STATE OF NEW YORK
DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237
www.health.ny.gov

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

Sue Kelly
Executive Deputy Commissioner

March 31, 2011

Mr. Mark Cooley
Department of Health & Human Services
Centers for Medicare & Medicaid Services
Medicaid National Institutional Reimbursement Team
7500 Security Boulevard, Mail Stop S3-13-15
Baltimore, MD 21244-1850

RE: SPA #11-03
Long Term Care Facility Services

Dear Mr. Cooley:

The State requests approval of the enclosed amendment #11-03 to the Title XIX (Medicaid) State Plan for long term care facility services to be effective January 1, 2011 (Appendix I). This amendment is being submitted based on enacted legislation. A summary of the proposed amendment is provided 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, Part 447, Subpart C, (42 CFR §447).

1. The State of New York pays for long-term care services using rates determined in accordance with methods and standards specified in an approved State Plan following a public process which complies with §1902(a)(13)(A) of the Social Security Act.

2. (a) It is estimated that the changes represented by the estimated average payment rates for long-term care facility services will have no noticeable short-term or long-term effect on the availability of services on a statewide and geographic area basis.

   (b) It is estimated that the changes represented by the estimated average payment rates for long-term care facility services will have no noticeable short-term or long-term effect on care furnished.

   (c) It is estimated that the changes represented by the estimated average payment rates for long-term care facility services will have no noticeable short-term or long-term effect on the extent of provider participation.

In accordance with 42 CFR §447.272, New York assures that the aggregate Medicaid payments for inpatient services provided by nursing facilities for each prescribed category of providers does not exceed the upper payment limit for the particular category of providers.

A copy of the pertinent section of proposed state statute is enclosed for your information (Appendix III). Copies of the public notice of this proposed amendment, which was given in the New York State Register on July 28, 2010, is also enclosed for your information (Appendix IV). In addition responses to the five standard funding questions and assurances are also enclosed (Appendix V).

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

Sincerely,

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

Enclosures

cc: Mr. 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: **11-03**	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, 2011**	
5. TYPE OF PLAN MATERIAL *(Check One)*: ☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT		
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*		
6. FEDERAL STATUTE/REGULATION CITATION: **Section 1902(a)(30) of the Social Security Act and 42 CFR Section 447.205**	7. FEDERAL BUDGET IMPACT: a. FFY **10/1/10-9/30/10 $0** b. FFY **10/1/11-9/30/11 $0**	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: **Attachment 4.19-D, page 50(b)**	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: **Attachment 4.19-D, page 50(b)**	
10. SUBJECT OF AMENDMENT: **Nursing Home Medicaid-Only Case Mix (FMAP = 58.77% as of effective date)**		
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 & Deputy Commissioner Department of Health** 15. DATE SUBMITTED: March 31, 2011	16. RETURN TO: **New York State Department of Health** **Corning Tower** **Empire State Plaza** **Albany, New York 12237**	
FOR REGIONAL OFFICE USE ONLY		
17. DATE RECEIVED:	18. DATE APPROVED:	
PLAN APPROVED – ONE COPY ATTACHED		
19. EFFECTIVE DATE OF APPROVED MATERIAL:	20. SIGNATURE OF REGIONAL OFFICIAL:	
21. TYPED NAME:	22. TITLE:	
23. REMARKS:		

FORM HCFA-179 (07-92)

Appendix I
2011 Title XIX State Plan
First Quarter Amendment
Long-Term Care Facility Services
Amended SPA Pages

(5) Cost reports submitted by facilities for the 2002 calendar year or any subsequent year used to determine the operating component of the 2009 rate shall be subject to audit through December 31, 2014. Facilities will therefore retain all fiscal and statistical records relevant to such costs reports. Any audit of the 2002 cost report, which is commenced on or before December 31, 2014, may be completed subsequent to that date and used for adjusting the Medicaid rates that are based on such costs.

(e) Additionally, the operating component of the rates effective April 1, 2009 shall

(1) be subject to a case mix adjustment through application of the relative Resource Utilization Groups System (RUGS-III) used by the federal government for Medicare, revised to reflect NYS wage and fringe benefits, and based on Medicaid only patient data. New York State wages are used to determine the weight of each RUG. The cost for each RUG is calculated using the relative resources for registered nurses, licensed practical nurses, aides, therapists, and therapy aides using the 1995 – 97 federal time study. The minutes from the study are multiplied by the NY average dollar per hour to determine the fiscal resources needed to care for that patient type for one day. This amount is multiplied by the number of patients in that RUG. RUG weights are assigned based on the distance from the statewide average. The RUGS-III weights shall be increased for the following resident categories:

(i) 30 minutes for impaired cognition A;
(ii) 40 minutes for impaired cognition B; and
(iii) 25 minutes for reduced physical functions B.

Medicaid only case mix adjustments shall be made in January and July of each calendar year, except that no case mix adjustment shall be made in January 2011. The adjustments and related patient classifications for each facility shall be subject to audit review in accordance with regulations promulgated by the Commissioner of Health[,and effective January 1, 2009 shall];

(2) incorporate the continuation, through 2009 and subsequent years, of the adjustment for extended care of persons with traumatic brain injury in accordance with the provisions of this Attachment;

(3) incorporate the continuation, through 2009 and subsequent years, of the adjustment for the cost of providing Hepatitis B vaccinations in accordance with the provisions of this Attachment;

(4) reflect a per diem add-on of $8, trended from 2006 to 2009 and thereafter, for each patient who:

Appendix II
2011 Title XIX State Plan
First Quarter Amendment
Long-Term Care Facility Services
Summary

SUMMARY
SPA #11-03

This state plan amendment provides that the nursing home Medicaid-only case mix adjustments scheduled for January 1, 2011, shall not be made.

Appendix III
2011 Title XIX State Plan
First Quarter Amendment
Long-Term Care Facility Services
Authorizing Provisions

STATE OF NEW YORK

S. 6608 A. 9708

SENATE - ASSEMBLY

January 19, 2010

IN SENATE -- A BUDGET BILL, submitted by the Governor pursuant to article seven of the Constitution -- read twice and ordered printed, and when printed to be committed to the Committee on Finance

IN ASSEMBLY -- A BUDGET BILL, submitted by the Governor pursuant to article seven of the Constitution -- read once and referred to the Committee on Ways and Means

AN ACT to amend the public health law, the insurance law, the state finance law, the elder law and the county law, in relation to the early intervention program for infants and toddlers with disabilities and their families; to amend the public health law, in relation to requiring physicians to register and maintain an account with the department of health's health provider network; to amend the public health law and the state finance law, in relation to cardiac service information; to amend the public health law, in relation to the health information technology demonstration program; to amend part C of chapter 57 of the laws of 2006, relating to establishing a cost of living adjustment for designated human services programs, in relation to eligible programs; and to repeal certain provisions of the public health law, the state finance law, section 1 of chapter 462 of the laws of 1996, relating to establishing a quality incentive payment program, and the elder law relating thereto (Part A); to amend the public health law, in relation to the assessment of general hospitals, Medicaid rates of reimbursement general hospital indigent care pools, and preferred drug programs; to amend the public health law and chapter 474 of the laws of 1996, amending the education law and other laws relating to rates for residential health care facilities, in relation to reimbursements; to amend the social services law and the public health law, in relation to prescription drug coverage for needy persons; to amend the public health law, in relation to funds for tobacco control and insurance initiative pools, and health care initiatives pools; to amend the general business law and the social services law, in relation to authorizing moneys paid in advance for funeral merchandise or services for family members; to amend the social services law, in relation to authorizing the commissioner of health to assume responsibility for transportation costs; to amend the public health law, in relation to covering medically necessary ortho-

EXPLANATION--Matter in *italics* (underscored) is new; matter in brackets [ ] is old law to be omitted.

LBD12671-01-0

dential health care facility's gross receipts received from all patient care services and other operating income on a cash basis for the period April first, two thousand two through March thirty-first, two thousand three for hospital or health-related services, including adult day services; provided, however, that residential health care facilities' gross receipts attributable to payments received pursuant to title XVIII of the federal social security act (medicare) shall be excluded from the assessment; provided, however, that for all such gross receipts received on or after April first, two thousand three through March thirty-first, two thousand five, such assessment shall be five percent, and further provided that for all such gross receipts received on or after April first, two thousand five through March thirty-first, two thousand nine, and on or after April first, two thousand nine through March thirty-first, two thousand [eleven] ten, such assessment shall be six percent, and provided further, however, that on and after April first, two thousand ten, such assessment shall be seven percent.

§ 4. Paragraph (c) of subdivision 10 of section 2807-d of the public health law, as amended by section 2 of part H of chapter 686 of the laws of 2003, is amended to read as follows:

(c) provided, however, that for the purposes of determining rates of payment pursuant to this article for residential health care facilities, the assessment imposed pursuant to subparagraph (vi) of paragraph (b) of subdivision two of this section shall be a reimbursable cost to be reflected as timely as practicable, and subsequently reconciled to actual cost, in rates of payment applicable within the assessment period, provided, however, that such assessments in excess of six percent shall not be a reimbursable cost for the purposes of determining medicaid rates of payment.

§ 5. Subparagraph (i) of paragraph (b) of subdivision 2-b of section 2808 of the public health law, as amended by section 3 of part D of chapter 58 of the laws of 2009, is amended to read as follows:

(i) Subject to the provisions of subparagraphs (ii) through (xiv) of this paragraph, for periods on and after April first, two thousand nine through [March thirty-first, two thousand ten] February twenty-eighth, two thousand eleven the operating cost component of rates of payment shall reflect allowable operating costs as reported in each facility's cost report for the two thousand two calendar year, as adjusted for inflation on an annual basis in accordance with the methodology set forth in paragraph (c) of subdivision ten of section twenty-eight hundred seven-c of this article, provided, however, that for those facilities which do not receive a per diem add-on adjustment pursuant to subparagraph (ii) of paragraph (a) of this subdivision, rates shall be further adjusted to include the proportionate benefit, as determined by the commissioner, of the expiration of the opening paragraph and paragraph (a) of subdivision sixteen of this section and of paragraph (a) of subdivision fourteen of this section, and provided further that the operating cost component of rates of payment for those facilities which did not receive a per diem adjustment in accordance with subparagraph (ii) of paragraph (a) of this subdivision shall not be less than the operating component such facilities received in the two thousand eight rate period, as adjusted for inflation on an annual basis in accordance with the methodology set forth in paragraph (c) of subdivision ten of section twenty-eight hundred seven-c of this article and further provided, however, that rates for facilities whose operating cost component reflects base year costs subsequent to January first, two thousand two shall have rates computed in accordance with this paragraph, utiliz-

ing allowable operating costs as reported in such subsequent base year period, and trended forward to the rate year in accordance with applicable inflation factors.

§ 5-a. The opening paragraph and subparagraph (vi) of paragraph (a), and subparagraph (i) of paragraph (d) of subdivision 2-c of section 2808 of the public health law, as added by section 5 of part D of chapter 58 of the laws of 2009, are amended to read as follows:

Notwithstanding any inconsistent provision of this section or any other contrary provision of law and subject to the availability of federal financial participation, the operating costs of rates of payment by governmental agencies for inpatient services provided by residential health care facilities on and after [April first, two thousand ten] March first, two thousand eleven shall be determined in accordance with the following; provided, however, that the provisions of paragraph (d) of this subdivision shall be effective on and after April first, two thousand ten:

(vi) Notwithstanding subparagraph (i) of this paragraph, the operating cost component of the rates, effective [April first, two thousand ten] March first, two thousand eleven for the following categories of facilities, as established pursuant to applicable regulations, shall reflect the rates in effect for such facilities on [March thirty-first, two thousand ten] February twenty-eighth, two thousand eleven, as adjusted for inflation in accordance with applicable statutes: (A) AIDS facilities or discrete AIDS units within facilities, (B) discrete units for residents receiving care in a long-term inpatient rehabilitation program for traumatic brain injured persons, (C) discrete units providing specialized programs for residents requiring behavioral interventions, (D) discrete units for long-term ventilator dependent residents, and (E) facilities or discrete units within facilities that provide extensive nursing, medical, psychological and counseling support services solely to children. Such rate shall remain in effect until the department, in consultation with representatives of the nursing home industry, as selected by the commissioner, develops a regional pricing or alternative methodology for determining such rates.

(i) Subject to the availability of federal financial participation, the commissioner is authorized to establish a quality of care incentive pool or pools for eligible residential health care facilities and increase Medicaid rates of payment for such eligible facilities from this pool or pools in aggregate amounts of up to fifty million dollars for the state fiscal year beginning April first, two thousand ten and within amounts appropriated for each state fiscal year thereafter. Within amounts available, payments will be determined by the commissioner by applying criteria, including, but not limited to, the quality components of the minimum data set required under federal law, survey information, direct care staffing, including labor costs, and other facility data.

§ 5-b. Section 2 of part D of chapter 58 of the laws of 2009, amending the public health law and other laws relating to Medicaid reimbursements to residential health care facilities, is amended to read as follows:

§ 2. Notwithstanding paragraph (b) of subdivision 2-b of section 2808 of the public health law or any other contrary provision of law, with regard to adjustments to medicaid rates of payment for inpatient services provided by residential health care facilities for the period April 1, 2009 through March 31, 2010, made pursuant to paragraph (b) of subdivision 2-b of section 2808 of the public health law, the commissioner of health and the director of the budget shall, upon a determi-

Chapter 58 of the Laws of 2010

nation that such adjustments, including the application of adjustments authorized by the provisions of paragraph (g) of subdivision 2-b of section 2808 of the public health law, shall result in an aggregate increase in total Medicaid rates of payment for such services for such period that is less than or more than two hundred ten million dollars ($210,000,000), make such proportional adjustments to such rates as are necessary to result in an increase of such aggregate expenditures of two hundred ten million dollars ($210,000,000), [and provided further, however, that the operating component of such rates for the period April 1, 2009 through March 31, 2010 shall not be subject to case mix adjustments pursuant to subparagraph (ii) of paragraph (b) of subdivision 2-b of section 2808 of the public health law, as otherwise scheduled pursuant to such subparagraph for January of 2010,] and provided further, however, that notwithstanding [subdivision 2-c of] section 2808 of the public health law or any other contrary provision of law, with regard to adjustments to inpatient rates of payment made pursuant to [subdivision 2-c of] section 2808 of the public health law for inpatient services provided by residential health care facilities for the period April 1, 2010 through March 31, 2011, the commissioner of health and the director of the budget shall, upon a determination by such commissioner and such director that such rate adjustments shall, prior to the application of any applicable adjustment for inflation, result in an aggregate increase in total Medicaid rates of payment for such services, including payments made pursuant to subparagraph (i) of paragraph (d) of subdivision 2-c of section 2808 of the public health law, make such proportional adjustments to such rates as are necessary to reduce such total aggregate rate adjustments such that the aggregate total reflects no such increase or decrease, and provided further, however, the case mix adjustments as otherwise authorized by subparagraph (ii) of paragraph (b) of subdivision 2-b of section 2808 of the public health law and as scheduled for January of 2011 shall not be made. Adjustments made pursuant to this section shall not be subject to subsequent correction or reconciliation.

§ 5-c. Section 48 of part C of chapter 109 of the laws of 2006, amending the social services law and other laws relating to the Medicaid reimbursement rate settings, as amended by section 6 of part D of chapter 58 of the laws of 2009, is amended to read as follows:

§ 48. Notwithstanding any contrary provision of law, the commissioner of health shall, by no later than May 15, 2007, establish a workgroup pertaining to Medicaid reimbursement rate-setting for residential health care facilities for future periods, including, but not limited to, the following areas:

(a) operating costs that should be considered allowable in the development of regional prices;

(b) identification of appropriate cost differentials among facilities based on factors including, but not limited to, size, affiliation, location, public versus non-public, facility layout, culture exchange initiatives and labor costs, including the most appropriate mechanism to adjust rates of payment to reflect appropriate cost differentials related to direct care staffing, including adjustments to the direct component of the operating cost component of such rate, establishment of a quality care incentive pool pursuant to subdivision [(2-c)] 2-c of section 2808 of the public health law or other mechanisms;

(c) reimbursement for facilities providing care to specialized populations with specialized care needs;

(d) the relationship between facility spending on various costs and quality of care and patient outcomes;

Appendix IV
2011 Title XIX State Plan
First Quarter Amendment
Long-Term Care Facility Services
Public Notice

MISCELLANEOUS NOTICES/HEARINGS

Notice of Abandoned Property Received by the State Comptroller

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

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

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

PUBLIC NOTICE
Town of Big Flats

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

A copy of the proposed questionnaire may be obtained from: Town of Big Flats, Attn: Linda Cross, Town Clerk, 476 Maple St., P.O. Box 449, Big Flats, NY 14814, (607) 562-8443, ext. 201

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

PUBLIC NOTICE
Department of Health

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

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

Inpatient Hospital Services

- Effective for periods on or after August 1, 2010, the Commissioner of Health is authorized to seek federal approval to utilize certified public expenditures (CPE) with regard to Medicaid payments made to or on behalf of non-state-owned general public hospitals located in a city of more than one million persons in order to recognize otherwise un-reimbursed allowable medical assistance costs related to hospital inpatient services. General public hospitals seeking to utilize CPEs for Medicaid payment purposes shall provide documentation and supporting data as the Commissioner of Health deems necessary to further such utilization. The federal matching funds received for approved CPEs shall be remitted to the general public hospital whose expenditures formed the basis for such CPE. Further, the amount of such CPEs shall be excluded from all calculations used to determine the amount the Department of Health is obligated to reimburse social services districts for medical assistance for needy persons and the administration thereof.
  - The social services district in which an eligible public general hospital is physically located shall be responsible for payments for all services provided by such public general hospital for furnishing medical assistance to the eligible persons receiving such services.
  - Social services district funding of the non-federal share of these payment increases shall be deemed to be voluntary for purposes of the increased Federal Medical Assistance Percentage (FMAP) provisions of the American Recovery and Reinvestment Act (ARRA) of 2009. If the Centers for Medicare and Medicaid Services determine that such non-federal share payments are not voluntary or otherwise disallows federal financial participation in such payments, these provisions shall be null and void and payments made pursuant to these provisions shall be recouped by the Commissioner of Health.

Indigent Care

- As noticed on June 30, 2010, additional inpatient hospital payments made to eligible general hospitals, including safety net hospitals but not major public general hospitals, which provide emergency room services, shall be made as upper payment limit (UPL) payments in aggregate monthly payments. However, such UPL payments are no longer conditioned upon the availability of enhanced FMAP payments.
- The authority to reserve, set-aside and distribute 10 percent of the aggregate distributions from the general hospital indigent care pool to each general hospital, in accordance with PHL sections 2807-k and 2807-w, shall be extended indefinitely.
- Extends through March 31, 2011, the authorization to distribute Indigent Care and High Need Indigent Care disproportionate share payments in accordance with the approved methodology.

Long Term Care Services

- The nursing home rebasing of base year costs provisions have been extended through June 30, 2011, as previously noticed on December 9, 2009 and March 31, 2010.
- Effective for periods on and after July 1, 2011, the operating cost component of the rates, for the following categories of facilities shall reflect the rates in effect for such facilities on June 30, 2011, as adjusted for inflation in accordance with statutory provisions:
  - AIDS facilities or discrete AIDS units;
  - discrete units for residents receiving care in a long-term inpatient rehabilitation program for traumatic brain injury;
  - discrete units providing specialized programs for residents requiring behavioral interventions;
  - discrete units for long-term ventilator dependent residents; and
  - facilities or discrete units that provide extensive nursing, medical, psychological and counseling support services solely to children.

Non-institutional Services

- Effective for the period August 1, 2010 through March 31, 2011, and annually thereafter, upon the election of the social services district in which an eligible diagnostic and treatment center (DTC) is physically located, up to $12.6 million in additional annual Medicaid payments may be paid to public DTCs operated by the New York City Health and Hospitals Corporation. Such payments will be based on each DTC's proportionate share of the sum of all clinic visits for all facilities eligible for an adjustment for the base year two years prior to the rate year. The proportionate share payments may be added to rates of payment or made as aggregate payments to eligible DTCs.
  - The social services district in which an eligible public DTC is physically located shall be responsible for any payment increases for such public DTC services provided regardless of whether another social services district or the Department of Health may otherwise be responsible for furnishing medical assistance to eligible persons receiving such services.
  - Any payment increases for DTC services shall be effective for purposes of determining payments for public DTCs contingent on receipt of all approvals required by federal law or regulations for federal financial participation. If federal approvals are not granted for payment increases for DTC services, payments to eligible public DTCs shall be determined without consideration of such amounts or such components. In the event of federal disapproval, public DTCs shall refund to the State, or the State may recoup from prospective payments, any payment received, including those based on a retroactive reduction in the payments. Any reduction related to federal upper payment limits shall be deemed to apply first to these payments.
  - Reimbursement by the State for payments made for services provided by public DTCs shall be limited to the amount of federal funds properly received or to be received on account of such expenditures. Further, payments shall be excluded from all calculations determining the amount the Department of Health is obligated to reimburse social services districts for medical assistance for needy persons and the administration thereof.
  - Social services district funding of the non-federal share of payment increases for DTCs shall be deemed to be voluntary for purposes of the increased FMAP provisions of the ARRA of 2009. If the Centers for Medicare and Medicaid Services determine that such non-federal share payments are not voluntary or otherwise disallows federal financial participation in such payments, these provisions shall be null and void and payments made pursuant to these provisions shall be recouped by the Commissioner of Health.
- Effective for the period August 1, 2010 through March 31, 2011, and annually thereafter, up to $5.4 million in additional annual Medicaid payments may be paid to county operated free-standing clinics, not including facilities operated by the New York City Health and Hospitals Corporation, for services provided by such DTC and those provided by a county operated freestanding mental health or substance abuse DTC. Distributions shall be based on each eligible facility's proportionate share of the sum of all DTC and clinic visits for all eligible facilities receiving payments for the base year two years prior to the rate year. The proportionate share payments may be added to rates of payment or made as aggregate payments to eligible facilities.
  - Local social services districts may decline increased payments to their sponsored DTCs and free-standing clinics, provided they provide written notification to the Commissioner of Health, within 30 days following receipt of notification of a payment.
  - The social services district in which an eligible public DTC is physically located shall be responsible for any payment increases for such public DTC for all DTC services provided regardless of whether another social services district or the Department of Health may otherwise be responsible for furnishing medical assistance to the eligible persons receiving such services.
  - Any payment increases for DTC services shall be effective for purposes of determining payments for public DTCs contingent on receipt of all approvals required by federal law or regulations for federal financial participation. If federal approvals are not granted for payment increases for DTC services, payments to eligible public DTCs shall be determined without consideration of such amounts or such components. In the event of federal disapproval, public DTCs shall refund to the State, or the State may recoup from prospective payments, any payment received, including those based on a retroactive reduction in the payments. Any reduction related to federal upper payment limits shall be deemed to apply first to amounts provided pursuant to these provisions.
  - Reimbursement by the State for payments made for services provided by public DTCs shall be limited to the amount of federal funds properly received or to be received on account of such expenditures. Further, payments shall be excluded from all calculations determining the amount the Department of Health is obligated to reimburse social services districts for medical assistance for needy persons and the administration thereof.
  - Social services district funding of the non-federal share of payment increases for DTCs shall be deemed to be voluntary for purposes of the increased FMAP provisions of the ARRA of 2009. If the Centers for Medicare and Medicaid Services determine that such non-federal share payments are not voluntary or otherwise disallows federal financial participation in such payments, these provisions shall be null and void and payments made pursuant to these provisions shall be recouped by the Commissioner of Health.
- Effective for periods on or after August 1, 2010, the Commissioner of Health is authorized to seek federal approval to utilize certified public expenditures (CPE) with regard to Medicaid payments made to or on behalf of non-state-owned general public hospitals located in a city of more than one million persons in order to recognize otherwise un-reimbursed allowable medical assistance costs related to hospital outpatient services. General public hospitals seeking to utilize CPEs for Medicaid payment purposes shall provide documentation and supporting data as the Commissioner of Health deems necessary to further such utilization. The federal matching funds received for approved CPEs shall be remitted to the general public hospital whose expenditures formed the basis for such CPE. Further, the amount of such CPEs shall be excluded from all calculations used to determine the amount the Department of Health is obligated to reimburse social services districts for medical assistance for needy persons and the administration thereof.
  - The social services district in which an eligible public general hospital is physically located shall be responsible for payments for all services provided by such public general hospital for furnishing medical assistance to the eligible persons receiving such services.
  - Social services district funding of the non-federal share of these payment increases shall be deemed to be voluntary for purposes of the increased Federal Medical Assistance Percentage (FMAP) provisions of the American Recovery and Reinvestment Act (ARRA) of 2009. If the Centers for Medicare and Medicaid Services determine that such non-federal share payments are not voluntary or otherwise disallows federal financial participation in such payments, these provisions shall be null and void and payments made pursuant to these provisions shall be recouped by the Commissioner of Health.

The following is a clarification to a previously noticed provision for long term care services:

- Effective for periods April 1, 2010 through June 30, 2011, regarding inpatient rates of payment for RHCFs, if it is determined by the Commissioner of Health and the Director of the Budget, that rates computed pursuant to applicable provisions of PHL section 2808(2-b)(b) shall, prior to the application of any applicable adjustment for inflation, result in an aggregate increase in such rates from the prior year's rates, proportional adjustments to such rates will be made as are necessary to ensure there is no such aggregate increase or decrease. Additionally, the case mix adjust-

ments scheduled for January of 2011 will not be made. Adjustments made will not be subject to subsequent correction or reconciliation.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to these proposed initiatives for state fiscal year 2010/2011 is $45.9 million.

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

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

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

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

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

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

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

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

For further information and to review and comment, please contact: Philip N. Mossman, Department of Health, Bureau of HCRA Operations & Financial Analysis, Corning Tower Bldg, Rm. 984, Empire State Plaza, Albany, NY 12237, (518) 474-1673, (518) 473-8825 (FAX), PNM01@health.state.ny.us

PUBLIC NOTICE

Monroe County Water Authority

Monroe County Water Authority is requesting proposals from qualified administrative services agencies, and/or financial organizations relating to administration, trustee services and/or funding of a deferred compensation plan for employees of the Monroe County Water Authority meeting the requirements of Section 457 of the Internal Revenue Code and Section 5 of the State Finance Law, including all rules and regulations issued pursuant thereto.

A copy of the proposed questionnaire may be obtained, by e-mail request, from: diane.hendrickson@mcwa.com, Diane Hendrickson, Human Resources, 475 Norris Dr., Rochester NY 14610

All proposals must be submitted no later than 30 days from the date of publication in the New York *State Register* and received no later than 4:30 p.m.

PUBLIC NOTICE

Department of State

Proclamation

Revoking Limited Liability Partnerships

W*HEREAS,* Article 8-B of the Partnership Law, requires registered limited liability partnerships and New York registered foreign limited liability partnerships to furnish the Department of State with a statement every five years updating specified information, and

W*HEREAS*, the following registered limited liability partnerships and New York registered foreign limited liability partnerships have not furnished the department with the required statement, and

W*HEREAS*, such registered limited liability partnerships and New York registered foreign limited liability partnerships have been provided with 60 days notice of this action;

NOW, THEREFORE, I, Lorraine A. Cortés-Vázquez, Secretary of State of the State of New York, do declare and proclaim that the registrations of the following registered limited liability partnerships are hereby revoked and the status of the following New York foreign limited liability partnerships are hereby revoked pursuant to the provisions of Article 8-B of the Partnership Law, as amended:

DOMESTIC REGISTERED LIMITED LIABILITY PARTNERSHIPS

REGISTERED LIMITED LIABILITY PARTNERSHIP REVOCATION OF REGISTRATION A 1

A

ANDREOZZI & FICKESS, LLP (04)
ATKINSON & HEFFRON, LLP (05)

B

BLATT & DAUMAN LLP (04)
BRAND BRAND NOMBERG & ROSENBAUM, LLP (04)

C

CAMPBELL & SHELTON LLP (04)
CARABBA, LOCKE LLP (99)
CARLOS M. VELAZQUEZ & ASSOCIATES, LLP (05)
CLARK, CUYLER, MAFFEI & MEDEROS, LLP (05)
COFFINAS & COFFINAS, LLP (00)
CONDOR ROCK CONSULTING, LLP (04)
CRONIN & VRIS, LLP (00)
CROTON MEDICAL ASSOCIATES, LLP (00)

E

EISENBERG & MARGOLIS, LLP (05)
ELHILOW & MAIOCCHI, LLP (95)

F

FARUQI & FARUQI, LLP (95)
FLANAGAN, COOKE & FRENCH, LLP (00)
FRANK & ZIMMERMAN & COMPANY, LLP (95)

G

GARGUILO & ORZECHOWSKI LLP (99)
GAUTHIER & MARTIAN LLP (00)
GENSER, DUBOW, GENSER & CONA LLP (99)
GOLDBERG AND WEINBERGER LLP (00)
GREENFIELD IMAGING ASSOCIATES WEST LLP (00)

H

H. BRADLEY DAVIDSON, D.D.S. AND MICHAEL K. KEATING, D.D.S., (95)
HIRSCH, LEVINE, GREENE, INDRIOLO & HISIGER, L.L.P. (99)

J

JOSEPH, RENNIE & ASSOCIATES, LLP (05)

Appendix V
2011 Title XIX State Plan
First Quarter Amendment
Long-Term Care Facility Services
Responses to Standard Funding Questions

LONG-TERM CARE FACILITY SERVICES
State Plan Amendment #11-03

CMS Standard Funding Questions (NIRT Standard Funding Questions)

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

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

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

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

   Response: Payments made to service providers under the provisions of this SPA are funded through a budget 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, by federal definition, are not supplemental or enhanced payments.

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

   Response: The nursing facilities upper payment limit (UPL) is calculated in accordance with 42 CFR part 447. The UPL calculation determines the difference between the Medicaid rates being paid in New York State and what they would have been if they had been calculated using Medicare principles. The Medicaid UPL for nursing facility services was modified by redefining the categories for which states are required to estimate separate aggregate upper payments limits. Those categories are defined as state government operated facilities, privately operated facilities, and non-state government operated facilities. The UPL calculation for state government operated and private facilities is based on the Medicare Prospective Payment System and Medicaid rates; the UPL calculation for non-state government operated facilities is based on Medicare cost principles and Medicaid costs.

   The State submitted a revised UPL calculation for nursing facility services to CMS on January 22, 2010, and is currently awaiting approval.

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 nursing facility services is a cost-based prospective payment methodology subject to ceiling. We are unaware of any requirement under current federal law or regulation that limits individual provider payments to their actual costs.

Assurances:

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

   Response: The State hereby provides assurances that it remains in compliance with the terms of the Recovery Act with regard to the requirements pertaining to the maintenance of effort, State or local match, prompt payment,

rainy day funds, and eligible expenditures. In addition, the HHS Office of Inspector General has reviewed the State's compliance with the political subdivision requirement for increased FMAP under ARRA and found the State to be in compliance with this provision (Report A-02-09-01029).

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

   Response: In New York State, Indian Health Programs and Urban Indian Organizations do not furnish long-term care services; therefore, solicitation of advice on this issue was not applicable.