NEW YORK
state department of
HEALTH

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

Sue Kelly
Executive Deputy Commissioner

June 4, 2012

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

Re: SPA #12-21
Inpatient Hospital Services

Dear Mr. Cooley:

The State requests approval of the enclosed amendment #12-21 to the Title XIX (Medicaid) State Plan for inpatient hospital services to be effective May 1, 2012 (Appendix I). This amendment is being submitted based upon State regulation. 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 was given in the New York State Register on April 25, 2012.

It is estimated that the changes represented by 2012 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.

A copy of the proposed regulation is enclosed for your information (Appendix III). In addition, responses to the five standard funding questions and the standard access questions are also enclosed (Appendix V and VII, respectively).

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

Sincerely,

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: HEALTH CARE FINANCING ADMINISTRATION	1. TRANSMITTAL NUMBER: **12-21**	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 **May 1, 2012**	

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 05/01/12 – 09/30/12 ($ 4,363,636)** **b. FFY 10/01/12 – 09/30/13 ($ 10,036,364)**
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: **Attachment 4.19-A: page 106(a)**	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: **Attachment 4.19-A: page 106(a)**

10. SUBJECT OF AMENDMENT:
Continued reduction to inpatient statewide base price (FMAP = 50%)

11. GOVERNOR'S REVIEW *(Check One)*:

☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. 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: June 4, 2012	

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
2012 Title XIX State Plan
Second Quarter Amendment
Hospital Inpatient Services
Amended SPA Pages

4. To establish the Transition II Pool, effective October 20, 2010, the statewide base price will be reduced such that the level of total Medicaid payments shall be decreased for the periods specified on the 'Transition II Pool' section by the corresponding Transition II fund amount.

5. For the period effective July 1, 2011 through March 31, 2012, the statewide base price will be reduced such that the level of total Medicaid payments are decreased by $24.2 million.

6. For the period May 1, 2012, through March 31, 2013, and for state fiscal year periods on and after April 1, 2013, the statewide base price shall be adjusted such that total Medicaid payments are decreased for such period and for each such state fiscal year period by $19,200,000.

Appendix II
2012 Title XIX State Plan
Second Quarter Amendment
Hospital Inpatient Services
Summary

SUMMARY
SPA #12-21

This State Plan Amendment proposes to continue the reduction to the statewide base price in a new amount of $19,200,000 for the period May 1, 2012 through March 31, 2013, and for each state fiscal year beginning on and after April 1, 2013.

Appendix III
2012 Title XIX State Plan
Second Quarter Amendment
Hospital Inpatient Services
Authorizing Provisions

Delaware	Oswego	Warren
Essex	Otsego	Washington
Franklin	Putnam	Wayne
Fulton	Rensselaer	Wyoming
Genesee	St. Lawrence	Yates
Greene		

The following nine counties have certain townships with population densities of 150 persons or less per square mile:

Albany	Erie	Oneida
Broome	Monroe	Onondaga
Dutchess	Niagara	Orange

Compliance Requirements:

There are no new compliance requirements as a result of the proposed rule.

Professional Services:

No new additional professional services are required in order for providers in rural areas to comply with the proposed amendments.

Compliance Costs:

No additional compliance costs are anticipated as a result of this rule.

Minimizing Adverse Impact:

To ensure a smooth transition to the new pricing methodology by mitigating significant fluctuations (increases or decreases) in the amount of Medicaid revenues received by nursing homes, per diem transition rate adjustments will be included to phase-in the new pricing methodology over a five-year period, with full implementation in the sixth year. The new methodology will also, by limiting the potential bases of subsequent administrative rate appeals and audit adjustments, enhance the stability and certainty of initial Medicaid payments and reduce the likelihood of litigation.

Rural Area Participation:

The Department, in collaboration with the Nursing Home Industry Associations (which include representation of rural nursing homes) worked collaboratively to develop the key components of the statewide pricing methodology. In addition, a Federal Public Notice, published in the New York State Register invited comments and questions from the general public.

Job Impact Statement

A Job Impact Statement is not required pursuant to Section 201-a(2)(a) of the State Administrative Procedure Act. It is not expected that the proposed rule to establish a new Medicaid reimbursement methodology for Nursing Homes will have a material impact on jobs or employment opportunities across the Nursing Home industry. To ensure a smooth transition to the new pricing methodology by mitigating significant fluctuations (increases or decreases) in the amount of Medicaid revenues received by nursing homes, per diem transition rate adjustments will be included in the proposed regulations to phase-in the new pricing methodology over a five-year period, with full implementation in the sixth year.

EMERGENCY RULE MAKING

Reduction to Statewide Base Price

I.D. No. HLT-20-12-00014-E

Filing No. 434

Filing Date: 2012-05-01

Effective Date: 2012-05-01

PURSUANT TO THE PROVISIONS OF THE State Administrative Procedure Act, NOTICE is hereby given of the following action:

Action taken: Amendment of section 86-1.16 of Title 10 NYCRR.

Statutory authority: Public Health Law, section 2807-c(35)

Finding of necessity for emergency rule: Preservation of public health.

Specific reasons underlying the finding of necessity: It is necessary to issue the proposed regulations on an emergency basis in order to achieve targeted savings.

Public Health Law section 2807-c(35)(b) specifically provides the Commissioner of Health with authority to issue hospital inpatient rate-setting regulations as emergency regulations.

Further, there is compelling interest in enacting these regulations immediately in order to secure federal approval of the associated Medicaid State Plan Amendment.

Subject: Reduction to Statewide Base Price.

Purpose: Continues a reduction to the statewide base price for inpatient services.

Text of emergency rule: Pursuant to the authority vested in the Commissioner of Health by section 2807-c(35)(b) of the Public Health Law, Subdivision (c) of section 86-1.16 of Subpart 86-1 of Title 10 of the Official Compilation of Codes, Rules and Regulations of the State of New York is amended, to be effective May 1, 2012, to read as follows:

(c)*(1)* For the period effective July 1, 2011 through March 31, 2012, the statewide base price shall be adjusted such that total Medicaid payments are decreased by $24,200,000.

(2) For the period May 1, 2012 through March 31, 2013, the statewide base price shall be adjusted such that total Medicaid payments are decreased for such period by $19,200,000.

This notice is intended to serve only as a notice of emergency adoption. This agency intends to adopt this emergency rule as a permanent rule and will publish a notice of proposed rule making in the *State Register* at some future date. The emergency rule will expire July 29, 2012.

Text of rule and any required statements and analyses may be obtained from: Katherine Ceroalo, DOH, Bureau of House Counsel, Reg. Affairs Unit, Room 2438, ESP Tower Building, Albany, NY 12237, (518) 473-7488, email: regsqna@health.state.ny.us

Regulatory Impact Statement

Statutory Authority:

The requirement to implement a modernized Medicaid reimbursement system for hospital inpatient services based upon 2005 base year operating costs pursuant to regulations is set forth in section 35 of part B as added by Chapter 58 of the laws of 2009. Section 2807-c(35) of the Public Health Law states that the Commissioner has the authority to set emergency regulations for general hospital inpatient rates and such regulations shall include but not be limited to a case-mix neutral Statewide base price. Such Statewide base price will exclude certain items specified in the statute and any other factors as may be determined by the Commissioner.

Legislative Objectives:

The Legislature and Medicaid Redesign Team adopted a proposal to reduce unnecessary cesarean deliveries to promote quality care and reduce unnecessary expenditures. Due to industry concerns with the initial proposal, it was determined that a more clinically sound method needed to be developed. To generate immediate savings, however, a $24.2 million gross ($12.1 million State share) reduction in the statewide base price was implemented for 2011-12 while an obstetrical workgroup worked to develop a more clinically sound approach to meet Legislative objectives. Based on the results of workgroup meetings, a new proposal was developed which achieved less savings than required by the Financial Plan ($5 million gross/$2.5 million State share). Therefore, this emergency amendment continues the base price reduction at $19.2 million gross ($9.6 million State share) to account for the difference through March 31, 2013.

Needs and Benefits:

The proposed amendment appropriately implements the provisions of Public Health Law section 2807-c(35)(b)(xii), which authorizes the Commissioner to address the inappropriate use of cesarean deliveries. Cesarean deliveries are surgical procedures that inherently involve risks; however, elective cesarean deliveries increase the risks unnecessarily. Therefore, high rates of cesarean deliveries are increasingly viewed as indicative of quality of care issues.

Due to industry concerns with the initial proposal, it was determined that a more clinically sound approach to meeting Legislative objectives needed to be developed. To generate immediate savings, however, a $24.2 million gross ($12.1 million State share) reduction in the statewide base price was implemented for 2011-12 while an obstetrical workgroup worked to develop such an approach. Based on the results of those meetings, a new proposal was developed which achieved less savings than required by the Financial Plan ($5 million gross/$2.5 million State share). Therefore, this emergency amendment continues the base price reduction at $19.2 million gross ($9.6 million State share) to account for the difference through March 31, 2013.

COSTS:

Costs to State Government:

There are no additional costs to State government as a result of this amendment.

Costs of Local Government:

There will be no additional cost to local governments as a result of these amendments.

Costs to the Department of Health:

There will be no additional costs to the Department of Health as a result of this amendment.

Local Government Mandates:
The proposed amendments do not impose any new programs, services, duties or responsibilities upon any county, city, town, village, school district, fire district or other special district.
Paperwork:
There is no additional paperwork required of providers as a result of these amendments.
Duplication:
These regulations do not duplicate existing State and Federal regulations.
Alternatives:
No significant alternatives are available at this time. In collaboration with the hospital industry, the State developed a more clinically sound method to achieve savings. However, this amount was less than was required by the Financial Plan. Thus, there is no option to not act on this initiative since the Enacted Budget assumed savings that total $24.2 million.
Federal Standards:
This amendment does not exceed any minimum standards of the federal government for the same or similar subject areas.
Compliance Schedule:
Section 86-1.16 requires that the statewide base price be reduced by $19,200,000 for the period May 1, 2012, through March 31, 2013.

Regulatory Flexibility Analysis

Effect on Small Business and Local Governments:
For the purpose of this regulatory flexibility analysis, small businesses were considered to be general hospitals with 100 or fewer full time equivalents. Based on recent financial and statistical data extracted from the Institutional Cost Report, seven hospitals were identified as employing fewer than 100 employees.
Health care providers subject to the provisions of this regulation under section 2807-c(35) of the Public Health Law will see a minimal decrease in funding as a result of the reduction in the statewide base price.
This rule will have no direct effect on Local Governments.
Compliance Requirements:
No new reporting, recordkeeping or other compliance requirements are being imposed as a result of these rules. Affected health care providers will bill Medicaid using procedure codes and ICD-9 codes approved by the American Medical Association, as is currently required. The rule should have no direct effect on Local Governments.
Professional Services:
No new or additional professional services are required in order to comply with the proposed amendments.
Compliance Costs:
As a result of the new provision of 86-1.16, overall statewide aggregate hospital Medicaid revenues for hospital inpatient services will decrease in an amount corresponding to the total statewide base price reduction.
Economic and Technological Feasibility:
Small businesses will be able to comply with the economic and technological aspects of this rule. The proposed amendments are technologically feasible because it requires the use of existing technology. The overall economic impact to comply with the requirements of this regulation is expected to be minimal.
Minimizing Adverse Impact:
The proposed amendments reflect statutory intent and requirements.
Small Business and Local Government Participation:
Hospital associations participated in discussions and contributed comments through the State's Medicaid Redesign Team process regarding these changes.

Rural Area Flexibility Analysis

Types and Estimated Numbers of Rural Areas:
This rule applies uniformly throughout the state, including rural areas. Rural areas are defined as counties with a population less than 200,000 and counties with a population of 200,000 or greater that have towns with population densities of 150 persons or fewer per square mile. The following 43 counties have a population of less than 200,000 based upon the United States Census estimated county populations for 2010 (http://quickfacts.census.gov). Approximately 17% of small health care facilities are located in rural areas.

Allegany County	Greene County	Schoharie County
Cattaraugus County	Hamilton County	Schuyler County
Cayuga County	Herkimer County	Seneca County
Chautauqua County	Jefferson County	St. Lawrence County
Chemung County	Lewis County	Steuben County
Chenango County	Livingston County	Sullivan County
Clinton County	Madison County	Tioga County
Columbia County	Montgomery County	Tompkins County
Cortland County	Ontario County	Ulster County
Delaware County	Orleans County	Warren County
Essex County	Oswego County	Washington County
Franklin County	Otsego County	Wayne County
Fulton County	Putnam County	Wyoming County
Genesee County	Rensselaer County	Yates County
	Schenectady	

The following counties have a population of 200,000 or greater and towns with population densities of 150 persons or fewer per square mile. Data is based upon the United States Census estimated county populations for 2010.

Albany County	Monroe County	Orange County
Broome County	Niagara County	Saratoga County
Dutchess County	Oneida County	Suffolk County
Erie County	Onondaga County	

Compliance Requirements:
No new reporting, recordkeeping, or other compliance requirements are being imposed as a result of this proposal.
Professional Services:
No new additional professional services are required in order for providers in rural areas to comply with the proposed amendments.
Compliance Costs:
No initial capital costs will be imposed as a result of this rule, nor is there an annual cost of compliance.
Minimizing Adverse Impact:
The proposed amendments reflect statutory intent and requirements.
Rural Area Participation:
This amendment is the result of discussions with industry associations as part of the Medicaid Redesign team process. These associations include members from rural areas. As well, the Medicaid Redesign Team held multiple regional hearings and solicited ideas through a public process.

Job Impact Statement

A Job Impact Statement is not required pursuant to Section 201-a(2)(a) of the State Administrative Procedure Act. It is apparent from the nature and purpose of the proposed rule that it will not have a substantial adverse impact on jobs or employment opportunities. The proposed emergency regulation revises the final statewide base price for the period beginning May 1, 2012, through March 31, 2013.

Department of Law

NOTICE OF WITHDRAWAL

Freedom of Information Law

I.D. No. LAW-08-12-00003-W

PURSUANT TO THE PROVISIONS OF THE State Administrative Procedure Act, NOTICE is hereby given of the following action:

Action taken: Notice of proposed rule making, I.D. No. LAW-08-12-00003-P, has been withdrawn from consideration. The notice of proposed rule making was published in the *State Register* on February 22, 2012.

Subject: Freedom of Information Law.

Reason(s) for withdrawal of the proposed rule: The Department of Law received one objection to the proposed consensus rule.

REVISED RULE MAKING
NO HEARING(S) SCHEDULED

Determining When Funds Escrowed in Connection with the Offer or Sale of Cooperative Interests in Realty May be Released

I.D. No. LAW-50-11-00002-RP

PURSUANT TO THE PROVISIONS OF THE State Administrative Procedure Act, NOTICE is hereby given of the following revised rule:

Appendix IV
2012 Title XIX State Plan
Second Quarter Amendment
Hospital Inpatient Services
Public Notice

An application for a waiver of the requirements of paragraph a of subdivision 7 of section 176-b of the Town Law, which limits the membership of volunteer fire companies to forty-five per centum of the actual membership of the fire company, has been submitted by the Sauquoit Fire District #1, County of Oneida.

Pursuant to section 176-b of the Town Law, the non-resident membership limit shall be waived provided that no adjacent fire department objects within sixty days of the publication of this notice.

Objections shall be made in writing, setting forth the reasons such waiver should not be granted, and shall be submitted to: Bryant D. Stevens, State Fire Administrator, Office of Fire Prevention and Control, 99 Washington Ave., Suite 500, Albany, NY 12210-2833

Objections must be received by the State Fire Administrator within sixty days of the date of publication of this notice.

In cases where an objection is properly filed, the State Fire Administrator shall have the authority to grant a waiver upon consideration of (1) the difficulty of the fire company or district in retaining and recruiting adequate personnel; (2) any alternative means available to the fire company or district to address such difficulties; and (3) the impact of the waiver on adjacent fire departments.

For further information, please contact: Deputy Chief Donald Fischer, Office of Fire Prevention and Control, 99 Washington Ave., Suite 500, Albany, NY 12210-2833, (518) 474-6746, Dfischer@dhses.ny.gov

PUBLIC NOTICE

City of Glen Cove
Transfer Station Operation & Maintenance
Solid Waste Transport
Recycling and Disposal Services
Final Request for Proposals (FRFP)

PLEASE TAKE NOTICE, that pursuant to, and accordance with, Subdivision 4 of Section 120-w of the General Municipal Law, the City of Glen Cove hereby gives notice of its Final Request for Proposals (FRFP) for the financing, provision of transportation means and services and the facilities, having to do with the operation and maintenance of the City of Glen Cove solid waste transfer station and for the transportation, recycling and disposal of City of Glen Cove municipal solid waste. The means, services and facilities are expected to include: certain capital improvements to the City of Glen Cove solid waste transfer station; the operation and maintenance of the City of Glen Cove solid waste transfer station; transfer haul vehicles; the processing, transportation, recycling and disposal of solid waste; administrative management; maintenance support; and customer service support to perform services as specified in FRFP. Issued with the FRFP, may be comments filed in relation to the previously released Draft Request for Proposals (DRFP), and the City's findings related to the substantive elements of such comments.

Copies of the FRFP may be obtained at the City of Glen Cove Finance Department, Purchasing Division, Attn: Ms. Nancy Andreiev, City Purchasing Agent, City of Glen Cove City Hall, First Floor, 9 Glen Street, Glen Cove, New York 11542 between the hours of 9:00 A.M., 4:30 P.M., except Saturdays, Sundays and Holidays, on and after Monday, April 30, 2012 for a nonrefundable fee of ONE HUNDRED DOLLARS ($100.00), until Tuesday, May 22, 2012.

One (1) original and 4 (four) copies of the FRFP must be received at the office of William Archambault, Director of Public Works, City of Glen Cove City Hall, Room 301, 9 Glen Street, Glen Cove, New York 11542, no later than 3:00 p.m. on Tuesday, May 22, 2012.

The City of Glen Cove shall also provide a copy of the FRFP for review on or after April 30, 2012 until May 22, 2012, at the following two locations: (1) the Office of the City Clerk, City Hall, 9 Glen Street, New York 11542, and (2) the Glen Cove Public Library, 4 Glen Cove Avenue, Glen Cove, New York 11542.

PUBLIC NOTICE

Department of Health

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

The Department of Health proposes to amend the Title XIX (Medicaid) State Plan for institutional, long term care, and non-institutional services to comply with recently enacted statutory provisions. The following provides clarification to provisions previously noticed on March 30, 2012, and notification of new significant changes:

All Services

- The amount appropriated for previously noticed provisions regarding the Essential Community Provider Network and the Vital Access Providers initiatives in the enacted budget is now $86.4 million, which is a reduction of $13.6 million for state fiscal year 2012/13; however, the annual increase in state fiscal year 2013/14 remains $100 million.
- To clarify, effective April 1, 2012, regularly scheduled phased reductions to hospital inpatient Transition II funding of $25 million will be redirected to the Safety Net/VAP funding instead of the development of the inpatient statewide base price.

The annual increase in gross Medicaid expenditures for both initiatives for state fiscal year 2012/13 is $86.4, including the redirection of the hospital inpatient Phase II funding.

Institutional Services

- Effective May 1, 2012, the statewide base price will be reduced by $19.2 million for state fiscal year 2012/13 and $19.2 million for state fiscal year 2013/14 as compared to the $24.2 million in state fiscal year 2011/12.

Long Term Care Services

- Effective on and after April 1, 2012, for rate periods on and after July 1, 2012, for services provided to residential health care facility residents 21 years of age and older, the Commissioner of Health shall implement a methodology which establishes reimbursement rates for reserved bed days.
  - Such methodology shall, for each Medicaid patient for any 12-month period, provide for reimbursement for reserved bed days for up to an aggregate of 14 days for hospitalizations and for other therapeutic leave of absences consistent with a plan of care ordered by such patient's treating health care professional, and up to an aggregate of 10 days of other leaves of absence.
  - If the Commissioner, in consultation with the Director of the Budget, determines that such methodology shall achieve projected aggregate Medicaid savings of less than $40 million for state fiscal year beginning April 1, 2012, and each state fiscal year thereafter, the Commissioner shall establish a prospective per diem rate adjustment for all nursing homes, other than those providing services primarily to children under the age of 21, sufficient to achieve such $40 million in savings for each such state fiscal year.
- Effective April 1, 2012, an assisted living program (ALP), that is not itself a certified home health agency (CHHA), shall contract with one or more CHHAs for the provision of services pursuant to Article 36 of the Public Health Law.
  - An ALP shall, either directly or through contract with a certified home health agency, conduct an initial assessment to determine whether a person would otherwise require placement in a residential health care facility if not for the availability of the ALP and is appropriate for admission to an ALP.
  - No person shall be determined eligible for and admitted to an ALP unless the ALP finds that the person meets the criteria provided above.
  - Appropriate services shall be provided to an eligible person only in accordance with a plan of care which is based upon an initial assessment and periodic reassessments conducted by an ALP, either directly or through contract with a CHHA. A reassessment shall be conducted as frequently as is required to respond to changes in the resident's condition and ensure immediate access to necessary and appropriate services by the resident, but in no event less frequently than once every six months. No person shall be admitted to or retained in an ALP unless the person can be safely and adequately cared for with the provision of services determined by such assessment or reassessment.

- The Commissioner of Health will also provide for reimbursement of the cost of preadmission assessments conducted directly by ALPs, which previously would have been performed by and reimbursed to the CHHA. There is no annual increase or decrease in gross Medicaid dollars for this initiative in state fiscal year 2012/13.

Non-institutional Services

- Effective April 1, 2012, the APG investment for hospital outpatient payments will be reduced by $25 million.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to these initiatives contained in the budget for state fiscal year 2012/2013 is $26.4 million.

The public is invited to review and comment on this proposed state plan amendment. Copies of which will be available for public review on the Department's website at: http://www.health.ny.gov/regulations/state_plans/status.

In addition, copies of the proposed state plan amendments will be on file and available for public review in each local (county) social services district.

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

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

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 long term care services to comply with regulations authorized under existing State statute. The following significant changes are proposed:

Long Term Care Services

- Effective for services provided on and after May 1, 2012, Medicaid payments for certified home health care agencies (CHHA), except for such services provided to children under 18 years of age and except for services provided to a special needs population of medically complex and fragile children, adolescents and young disabled adults by a CHHA operating under a pilot program approved by the Department of Health, shall be based on payment amounts calculated for 60-day episodes of care.
  - The base price paid for 60-day episodes of care shall be adjusted by an individual patient case mix index, and also by a regional wage index factor. Such case mix adjustments shall include an adjustment factor for CHHAs providing care primarily to a special needs patient population coming under the jurisdiction of the Office of People with Developmental Disabilities (OPWDD) and consisting of no fewer than 200 such patients. The annual increase in gross Medicaid expenditures attributable to this initiative for state fiscal year 2012/13 is $600,000.
- Effective July 1, 2012 or upon the effective date of the applicable regulation, the capital cost component of the Medicaid rates of eligible residential health care facilities (RHCF) shall be adjusted, as determined by the Commissioner of Health, to reflect the costs of the annual debt service related to the financing of an automatic sprinkler system that will be in compliance with applicable federal regulations set forth in 42 CFR 483.70(a)(8).
  - Eligible facilities are those facilities which the Commissioner determines are financially distressed in terms of their being unable to finance the installation of automatic sprinkler systems as required by the federal regulations. In making such determinations of eligibility, the Commissioner shall consider information obtained from a facility's cost report, and such other information as may be required by the Commissioner, including, but not limited to:
    - operating profits and losses;
    - eligibility for funding pursuant to the capital cost reimbursement section of Subpart 86-2 of the Public Health Law;
    - unrestricted fund balances;
    - documentation demonstrating the inability of the facility to independently access the credit markets;
    - information related to the health and safety of a facility's residents;
    - other financial information as may be required from the facility by the Commissioner; and
    - the filing of Certificate of Need (CON) information, or the receipt of required CON approvals, as appropriate.
  - As a condition for the receipt of sprinkler funding, each eligible RHCF shall:
    - Prepare a schedule setting forth, by month, the estimated debt service payable, assuming level principal and interest payments over the life of the financing. Such schedule, along with such other information as may be required by the Commissioner, shall be provided to the Commissioner for review and approval at least 60 days prior to the due date of such first debt service payment (or such shorter period as the Commissioner may permit); and
    - Deposit into a separate account maintained by the facility, Medicaid revenues attributable to the capital rate adjustments for such sprinklers, and any other additional facility revenues needed to cover the scheduled debt service payments attributable to such sprinklers. All such deposits in such account shall be used solely for the purpose of satisfying such debt service payments.
  - The estimated annual increase in gross Medicaid expenditures attributable to this initiative for state fiscal year 2102/13 is $17 million.
- Effective for services provided on and after May 1, 2012, rates of payment for residential health care facilities which have received approval by the Commissioner of Health to provide services to more than 25 patients whose medical condition is HIV Infection Symptomatic, and the facility is not eligible for separate and distinct payment rates for AIDS facilities or discrete AIDS units, shall be adjusted by a per diem adjustment that shall not be in excess of the difference between such facility's 2010 allowable cost per day, as determined by the Commissioner, and the weighted average non-capital component of the rate in effect on and after January 1, 2012, and as subsequently updated by case mix adjustments made in July and January of each calendar year. The estimated annual increase in gross Medicaid expenditures attributable to this initiative for state fiscal year 2012/13 is $1 million.

Appendix V
2012 Title XIX State Plan
Second Quarter Amendment
Hospital Inpatient Services
Responses to Standard Funding Questions

APPENDIX V
HOSPITAL SERVICES
State Plan Amendment 12-21

CMS Standard Funding Questions (NIRT Standard Funding Questions)

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

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

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

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

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

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

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

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

   Response: Based on guidance from CMS, the State and CMS staff will engage in discussions to develop a strategic plan to complete the appropriate UPL demonstration.

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

   Response: The rate methodology included in the approved state plan for institutional services is prospective payment. We are unaware of any requirement under current federal law or regulation that limits individual provider payments to their actual costs.

ACA Assurances:

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

   MOE Period.
   - **Begins on: March 10, 2010, and**
   - **Ends on: The date the Secretary of the Federal Department of Health and Human Services determines an Exchange established by a State under the provisions of section 1311 of the Affordable Care Act is fully operational.**

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

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

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

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

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

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

Tribal Assurance:

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

IHCIA Section 2107(e)(I) of the Act was also amended to apply these requirements to the Children's Health Insurance Program CHIP. Consultation is required concerning Medicaid and CHIP matters having a direct impact on Indian health programs and Urban Indian organizations.

a) **Please describe the process the State uses to seek advice on a regular ongoing basis from federally recognized tribes Indian Health Programs and Urban Indian Organizations on matters related to Medicaid and CHIP programs and for consultation on State Plan Amendments waiver proposals waiver extensions waiver amendments**

waiver renewals and proposals for demonstration projects prior to submission to CMS.

b) **Please include information about the frequency inclusiveness and process for seeking such advice.**

c) **Please describe the consultation process that occurred specifically for the development and submission of this State Plan Amendment when it occurred and who was involved.**

Response: Tribal consultation in accordance with the State's tribal consultation policy, as approved in SPA #11-06, was performed, and documentation of such is being forwarded to CMS. To date, no comments have been received.

Appendix VI
2012 Title XIX State Plan
Second Quarter Amendment
Hospital Inpatient Services
Responses to Standard Access Questions

APPENDIX VI
INPATIENT SERVICES
State Plan Amendment 12-21

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 reduce the statewide base price by $19.2 million for the period May 1, 2012, through March 30, 2013, and for each state fiscal year thereafter. Since the reduction to the statewide base price for the most recent state fiscal year was $24.2 million and no access issues were experienced, it is not expected that this lesser reduction will have a negative impact on providers.

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. The current amendment extends the rate modification, which was previously agreed upon by the State and industry representatives under this process, into the out years.

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: Again, since the reduction to the statewide base price for the most recent state fiscal year was $24.2 million and no access issues were experienced, it is not expected that this lesser reduction will have a negative impact on providers. In addition, 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, 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.