NEW YORK
state department of
HEALTH

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

Sue Kelly
Executive Deputy Commissioner

September 28, 2012

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

Re: SPA #12-28
Inpatient Hospital Services

Dear Mr. Cooley:

The State requests approval of the enclosed amendment #12-28 to the Title XIX (Medicaid) State Plan for inpatient hospital services to be effective September 1, 2012 (Appendix I). This amendment is being submitted based upon regulations anticipated to be effective September 1, 2012. 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 March 28, 2012, and further clarified on August 29, 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.

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

If you have any questions regarding this State Plan Amendment submission, 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: **12-28**	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 **September 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 09/01/12 – 09/30/12 $ 8,978** **b. FFY 10/01/12 – 09/30/13 $107,734**
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: **Attachment 4.19-A: Contents, Page 165**	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: **Attachment 4.19-A: Contents, Page 165**

10. SUBJECT OF AMENDMENT:
Inpatient Language Assistance
(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** **Bureau of HCRA Oper & Financial Analysis** **99 Washington Ave – One Commerce Plaza** **Suite 810** **Albany, NY 12210**
13. TYPED NAME: **Jason A. Helgerson**	
14. TITLE: **Medicaid Director & Deputy Commissioner Department of Health**	
15. DATE SUBMITTED: September 28, 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
Third Quarter Amendment
Hospital Inpatient Services
Amended SPA Pages

New York
Contents

Attachment 4.19-A
Part I

Hospital Inpatient Reimbursement – Effective December 1, 2009

TN # 12-28 **Approval Date** _____

Supersedes TN# 10-33-B **Effective Date** _____

Reimbursement for language assistance services in hospital inpatient settings:

Effective for hospital inpatient services provided on and after September 1, 2012, a Medicaid rate of payment for language interpretation services provided to patients with limited English proficiency (LEP) and communication services provided for patients who are deaf and hard of hearing will be established as follows:

(1) Payment will be established on a per unit basis, with the unit of payment based on the number of minutes of language assistance services provided.

(2) A maximum of two billable units of language assistance services will be allowable per patient per day with the billable units defined as follows:

i) 1st billable unit – for encounters providing one to 22 minutes of language assistance service.

ii) 2nd billable unit – for encounters providing additional minutes (23+) beyond the initial 22 minutes of language assistance services during the given patient day.

(3) The rate of payment will be established at $11.00 per unit of language assistance services, with a maximum payment per inpatient day of care of $22.00.

(4) To be reimbursable, the language assistance services must be provided by an independent third party, a dedicated hospital employee or a third party vendor (e.g., telephonic interpretation service) whose sole function is to provide interpretation services for individuals with LEP and communication services for patients who are deaf and hard of hearing.

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

SUMMARY
SPA #12-28

This State Plan Amendment proposes to establish a payment rate to reimburse hospitals for the cost of providing interpretation services for patients with limited English proficiency (LEP) and communication services for patients who are deaf and hard of hearing. Effective for services provided on and after September 1, 2012, a new payment rate established on a per unit basis will be available for language assistance services, with a maximum of two billable units allowable per patient per day. The billable units of payment are defined as follows:

- 1st billable unit for providing one to 22 minutes of language assistance service.
- 2nd billable unit for additional minutes (23+) provided beyond the initial 22 minutes of language assistance service.

The payment rate is established at $11.00 per unit of service for a maximum payment of $22.00 per patient per day.

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

Pursuant to the authority vested in the Commissioner of Health by Section 2807-c(35) of the Public Health Law, Part 86-1 of Title 10 (Health) of the Official Compilation of Codes, Rules and Regulations of the State of New York is hereby amended to be effective September 1, 2012, to read as follows:

Subpart 86-1 of title 10 NYCRR is amended by adding a new section 86-1.45 to read as follows:

86-1.45 - Reimbursement for language assistance services in hospital inpatient settings. For hospital inpatient services provided on and after September 1, 2012, in addition to the inpatient rates of payment computed in accordance with this Subpart, a separately billable rate of payment shall be available for providing language assistance services, if applicable, in accordance with the following:

(a) A discrete rate of payment for language interpretation services provided to patients with limited English proficiency (LEP) and communication services provided for patients who are deaf and hard of hearing will be established as follows:

(1) Payment will be established on a per unit basis with the unit of payment determined based on the number of minutes of language assistance service provided.

(2) A maximum of two billable units of language assistance services will be allowable per patient per day with the billable units defined as follows:

i) 1st billable unit – for encounters providing up to and including the first 22 minutes of language assistance service.

ii) 2nd billable unit – for encounters providing additional minutes (23+) beyond the initial 22 minutes of language assistance services during the given patient day.

(b) The rate of payment will be established at $11.00 per unit of language assistance service provided, with a maximum allowable payment per inpatient day of care of $22.00.

(c) To be reimbursable, the language assistance service must be provided by an independent third party, a dedicated hospital employee or a third party vendor (e.g., telephonic interpretation service) whose sole function is to provide interpretation services for individuals with LEP and communication services for people who are deaf and hard of hearing.

Appendix IV
2012 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 Health

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

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

All Services

- Effective April 1, 2012, the Essential Community Provider Network and the Vital Access Providers initiatives will be established to ensure access to care for patients.

Essential Community Provider Network: New York State will assume an active role in ensuring certain essential community providers (hospitals, nursing homes, D&TCs or home health providers) be eligible to receive short-term funding to achieve defined operational goals such as a facility closure, merger, integration or reconfiguration of services.

- To receive funding under this initiative, providers must apply to the Department of Health for consideration and present a plan with clearly defined benchmarks for achieving well-articulated goals, including improved quality, efficiency, and the alignment of health care resources with community health needs. The plan must also include a budget that will be the basis for reimbursement and for identifying required financial resources. Failure to meet goals articulated in the plan within the defined timelines (no more than 2-3 years) will result in the immediate termination of the rate enhancement. The facility must also demonstrate how its plan and the investment will ultimately return savings long term for the Medicaid program.
- The Commissioner of Health will make the final decision concerning which facilities are eligible by applying the following criteria:
  - Demonstration of integration of services with other providers and improved quality, access, and efficiency;
  - Engagement with community stakeholders and responsiveness of plan to community health needs;
  - Financial viability based upon certain metrics (profitability, debt load, and liquidity);
  - Provision of care to financially and medically vulnerable populations;
  - Provision of essential health services; and/or
  - Provision of an otherwise unmet health care need (e.g., behavioral health services).
- Benchmarks that must be present in any acceptable plan are key to the success of this initiative. Such measures might include:
  - Administrative and operational efficiencies;
  - Quality and population health standards;
  - Provision of essential services;
  - Improved integration or collaboration with other entities; and/or
  - Achieving health care cost savings.
- Furthermore, as part of the requirement for a provider to receive funds through this initiative, the Department of Health must approve of the applicant's governance structure and the ability of its board and executive leadership to implement the plan and take decisive steps to stabilize the financial condition of the facility, while improving quality and efficiency. In addition, it is also possible restructuring officers and new board members (with expertise in certain areas) could be recruited to replace or enhance the existing leadership as a means to ensure the plan's fruition.

Vital Access Providers (VAP): This initiative will be established to provide ongoing rate enhancement to a small group of hospitals, nursing homes, D&TCs, and home care providers, under more stringent basis over a longer term. These facilities will be required to submit a plan and a budget for meeting defined goals, which would include approaches to advance community care, but the purpose of these funds is to provide longer term operational support. Examples of providers that could receive this designation and enhancement could include efficient hospitals and other providers in rural communities that have already reconfigured services to create integrated systems of care and that require a rate enhancement to remain financially viable and continue to provide a service not offered elsewhere in the community (e.g., emergency department, trauma care, obstetrics). Furthermore, in urban areas, qualifying providers will be unique in that they serve a very high proportion of Medicaid and financially vulnerable populations, provide unique services that are not offered by other providers within the community, and have serious financial problems.

- The VAP provider designation and any allocation of funds are subject to approval by the Commissioner of Health and are pursuant to a dynamic plan to better the health of the community.
- Facilities will be required to demonstrate satisfaction of benchmarks specified by the Commissioner.

- Effective April 1, 2012, regularly scheduled phased reductions to hospital inpatient Transition II funding 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 initia-

tives for state fiscal year 2012/13 is $100 million, including the redirection of the hospital inpatient Phase II funding.

- Continues Ambulatory Patient Group (APG) rates of payment for Medicaid services for outpatient hospital services, general hospital emergency services, ambulatory surgical services, for dates of service on and after April 1, 2012, and for diagnostic and treatment center services, for dates of services on and after July 1, 2012, except those payments made on behalf of persons enrolled in Medicaid HMO or Family Health Plus.
- For state fiscal year beginning April 1, 2012 and forward provide Medicaid reimbursement to hospitals for inpatient and ambulatory care services, and to free standing diagnostic and treatment centers through modification of APG payments, for the provision of interpretation services for patients with limited English proficiency (LEP) and communication services for people who are deaf and hard of hearing. The increase in gross Medicaid expenditures for state fiscal year 2012/13 is $2.70 million.

Institutional Services

- For the state fiscal year beginning April 1, 2012 through March 31, 2013, continues specialty hospital adjustments for hospital inpatient services provided on and after April 1, 2012, 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 April 1, 2012, the Commissioner of Health shall incorporate quality related measures including, potentially preventable re-admissions (PPRs) and other potentially preventable negative outcomes (PPNOs) and provide for rate adjustments or payment disallowances related to same. Such rate adjustments or payment disallowances will be calculated in accordance with methodologies, as determined by the Commissioner of Health, and based on a comparison of the actual and risk adjusted expected number of PPRs and other PPNOs in a given hospital and with benchmarks established by the Commissioner. Such adjustments or disallowances for PPRs and other PPNOs will result in an aggregate reduction in Medicaid payments of no less than $51 million annually for periods beginning April 1, 2012 through March 31, 2013, provided that such aggregate reductions shall be offset by Medicaid payment reductions occurring as a result of decreased PPRs for the periods April 1, 2012 through March 31, 2013, and as a result of decreased PPRs and PPNOs for the period April 1, 2012 through March 31, 2013. Such rate adjustments or payment disallowances shall not apply to behavioral health PPRs or to readmissions that occur on or after 15 days following an initial admission. The annual decrease in gross Medicaid expenditures for state fiscal year 2012/13 is $51 million.

Long Term Care Services

- Effective April 1, 2012, for rate periods on and after April 1, 2012, for services provided to residential health care facility residents 21 years of age and older, the Commissioner of Health shall promulgate regulations, which may be emergency regulations, establishing reimbursement rates for reserved bed days, provided, however, that such regulations shall achieve an aggregate annualized reduction in reimbursement for such reserved bed days of no less than $40 million, as determined by the Commissioner.
  - If federal financial participation is not available for rate adjustments, or regulations promulgated thereunder, then, for such rate periods, Medicaid rates for inpatient services shall not include any factor or payment amount for such reserved bed days with regard to residents 21 years of age or older. In addition, for such rate periods upward revisions to Medicaid rates shall be provided, however, such upward revisions shall not in the aggregate, as determined by the Commissioner, exceed, on an annual basis, an amount equal to current annual Medicaid payments for reserved bed days, less than $40 million.
- To clarify the previously noticed provisions of March 30, 2011, December 28, 2011 and March 14, 2012, related to Certified Home Health Agencies (CHHA) episodic pricing, Medicaid payments for services provided by CHHAs will be effective May 1, 2012.
- The current authority to adjust Medicaid rates of payment for personal care services, provided in local social services districts which include a city with a population of over one million persons and distributed in accordance with memorandums of understanding entered into between the State and such local districts for purpose of supporting recruitment and retention of personal care service workers has been extended for the period April 1, 2012 through March 31, 2014. Payments for the periods April 1, 2012 through March 31, 2013; and April 1, 2013 through March 31, 2014, shall not exceed, in the aggregate, $340 million for each applicable period.
- The current authority to adjust Medicaid rates of payment for personal care services provided in local social services districts which shall not include a city with a population of over one million persons, for purpose of supporting recruitment and retention of personal care service workers has been extended for the period April 1, 2012 through March 31, 2014. Payments for the period April 1, 2012 through March 31, 2013; and April 1, 2013 through March 31, 2014, shall be up to $28.5 million for each applicable period.
- The current authority to adjust Medicaid rates of payment for certified home health agencies, AIDS home care programs, and hospice programs for purposes of supporting recruitment and retention of non-supervisory health care workers or any worker with direct patient care responsibility has been extended for the period April 1, 2012 through March 31, 2014. Payments shall not exceed in the aggregate, $100 million for each of the following periods: April 1, 2012 through March 31, 2013; and April 1, 2013 through March 31, 2014, and shall be calculated in accordance with the previously approved methodology. Such adjustments to rates of payment shall be allocated proportionally based on each certified home health agency's, AIDS home care and hospice programs' home health aide or other direct care services total annual hours of service provided to Medicaid patients, as reported in each such agency's most recently available cost report as submitted to the Department. Payments made shall not be subject to subsequent adjustment or reconciliation.

Non-institutional Services

- For State fiscal years beginning April 1, 2012 through March 31, 2013, continues hospital outpatient payment adjustments that increase the operating cost components of rates of payment for hospital outpatient and emergency departments for public general hospitals other than those operated by the State of New York or the State University of New York, which are located in a city with a population of over one million. The eligibility criteria remain unchanged. Payments to eligible public general hospitals may be added to rates of payment or made as aggregate payments. The increase in Medicaid expenditures for state fiscal year 2012/13 is $287 million.
- The Ambulatory Patient Group (APG) reimbursement methodology is revised to include recalculated weights that will become effective on or after April 1, 2012. There is no estimated annual change to gross Medicaid expenditures as a result of this proposal.
- Effective on or after April 1, 2012, adults, age 21 and older, with a diagnosis of diabetes mellitus may obtain podiatry services from podiatrists in private practice. The decrease in gross Medicaid expenditures for state fiscal year 2012/13 is $4.40 million.
- Effective on or after April 1, 2012, lactation counseling services for pregnant and postpartum women will be provided when such services are ordered by a physician, registered physician's assistant, registered nurse practitioner, or licensed midwife and provided by a certified lactation consultant, as determined by the Commissioner of Health. The decrease in gross Medicaid expenditures for state fiscal year 2012/13 is $8.40 million.

- As of April 1, 2011, hospital outpatient clinics and DTCs may bill for Smoking Cessation Counseling (SCC) service as part of the provider's Ambulatory Patient Group (APG) claim for outpatient services. However, Federally Qualified Health Centers (FQHCs) that did not opt into APGs would not have the ability to bill for SCC services. The establishment of the FQHC SCC rates will allow FQHC providers to bill for SCC services. The rates that have been established are as follows: FQHC Individual Smoking Cessation Counseling and FQHC Group Smoking Cessation Counseling. These rates will be effective April 1, 2012 and thereafter. The increase in gross Medicaid expenditures for state fiscal year 2012/13 is $8.50 million.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to reform and other initiatives contained in the budget for state fiscal year 2012/2013 is $475.9 million; and the estimated annual net aggregate increase in gross Medicaid expenditures attributable to an extension of pertinent disproportionate share (DSH) and upper payment limit (UPL) payments for state fiscal year 2012/2013 is $1.4 billion.

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 non-institutional services to comply with enacted statutory provisions. The following clarifying changes are proposed:

Non-Institutional Services

The following clarifications are to the March 30, 2011 noticed provision for Health Home Services.

Effective April 1, 2012, the Department of Health, in collaboration with the Office of Mental Health, the Office for Alcoholism and Substance Abuse Services, and the Office of People with Developmental Disabilities will be authorized to begin Medicaid coverage for Health Home Services to high-cost, high-need enrollees in the counties of Dutchess, Erie, Manhattan, Monroe, Orange, Putnam, Queens, Richmond, (Staten Island), Rockland, Suffolk, Sullivan, Ulster and Westchester. The previous effective date was October 1, 2011.

Payment for Health Homes service will be a per-member, per-month (PMPM) care management fee that is adjusted based on region and case mix (from 3M™ Clinical Risk Groups (CRG) method). This fee will eventually be adjusted by (after the data is available) patient functional status. As a result, reimbursement will be reflective of cost-associated adjustments in the intensity and frequency of intervention based on patient's current condition and needs (from tracking to high touch).

This care management fee will be paid in two increments based on whether a patient is in 1) the case finding group, or 2) the active care management group. The case finding group will receive a PMPM that is a reduced percentage (80 percent) of the active care management PMPM. The case finding PMPM is only available for up to the first three months after a patient has been assigned to a given Health Home, and this PMPM is intended to cover the cost of outreach and engagement. Once a patient has been assigned a care manager and is actively engaged in the Health Home program, the active care management PMPM may be billed.

If the State achieves overall savings from the implementation of this program, Health Home providers will be eligible to participate in a shared savings pool. The pool will be developed at the end of the first year of health home operation and will consist of a percentage (up to 30 percent) of the documented State share savings derived from Health Home operation. The State will use a method to adjust savings for regression to the mean before setting up the pool. If the federal portion of savings becomes eligible for shared savings with providers, then a portion of those savings will be included in the pool based on any federal conditions that may be applied to such savings.

The estimated net aggregate decrease in gross Medicaid expenditures attributable to this initiative for the period April 1, 2012 through September 30, 2012 is $9.8 million and for the period October 1, 2012 through September 30, 2013 is $58.3 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 amendment 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:

Place: Empire State Development Corporation (ESDC)
633 3rd Avenue
37th Floor
New York, NY

Identification and sign-in are required at this location. *For further information, or if you need a reasonable accommodation to attend this meeting, contact*: Louis Stellato, Division of Criminal Justice Services, Office of Forensic Services, Four Tower Place, Albany, NY 12203, (518) 457-1901

PUBLIC NOTICE

Division of Criminal Justice Services
Commission on Forensic Science

Pursuant to Public Officers Law section 104, the Division of Criminal Justice Services gives notice of a meeting of the New York State Commission on Forensic Science to be held on:

Date: Tuesday, December 11, 2012
Time: 1:00 p.m.
Place: Empire State Development Corporation (ESDC)
633 3rd Avenue
38th Floor - Governor's Press Room
New York, NY

Identification and sign-in are required at this location. *For further information, or if you need a reasonable accommodation to attend this meeting, contact*: Louis Stellato, Division of Criminal Justice Services, Office of Forensic Services, Four Tower Place, Albany, NY 12203, (518) 457-1901

PUBLIC NOTICE

Office of Fire Prevention and Control

Pursuant to Section 176-b of the Town Law, the Office of Fire Prevention and Control hereby gives notice of the following:

Application for Waiver of the Limitation on Non-resident Members of Volunteer Fire Companies

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 East Marion Fire District, County of Suffolk.

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, e-mail Dfischer@dhses.ny.gov

PUBLIC NOTICE

Department of Health

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

The Department of Health proposes to amend the Title XIX (Medicaid) State Plan for inpatient services to comply with enacted statutory provisions. The following provides clarification to provisions previously noticed on March 28, 2012:

Institutional Services

- Effective on or after September 1, 2012, Medicaid reimbursement will be provided to hospitals for inpatient services, through a discrete language assistance payment rate, for the provision of interpretation services for patients with limited English proficiency (LEP) and communication services for patients who are deaf and hard of hearing.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2012/2013 is $125,689.

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
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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), e-mail: spa_inquiries@health.state.ny.us

PUBLIC NOTICE

Homes and Community Renewal
2013 Annual Action Plan
Public Comment Period Notice

In order to maintain its eligibility to administer certain federal funds for affordable housing and community development, New York State (NYS) must prepare an Annual Action Plan (AAP) and submit it to the U.S. Department of Housing and Urban Development. For one specific program year, the AAP describes the State's proposed use of available federal and other resources to address the priority needs and specific objectives in the Consolidated Plan; the State's method for distributing funds to local governments and not-for-profit organiza-

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

APPENDIX V
HOSPITAL SERVICES
State Plan Amendment 12-28

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 UPL demonstration for 2012.

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 [ ] / would not [X] violate these provisions, if they remained in effect on or after January 1, 2014.

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

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

Tribal Assurance:

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

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

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

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

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

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

Response: The process that New York State uses is detailed in SPA #11-06, which was approved by CMS on 8/4/11. The tribal leaders were sent information regarding the SPA via postal mail, and the health clinic administrators were emailed the same information. Copies of tribal consultation are enclosed.