



## Department of Health

**ANDREW M. CUOMO**  
Governor

**HOWARD A. ZUCKER, M.D., J.D.**  
Commissioner

**SALLY DRESLIN, M.S., R.N.**  
Executive Deputy Commissioner

SEP 22 2017

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

Re: SPA #17-0062  
Inpatient Hospital Services

Dear Mr. Cooley:

The State requests approval of the enclosed amendment #17-0062 to the Title XIX (Medicaid) State Plan for inpatient hospital services to be effective August 1, 2017 (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.

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 July 26, 2017.

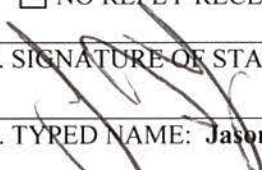
Copies of pertinent sections of enacted legislation are enclosed for your information (Appendix III). In addition, responses to the five standard funding questions are also enclosed (Appendix V).

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, Office of Health Insurance Programs at (518) 474-6350.

Sincerely,

  
Jason A. Helgerson  
Medicaid Director  
Office of Health Insurance Programs

Enclosures  
cc: Mr. Michael Melendez  
Mr. Tom Brady

<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</b>		1. TRANSMITTAL NUMBER: <b>17-0062</b>	2. STATE <b>New York</b>
<b>FOR: HEALTH CARE FINANCING ADMINISTRATION</b>		3. PROGRAM IDENTIFICATION: <b>TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)</b>	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE <b>August 1, 2017</b>	
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: <b>§ 1902(a) of the Social Security Act, and 42 CFR 447</b>		7. FEDERAL BUDGET IMPACT: ( <i>in thousands</i> ) <b>a. FFY 08/01/17-09/30/17 \$ 1,250.13</b> <b>b. FFY 10/01/17-09/30/18 \$ 6,250.63</b>	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: <b>Attachment 4.19-A: Pages 136(d), 136(d.1), 136(d.2), 136(d.3), 136(d.4)</b>		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT ( <i>If Applicable</i> ):	
10. SUBJECT OF AMENDMENT: <b>Safety Net/VAP-IP-Essential Community Providers (FMAP = 50%)</b>			
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: <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>Jason A. Helgerson</b>			
14. TITLE: <b>Medicaid Director Department of Health</b>			
15. DATE SUBMITTED: <b>SEP 22 2017</b>			
<b>FOR REGIONAL OFFICE USE ONLY</b>			
17. DATE RECEIVED:		18. DATE APPROVED:	
<b>PLAN APPROVED – ONE COPY ATTACHED</b>			
19. EFFECTIVE DATE OF APPROVED MATERIAL:		20. SIGNATURE OF REGIONAL OFFICIAL:	
21. TYPED NAME:		22. TITLE:	
23. REMARKS:			

**Appendix I**  
**2017 Title XIX State Plan**  
**Third Quarter Amendment**  
**Amended SPA Pages**

**New York  
136(d)**

c. Temporary rate adjustments have been approved for the following essential community providers in the amounts and for the effective periods listed:

**Essential Community Providers:**

<b>Provider Name</b>	<b>Gross Medicaid Rate Adjustment</b>	<b>Rate Period Effective</b>
<u>A.O. Fox Memorial Hospital</u>	<u>\$328,500</u>	<u>08/01/2017 – 03/31/2018</u>
	<u>\$328,500</u>	<u>04/01/2018 – 03/31/2019</u>
<u>Adirondack Medical Center</u>	<u>\$78,500</u>	<u>08/01/2017 – 03/31/2018</u>
	<u>\$78,500</u>	<u>04/01/2018 – 03/31/2019</u>
<u>Alice Hyde Hospital Association</u>	<u>\$208,000</u>	<u>08/01/2017 – 03/31/2018</u>
	<u>\$208,000</u>	<u>04/01/2018 – 03/31/2019</u>
<u>Auburn Memorial Hospital</u>	<u>\$78,500</u>	<u>08/01/2017 – 03/31/2018</u>
	<u>\$78,500</u>	<u>04/01/2018 – 03/31/2019</u>
<u>Bassett Hospital of Schoharie County-Cobleskill Reg.</u>	<u>\$103,500</u>	<u>08/01/2017 – 03/31/2018</u>
	<u>\$103,500</u>	<u>04/01/2018 – 03/31/2019</u>
<u>Brooks Memorial Hospital</u>	<u>\$303,500</u>	<u>08/01/2017 – 03/31/2018</u>
	<u>\$303,500</u>	<u>04/01/2018 – 03/31/2019</u>
<u>Canton-Potsdam Hospital</u>	<u>\$58,500</u>	<u>08/01/2017 – 03/31/2018</u>
	<u>\$58,500</u>	<u>04/01/2018 – 03/31/2019</u>
<u>Carthage Area Hospital</u>	<u>\$353,500</u>	<u>08/01/2017 – 03/31/2018</u>
	<u>\$353,500</u>	<u>04/01/2018 – 03/31/2019</u>
<u>Catskill Regional Hospital-Sullivan</u>	<u>\$328,500</u>	<u>08/01/2017 – 03/31/2018</u>
	<u>\$328,500</u>	<u>04/01/2018 – 03/31/2019</u>
<u>Catskill Regional Medical Center – Hermann Division</u>	<u>\$128,500</u>	<u>08/01/2017 – 03/31/2018</u>
	<u>\$128,500</u>	<u>04/01/2018 – 03/31/2019</u>
<u>Cayuga Medical Center-Ithaca</u>	<u>\$153,500</u>	<u>08/01/2017 – 03/31/2018</u>
	<u>\$153,500</u>	<u>04/01/2018 – 03/31/2019</u>
<u>Champlain Valley Physicians HMC</u>	<u>\$103,500</u>	<u>08/01/2017 – 03/31/2018</u>
	<u>\$103,500</u>	<u>04/01/2018 – 03/31/2019</u>

TN #17-0062

Approval Date \_\_\_\_\_

Supersedes TN NEW

Effective Date \_\_\_\_\_

**New York  
136(d.1)**

**Essential Community Providers (cont'd):**

<b>Provider Name</b>	<b>Gross Medicaid Rate Adjustment</b>	<b>Rate Period Effective</b>
<u>Chenango Memorial Hospital</u>	\$103,500	08/01/2017 – 03/31/2018
	\$103,500	04/01/2018 – 03/31/2019
<u>Claxton Hepburn Medical Center</u>	\$128,500	08/01/2017 – 03/31/2018
	\$128,500	04/01/2018 – 03/31/2019
<u>Clifton-Fine Hospital</u>	\$353,500	08/01/2017 – 03/31/2018
	\$353,500	04/01/2018 – 03/31/2019
<u>Columbia Memorial Hospital</u>	\$153,500	08/01/2017 – 03/31/2018
	\$153,500	04/01/2018 – 03/31/2019
<u>Community Memorial Hospital</u>	\$208,000	08/01/2017 – 03/31/2018
	\$208,000	04/01/2018 – 03/31/2019
<u>Corning Hospital</u>	\$58,500	08/01/2017 – 03/31/2018
	\$58,500	04/01/2018 – 03/31/2019
<u>Cortland Memorial Hospital</u>	\$328,500	08/01/2017 – 03/31/2018
	\$328,500	04/01/2018 – 03/31/2019
<u>Cuba Memorial Hospital</u>	\$328,500	08/01/2017 – 03/31/2018
	\$328,500	04/01/2018 – 03/31/2019
<u>Delaware Valley Hospital</u>	\$128,500	08/01/2017 – 03/31/2018
	\$128,500	04/01/2018 – 03/31/2019
<u>Elizabethtown Community Hospital</u>	\$128,500	08/01/2017 – 03/31/2018
	\$128,500	04/01/2018 – 03/31/2019
<u>Ellenville Community Hospital</u>	\$128,500	08/01/2017 -03/31/2018
	\$128,500	04/01/2018 – 03/31/2019
<u>Gouvernor Hospital</u>	\$247,500	08/01/2017 – 03/31/2018
	\$247,500	04/01/2018 – 03/31/2019
<u>Ira Davenport Memorial Hospital</u>	\$353,500	08/01/2017 – 03/31/2018
	\$353,500	04/01/2018 – 03/31/2019

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Effective Date \_\_\_\_\_

**New York  
136(d.2)**

**Essential Community Providers (cont'd):**

<b>Provider Name</b>	<b>Gross Medicaid Rate Adjustment</b>	<b>Rate Period Effective</b>
<u>Jones Memorial Hospital</u>	<u>\$192,000</u>	<u>08/01/2017 – 03/31/2018</u>
	<u>\$192,000</u>	<u>04/01/2018 – 03/31/2019</u>
<u>Lewis County General Hospital</u>	<u>\$328,500</u>	<u>08/01/2017 – 03/31/2018</u>
	<u>\$328,500</u>	<u>04/01/2018 – 03/31/2019</u>
<u>Little Falls Hospital</u>	<u>\$136,000</u>	<u>08/01/2017 – 03/31/2018</u>
	<u>\$136,000</u>	<u>04/01/2018 – 03/31/2019</u>
<u>Margaretville Memorial Hospital</u>	<u>\$353,500</u>	<u>08/01/2017 – 03/31/2018</u>
	<u>\$353,500</u>	<u>04/01/2018 – 03/31/2019</u>
<u>Mary Imogene Bassett Hospital</u>	<u>\$104,000</u>	<u>08/01/2017 – 03/31/2018</u>
	<u>\$104,000</u>	<u>04/01/2018 – 03/31/2019</u>
<u>Massena Memorial Hospital</u>	<u>\$203,500</u>	<u>08/01/2017 – 03/31/2018</u>
	<u>\$203,500</u>	<u>04/01/2018 – 03/31/2019</u>
<u>Medina Memorial Hospital</u>	<u>\$136,000</u>	<u>08/01/2017 – 03/31/2018</u>
	<u>\$136,000</u>	<u>04/01/2018 – 03/31/2019</u>
<u>Moses-Ludington Hospital</u>	<u>\$253,500</u>	<u>08/01/2017 – 03/31/2018</u>
	<u>\$253,500</u>	<u>04/01/2018 – 03/31/2019</u>
<u>Nathan Littauer Hospital</u>	<u>\$103,500</u>	<u>08/01/2017 – 03/31/2018</u>
	<u>\$103,500</u>	<u>04/01/2018 – 03/31/2019</u>
<u>Northern Dutchess Hospital</u>	<u>\$58,500</u>	<u>08/01/2017 – 03/31/2018</u>
	<u>\$58,500</u>	<u>04/01/2018 – 03/31/2019</u>
<u>Noyes Memorial Hospital</u>	<u>\$103,500</u>	<u>08/01/2017 – 03/31/2018</u>
	<u>\$103,500</u>	<u>04/01/2018 – 03/31/2019</u>
<u>O'Connor Hospital</u>	<u>\$128,500</u>	<u>08/01/2017 – 03/31/2018</u>
	<u>\$128,500</u>	<u>04/01/2018 – 03/31/2019</u>
<u>Olean General Hospital-Main</u>	<u>\$103,500</u>	<u>08/01/2017 – 03/31/2018</u>
	<u>\$103,500</u>	<u>04/01/2018 – 03/31/2019</u>

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New York  
136(d.3)

**Essential Community Providers (cont'd):**

<b>Provider Name</b>	<b>Gross Medicaid Rate Adjustment</b>	<b>Rate Period Effective</b>
<u>Oneida City Hospital</u>	<u>\$153,500</u>	<u>08/01/2017 – 03/31/2018</u>
	<u>\$153,500</u>	<u>04/01/2018 – 03/31/2019</u>
<u>Oswego Hospital</u>	<u>\$136,000</u>	<u>08/01/2017 – 03/31/2018</u>
	<u>\$136,000</u>	<u>04/01/2018 – 03/31/2019</u>
<u>River Hospital</u>	<u>\$328,500</u>	<u>08/01/2017 – 03/31/2018</u>
	<u>\$328,500</u>	<u>04/01/2018 – 03/31/2019</u>
<u>Samaritan Medical Center</u>	<u>\$58,500</u>	<u>08/01/2017 – 03/31/2018</u>
	<u>\$58,500</u>	<u>04/01/2018 – 03/31/2019</u>
<u>Schuyler Hospital</u>	<u>\$240,000</u>	<u>08/01/2017 – 03/31/2018</u>
	<u>\$240,000</u>	<u>04/01/2018 – 03/31/2019</u>
<u>Soldiers and Sailors Memorial Hospital</u>	<u>\$192,000</u>	<u>08/01/2017 – 03/31/2018</u>
	<u>\$192,000</u>	<u>04/01/2018 – 03/31/2019</u>
<u>St. James Mercy Hospital</u>	<u>\$353,500</u>	<u>08/01/2017 – 03/31/2018</u>
	<u>\$353,500</u>	<u>04/01/2018 – 03/31/2019</u>
<u>St. Mary's Healthcare-St.Mary's Hospital</u>	<u>\$153,500</u>	<u>08/01/2017 – 03/31/2018</u>
	<u>\$153,500</u>	<u>04/01/2018 – 03/31/2019</u>
<u>TLC Health Network</u>	<u>\$353,500</u>	<u>08/01/2017 – 03/31/2018</u>
	<u>\$353,500</u>	<u>04/01/2018 – 03/31/2019</u>
<u>Tri Town Regional Hospital</u>	<u>\$58,500</u>	<u>08/01/2017 – 03/31/2018</u>
	<u>\$58,500</u>	<u>04/01/2018 – 03/31/2019</u>
<u>United Memorial Medical Center – North Street Division</u>	<u>\$103,500</u>	<u>08/01/2017 – 03/31/2018</u>
	<u>\$103,500</u>	<u>04/01/2018 – 03/31/2019</u>

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New York  
136(d.4)

**Essential Community Providers (cont'd):**

<b>Provider Name</b>	<b>Gross Medicaid Rate Adjustment</b>	<b>Rate Period Effective</b>
<u>Westfield Memorial Hospital</u>	<u>\$353,500</u>	<u>08/01/2017 – 03/31/2018</u>
	<u>\$353,500</u>	<u>04/01/2018 – 03/31/2019</u>
<u>Wyoming County Community Hospital</u>	<u>\$208,000</u>	<u>08/01/2017 – 03/31/2018</u>
	<u>\$208,000</u>	<u>04/01/2018 – 03/31/2019</u>
<u>WCA Hospital</u>	<u>\$228,500</u>	<u>08/01/2017 – 03/31/2018</u>
	<u>\$228,500</u>	<u>04/01/2018 – 03/31/2019</u>

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**Appendix II**  
**2017 Title XIX State Plan**  
**Third Quarter Amendment**  
**Summary**

**SUMMARY**  
**SPA #17-0062**

This State Plan Amendment proposes to modify the listing of hospitals previously approved to receive temporary rate adjustments under the closure, merger, consolidation, acquisition, or restructuring of a health care provider. The additional adjustments for providers for which approval is being requested are listed below:

A.O Fox Memorial Hospital, Adirondack Medical Center, Alice Hyde Hospital Association, Auburn Memorial Hospital, Bassett Hospital of Schoharie County- Cobleskill Reg, Brooks Memorial Hospital, Canton-Potsdam Hospital, Carthage Area Hospital, Catskill Regional Hospital – Sullivan, Catskill Regional Medical Center-Hermann Div, Cayuga Medical Center-Ithaca, Champlain Valley Physicians HMC, Chenango Memorial Hospital, Claxton Hepburn Hospital, Clifton-Fine Hospital, Columbia Memorial Hospital, Community Memorial Hospital, Corning Hospital, Cortland Memorial Hospital, Cuba Memorial Hospital, Delaware Valley Hospital, Elizabethtown Community Hospital, Ellenville Community Hospital, Gouverneur Hospital, Ira Davenport Memorial Hospital, Jones Memorial Hospital, Lewis County General Hospital, Little Falls Hospital, Margaretville Memorial Hospital, Mary Imogene Bassett Hospital, Massena Memorial Hospital, Medina Memorial Hospital, Moses-Ludington Hospital, Nathan Littauer Hospital, Northern Dutchess Hospital, Noyes Memorial Hospital, O'Connor Hospital, Olean General Hospital – Main, Oneida City Hospital, Oswego Hospital, River Hospital, Samaritan Medical Center, Schuyler Hospital, Soldiers and Sailors Memorial Hospital, St. James Mercy Hospital, TLC Health Network, Tri Town Regional, Westfield Memorial Hospital, Wyoming County Community Hospital, WCA Hospital, United Memorial Medical Center, St. Mary's Healthcare.

**Appendix III**  
**2017 Title XIX State Plan**  
**Third Quarter Amendment**  
**Authorizing Provisions**

SPA 17-0062

Public Health Law

§ 2826. Temporary adjustment to reimbursement rates. (a) Notwithstanding any provision of law to the contrary, within funds appropriated and subject to the availability of federal financial participation, the commissioner may grant approval of a temporary adjustment to the non-capital components of rates, or make temporary lump-sum Medicaid payments, to eligible general hospitals, skilled nursing facilities, clinics and home care providers, provided however, that should federal financial participation not be available for any eligible provider, then payments pursuant to this subdivision may be made as grants and shall not be deemed to be medical assistance payments.

(b) Eligible providers shall include:

- (i) providers undergoing closure;
- (ii) providers impacted by the closure of other health care providers;
- (iii) providers subject to mergers, acquisitions, consolidations or restructuring; or
- (iv) providers impacted by the merger, acquisition, consolidation or restructuring of other health care providers.

(c) Providers seeking temporary rate adjustments under this section shall demonstrate through submission of a written proposal to the commissioner that the additional resources provided by a temporary rate adjustment will achieve one or more of the following:

- (i) protect or enhance access to care;
- (ii) protect or enhance quality of care;
- (iii) improve the cost effectiveness of the delivery of health care services; or
- (iv) otherwise protect or enhance the health care delivery system, as determined by the commissioner.

(c-1) The commissioner, under applications submitted to the department pursuant to subdivision (d) of this section, shall consider criteria that includes, but is not limited to:

- (i) Such applicant's financial condition as evidenced by operating margins, negative fund balance or negative equity position;
- (ii) The extent to which such applicant fulfills or will fulfill an unmet health care need for acute inpatient, outpatient, primary or residential health care services in a community;
- (iii) The extent to which such application will involve savings to the Medicaid program;
- (iv) The quality of the application as evidenced by such application's long term solutions for such applicant to achieve sustainable health care services, improving the quality of patient care, and/or transforming the delivery of health care services to meet community needs;
- (v) The extent to which such applicant is geographically isolated in relation to other providers; or
- (vi) The extent to which such applicant provides services to an underserved area in relation to other providers.

(d) (i) Such written proposal shall be submitted to the commissioner at least sixty days prior to the requested effective date of the temporary rate adjustment, and shall include a proposed budget to achieve the goals of the proposal. Any Medicaid payment issued pursuant to this section shall be in effect for a specified period of time as determined by the commissioner, of up to three years. At the end of the

specified timeframe such payments or adjustments to the non-capital component of rates shall cease, and the provider shall be reimbursed in accordance with the otherwise applicable rate-setting methodology as set forth in applicable statutes and regulations. The commissioner may establish, as a condition of receiving such temporary rate adjustments or grants, benchmarks and goals to be achieved in conformity with the provider's written proposal as approved by the commissioner and may also require that the facility submit such periodic reports concerning the achievement of such benchmarks and goals as the commissioner deems necessary. Failure to achieve satisfactory progress, as determined by the commissioner, in accomplishing such benchmarks and goals shall be a basis for ending the facility's temporary rate adjustment or grant prior to the end of the specified timeframe. (ii) The commissioner may require that applications submitted pursuant to this section be submitted in response to and in accordance with a Request For Applications or a Request For Proposals issued by the commissioner.

(e) Notwithstanding any law to the contrary, general hospitals defined as critical access hospitals pursuant to title XVIII of the federal social security act shall be allocated no less than seven million five hundred thousand dollars annually pursuant to this section. The department of health shall provide a report to the governor and legislature no later than June first, two thousand fifteen providing recommendations on how to ensure the financial stability of, and preserve patient access to, critical access hospitals, including an examination of permanent Medicaid rate methodology changes.

(e-1) Thirty days prior to executing an allocation or modification to an allocation made pursuant to this section, the commissioner shall provide written notice to the chair of the senate finance committee and the chair of the assembly ways and means committee with regards to the intent to distribute such funds. Such notice shall include, but not be limited to, information on the methodology used to distribute the funds, the facility specific allocations of the funds, any facility specific project descriptions or requirements for receiving such funds, the multi-year impacts of these allocations, and the availability of federal matching funds. The commissioner shall provide quarterly reports to the chair of the senate finance committee and the chair of the assembly ways and means committee on the distribution and disbursement of such funds. Within sixty days of the effectiveness of this subdivision, the commissioner shall provide a written report to the chair of the senate finance committee and the chair of the assembly ways and means committee on all awards made pursuant to this section prior to the effectiveness of this subdivision, including all information that is required to be included in the notice requirements of this subdivision.

(f) Notwithstanding any provision of law to the contrary, and subject to federal financial participation, no less than ten million dollars shall be allocated to providers described in this subdivision; provided, however that if federal financial participation is unavailable for any eligible provider, or for any potential investment under this subdivision then the non-federal share of payments pursuant to this subdivision may be made as state grants.

(i) Providers serving rural areas as such term is defined in section two thousand nine hundred fifty-one of this chapter, including but not limited to hospitals, residential health care facilities, diagnostic and treatment centers, ambulatory surgery centers and clinics shall be eligible for enhanced payments or reimbursement under a supplemental rate methodology for the purpose of promoting access and improving the quality of care.

(ii) Notwithstanding any provision of law to the contrary, and subject to federal financial participation, essential community providers, which, for the purposes of this section, shall mean a provider that offers health services within a defined and isolated geographic region where such services would otherwise be unavailable to the population of such region, shall be eligible for enhanced payments or reimbursement under a supplemental rate methodology for the purpose of promoting access and improving quality of care. Eligible providers under this paragraph may include, but are not limited to, hospitals, residential health care facilities, diagnostic and treatment centers, ambulatory surgery centers and clinics.

(iii) In making such payments the commissioner may contemplate the extent to which any such provider receives assistance under subdivision (a) of this section and may require such provider to submit a written proposal demonstrating that the need for monies under this subdivision exceeds monies otherwise distributed pursuant to this section.

(iv) Payments under this subdivision may include, but not be limited to, temporary rate adjustments, lump sum Medicaid payments, supplemental rate methodologies and any other payments as determined by the commissioner.

(v) Payments under this subdivision shall be subject to approval by the director of the budget.

(vi) The commissioner may promulgate regulations to effectuate the provisions of this subdivision.

(vii) Thirty days prior to adopting or applying a methodology or procedure for making an allocation or modification to an allocation made pursuant to this subdivision, the commissioner shall provide written notice to the chairs of the senate finance committee, the assembly ways and means committee, and the senate and assembly health committees with regard to the intent to adopt or apply the methodology or procedure, including a detailed explanation of the methodology or procedure.

(viii) Thirty days prior to executing an allocation or modification to an allocation made pursuant to this subdivision, the commissioner shall provide written notice to the chairs of the senate finance committee, the assembly ways and means committee, and the senate and assembly health committees with regard to the intent to distribute such funds. Such notice shall include, but not be limited to, information on the methodology used to distribute the funds, the facility specific allocations of the funds, any facility specific project descriptions or requirements for receiving such funds, the multi-year impacts of these allocations, and the availability of federal matching funds. The commissioner shall provide quarterly reports to the chair of the senate finance committee and the chair of the assembly ways and means committee on the distribution and disbursement of such funds.

(g) Notwithstanding subdivision (a) of this section, and within amounts appropriated for such purposes as described herein, for the period of April first, two thousand fifteen through March thirty-first, two thousand sixteen, the commissioner may award a temporary adjustment to the non-capital components of rates, or make temporary lump-sum Medicaid payments to eligible general hospitals in severe financial distress to enable such facilities to maintain operations and vital services while such facilities establish long term solutions to achieve sustainable health services.

(i) Eligible general hospitals shall include:

(A) a public hospital, which for purposes of this subdivision, shall mean a general hospital operated by a county or municipality, but shall exclude any such hospital operated by a public benefit corporation;

(B) a federally designated critical access hospital;  
(C) a federally designated sole community hospital; or  
(D) a general hospital that is a safety net hospital, which for purposes of this subdivision shall mean:

(1) such hospital has at least thirty percent of its inpatient discharges made up of Medicaid eligible individuals, uninsured individuals or Medicaid dually eligible individuals and with at least thirty-five percent of its outpatient visits made up of Medicaid eligible individuals, uninsured individuals or Medicaid dually-eligible individuals; or

(2) such hospital serves at least thirty percent of the residents of a county or a multi-county area who are Medicaid eligible individuals, uninsured individuals or Medicaid dually-eligible individuals.

(ii) Eligible applicants must demonstrate that without such award, they will be in severe financial distress through March thirty-first, two thousand sixteen, as evidenced by:

(A) certification that such applicant has less than fifteen days cash and equivalents;

(B) such applicant has no assets that can be monetized other than those vital to operations; and

(C) such applicant has exhausted all efforts to obtain resources from corporate parents and affiliated entities to sustain operations.

(iii) Awards under this subdivision shall be made upon application to the department.

(A) Applications under this subdivision shall include a multi-year transformation plan that is aligned with the delivery system reform incentive payment ("DSRIP") program goals and objectives. Such plan shall be approved by the department and shall demonstrate a path towards long term sustainability and improved patient care.

(B) The department may authorize initial award payments to eligible applicants based solely on the criteria pursuant to paragraphs (i) and (ii) of this subdivision.

(C) Notwithstanding subparagraph (B) of this paragraph, the department may suspend or repeal an award if an eligible applicant fails to submit a multi-year transformation plan pursuant to subparagraph (A) of this paragraph that is acceptable to the department by no later than the thirtieth day of September two thousand fifteen.

(D) Applicants under this subdivision shall detail the extent to which the affected community has been engaged and consulted on potential projects of such application, as well as any outreach to stakeholders and health plans.

(E) The department shall review all applications under this subdivision, and determine:

(1) applicant eligibility;

(2) each applicant's projected financial status;

(3) each applicant's proposed use of funds to maintain critical services needed by its community; and

(4) the anticipated impact of the loss of such services.

(F) After review of all applications under this subdivision, and a determination of the aggregate amount of requested funds, the department shall make awards to eligible applicants; provided, however, that such awards may be in an amount lower than such requested funding, on a per applicant or aggregate basis.

(iv) Awards under this subdivision may not be used for:

(A) capital expenditures, including, but not limited to: construction, renovation and acquisition of capital equipment, including major medical equipment;

- (B) consultant fees;
- (C) retirement of long term debt; or
- (D) bankruptcy-related costs.

(v) Payments made to awardees pursuant to this subdivision shall be made on a monthly basis. Such payments will be based on the applicant's actual monthly financial performance during such period and the reasonable cash amount necessary to sustain operations for the following month. The applicant's monthly financial performance shall be measured by such applicant's monthly financial and activity reports, which shall include, but not be limited to, actual revenue and expenses for the prior month, projected cash need for the current month, and projected cash need for the following month.

(vi) The department shall provide a report on a quarterly basis to the chairs of the senate finance, assembly ways and means, senate health and assembly health committees. Such reports shall be submitted no later than sixty days after the close of the quarter, and shall include for each award, the name of the applicant, the amount of the award, payments to date, and a description of the status of the multi-year transformation plan pursuant to paragraph (iii) of this subdivision.



**Appendix IV**  
**2017 Title XIX State Plan**  
**Third Quarter Amendment**  
**Public Notice**

3220 Northern Boulevard  
Long Island City, New York 11101

Kings County, Fulton Center  
114 Willoughby Street  
Brooklyn, New York 11201

Bronx County, Tremont Center  
1916 Monterey Avenue  
Bronx, New York 10457

Richmond County, Richmond Center  
95 Central Avenue, St. George  
Staten Island, New York 10301

*For further information and to review and comment, please contact:*  
Department of Health, Bureau of Federal Relations & Provider Assessments, 99 Washington Ave., One Commerce Plaza, Suite 1460, Albany, NY 12210, spa\_inquiries@health.ny.gov

**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 institutional temporary rate adjustments to providers that are undergoing a closure, merger, consolidation, acquisition or restructuring themselves or other health care providers. These payments are authorized by § 2826 of the New York Public Health Law.

This notice provides for a temporary rate adjustment with an aggregate payment amounts totaling up to \$10,001,000 annually, for the period April 1, 2017 through March 31, 2019. These payments will be made to the following approved providers: A.O Fox Memorial Hospital, Adirondack Medical Center, Alice Hyde Hospital Association, Auburn Memorial Hospital, Bassett Hospital of Schoharie County- Cobleskill Reg, Brooks Memorial Hospital, Canton-Potsdam Hospital, Carthage Area Hospital, Catskill Regional Hospital – Sullivan, Catskill Regional Medical Center-Hermann Div, Cayuga Medical Center-Ithaca, Champlain Valley Physicians HMC, Chenango Memorial Hospital, Claxton Hepburn Hospital, Clifton-Fine Hospital, Columbia Memorial Hospital, Community Memorial Hospital, Corning Hospital, Cortland Memorial Hospital, Cuba Memorial Hospital, Delaware Valley Hospital, Elizabethtown Community Hospital, Ellenville Community Hospital, Gouverneur Hospital, Ira Davenport Memorial Hospital, Jones Memorial Hospital, Lewis County General Hospital, Little Falls Hospital, Margaretville Memorial Hospital, Mary Imogene Bassett Hospital, Massena Memorial Hospital, Medina Memorial Hospital, Moses-Ludington Hospital, Nathan Littauer Hospital, Northern Dutchess Hospital, Noyes Memorial Hospital, O’Connor Hospital, Olean General Hospital – Main, Oneida City Hospital, Oswego Hospital, River Hospital, Samaritan Medical Center, Schuylers Hospital, Soldiers and Sailors Memorial Hospital, St. James Mercy Hospital, TLC Health Network, Tri Town Regional, Westfield Memorial Hospital, Wyoming County Community Hospital, WCA Hospital, United Memorial Medical Center, St. Mary’s Healthcare.

The public is invited to review and comment on this proposed State Plan Amendment. Copies of which will be available for public review on the Department’s website at [http://www.health.ny.gov/regulations/state\\_plans/status](http://www.health.ny.gov/regulations/state_plans/status).

Copies of the proposed State Plan Amendments will be on file in each local (county) social services district and available for public review.

For the New York City district, copies will be available at the following places:

New York County  
250 Church Street  
New York, New York 10018

Queens County, Queens Center  
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Long Island City, New York 11101

Kings County, Fulton Center  
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Brooklyn, New York 11201

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Staten Island, New York 10301

*For further information and to review and comment, please contact:*  
Department of Health, Division of Finance and Rate Setting, 99 Washington Ave., One Commerce Plaza, Suite 1460, Albany, NY 12210, spa\_inquiries@health.ny.gov

**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 non-institutional services. The following changes are proposed:

The following is a clarification to the June 14, 2017 noticed provision which proposed to reduce the per member per month (pmpm) “outreach” payment for members in the case finding group that have been assigned to a Health Home. This notice clarifies that the proposed State Plan Amendment will also simplify and modify the Health Home services per member per month care management fee to be based on region and case mix that will be defined by type of population served.

The public is invited to review and comment on this proposed State Plan Amendment, a copy of which will be available for public review on the Department’s website at [http://www.health.ny.gov/regulations/state\\_plans/status](http://www.health.ny.gov/regulations/state_plans/status).

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Department of Health, Division of Finance and Rate Setting, 99  
Washington Ave., One Commerce Plaza, Suite 1460, Albany, NY  
12210, spa\_inquiries@health.ny.gov

## 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 institutional services to comply with enacted State Fiscal Year 2017/18 Budget statutory provisions included in Public Health Law § 2826. The following provides a clarification to provisions previously noticed on July 26, 2017:

This notice provides for a temporary rate adjustment with an aggregate payment totaling no less than \$7.5 million annually for Critical Access Hospitals (CAHs), for the period April 1, 2017 through March 31, 2019. These payments will be made to the following: Carthage Area Hospital, Catskill Regional Medical Center-Hermann, Clifton-Fine Hospital, Community Memorial Hospital, Cuba Memorial Hospital, Delaware Valley Hospital, Elizabethtown Community Hospital, Ellenville Regional Hospital, Gouverneur Hospital, Lewis County General Hospital, Little Falls Hospital, Margaretville Hospital, Moses Ludington Hospital, O'Connor Hospital, River Hospital, Schuyler Hospital, Soldiers and Sailors Memorial Hospital of Yates, Co as well as Medina Memorial Hospital.

The public is invited to review and comment on this proposed State Plan Amendment. Copies of which will be available for public review on the Department's website at [http://www.health.ny.gov/regulations/state\\_plans/status](http://www.health.ny.gov/regulations/state_plans/status).

Copies of the proposed State Plan Amendments will be on file in each local (county) social services district and available for public review.

For the New York City district, copies will be available at the following places:

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Department of Health, Bureau of Federal Relations & Provider Assessments, 99 Washington Ave., One Commerce Plaza, Suite 1460, Albany, NY 12210, spa\_inquiries@health.ny.gov

## 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 institutional temporary rate adjustments to providers that are undergoing a closure, merger, consolidation, acquisition or restructuring themselves or other health care providers. These payments are authorized by § 2826 of the New York Public Health Law. The following provides a clarification to provisions previously noticed on July 26, 2017:

This notice provides for a temporary rate adjustment with an aggregate payment amounts totaling no less than \$10,001,000 annually, for the period April 1, 2017 through March 31, 2019. These payments will be made to the following approved providers: A.O Fox Memorial Hospital, Adirondack Medical Center, Alice Hyde Hospital Association, Auburn Memorial Hospital, Bassett Hospital of Schoharie County- Cobleskill Reg, Brooks Memorial Hospital, Canton-Potsdam Hospital, Carthage Area Hospital, Catskill Regional Hospital – Sullivan, Catskill Regional Medical Center-Hermann Div, Cayuga Medical Center-Ithaca, Champlain Valley Physicians HMC, Chenango Memorial Hospital, Claxton Hepburn Hospital, Clifton-Fine Hospital, Columbia Memorial Hospital, Community Memorial Hospital, Corning Hospital, Cortland Memorial Hospital, Cuba Memorial Hospital, Delaware Valley Hospital, Elizabethtown Community Hospital, Ellenville Community Hospital, Gouverneur Hospital, Ira Davenport Memorial Hospital, Jones Memorial Hospital, Lewis County General Hospital, Little Falls Hospital, Margaretville Memorial Hospital, Mary Imogene Bassett Hospital, Massena Memorial Hospital, Medina Memorial Hospital, Moses-Ludington Hospital, Nathan Littauer Hospital, Northern Dutchess Hospital, Noyes Memorial Hospital, O'Connor Hospital, Olean General Hospital – Main, Oneida City Hospital, Oswego Hospital, River Hospital, Samaritan Medical Center, Schuyler Hospital, Soldiers and Sailors Memorial Hospital, St. James Mercy Hospital, TLC Health Network, Tri Town Regional, Westfield Memorial Hospital, Wyoming County Community Hospital, WCA Hospital, United Memorial Medical Center, St. Mary's Healthcare.

The public is invited to review and comment on this proposed State Plan Amendment. Copies of which will be available for public review on the Department's website at [http://www.health.ny.gov/regulations/state\\_plans/status](http://www.health.ny.gov/regulations/state_plans/status).

Copies of the proposed State Plan Amendments will be on file in each local (county) social services district and available for public review.

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12210. [spa\\_inquiries@health.ny.gov](mailto:spa_inquiries@health.ny.gov)

**Appendix V**  
**2017 Title XIX State Plan**  
**Third Quarter Amendment**  
**Responses to Standard Funding Questions**

**APPENDIX V  
HOSPITAL SERVICES  
State Plan Amendment #17-0062**

**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 the 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 2 CFR 200 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 Medicaid General Fund Local Assistance Account, which is part of the Global Cap. The Global Cap is funded by General Fund and HCRA resources. There have been no new provider taxes and no existing taxes have been modified as a result of this State Plan Amendment.

**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 add-on services payments made to those providers listed who will receive temporary rate adjustments to be paid quarterly during each period in equal installments.

**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 447.272, 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:** The 2016 Inpatient UPL has been completed. The State and CMS are having ongoing discussions regarding the inpatient UPL demonstration for 2017.

**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 prospective payment. We are unaware of any requirement under current federal law or regulation that limits individual provider payments to their actual costs.

#### **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 FMAs 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 State 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.