NEW YORK
state department of
HEALTH

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

Sue Kelly
Executive Deputy Commissioner

March 31, 2014

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

Re: SPA #14-14
Inpatient Hospital Services

Dear Mr. Cooley:

The State requests approval of the enclosed amendment #14-14 to the Title XIX (Medicaid) State Plan for inpatient hospital services to be effective January 1, 2014 (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 were given in the New York State Register on December 30, 2013.

It is estimated that the changes represented by 2013 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.

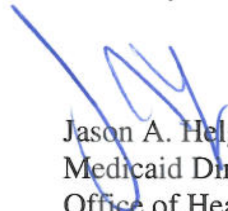
In accordance with 42 CFR §447.272(c), New York assures that its aggregate disproportionate share hospital payments do not exceed the disproportionate share hospital payment limit.

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 State regulation are enclosed for your information (Appendix III). In addition, responses to the five standard funding questions and the standard access questions are also enclosed (Appendix V and 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,

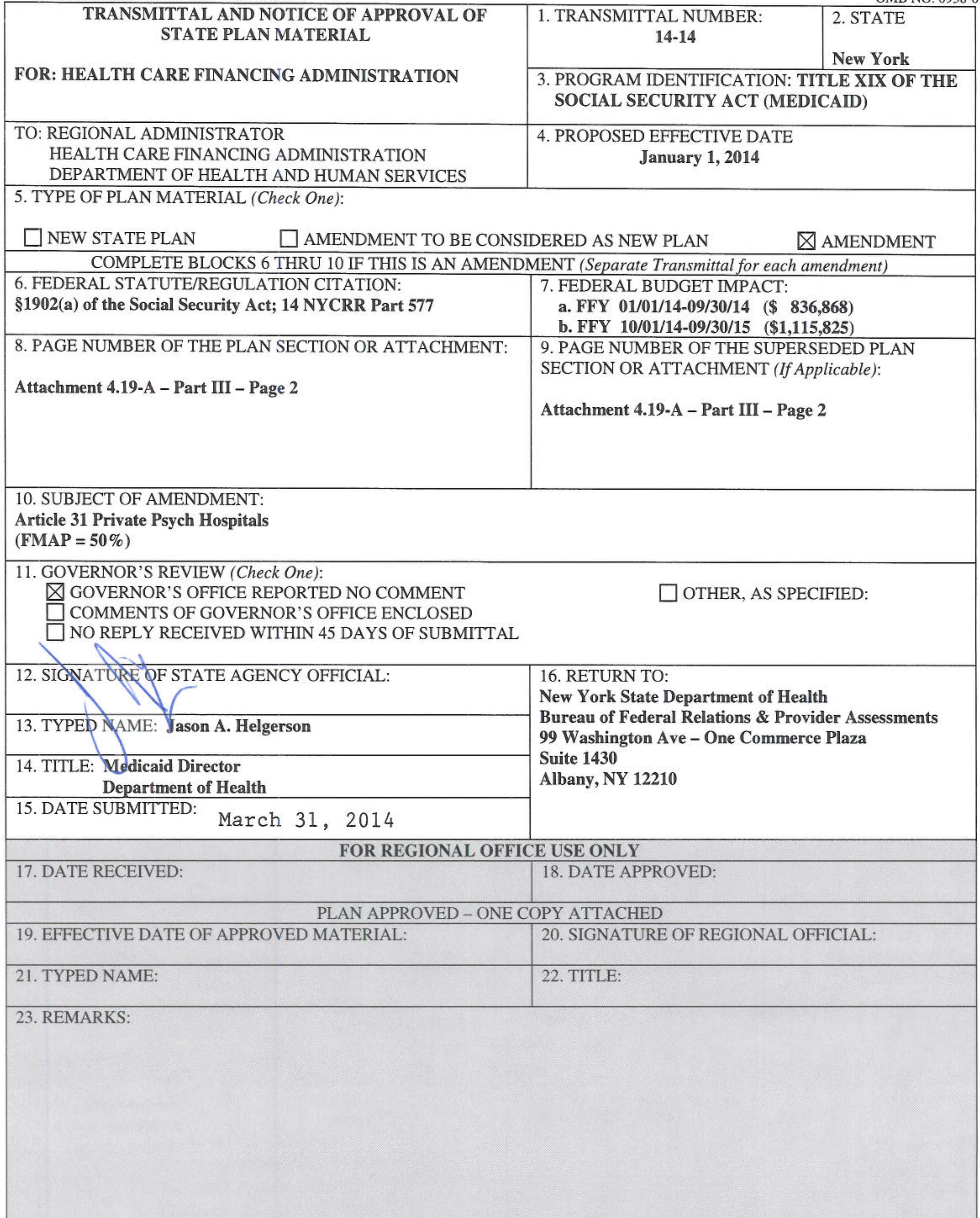


Jason A. Helgerson
Medicaid Director
Office of Health Insurance Programs

Enclosures

cc: Mr. Michael Melendez
Mr. Tom Brady

FORM APPROVED
OMB NO. 0938-0193



TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: **14-14**

2. STATE **New York**

3. PROGRAM IDENTIFICATION: **TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)**

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE **January 1, 2014**

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
§1902(a) of the Social Security Act; 14 NYCRR Part 577

7. FEDERAL BUDGET IMPACT:
a. FFY 01/01/14-09/30/14 ($ 836,868)
b. FFY 10/01/14-09/30/15 ($1,115,825)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-A – Part III – Page 2

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-A – Part III – Page 2

10. SUBJECT OF AMENDMENT:
Article 31 Private Psych Hospitals
(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:

13. TYPED NAME: **Jason A. Helgerson**

14. TITLE: **Medicaid Director**
Department of Health

15. DATE SUBMITTED: March 31, 2014

16. RETURN TO:
New York State Department of Health
Bureau of Federal Relations & Provider Assessments
99 Washington Ave – One Commerce Plaza
Suite 1430
Albany, NY 12210

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED:

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:

22. TITLE:

23. REMARKS:

Appendix I
2014 Title XIX State Plan
First Quarter Amendment
Amended SPA Pages

In determining allowable operating costs for any base year there is applied a limitation, which is derived from the fiscal year one year prior to the base year, increased by the Medicare inflation factor for hospitals and units excluded from the prospective payment system. Both the base year and the limitation are subject to an administration cost screen. The administration cost screen is derived from the costs in the fiscal year one year prior to the base year (i.e. the same cost year the limitation is derived from), and is the group average cost plus ten percent. Separate administration cost screens are calculated for hospitals greater than 100 beds (group one), and hospitals less than 100 beds (group two). The allowable costs are the lesser of the base year operating costs or the limitation. The allowable operating costs are then increased for inflation to the rate year by the Medicare inflation factor described above, except that the 1996 Medicaid rates will not include an inflation factor for 1996 effective July 1, 1996, and the 2010 Medicaid rates will not include an inflation factor for 2010 effective January 1, 2010, and the 2014 Medicaid rates will not include an inflation factor for 2014 effective January 1, 2014. Such inflation factor shall be as determined by the Federal Government each year prior to the effective date of the payment rates calculated herein.

Rates of payment in effect on December 31, 2011, will continue in effect for the periods January 1, 2012 through December 31, 2012, and January 1, 2013 through December 31, 2013.

Appeals from rate determinations are heard by the Commissioner. The Commissioner may hear requests for rate revisions which are based on errors in the calculation of the rate or in the data submitted by the facility or based on significant changes in operating costs resulting from changes in services, programs or capital projects approved by the Commissioner in connection with OMH's certificate of need procedures. Revised rates must be certified by the Commissioner and approved by the Director of the Budget.

1. CAPITAL COSTS

[To] [a]Allowable capital cost will be added to allowable operating costs [are added allowable capital costs]. Allowable capital costs are determined by the application of the principles developed for determining reasonable cost payments under the Medicare program. Allowable capital costs include an allowance for depreciation and interest. To be allowable, capital expenditures subject to the Office of Mental Health's certificate of need procedures must be reviewed and approved by the Office of Mental Health.

The allowed capital cost component of the budget based rate will be based upon approved annual budgeted costs and approved budgeted patient days retroactively adjusted to actual certified costs divided by the higher of the actual patient days or the approved budgeted patient days.

Transfer of Ownership

In establishing an appropriate allowance for depreciation and for interest on capital indebtedness with respect to an asset of a hospital which has undergone a change of ownership, that the valuation of the asset after such change of ownership shall be the lesser of the allowable acquisition cost of such asset to the owner of record as of July 18, 1984 (or, in the case of an asset not in existence as of such date, the first owner of record of the asset after such date), or the acquisition cost of such asset to the new owner.

Appendix II
2014 Title XIX State Plan
First Quarter Amendment
Summary

SUMMARY
SPA #14-14

This State Plan Amendment proposes to reflect that no trend factor will be applied to allowable costs, for private psychiatric hospitals licensed under Article 31 of the Mental Hygiene Law and issued an operating certificate in accordance with 14 NYCRR Part 582, effective January 1, 2014.

Appendix III
2014 Title XIX State Plan
First Quarter Amendment
Authorizing Provisions

that technology will continue to be used. However, statutory requirements to report reportable incidents to the Justice Center in the manner specified by the Justice Center may impose new technology requirements if that is the manner specified by the Justice Center. However, this is not a direct impact caused by the regulations.

6. Minimizing adverse economic impact: The amendments may result in an adverse economic impact for small business providers due to additional compliance activities and associated compliance costs. However, as stated earlier, OMH expects that compliance with these new regulations will result in savings in the long term and there may be some short term savings as a result of the conduct of investigations by the Justice Center.

OMH has reviewed the regulations to determine if there were any viable approaches for minimizing adverse economic impact as suggested in section 202-b(1) of the State Administrative Procedure Act; none were readily identified. However, OMH did not consider the exemption of small businesses from these amendments or the establishment of differing compliance or reporting requirements since OMH considers compliance with the amendments to be crucial for the health, safety, and welfare of the individuals served by small business providers.

7. Small business participation: Chapter 501 of the Laws of 2012 was originally a Governor's Program Bill which received extensive media attention. Providers have had the opportunity to become familiar with its provisions since it was made available on various government websites last June. Furthermore, in accordance with statutory requirements, the rule was presented to the Mental Health Services Council for review and recommendations.

8. The amendments include a penalty for violating the regulations of a fine not to exceed $1,000 per day or $15,000 per violation in accordance with section 31.16 of the Mental Hygiene Law and/or may suspend, revoke, or limit an operating certificate or take any other appropriate action, in accordance with applicable law and regulations. However, due process is available to a provider via 14 NYCRR Part 503.

Rural Area Flexibility Analysis

1. Description of the types and estimation of the number of rural areas in which the rule will apply: OMH services are provided in every county in New York State. Forty-three counties have a population of less than 200,000: Allegany, Cattaraugus, Cayuga, Chautauqua, Chemung, Chenango, Clinton, Columbia, Cortland, Delaware, Essex, Franklin, Fulton, Genesee, Greene, Hamilton, Herkimer, Jefferson, Lewis, Livingston, Madison, Montgomery, Ontario, Orleans, Oswego, Otsego, Putnam, Rensselaer, St. Lawrence, Schenectady, Schoharie, Schuyler, Seneca, Steuben, Sullivan, Tioga, Tompkins, Ulster, Warren, Washington, Wayne, Wyoming and Yates. Additionally, 10 counties with certain townships have a population density of 150 persons or less per square mile: Albany, Broome, Dutchess, Erie, Monroe, Niagara, Oneida, Onondaga, Orange, and Saratoga.

The amendments have been reviewed by OMH in light of their impact on rural areas. The regulations make revisions and in some cases enhance OMH's current requirements for incident management programs, which will necessitate some changes in compliance activities and result in additional costs and savings to providers, including those in rural areas. However, OMH is unable to quantify the potential additional costs and savings to providers as a result of these amendments. In any event, OMH considers that the improvements in protections for people served in the OMH system will help safeguard individuals from harm and abuse and that the benefits more than outweigh any potential negative impacts on all providers.

The geographic location of any given program (urban or rural) will not be a contributing factor to any additional costs to providers.

2. Compliance requirements: The regulations add some new requirements with which providers must comply. Amendments associated with the implementation of Chapter 501 include a requirement that providers report "reportable incidents" and deaths to the Justice Center. In addition, the regulations impose an obligation on providers to obtain an examination for physical injuries, and there is a requirement that, for a finding of psychological abuse to be substantiated, a clinical assessment is needed in order to demonstrate the impact of the conduct on the individual receiving services.

Current OMH regulations require reporting and investigation of incidents, and that providers request criminal background checks. While the amendments incorporate some changes, the basic requirements are conceptually unchanged. OMH therefore expects that additional compliance activities associated with these changes will be minimal. However, there will be additional compliance activities associated with checking the Staff Exclusion List.

Providers must comply with the new requirement to complete investigations within a 50-day timeframe, to enable OMH to submit results to the Justice Center within 60 days. Providers must also comply with new requirements to enhance the independence of investigators and incident review committees. However, OMH expects that additional compliance activities will be minimal since providers are already required to comply with existing incident management program requirements; these revisions primarily enhance current requirements.

3. Professional services: There may be additional professional services required for rural providers as a result of these amendments. The amendments will not add to the professional service needs of rural providers.

4. Compliance costs: There may be modest costs for rural providers associated with the amendments. There also may be nominal costs for rural providers to comply with the expanded notification requirements. However, all providers may experience savings if the Justice Center or OMH assumes responsibility for investigations that were previously conducted by provider staff.

In the long term, compliance activities associated with the implementation of these amendments are expected to reduce future incidents and abuse, resulting in savings for both urban and rural area providers as well as benefits to the wellbeing of individuals receiving services.

5. Minimizing adverse impact: The amendments may result in an adverse economic impact for rural providers due to additional compliance activities and associated compliance costs. However, as stated earlier, OMH expects that compliance with these enhanced regulations will result in savings in the long term and there may be some short-term savings as a result of the conduct of investigations by the Justice Center.

OMH has reviewed the regulations to determine if there were any viable approaches for minimizing adverse economic impact as suggested in section 202-b(1) of the State Administrative Procedure Act; none were readily identified. However, OMH did not consider the exemption of rural area providers from the amendments or the establishment of differing compliance or reporting requirements, since OMH considers compliance with the amendments to be crucial for the health, safety, and welfare of the individuals served by rural area providers.

6. Participation of public and private interests in rural areas: Chapter 501 of the Laws of 2012 was originally a Governor's Program Bill which received extensive media attention. Providers have had the opportunity to become familiar with its provisions since it was made available on various government websites last June. Furthermore, in accordance with statutory requirements, the rule was presented to the Mental Health Services Council for review and recommendations.

Job Impact Statement

A Job Impact Statement for these amendments is not being submitted because OMH does not anticipate a substantial adverse impact on jobs and employment opportunities.

The amendments incorporate a number of reforms to improve the quality and consistency of incident management activities throughout the OMH system. However, it is not anticipated that these reforms will negatively impact jobs or employment opportunities. The amendments that impose new requirements on providers, such as additional reporting requirements and the timeframe for completion of investigations, will not result in an adverse impact on jobs. OMH anticipates that there will be no effect on jobs as agencies will utilize current staff to perform the required compliance activities.

Chapter 501 of the Laws of 2012 and these implementing regulations will also mean that some functions that are currently performed by OMH staff will instead be performed by the staff of the Justice Center. OMH expects that the volume of incidents and occurrences investigated will be roughly similar. To the extent that the Justice Center performs investigations, oversees the management of reportable incidents, and manages requests for criminal history record checks, the result is expected to be neutral in that positions lost by OMH will be gained by the Justice Center.

It is therefore apparent from the nature and purpose of the rule that it will not have a substantial adverse impact on jobs and employment opportunities.

EMERGENCY/PROPOSED RULE MAKING NO HEARING(S) SCHEDULED

Rates of Reimbursement - Hospitals Licensed by the Office of Mental Health

I.D. No. OMH-01-14-00013-EP
Filing No. 1242
Filing Date: 2013-12-20
Effective Date: 2013-12-20

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

Proposed Action: Amendment of Part 577 of Title 14 NYCRR.

Statutory authority: Mental Hygiene Law, sections 7.09 and 43.02

Finding of necessity for emergency rule: Preservation of public health, public safety and general welfare.

Specific reasons underlying the finding of necessity: The amendments are the result of an administrative action consistent with Chapter 56 of the Laws of 2013 (the 2013-2014 enacted State Budget). Effective January 1, 2014, the proposal reduces the growth rate of Medicaid reimbursement for private psychiatric hospitals licensed pursuant to Article 31 of the Mental Hygiene Law. These regulatory amendments are the result of an extensive review of the rate methodology and cost reports by not only the Office of Mental Health, but also the Department of Health, in its role as the new rate setting entity. Therefore, OMH was not able to use the regular rule making process established by the State Administrative Procedure Act because there was not sufficient time to develop and promulgate regulations prior to January 1, 2014. Because all health care providers need to operate within the constraints of the enacted State budget, managing the growth of Medicaid is critical to maintaining essential health services during the budget year. Therefore, this rule is being adopted on an emergency basis until such time as it has been formally adopted through the SAPA rule promulgation process.

Subject: Rates of Reimbursement - Hospitals Licensed by the Office of Mental Health.

Purpose: Remove the 2014 trend factor for article 31 private psychiatric hospitals effective January 1, 2014.

Text of emergency/proposed rule: 1. Paragraph (1) of subdivision (e) of Section 577.7 is amended to read as follows:

(1) Allowable operating costs in the rate year are calculated by choosing the lower of the base year cost computed on a per diem basis or the limitation cost computed on a per diem basis, and trending this amount forward two years by the inflation factor, except for the rate period effective January 1, 2010, to December 31, 2010, when the inflation factor used to trend costs will be limited to the inflation factor for the first year of the two-year period, *and the rate period effective January 1, 2014, to December 31, 2014, when there will be no inflation factor used to trend costs*. Administration costs, as contained in and part of operating costs, shall be subject to an administrative cost screen. Two separate administrative cost screens shall be calculated, one for hospitals with greater than 100 beds (group one), and one for hospitals with 100 or less beds (group two). The administrative cost screen is derived from the costs in the fiscal year one year prior to the base year (i.e., the same cost year from which the limitation is derived), and shall be the group average per diem cost plus 10 percent.

2. Paragraph (4) of subdivision (h) of Section 577.7 is amended to read as follows:

(4) The operating cost component of the rate will be updated annually, except for the period January 1, 2010, to December 31, 2010, *and the period January 1, 2014, to December 31, 2014,* with the Medicare inflation factor for hospitals and units excluded from the prospective payment system, until the hospital has operated for six months at a minimum occupancy level of at least 75 percent and files its first cost report for that same period in accordance with section 577.5 of this Part.

This notice is intended: to serve as both a notice of emergency adoption and a notice of proposed rule making. The emergency rule will expire March 19, 2014.

Text of rule and any required statements and analyses may be obtained from: Sue Watson, NYS Office of Mental Health, 44 Holland Avenue, Albany, NY 12229, (518) 474-1331, email: Sue.Watson@omh.ny.gov

Data, views or arguments may be submitted to: Same as above.

Public comment will be received until: 45 days after publication of this notice.

Regulatory Impact Statement

1. Statutory authority: Section 7.09 of the Mental Hygiene Law grants the Commissioner of the Office of Mental Health the authority and responsibility to adopt regulations that are necessary and proper to implement matters under his/her jurisdiction.

Section 43.02 of the Mental Hygiene Law provides that the Commissioner has the power to establish standards and methods for determining rates of payment made by government agencies pursuant to Title 11 of Article 5 of the Social Services Law for services provided by facilities, including hospitals, licensed by the Office of Mental Health.

2. Legislative objectives: Article 7 of the Mental Hygiene Law reflects the Commissioner's authority to establish regulations regarding mental health programs. The amendments to Part 577 are needed to reduce the growth rate of Medicaid reimbursement for private psychiatric hospitals licensed pursuant to Article 31 of the Mental Hygiene Law. (Note: These amendments are not applicable to psychiatric hospitals which are jointly licensed pursuant to Article 31 of the Mental Hygiene Law, as well as Article 28 of the Public Health Law.) These amendments are the result of an administrative action consistent with Chapter 56 of the Laws of 2013 (the 2013-2014 enacted State Budget).

3. Needs and benefits: Effective January 1, 2014, the amendments remove the 2014 trend factor of 5.216 percent in developing the 2014 per diem Medicaid rates for Article 31 private psychiatric hospitals. Normally, under the Commissioner's authority, OMH trends base year costs forward two years to the rate year by using two annual trend factors (representing a trend factor for the year preceding the rate year and another trend factor for the rate year). But for the 2014 rate year, OMH will not use a trend factor. This action is consistent with the elimination of the inflationary adjustments and trends applied to rates for community mental health programs in 2013-2014. As a result, the rate of growth in Medicaid expenditures for the private psychiatric hospitals will be slowed, but the expectation is that the level of services provided by such hospitals will be maintained. OMH will be recognizing a more current cost report period in the calculation of the 2014 rates, after having frozen rates in prior periods, which will allow for more current actual expenditures to be recognized in the rate calculation.

4. Costs:

(a) cost to State government: These regulatory amendments will not result in any additional costs to State government. These amendments are expected to result in a savings to State government of $1.12 million.

(b) cost to local government: These regulatory amendments will not result in any additional costs to local government.

(c) cost to regulated parties: This regulatory amendment will not result in any additional cost to regulated parties, but will reduce the rate of growth in Medicaid payments that the Article 31 private psychiatric hospitals would have received, projected to be 5.216 percent. Currently there are six such providers. It is estimated that this action will result in an annual reduction in Medicaid growth of approximately $1.12 million State share of Medicaid ($2.23 million gross Medicaid).

5. Local government mandates: These regulatory amendments will not result in any additional imposition of duties or responsibilities upon county, city, town, village, school or fire districts.

6. Paperwork: This rule should not substantially increase the paperwork requirements of affected providers.

7. Duplication: These regulatory amendments do not duplicate existing State or federal requirements.

8. Alternatives: As noted above, this amendment is consistent with the 2013-2014 enacted State Budget and the budgetary constraints included therein. The elimination of the 2014 trend factor of 5.216 percent is consistent with the elimination of the inflationary adjustments and trends applied to rates for community mental health programs in 2013-2014, and reflects the serious fiscal condition of the State. The only alternative to this rule making would have been to make budgetary cuts to another program which may have already sustained previous cuts and could have the potential for putting those providers at financial risk. Therefore, that alternative was not considered. It should be noted that OMH has not applied a trend factor to other cost-based reimbursement programs in the 2013-14 fiscal year, nor have cost of living adjustments been made to other payments in this year.

9. Federal standards: The regulatory amendments do not exceed any minimum standards of the federal government for the same or similar subject areas.

10. Compliance schedule: The regulatory amendments would become effective immediately upon adoption.

Regulatory Flexibility Analysis

The rule making will reduce the rate of growth in Medicaid reimbursement associated with private psychiatric hospitals licensed pursuant to Article 31 of the Mental Hygiene Law. The proposed change is consistent with the 2013-2014 enacted State Budget. This change removes the 2014 trend factor in the development of the 2014 per diem Medicaid rates for Article 31 private psychiatric hospitals, and, as a result, slows the rate of growth in Medicaid expenditures. There will be no adverse economic impact on small businesses or local governments; therefore, a regulatory flexibility analysis is not submitted with this notice.

Rural Area Flexibility Analysis

A Rural Area Flexibility Analysis is not submitted with this notice because the rule making, which serves to reduce the growth rate of Medicaid reimbursement associated with private psychiatric hospitals licensed pursuant to Article 31 of the Mental Hygiene Law, will not impose any adverse economic impact on rural areas. The proposed change is consistent with the 2013-2014 enacted State Budget. This change removes the 2014 trend factor in the development of the 2014 per diem Medicaid rates for Article 31 private psychiatric hospitals, and, as a result, slows the rate of growth in Medicaid expenditures.

Job Impact Statement

A Job Impact Statement is not submitted with this notice because the regulation eliminates the 2014 trend factor in the development of the 2014

per diem Medicaid rates for Article 31 private psychiatric hospitals, and, as a result, slows the rate of growth in Medicaid expenditures. The proposed change is consistent with the 2013-2014 enacted State Budget. No adverse impact on jobs and employment opportunities is expected as a result of this rule making.

Department of Motor Vehicles

NOTICE OF ADOPTION

Enforcement of Dealer Related Regulations

I.D. No. MTV-25-13-00004-A

Filing No. 1249

Filing Date: 2013-12-24

Effective Date: 2014-01-08

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

Action taken: Amendment of section 78.32 of Title 15 NYCRR.

Statutory authority: Vehicle and Traffic Law, sections 215(a) and 415(9)(b)

Subject: Enforcement of dealer related regulations.

Purpose: To authorize DMV to take action against dealers who file misleading or false statements in relation to lien satisfaction filing.

Text or summary was published in the June 19, 2013 issue of the Register, I.D. No. MTV-25-13-00004-P.

Final rule as compared with last published rule: No changes.

Text of rule and any required statements and analyses may be obtained from: Heidi Bazicki, Department of Motor Vehicles, 6 Empire State Plaza, Rm. 526, Albany, NY 12228, (518) 474-0871, email: heidi.bazicki@dmv.ny.gov

Assessment of Public Comment

The agency received no public comment.

NOTICE OF ADOPTION

Proof of Satisfaction of Lien by Dealers

I.D. No. MTV-25-13-00005-A

Filing No. 1250

Filing Date: 2013-12-24

Effective Date: 2014-01-08

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

Action taken: Amendment of section 20.17 of Title 15 NYCRR.

Statutory authority: Vehicle and Traffic Law, sections 215(a), 2121(a) and (b)

Subject: Proof of satisfaction of lien by dealers.

Purpose: To establish procedures for dealers to demonstrate that they have satisfied a lien in order to obtain a clear title.

Text or summary was published in the June 19, 2013 issue of the Register, I.D. No. MTV-25-13-00005-RP.

Final rule as compared with last published rule: No changes.

Text of rule and any required statements and analyses may be obtained from: Heidi Bazicki, Department of Motor Vehicles, 6 Empire State Plaza, Rm. 526, Albany, NY 12228, (518) 474-0871, email: heidi.bazicki@dmv.ny.gov

Assessment of Public Comment

The American Financial Services Association (AFSA) submitted two comments about the revised rule.

Comment: AFSA, as it did in response to the original proposed rule, suggests that the rule should require a standard form in prominent type alerting the lienholder that its security interest will be released unless the lienholder objects. The required notice in Section 20.17(b)(3) of the rule should be incorporated in the standard form.

Response: The Department continues to believe that a standardized form is unnecessary because Section 20.17(b)(3) of the rule explicitly sets forth the language that must be used in the dealer's notice to the lienholder about the pending release of its lien. In addition, the rule provides that the notice shall be in 14-point type or larger, which should be sufficiently prominent to distinguish the notice from other correspondence. If the Department determines, based on experience after the rule has been in effect, that a standardized form is necessary, the Department always has the option of producing such a form.

Comment: AFSA requests the Department to clarify the meaning of the term "good funds" in Section 20.17(b) of the rule and suggests that the term should not include a check unless it is certified.

Response: This comment appears to conflate two separate issues: (i) the meaning of the term "good funds" and (ii) the acceptable forms of payment to satisfy a lien. As to the first issue, the term "good funds" is not defined in statute, and the Department declines the invitation to define the term in the rule. "Good funds" is a widely used term in commercial transactions and is generally understood to mean that the money tendered in payment of a debt has value equal to the amount of the debt. For example, a payment in cash must be legal tender and not counterfeit. A check or similar instrument tendered in payment must not be forged and there must be sufficient money in the account to pay the instrument. In any event, a requirement that funds be "good" does not dictate the particular form in which a payment must be made.

As to the second issue, acceptable forms of payment to satisfy a lien are dictated by the statute and described further in the rule. Section 2121(b) of the Vehicle and Traffic Law states, in pertinent part, that "evidence that a security interest has been satisfied shall include: (i) evidence that an interbank or electronic transfer of funds has been made; or (ii) evidence that a copy of a cashier's or bank check has been delivered; or (iii) other evidence as determined to be satisfactory by the commissioner." In conformance with the statute, Section 20.17(b)(5) of the rule provides that the only acceptable forms of evidence that payment has been made to satisfy the lien are (i) a transmission receipt for an interbank or electronic funds transfer, (ii) a copy of a bank or cashier's check, or (iii) a written statement from the lienholder acknowledging that the lien has been satisfied. The Department therefore believes the rule is sufficiently clear on this point.

PROPOSED RULE MAKING
NO HEARING(S) SCHEDULED

Appeals Board Procedures

I.D. No. MTV-01-14-00002-P

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

Proposed Action: This is a consensus rule making to amend Part 155 of Title 15 NYCRR.

Statutory authority: Vehicle and Traffic Law, sections 215(a), 261, 469 and 471-a(5)

Subject: Appeals Board procedures.

Purpose: To conform Part 155 to the Appeals Board's current policies and procedures.

Text of proposed rule: Subdivisions (a), (c) and (d) of section 155.1 are amended to read as follows:

155.1 Administrative appeals board.

(a) The appeals board as established by section 228, article 2-A of the Vehicle and Traffic Law shall also constitute the administrative appeals board under article 3-A of such law. Each appeal shall be considered by members of the board, sitting as a panel. Each panel shall consist of three members designated as hereinafter provided. Hearing officers may be designated as members of each panel. At least two votes shall be required for a decision. (Appeals arising from determinations made pursuant to article 2-A of the Vehicle and Traffic Law, adjudication of traffic infractions, shall be considered and determined in accordance with regulations prescribed in Part [125] *126* of the regulations of the commissioner.)

(c) General direction and supervision of the administrative appeals board shall be exercised by the [Chairman] Chairperson of the Motor Vehicle Appeals Board who shall designate the individual members and presiding officers of the various panels and shall be the presiding officer of any panel of which he *or she* is a member. [The vice-chairman of the motor vehicle appeals board shall assist the chairman in the general direction and supervision of the administrative appeals board, perform the functions of the chairman in the absence of the chairman and, unless the chairman shall also be a member of the panel, shall be the presiding officer of any panel of which he is a member.]

(d) Members of the public, attorneys, and interested parties may obtain information or make submissions or requests concerning administrative appeals by writing to *the Appeals Board at:*

Appendix IV
2014 Title XIX State Plan
First Quarter Amendment
Public Notice

sessments, 99 Washington Ave. – One Commerce Plaza, Suite 1430, Albany, NY 12210, (518) 474-1673, (518) 473-8825 (FAX), e-mail: 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. The following changes are proposed:

Effective January 1, 2014 through December 31, 2014, the State will continue to reimburse converted Targeted Case Management (TCM) providers at their existing Health Home legacy TCM rates for the following Phase 1 counties: Bronx, Brooklyn, Nassau, Warren, Washington, Essex, Hamilton, Clinton, Franklin and Schenectady.

Effective April 1, 2014 through December 31, 2014, the State will continue to reimburse converted Targeted Case Management (TCM) providers at their existing Health Home legacy TCM rates for the following Phase 2 counties: Dutchess, Erie, Manhattan, Monroe, Orange, Putnam, Queens, Richmond, Rockland, Suffolk, Sullivan, Ulster, and Westchester.

Effective July 1, 2014 through December 31, 2014, the State will continue to reimburse converted Targeted Case Management (TCM) providers at their existing Health Home legacy TCM rates for the following Phase 3 counties: Albany, Alleghany, Broome, Cattaraugus, Cayuga, Chautauqua, Chemung, Chenango, Columbia, Cortland, Delaware, Fulton, Genesee, Greene, Herkimer, Jefferson, Lewis, Livingston, Madison, Montgomery, Niagara, Ontario, Oneida, Onondaga, Orleans, Oswego, Otsego, Rensselaer, Saratoga, Schoharie, Schuyler, Seneca, St. Lawrence, Steuben, Tioga, Tompkins, Wayne, Wyoming and Yates.

The Department is extending the legacy rate until December 31, 2014, in order to provide the Department time to work with stakeholders to develop a Health Home payment methodology to better align the Health Home payment methodology to acuity between now and when the State begins to transition the behavioral health benefit into Managed Care on January 1, 2015. It is anticipated that this new payment methodology would be paid by Managed Care plans for a transitional period of time beginning in 2015.

The Health Home projected fiscal impact of extending these rates for Phases 1, 2 and 3 until December 31, 2014 is $3,842,092 in SFY 13-14 and $33,635,470 in SFY 14-15.

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.

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

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

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

Queens County, Queens Center
3220 Northern Boulevard
Long Island City, New York 11101

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

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

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

For further information and to review and comment, please contact: Department of Health, Bureau of Federal Relations & Provider Assessments, 99 Washington Ave. – One Commerce Plaza, Suite 1430, Albany, NY 12210, (518) 474-1673, (518) 473-8825 (FAX), e-mail: 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 private psychiatric hospitals licensed pursuant to Article 31 of the Mental Hygiene Law and issued an operating certificate in accordance with 14 NYCRR Part 582. This amendment will serve to reflect that no trend factor will be applied to allowable costs. This amendment will be effective January 1, 2014.

The estimated annual net aggregate decrease in gross Medicaid expenditures attributable to this initiative contained in the budget for State fiscal year 2013-2014 is ($2.231 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.

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

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

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For further information and to review and comment, please contact: Department of Health, Bureau of Federal Relations & Provider Assessments, 99 Washington Ave. – One Commerce Plaza, Suite 1430, Albany, NY 12210, (518) 474-1673, (518) 473-8825 (FAX), e-mail: spa_inquiries@health.state.ny.us

PUBLIC NOTICE

Uniform Code Regional Boards of Review

Pursuant to 19 NYCRR 1205, the petitions below have been received by the Department of State for action by the Uniform Code Regional Boards of Review. Unless otherwise indicated, they involve requests for relief from provisions of the New York State Uniform

Appendix V
2014 Title XIX State Plan
First Quarter Amendment
Responses to Standard Funding Questions

HOSPITAL SERVICES
State Plan Amendment #14-14

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: The total annual Medicaid reimbursement for all nine private psychiatric hospitals (PPHs) is approximately $45 million. The entire balance of Medicaid payments that is paid directly to the PPHs is retained by them to support their costs of operations.

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: The entire non-Federal share of Medicaid payments for inpatient hospital services under the State plan provided by PPHs is paid by State funds provided by appropriations enacted by the State legislature.

Regarding CMS' inquiry as to the use of certified public expenditures (CPEs) and intergovernmental transfers (IGTs) by the State please note that New York does not utilize CPEs or IGTs to assist in financing any portion of the non-Federal share of Medicaid payments to PPHs.

Regarding CMS' inquiry as to the use of provider taxes by the State please note that New York does not impose any provider taxes to fund the non-Federal share of Medicaid payments to PPHs.

Regarding the State's practices for verifying that expenditures being certified are eligible for Federal matching funds in accordance with 42 CFR §433.51(b), the State Department of Health (DOH) contracts with a fiscal agent, Computer Sciences Corporation (CSC), to process Medicaid claims and make payments to providers. The fiscal agent processes claims and pays providers for services rendered to eligible Medicaid recipients through the EMEDNY System, a computerized payment and information reporting system. All claims are subjected to numerous system edits to help ensure only legitimate services are reimbursed to properly enrolled providers. In addition, both the DOH and the New York State Comptroller's office subject Medicaid claims to both prepayment and post-payment audits to ensure that providers comply with all applicable State and Federal laws and regulations.

In New York State Medicaid payments are issued to providers every Wednesday. CSC provides a weekly summary to the DOH that includes the total Federal, State, and local funding required to support all checks to be released for payment to providers. The DOH arranges for the required funds to be placed in an escrow account until they are needed to pay for the checks presented by providers. All Federal Medicaid matching funds are drawn down by the State in accordance with an agreement between the United States Department of the Treasury and the State as required by the Cash Management Improvement Act of 1990, as amended.

On a quarterly basis CSC provides a report of paid claims to the DOH. The DOH combines that expenditure information with data concerning other Medicaid expenditures made directly by the DOH or other State agencies. The DOH then submits the CMS-64 report to the Department of Health and Human Services, which enables the State to earn the appropriate Federal reimbursement for its certified claims submitted either by providers of service or by State agency representatives. These procedures are followed by the State in order to ensure that Federal Medicaid funds are only used to pay for legitimate Medicaid services.

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: No supplemental or enhanced payments are made for PPH services.

4. **Please provide a detailed description of the methodology used by the state to estimate the upper payment limit (UPL) for each class of providers (State owned or operated, non-state government owned or operated, and privately owned or operated). Please provide a current (i.e. applicable to the current rate year) UPL demonstration. Under regulations at 42 CFR 447.272, States are prohibited from setting payment rates for Medicaid inpatient services that exceed a reasonable estimate of the amount that would be paid under Medicare payment principals.**

   Response: Based on guidance from CMS, the State submitted the 2012 inpatient UPL demonstration on October 30, 2013. The 2013 room analysis was submitted November 4, 2013, both of which are under review by CMS.

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: All providers included in this proposed SPA are either for profit or not-for-profit corporations. This SPA language is not applicable for government providers.

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 [✓] 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:

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

Response: Tribal consultation was performed in accordance with the State's tribal consultation policy as approved in SPA 11-06, and documentation of such is included with this submission. To date, no feedback has been received from any tribal representative in response to the proposed change in this SPA