NEW YORK
state department of
HEALTH

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

Sue Kelly
Executive Deputy Commissioner

September 30, 2011

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

Re: SPA #11-82
Inpatient Hospital Services

Dear Mr. Cooley:

The State requests approval of the enclosed amendment #11-82 to the Title XIX (Medicaid) State Plan for inpatient hospital services to be effective July 1, 2011 (Appendix I). This amendment is being submitted based upon enacted legislation. A summary of the proposed amendment is contained in Appendix II.

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

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

Notice of the changes in the methods and standards for setting payment rates for general hospital inpatient services were given in the New York State Register on June 29, 2011 (Appendix IV).

It is estimated that the changes represented by 2011 payment rates for inpatient general hospital services will have no noticeable short-term or long-term effect on the availability of services on a statewide or geographic area basis, the type of care furnished, or the extent of provider participation.

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

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

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

If you have any questions regarding this matter, please do not hesitate to contact John E. Ulberg, Jr., Director, Division of Health Care Financing at (518) 474-6350.

Sincerely,

Jason A. Helgerson
Medicaid Director
Deputy Commissioner
Office of Health Insurance Programs

Enclosures

cc: Mr. Michael Melendez
Mr. Tom Brady

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: CENTERS FOR MEDICARE & MEDICAID SERVICES	1. TRANSMITTAL NUMBER: **11-82**	2. STATE **New York**
	3. PROGRAM IDENTIFICATION: **TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)**	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE **July 1, 2011**	

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: **Section 1902(a) of the Social Security Act, and 42 CFR 447**	7. FEDERAL BUDGET IMPACT: a. **FFY 07/01/11-09/30/11 ($666,667)** b. **FFY 10/01/11-09/30/12 ($1,333,333)**
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: **Attachment 4.19-A: Pages 120(a)(ii), 120(a)(iii), 120(a)(iv), 120(b), 120(b.1), 120(b)(1), 120(b)(2)**	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: **Attachment 4.19-A: Pages 120(b), 120(b)(1), 120(b)(2)**

10. SUBJECT OF AMENDMENT:
Potentially Preventable Conditions (PPCs)/Potentially Preventable Readmissions (PPRs)
(FMAP = 50% 7/1/11 forward)

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** **Corning Tower** **Empire State Plaza** **Albany, New York 12237**
13. TYPED NAME: **Jason A. Helgerson**	
14. TITLE: **Medicaid Director & Deputy Commissioner Department of Health**	
15. DATE SUBMITTED: September 30, 2011	

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:

FORM HCFA-179 (07-92)

Appendix I
2011 Title XIX State Plan
Third Quarter Amendment
Hospital Inpatient Services
Amended SPA Pages

Potentially Preventable Negative Outcomes (PPNOs)

Potentially Preventable Complications

For discharges occurring on and after July 1, 2011 through March 31, 2012, Medicaid rates of payment to hospitals that have an excess number of complications based on the criteria set forth in the Complication Criteria Section, as determined by a risk adjusted comparison of the actual and expected number of complications in a hospital as described by the Methodology Section, shall be reduced in accordance with the Payment Calculation Section. Such rate adjustments shall result in an aggregate reduction in Medicaid payments of an amount as determined by the Commissioner of Health.

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

1. Potentially Preventable Complications (PPC) shall mean harmful events or negative outcomes that develop after hospital admission and may result from processes of care and treatment rather than from natural progression of the underlying illness, as defined under the grouping logic software developed and published by 3M Health Information Systems, Inc. (3M). The software identifies 1,450 ICD-9-CM diagnosis codes as a PPC diagnoses. Each ICD-9-CM code designated as a PPC diagnosis was assigned to one of 64 mutually exclusive complication groups called PPCs. A list of such PPCs are available on the following Department of Health website link:

   http://health care/Medicaid/Quality/Potentially Preventable Negative Outcomes

2. Hospital shall mean a general hospital as defined pursuant to the Hospital Inpatient Reimbursement – Effective December 1, 2009 Section, excluding, effective July 1, 2011, those hospitals exempt from the APR-DRG reimbursement methodology and critical access hospitals.
3. Observed Complication Rate shall be calculated for each of the APR-DRG severity of illness (SOI) combinations for the 64 PPCs as the total discharges within each APR-DRG SOI with the PPC divided by the total at-risk discharges for the given APR-DRG SOI.
4. Statewide Complication Rate shall be calculated for each PPC and APR-DRG SOI combination as the sum of the observed complication rate for all hospitals.
5. Expected Complication Rate shall be calculated for each hospital by PPC and APR-DRG SOI combination by multiplying the number of hospital specific at-risk discharges in each APR-DRG SOI by the statewide complication rate.
6. Excess Complication Rate shall mean the difference between the observed complication rate and the expected complication rate for each APR-DRG SOI for all hospitals.

7. PPC Cost shall mean the incremental difference in cost between a discharge with a particular PPC and that same discharge without the PPC. A linear regression, at the discharge level, predicts the risk adjusted incremental charge for each PPC. The ratio of average payments, developed using the Medicaid rate effective as of October 2010 applied to 2009 Statewide Planning and Research Cooperative System (SPARCS) data for Medicaid discharges, to average charges is multiplied by the PPC charge estimates, from the regression analysis, to calculate cost estimates.

Complication Criteria.

A complication is a condition that develops after admission to the hospital. Complications may or may not be preventable. For a complication to qualify as a PPC, the secondary diagnosis must meet the following criteria:

a. Shall not be redundant with the diagnosis that was the reason for hospital admission;

b. Shall not be an inevitable, natural, or expected consequence or manifestation of the reason for hospital admission;

c. Shall be expected to have a significant impact on short or long-term debility, mortality, patient suffering, or resource use; and

d. Shall have a relatively narrow spectrum of manifestations, meaning that the impact of the diagnosis on the clinical course or on the resource use must not be significant for some patients but trivial for others.

Methodology.

1. The expected complication rate shall be reduced by a percentage as determined by the Commissioner of Health.

2. For each PPC, the excess complication rate shall be multiplied by the PPC cost. In the event the observed complication rate for a hospital is lower than the expected complication rate, after the expected complication rate has been reduced by the applicable percentage in accordance with this section, the risk adjusted excess complication rate for that PPC shall be set at zero.

3. For each hospital, a hospital specific complication rate adjustment factor shall be computed as the ratio of the hospital's aggregate excess costs of every PPC and the hospital's total Medicaid operating payments for the same period.

Adjustment for Hospitals With Unreliable Present On Admission (POA) Data.

Each hospital shall be evaluated on five criteria for the reliability of the POA indicator in Medicaid discharge data. Two levels of POA quality shall be established for each of the criteria, "red" and "grey" zones. The criteria and levels shall be as follows:

1. The percent of pre-existing diagnoses that are coded as not present on admission: "red" shall be greater than or equal to 7.5%, "grey" shall be greater than or equal to 5%, but less than 7.5%.

2. Excluding pre-existing and exempt diagnoses, the percent of remaining diagnoses coded as uncertain: "red" shall be greater than or equal to 10%, "grey" shall be greater than or equal to 5%, but less than 10%.

3. Excluding pre-existing, exempt, and perinatal diagnoses, a high percentage of remaining diagnoses coded as present on admission: "red" shall be greater than or equal to 96%, "grey" shall be greater than or equal to 93%, but less than 96%.

4. Excluding pre-existing, exempt, and perinatal diagnoses, a low percentage of remaining diagnoses coded as present on admission: "red" shall be less than or equal to 70%, "grey" shall be greater than or equal to 70%, but less than 77%; and

5. For surgical cases only, the percent of secondary diagnoses coded as present on admission: "red" shall be greater than or equal to 40%, "grey" shall be greater than or equal to 30%, but less than 40%.

Hospitals are determined to have unreliable POA data if any of the five criteria are in the "red" zone, or if two or more of the five criteria are in the "grey" zone. A regional complication rate adjustment factor shall be computed for each hospital deemed to have unreliable POA data.

Potentially Preventable Hospital Readmissions

For discharges occurring on and after July 1, 2010 through March 31, 2012, Medicaid rates of payment to hospitals that have an excess number of readmissions based on the criteria set forth in the Readmission Criteria Section, as determined by a risk adjusted comparison of the actual and expected number of readmissions in a hospital as described by the Methodology Section, shall be reduced in accordance with the Payment Calculation Section. Such rate adjustments shall result in an aggregate reduction in Medicaid payments of $27.8 million for the period July 1, 2010 through March 31, 2011 and $37 million for the period April 1, 2011 through March 31, 2012.

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

1. Potentially Preventable Readmissions (PPR) shall mean a readmission to a hospital that follows a prior admission from a hospital within 14 days, and that is clinically-related to the prior hospital admission, as defined under the grouping logic software developed and published by 3M Health Information Systems, Inc. (3M), version 26.1 for the period July 1, 2010 through June 30, 2011 and version 28 for the period July 1, 2011 through March 31, 2012.
2. Hospital shall mean a general hospital as defined pursuant to the Hospital Inpatient Reimbursement – Effective December 1, 2009 Section, excluding, effective July 1, 2011, those hospitals exempt from the APR-DRG reimbursement methodology and critical access hospitals.
3. For the period July 1, 2010 through June 30, 2011, the Expected Potentially Preventable Readmissions are derived using a logistic regression analysis that produces a predicted probability (a number ranging from zero to one) that a hospital admission would be followed by at least one PPR. The total number of expected PPRs shall equal the sum of the expected probabilities of a PPR for all admissions at each hospital. Effective for the period July 1, 2011, through March 31, 2012, the Expected Potentially Preventable Readmissions shall be derived using indirect standardization. A statewide PPR rate, the number of at-risk admissions followed by at least 1 PPR divided by the total number of at-risk admissions, for every APR-DRG severity of illness (SOI) combination shall be multiplied by the number of at-risk admissions in that APR-DRG SOI at each hospital. The sum of all APR-DRG SOI combinations shall be the Expected PPRs.
4. Observed Rate of Readmission shall mean the number of admissions in each hospital that were actually followed by at least one PPR divided by the total number of admissions.

5. Expected Rate of Readmission shall mean a risk adjusted rate for each hospital that accounts for the severity of illness, APR-DRG, and age of patients at the time of discharge preceding the readmission. It shall equal the number of expected PPRs divided by the total number of at risk hospital admissions at that hospital.
6. Excess Rate of Readmission shall mean the difference between the observed rate of readmission and the expected rate of readmission for each hospital.
7. For the period July 1, 2010 through June 30, 2011, Behavioral Health shall mean an admission that includes a primary or secondary diagnosis of a major mental health related condition. Effective for the period July 1, 2011 through March 31, 2012, Behavioral Health shall mean an admission that is assigned to a Major Diagnostic Category of 19-Mental Diseases and Disorders or 20-Alcohol/Drug Use and Alcohol/Drug Induced Organic Mental Disorders.

8. Average Hospital Specific Payment shall equal the Medicaid operating payment, using the applicable Medicaid rates for such period, of the total number of PPRs identified for each hospital divided by the total number of PPRs identified for each hospital.

Readmission Criteria.

1. A readmission is a return hospitalization following a prior discharge that meets all of the following criteria:
    a. The readmission could reasonably have been prevented by the provision of appropriate care consistent with accepted standards in the prior discharge or during the post discharge follow-up period.
    b. The readmission is for a condition or procedure related to the care during the prior discharge or the care during the period immediately following the prior discharge and including, but not limited to:
        i. the same or closely related condition or procedure as the prior discharge;
        ii. an infection or other complication of care;
        iii. a condition or procedure indicative of a failed surgical intervention; or
        iv. an acute decompensation of a coexisting chronic disease.
    c. The readmission is back to the same or to any other hospital.
2. Readmissions, for the purposes of determining PPRs, excludes the following circumstances:
    a. The original discharge was a patient initiated discharge and was Against Medical Advice (AMA) and the circumstances of such discharge and readmission are documented in the patient's medical record.
    b. For the period July 1, 2010 through June 30, 2011, [T]the original discharge was for the purpose of securing treatment of a major or metastatic malignancy, multiple trauma, burns, neonatal and obstetrical admissions. Effective for the period July 1, 2011 through March 31, 2012, the original discharge was for the purpose of securing treatments of the admissions listed on the following Department of Health website link: http://health care/Medicaid/Quality/Potentially Preventable Negative Outcomes
    c. The readmission was a planned readmission that occurred on or after 15 days following an initial admission.
    d. For readmissions occurring during the period up through March 31, 2012, the readmissions involve a discharge determined to be behavioral health related.

Methodology.

1. For the period July 1, 2010 through June 30, 2011, [R]rate adjustments for each hospital shall be calculated using 2007 Medicaid paid claims data for discharges that occurred between January 1, 2007 and December 31, 2007. Effective for the period July 1, 2011 through March 31, 2012, rate adjustments for each hospital shall be calculated using 2009 Medicaid claims data for discharges that occurred between January 1, 2009 and December 31, 2009.

2. The expected rate of readmission shall be reduced by:

   (a) 24% for periods prior to September 30, 2010;

   (b) 38.5% for the period October 1, 2010 through December 31, 2010;

   (c) 33.3% for the period[s on and after] January 1, 2011 through June 30, 2011.

   (d) A percentage determined by the Commissioner for the period on and after July 1, 2011.

3. The excess rate of readmission is multiplied by the total number of at risk hospital admissions at each hospital to determine the total number of risk adjusted excess readmissions.

4. In the event the observed rate of readmission for a hospital is lower than the expected rate of readmission, after the expected rate of readmission has been reduced by the applicable percentage in accordance with this section, the risk adjusted excess readmissions shall be set at zero.

Payment Calculation.

1. An average hospital specific payment will be used to compute the total Medicaid operating payments, excluding behavioral health, associated with the risk adjusted excess readmissions in each hospital.

2. The Medicaid case payment rate for the applicable rate period shall be used to compute the total Medicaid operating payments for all non-behavioral health Medicaid discharges in each hospital.

3. For each hospital, a hospital specific readmission adjustment factor shall be computed as the ratio of the hospital's total Medicaid operating payments for the applicable rate period associated with the risk adjusted excess readmissions identified in the Methodology Section and the hospital's total Medicaid operating payments for the same rate period for all non-behavioral health Medicaid discharges in each hospital as determined pursuant to this Section.

Appendix II
2011 Title XIX State Plan
Third Quarter Amendment
Hospital Inpatient Services
Summary

SUMMARY
SPA #11-82

This state plan amendment proposes to update several components used in the potentially preventable readmission (PPRs) methodology, and establish quality related measures pertaining to potentially preventable conditions and complications of care acquired in the hospital to be effective July 1, 2011.

Appendix III
2011 Title XIX State Plan
Third Quarter Amendment
Hospital Inpatient Services
Authorizing Provisions

SPA 11-82

Chapter 59 of the Laws of 2011

S.2809-D/A-4009.D - Part H

§ 35-a. Subparagraph (v) of paragraph (b) of subdivision 35 of section 2807-c of the public health law

(v) [Such] such regulations shall incorporate quality related measures [pertaining to], including, but not limited to, potentially preventable [complications and] re-admissions (PPRs) and provide for rate adjustments or payment disallowances related to PPRs and other potentially preventable negative outcomes (PPNOs), which shall be calculated in accordance with methodologies as determined by the commissioner, provided, however, that such methodologies shall be based on a [risk adjusted] comparison of the actual and [the] risk adjusted expected number of PPRs and other PPNOs in a given hospital and with benchmarks established by the commissioner and provided further that such rate adjustments or payment disallowances shall result in an aggregate reduction in Medicaid payments of no less than thirty-five million dollars for the period July first, two thousand ten through March thirty-first, two thousand eleven and no less than [forty-seven] fifty-one million dollars for the period April first, two thousand eleven through March thirty-first, two thousand twelve, provided further that such aggregate reductions shall be offset by Medicaid payment reductions occurring as a result of decreased PPRs during the period July first, two thousand ten through March thirty-first, two thousand eleven and the period April first, two thousand eleven through March thirty-first, two thousand twelve and as a result of decreased PPNOs during the period April first, two thousand eleven through March thirty-first, two thousand twelve; and provided further that [the regulations promulgated pursuant to this subparagraph shall be effective on and after July first, two thousand ten, and provided further, however, that] for the period July first, two thousand ten through March thirty-first, two thousand twelve, such rate adjustments or payment disallowances shall not apply to behavioral health PPRs; or to readmissions that occur on or after fifteen days following an initial admission. By no later than [April] July first, two thousand eleven the commissioner shall enter into consultations with representatives of the health care facilities subject to this section regarding potential prospective revisions to applicable methodologies and benchmarks set forth in regulations issued pursuant to this subparagraph;

Appendix IV
2011 Title XIX State Plan
Third Quarter Amendment
Hospital Inpatient Services
Public Notice

MISCELLANEOUS NOTICES/HEARINGS

Notice of Abandoned Property Received by the State Comptroller

Pursuant to provisions of the Abandoned Property Law and related laws, the Office of the State Comptroller receives unclaimed monies and other property deemed abandoned. A list of the names and last known addresses of the entitled owners of this abandoned property is maintained by the office in accordance with Section 1401 of the Abandoned Property Law. Interested parties may inquire if they appear on the Abandoned Property Listing by contacting the Office of Unclaimed Funds, Monday through Friday from 8:00 a.m. to 4:30 p.m., at:

1-800-221-9311
or visit our web site at:
www.osc.state.ny.us

Claims for abandoned property must be filed with the New York State Comptroller's Office of Unclaimed Funds as provided in Section 1406 of the Abandoned Property Law. For further information contact: Office of the State Comptroller, Office of Unclaimed Funds, 110 State St., Albany, NY 12236.

PUBLIC NOTICE
Department of Civil Service

PURSUANT to the Open Meetings Law, the New York State Civil Service Commission hereby gives public notice of the following:

Please take notice that the regular monthly meeting of the State Civil Service Commission for April 2011 will be conducted on April 14 commencing at 10:00 a.m. This meeting will be conducted at New York Network, Suite 146, South Concourse, Empire State Plaza, Albany, NY. Directions and parking information available at (www.nyn.suny.edu).

For further information, contact: Office of Commission Operations, Department of Civil Service, Alfred E. Smith State Office Bldg., Albany, NY 12239, (518) 473-6598

PUBLIC NOTICE
Department of Health

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

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

All Services

• Effective on and after April 1, 2011, no annual trend factor will be applied pursuant to the provisions of Public Health Law § 2807-c(10)(c) to rates of payment for hospital inpatient, residential health care facilities, certified home health agencies, personal care services, and adult day health care services provided to patients diagnosed with AIDS. This includes the elimination of the 2011 trend factor effective for rates of payment April 1, 2011, and thereafter. In addition, the Department is authorized to promulgate regulations, to be effective April 1, 2011, such that no annual trend factor may be applied to rates of payment by the Department of Health for assisted living program services, adult day health care services or personal care services provided in those local social services districts, including New York City, whose rates of payment for services is established by such social services districts pursuant to a rate-setting exemption granted by the Department. This includes the elimination of the 2011 trend factor effective for rates of payment April 1, 2011, and thereafter.

- Effective for dates of service April 1, 2011, through March 31, 2012, and each state fiscal year thereafter, all non-exempt Medicaid payments as referenced below will be uniformly reduced by two percent. Such reductions will be applied only if an alternative method that achieves at least $345 million in Medicaid state share savings annually is not implemented.

- Medicaid administration costs paid to local governments, contractors and other such entities will also be reduced in the same manner as described above.

- Payments exempt from the uniform reduction based on federal law prohibitions include, but are not limited to, the following:

• Federally Qualified Health Center services;

• Indian Health Services and services provided to Native Americans;

• Supplemental Medical Insurance - Part A and Part B;

• State Contribution for Prescription Drug Benefit (aka Medicare Part D payments);

• Any local share cap payment required by the Federal Medical Assistance Percentage (FMAP) increase legislation;

• Required payments related to the School Supportive Health Services Program and Preschool Supportive Health Services Program settlement agreement;

• Services provided to American citizen repatriates; and

• Hospice Services.

- Payments exempt from the uniform reduction based on being funded exclusively with federal and/or local funds include, but are not limited to, the following:

• Upper payment limit payments to non-state owned or operated governmental providers certified under Article 28 of the NYS Public Health Law;

• Certified public expenditure payments to the NYC Health and Hospital Corporation;

• Certain disproportionate share payments to non-state operated or owned governmental hospitals;

• Certain managed care payments pursuant to section 3-d of Part B of the Chapter 58 of the Laws of 2010; and

• Services provided to inmates of local correctional facilities.

- Payments pursuant to the mental hygiene law will be exempt from the reduction;

- Court orders and judgments; and

- Payments where applying the reduction would result in a lower FMAP as determined by the Commissioner of Health and the Director of the Budget will be exempt.

• Medicaid expenditures will be held to a year to year rate of growth spending cap which does not exceed the rolling average of the preceding 10 years of the medical component of the Consumer Price Index (CPI) as published by the United States Department of Labor, Bureau of Labor Statistics.

- The Director of the Budget and the Commissioner of Health will periodically assess known and projected Medicaid expenditures to determine whether the Medicaid growth spending cap appears to be pierced. The cap may be adjusted to account for any revision in State Financial Plan projections due to a change in the FMAP amount, provider based revenues, and beginning April 1, 2012, the operational costs of the medical indemnity fund. In the event it is determined that Medicaid expenditures exceed the Medicaid spending cap, after any adjustment to the cap if needed, the Director of the Division of the Budget and the Commissioner of Health will develop a Medicaid savings allocation plan to limit the Medicaid expenditures by the amount of the projected overspending. The savings allocation plan will be in compliance with the following guidelines:

• The plan must be in compliance with the federal law;

• It must comply with the State's current Medicaid plan, amendment, or new plan that may be submitted;

• Reductions must be made uniformly among category of service, to the extent practicable, except where it is determined by the Commissioner of Health that there are grounds for non-uniformity; and

• The exceptions to uniformity include but are not limited to: sustaining safety net services in underserved communities, to ensuring that the quality and access to care is maintained, and to avoiding administrative burden to Medicaid applicants and recipients or providers.

Medicaid expenditures will be reduced through the Medicaid savings allocation plan by the amount of projected overspending through actions including, but not limited to: modifying or suspending reimbursement methods such as fees, premium levels, and rates of payment; modifying or discontinuing Medicaid program benefits; seeking new waivers or waiver amendments.

Institutional Services

• For the state fiscal year beginning April 1, 2011 through March 31, 2012, continues specialty hospital adjustments for hospital inpatient services provided on and after April 1, 2011, to public general hospitals, other than those operated by the State of New York or the State University of New York, located in a city with a population of over one million and receiving reimbursement of up to $1.08 billion annually. Payments to eligible public general hospitals may be added to rates of payment or made as aggregate payments.

• Effective for periods on and after January 1, 2011, for purposes of calculating maximum disproportionate share (DSH) payment distributions for a rate year or part thereof, costs incurred of furnishing hospital services net of medical assistance payments, other than DSH payments, and payments by uninsured patients shall for the 2011 calendar year, be determined initially based on each hospital's submission of a fully completed 2008 DSH hospital data collection tool, which is required to be submitted to the Department, and shall be subsequently revised to reflect each hospital's submission of a fully completed 2009 DSH hospital data collection tool, which is required to be submitted to the Department.

- For calendar years on and after 2012, such initial determinations shall reflect submission of data as required by the Commissioner on a specific date. All such initial determinations shall subsequently be revised to reflect actual rate period data and statistics. Indigent care payments will be withheld in instances when a hospital has not submitted required information by the due dates, provided, however, that such payments shall be made upon submission of such required data.

- For purposes of eligibility to receive DSH payments for a rate year or part thereof, the hospital inpatient utilization rate shall be determined based on the base year statistics and costs incurred of furnishing hospital services determined in accordance with the established methodology that is consistent with all federal requirements.

• Extends through December 31, 2014, the authorization to distribute Indigent Care and High Need Indigent Care disproportionate share payments in accordance with the previously approved methodology.

• For state fiscal years beginning April 1, 2011, and for each state fiscal year thereafter, additional medical assistance payments for inpatient hospital services may be made to public general hospitals operated by the State of New York or the State University of New York, or by a county which shall not include a city with a population over one million, and those public general hospitals located in the counties of Westchester, Erie, or Nassau, up to one hundred percent (100%) of each such public hospital's medical assistance and uninsured patient losses after all other medical assistance, including disproportionate share payments to such general hospitals. Payments may be added to rates of payment or made as aggregate payments. Payments will be based initially on reported reconciled data from the base year two years prior to the payment year adjusted for authorized Medicaid rate changes and further reconciled to actual reported data from such payment year.

• Public general hospitals, other than those operated by the State of New York or the State University of New York, that are located in a city with a population of over one million may receive additional medical assistance DSH payments for inpatient hospital services for the state fiscal year beginning April 1, 2011 through March 31, 2012, and annually thereafter, in the amount of up to $120 million, as further increased by up to the maximum payment amounts permitted under sections 1923(f) and (g) of the federal Social Security Act, as determined by the Commissioner of Health after application of all other disproportionate share hospital payments. Payments may be added to rates of payment or made as aggregate payments. Payments will be based initially on reported reconciled data from the base year two years prior to the payment year adjusted for authorized Medicaid rate changes and further reconciled to actual reported data from such payment year.

• Extends current provisions to services on and after April 1, 2011, the reimbursable operating cost component for general hospital inpatient rates will be established with the 2006 final trend factor equal to the final Consumer Price Index (CPI) for all urban consumers less 0.25%.

• The State proposes to extend, effective April 1, 2011, and thereafter, certain cost containment initiatives that were enacted in Chapter 81 of the Laws of 1995 and extended by subsequent legislation. The extended provisions are as follows: (1) hospital capital costs shall exclude 44% of major moveable equipment costs; (2) elimination of reimbursement of staff housing operating and capital costs; and (3) budgeted capital inpatient costs of a general hospital applicable to the rate year shall be decreased to reflect the percentage amount by which the budgeted costs for capital related inpatient costs of the hospital for the base year two years prior to the rate year exceeded actual costs.

• Per federal requirements, the Commissioner of Health shall promulgate regulations effective July 1, 2011 that will deny Medicaid payment for costs incurred for hospital acquired conditions (HACs). The regulations promulgated by the Commissioner shall incorporate the listing of Medicaid HACs in the yet to be issued final federal rule.

• The Commissioner of Health shall promulgate regulations to incorporate quality related measures pertaining to potentially preventable conditions and complications, including, but not limited to, diseases or complications of care acquired in the hospital and injuries sustained in the hospital.

• Effective April 1, 2011, hospital inpatient rates of payment for cesarean deliveries will be limited to the average Medicaid payment for vaginal deliveries. All cesarean claims will be subject to an appeal process to determine if the services were medically necessary thus warranting the higher Medicaid payment.

• Effective April 1, 2011, the Department is proposing to expand the current Patient Centered Medical Home (PCMH) to more payers and incorporate several provisions to improve medical care. Two provisions result in a change in the methods by which Medicaid fee-for-service (FFS) reimburses Medicaid providers who are designated by the National Committee for Quality Assurance as patient centered medical homes: 1) testing new models of payment to high-volume Medicaid primary care medical home practices which incorporate risk-adjusted global payments with care management and pay-for-performance, and 2) improving the relationship of FFS Medicaid members to medical homes by creating medical home payments only for FFS members who have evidence of ongoing continuity relationship with provider/practice and providing more reliable care manage-

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

The public is invited to review and comment on this proposed state plan amendment.

For further information or to review and comment on this proposed state plan amendment, please contact or write: Patricia A. Keller, RPh., Department of Health, Office of Health Insurance Programs, Division of Policy and Program Guidance, Empire State Plaza, Rm. 720, Corning Tower, Albany, NY 12237, (518) 474-9219, (518) 473-5508 (FAX), PAK04@health.state.ny.us

PUBLIC NOTICE
Department of Health

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

The Department of Health proposes to amend the Title XIX (Medicaid) State Plan for inpatient hospital services to clarify recently enacted statutory provisions. The following provides clarification to previously noticed provisions:

Inpatient Hospital Services

- To clarify the previously noticed provision on March 30, 2011, regarding the denial of Medicaid payments for costs incurred for hospital acquired conditions (HACs), the following is list of conditions that, effective July 1, 2011, Medicaid will not pay the incremental cost associated with such condition when it is acquired within the hospital setting:
  - A foreign object retained within a patient's body after surgery.
  - The development of an air embolism within a patient's body.
  - A patient blood transfusion with incompatible blood.
  - A patient's development of stage III or stage IV pressure ulcers.
  - Patient injuries resulting from accidental falls and other trauma, including, but not limited to fractures; dislocations; intracranial injuries; crushing injuries; burns; and electronic shock.
  - A patient's manifestations of poor glycemic control, including, but not limited to diabetic ketoacidosis; nonketotic hyperosmolar coma; hypoglycemic coma; secondary diabetes with ketoacidosis; and secondary diabetes with hyperosmolarity.
  - A patient's development of a catheter-associated urinary tract infection.
  - A patient's development of a vascular catheter-associated infection.
  - A patient's development of a surgical site infection following a coronary artery bypass graft - mediastinitis; bariatric surgery, including, but not limited to, laparoscopic gastric bypass, gastroenterostomy and laparoscopic gastric restrictive surgery; or orthopedic procedures, including, but not limited to, such procedures performed on the spine, neck, shoulder and elbow.
  - Development of deep vein thrombosis or a pulmonary embolism in connection with a total knee replacement or a hip replacement excluding pediatric and obstetric patients.

A pediatric patient is defined as age 17 and under. An obstetric patient is defined when at least one primary or secondary diagnosis code include an indication of pregnancy. A list of such codes will be made available on the Department of Health website. There is no additional gross Medicaid savings attributed to this clarification.

- The potentially preventable readmission (PPR) methodology will be updated effective July 1, 2011. Rate adjustments will be based on a comparison of the actual and the expected number of PPRs, adjusted for benchmarks as determined by the Commissioner, in a given hospital using 2009 Medicaid paid claims data; version 28.0 of the 3M Health Information System APR Software; excluding cases that grouped to the MDC 19 (Mental Diseases and Disorders) and MDC 20 (Alcohol/Drug Use and Alcohol/Drug Induced Organic Mental Disorders) categories; and excluding readmissions to facilities that are exempt from the case based payment system. There is no additional gross Medicaid savings attributed to the update of this methodology.
- The following is a clarification to current inpatient reimbursement methodologies in the State Plan that are currently in practice:
  - Regarding the statewide base price, discharges for non-comparable adjustments will no longer include patients who are transferred to a facility or unit that is exempt from the case-based system. However, newborns transferred to an exempt hospital for neonatal care will remain included as discharges for non-comparable adjustments.
  - The allowable costs of fixed capital associated with capital expense reimbursement no longer include hospitals financed according to Article 28-B of the Public Health Law (i.e., amortization instead of depreciation; approved expenses, such as interest, that are associated with both fixed capital and major movable equipment).
  - In order for interest to be considered an allowable cost for all medical facilities, it must exclude any costs or fees that were accumulated due to an interest rate swap agreement.
  - Each hospital is subject to a two-percent reduction in their rate if they fail to submit their fee to support the statewide planning and research cooperative system in accordance with the stated schedule. This rate reduction is an increase from the one-percent rate that was previously stated.
  - High cost outlier rates of payment for inpatient hospital services provided by out-of-state providers will be calculated in accordance with the outlier rates of payment methodology used for in-state hospitals. However, the single exception to this is the wage equalization factor which will be based on the weighted average of the upstate or downstate region. The downstate region of New York State shall apply with regard to services provided by out-of-state providers located in the New Jersey counties of Sussex, Passaic, Bergin, Hudson, Essex, Union, Middlesex and Monmouth, in the Pennsylvania county of Pike, and in the Connecticut counties of Fairfield and Litchfield.
  - Capital rates of payment for services provided by out-of-state providers will be the weighted average of the capital component of the inpatient rates for similar services in New York State hospitals.

There is no additional gross Medicaid savings or cost attributed to the clarification of these methodologies.

For all of these initiatives, there is no change in gross Medicaid expenditures for state fiscal year 2011/2012.

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
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

The public is invited to review and comment on these proposed state plan amendments.

For further information and to review and comment, please contact: Department of Health, Bureau of HCRA Operations & Financial Analysis, Corning Tower Bldg., Rm. 984, Empire State Plaza, Albany, NY 12237, (518) 474-1673, (518) 473-8825 (FAX), spa_inquiries@health.state.ny.us

PUBLIC NOTICE
Office of Mental Health

As a result of the enacted 2011-2012 State Budget, the New York State Office of Mental Health hereby gives notice that it is proposing to amend its Medicaid State Plan to reflect the continuation of the 2010-2011 rates for the 2011-2012 rate year for Residential Treatment Facilities for Children and Youth, effective July 1, 2011.

PUBLIC NOTICE
New York State Association of Counties (NYSAC)

NYSAC is soliciting proposals from administrative service agencies relating to trust service, managed accounts, administration and/or funding of a Deferred Compensation Plan for the employees of NYSAC. They must meet the requirements of section 457 of the Internal Revenue Code and Section 5 of the State Finance Law, including all rules and regulations issued pursuant thereto.

A copy of the proposal questionnaire may be obtained from: NYSAC, Attn: Karen Catalfamo, Fiscal/Office Manager, 540 Broadway, Albany, NY 12207

All proposals must be received no later than 30 days from the date of publication in the New York *State Register*.

PUBLIC NOTICE
Oneida-Herkimer Solid Waste Authority
FINAL REQUEST FOR PROPOSALS (RFP)
TRANSPORTATION OF SOLID WASTE TO THE ONEIDA-HERKIMER LANDFILL FOR ONEIDA-HERKIMER SOLID WASTE MANAGEMENT AUTHORITY

Pursuant to New York State General Municipal Law, Section 120-w, the Oneida-Herkimer Solid Waste Authority hereby gives notice of the following:

The Oneida-Herkimer Solid Waste Authority (OHSWA) desires to procure an agreement for 5 years beginning 10/24/11 for transportation of non-recyclable waste from 2 transfer stations to the Oneida-Herkimer Landfill, Ava, NY. Responses to the Final RFP must be received by 1:00 p.m. 7/13/2011.

Copies of the Final RFP may be obtained at www.ohswa.org or through the contact below: James V. Biamonte, Contracting Officer, 1600 Genesee St., Utica, NY 13502

SALE OF FOREST PRODUCTS
Cortland Reforestation Area No. 6
Contract No. X007946

Pursuant to Section 9-0505 of the Environmental Conservation Law, the Department of Environmental Conservation hereby gives Public Notice of the following:

Sealed bids for 68.4 MBF more or less of sawtimber and 45 cords more or less of hardwood/pulpwood/firewood, located on Cortland Reforestation Area No. 6, Cuyler Hill State Forest, Stand E-13.1, will be accepted at the Department of Environmental Conservation, Contract Unit, 625 Broadway, 10th Fl., Albany, NY 12233-5027 until 11:00 a.m., Thursday, July 7, 2011.

For further information, contact: Mark Zubal, Senior Forester, Department of Environmental Conservation, Division of Lands and Forests, Region 7, 1285 Fisher Ave., Cortland, NY 13045-1090, (607) 753-3095 x217

SALE OF FOREST PRODUCTS
Delaware Reforestation Area No. 7
Contract No. X008228

Pursuant to Section 9-0505 of the Environmental Conservation Law, the Department of Environmental Conservation hereby gives Public Notice for the following:

Sealed bids for 425.7 MBF more or less of softwood sawtimber and 1.5 MBF more or less of misc. hardwood sawtimber, located on Delaware Reforestation Area No. 7, Stand A-20, will be accepted at the Department of Environmental Conservation, Bureau of Procurement & Expenditure Services, 625 Broadway, 10th Fl., Albany, NY 12233-5027 until 11:00 a.m., Thursday, July 7, 2011.

For further information, contact: Ben Peters, Senior Forester, Department of Environmental Conservation, Division of Lands and Forests, Region 4, 65561 State Hwy. 10, Suite 1, Stamford, NY 12167-9503, (607) 652-7365

Appendix V
2011 Title XIX State Plan
Third Quarter Amendment
Hospital Inpatient Services
Responses to Standard Funding Questions

HOSPITAL SERVICES
State Plan Amendment #11-82

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 or D) of your state plan.

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

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

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

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

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

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

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

   Response: The State submitted the 2011 inpatient UPL to CMS for review and approval on September 9, 2011.

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.

Assurances:

1. **In compliance with provisions of the Recovery Act, the State should provide assurances that they are in compliance with the terms of the Recovery Act concerning (1) Maintenance of Effort (MOE); (2) State or local match; (3) Prompt payment; (4) Rainy day funds; and (5) Eligible expenditures (e.g. no DSH or other enhanced match payments).**

   Response: The State hereby provides assurances that it remains in compliance with the terms of the Recovery Act with regard to the requirements pertaining to the maintenance of effort, State or local match, prompt payment, rainy day funds, and eligible expenditures. In addition, the HHS Office of Inspector General has reviewed the State's compliance with the political subdivision requirement for increased FMAP under ARRA and found the State to be in compliance with this provision (Report A-02-09-01029).

2. **The State needs to verify it is in compliance with the provisions of Section 5006 of the Recovery Act concerning tribal consultations for the SPA, or an explanation why the provisions did not apply in this instance.**

Response: The provision concerning tribal consultations does not apply to this SPA since Indian Health Programs in New York State do not provide inpatient hospital services and, therefore, receive no Medicaid payments for such services.

Appendix VI
2011 Title XIX State Plan
Third Quarter Amendment
Hospital Inpatient Services
Responses to Standard Access Questions

INPATIENT SERVICES
State Plan Amendment #11-82

CMS Standard Access Questions

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

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

   Response: This amendment seeks to update several components used in the potentially preventable readmission (PPRs) methodology, and establish quality related measures pertaining to potentially preventable conditions and complications of care acquired in the hospital to be effective July 1, 2011. This plan will create incentives for healthcare improvement by linking payment to quality measures as a way to focus quality improvement efforts to assist in the design of a safer health care delivery system. Further, this amendment builds off a former approved policy of PPRs and only requires that savings be increased by $4 million in gross. This additional savings is minimal, given the total amount of expenditures for inpatient services. Therefore, the State feels it is compliant with the requirements of 1902(a)(30).

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

   Response: The State has various ways to ensure that access levels in the Medicaid program are retained and is currently not aware of any access issues, particularly since there is excess bed capacity for both hospitals and nursing homes. Additionally, hospital and nursing home providers must notify and receive approval from the Department's Office of Health Systems Management (OHSM) in order to discontinue services. This Office monitors and considers such requests in the context of access as they approve/deny changes in services. Finally, providers cannot discriminate based on source of payment.

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

   Finally, the State ensures that there is sufficient provider capacity for Medicaid Managed Care plans as part of its process to approve managed care rates and plans.

Should sufficient access to services be compromised, the State would be alerted and would take appropriate action to ensure retention of access to such services.

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

   Response: This change was enacted by the State Legislature as part of the negotiation of the 2011-12 Budget. The impact of this change was weighed in the context of the overall Budget in the State. The legislative process provides opportunities for all stakeholders to lobby their concerns, objections, or support for various legislative initiatives.

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

   Response: Should any essential community provider experience Medicaid or other revenue issues that would prevent access to needed community services, per usual practice, the State would meet with them to explore the situation and discuss possible solutions, if necessary.

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

   Response: Over the course of the past three years, the State has undertaken a massive reform initiative to better align reimbursement with care. When fully implemented in 2010-11, the initiative will invest over $600 million in the State's ambulatory care system (outpatient, ambulatory surgery, emergency department, clinic and physicians) to incentivize care in the most appropriate setting. The State has also increased its physician reimbursement schedule to resemble Medicare payments for similar services, thus ensuring continued access for Medicaid beneficiaries. Further, the State is implementing initiatives that will award $600 million annually, over five years, to providers who promote efficiency and quality care through the Federal-State Health Reform Partnership(F-SHRP)/ NYS Healthcare Efficiency and Affordability Law (HEAL). While some of these initiatives are outside the scope of the State Plan, they represent some of the measures the State is taking to ensure quality care for the State's most vulnerable population.