NEW YORK
state department of
HEALTH

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

Sue Kelly
Executive Deputy Commissioner

March 31, 2014

Mr. Michael Melendez
Associate Regional Administrator
Department of Health & Human Services
Centers for Medicare & Medicaid Services
New York Regional Office
Division of Medicaid and Children's Health Operations
26 Federal Plaza - Room 37-100 North
New York, New York 10278

RE: SPA #13-56

Dear Mr. Melendez:

The State requests approval of the enclosed amendment #13-56 to the Title XIX (Medicaid) State Plan effective January 1, 2014 (Appendix I).

The plan amendment along with appropriate attachments and the CMS-179 form is enclosed and is being submitted as requested by CMS.

If you or your staff have any questions or need any assistance, please contact Karla Knuth of my staff at (518) 474-1673.

Sincerely,

Jason A. Helgerson
Medicaid Director
Office of Health Insurance Programs

Enclosures

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: **13-56**	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 **January 1, 2014**	

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: **42 CFR 431.10; 431.11; 431.12; 431.50**	7. FEDERAL BUDGET IMPACT: **a. FFY 01/01/14-09/30/14 $ 0** **b. FFY 10/01/14-09/30/15 $ 0**
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: **MAGI SPA: PDFs A1, A2, A3** **Attachment 1.1: Page 9**	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: **Attachment 1.1: Pages 1-9; Attachment 1.1-B: Pages 1-2; Attachment 1.2-A: Pages 1-16; Attachment 1.2-B: Pages 1-6; Attachment 1.2-C: Page 1; Attachment 1.2-D: Pages 1-7**

10. SUBJECT OF AMENDMENT:
Single State Agency

11. GOVERNOR'S REVIEW *(Check One)*:
☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:	16. RETURN TO: **New York State Department of Health** **Bureau of Federal Relations & Provider Assessments** **99 Washington Ave – One Commerce Plaza** **Suite 1430** **Albany, NY 12210**
13. TYPED NAME: **Jason A. Helgerson**	
14. TITLE: **Medicaid Director** **Department of Health**	
15. DATE SUBMITTED: March 31, 2014	

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
2014 Title XIX State Plan
First Quarter Amendment
Amended SPA Pages

Medicaid Administration

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

State Plan Administration Designation and Authority — A1

42 CFR 431.10

Designation and Authority

State Name: New York State

As a condition for receipt of Federal funds under title XIX of the Social Security Act, the single state agency named below submits the following state plan for the medical assistance program, and hereby agrees to administer the program in accordance with the provisions of this state plan, the requirements of titles XI and XIX of the Act, and all applicable Federal regulations and other official issuances of the Department.

Name of single state agency: Department of Health

Type of Agency:

- ○ Title IV-A Agency
- ◉ Health
- ○ Human Resources
- ○ Other

Type of Agency:

The above named agency is the single state agency designated to administer or supervise the administration of the Medicaid program under title XIX of the Social Security Act. (All references in this plan to "the Medicaid agency" mean the agency named as the single state agency.)

The state statutory citation for the legal authority under which the single state agency administers the state plan is:

NY Social Services 363-a, PHL 201

The single state agency supervises the administration of the state plan by local political subdivisions.

◉ Yes ○ No

The state statutory citation for the legal authority under which the agency supervises the administration of the plan on a statewide basis is:

NY Social Services 363-a, PHL 201, PHL 206

The state statutory citation under which the single state agency has legal authority to make rules and regulations that are binding on the political subdivisions administering the plan is:

NY Social Services 363-a

☑ The certification signed by the state Attorney General identifying the single state agency and citing the legal authority under which it administers or supervises administration of the program has been provided.

Medicaid Administration

An attachment is submitted.

The state plan may be administered solely by the single state agency, or some portions may be administered by other agencies.

The single state agency administers the entire state plan under title XIX (i.e., no other agency or organization administers any portion of it).

○ Yes ◉ No

☒ Waivers of the single state agency requirement have been granted under authority of the Intergovernmental Cooperation Act of 1968.

The waivers are still in effect.

◉ Yes ○ No

Enter the following information for each waiver:

Remove

Date waiver granted (MM/DD/YY):

The type of responsibility delegated is (check all that apply):

☐ Determining eligibility

☒ Conducting fair hearings

☐ Other

Name of state agency to which responsibility is delegated:

NYS Office of Temporary and Disability Assistance (OTDA).

Describe the organizational arrangement authorized, the nature and extent of responsibility for program administration delegated to the above named agency, and the resources and/or services of such agency to be utilized in administration of the plan:

Eligibility notices issued by the State Medicaid agency notify applicants/beneficiaries of fair hearing rights and how to obtain a fair hearing. Consistent with relevant federal and state law with respect thereto and as designated by the Department of Health (DOH), when fair hearings are requested, OTDA: provides such hearings for Medicaid applicants or beneficiaries with respect to their Medicaid eligibility and any adverse agency action with respect thereto; issues final administrative decisions on behalf of the DOH Commissioner; takes such steps as may be necessary to enforce DOH's final determinations and decisions.

The methods for coordinating responsibilities among the agencies involved in administration of the plan under the alternate organizational arrangement are as follows:

The Department of Health communicates Medicaid eligibility and policy directives to OTDA and trains OTDA personnel on such matters. DOH maintains policies and procedures reasonably necessary to monitor and evaluate the effectiveness and efficiency of the activities performed by OTDA with regard to conducting fair hearings.

Add

☐ The agency that administers or supervises the administration of the plan under Title X of the Act as of January 1, 1965, has been separately designated to administer or supervise the administration of that portion of this plan related to blind individuals.

Medicaid Administration

The entity or entities that have responsibility for determinations of eligibility for families, adults, and for individuals under 21 are:

- ☒ The Medicaid agency
- ☐ Single state agency under Title IV-A (in the 50 states or the District of Columbia) or under Title I or XVI (AABD) in Guam, Puerto Rico, or the Virgin Islands
- ☐ An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act

The entity that has responsibility for determinations of eligibility for the aged, blind, and disabled are:

- ☐ The Medicaid agency
- ☐ Single state agency under Title IV-A (in the 50 states or the District of Columbia) or under Title I or XVI (AABD) in Guam, Puerto Rico, or the Virgin Islands
- ☐ An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act
- ☒ The Federal agency administering the SSI program

  Indicate which agency determines eligibility for any groups whose eligibility is not determined by the Federal agency:

  - ☒ Medicaid agency
  - ☐ Title IV-A agency
  - ☐ An Exchange

The entity or entities that have responsibility for conducting fair hearings with respect to denials of eligibility based on the applicable modified adjusted gross income standard are:

- ☒ Medicaid agency
- ☐ An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act
- ☐ An Exchange appeals entity, including an entity established under section 1411(f) of the Affordable Care Act

The agency has established a review process whereby the agency reviews appeals decisions made by the Exchange or Exchange appeals entity or other state agency, but only with respect to conclusions of law, including interpretations of state or federal policies.

○ Yes ◉ No

State Plan Administration
Organization and Administration — A2

42 CFR 431.10
42 CFR 431.11

Organization and Administration

Provide a description of the organization and functions of the Medicaid agency.

OHIP and the Office of Health Benefit Exchange are two separate offices, out of a total of twelve offices under the authority of the Commissioner of the Department of Health. OHIP is responsible for administering New York's Medicaid program by collaborating with stakeholders across the health care industry including other state agencies, local and federal government agencies, providers, members, and community-based organizations to optimize the health of Medicaid members. The Fair hearing process for the MAGI population is within the Office of Health Benefit Exchange and a description of the process is attached.
OHIP encompasses eight distinct divisions.

Division of Finance and Rate Setting
This division is responsible for all functions within OHIP related to rate setting, including managed care rates.

Division of Program Development and Management
This division is responsible for all policy and strategic planning including waiver and State Plan Amendments, and policy related to medical, dental, pharmacy (including EPIC), behavioral health and transportation management.

Division of Health Plan Contracting & Oversight
This division is responsible for managed care organization (MCO) contracting, oversight of health plan compliance with applicable federal and state regulations.

Division of Long Term Care
This division is responsible for the managed long term care program which includes oversight of the growth of the program as well as other care coordination models.

Division of OHIP Operations
This division is responsible for fee-for-service (FFS) program management and operations for medical and dental prior approval, pended claim reviews, utilization edit development, rate loading and payment file maintenance, provider enrollment and the electronic health records incentive program.

Division of Health Reform and Health Insurance Exchange Integration
The division is responsible for administering New York's Medicaid program by collaborating with stakeholders across the health care industry including other state agencies, local and federal government agencies, providers, members, and community-based organizations. The division interprets, develops and implements federal and state legislation. The division also establishes policies, guidelines and instructions by writing directives to local districts for all Medicaid populations including MAGI, Non-MAGI and persons who are aged, blind, or disabled. With division oversight, the local districts process applications and determine eligibility for non-MAGI, Presumptive eligibility for Pregnant Women and Children. Local districts also process renewals for the aforementioned populations, as well as, the MAGI population until the MAGI renewals are transitioned to the SBM. MAGI applications are processed by the New York State of Health with division guidance.

Division of OHIP Systems
This division is responsible for the oversight of the MMIS (eMedNY system) contract and the technical support of the development of the Health Exchange.

Division of Human Resources and Administration
This division interacts with OHIP management in planning, coordinating, developing and implementing all activities related to OHIP human resources

Upload an organizational chart of the Medicaid agency.

An attachment is submitted.

Provide a description of the structure of the state's executive branch which includes how the Medicaid agency fits in with other health, human service and public assistance agencies.

The Executive Branch of New York State is headed by the Governor. The Executive Branch is the part of the government that has the sole authority and responsibility for the daily administration of the State's business. New York State's governmental activities are carried out by several departments within the Executive Branch. The New York Department of Health is one of these agencies. The Department of Health coordinates policy and activities specifically to protect, improve and promote the health, productivity and well being of all New Yorkers. The Department of Health is responsible for the Medicaid program and allows the Office of Mental

Medicaid Administration

Health and Office of People with Developmental Disabilities to determine Medicaid eligibility in certain specific facility settings under their respective offices. The New York State of Health is a separate and distinct office within the Department of Health.

Entities that determine eligibility other than the Medicaid Agency (if entities are described under Designation and Authority)

Remove

Type of entity that determines eligibility:

- ○ Single state agency under Title IV-A (in the 50 states or the District of Columbia) or under Title I or XVI (AABD) in Guam, Puerto Rico, or the Virgin Islands
- ○ An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act
- ◉ The Federal agency administering the SSI program

Provide a description of the staff designated by the entity and the functions they perform in carrying out their responsibility.

Pursuant to a 1634 agreement, the Social Security Administration determines Medicaid eligibility for Supplemental Security Income recipients.

Add

Entities that conduct fair hearings other than the Medicaid Agency (if are described under Designation and Authority)

Remove

Type of entity that conducts fair hearings:

- ○ An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act
- ○ An Exchange appeals entity, including an entity established under section 1411(f) of the Affordable Care Act

Provide a description of the staff designated by the entity and the functions they perform in carrying out their responsibility.

Add

Supervision of state plan administration by local political subdivisions (if described under Designation and Authority)

Is the supervision of the administration done through a state-wide agency which uses local political subdivisions?

○ Yes ◉ No

The types of the local subdivisions that administer the state plan under the supervision of the Medicaid agency are:

- ◉ Counties
- ○ Parishes
- ○ Other

Are all of the local subdivisions indicated above used to administer the state plan?

◉ Yes ○ No

Indicate the number used to administer the state plan: 58

Medicaid Administration

Description of the staff and functions of the local subdivisions:

Local Department of Social Services employees are civil servants qualified to be appointed to various positions. They receive and process Medicaid applications pursuant to New York State laws and regulations. They determine financial eligibility, categorical classification, continued financial eligibility, and income maintenance review for the Aged, Blind, Disabled, Presumptive eligibility for Pregnant Women, Children and non-MAGI categories, as well as, renewal determinations of MAGI categories until such time as the categories can be transitioned to the Health Benefit Exchange.

State Plan Administration Assurances — A3

42 CFR 431.10
42 CFR 431.12
42 CFR 431.50

Assurances

☑ The state plan is in operation on a statewide basis, in accordance with all the requirements of 42 CFR 431.50.

☑ All requirements of 42 CFR 431.10 are met.

☑ There is a Medical Care Advisory Committee to the agency director on health and medical services established in accordance with meeting all the requirements of 42 CFR 431.12.

☑ The Medicaid agency does not delegate, to other than its own officials, the authority to supervise the plan or to develop or issue policies, rules, and regulations on program matters.

Assurance for states that have delegated authority to determine eligibility:

☑ There is a written agreement between the Medicaid agency and the Exchange or any other state or local agency that has been delegated authority to determine eligibility for Medicaid eligibility in compliance with 42 CFR 431.10(d).

Assurances for states that have delegated authority to conduct fair hearings:

☐ There is a written agreement between the Medicaid agency and the Exchange or Exchange appeals entity that has been delegated authority to conduct Medicaid fair hearings in compliance with 42 CFR 431.10(d).

☐ When authority is delegated to the Exchange or an Exchange appeals entity, individuals who have requested a fair hearing are given the option to have their fair hearing conducted instead by the Medicaid agency.

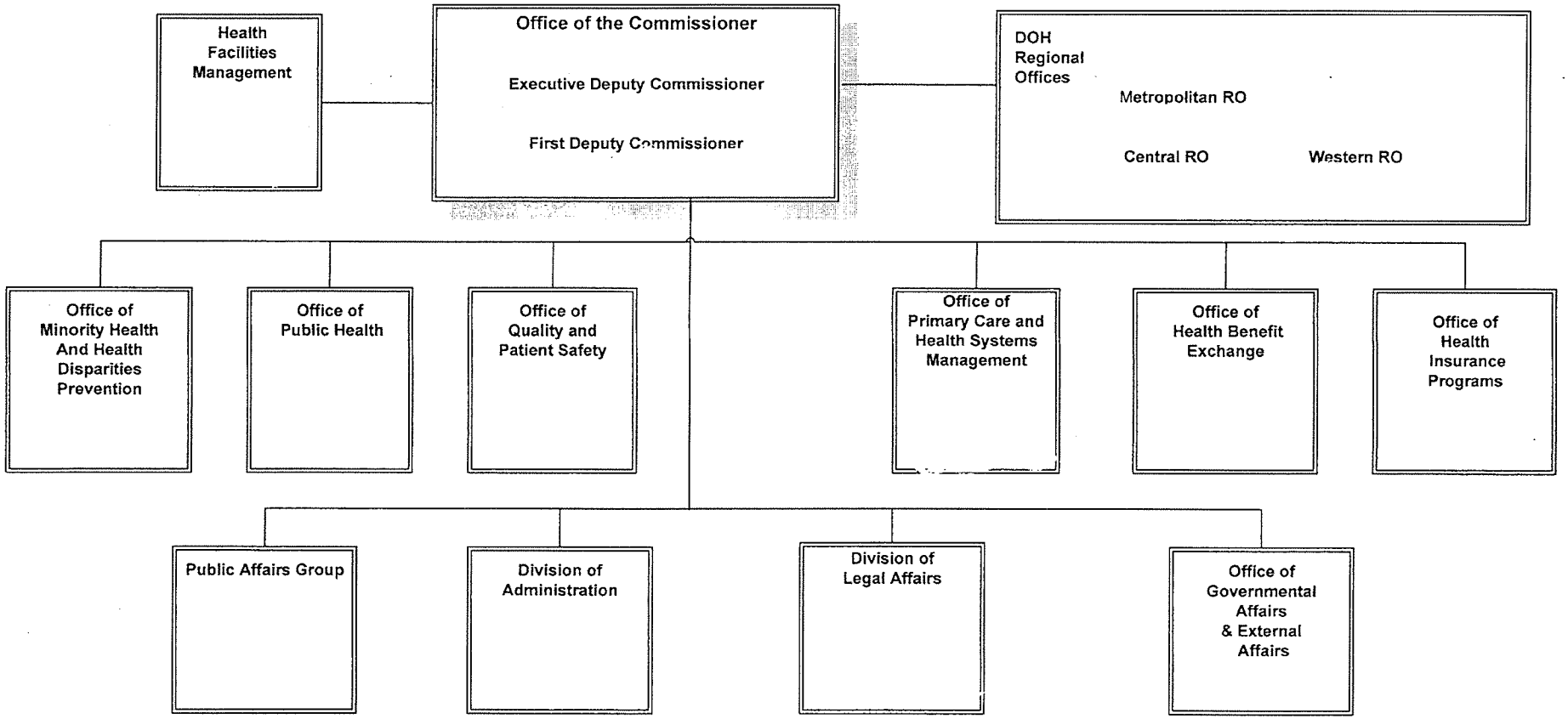
Assurance for states that have delegated authority to determine eligibility and/or to conduct fair hearings:

☑ The Medicaid agency does not delegate authority to make eligibility determinations or to conduct fair hearings to entities other than government agencies which maintain personnel standards on a merit basis.

PRA Disclosure Statement

NEW YORK
state department of
HEALTH

October 2013



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[STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT MEDICAL ASSISTANCE PROGRAM]

[Citation
45 CFR
Part 201
AT-76-141

As a condition for receipt of Federal funds under title XIX of the Social Security Act, the

New York State Department of Health
(single state agency)

submits the following State plan for the medical assistance program , and hereby agrees to administer the program in accordance with the provisions of this State plan, the requirements of titles XI and XIX of the Act, and all applicable Federal regulations and other official issuances of the Department.]

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[SECTION 1 SINGLE STATE AGENCY ORGANIZATION

Citation
42 CFR 431.10
AT-79-29

1.1 Designation and Authority

(a) The New York State Department of Health is the single State agency designated to administer or supervise the administration of the Medicaid program under title XIX of the Social Security Act. (All references in this plan to "the Medicaid agency" mean the agency named in this paragraph.)

ATTACHMENT 1.1-A is a certification signed by the State Attorney General identifying the single State agency and citing the legal authority under which it administers or supervises administration of the program.]

NOTE: The information on this page has been replaced by PDF Forms A1, A2 & A3 effective January 1, 2014.

[**Citation**
Section 1902(a)
of the Act

1.1(b) The State agency that administered or supervised the administration of the plan approved under Title X of the Act as of January 1, 1965, has been separately designated to administer or supervise the administration of that part of this plan which relates to blind individuals.

[X] Yes. The State Agency so Designated is:
Commission for the Blind and
Visually Handicapped.

This agency has a separate plan covering that portion of the State Plan under Title XIX for which it is responsible.

[ ] Not applicable. The entire plan under Title XIX is administered or supervised by State agency named in paragraph 1.1(a).]

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[**Citation**
Intergovernmental
Cooperation Act
Of 1968

1.1(c) Waivers of the single State agency requirement which are currently operative have been granted under authority of the Intergovernmental Cooperation Act of 1968.

[X] Yes. ATTACHMENT 1.1-B describes these waivers and the approved alternative organizational arrangements.

[ ] Not applicable. Waivers are no longer in effect.

[ ] Not applicable. No waivers have ever been granted.]

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[**Citation**
42 CFR 431.10
AT-79-29

[X] The agency named in paragraph 1.1(a) has responsibility for all determinations of eligibility for Medicaid under this Plan.

[ ] Determinations of eligibility for Medicaid under this plan are made by the agency(ies) specified in Attachment 2.2-A. There is a written agreement between the agency named in paragraph 1.1(a) and other agency(ies) making such determinations for specific groups covered under this plan. The agreement defines the relationships and respective responsibilities of the agencies.]

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[**Citation**
42 CFR 431.10
AT-79-29

1.1(e) All other provisions of this plan are administered by the Medicaid agency except for those functions for which final authority has been granted to a Professional Standards Review Organization under title XI of the Act.

(f) All other requirements of 42 CFR 431.10 are met.]

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[**Citation**
42 CFR 431.11
AT-79-29

1.2 Organization for Administration

(a) Attachment 1.2-A contains a description of the organization and functions of the Medicaid agency and an organization chart of the agency.

(b) Within the State agency, the Office of Medicaid Management has been designated As the medical assistance unit. Attachment 1.2-B contains a description of the organization and functions of the medical assistance unit and an organizational chart of the unit.

(c) Attachment 1.2-C contains a description of the kinds and numbers of professional medical personnel and supporting staff used in the administration of the plan and their responsibilities.

(d) Eligibility determinations are made by the State or local staff of an agency other than the agency named in paragraph 1.1(a). Attachment 1.2-D contains a description of the staff designated to make such determinations and the functions they will perform.

[x] Not applicable. Only staff of the agency named in paragraph 1.1(a) make such determinations.]

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[Citation	Condition or Requirement
Citation 42 CFR 431.50 (b) AT-79-29	**1.3 Statewide Operation** The plan is in operation on a Statewide basis in accordance with all requirements of 42 CFR 431.50. [x] The plan is State administered. [x] The plan is administered by the political subdivisions of the State and is mandatory on them.]

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

[1.4 State Medical Care Advisory Committee (42 CFR 431.12(b))
There is an advisory committee to the Medicaid agency director on health and medical care services established in accordance with and meeting all the requirements of 42 CFR 431.12.]

Tribal Consultation Requirements
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 (IHS), 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.

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. Please include information about the frequency, inclusiveness and process for seeking such advice.

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.

Tribal Consultation Process
For changes to the State's Medicaid Plan (Plan) that require a State Plan Amendment (SPA), Indian nation leaders and health clinic administrators and Urban Indian Organization leaders and health department administrators will be sent a copy of the Federal Public Notice related to a particular SPA, along with a cover letter offering the availability of State staff to meet with respective Indian leaders in person upon requests made within two weeks of the date of notification. At least two weeks' prior to submitting a SPA to CMS for approval, a draft copy of the proposed amendment will be forwarded to the above Indian representatives, allowing for a two-week comment period. Indian health clinic administrators will be notified via e-mail, and all other Indian representatives will be notified via U.S. Postal Service.

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[STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT MEDICAL ASSISTANCE PROGRAM]

[State of New York]

[WAIVER(S) OF THE SINGLE STATE AGENCY REQUIREMENT GRANTED UNDER THE INTERGOVERNMENTAL COOPERATION ACT OF 1968]

[_____

Waiver #1, *
Limited

a. Waiver was granted on May 11, 1969
(date)

b. The organizational arrangement authorized, the nature and extent of responsibility for program administration delegated to Department of Mental Hygiene, and
(name of agency)
the resources and/or services of such agency to be utilized in administration of the plan are described below:

Permits State funds to be appropriated directly to the Department of Mental Hygiene for medical assistance under Title XIX for patients in State mental hospitals and schools for the mentally retarded.

Waiver #2: Granted 7/24/70 Department of Mental Hygiene and Narcotics Addiction Control Commission

Limited waiver permits State funds to be appropriated directly to the Department of Mental Hygiene and Narcotics Addiction Control Commission for Intermediate Care Facilities services under Title XVI, (Now Title XIX)

Waiver #3: Granted 7/1/71 Department of Health

Limited waiver permits State funds to be appropriated directly to Department of Health for administering and supervising the medical aspects of Title XIX Program.

* 1 / ("...illegible text here..." have been granted is certified in ...."illegible text")]

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[c. The methods for coordinating responsibilities among the several agencies involved in administration of the plan under the alternate organizational arrangement are as follows:

Under Title II of the Social Services Law, the Department of Social Services has the responsibility of assuring the accuracy of the claims presented for the Federal reimbursement under Title XIX. as the Single State Agency it is responsible for auditing the Title XIX expenditures of the Departments of Health, Mental Hygiene, and the Narcotics Addiction Control Commission.

Under Section 1, Article V of the New York State Constitution and Section 6, Article 2 of the State Finance Law, the State Comptroller has audit responsibility for examination of expenditures, accounts, revenues, and receipts. He is responsible for all fiscal matters, including the accounting systems in State department and agencies. For this reason, the State Comptroller is responsible for conducting audits of Title XIX expenditures made by the Department of Mental Hygiene, Health and the Narcotics Addiction Control Commission, and for reviewing the methods of accounting used by these departments. Under U.S. Bureau of the Budget Circular A-87 we claim for the indirect costs of the services performed by the Department of Audit and Control on behalf of our Federal programs. These indirect costs include the Comptroller's audit functions on behalf of our Title XIX Medicaid Program.]

New York
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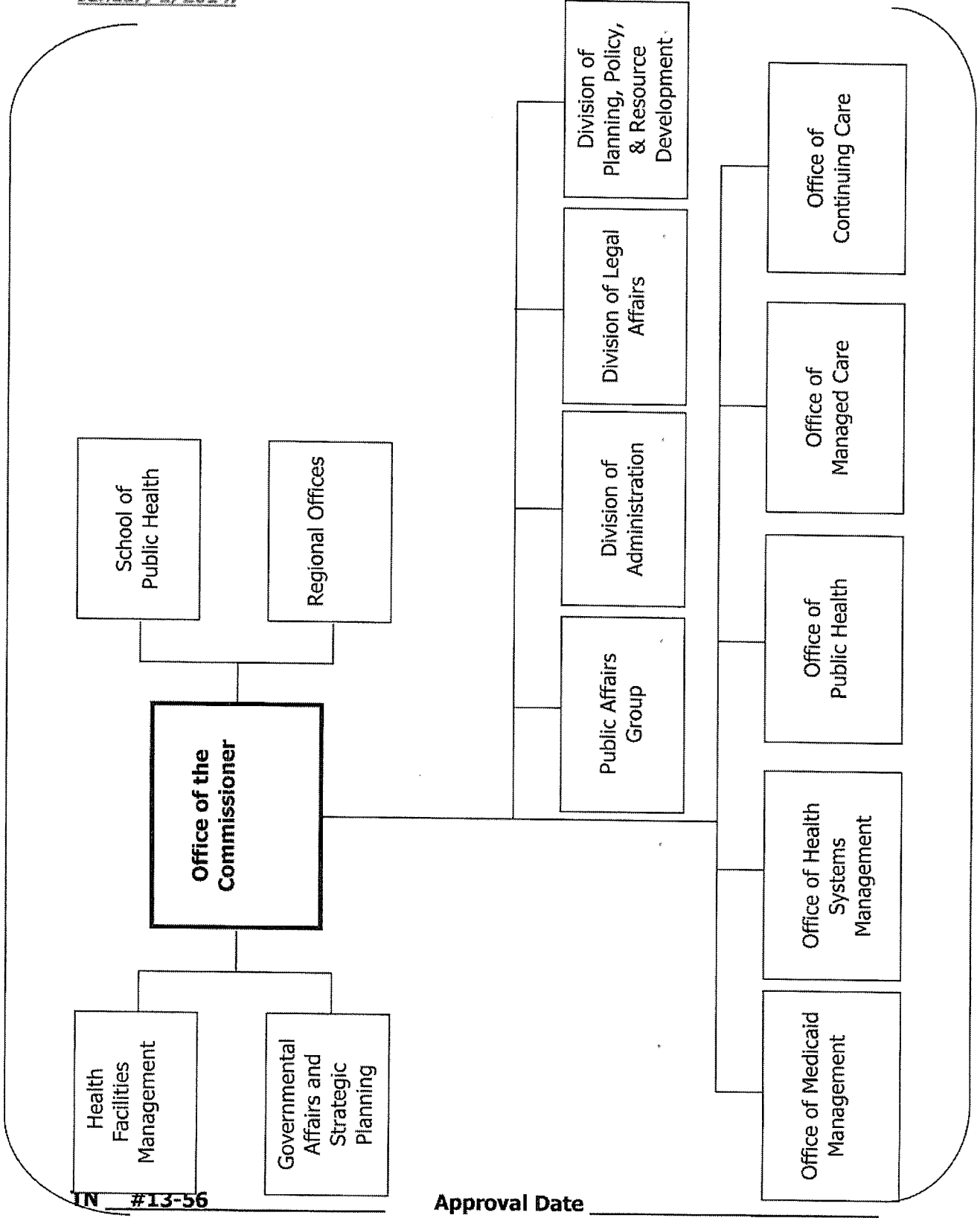

TN #13-56 **Approval Date** _____

Supersedes TN #98-47 **Effective Date** _____

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2

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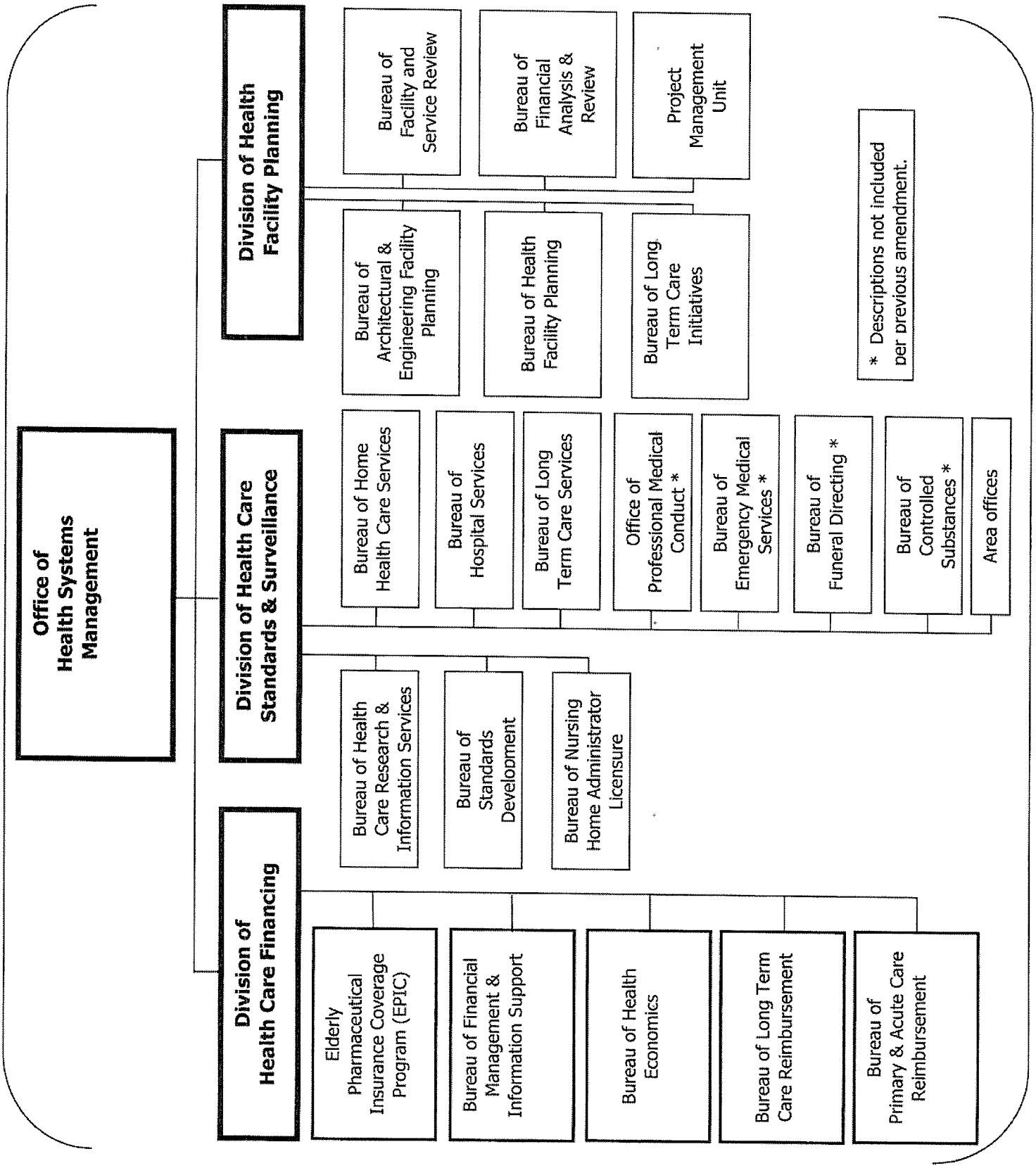

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[Organizational Unit: Division of Health Care Standards and Surveillance

The responsibilities discharged through the Division of Health Care Standards and Surveillance support the Department's mandated purposes of protecting, promoting and preserving the health of the residents of New York State. The Division's activities, include setting the minimum inspection of facilities needed to monitor and enforce those standards to safeguard the health of the State's entire population, regardless of geographic location or ability to pay. From the newborns in hospitals to the elderly in the nursing homes, the constant surveillance of the full spectrum of medical services provided to the State's varied population groups serves to reduce morbidity and mortality by enduring that those services meet Federal and State requirements. This surveillance process includes not only the routine inspection of providers, but also the investigation of all complaints received. Whether they are the frail elderly of the State's population, or the developmentally disabled children, the surveillance of health care providers helps to ensure that the quality of their lives reaches optimal levels.

The Division discharges its responsibilities through two groups, the Health Care Standards and Analysis Group and the Health Care Surveillance Group.

The Health Care Standards and Analysis Group is comprised of the following bureaus:

1. Bureau of Standards Development

2. Bureau of Health Care Research and Information Services

3. Bureau of Nursing Home Administrator Licensure

The Health Care Surveillance Group is comprised of the following three bureaus:

1. Bureau of Hospital Services

2. Bureau of Long Term Care Services]

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[3. Bureau of Home Health Care Services

The Group's surveillance function is discharged through area offices located in Albany, Buffalo, Rochester, Syracuse, New York City and New Rochelle. In addition, the New Rochelle area office operates a sub-office on Long Island.

Staff resources are directed toward meeting objectives which will ensure the provision of accessible, efficient, effective and high quality health care services.]

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[Organizational Unit: Bureau of Standards Development

The Bureau develops health care standards necessary to implement Federal and State legislation applicable to all types of health care providers and services. These standards include facility or agency operating standards and standards governing the quality and availability of services provided under the Medical Assistance Program (Medicaid). In addition to the revision and modification of standards related to established forms of health care services, the Bureau is responsible for the formulation of standards dealing with new and innovative program areas. The Bureau also staffs the Code Committee of the State Hospital Review and Planning Council.

The Bureau, through its Pharmacy Unit, maintains the list of drugs eligible for reimbursement under the NYS Medicaid program, and the list of drugs eligible to the substituted for brand name prescription drugs under the NYS Generic Drug Substitution Program. Pharmaceutical provider plans, to ensure compliance with the Drug Imprinting and Labeling Law, are monitored by the Pharmacy Unit. In addition, support is provided to the EPIC (Elderly Pharmaceutical Insurance Coverage) program to determine the appropriateness of drugs covered under that program.

The Bureau has responsibility for the administration of Medical Assistance Program training funds and assists in the development of specific training initiatives.

The Bureau serves as the primary resource to the OHSM on the qualifications and scope of practice of particular professions. The staff includes administrative as well as professional personnel in various clinical care disciplines including dentistry, medicine, nursing, occupational therapy, pharmacy, and social work.]

New York
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NOTE: The information on this page has been replaced by PDF Forms A1, A2 & A3 effective January 1, 2014.

[Organizational Unit: Bureau of Health Care Research and Information Services

The Bureau of Health Care Research and Information Services (BHCR/IS) staff generate and maintain data registries in support of the Division's standard setting and surveillance activities and coordinate health care research and analysis activities throughout the Division. These services, provided through the use of quantitative analysis, management science and electronic data processing, enhance the Division's ability to meet its objective of assuring that the State's health system provides high quality care, thus reducing morbidity and mortality.

The Bureau has four organizational units:

- Systems Development: This unit is responsible for the planning and implementation of mainframe user systems and user portions of production systems that support the regulatory missions of the Division.

- Policy Analysis: This unit is responsible for providing quantitative policy analysis and program evaluation services to the regulatory bureaus within the Division and to OHSM executive staff.

- Personal Computer/Data Communications Support and Application Programming: This unit is responsible for the completion of all special purpose computer programming tasks requested by executive of program staff, and for the installation and support of PC equipment, terminals and printers throughout the Division.

- Information Systems and Health Statistics Group (ISHS) Liaison: An individual has been designated for lead responsibility in coordinating day-to-day contacts between Division staff and ISHS. In addition to facilitating Divisional access to ISHS services, this arrangement provides a quasi-management link to the production programmers assigned to the Division.]

New York
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NOTE: The information on this page has been replaced by PDF Forms A1, A2 & A3 effective January 1, 2014.

[Organizational Unit: Bureau of Nursing Home Administrator Licensure

The activities of the Bureau of Nursing Home Administrator Licensure help to ensure the provision of appropriate and necessary health care services to the chronically ill and frail elderly population residing in nursing homes in New York State.

The Bureau of Nursing Home Administrator Licensure (BNHAL) services as staff to the New York State Board of Examiners of Nursing Home Administrators. The Board is responsible for establishing standards of education, training, and experience and providing for the examination, licensure, and registration of nursing home administrators in New York State. Currently, there are 3,650 individuals licensed as nursing home administrators in New York State.

The Board is also responsible for initiating disciplinary action against administrators who violate provisions of Article 28-D of the Public Health Law, which defines the practice of nursing home administration. The Board may suspend, revoke, annul or censure the license or registration of an administrator for violations of the Public Health law. In addition, the Board may assess civil penalties against administrators when it deems appropriate.]

New York
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NOTE: The information on this page has been replaced by PDF Forms A1, A2 & A3 effective January 1, 2014.

[Organizational Unit: Bureau of Home Health Services (HHS)

The Bureau of Home Health Services has six primary areas of program responsibility: 1) regulation and certification of Certified Home Health Agencies (CHHA), 2) licensure and regulation of home care service agencies, 3) development and implementation of the Long Term Home Health Care Program (LTHHCP), 4) certification and regulation of the Hospice program, 5) development, implementation and evaluation of the Chapter 831 Home Health Care Grant program and Home Health Grant Training program, and 6) provision of staff support to the State Council on Health Care Services. The Bureau is responsible for coordinating the activities of program staff in these areas through the six OHSM area offices.

The development of cost effective and high quality noninstitutional alternatives is the common thread which unifies the Bureau's major responsibilities. Each major program area is developmental in nature when compared to the more traditional forms of health delivery. A major focus of Bureau activity is the creation and implementation of innovative surveillance protocols for assuring quality in the care delivered by such programs. The facilitation and revision of legislation, regulations, and policies to create the proper environment for the development and competitive existence of home based programs is also a major component of such ongoing activities.]

New York
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NOTE: The information on this page has been replaced by PDF Forms A1, A2 & A3 effective January 1, 2014.

[Organizational Unit: Bureau of Hospital Services

The primary goal of the Bureau of Hospital Services is to promote and assure the quality of inpatient, outpatient and emergency room care provided in the 268 hospitals established under Article 28 of the Public Health Law..

In the assurance of regulatory compliance, the Bureau's programs include a comprehensive Article 28 survey program, targeted Article 28 surveys, complaint investigation surveys, the incident reporting program, character and competence reviews as part of the certificate of need process, and Title XVIII surveys. In addition, the Bureau initiates enforcement actions against facilities to ensure regulatory compliance.

During the 1988-89 fiscal year, the Department consolidated its Utilization Review (UR) program, and as a result, the Department now has one Medicaid UR agent for upstate New York (Network Design Group) and one for the New York City and Long Island region (Island Peer Review Organization). The actual review activity is being conducted through contractual arrangements with these two medical review groups.

Comprehensive Article 28 Survey Program

The comprehensive Article 28 survey program is designed to focus on patient outcomes through the assessment of quality of patient care and the effectiveness of internal hospital quality assurance systems.]

New York
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NOTE: The information on this page has been replaced by PDF Forms A1, A2 & A3 effective January 1, 2014.

[Organizational Unit: BUREAU OF LONG TERM CARE SERVICES

The Bureau of Long Term Care Services is the central program office responsible for the Office of Health Systems Management's long term care regulatory activities. The Bureau is responsible for directing the area office surveillance program as specified by the Health Care Financing Administration under the 1864 Agreement designating the Department of Health as the state surveillance agent for nursing homes. The program is required to enforce facility operating standards and monitor the quality of care delivered to approximately 103, 714 patients/residents residing in 628 long term care facilities as specified in Titles XVIII/XIX of the Federal Social Security Act and Article 28 of the Public Health Law.

As the central, coordinative point for the survey process, the Bureau must assure that long term care standards are enforced effectively and uniformly throughout the State. The Bureau's activities are directed at ensuring that the State's skilled nursing facilities are providing all services and care necessary to enable each resident to achieve his or her highest practicable level of physical, mental and psychosocial well-being as required by federal regulation.

The activities of the Bureau of Long Term Care Services are carried out by three separate units within the Bureau: (1) Quality Assurance, Complaint Investigation, and Enforcement; (2) Surveillance Program Operations and Development; and (3) Facility Operations and Control.]

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NOTE: The information on this page has been replaced by PDF Forms A1, A2 & A3 effective January 1, 2014.

[Organizational Unit: Division of Health Facility Planning

The Division of Health Facility Planning, funded within the Health Care Standards and Surveillance program is responsible for the administration of the State's Certificate of Need (CON) activities. The State mandated CON program provides a planning mechanism to ensure that health care resources are developed and made available to the public in a comprehensive, coordinated manner which is responsive to the public's health care needs. Each proposal is evaluated based on community need for beds and services, financial feasibility and cost efficiency of the project, and the competence and character of the sponsors. The review of CON applications and determination of need provide a vital step in achieving the Department's goal of quality care for all that is affordable and accessible.

In addition to its responsibility for administering the State's CON program, the Division is involved in activities designed to improve the efficiency of the existing health care network.
Through examination of specific facilities and services, the Division makes recommendations regarding the merger or consolidation of facilities and changes in services to more appropriately reflect factors such as utilization and facility financial status.

The Division is composed of two groups: The Health Facility Planning Group and the Certificate of Need Review Group.

The Health Facility Planning Group is composed of two groups: The Health Facility Planning Group and the Certificate of Need Review Group.

The Health Facility Planning Group is composed of two bureaus:

1. Bureau of Health Facility Planning

2. Bureau of Architectural and Engineering Facility Planning

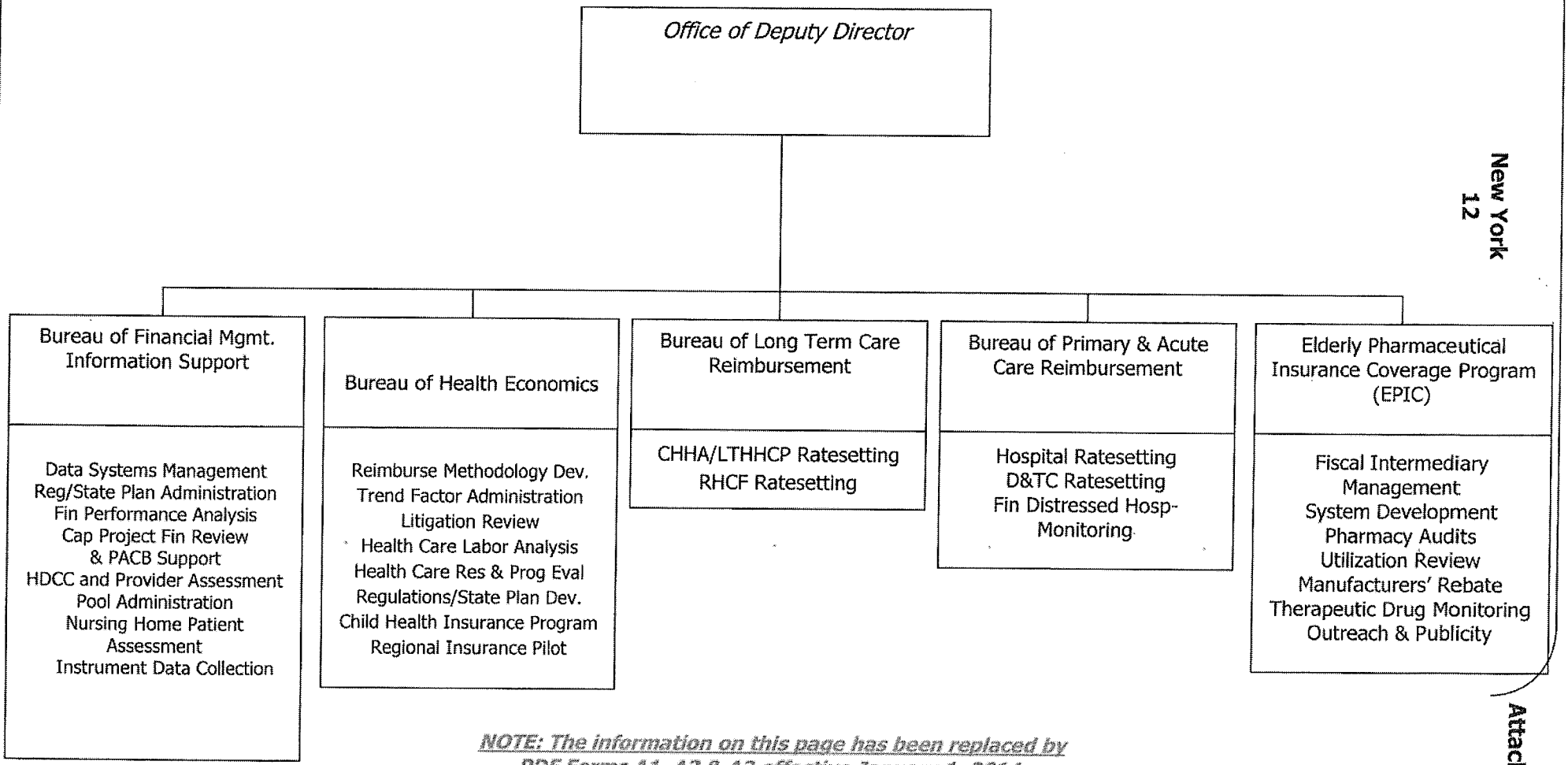
The Certificate of Need Review Group is composed of two bureaus and one unit:

1. Bureau of Facility and Service Review

2. Bureau of Financial Analysis and Review

3. Project Management Unit]

Division of Health Care Financing



New York
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NOTE: The information on this page has been replaced by PDF Forms A1, A2 & A3 effective January 1, 2014.

TN #13-56 **Approval Date** _____

Supersedes TN #97-10 **Effective Date** _____

Attachment 1.2-A

New York
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NOTE: The information on this page has been replaced by PDF Forms A1, A2 & A3 effective January 1, 2014.

[DIVISION OF HEALTH CARE FINANCING

The Division of Health Care Financing is organizationally responsible for ensuring that health care resources are most appropriately allocated. Financial management of New York State's health care system is accomplished through a variety of activities. They include developing reimbursement methodologies, setting third party reimbursement rates, administering State revenue collection programs generated through various assessments charged to health care providers, and reviewing the financing mechanisms of proposed health facility construction and expansion projects. Alternative health care financing mechanisms that offer potential cost control incentives and savings are also examined, tested and evaluated.

The following units are responsible for carrying out the duties of the Division:

1. Bureau of Health Economics
2. Bureau of Primary and Acute Care Reimbursement
3. Bureau of Financial Management and Information Support
4. Bureau of Long Term Care Reimbursement

THE MAJOR RESPONSIBILITIES OF THE DIVISION INCLUDE:

- Calculating and/or promulgating and approving rates of payment for hospitals, residential health care facilities, diagnostic and treatment centers, home health agencies, and other Article 28, 36, 40, 43, and 44 certified facilities.
- Adjudicating appeals to rates of payment consistent with regulations and statute.
- Developing and evaluating new and alternative financing methods for health care providers and insurers. These financing methods include improving methods of pricing health care services, refining patient provider encounters, and examining capital financing methods and utilizing insurance vehicles for providing health care services for the uninsured and underinsured.
- Administering several grant programs for global budgeting, health networks and health care demonstrations.
- Developing and implementing sponsored health care financing research activities.]

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NOTE: The information on this page has been replaced by PDF Forms A1, A2 & A3 effective January 1, 2014.

- Establishing and administering the financing reforms detailed in the Health Care Reform Act of 1996. Developing policies, procedures and protocols that will for the first time, allow New York to move to negotiated rates for hospital care and will continue support of public policy priorities including uncompensated care, graduate medical education and numerous health care initiatives.

- Administering approximately $2.0 billion in pooled funds financed through health care provider and insurer assessments and surcharges for medically indigent subsidies, various health care project initiatives, graduate medical education and physician excess malpractice coverage.

- Administering collection of statutory assessments on health care providers pertaining to the Health Facility Cash Receipts Assessment Program, and the HMO Differential.

- Maintaining the Patient Review Instrument (PRI) processing system, including collection of data via electronic mail, correction of data, auditing of data, assignment of Resource Utilization Group (RUG), and updating of Residential Health Care Facility (RHCF) rates to reflect changes in case mix index (CMI).

- Collecting cost report data via electronic mail for five provider groups; hospitals, RHCFs, Diagnostic & Treatment Centers (D&TCs), Certified Home Health Agencies (CHHAs), and Long Term Home Health Care Programs (LTHHCPs).

- Providing financial analysis services to State mortgage loan programs which provide construction financing to non-profit nursing homes and hospitals.

- Designing and evaluating payment methodologies for hospitals, nursing homes and ambulatory care programs which includes conducting research studies to support Departmental policy recommendations concerning payment for and delivery of health care services; preparing Title XIX (Medicaid) State Plans for health care services which are submitted to the federal government to procure Medicaid federal financial participation; drafting regulations to implement reimbursement methodologies; preparing responses to litigation brought against the Department by providers pertaining to reimbursement methodologies; responding to inquiries from industry, other State agencies, legislative staff and the general public regarding the Medicaid financing systems; and, developing grant applications to procure outside funding for research on financing issues and economic analyses of health care systems.]

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NOTE: The information on this page has been replaced by PDF Forms A1, A2 & A3 effective January 1, 2014.

- Coordinating the development of all new Medicaid Program finance regulations and providing administrative services to the State Hospital Review and Planning Council, Fiscal Policy Committee and Medical Advisory Committee.

- Ensuring compliance with Federal statutory requirements relating to the State's provider tax programs . This includes preparation of any necessary waiver applications, and corresponding statistical testing and analysis, pursuant to Federal Law.

- Ensuring compliance with Federal Disproportionate Share payment limitations. This includes projecting hospital distributions, Medicaid and uninsured net revenue/losses and implementing such limits into the pool distribution process.

- Monitoring the Receivership Program and its related Receivership Fund, calculating capital costs, monitoring the Article 28-A Mortgage Program and controlling its related Operating Escrow Account activities.

- Monitoring and evaluating the uniform physician billing form and electronic claims submission legislative requirements, including coordination of the activities of the Physician Claim Task Force.]

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NOTE: The information on this page has been replaced by PDF Forms A1, A2 & A3 effective January 1, 2014.

[Organizational Unit: Elderly Pharmaceutical Insurance Coverage Program (EPIC)

The Elderly Pharmaceutical Insurance Coverage (EPIC) program provides assistance to low and moderate income elderly through subsidizing the costs of their prescription medications. As of March 1990, over 76,000 seniors were enrolled in EPIC. Since the program began in October 1987, EPIC has saved these older New Yorkers over $52 million on the costs of their medications.

The program performs outreach and promotion to inform seniors about the program, enrolls eligible persons, supervises a large contractual operation which processes payments to pharmacies and participants, and performs audits of both the contractor and the providers to assure the fiscal integrity of program operations. In addition, a utilization review function assists in the detection of potential fraud or abuse, research is completed on various aspects of program participation and utilization, and a process for reconsideration and fair hearing is maintained to address participant and provider disputes.]

NOTE: The information on this page has been replaced by PDF Forms A1, A2 & A3 effective January 1, 2014.

New York State Department of Health
Office of Medicaid Management

Bureau of Enforcement Activities

Bureau of Administration and Resource Support

Office of the Director

Division of Information and System Support

Division of Consumer and Local District Relations

Division of Provider Relations

Bureau of Policy Development and Agency Relations

CONSUMERS

LOCAL DISTRICTS

PROVIDERS

STATE AGENCIES

Approval Date _____

Effective Date _____

TN #13-56

Supersedes TN #98-45

New York
2

NOTE: The information on this page has been replaced by PDF Forms A1, A2 & A3 effective January 1, 2014.

[***Office of the Director***

The Office of the Director leads and supports the work of the Office of Medicaid Management (OMM). The Director's Office performs the following functions:

- Provide ambassadorship to the outside world
- Works with Department of Health (DOH) executives on high-level DOH management and strategy
- Leads the overall internal functioning of OMM
- Serves as a resource to OMM managers to clarify director's views on emerging issues
- Establishes and holds division heads accountable for performance agreements]

New York
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NOTE: The information on this page has been replaced by PDF Forms A1, A2 & A3 effective January 1, 2014.

[***Bureau of Administration & Resource Support***

The Bureau of Administration and Resource Support provides the other OMM units with the necessary resources to produce OMM's expected results. The Bureau performs the following functions:

- Forecasts and plans resources
- Allocates resources to the divisions and bureaus
- Manages and tracks financial State Purposes expenditures
- Coordinates the preparation of budget initiatives
- Acquires human resources necessary to support program needs
- Secures materials and equipment needed by OMM units
- Space planning
- Day-to-day operational needs]

New York
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NOTE: The information on this page has been replaced by PDF Forms A1, A2 & A3 effective January 1, 2014.

[***Division of Consumer and Local District Relations***

The Division of Consumer and Local District Relations will help serve both OMM consumers and local governments. The Division will perform the following functions:

- Create eligibility guidelines
- Determine consumer eligibility (including Third Party Liability and disability reviews)
- Provide local district support (technical assistance, training, transportation)
- Resolving consumer complaints
- Assessing performance of local districts
- Educating consumers
- Connecting consumers to the correct services]

New York
5

NOTE: The information on this page has been replaced by PDF Forms A1, A2 & A3 effective January 1, 2014.

[***Division of Information and System Support***

The Division of Information and System Support will manage and support the information and system needs of the entire OMM organization. The Division will perform the following functions:

- Developing systems (planning, coordination and testing)
- Procuring and monitoring system contracts
- Monitoring and correcting the work of systems contractors
- Responding to data requests
- Developing and supporting OMM's internal PC/LAN system (strategic planning, maintenance, Internet access, help desk)]

New York
6

NOTE: The information on this page has been replaced by PDF Forms A1, A2 & A3 effective January 1, 2014.

[***Bureau of Enforcement Activities***

The Bureau of Enforcement Activities will combat actions of those groups and individuals who fail to comply with Medicaid and OMM rules and regulations. The Bureau will perform the following functions:

- Confirm occurrences of Medicaid fraud (investigation processing)
- Penalizing (sanctioning) providers guilty of Medicaid fraud
- Penalizing (sanctioning) recipients guilty of Medicaid fraud
- Actualizing due process
- Supporting prosecution with/by other law enforcement authorities
- Establishing and maintaining internal controls for OMM]

New York
1

NOTE: The information on this page has been replaced by PDF Forms A1, A2 & A3 effective January 1, 2014.

[STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT]

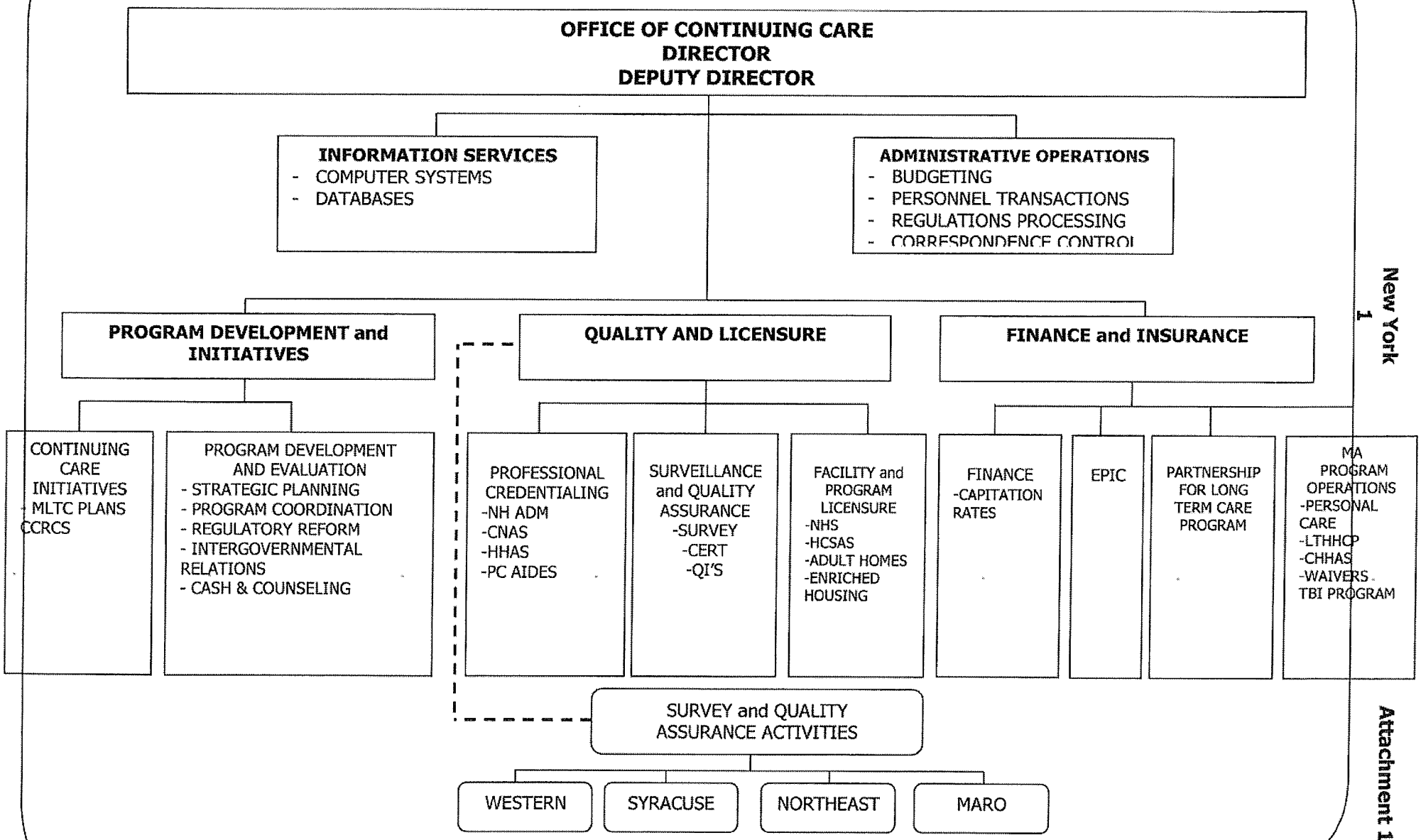
[State of New York]

[Staffing Summary of Personnel
Used in the Administration of the Plan]

[New York State Department of Health

Division of Health Care Financing	115
Division of Health Standards and Surveillance	135
Office of Medicaid Management	400
Office of Managed Care	130
Division of Administration	30
Division of Legal Affairs	15
Information Systems & Health Statistics Group	50]

NOTE: The information on this page has been replaced by PDF Forms A1, A2 & A3 effective January 1, 2014.



New York 1

Attachment 1.2-D

TN #13-56 **Approval Date** _____

Supersedes TN #98-47 **Effective Date** _____

New York
2

NOTE: The information on this page has been replaced by PDF Forms A1, A2 & A3 effective January 1, 2014.

[***Executive Office***

Policy and oversight for:

- Nursing Homes
- Adult Care Facilities
- Home Health Care Services
- Elderly Pharmaceutical Insurance Coverage
- Long Term Care manage Care
- Partnership for Long Term Care Insurance
- Personal Care
- Waiver Programs
- Aide Training Programs]

New York
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NOTE: The information on this page has been replaced by PDF Forms A1, A2 & A3 effective January 1, 2014.

[***Division of Program Development and Initiatives***

The Division is responsible for:

- Program Development
- Regulatory Reform
- Strategic Planning
- Intergovernmental Relations
- Cash and Counseling
- Managed Long Term Care Demonstrations
- Continuing Care Retirement Communities]

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NOTE: The information on this page has been replaced by PDF Forms A1, A2 & A3 effective January 1, 2014.

[***Division of Quality and Licensure***

The Division is responsible for:

Licensure, Surveillance and Quality Initiatives for:

- Adult Homes
- Home Health Care Services Agencies
- Nursing Homes
- Enriched Housing Programs
- Assisted Living Programs
- Residences for Adults

Credentialing of:

- Nursing Home Administrators
- Certified Nursing Aides
- Home Health Aides
- Personal Care Aides]

New York
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NOTE: The information on this page has been replaced by PDF Forms A1, A2 & A3 effective January 1, 2014.

[***Division of Finance and Insurance***

The Division is responsible for:

- Long Term Care Capitated Rates
- Elderly Pharmaceutical Insurance Coverage
- Long Term Care Partnership Plan
- Traumatic Brain Injury Program
- Personal Care
- Long Term Home Health Care Program
- Community Home Health Agency Services and Waivers]

New York
6

NOTE: The information on this page has been replaced by PDF Forms A1, A2 & A3 effective January 1, 2014.

[***Information Services***

The Bureau is responsible for:

- Network Administration
- Computer Support
- Database Administration
- Research and Evaluation Systems Activities]

New York
7

NOTE: The information on this page has been replaced by PDF Forms A1, A2 & A3 effective January 1, 2014.

[***Administration Services***

The Bureau is responsible for:

- Budget
- Personnel
- Regulation Processing
- Correspondence Control]

Appendix II
2014 Title XIX State Plan
First Quarter Amendment
Summary

SUMMARY
SPA #13-56

This State Plan Amendment proposes to identify the Department of Health as the Single State Agency to submit and administer State plans for the Medicaid program for New York.

Individual Marketplace Appeals

A. Standard Process

Applicants and recipients who are dissatisfied with determinations and redeterminations made by the Individual Marketplace may request appeals within sixty days of the date on the notice of eligibility determination by telephone, mail, and fax. They will also be able to request appeals through their Marketplace accounts in the future. Persons who contend that an eligibility determination is untimely may also request an appeal. Upon receipt of an appeal request, the Marketplace will promptly notify the appellant that the request has been received and the Marketplace will determine whether the appeal request is "valid." The notice acknowledging receipt of the appeal request will include a form for the appellant to complete that authorizes the release of protected information used in determining their eligibility including federal tax information and the authorization of a designated representative.

"Valid" appeal requests will be scheduled for a hearing, unless all issues are resolved during the informal resolution process. Consumers can utilize the informal resolution process at any time before their hearing takes place. During the informal resolution process, the right to a hearing is preserved and, if the case does not advance to a hearing, the informal resolution decision is final and binding. If the appeal advances to a hearing, the appellant will not be asked to duplicate information or documentation previously provided during the application of informal resolution process.

Initially, hearings will be held by telephone. Notification of the date and time of the hearing will be sent to the appellant no later than fifteen (15) days prior to the date of the hearing. All hearings will be held by one (or more) impartial hearing officers who have not been directly involved in the eligibility determination or any prior Marketplace appeal decisions in the same matter.

Within ninety (90) days of the appeal request, the appeals unit will send the appellant a written notice of the appeal decision and a written decision. The notice of appeal decision will provide instructions about how to cease pended eligibility, if applicable. The decisions will be based exclusively on the information and evidence used to determine the appellant's eligibility, as well as any additional relevant evidence presented during the appeals process. Decisions will provide a plain language description of the effect of the decision on the appellant's eligibility. They will also summarize the relevant facts, identify the legal basis for the decision, state the decision's effective date, provide an explanation of the appellant's right to pursue the appeal

before the HHS appeals entity, and indicate that the unit's decision is final, unless the appellant pursues an appeal with HHS.

When an appeals request is determined invalid, no hearing will be scheduled. Instead, the appeals unit will promptly send notification to the appellant that the appeal has not been accepted. That notice will explain the nature of the defect and inform the appellant that the appellant may cure the defect and resubmit the appeal request within sixty (60) days from the date of the notice of eligibility determination. If a valid amended appeal request is received within sixty (60) days of the date of the notice of eligibility determination, that amended request will be processed for a hearing as set forth above.

Certain appeals will be dismissed without a hearing or any review on the merits. Those appeals include the following: (1) appeals withdrawn by the appellant in writing; 2) appeals requested by an appellant who has failed to attend a scheduled hearing and who has not established good cause for that default; 3) appeals that are not based on a valid appeal request; and 4) appeals requested by someone who dies while the appeal is pending. Timely notice of the dismissal will be provided to the appellant or the appellant's authorized representative and that notice will include the reason for the dismissal, the effect of the dismissal on the appellant's eligibility, and an explanation as to how the appellant may show good cause to vacate the dismissal.

Dismissals will be vacated and a hearing will be conducted when the appellant makes a written request within thirty (30) days of the date of the notice of dismissal that establishes good cause for vacating the dismissal.

B. Expedited Appeals

When the appeals unit receives a request for an expedited appeal, the unit will promptly review the request to determine whether the request meets the standard for an expedited appeal (an immediate need for health services such that the standard appeal process could jeopardize the appellant's life, health or ability to attain, maintain, or regain maximum function).

If the appeals unit determines that the appellant has met the standard for an expedited appeal, a hearing will be scheduled promptly and a decision will be issued as expeditiously as reasonably possible, consistent with the timeframe established by the Secretary of HHS.

If the appeals unit determines that the appellant has not met the standard for an expedited appeal, prompt electronic or oral notification of that determination will be provided to the appellant, if possible. Oral notification will be followed by written notice, which provides the

reason for the denial, informs the appellant that the appeal will follow the standard appeal process and explains the appellant's rights under the standard appeal process. That written notice will be provided within timeframes established by the Secretary of the United States Department of Health and Human Services.