

NEW YORK
state department of
HEALTH

Nirav R. Shah, M.D., M.P.H.
Commissioner

Sue Kelly
Executive Deputy Commissioner

June 26, 2013

National Institutional Reimbursement Team
Attention: Mark Cooley
CMS, CMCS
7500 Security Boulevard, M/S S3-14-28
Baltimore, MD 21244-1850

Re: SPA #13-20
Inpatient Hospital Services

Dear Mr. Cooley:

The State requests approval of the enclosed amendment #13-20 to the Title XIX (Medicaid) State Plan for inpatient hospital services to be effective April 1, 2013 (Appendix I). This amendment is being submitted based upon enacted legislation. A summary of the proposed amendment is contained in Appendix II.

This amendment is submitted pursuant to §1902(a) of the Social Security Act (42 USC 1396a(a)) and Title 42 of the Code of Federal Regulations (CFR), Part 447, Subpart C.

The State of New York pays for inpatient general hospital services using rates determined in accordance with methods and standards specified in an approved State Plan, following a public process, which complies with Social Security Act §1902(a)(13)(A).

Notice of the changes in the methods and standards for setting payment rates for general hospital inpatient services were given in the New York State Register on March 27, 2013.

It is estimated that the changes represented by 2013 payment rates for inpatient general hospital services will have no noticeable short-term or long-term effect on the availability of services on a statewide or geographic area basis, the type of care furnished, or the extent of provider participation.

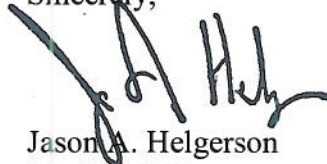
In accordance with 42 CFR §447.272(c), New York assures that its aggregate disproportionate share hospital payments do not exceed the disproportionate share hospital payment limit.

In accordance with §1923(g) of the Social Security Act, New York assures that it has calculated facility specific limits for disproportionate share payments for each disproportionate share hospital. New York assures that it will not make disproportionate share payments to a hospital in excess of the facility specific limits established for such hospital.

Copies of pertinent sections of enacted State statute are enclosed for your information (Appendix III). In addition, responses to the five standard funding questions and the standard access questions are also enclosed (Appendix V and VII, respectively).

If you have any questions regarding this matter, please do not hesitate to contact John E. Ulberg, Jr., Medicaid Chief Financial Officer, Division of Finance and Rate Setting at (518) 474-6350.

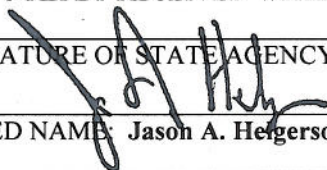
Sincerely,

A handwritten signature in black ink, appearing to read "Jason A. Helgerson". The signature is written in a cursive style with a large initial "J" and "H".

Jason A. Helgerson
Medicaid Director
Office of Health Insurance Programs

Enclosures

cc: Mr. Michael Melendez
Mr. Tom Brady

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: HEALTH CARE FINANCING ADMINISTRATION		1. TRANSMITTAL NUMBER: 13-20	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, 2013	
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: Section 1902(a) of the Social Security Act, and 42 CFR 447		7. FEDERAL BUDGET IMPACT: a. FFY 04/01/13-09/30/13 \$ (25.8M) b. FFY 10/01/13-09/30/14 \$ (51.6M)	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-A: A(1)(b)		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (<i>If Applicable</i>):	
10. SUBJECT OF AMENDMENT: 2% Across the Board Reduction – 2-Year Extension - IP (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 Bureau of Federal Relations & Provider Assessments 99 Washington Ave – One Commerce Plaza Suite 810 Albany, NY 12210	
13. TYPED NAME: Jason A. Helgeson			
14. TITLE: Medicaid Director Department of Health			
15. DATE SUBMITTED: June 26, 2013			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED:		18. DATE APPROVED:	
PLAN APPROVED – ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL:		20. SIGNATURE OF REGIONAL OFFICIAL:	
21. TYPED NAME:		22. TITLE:	
23. REMARKS:			

**Appendix I
2013 Title XIX State Plan
Second Quarter Amendment
Hospital Inpatient Services
Amended SPA Pages**

New York
A(1)(b)

Across the Board 2% Payment Reduction – effective 4/1/13 - 3/31/15

- (1) For dates of service on and after April 1, 2013 through March 31, 2015, payments for services as specified in paragraph (2) of this Section will be reduced by 2%.
- (2) Payments in this Attachment subject to the reduction in paragraph (1) are the following:

Part I – Methods and Standards for Establishing Payments – Inpatient Hospital Care

- a) Hospital Inpatient Reimbursement as calculated pursuant to Part 1 of this Attachment. Pages 103-139
- b) Indigent Care Pool Reform – effective January 1, 2013 as calculated pursuant to Part 1 of this Attachment. Pages 161(d)-161(g)
- c) Graduate Medical Education – Medicaid Managed Care Reimbursement as calculated pursuant to Part 1 of this Attachment. Pages 149-150
- d) Hospital Disproportionate Share payments made to governmental general hospitals operated by the State of New York or the State University of New York as calculated pursuant to Part 1 of this Attachment. Pages 153-154
- e) Government General Hospital Indigent Care Adjustment as calculated pursuant to Part 1 of this Attachment. Page 160
- f) Additional Disproportionate Share Payments to voluntary non-profit hospitals as calculated pursuant to Part 1 of this Attachment. Page 162

TN #13-20

Approval Date _____

Supersedes TN NEW

Effective Date _____

Appendix II
2013 Title XIX State Plan
Second Quarter Amendment
Hospital Inpatient Services
Summary

SUMMARY
SPA #13-20

This State Plan Amendment proposes to make a 2% reduction uniformly across most hospital inpatient payments made under the State's Institutional State Plan Amendment (4.19-A). Such payment reductions will commence for services provided on or after April 1, 2013 and continue through March 31, 2015.

**Appendix III
2013 Title XIX State Plan
Second Quarter Amendment
Hospital Inpatient Services
Authorizing Provisions**

CHAPTER 56 OF THE LAWS OF 2013 - PART A

Section 1. Subdivision (a) of section 90 of part H of chapter 59 of the laws of 2011, amending the public health law and other laws, relating to general hospital inpatient reimbursement for annual rates, is amended to read as follows:

(a) Notwithstanding any other provision of law to the contrary, for the state fiscal years beginning April 1, 2011 and ending on March 31, ~~2013~~ 2015, all Medicaid payments made for services provided on and after April 1, 2011, shall, except as hereinafter provided, be subject to a uniform two percent reduction and such reduction shall be applied, to the extent practicable, in equal amounts during the fiscal year, provided, however, that an alternative method may be considered at the discretion of the commissioner of health and the director of the budget based upon consultation with the health care industry including but not limited to, a uniform reduction in Medicaid rates of payments or other reductions provided that any method selected achieves up to \$345,000,000 in Medicaid state share savings in state fiscal year 2011-12 and up to \$357,000,000 annually in state fiscal ~~year~~ years 2012-13, 2013-14 and 2014-15 except as hereinafter provided, for services provided on and after April 1, 2011 through March 31, ~~2013~~ 2015. Any alternative methods to achieve the reduction must be provided in writing and shall be filed with the senate finance committee and the assembly ways and means committee not less than thirty days before the date on which implementation is expected to begin. Nothing in this section shall be deemed to prevent all or part of such alternative reduction plan from taking effect retroactively, to the extent permitted by the federal centers for medicare and medicaid services.

**Appendix IV
2013 Title XIX State Plan
Second Quarter Amendment
Hospital Inpatient Services
Public Notice**

DAI will do business as Disability Rights New York (DRNY) and will operate all of the P&A/CAP programs authorized under federal law. DRNY will continue to serve existing clients and cases of the current P&A system or refer them to other sources of legal advocacy as appropriate, without disruption.

The Governor has, simultaneously with this public notice, provided notice to CQCAPD as the existing P&A and CAP; the State Rehabilitation Advisory Council; and the State Independent Living Council. Interested persons may wish to write to CQCAPD to obtain a copy of its response to that notice. Such requests should be sent to the address above.

Public comment on this redesignation will be accepted until April 5, 2013. Comments should be sent to the following:

Protection and Advocacy Redesignation
The Capitol
Albany, NY 12224
Email: protectionandadvocacy@exec.ny.gov

A public hearing on the proposed redesignation will be held on April 9, 2013, at 1:00 p.m., Empire State Plaza, Meeting Rooms 3 and 4, Albany, New York.

For further information, contact: Protection and Advocacy Redesignation, The Capitol, Albany, New York 12224. Email: protectionandadvocacy@exec.ny.gov

PUBLIC NOTICE

Department of Health

The New York State Department of Health (DOH) is required by the provisions of the federal Beaches Environmental Assessment and Coastal Health (BEACH) Act to provide for public review and comment on the Department's beach monitoring and notification plan. The BEACH Act (Section 406(b) of the Clean Water Act) enacted a federal Environmental Protection Agency grant program available to states, such as New York, with coastal recreational waters. Coastal recreational waters include the Great Lakes and marine coastal waters that are designated for swimming, bathing, surfing, or similar water contact activities. The Act is not applicable to inland waters or waters upstream of the mouth of a river or stream having an unimpaired natural connection with the open sea.

The beach monitoring and public notification plan also includes information on the beach evaluation and classification process, including a list of waters to be monitored and beach ranking. Also included in this plan, is the sampling design and monitoring plan, including sampling location and sampling frequency. Lastly, the plan contains information on procedures for public notification and risk communication, including methods to notify the public of a swimming advisory or beach closure.

Any interested parties and/or agencies desiring to review and/or comment on the beach monitoring and notification plan for coastal recreational waters may do so by writing to: Timothy M. Shay, Section Chief, Department of Health, Center for Environmental Health, Bureau of Community Environmental Health and Food Protection, Empire State Plaza, Corning Tower Bldg., Rm. 1395, Albany, NY 12237. Fax (518) 402-7600

PUBLIC NOTICE

Department of Health

Pursuant to 42 CFR Section 447.205, the Department of Health hereby gives public notice of the following:

The Department of Health proposes to amend the Title XIX (Medicaid) State Plan for inpatient, long term care, and non-institutional services and prescription drugs to comply with recently proposed statutory provisions. The following significant changes and clarifications are proposed:

All Services

- Effective on and after April 1, 2013, no annual trend factor will be applied pursuant to the provisions of Public Health Law § 2807-c(10)(c) to rates of payment for hospital inpatient services, residential health care facility inpatient services, adult day health care outpatient

services, hospital outpatient services and diagnostic and treatment care services, certified home health agencies, personal care services, adult day health care services provided to patients diagnosed with AIDS, personal care services provided in those local social services districts, including New York City, whose rates of payment for services is established by such social services districts pursuant to a rate-setting exemption granted by the Department, assisted living program services and hospice services. This includes the elimination of the trend factor effective for Medicaid rate periods April 1, 2013, and thereafter.

The annual decrease in gross Medicaid expenditures for state fiscal year 2013/14 is \$436.4 million.

- Continues, effective for dates of service April 1, 2013, through March 31, 2015, all non-exempt Medicaid payments as referenced below will be uniformly reduced by two percent.

The annual decrease in gross Medicaid expenditures for state fiscal year 2013/14 is \$714 million.

- The amount appropriated for Essential Community Provider Network and Vital Access Provider initiatives will be increased to \$182 million in state fiscal year 2013/14 and subsequently decreased to \$153 million in state fiscal year 2014/15. Included in this initiative is a \$30 million reallocation of nursing home financially disadvantaged funding to the vital access provider initiative.

The annual increase in gross Medicaid expenditures for state fiscal year 2013/14 is \$52 million.

- Consistent with Section 1202 of the Affordable Care Act, certain primary care providers (e.g., physicians, physician's assistants and nurse practitioners) will be reimbursed at the Medicare rate for Medicaid primary care services furnished in calendar years 2013 and 2014 in institutional and non-institutional settings, including nursing homes. This provision applies to evaluation and management (E&M) and vaccine administration services when delivered by a physician with a specialty designation of family medicine, general internal medicine, or pediatric medicine. The purpose of this provision is to encourage more physicians to participate in Medicaid, and thereby promote access to primary care services for current and new Medicaid beneficiaries to be served via coverage expansion in 2014.

It is estimated that the impact to the provider community will be a gross annual increase in state fiscal year 2013/14 of \$227.9 million. This includes the State eliminating the physician's portion of the two percent reduction that was enacted as part of the 2011-2012 State Fiscal Year consistent with the Federal Regulation.

Institutional Services

- For the state fiscal year beginning April 1, 2013 through March 31, 2014, continues specialty hospital adjustments for hospital inpatient services provided on and after April 1, 2013, to public general hospitals, other than those operated by the State of New York or the State University of New York, located in a city with a population of over one million and receiving reimbursement of up to \$1.08 billion annually. Payments to eligible public general hospitals may be added to rates of payment or made as aggregate payments.

- For state fiscal years beginning April 1, 2013 through March 31, 2016, additional medical assistance payments for inpatient hospital services may be made to public general hospitals operated by the State of New York or the State University of New York, or by a county which shall not include a city with a population over one million, and those public general hospitals located in the counties of Westchester, Erie, or Nassau, up to one hundred percent (100%) of each such public hospital's medical assistance and uninsured patient losses after all other medical assistance, including disproportionate share payments to such general hospitals. Payments may be added to rates of payment or made as aggregate payments. Payments will be based initially on reported reconciled data from the base year two years prior to the payment year adjusted for authorized Medicaid rate changes and further reconciled to actual reported data from such payment year.

- Extends current provisions for services April 1, 2013 through March 31, 2015, the reimbursable operating cost component for general hospital inpatient rates will be established with the 2006 final trend factor equal to the final Consumer Price Index (CPI) for all urban consumers less 0.25%.

Appendix V
2013 Title XIX State Plan
Second Quarter Amendment
Hospital Inpatient Services
Responses to Standard Funding Questions

**APPENDIX V
HOSPITAL SERVICES
State Plan Amendment #13-20**

CMS Standard Funding Questions (NIRT Standard Funding Questions)

The following questions are being asked and should be answered in relation to all payments made to all providers under Attachment 4.19-A of your state plan.

- 1. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by States for services under the approved State plan. Do providers receive and retain the total Medicaid expenditures claimed by the State (includes normal per diem, supplemental, enhanced payments, other) or is any portion of the payments returned to the State, local governmental entity, or any other intermediary organization? If providers are required to return any portion of payments, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the amount or percentage of payments that are returned and the disposition and use of the funds once they are returned to the State (i.e., general fund, medical services account, etc.)**

Response: Providers do retain the payments made pursuant to this amendment. However, this requirement in no way prohibits the public provider, including county providers, from reimbursing the sponsoring local government for appropriate expenses incurred by the local government on behalf of the public provider. The State does not regulate the financial relationships that exist between public health care providers and their sponsoring governments, which are extremely varied and complex. Local governments may provide direct and/or indirect monetary subsidies to their public providers to cover on-going unreimbursed operational expenses and assure achievement of their mission as primary safety net providers. Examples of appropriate expenses may include payments to the local government which include reimbursement for debt service paid on a provider's behalf, reimbursement for Medicare Part B premiums paid for a provider's retirees, reimbursement for contractually required health benefit fund payments made on a provider's behalf, and payment for overhead expenses as allocated per federal Office of Management and Budget Circular A-87 regarding Cost Principles for State, Local, and Indian Tribal Governments. The existence of such transfers should in no way negate the legitimacy of these facilities' Medicaid payments or result in reduced Medicaid federal financial participation for the State. This position was further supported by CMS in review and approval of SPA 07-07C when an on-site audit of these transactions for New York City's Health and Hospitals Corporation was completed with satisfactory results.

2. **Section 1902(a)(2) provides that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan. Please describe how the state share of each type of Medicaid payment (normal per diem, supplemental, enhanced, other) is funded. Please describe whether the state share is from appropriations from the legislature to the Medicaid agency, through intergovernmental transfer agreements (IGTs), certified public expenditures (CPEs), provider taxes, or any other mechanism used by the state to provide state share. Note that, if the appropriation is not to the Medicaid agency, the source of the state share would necessarily be derived through either an IGT or CPE. In this case, please identify the agency to which the funds are appropriated. Please provide an estimate of total expenditure and State share amounts for each type of Medicaid payment. If any of the non-federal share is being provided using IGTs or CPEs, please fully describe the matching arrangement including when the state agency receives the transferred amounts from the local government entity transferring the funds. If CPEs are used, please describe the methodology used by the state to verify that the total expenditures being certified are eligible for Federal matching funds in accordance with 42 CFR 433.51(b). For any payment funded by CPEs or IGTs, please provide the following:**
- (i) a complete list of the names of entities transferring or certifying funds;**
 - (ii) the operational nature of the entity (state, county, city, other);**
 - (iii) the total amounts transferred or certified by each entity;**
 - (iv) clarify whether the certifying or transferring entity has general taxing authority; and,**
 - (v) whether the certifying or transferring entity received appropriations (identify level of appropriations).**

Response: Payments made to service providers under the provisions of this SPA are funded through a general appropriation received by the State agency that oversees medical assistance (Medicaid), which is the Department of Health. The source of the appropriation is the Local Assistance Account under the General Fund/Aid to Localities.

3. **Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan. If supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to each provider type.**

Response: The payments authorized for this provision are not supplemental or enhanced payments.

- 4. Please provide a detailed description of the methodology used by the state to estimate the upper payment limit (UPL) for each class of providers (State owned or operated, non-state government owned or operated, and privately owned or operated). Please provide a current (i.e. applicable to the current rate year) UPL demonstration. Under regulations at 42 CFR 4447.272, States are prohibited from setting payment rates for Medicaid inpatient services that exceed a reasonable estimate of the amount that would be paid under Medicare payment principals.**

Response: Based on guidance from CMS, the State will submit the current UPL demonstration by June 30, 2013.

- 5. Does any governmental provider receive payments that in the aggregate (normal per diem, supplemental, enhanced, other) exceed their reasonable costs of providing services? If payments exceed the cost of services, do you recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report?**

Response: The rate methodology included in the approved State Plan for institutional services is a prospective payment methodology. We are unaware of any requirement under current federal law or regulation that limits individual provider payments to their actual costs. For Disproportionate Share Hospital (DSH) payments, the State assures that there are not DSH payments made to hospitals in excess of the cost of providing inpatient and outpatient services to Medicaid and uninsured patients net of revenues required. In the event the State determines a DSH payment has been made in excess of its DHS cap the Federal share of such payment is recouped and returned to CMS on the quarterly expenditure report.

ACA Assurances:

- 1. Maintenance of Effort (MOE). Under section 1902(gg) of the Social Security Act (the Act), as amended by the Affordable Care Act, as a condition of receiving any Federal payments under the Medicaid program during the MOE period indicated below, the State shall not have in effect any eligibility standards, methodologies, or procedures in its Medicaid program which are more restrictive than such eligibility provisions as in effect in its Medicaid program on March 10, 2010.**

MOE Period.

- **Begins on:** March 10, 2010, and
- **Ends on:** The date the Secretary of the Federal Department of Health and Human Services determines an Exchange established by a State

under the provisions of section 1311 of the Affordable Care Act is fully operational.

Response: This SPA complies with the conditions of the MOE provision of section 1902(gg) of the Act for continued funding under the Medicaid program.

- 2. Section 1905(y) and (z) of the Act provides for increased FMAPs for expenditures made on or after January 1, 2014 for individuals determined eligible under section 1902(a)(10)(A)(i)(VIII) of the Act. Under section 1905(cc) of the Act, the increased FMAP under sections 1905(y) and (z) would not be available for States that require local political subdivisions to contribute amounts toward the non-Federal share of the State's expenditures at a greater percentage than would have been required on December 31, 2009.**

Prior to January 1, 2014 States may potentially require contributions by local political subdivisions toward the non-Federal share of the States' expenditures at percentages greater than were required on December 31, 2009. However, because of the provisions of section 1905(cc) of the Act, it is important to determine and document/flag any SPAs/State plans which have such greater percentages prior to the January 1, 2014 date in order to anticipate potential violations and/or appropriate corrective actions by the States and the Federal government.

Response: This SPA would [] / would not [✓] violate these provisions, if they remained in effect on or after January 1, 2014.

- 3. Please indicate whether the State is currently in conformance with the requirements of section 1902(a)(37) of the Act regarding prompt payment of claims.**

Response: This SPA does comply with the requirements of section 1902(a)(37) of the Act regarding prompt payment of claims.

Tribal Assurance:

Section 1902(a)(73) of the Social Security Act the Act requires a State in which one or more Indian Health Programs or Urban Indian Organizations furnish health care services to establish a process for the State Medicaid agency to seek advice on a regular ongoing basis from designees of Indian health programs whether operated by the Indian Health Service HIS Tribes or Tribal organizations under the Indian Self Determination and Education Assistance Act ISDEAA or Urban Indian Organizations under the Indian Health Care Improvement Act.

IHCIA Section 2107(e)(I) of the Act was also amended to apply these requirements to the Children's Health Insurance Program CHIP.

Consultation is required concerning Medicaid and CHIP matters having a direct impact on Indian health programs and Urban Indian organizations.

- a) Please describe the process the State uses to seek advice on a regular ongoing basis from federally recognized tribes Indian Health Programs and Urban Indian Organizations on matters related to Medicaid and CHIP programs and for consultation on State Plan Amendments waiver proposals waiver extensions waiver amendments waiver renewals and proposals for demonstration projects prior to submission to CMS.**
- b) Please include information about the frequency inclusiveness and process for seeking such advice.**
- c) Please describe the consultation process that occurred specifically for the development and submission of this State Plan Amendment when it occurred and who was involved.**

Response: Tribal consultation was performed in accordance with the State's tribal consultation policy as approved in SPA 11-06, and documentation of such is included with this submission. To date, no feedback has been received from any tribal representative in response to the proposed change in this SPA.

Appendix VI
2013 Title XIX State Plan
Second Quarter Amendment
Hospital Inpatient Services
Responses to Standard Access Questions

**APPENDIX VI
HOSPITAL SERVICES
State Plan Amendment #13-20**

CMS Standard Access Questions

The following questions have been asked by CMS and are answered by the State in relation to all payments made to all providers under Attachment 4.19-A of the state plan.

- 1. Specifically, how did the State determine that the Medicaid provider payments that will result from the change in this amendment are sufficient to comply with the requirements of 1902(a)(30)?**

Response: This amendment seeks to extend the 2 percent reduction for certain Medicaid payments for the period of April 1, 2013 through March 30, 2015. This reduction is not expected to affect the State's compliance with the requirements of 1902(a)(30), given the fact that the reduction is a proportionately small amount, the impact of which is spread among many providers thus further reducing the impact for any individual provider.

- 2. How does the State intend to monitor the impact of the new rates and implement a remedy should rates be insufficient to guarantee required access levels?**

Response: The State has various ways to ensure that access levels in the Medicaid program are retained and is currently not aware of any access issues. First, institutional providers (i.e., hospitals, clinics, and nursing homes), must notify and request approval from the Department's Office of Health Systems Management to discontinue services. This Department will monitor these requests and will take it into consideration as they approve/deny changes in services. In addition, these providers cannot discriminate based on source of payment and there is excess bed capacity for hospitals and nursing homes.

Second, for providers that are not subject to a notification, the State will continually monitor provider complaint hotlines to identify geographic areas of concern and/or service types. If Medicaid beneficiaries begin to encounter access issues, the Department would expect to see a marked increase in complaints. These complaints will be identified and analyzed in light of the changes proposed in this State Plan Amendment.

Finally, the State ensures that there is sufficient provider capacity for Medicaid Managed Care plans as part of its process to approve managed care rates and plans. Should sufficient access to services be compromised, the State would be alerted and would take appropriate action to retain such access to services.

Regardless of rate reductions, the Department routinely utilizes several data sources to monitor access levels for Medicaid eligible individuals and there by rapidly evaluates and responds to any potential downward trends in access. These include the following:

- Monitoring the number and types of service discontinuation requests through its Certificate of Need (CON) process, which enables identification of any regional or aggregate variances from prior periods.
- Monitoring the number and types of contacts received through the complaint hotlines overseen by the Office of Health Systems Management, which enables identification of any regional or aggregate variances from prior periods.
- Monitoring utilization per beneficiary and per provider via monthly MARS reports, which enables identification of any regional or aggregate variances from prior periods.

In addition, from a proactive stance, the Department continues to:

- Provide financial support to Medicaid Transition Hospitals to assist with implementation of their strategic plans.
- Support restructuring of the acute care industry through abundant funding of the NYS Healthcare Efficiency and Affordability Law (HEAL-NY) and the Federal-State Health Reform Partnership (FSHRP) programs. Specifically, funding supports the restructuring and rightsizing of inpatient capacity with investments in IT and in treatment settings most appropriate to care, including increases to ambulatory and primary care capacity.
- Support industry efforts to become more efficient and effective in serving populations, including reducing lengths of stay and preventable readmissions, as well as developing regional health care delivery arrangements.
- Use bed need methodology models to evaluate and respond to requests for new beds and for bed closures

3. How were providers, advocates and beneficiaries engaged in the discussion around rate modifications? What were their concerns and how did the State address these concerns?

Response: This change was enacted by the State Legislature as part of the negotiation of the final 2013-14 Budget. The impact of the reduction was weighed in the context of the overall Budget in the State. The legislative process provides opportunities for all stakeholders to lobby their concerns, objections, or support for various legislative initiatives.

4. What action(s) does the State plan to implement after the rate change takes place to counter any decrease to access if the rate decrease is found to prevent sufficient access to care?

Response: No less than 30 days prior to the conclusion of each State Fiscal Year of the reduction the Department will prepare and transmit a report that details the

actions taken to implement the Medicaid state share reductions. Furthermore, during the effective period of this reduction, should any essential community provider experience Medicaid or other revenue issues that would prevent access to needed community services, we would (per our usual practice) meet with them to explore the situation and discuss possible solutions, if necessary.

5. Is the State modifying anything else in the State Plan which will counterbalance any impact on access that may be caused by the decrease in rates (e.g. increasing scope of services that other provider types may provide or providing care in other settings)?

Response: Over the course of the past three years, the State has undertaken a massive reform initiative that aligns reimbursement with care. The State has also increased the fee schedule used to pay physicians. This increase was meant to ensure access to Medicaid beneficiaries as well as make the State's reimbursement more in line with what Medicare pays for similar services. Further, the State is in the process of implementing and awarding \$600 million annually, over five years, monies to providers to promote efficiency and quality care through the Federal-State Health Reform Partnership(F-SHRP)/ NYS Healthcare Efficiency and Affordability Law (HEAL). While some of these initiatives are outside of the State Plan, they are some of the measures the State is taking to ensure quality care to the State's most vulnerable population.