cost per discharge add-on	Add-Ons to the Acute Rate Per Discharge
=	Medicaid FFS rate per discharge	

a. The rate elements included in the chart are developed as described within the sections of this Attachment.

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Service Intensity Weights (SIW) and Average Length-of-Stay (ALOS).

1. The table of SIWs and statewide ALOS effective on and after July 1, 2018 is published on the New York State Department of Health website at:

   http://www.health.ny.gov/facilities/hospital/reimbursement/apr-drg/weights/

   and reflects the cost weights and ALOS 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 (3) of this section. 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 beginning on and after July 1, 2018, the SIWs and statewide ALOS table will be computed using SPARCS and reported cost data from the 2012, 2013 and 2014 calendar years as submitted to the Department.

3. The DRG classification system used in rates, as defined in paragraph (1) of the Definitions Section of this Attachment, will be as follows:

   a. Effective on and after July 1, 2018, Version 34 of the APR-DRG classification system will be used.

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Add-Ons to the Acute Rate Per Discharge.

Rates of payment computed pursuant to this Attachment will include operating cost add-on payments to the statewide base price payment as follows:

1. The base period used for the add-on development will be as defined in the Definitions Section.
2. The costs and discharges used in the development of the add-ons will be total acute inpatient costs and discharges.
3. All add-on components of the acute operating per discharge rate will be reduced by the Budget Neutrality Factor pursuant to the Statewide Base Price Section of this Attachment.

    a. For rates beginning on and after January 1, 2017, the hospital specific minimum wage payment per discharge, as identified in paragraph (11) of this Section, will be not be subject to a reduction by the "Budget Neutrality Factor" pursuant to the Statewide Base Price Section of this Attachment and will continue until minimum wage costs have been included within the development of the Statewide Base price.

4. A direct graduate medical education (DGME) payment per discharge will be added to the acute rates of teaching general hospitals after the application of SIW, WEF, and Indirect Graduate Medical Education (IME) adjustments to the statewide base price. The DGME will be calculated for each hospital by dividing the facility's total reported [Medicaid] DGME costs by its total reported [Medicaid] discharges pursuant to paragraphs (1) through (3) of this Section. DGME costs will be those costs defined in the Definitions Section and trended forward to such rate period in accordance with applicable provisions of this Attachment

5. a. An indirect GME payment per discharge will be added to the acute rates of teaching general hospitals after the application of SIW and WEF adjustments to the statewide base price and will be calculated by multiplying such rates by the indirect teaching cost percentage determined by the following formula:

$$(1 - (1 / (1 + 1.03(((1 + r) ^0.0405) - 1))))$$

where "r" equals the ratio of residents and fellows to beds based on the medical education statistics for the hospital based on paragraph (7) of this Section and the staffed beds for the general hospital reported in the base period, as defined in the Definitions Section, but excluding exempt unit beds and nursery bassinettes.

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b. Indirect GME costs are those costs defined in the Definitions Section, derived from the base year, as also defined in the Definitions Section, and trended forward to such rate period in accordance with applicable provisions of this Attachment.

6. For rates beginning on and after July 1, 2018, the ratio of residents and fellows to bed will be based on the medical education statistics as reported on Exhibit 3 of the Hospital Institutional Cost report for the base year, as defined in the Definitions Section.

7. A non-comparable payment per discharge will be added to acute rates after the application of SIW, WEF, and IME adjustments to the statewide base price and the addition of the DGME payment and will be calculated for each hospital by dividing the facility's total reported costs, pursuant to paragraphs (1) through (3) of this Section, for qualifying non-comparable cost categories by its total reported discharges pursuant to the Definitions Section. Non-comparable hospital costs are those costs defined in the Definitions Section, derived from the base year, as also defined in the Definitions Section, and trended forward to such rate period in accordance with applicable provisions of this Attachment.

8. At the time non-comparable base year costs are updated in accordance with applicable provisions of this Section, cost transfers between affiliated facilities, for non-comparable costs as defined in the Definitions Section for other than DME or IME, due to the transfer of an entire service for organizational restructuring, will be adjusted in the payment rate. The non-comparable costs will be eliminated from the rate for the hospital closing the service and included in the rate for the receiving hospital. The costs transferred and utilized in the receiving hospital's rate will be the base year costs of the facility closing the service as defined in the Definitions Section. No revisions to the costs will be allowed.

9. The add-ons described in this section will be adjusted to reflect the transition factor per paragraph (1)(a)(ii) of the Transition Section of this Attachment.

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1. **Transition**

a. For discharges beginning on July 1, 2018 through December 31, 2021, a transition factor will be applied as follows:

i. The factor will be applied to the operating statewide base price as stated in row 5 in the Medicaid acute claim payment chart of the Statewide Base Price Section of this Attachment.

ii. The factor will be applied to all add-on operating cost components of the acute rate per discharge as stated in paragraph (10) of the Add-ons to the Acute Rate Per Discharge Section of this Attachment.

b. Hospital estimated losses and gains for the transition development will be calculated by comparing the estimated revenue, by provider, based on the newly developed rate using the updated base year and associated policy updates in comparison to the last rate developed with the previous base year and policy. Claims from the year discharges, as defined in the Definitions Section of this Attachment, will be used to calculate both the updated and previous base year revenue.

c. Hospital estimated losses which are due to the implementation of the updated base year pursuant to the Definitions Section of this Attachment and associated policy updates, will be limited as follows:

i. for the period July 1, 2018 through December 31, 2018, hospital specific estimated losses will be limited to 1% of the hospital's current revenues;

ii. for the period January 1, 2019 through December 31, 2019, the limitation on estimated losses will be increased to 2% of the hospital's current revenues;

iii. for the period January 1, 2020 through December 31, 2020, the limitation on estimated losses will be increased to 3% of the hospital's current revenues.

iv. for the period January 1, 2021 through December 31, 2021, the limitation on estimated losses will be increased to 4% of the hospital's current revenues.

d. The transition limitation on estimated losses, defined in paragraph (1)(b) of this section, will be offset as follows:

i. Utilizing two million four-hundred thousand dollars for hospitals that have closed since January 1, 2014;

ii. A cap on a hospital's estimated gain, as described in paragraph (1)(b) of this Section, shall be applied as necessary each year in order to achieve budget neutrality pursuant to the Statewide Base Price Section of this Attachment. This will be accomplished as follows:

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1. The cap on the estimated gain is derived through the "Goal Seek" programming in Microsoft excel, as defined in the Definitions Section, to determine the percentage necessary to hold payments budget neutral to the target total Medicaid operating payments, per the Statewide Base Price Section of this Attachment, with the limit on the losses.

2. For the period July 1, 2018 through December 31, 2018, the cap on gains is 3.5633%. When the cap on losses is revised, based on paragraph (c) of this section, the cap on gains will be increased.

e. The facility specific transition factor is determined by dividing the dollars associated with the total transition adjustment from gains or losses by the total facility specific projected revenue based on the newly developed rates using the updated base year and associated policy updates.

i. The total projected facility specific revenue excludes revenue from cost outlier cases since the transition factor does not apply to cost outlier payments.

f. The transition factor will not be subject to reconciliation.

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Outlier Rates of Payment.

1. High cost outlier rates of payment will be calculated by converting 100% of the total billed patient charges, as approved by IPRO, to cost by applying the hospital's charge converter as defined in the Definitions Section. Such calculation will use the most recent charge converter available as subsequently updated to reflect the data from the year in which the discharge occurred, and will equal the excess costs above the high cost outlier threshold.

   i. For payment, the high cost outlier threshold will be adjusted by the hospital specific wage equalization factor (WEF), as defined in the Definitions Section of this Attachment, prior to determining the excess costs above the high cost outlier threshold as stated in paragraph (1)(a) of this Section.

2. The high cost outlier threshold will be developed for each Diagnosis Related Group (DRG) using acute Medicaid operating costs which are derived from the year discharges used in the Statewide Base Price Section and defined in the Definitions Section of this Attachment. The high cost thresholds will be scaled to maintain budget neutrality ~~,~~ to targeted outlier payments developed pursuant to the Statewide Base Price Section.

   i. The high cost outlier thresholds will be updated at the time the Service Intensity Weights (SIWs) are updated in accordance with the SIW and ALOS Section.

   ii. Cost outlier thresholds for each base APR-DRG effective on and after July 1, 2018, have been posted to the Department of Health's public website at the following:

   http://www.health.ny.gov/facilities/hospital/reimbursement/apr-drg/tresholds/

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Alternate Level of Care Payments (ALC).

1. For rates beginning on and after July 1, 2018, hospitals will be reimbursed for ALC days at the appropriate 2013 group average operating cost component of rates of payment for hospital-based residential health care facilities established pursuant to Attachment 4.19-D, trended to the rate year.

   The determination of the group average operating rate for hospital-based residential health care facilities specified in this paragraph will be based on the combination of residential health care facilities as follows:

   a. The downstate group will consist of residential health care facilities located in the New York counties of Bronx, New York, Kings, Queens, Richmond, Nassau, Suffolk, Westchester, Rockland, Orange, Putnam, and Dutchess.

   b. The upstate group will consist of all other residential health care facilities in the State.

2. Hospitals that convert medical/surgical beds to residential health care beds will be reimbursed for services provided in the converted beds in accordance with Attachment 4.19-D.