NEW YORK
state department of
HEALTH

Howard A. Zucker, M.D., J.D.
Acting Commissioner of Health

Sue Kelly
Executive Deputy Commissioner

December 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 #14-022
Inpatient Hospital Services

Dear Mr. Cooley:

The State requests approval of the attached amendment #14-022 to the Title XIX (Medicaid) State Plan for inpatient hospital services to be effective November 1, 2014 (Appendix I). This amendment is being submitted based upon State regulations. 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 October 29, 2014.

It is estimated that the changes represented by 2014 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 regulations are attached for your information (Appendix III). In addition, responses to the five standard funding questions are also attached (Appendix V).

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

Attachments

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: **14-022**	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 **November 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, and 42 CFR 447**	7. FEDERAL BUDGET IMPACT: **(in thousands)** **a. FFY 11/01/14-09/30/15 $ 1,295** **b. FFY 10/01/15-09/30/16 $ 789**
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: **Attachment 4.19-A: Page 136(b)**	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: **Attachment 4.19-A: Page 136(b)**

10. SUBJECT OF AMENDMENT:
Safety Net/VAP – Mary Imogene Bassett Hospital
(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 Federal Relations & Provider Assessments** **99 Washington Ave – One Commerce Plaza** **Suite 1460** **Albany, NY 12210**
13. TYPED NAME: **Jason A. Helgerson**	
14. TITLE: **Medicaid Director** **Department of Health**	
15. DATE SUBMITTED: DEC 3 1 2014	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:	18. DATE APPROVED:
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL:	20. SIGNATURE OF REGIONAL OFFICIAL:
21. TYPED NAME:	22. TITLE:
23. REMARKS:	

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

New York
136(b)

b. Temporary rate adjustments have been approved for the following hospital providers in the amounts and for the effective periods listed:

Hospitals:

Provider Name	Gross Medicaid Rate Adjustment	Rate Period Effective
Benedictine/Kingston Hospital	$2,500,000	02/01/2014 – 03/31/2014
Brookdale Hospital Medical Center	$14,000,000	02/01/2014 – 03/31/2014
Brooklyn Hospital Center	$5,000,000	02/01/2014 – 03/31/2014
	$5,000,000	04/01/2014 – 03/31/2015
Interfaith Medical Center	$12,900,000	11/01/2013 – 03/31/2014
Kingsbrook Jewish Medical Center	$3,700,000	11/01/2013 – 03/31/2014
	$3,700,000	04/01/2014 – 03/31/2015
Kings County Hospital Center	$1,000,000	01/01/2014 – 03/31/2014
Lincoln Medical & Mental Health Center	$963,687	04/01/2012 – 03/31/2013
	$963,687	04/01/2013 – 03/31/2014
Mary Imogene Bassett Hospital	$1,563,900	11/01/2014 – 03/31/2015
	$2,050,438	04/01/2015 – 03/31/2016
	$1,104,187	04/01/2016 – 03/31/2017
	$281,250	04/01/2017 – 03/31/2018
Montefiore Medical Center	$6,000,000	11/01/2013 – 03/31/2014
	$36,000,000	04/01/2014 – 03/31/2015
	$23,000,000	04/01/2015 – 03/31/2016
New York Methodist Hospital	$3,005,000	01/01/2014 – 03/31/2014
	$3,201,500	04/01/2014 – 03/31/2015
	$3,118,500	04/01/2015 – 03/31/2016
Niagara Falls Memorial Medical Center	$228,318	04/01/2012 – 03/31/2013
	$171,237	04/01/2013 – 12/31/2013
	$318,755	01/01/2014 – 03/31/2014
	$501,862	04/01/2014 – 03/31/2015
	$260,345	04/01/2015 – 03/31/2016

Appendix II
2014 Title XIX State Plan
Fourth Quarter Amendment
Summary

SUMMARY
SPA #14-022

This State Plan Amendment proposes to modify the listing of Hospitals previously approved to receive temporary rate adjustments under the closure, merger, consolidation, acquisition or restructuring of a health care provider. The additional provider for which approval is being requested is Mary Imogene Bassett Hospital.

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

tute, published in the New York State Register invited comments and questions from the general public

Job Impact Statement

A Job Impact Statement is not required pursuant to Section 201-a(2)(a) of the State Administrative Procedure Act. It is not expected that the proposed rule to accelerate capital reimbursement for costs related to the installation of automatic sprinkler systems will have a material impact on jobs or employment opportunities across the Nursing Home industry.

NOTICE OF ADOPTION

Hospital Temporary Rate Adjustments

I.D. No. HLT-14-12-00006-A
Filing No. 569
Filing Date: 2012-06-13
Effective Date: 2012-07-03

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

Action taken: Amendment of section 86-1.31 of Title 10 NYCRR.

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

Subject: Hospital Temporary Rate Adjustments.

Purpose: No longer require that a merger, acquisition or consolidation needs to occur on or after the year the rate is based upon.

Text or summary was published in the April 4, 2012 issue of the Register, I.D. No. HLT-14-12-00006-P.

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

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

Assessment of Public Comment

The agency received no public comment.

NOTICE OF ADOPTION

Temporary Rate Adjustment (TRA) - Residential Health Care Facilities (RHCF) (Nursing Homes)

I.D. No. HLT-14-12-00007-A
Filing No. 570
Filing Date: 2012-06-13
Effective Date: 2012-07-03

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

Action taken: Addition of section 86-2.39 to Title 10 NYCRR.

Statutory authority: Public Health Law, section 2808(2-c)(d)

Subject: Temporary Rate Adjustment (TRA) - Residential Health Care Facilities (RHCF) (Nursing Homes).

Purpose: To provide a TRA to eligible RHCFs subject to or impacted by closure, merger, acquisition, consolidation, or restructuring.

Text or summary was published in the April 4, 2012 issue of the Register, I.D. No. HLT-14-12-00007-P.

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

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

Assessment of Public Comment

The agency received no public comment.

NOTICE OF ADOPTION

Temporary Rate Adjustment (TRA) - Licensed Ambulatory Care Facilities (LACF)

I.D. No. HLT-14-12-00008-A
Filing No. 571
Filing Date: 2012-06-13
Effective Date: 2012-07-03

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

Action taken: Addition of section 86-8.15 to Title 10 NYCRR.

Statutory authority: Public Health Law, section 2807(2-a)(e)

Subject: Temporary Rate Adjustment (TRA) - Licensed Ambulatory Care Facilities (LACF).

Purpose: Expand TRA to include Article 28 LACFs subject to or affected by closure, merger, acquisition, consolidation, or restructuring.

Text or summary was published in the April 4, 2012 issue of the Register, I.D. No. HLT-14-12-00008-P.

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

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

Assessment of Public Comment

The agency received no public comment.

Department of Motor Vehicles

PROPOSED RULE MAKING NO HEARING(S) SCHEDULED

Genesee County Motor Vehicle Use Tax

I.D. No. MTV-27-12-00007-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 29 of Title 15 NYCRR.

Statutory authority: Vehicle and Traffic Law, sections 215(a) and 401(6)(d)(ii); and Tax Law, section 1202(e)

Subject: Genesee County motor vehicle use tax.

Purpose: To impose a Genesee County motor vehicle use tax.

Text of proposed rule: Section 29.12 is amended by adding a new subdivision (aj) to read as follows:

(aj) Genesee County. The Genesee County Legislature adopted a local on November 9, 2011, to establish a Genesee County Motor Vehicle Use Tax. The Chairman of the Genesee County Legislature entered into an agreement with the Commissioner of Motor Vehicles for the collection of the tax in accordance with the provisions of this Part, for the collection of such tax on original registrations made on and after October 1, 2012 and upon the renewal of registrations expiring on and after December 1, 2012. The County Treasurer is the appropriate fiscal officer, except that the County Attorney is the appropriate legal officer of Genesee County referred to in this Part. The tax due on passenger motor vehicles for which the registration fee is established in paragraph (a) of subdivision (6) of Section 401 of the Vehicle and Traffic Law shall be $5.00 per annum on such motor vehicles weighing 3,500 lbs. or less and $10.00 per annum for such motor vehicles weighing in excess of 3,500 lbs. The tax due on trucks, buses and other commercial motor vehicles for which the registration fee is established in subdivision (7) of Section 401 of the Vehicle and Traffic Law used principally in connection with a business carried on within Genesee County, except for vehicles used in connection with the operation of a farm by the owner or tenant thereof shall be $10.00 per annum.

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

Data, views or arguments may be submitted to: Ida L. Traschen, DMV, same as above.

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

Consensus Rule Making Determination

This proposed regulation would create a new 15 NYCRR Part 29.12(aj) to provide for the collection of a Genesee County motor vehicle use tax by the Department of Motor Vehicles. Pursuant to the authority contained in Tax Law section 1202(e) and Vehicle and Traffic Law section 401(6)(d)(ii), the Commissioner must collect a motor vehicle use tax if a county has enacted a local law requiring the collection of such tax.

On November 9, 2011, the Genesee County Legislature enacted a local law requiring that a motor vehicle use tax be imposed on passenger and commercial vehicles. Pursuant to this law, the Commissioner is required to collect the tax on behalf of the county and transmit the revenue to the

times a year on the MLOs newly employed by them or dismissed for cause, determine that each MLO employed by or affiliated with them has the character, fitness and education qualifications to warrant the belief he or she will engage in mortgage loan originating honestly, fairly and efficiently, and, finally, retain acceptable documentation as evidence of satisfactory completion of required education courses for each MLO for a period of six years. The Department believes that this rule will not impose a burdensome set of requirements on entities operating in rural areas.

Costs. Some mortgage businesses in rural areas may choose to pay the increased costs associated with the continuing education requirements and the fees associated with licensing and annual renewal of their MLOs, but are not required to do so. The regulation sets forth a background investigation fee of $125.00, an initial license processing fee of $50.00 and an annual license renewal fee of $50.00. There will also be a fee for the processing of fingerprints and fees to cover the cost of third party processing of the application. The latter two fees will be posted on the Department's website. Costs associated with electronic filing of quarterly employment reports and retaining for six years evidence of completion by MLOs of required continuing education courses are expected to be minimal. The cost of continuing education is estimated to be approximately $500 every two years. The Department's increased effectiveness in fighting mortgage fraud and predatory lending will lower costs related to litigation and will decrease losses to consumers and the mortgage industry by hundreds of millions of dollars.

Minimizing Adverse Impacts. The industry supported passage of the prior Article 12-E and had substantial opportunity to comment on the specific requirements of this statute and its supporting regulation. In addition, the industry was involved in a dialogue with the Department during rule development.

The revised regulations implement revised Article 12-E of the Banking Law, which in turn closely tracks the provisions of Title V of the federal Housing and Economic Recovery Act of 2008, also known as the S.A.F.E. Mortgage Licensing Act (the "SAFE Act"). Hence, the licensing and regulation of mortgage loan originators in New York now closely tracks the federal standard. If New York did not adopt this standard, the SAFE Act requires that the federal Department of Housing and Urban Development assume the licensing of MLOs in New York State.

Rural Area Participation. Representatives of various entities, including mortgage bankers and brokers conducting business in rural areas and entities that conduct mortgage originating in rural areas, participated in outreach meetings that were conducted during the process of drafting the prior Article 12-E and the implementing regulations. As noted above, the revised statute and regulations closely track the provisions of the federal SAFE Act.

Job Impact Statement

Revised Article 12-E of the Banking Law, effective on July 11, 2009, replaces the prior version of Article 12-E with respect to the licensing and regulation of mortgage loan servicers. This proposed regulation sets forth the application, exemption and approval procedures for licensing registration as a Mortgage Loan Originator (MLO), as well as financial responsibility requirements for individuals engaging in MLO activities. The proposed regulation also provides transition rules for individuals who engaged in MLO activities under the prior version of the article to become licensed under the new statute.

The requirement to comply with the proposed regulations is not expected to have a significant adverse effect on jobs or employment activities within the mortgage loan servicing industry. This is because individuals were already subject to regulation under the prior version of Article 12-E of the Banking Law. New Article 12-E and Part 420 are intended to conform the regulation of MLOs to the requirements of federal law. Absent action by New York to conform this regulation to federal requirements, federal law authorized the Department of Housing and Urban Affairs to take control of the regulation of MLOs in New York State.

As will their predecessors, the new statute and proposed regulations require the use of the internet-based National Mortgage Licensing System and Registry (NMLS), developed by the Conference of State Bank Supervisors and the American Association of Residential Mortgage Regulators. This system uses a common on-line application for MLO registration in New York and other participating states. It is believed that any remaining adverse impact would be due primarily to the nature and purpose of the statutory licensing requirement rather than the provisions of the proposed regulations.

Supervisory Procedure 108 relates to the approval by the Superintendent of Financial Services (formerly the Superintendent of Banks) of educational courses and course providers for MLOs. Under revised Article 12-E, this function has been transferred to the NMLS. Moreover, educational requirements have been increased under the new law and proposed regulation by the Superintendent.

Department of Health

EMERGENCY RULE MAKING

Hospital Temporary Rate Adjustments

I.D. No. HLT-14-12-00006-E
Filing No. 450
Filing Date: 2012-05-11
Effective Date: 2012-05-11

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

Action taken: Amendment of section 86-1.31 of Title 10 NYCRR.

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

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

Specific reasons underlying the finding of necessity: Paragraph (b) of subdivision 35 of section 2807-e of the Public Health Law (as added by Section 2 of Part C of Chapter 58 of the Laws of 2009) specifically provides the Commissioner of Health with authority, effective for periods on and after December 1, 2009, to issue emergency regulations in order to compute hospital inpatient rates as authorized in accordance with the provisions of such subdivision 35.

Subject: Hospital Temporary Rate Adjustments.

Purpose: No longer require that a merger, acquisition or consolidation needs to occur on or after the year the rate is based upon.

Text of emergency rule: Subdivision (b) of section 86-1.31 of title 10 of NYCRR is hereby REPEALED and a new subdivision (b) is added, to read as follows:

(b) Closures, mergers, acquisitions, consolidations and restructurings.

(1) The commissioner may grant approval of a temporary adjustment to the non-capital components of rates calculated pursuant to this subpart for eligible general hospitals.

(2) Eligible facilities shall include:

(i) facilities undergoing closure;

(ii) facilities impacted by the closure of other health care providers;

(iii) facilities subject to mergers, acquisitions, consolidations or restructuring; or

(iv) facilities impacted by the merger, acquisition, consolidation or restructuring of other health care providers.

(3) Facilities seeking rate adjustments under this section shall demonstrate through submission of a written proposal to the commissioner that the additional resources provided by a temporary rate adjustment will achieve one or more of the following:

(i) protect or enhance access to care;

(ii) protect or enhance quality of care;

(iii) improve the cost effectiveness of the delivery of health care services; or

(iv) otherwise protect or enhance the health care delivery system, as determined by the commissioner.

(4) (i) Such written proposal shall be submitted to the commissioner at least sixty days prior to the requested effective date of the temporary rate adjustment and shall include a proposed budget to achieve the goals of the proposal. Any temporary rate adjustment issued pursuant to this section shall be in effect for a specified period of time as determined by the commissioner, of up to three years. If the end of the specified timeframe, the facility shall be reimbursed in accordance with the otherwise applicable rate-setting methodologies as set forth in applicable statutes and this Subpart. The commissioner may establish, as a condition of receiving such a temporary rate adjustment, benchmarks and goals to be achieved in conformity with the facility's written proposal as approved by the commissioner and may also require that the facility submit such periodic reports concerning the achievement of such benchmarks and goals as the commissioner deems necessary. Failure to achieve satisfactory progress as determined by the commissioner, in accomplishing such benchmarks and goals shall be a basis for ending the facility's temporary rate adjustment prior to the end of the specified timeframe.

(ii) The commissioner may require that applications submitted pursuant to this section be submitted in response to and in accordance with a Request For Applications or a Request For Proposals issued by the commissioner.

This notice is intended to serve only as a notice of emergency adoption. This agency intends to adopt the provisions of this emergency rule as a permanent rule, having previously submitted to the Department of State a notice of proposed rule making, I.D. No. HLT-14-12-00006-P, Issue of April 4, 2012. The emergency rule will expire July 9, 2012.

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

Regulatory Impact Statement

Statutory Authority:

The statutory authority for this regulation is contained in Section 2807-c (35)(b) of the Public Health Law (PHL) which authorizes the Commissioner to promulgate regulations, including emergency regulations, with regard to Medicaid reimbursement rates for general hospital inpatient services. Such rate regulations are set forth in Subpart 86-1 of Title 10 (Health) of the Official Compilation of Codes, Rules and Regulation of the State of New York.

Legislative Objectives:

Subpart 86-1 of Title 10 (Health) of the Official Compilation of Codes, Rules and Regulation of the State of New York, paragraph (1) of subdivision (b) of section 1.31 will be amended to expand this temporary adjustment to eligible general hospitals that are subject to or impacted by the closure, merger, acquisition, consolidation, or restructuring of a health care provider in their service delivery area. In addition, the proposed regulation sets forth the conditions under which a provider will be considered eligible, the requirements for requesting a temporary rate adjustment, and the conditions that must be met in order to receive a temporary rate adjustment. The temporary rate adjustment shall be in effect for a specified period of time, as approved by the Commissioner, of up to three years. This regulation is necessary in order to maintain beneficiaries' access to services by providing needed relief to providers who meet the criteria.

Proposed section 86-1.31(b) requires providers seeking a temporary rate adjustment to submit a written proposal demonstrating that the additional resources provided by a temporary rate adjustment will achieve one or more of the following: (i) protect or enhance access to care; (ii) protect or enhance quality of care; (iii) improve the cost effectiveness of the delivery of health care services; or (iv) otherwise protect or enhance the health care delivery system, as determined by the Commissioner. The proposed amendment permits the Commissioner to establish benchmarks and goals, in conformity with a provider's written proposal as approved by the Commissioner, and to require the provider to submit periodic reports concerning the provider's progress toward achievement of such. Failure to achieve satisfactory progress in accomplishing such benchmarks and goals, as determined by the Commissioner, shall be a basis for ending the provider's temporary rate adjustment prior to the end of the specified timeframe.

Needs and Benefits:

In the center of a changing health care delivery system, the closure of a health care provider within a community often happens without adequate planning of resources for the remaining health care providers in the service delivery area. In addition, maintaining access to needed services while also maintaining or improving quality becomes challenging for the remaining providers. The additional reimbursement provided by this adjustment will support the remaining providers in achieving these goals, thus improving quality while reducing health care costs.

Costs:

Costs to Private Regulated Parties:

There will be no additional costs to private regulated parties. The only additional data requested from providers would be periodic reports demonstrating progress against benchmarks and goals.

Costs to State Government:

There is no additional aggregate increase in Medicaid expenditures anticipated as a result of these regulations, as the cost of the temporary rate adjustment will be offset by the overall reduction in Medicaid expenditures due to the closure, merger, acquisition, consolidation, or restructuring.

Costs to Local Government:

Local districts' share of Medicaid costs is statutorily capped; therefore, there will be no additional costs to local governments as a result of this proposed regulation.

Costs to the Department of Health:

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

Local Government Mandates:

The proposed regulation does not impose any new programs, services, duties or responsibilities upon any county, city, town, village, school district, fire district or other special district.

Paperwork:

An eligible provider must submit a written proposal, including a proposed budget. If a temporary rate adjustment is approved for a provider, the provider must submit periodic reports, as determined by the Commissioner, concerning the achievement of benchmarks and goals that are established by the Commissioner and are in conformity with the provider's approved written proposal.

Duplication:

This is an amendment to an existing State regulation and does not duplicate any existing federal, state or local regulations.

Alternatives:

No significant alternatives are available. Any potential projects that would otherwise qualify for funding pursuant to the revised regulation would, in the absence of this amendment, either not proceed or would require the use of existing provider resources.

Federal Standards:

The proposed regulation does not exceed any minimum standards of the federal government for the same or similar subject area.

Compliance Schedule:

The proposed regulation provides the Commissioner of Health the authority to grant approval of temporary adjustments to rates calculated for general hospitals that are subject to or impacted by the closure, merger, acquisition, consolidation, or restructuring of a health care provider, for a specified period of time, as determined by the Commissioner, of up to three years.

Regulatory Flexibility Analysis

Effect of Rule:

For the purpose of this regulatory flexibility analysis, small businesses were considered to be general hospitals with 100 or fewer full-time equivalents. Based on recent financial and statistical data extracted from the Institutional Cost Report, seven hospitals were identified as employing fewer than 100 employees.

No health care providers subject to this regulation will see a decrease in average per-discharge Medicaid funding as a result of this regulation.

This rule will have no direct effect on local governments.

Compliance Requirements:

Providers that are granted a temporary rate adjustment must submit periodic reports, as determined by the Commissioner, concerning the achievement of benchmarks and goals that are established by the Commissioner and are in conformity with the provider's approved written proposal.

The rule will have no direct effect on local governments.

Professional Services:

No new or additional professional services are required in order to comply with the proposed amendments.

Compliance Costs:

No initial capital costs will be imposed as a result of this rule, nor is there an annual cost of compliance.

Economic and Technological Feasibility:

Small businesses will be able to comply with the economic and technological aspects of this rule because there are no technological requirements other than the use of existing technology, and the overall economic aspect of complying with the requirements is expected to be minimal.

Minimizing Adverse Impact:

This regulation seeks to provide needed relief to eligible providers, thus a positive impact for small businesses that are eligible and no impact for the remainder. In addition, local districts' share of Medicaid costs is statutorily capped; therefore, there will be no adverse impact to local governments as a result of this proposal.

Small Business and Local Government Participation:

The State filed a Federal Public Notice, published in the State Register, prior to the effective date of the change. The Notice provided a summary of the action to be taken and instructions as to where the public, including small businesses and local governments, could locate copies of the corresponding proposed State Plan Amendment. The Notice further invited the public to review and comment on the related proposed State Plan Amendment. In addition, contact information for the Department of Health was provided for anyone interested in further information.

Rural Area Flexibility Analysis

Effect on Rural Areas:

Rural areas are defined as counties with populations less than 200,000 and, for counties with populations greater than 200,000, include towns with population densities of 150 persons or less per square mile. The following 43 counties have populations of less than 200,000:

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

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

Albany	Erie	Oneida
Broome	Monroe	Onondaga
Dutchess	Niagara	Orange

Compliance Requirements:

For hospitals that receive the temporary rate adjustment, periodic reports must be submitted concerning the achievement of benchmarks and goals as approved by the Commissioner.

Professional Services:

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

Compliance Costs:

No initial capital costs will be imposed as a result of this rule, nor is there an annual cost of compliance.

Minimizing Adverse Impact:

This regulation provides needed relief to eligible providers, thus a positive impact for small businesses that are eligible and no impact for the remainder. In addition, local districts' share of Medicaid costs is statutorily capped; therefore, there will be no adverse impact to local governments as a result of this proposal.

Rural Area Participation:

A concept paper was shared with the hospital industry associations, which include members from rural areas. Comments were received and taken into consideration while drafting the regulations. In addition, a Federal Public Notice, published in the New York State Register invited comments and questions from the general public.

Job Impact Statement

A Job Impact Statement is not required pursuant to Section 201-a(2)(a) of the State Administrative Procedure Act. It is apparent, from the nature and purpose of the proposed rule, that it will not have a substantial adverse impact on jobs or employment opportunities. The proposed regulation expands the temporary rate adjustment to eligible hospitals that are subject to or impacted by the closure, merger, acquisition, consolidation, or restructuring of a health care provider in its service delivery area. In addition, the proposed regulation sets forth the conditions under which a provider will be considered eligible, the requirements for requesting a temporary rate adjustment, and the conditions that must be met in order to receive a temporary rate adjustment. The proposed regulation has no implications for job opportunities.

EMERGENCY RULE MAKING

Temporary Rate Adjustment (TRA) - Residential Health Care Facilities (RHCF) (Nursing Homes)

I.D. No. HLT-14-12-00007-E

Filing No. 448

Filing Date: 2012-05-11

Effective Date: 2012-05-11

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

Action taken: Addition of section 86-2.39 to Title 10 NYCRR.

Statutory authority: Public Health Law, section 2808(2-c)(d)

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

Specific reasons underlying the finding of necessity: Public Health Law Section 2808(2-c)(d), as enacted by Section 95 of Part H of Chapter 59 of the Laws of 2011, specifically provides the Commissioner of Health with authority to issue emergency regulations in order to compute rates of payment for residential health care facilities. It is necessary to issue this regulation on an emergency basis in order to maintain Medicaid beneficiaries' access to services by providing financial relief to eligible providers.

Subject: Temporary Rate Adjustment (TRA) - Residential Health Care Facilities (RHCF) (Nursing Homes).

Purpose: To provide a TRA to eligible RHCFs subject to or impacted by closure, merger, acquisition, consolidation, or restructuring.

Text of emergency rule: Subpart 86-2 of title 10 of NYCRR is amended by adding a new section 86-2.39, to read as follows:

86-2.39 Closures, mergers, acquisitions, consolidations and

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

sessments, 99 Washington Ave. – One Commerce Plaza, Suite 1460, Albany, NY 12210, or 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 institutional services related to temporary rate adjustments to general hospitals that are undergoing a closure, merger, consolidation, acquisition or restructuring of themselves or other health care providers. These payments are currently authorized by current State statutory and regulatory provisions. The following significant and clarifying changes are as follows:

Additional temporary rate adjustments have been reviewed and approved for Mary Imogene Bassett Hospital with aggregate payment amounts totaling up to $1,563,900 for the period November 1, 2014 through March 31, 2015, $2,050,438 for the period April 1, 2015 through March 31, 2016, $1,104,187 for the period April 1, 2016 through March 31, 2017, and $281,250 for the period April 1, 2017 through March 31, 2018.

The temporary rate adjustment for Arnot Ogden Medical Center, previously noticed on September 10, 2014 and October 8, 2014, is clarified to be approved for (and under the name of) St. Joseph's Hospital (part of Arnot Health) rather than Arnot Ogden Medical, which is a different hospital.

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 also 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 1460, Albany, NY 12210, or e-mail: spa__inquiries@health.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 non-institutional services to comply with enacted statutory provisions. The following changes are proposed for Medicaid transportation services:

Non-Institutional Services

Effective November 1, 2014, the Commissioner of Health is adding seven Western New York counties to the management of transportation services, which are under State control.

The estimated annual net aggregate in gross Medicaid savings attributable to this initiative for State fiscal year 2014-2015 is $687,000.

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.

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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 1460, Albany, NY 12210, or e-mail: spa__inquiries@health.ny.gov

PUBLIC NOTICE
New York State and Local Retirement System

Pursuant to Retirement and Social Security Law, the New York State and Local Employees' Retirement System hereby gives public notice of the following:

The persons whose names and last known addresses are set forth below appear from records of the above named Retirement System to be entitled to accumulated contributions held by said retirement system whose membership terminated pursuant to Section 613 of the Retirement and Social Security Law on or before September 30, 2013. This notice is published pursuant to Section 109 of the Retirement and Social Security Law of the State of New York. A list of the names contained in this notice is On file and open to public inspection at the office of the New York State and Local Retirement System located at the 110 State St., in the City of Albany, New York. At the expiration of six months from the date of the publication of this notice. The accumulated contributions of the persons so listed shall be deemed abandoned and shall be placed in the pension accumulation fund to be used for the purpose of said fund. Any accumulated contributions so deemed abandoned and transferred to the pension accumulation fund may be claimed by the persons who made such accumulated contributions or, in the event of his death, by his estate or such person as he shall have nominated to receive such accumulated contributions, by

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

APPENDIX V
HOSPITAL SERVICES
State Plan Amendment #14-022

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 add-on services payments made to the provider listed who will receive temporary rate adjustments to be paid quarterly during each period in equal installments.

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

   Response: The State and CMS are having ongoing discussions to resolve issues with prior years UPLs. Based on guidance from CMS, the State and CMS will develop a strategic plan to complete the inpatient UPL demonstration and submit it as soon as practical.

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 [✓] 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: 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.