NEW YORK
state department of
HEALTH

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

Sue Kelly
Executive Deputy Commissioner

March 28, 2012

National Institutional Reimbursement Team
Attention: Mark Cooley
CMS, CMCS
7500 Security Boulevard, M/S S2-01-16
Baltimore, MD 21244-1850

RE: SPA #11-23-A
Long-Term Care Facility Services

Dear Mr. Cooley:

The State requests approval of the enclosed amendment #11-23-A to the Title XIX (Medicaid) State Plan for long-term care facility services to be effective January 1, 2012 (Appendix I). This amendment is being submitted based on enacted legislation and proposed regulation. 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.

Copies of the pertinent sections of State statute and draft regulation are enclosed for your information (Appendix III). Copies of the public notice of this proposed amendment, which were given in the New York State Register on March 30, 2011, and December 28, 2011, are also enclosed for your information (Appendix IV). In addition, responses to the five standard funding questions (Appendix V) and documentation of tribal consultation are also enclosed.

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

Sincerely,

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

Enclosures

cc: Mr. Michael Melendez
Mr. Tom Brady

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: HEALTH CARE FINANCING ADMINISTRATION	1. TRANSMITTAL NUMBER: #11-23-A	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, 2012**	

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

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

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

6. FEDERAL STATUTE/REGULATION CITATION: **Section 1902(a) of the Social Security Act, and 42 CFR 447**	7. FEDERAL BUDGET IMPACT: a. **FFY 01/1/12-9/30/12 $ 0** b. **FFY 10/1/12-9/30/13 $ 0**
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-D: Pages 110(d)(3), 110(d)(4), 110(d)(5), 110(d)(6), 110(d)(7), 110(d)(8), 110(d)(9), 110(d)(10), 110(d)(11), 110(d)(12), 110(d)(13), 110(d)(14), 110(d)(15), 110(d)(16), 110(d)(17), 110(d)(18), 110(d)(19), 110(d)(20), 110(d)(21)	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

10. SUBJECT OF AMENDMENT:
Statewide Pricing Methodology for NHs
(FMAP = 50% 7/1/11 forward)

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

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

12. SIGNATURE OF STATE AGENCY OFFICIAL:	16. RETURN TO: **New York State Department of Health** **Corning Tower** **Empire State Plaza** **Albany, New York 12237**
13. TYPED NAME: **Jason A. Helgerson**	
14. TITLE: **Medicaid Director & Deputy Commissioner Department of Health**	
15. DATE SUBMITTED: March 28, 2012	

FOR REGIONAL OFFICE USE ONLY

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

23. REMARKS:

Appendix I
2012 Title XIX State Plan
First Quarter Amendment
Long-Term Care Facility Services
Amended SPA Pages

Computation of a Price for the Operating Component of the Rate

a) Effective January 1, 2012, the operating component of rates of payment for non-specialty residential health care facilities (RHCFs) shall be a price and shall consist of the sum of the direct, indirect and non-comparable price components.

b) For purposes of calculating the direct and indirect price component of the rates, peer group shall mean:

1) all non-specialty facilities (NSF)
2) all non-specialty hospital-based facilities and non-specialty freestanding facilities with certified bed capacities of 300 beds or more (NSHB/NS300+)
3) non-specialty freestanding facilities with certified bed capacities of less than 300 beds (NS300-)

i) specialty facilities shall mean:
(1) AIDS facilities or discrete AIDS units within facilities;
(2) discrete units for residents receiving care in a long-term inpatient rehabilitation program for traumatic brain injured persons;
(3) discrete units providing specialized programs for residents requiring behavioral interventions;
(4) discrete units for long-term ventilator dependent residents; and
(5) facilities or discrete units within facilities that provide extensive nursing, medical, psychological and counseling support services solely to children

c) The direct component of the price shall consist of a blended rate to be determined as follows:

1) 50% of the direct NSF price which shall be based upon allowable operating costs and statistical data for the direct component of the price, as reported by each non-specialty facility in its cost report for the 2007 calendar year, reduced by the allowable costs percent reduction, and divided by total 2007 patient days, and

2) 50% of either:

   i) the direct NSHB/NS300+ price which shall be based upon allowable operating costs and statistical data for the direct component of the price, as reported by each non-specialty hospital-based facility and each non-specialty freestanding facility with certified bed capacities of 300 beds or more in its cost report for the 2007 calendar year, reduced by the allowable costs percent reduction, and divided by total 2007 patient days, or

   ii) the direct NS300- price which shall be based upon allowable operating costs and statistical data for the direct component of the price, as reported by each non-specialty facility with certified bed capacities of less than 300 beds in its cost report for the 2007 calendar year, reduced by the allowable costs percent reduction, and divided by total 2007 patient days.

3) The direct component of the price for each peer group shall be as follows:

New York
110(d)(5)

Attachment 4.19-D
(01/12)

	Direct Component of the Price Ineligible Price, Part D Eligible Price (NSHB/NS300+ Peer Group)				
Effective Date of Prices	Direct NSF Price (a)	50% of Direct NSF Price (b)	Direct NSHB/NS300+ Price (c)	50% of Direct NSHB/NS300+ Price (d)	Total Direct Component of Price for NSHB/NS300+ Peer Group (b)+(d)
January 1, 2012	$105.79	$52.90	$117.48	$58.74	$111.64
January 1, 2013	$111.82	$55.91	$124.17	$62.09	$118.00
January 1, 2014	$116.58	$58.29	$129.46	$64.73	$123.02
January 1, 2015	$117.94	$58.97	$130.97	$65.49	$124.46
January 1, 2016	$118.48	$59.24	$131.57	$65.79	$125.03
January 1, 2017	$119.02	$59.51	$132.17	$66.09	$125.60
	Direct Component of the Price Part B Eligible Price, Part B and Part D Eligible Price (NSHB/NS300 + Peer Group)				
Effective Date of Prices	Direct NSF Price (a)	50% of Direct NSF Price (b)	Direct NSHB/NS300+ Price (c)	50% of Direct NSHB/NS300+ Price (d)	Total Direct Component of Price for NSHB/NS300+ Peer Group (b)+(d)
January 1, 2012	$104.34	$52.17	$115.94	$57.97	$110.14
January 1, 2013	$110.28	$55.14	$122.54	$61.27	$116.41
January 1, 2014	$114.98	$57.49	$127.76	$63.88	$121.37
January 1, 2015	$116.33	$58.17	$129.25	$64.63	$122.79
January 1, 2016	$116.86	$58.43	$129.84	$64.92	$123.35
January 1, 2017	$117.39	$58.70	$130.43	$65.22	$123.91

TN #11-23-A **Approval Date** _____

Supersedes TN NEW **Effective Date** _____

New York
110(d)(6)

Attachment 4.19-D
(01/12)

	Direct Component of the Price Ineligible Price, Part D Eligible Price (NS300- Peer Group)				
Effective Date of Prices	Direct NSF Price (a)	50% of Direct NSF Price (b)	Direct NS300- Price (c)	50% of Direct NS300- Price (d)	Total Direct Component of Price for NS300- Peer Group (b)+(d)
January 1, 2012	$105.79	$52.90	$99.30	$49.65	$102.55
January 1, 2013	$111.82	$55.91	$104.95	$52.48	$108.39
January 1, 2014	$116.58	$58.29	$109.43	$54.72	$113.01
January 1, 2015	$117.94	$58.97	$110.70	$55.35	$114.32
January 1, 2016	$118.48	$59.24	$111.21	$55.61	$114.85
January 1, 2017	$119.02	$59.51	$111.71	$55.86	$115.37
	Direct Component of the Price Part B Eligible Price, Part B and Part D Eligible Price (NS300- Peer Group)				
Effective Date of Prices	Direct NSF Price (a)	50% of Direct NSF Price (b)	Direct NS300- Price (c)	50% of Direct NS300- Price (d)	Total Direct Component of Price for NS300- Peer Group (b)+(d)
January 1, 2012	$104.34	$52.17	$97.90	$48.95	$101.12
January 1, 2013	$110.28	$55.14	$103.47	$51.74	$106.88
January 1, 2014	$114.98	$57.49	$107.88	$53.94	$111.43
January 1, 2015	$116.33	$58.17	$109.14	$54.57	$112.74
January 1, 2016	$116.86	$58.43	$109.64	$54.82	$113.25
January 1, 2017	$117.39	$58.70	$110.14	$55.07	$113.77

Subsequent updates to the peer group prices can be obtained by accessing the following link: http://www.health.ny.gov/XXXXXXXXXXXXXXXXXX

TN #11-23-A **Approval Date** _____

Supersedes TN NEW **Effective Date** _____

4) The allowable costs percent reduction for the direct component shall be as follows:

Effective Date	Allowable Cost Percent Reduction
January 1, 2012	19.545660%
January 1, 2013	14.963800%
January 1, 2014	11.339480%
January 1, 2015	10.305120%
January 1, 2016	9.893250%
January 1, 2017	9.485290%

Subsequent updates to the allowable costs percent reduction can be obtained by accessing the following link: http://www.health.ny.gov/XXXXXXXXXXXXXXXXXX

d) Allowable costs for the direct component of the rate shall include costs reported in the following functional cost centers on the facility's 2007 cost report (RHCF-4), or extracted from a hospital-based facility's 2007 cost report (RHCF-2) and the institutional cost report of its related hospital, from available certified cost reports as determined by the Commissioner, after first deducting costs attributable to specialty units and the hospital by applying appropriate traceback percentages; and capital costs.

i) Nursing administration (013);
ii) Activities (014);
iii) Social services (021);
iv) Transportation (022);
v) Physical therapy (039) (including associated overhead);
vi) Occupational therapy (040) (including associated overhead);
vii) Speech/hearing therapy (041) (including associated overhead);
viii) Central service supply (043);
ix) Residential health care facility (051); and
x) Pharmacy (042) (excluding the costs allocated to non comparables).

e) The direct component of the price shall be adjusted by a wage equalization factor (WEF). The WEF adjustment shall be calculated using cost and statistical data reported in each facility's 2009 cost report ((RHCF-4), or extracted from a hospital-based facility's 2009 cost report (RHCF-2) and the institutional cost report of its related hospital as applicable) from available certified cost reports as determined by the Commissioner, for the 2009 calendar year, subject to applicable traceback percentages. The WEF adjustment shall consist of 50% of a facility-specific direct WEF and 50% of a regional direct WEF.

1) The facility-specific direct WEF shall be calculated as follows:

1/((Facility-Specific Wage Ratio/ Wage Index) + (Facility-Specific Non-Wage Ratio))

i) The Facility-Specific Wage Ratio shall be calculated by dividing facility-specific total salaries and fringes related to direct cost centers for nursing administration (013), activities program (014), social services (021), transportation (022), physical therapy (039), occupational therapy (040), speech/hearing therapy (041), pharmacy (042), central service supply (043), and residential health care facility (051) by total direct operating expenses from such cost centers.

ii) The Wage Index shall be calculated by dividing facility-specific labor costs per hour by labor costs per hour for RNs, LPNs, aides and orderlies, therapists and therapist aides for all facilities from cost centers physical therapy (039), occupational therapy (040), speech/hearing therapy (041) and residential health care facility (051).

iii) The Facility-Specific Non-Wage Ratio shall be calculated by subtracting from 1 the Facility-Specific Wage Ratio.

2) A regional direct WEF shall be calculated for each of the following 16 regions. The county geographic boundaries shall be the sole factor considered for determining in which WEF region a facility is located.

Region	Consisting of the counties of:
Albany Region	Albany, Columbia, Fulton, Green, Montgomery, Rensselaer, Saratoga, Schenectady and Schoharie
Binghamton Region	Broome and Tioga
Central Rural Region	Cayuga, Cortland, Seneca, Tompkins and Yates
Elmira Region	Chemung, Schuyler and Steuben
Erie Region	Cattaraugus, Chautauqua, Erie, Niagara and Orleans
Glens Falls Region	Essex, Warren and Washington
Long Island Region	Nassau and Suffolk
New York City Region	Bronx, Kings, New York, Queens and Richmond
Northern Rural Region	Clinton, Franklin, Hamilton and St. Lawrence
Orange Region	Chenango, Delaware, Orange, Otsego, Sullivan and Ulster
Poughkeepsie Region	Dutchess and Putnam
Rochester Region	Livingston, Monroe, Ontario and Wayne
Syracuse Region	Madison and Onondaga
Utica Region	Herkimer, Jefferson, Lewis, Oneida and Oswego
Westchester Region	Rockland and Westchester
Western Rural Region	Allegany, Genesee, and Wyoming

3) The regional direct WEF shall be calculated for each of the 16 regions as follows:

1/((Regional Wage Ratio/ Regional Wage Index) + (Regional Non-Wage Ratio))

i) The Regional Wage Ratio shall be calculated by dividing total salaries and fringes related to direct costs in the region from cost centers for nursing administration (013), activities program (014), social services (021), transportation (022), physical therapy (039), occupational therapy (040), speech/hearing therapy (041), pharmacy (042), central service supply (043), and residential health care facility (051) by total direct operating expenses in the region from such cost centers.

ii) The Regional Wage Index shall be calculated by dividing labor costs per hour in the region by labor costs per hour for RNs, LPNs, aides and orderlies, therapists and therapist aides for all facilities from cost centers physical therapy (039), occupational therapy (040), speech/hearing therapy (041) and residential health care facility (051).

iii) The Regional Non-Wage Ratio shall be calculated by subtracting from 1 the Regional Wage Ratio.

4) The regional direct WEF adjustment to the direct component of the price for facilities for which 2009 cost report data is unavailable or insufficient to calculate the WEF as described above will be equal to 100% of the applicable regional WEF.

f) The direct component of the price shall be subject to a case mix adjustment in accordance with the following:

1) The application of the relative Resource Utilization Groups System (RUGS-III) as published by the Centers for Medicare and Medicaid Services and revised to reflect New York State wage and fringe benefits and based on Medicaid-only patient data.

2) New York State wages shall be used to determine the weight of each RUG. The cost for each RUG shall be calculated using the relative resources for RNs, LPNs, aides, therapists, and therapy aides and the 1995-97 federal time study. The minutes from the federal time study are multiplied by the NY average dollar per hour to determine the fiscal resources need to care for that patient type. This amount shall be multiplied by the number of patients in that RUG. RUG weights shall be assigned based on the distance from the statewide average. The RUGS III weights shall be increased by the following amounts for the following categories of residents:

   i) thirty minutes of certified nurse aide time for the impaired cognition A category,
   ii) forty minutes of certified nurse aide time for the impaired cognition B category, and
   iii) twenty-five minutes of certified nurse aide time for the reduced physical functions B category.

3) The case mix adjustment for the direct component of the price effective January 1, 2012, shall be calculated by dividing the Medicaid-only case mix derived from data for January 2011 by the all-payer case mix for the base year 2007.

   i) The all-payer case mix for base year 2007 shall be a blend of:

      (1) 50% of the case mix for all non-specialty facilities, and
      (2) 50% of the case mix for either:

         (a) all non-specialty hospital-based facilities and non-specialty freestanding facilities with certified bed capacities of 300 beds or more, or
         (b) non-specialty freestanding facilities with certified bed capacities of less than 300 beds.

4) Subsequent case mix adjustments to the direct component of the price for rate periods effective after January 1, 2012, shall be made in July and January of each calendar year and shall use Medicaid-only case mix data applicable to the previous case mix period (e.g., July 1, 2012, case mix adjustment will use January 2012 case mix data, and January 1, 2013, case mix adjustment will use July 2012 case mix data).

5) Case mix adjustments to the direct component of the price for facilities for which facility-specific case mix data is unavailable or insufficient shall be equal to the base year case mix of the peer group applicable to such facility.

6) The adjustments and related patient classifications for each facility shall be subject to audit review by the Office of Medicaid Inspector General.

g) The indirect component of the price shall consist of a blended rate to be determined as follows:

1) 50% indirect NSF price which shall be based upon allowable operating costs and statistical data for the indirect component of the price as reported in each non-specialty facility's cost report for the 2007 calendar year, reduced by the allowable costs percent reduction, and divided by total 2007 patient days; and

2) 50% of either:

i) The indirect NSHB/NS300+ price which shall be based upon allowable operating costs and statistical data for the indirect component of the price as reported by each non-specialty hospital-based facility and each non-specialty freestanding facility with certified bed capacity of 300 beds or more in its cost report for the 2007 calendar year, reduced by the allowable costs percent reduction, and divided by total 2007 patient days; or

ii) The indirect NS300- prices which shall be based upon allowable operating costs and statistical data for the indirect component of the price as reported by each non-specialty facility with certified bed capacity of less than 300 beds in its cost report for the 2007 calendar year, reduced by the allowable costs percent reduction, and divided by total 2007 patient days.

3) The indirect component of the price for each peer group shall be as follows:

	Indirect Component of the Price (NSHB/NS300+) Peer Group				
Effective Date of Prices	Indirect NSF Price (a)	50% of Indirect NSF Price (b)	Indirect NSHB/NS300+ Price (c)	50% of Indirect NSHB/NS300+ Price (d)	Total Indirect Component of Price for NSHB/NS300+ Peer Group (b)+(d)
January 1, 2012	$53.15	$26.58	$61.54	$30.77	$57.35
January 1, 2013	$56.18	$28.09	$65.04	$32.52	$60.61
January 1, 2014	$58.57	$29.29	$67.82	$33.91	$63.20
January 1, 2015	$59.26	$29.63	$68.61	$34.31	$63.94
January 1, 2016	$59.53	$29.77	$68.92	$34.46	$64.23
January 1, 2017	$59.80	$29.90	$69.23	$34.62	$64.52
	Indirect Component of the Price (NS300-)Peer Group				
Effective Date of Prices	Indirect NSF Price (a)	50% of Indirect NSF Price (b)	Indirect NS300- Price (c)	50% of Indirect NS300- Price (d)	Total Indirect Component of Price for NS300- Peer Group (b)+(d)
January 1, 2012	$53.15	$26.58	$48.49	$24.25	$50.82
January 1, 2013	$56.18	$28.09	$51.25	$25.63	$53.72
January 1, 2014	$58.57	$29.29	$53.44	$26.72	$56.01
January 1, 2015	$59.26	$29.63	$54.06	$27.03	$56.66
January 1, 2016	$59.53	$29.77	$54.31	$27.16	$56.92
January 1, 2017	$59.80	$29.90	$54.55	$27.28	$57.18

Subsequent updates to the prices can be obtained by accessing the following link: http:/www.health.ny.gov/xxxxxxxxx

4) The allowable costs percent reduction for the indirect component shall be as follows:

Effective Date	Allowable Cost Percent Reduction
January 1, 2012	19.545660%
January 1, 2013	14.963800%
January 1, 2014	11.339480%
January 1, 2015	10.305120%
January 1, 2016	9.893250%
January 1, 2017	9.485290%

Subsequent updates to the allowable costs percent reduction can be obtained by accessing the following link http://www.health.ny.gov/xxxxx

h) Allowable costs for the indirect component of the rate shall include costs reported in the following functional cost centers on the facility's 2007 cost report (RHCF-4), or extracted from a hospital-based facility's 2007 cost report (RHCF-2) and the institutional cost report of its related hospital, from available certified cost reports as determined by the Commissioner, after first deducting costs attributable to specialty units, and the hospital by applying appropriate trace back percentages; and capital costs:

i) Fiscal Services (004);
ii) Administrative Services (005);
iii) Plant Operations and Maintenance (006) with the exception of utilities and real estate occupancy taxes;
iv) Grounds (007);
v) Security (008);
vi) Laundry and Linen (009);

vii) Housekeeping (010);
viii) Patient Food Services (011);
ix) Cafeteria (012);
x) Non-Physician Education (015);
xi) Medical Education (016);
xii) Housing (018); and
xiii) Medical Records (019);

i) The indirect component of the price shall be adjusted by a wage equalization factor (WEF). The WEF adjustment shall be calculated using cost and statistical data reported by each facility's 2009 cost report ((RHCF-4), or extracted from a hospital-based facility's 2009 cost report (RHCF-2) and the institutional cost report of its related hospital as applicable) from available certified cost reports as determined by the Commissioner , subject to applicable trace back percentages. The WEF adjustment shall consist of 50% of a facility-specific indirect WEF and 50% of a regional indirect WEF.

1) The facility-specific indirect WEF shall be calculated as follows:

1/((Facility-Specific Wage Ratio/ Wage Index) + (Facility-Specific Non-Wage Ratio))

i) The Facility-Specific Wage Ratio shall be calculated by dividing facility-specific total salaries and fringes related to indirect cost centers for fiscal services (004), administrative services (005), plant operation and maintenance (006), grounds (007), security (008), laundry and linen (009), housekeeping (010), patient food service (011), cafeteria (012), non physician education (015), medical education (016), housing (018) and medical records (019), by total indirect operating expenses from such cost centers.

ii) The Wage Index shall be calculated by dividing facility-specific labor costs per hour by labor costs per hour for RNs, LPNs, aides and orderlies, therapists and therapist aides for all facilities from cost centers physical therapy (039), occupational therapy (040), speech/hearing therapy (041) and residential health care facility (051).

iii) The Facility-Specific Non-Wage Ratio shall be calculated by subtracting from 1 the Facility-Specific Wage Ratio.

2) A regional indirect WEF shall be calculated for each of the following 16 regions. The county geographic boundaries shall be the sole factor considered in determining which WEF region a facility is located.

Region	**Consisting of the counties of:**
Albany Region	Albany, Columbia, Fulton, Green, Montgomery, Rensselaer, Saratoga, Schenectady and Schoharie
Binghamton Region	Broome and Tioga
Central Rural Region	Cayuga, Cortland, Seneca, Tompkins and Yates
Elmira Region	Chemung, Schuyler and Steuben
Erie Region	Cattaraugus, Chautauqua, Erie, Niagara and Orleans
Glens Falls Region	Essex, Warren and Washington
Long Island Region	Nassau and Suffolk
New York City Region	Bronx, Kings, New York, Queens and Richmond
Northern Rural Region	Clinton, Franklin, Hamilton and St. Lawrence
Orange Region	Chenango, Delaware, Orange, Otsego, Sullivan and Ulster
Poughkeepsie Region	Dutchess and Putnam
Rochester Region	Livingston, Monroe, Ontario and Wayne
Syracuse Region	Madison and Onondaga
Utica Region	Herkimer, Jefferson, Lewis, Oneida and Oswego
Westchester Region	Rockland and Westchester
Western Rural Region	Allegany, Genesee, and Wyoming

3) The regional indirect WEF shall be calculated for each of the 16 regions as follows:

(1/(Regional Wage Ratio/ Region Wage Index) + Regional Non-Wage Ratio)

i) The Regional Indirect Wage Ratio shall be calculated by dividing total salaries and fringes related to indirect costs centers in the region for Fiscal Services (004), Administrative Services (005), Plant Operation and Maintenance (006), Grounds (007), Security (008), Laundry and Linen (009), Housekeeping (010), Patient Food Service (011), Cafeteria (012), Non Physician Education (015), medical education (016), housing (018) and Medical Records (019) for such indirect cost centers by total indirect operating expenses in the region from such cost centers.

ii) The Wage Index shall be calculated by dividing labor costs per hour in the Region by labor costs per hour for RNs, LPNs, aides and orderlies, therapists and therapist aides for all facilities from cost centers physical therapy (039), occupational therapy (040), speech/hearing therapy (041) and residential health care facility (051).

iii) The Regional Non-Wage Ratio shall be calculated by subtracting from 1 the Regional Wage Ratio.

4) The regional indirect WEF adjustment to the indirect component of the price for facilities for which 2009 cost report data is unavailable or insufficient to calculate the WEF as described above will be equal to 100% of the applicable regional WEF.

j) The non-comparable component of the price shall be calculated using allowable operating costs and statistical data as reported in each non-specialty facility's cost report for the 2007 calendar year, or from otherwise available certified cost reports as determined by the Commissioner, divided by total 2007 patient days or divided by patient days derived from otherwise available certified cost reports as determined by the Commissioner.

k) Allowable costs for the non-comparable component of the price shall include costs reported in the following functional cost centers on the facility's annual cost report (RHCF-4), or extracted from a hospital-based facility's annual costs report (RHCF-2) and the institutional cost report of its related hospital, or from otherwise available certified cost reports as determined by the Commissioner, after first deducting costs attributable to specialty units, and the hospital by applying appropriate trace back percentages; and capital costs:

i) Laboratory services (031);
ii) ECG (032);
iii) EEG (033);
iv) Radiology(034);
v) Inhalation Therapy (035);
vi) Podiatry (036);
vii) Dental (037);
viii) Psychiatric (038);
ix) Speech and Hearing Therapy – (Hearing Therapy Only including associated overhead) (041);
x) Medical Directors Office (017);
xi) Medical Staff Services (044);
xii) Utilization review (020);
xiii) Other ancillary services (045, 046, 047);
xiv) Costs of utilities associated with plant operations and maintenance; and
xv) Pharmacy costs pertaining to administrative overhead and costs of non-prescription drugs and supplies.

l) The non-comparable component of the price for facilities for which 2007 cost report data is unavailable or insufficient to calculate the non-comparable component as described above shall initially receive a non-comparable rate which is calculated using the most recently available certified cost report, as determined by the Commissioner, and if no such report is available, the regional average shall be utilized until such time as a certified cost report is available.

m) Per Diem Adjustments for Dementia, Bariatric, or Traumatic Brain-Injured Patients. If applicable, and as updated pursuant to the case mix adjustments described above, the operating component of the price shall be adjusted to reflect:

1) A per diem add-on in the amount of $8 for each dementia patient, defined as one who A) qualifies under both the RUG-III impaired cognition and the behavioral problems categories, or (B) has been diagnosed with Alzheimer's disease or dementia, is classified in the reduced physical functions A, B, or C or in behavioral problems A or B categories, and has an activities of daily living index score of ten or less.

2) A per diem add-on in the amount of $17 for each bariatric patient, defined as one whose body mass index is greater than thirty-five.

3) A per diem add-on in the amount of $36 for each traumatic brain-injured patient, defined as one requiring extended care as a result of that injury.

n) For the calendar year 2012, the operating component of the price of each non-specialty facility that fails to submit to the Commissioner data or reports on quality measures, as required and defined by regulation, shall be subject to a per diem reduction calculated by multiplying $50 million by each non-specialty facility's share of Medicaid days.

o) Per Diem Transition Adjustments: Over the five-year period beginning January 1, 2012, and ending December 31, 2016, non-specialty facilities shall be eligible for per diem transition rate adjustments, calculated as follows:

1) In each year for each non-specialty facility computations shall be made by the Department pursuant to subparagraphs (i) and (ii) below and per diem rate adjustments shall be made for each year such that the difference between such computations for each year is no greater than the percentage as identified in subparagraph (iii) below, of the total Medicaid revenue received from the non-specialty facility's July 7, 2011, rate (as transmitted in the Department's Dear Administrator Letter (DAL) dated November 9, 2011, and not subject to reconciliation or adjustment).

   (i) A non-specialty facility's Medicaid revenue, calculated by summing the direct component, indirect component, non-comparable components of the price in effect for each non-specialty facility on January 1, 2012, and multiplying such total by the non-specialty facility's 2010 Medicaid days or the most recently available Medicaid days as of October 24, 2011, as determined by the Commissioner.

   (ii) A non-specialty facility's Medicaid revenue calculated by multiplying the non-specialty facility's July 7, 2011, rate (as communicated to facilities by Department letter dated November 9, 2011) by the non-specialty facility's 2010 Medicaid days or the most recently available Medicaid days as of October 24, 2011, as determined by the Commissioner and deemed not subject to subsequent reconciliation or adjustment.

   (iii) In year one the percentage shall be 1.75%, in year two it shall be 2.5%, in year three it shall be 5.0%, in year four it shall be 7.5% and in year five it shall be 10.0%. In year six, the prices calculated in this section shall not be subject to per diem transition rate adjustments.

   (iv) Non-specialty facilities which do not have a July 7, 2011, rate as described above shall not be eligible for the per diem transition adjustment described herein.

p) Other Provisions:

1) The appointment of a receiver, the establishment of a new operator, or the replacement or renovation of an existing facility on or after January 1, 2012, shall not result in a revision to the operating component of the price.

2) For rate computation purposes, "patient days" shall include "reserved bed days," defined as the unit of measure denoting an overnight stay away from the facility for which the patient or the patient's third-party payor provides per diem reimbursement when the patient's absence is due to hospitalization or therapeutic leave.

3) The base year used to calculate the direct and indirect price components , the base year used to calculate the direct and indirect wage equalization factor, and the Resource Utilization Groups System used to calculate case mix and described herein shall be periodically updated as determined by the Commissioner.

q) Effective January 1, 2012, the non-capital component of the rate for the specialty facilities shall be the rates in effect for such facilities on January 1, 2009, as adjusted for inflation and rate appeals in accordance with applicable statutes. Such rates of payment in effect January 1, 2009, for AIDS facilities or discrete AIDS units within facilities shall be reduced by the AIDS occupancy factor.

1) For new specialty facilities without a January 1, 2009, rate but with a rate prior to April 1, 2009, the operating portion of the January 1, 2012, the rate will be the rate in effect on the date of opening.

2) For new specialty facilities without a January 1, 2009, rate that open between April 1, 2009, and July 7, 2011, the operating portion of January 1, 2012, rate will be the rate in effect July 7, 2011.

3) For new specialty facilities without a January 1, 2009, rate that open subsequent to July 7, 2011, the operating portion of the January 1, 2012, rate will be calculated as follows:

i. The initial rate will be based on budgeted costs prepared by the facility and approved by the Department and will become effective on the date of opening.

ii. The facility will file a cost report for the first twelve-month period that the specialty unit or specialty facility, as applicable, achieves 90% occupancy. The rate will become effective the first day of the twelve-month report.

4) There will be no case mix adjustments to specialty rates.

Appendix II
2012 Title XIX State Plan
First Quarter Amendment
Long-Term Care Facility Services
Summary

Summary
SPA #11-23-A

This State Plan Amendment proposes to establish a new reimbursement methodology for the operating component of non-specialty residential health care facilities ("nursing homes"). The operating component of the price is based upon allowable costs and is the sum of the direct price, indirect price and a facility-specific non-comparable price. The direct and indirect prices are a blend of a statewide price and a peer group price. There are two peer groups: 1) all non-specialty hospital-based facilities and non-specialty freestanding facilities with certified beds capacities of 300 or more, and 2) non-specialty freestanding facilities with certified bed capacities of less than 300 beds. The direct price is subject to a case mix adjustment and a wage index adjustment. The indirect price is subject to a wage index adjustment. Per diem adjustments to the operating component of the rate include add-ons for bariatric, traumatic brain-injured (TBI) extended care and dementia residents, adjustments for the reporting of quality data, and transition payments. Non-specialty facilities will transition to the price over a five-year period (2012-2016), with prices fully implemented beginning in 2017. The non-capital component of the rate for specialty facilities, which are not subject to the new reimbursement methodology, will be the rates in effect for such facilities on January 1, 2009.

Appendix III
2012 Title XIX State Plan
First Quarter Amendment
Long-Term Care Facility Services
Authorizing Provisions

§ 95. Subdivision 2-c of section 2808 of the public health law is REPEALED and a new subdivision 2-c is added to read as follows:

2-c. (a) Notwithstanding any inconsistent provision of this section or any other contrary provision of law and subject to the availability of federal financial participation, the non-capital component of rates of payment by governmental agencies for inpatient services provided by residential health care facilities on or after October first, two thousand eleven, but no later than January first, two thousand twelve, shall reflect a direct statewide price component, and indirect statewide price component, and a facility specific non-comparable component, utilizing allowable operating costs for a base year as determined by the commissioner by regulation. Such rate components shall be periodically updated to reflect changes in operating costs.

(b) The direct and indirect statewide price components shall be adjusted by a wage equalization factor and such other factors as determined to be appropriate to recognize legitimate cost differentials and the direct statewide price component shall be subject to a case mix adjustment utilizing the patients that are eligible for medical assistance pursuant to title eleven of article five of the social services law. Such wage equalization factor shall be periodically updated to reflect current labor market conditions.

(c) The non-capital component of the rates for: (i) AIDS facilities or discrete AIDS units within facilities; (ii) discrete units for residents receiving care in a long-term inpatient rehabilitation program for traumatic brain injured persons; (iii) discrete units providing specialized programs for residents requiring behavioral interventions; (iv) discrete units for long-term ventilator dependent residents; and (v) facilities or discrete units within facilities that provide extensive nursing, medical, psychological and counseling support services solely to children shall reflect the rates in effect for such facilities on January first, two thousand nine, as adjusted for inflation and rate appeals in accordance with applicable statutes, provided, however, that such rates for facilities described in subparagraph (i) of this paragraph shall reflect the application of the provisions of section twelve of part D of chapter fifty-eight of the laws of two thousand nine, and provided further, however, that insofar as such rates reflect trend adjustments

for trend factors attributable to the two thousand eight and two thousand nine calendar years the aggregate amount of such trend factor adjustments shall be subject to the provisions of section two of part D of chapter fifty-eight of the laws of two thousand nine, as amended.

(d) The commissioner shall promulgate regulations, and may promulgate emergency regulations, to implement the provisions of this subdivision. Such regulations shall be developed in consultation with the nursing home industry and advocates for residential health care facility residents and, further, the commissioner shall provide notification concerning such regulations to the chairs of the senate and assembly health committees, the chair of the senate finance committee and the chair of the assembly ways and means committee. Such regulations shall include provisions for rate adjustments or payment enhancements to facilitate a minimum four-year transition of facilities to the rate-setting methodology established by this subdivision and may also include, but not be limited to, provisions for facilitating quality improvements in residential health care facilities.

Subpart 86-2 of title 10 of NYCRR is amended by adding a new section 86-2.40, to read as follows:

86-2.40. Statewide prices for non-capital reimbursement. The non-capital cost components of residential health care facility ("facility") Medicaid rates for inpatient services for periods on and after January 1, 2012, shall be in accord with the following:

(a) "Specialty facilities" means those facilities or discrete units of facilities described in paragraph (c) of subdivision 2-c of section 2808 of the Public Health Law. Such facilities and such discrete units of facilities shall not be subject to the provisions of this section, other than subdivision (dd), and the costs and statistical data reported by such facilities and such discrete units of facilities shall not be included in the rate computations otherwise made pursuant to this section, and the term "facilities" as used in this section shall not be deemed to include such facilities.

(b) The operating component of rates shall be a price and shall consist of the sum of the direct, indirect and non-comparable price components.

(c) For purposes of calculating the direct and indirect price component of the rates, the following peer groups shall be established:

(1) all facilities;

(2) free-standing facilities with certified bed capacities of 300 beds or more and all hospital-based facilities as defined in 10 NYCRR 86-2.10(a)(13) ("HBF +300 bed"); and

(3) all free-standing facilities with certified bed capacities of less than 300 beds ("-300 bed").

(d) The direct component of the price shall consist of a blended rate, to be determined as follows:

(1) 50% of the direct price which shall be based upon allowable operating costs and statistical data for the direct component of the price as reported in each facility's cost report for the 2007 calendar year, reduced by the allowable costs percent reduction, and divided by total 2007 patient days; and

(2) 50% of either:

(i) the direct price of HBF +300 bed facilities, which shall be based upon allowable operating costs and statistical data for the direct component of the price as reported by each hospital-based facility and each free-standing facility with certified bed capacity of 300 beds or more in its cost report for the 2007 calendar year, reduced by the allowable costs percent reduction, and divided by total 2007 patient days, or

(ii) the direct price of -300 bed facilities, which shall be based upon allowable operating costs and statistical data for the direct component of the price as reported by each freestanding facility with certified bed capacity of less than 300 beds in its cost report for the 2007 calendar year, reduced by the allowable costs percent reduction, and divided by total 2007 patient days.

(e) (1) The direct component of the price for each peer group shall be as follows:

	Direct Component of the Price Ineligible Price, Part D Eligible Price (HBF +300 Bed Peer Group)				
Effective Date of Prices	**Direct Price (a)**	**50% of Direct Price (b)**	**Direct HBF +300 Bed Price (c)**	**50% of Direct HBF +300 Bed Price (d)**	**Total Direct Component of Price for HBF +300 Bed Peer Group (b)+(d)**
January 1, 2012	$105.79	$52.90	$117.48	$58.74	$111.64
January 1, 2013	$111.82	$55.91	$124.17	$62.09	$118.00
January 1, 2014	$116.58	$58.29	$129.46	$64.73	$123.02
January 1, 2015	$117.94	$58.97	$130.97	$65.49	$124.46
January 1, 2016	$118.48	$59.24	$131.57	$65.79	$125.03
January 1, 2017	$119.02	$59.51	$132.17	$66.09	$125.60
	Direct Component of the Price Part B Eligible Price, Part B and Part D Eligible Price (HBF +300 Bed Peer Group)				
Effective Date of Prices	**Direct Price (a)**	**50% of Direct Price (b)**	**Direct HBF +300 Bed Price (c)**	**50% of Direct HBF +300 Bed Price (d)**	**Total Direct Component of Price for HBF +300 Bed Peer Group (b)+(d)**
January 1, 2012	$104.34	$52.17	$115.94	$57.97	$110.14
January 1, 2013	$110.28	$55.14	$122.54	$61.27	$116.41
January 1, 2014	$114.98	$57.49	$127.76	$63.88	$121.37
January 1, 2015	$116.33	$58.17	$129.25	$64.63	$122.79
January 1, 2016	$116.86	$58.43	$129.84	$64.92	$123.35
January 1, 2017	$117.39	$58.70	$130.43	$65.22	$123.91

	Direct Component of the Price Ineligible Price, Part D Eligible Price (-300 Bed Peer Group)				
Effective Date of Prices	Direct Price (a)	50% of Direct Price (b)	Direct -300 Bed Price (c)	50% of Direct -300 Bed Price (d)	Total Direct Component of Price for -300 Bed Peer Group (b)+(d)
January 1, 2012	$105.79	$52.90	$99.30	$49.65	$102.55
January 1, 2013	$111.82	$55.91	$104.95	$52.48	$108.39
January 1, 2014	$116.58	$58.29	$109.43	$54.72	$113.01
January 1, 2015	$117.94	$58.97	$110.70	$55.35	$114.32
January 1, 2016	$118.48	$59.24	$111.21	$55.61	$114.85
January 1, 2017	$119.02	$59.51	$111.71	$55.86	$115.37
	Direct Component of the Price Part B Eligible Price, Part B and Part D Eligible Price (-300 Bed Peer Group)				
Effective Date of Prices	Direct Price (a)	50% of Direct Price (b)	Direct -300 Bed Price (c)	50% of Direct -300 Bed Price (d)	Total Direct Component of Price for -300 Bed Peer Group (b)+(d)
January 1, 2012	$104.34	$52.17	$97.90	$48.95	$101.12
January 1, 2013	$110.28	$55.14	$103.47	$51.74	$106.88
January 1, 2014	$114.98	$57.49	$107.88	$53.94	$111.43
January 1, 2015	$116.33	$58.17	$109.14	$54.57	$112.74
January 1, 2016	$116.86	$58.43	$109.64	$54.82	$113.25
January 1, 2017	$117.39	$58.70	$110.14	$55.07	$113.77

(2) As used in this subdivision, Medicare Ineligible Price shall mean the price applicable to Medicaid patients that are not Medicare eligible, Medicare Part B Eligible Price shall mean the price applicable to Medicaid patients that are Medicare Part B eligible, Medicare Part D Eligible Price shall mean the price applicable to Medicaid patients that are Medicare Part D eligible and Medicare Part B & Part D Eligible Price shall mean the price applicable to Medicaid patients that are Medicare Part B & Part D Eligible.

(3) Subsequent revisions to the peer group prices set forth in paragraph (1) of this subdivision shall be published on the New York State Department of Health website at: http://www.health..ny.gov

(f) The allowable costs percent reduction for the direct component shall be as follows:

Effective Date	Allowable Cost Percent Reduction
January 1, 2012	19.545660%
January 1, 2013	14.963800%
January 1, 2014	11.339480%
January 1, 2015	10.305120%
January 1, 2016	9.893250%
January 1, 2017	9.485290%

Subsequent revisions to the allowable costs percent reduction shall be published on the New York State Department of Health website at: http://www.health..ny.gov/

(g) Allowable costs for the direct component of the rate shall include costs reported in the following functional cost centers on the facility's 2007 cost report (RHCF-4), or extracted from a hospital-based facility's 2007 cost report (RHCF-2)and the institutional cost report of its related hospital, from available certified cost reports as determined by the Commissioner, after first deducting costs attributable to specialty units, and the hospital by applying appropriate trace back percentages; and capital costs:

(1) nursing administration (013);
(2) activities program (014);
(3) social services (021);
(4) transportation (022);
(5) physical therapy (039)(including associated overhead);
(6) occupational therapy (040)(including associated overhead);
(7) speech/hearing therapy (041)(Speech therapy portion only including associated overhead);
(8) central service supply (043);
(9) residential health care facility (051); and
(10) pharmacy (042)(excluding costs allocated to non-comparables).

(h) The direct component of the price shall be adjusted by a wage equalization factor (WEF). The WEF adjustment shall be calculated using cost and statistical data reported in each facility's 2009 cost report ((RHCF-4), or extracted from a hospital-based facility's 2009 cost report (RHCF-2) and the institutional cost report of its related hospital as applicable), from available certified cost reports as determined by the Commissioner, subject to applicable trace back percentages. The WEF adjustment shall consist of 50% of a Facility Specific Direct WEF and 50% of a Regional Direct WEF.

(i) The Facility Specific Direct WEF shall be calculated as follows:

1÷ ((Facility Specific Wage Ratio÷ Wage Index) + Facility Specific Non-Wage Ratio)

(1) The Facility Specific Wage Ratio shall be calculated by dividing facility-specific total salaries and fringes related to direct cost centers for nursing administration (013), activities program (014), social services (021), transportation (022), physical therapy (039), occupational therapy (040), speech/hearing therapy (041), pharmacy (042), central service supply (043), and residential health care facility (051) by total direct operating expenses from such cost centers.

(2) The Wage Index shall be calculated by dividing facility specific labor costs per hour by labor costs per hour for RNs, LPNs, aides and orderlies, therapists and therapist aides for all facilities from cost centers physical therapy (039), occupational therapy (040), speech/hearing therapy (041) and residential health care facility (051).

(3) The Facility Specific Non-Wage Ratio shall be calculated by subtracting from 1 the Facility Specific Wage Ratio.

(j) A Regional Direct WEF shall be calculated for each of the following 16 regions. The county geographic boundaries shall be the sole factor considered in determining which WEF region a facility is located in.

(1) Albany Region, consisting of the counties of Albany, Columbia, Fulton, Greene, Montgomery, Rensselaer, Saratoga, Schenectady and Schohaire

(2) Binghamton Region, consisting of the counties of Broome and Tioga

(3) Central Rural Region, consisting of the counties of Cayuga, Cortland, Seneca, Tompkins and Yates.

(4) Elmira Region, consisting of the counties of Chemung, Schuyler and Steuben.

(5) Erie Region, consisting of the counties of Cattaraugus, Chautaugua, Erie, Niagara and Orleans.

(6) Glens Falls Region, consisting of the counties of Essex, Warren and Washington.

(7) Long Island Region, consisting of the counties of Nassau and Suffolk.

(8) New York City Region, consisting of the counties of Bronx, Kings, New York, Queens and Richmond.

(9) Northern Rural Region, consisting of the counties of Clinton, Franklin, Hamilton and St. Lawrence.

(10) Orange Region, consisting of the counties of Chenango, Delaware, Orange, Otsego, Sullivan and Ulster.

(11) Poughkeepsie Region, consisting of the counties of Dutchess and Putnam.

(12) Rochester Region, consisting of the counties of Livingston, Monroe, Ontario and Wayne.

(13) Syracuse Region, consisting of the counties of Madison and Onondaga.

(14) Utica Region, consisting of the counties of Herkimer, Jefferson, Lewis, Oneida and Oswego.

(15) Westchester Region, consisting of the counties of Rockland and Westchester.
(16) Western Rural Region, consisting of the counties of Allegany, Genesee and Wyoming.

(k) The Regional Direct WEF shall be calculated for each of the 16 regions as follows:

1÷((Regional Wage Ratio÷Regional Wage Index)+ Regional Non-Wage Ratio)

(1) The Regional Wage Ratio shall be calculated by dividing total salaries and fringes related to direct costs in the Region from cost centers for nursing administration (013), Activities Program (014), social services (021), transportation (022), physical therapy (039), occupational therapy (040), speech/hearing therapy(041), pharmacy (42), central service supply (043), and residential health care facility (051) by total direct operating expenses in the Region from such cost centers.

(2) The Regional Wage Index shall be calculated by dividing labor costs per hour in the region by labor costs per hour for RNs, LPNs, aides and orderlies, therapists and therapist aides for all facilities from cost centers physical therapy (039), occupational therapy (040), speech/hearing therapy (041) and residential health care facility (051).

(3) The Regional Non-Wage Ratio shall be calculated by subtracting from 1 the Regional Wage Ratio.

(l) The Direct WEF adjustment to the direct component of the price for facilities for which 2009 cost report data is unavailable or insufficient to calculate the WEF as described in this section shall be equal to 100% of the applicable Regional WEF.

(m) The direct component of the price shall be subject to a case mix adjustment in accordance with the following:

(1) The application of the relative Resource Utilization Groups System (RUGS-III) as published by the Centers for Medicare and Medicaid Services and revised to reflect New York State wage and fringe benefits, and based on Medicaid only patient data.

(2) New York State wages shall be used to determine the weight of each RUG. The cost for each RUG shall be calculated using the relative resources for registered nurses, licensed practical nurses, aides, therapists, and therapy aides and the 1995-97 federal time study. The minutes from the federal time study shall be multiplied by the New York average dollar per hour to determine the fiscal resources need to care for that patient type. This amount shall be multiplied by the number of patients in that RUG. RUG weights shall be assigned

based on the distance from the Statewide average. The RUGS III weights shall be increased by the following amounts for the following categories of residents:

(i) thirty minutes of certified nurse aide time for the impaired cognition A category;

(ii) forty minutes of certified nurse aide time for the impaired cognition B category; and

(iii) twenty-five minutes of certified nurse aide time for the reduced physical functions B category.

(3) The case mix adjustment for the direct component of the price effective January 1, 2012 shall be calculated by dividing the Medicaid only case mix calculated using data for January 2011 by the all-payer case mix for the base year 2007.

(4) The all payer case mix for base year 2007 shall be a blend of:

(i) 50% of the case mix for all facilities, and

(ii) 50% of the case mix for either:

(*a*) free-standing facilities with certified bed capacities of 300 beds or more and all hospital-based facilities or

(*b*) all free-standing facilities with certified bed capacities of less than 300 beds.

(5) the Medicaid only case mix shall mean the case mix for patients where Medicaid is the primary payer.

(6) Subsequent case mix adjustments to the direct component of the price for rate periods effective after January 1, 2012 shall be made in July and January of each calendar year and shall use Medicaid-only case mix data applicable to the previous case mix period.

(7) Case mix adjustments to the direct component of the price for facilities for which which facility specific case mix data is unavailable or insufficient shall be equal to the base year case mix of the peer group applicable to such facility.

(8) The adjustments and related patient classifications for each facility shall be subject to audit review by the Office of the Medicaid Inspector General.

(n) The indirect component of the price shall consist of a blended rate to be determined as follows:

(1) 50% indirect price which shall be based upon allowable operating costs and statistical data for the indirect component of the price as reported in each facility's cost report for the 2007 calendar year, reduced by the allowable costs percent reduction, and divided by total 2007 patient days; and

(2) 50% of either:

(i) The indirect HBF +300 bed facility price which shall be based upon allowable operating costs and statistical data for the indirect component of the price as reported by each hospital-based facility and each free-standing facility with certified bed capacity of 300 beds or more in its cost report for the 2007 calendar year, reduced by the allowable costs percent reduction, and divided by total 2007 patient days; or

(ii) The indirect -300 bed facility price which shall be based upon allowable operating costs and statistical data for the indirect component of the price as reported by each freestanding facility with certified bed capacity of less than 300 beds in its cost report for the 2007 calendar year, reduced by the allowable costs percent reduction, and divided by total 2007 patient days

(o)(1) The indirect component of the price for each peer group shall be as follows:

	Indirect Component of the Price (HBF +300 Bed Peer Group)				
Effective Date of Prices	**Indirect Price (a)**	**50% of Indirect Price (b)**	**Indirect HBF +300 Bed Price (c)**	**50% of Indirect HBF +300 Bed Price (d)**	**Total Indirect Component of Price for HBF +300 Bed Peer Group (b)+(d)**
January 1, 2012	**$53.15**	**$26.58**	**$61.54**	**$30.77**	**$57.35**
January 1, 2013	**$56.18**	**$28.09**	**$65.04**	**$32.52**	**$60.61**
January 1, 2014	**$58.57**	**$29.29**	**$67.82**	**$33.91**	**$63.20**
January 1, 2015	**$59.26**	**$29.63**	**$68.61**	**$34.31**	**$63.94**
January 1, 2016	**$59.53**	**$29.77**	**$68.92**	**$34.46**	**$64.23**
January 1, 2017	**$59.80**	**$29.90**	**$69.23**	**$34.62**	**$64.52**
	Indirect Component of the Price (-300 Bed Peer Group)				
Effective Date of Prices	**Indirect Price (a)**	**50% of Indirect Price (b)**	**Indirect -300 Bed Price (c)**	**50% of Indirect -300 Bed Price (d)**	**Total Indirect Component of Price for -300 Bed Peer Group (b)+(d)**

January 1, 2012	**$53.15**	**$26.58**	**$48.49**	**$24.25**	**$50.82**
January 1, 2013	**$56.18**	**$28.09**	**$51.25**	**$25.63**	**$53.72**
January 1, 2014	**$58.57**	**$29.29**	**$53.44**	**$26.72**	**$56.01**
January 1, 2015	**$59.26**	**$29.63**	**$54.06**	**$27.03**	**$56.66**
January 1, 2016	**$59.53**	**$29.77**	**$54.31**	**$27.16**	**$56.92**
January 1, 2017	**$59.80**	**$29.90**	**$54.55**	**$27.28**	**$57.18**

(2) Subsequent revisions to the prices set forth in paragraph (1) of this subdivision shall be published on the New York State Department of Health website at: http://www.health..ny.gov

(p) The allowable costs percent reduction for the indirect component shall be as follows:

Effective Date	Allowable Cost Percent Reduction
January 1, 2012	19.545660%
January 1, 2013	14.963800%
January 1, 2014	11.339480%
January 1, 2015	10.305120%
January 1, 2016	9.893250%
January 1, 2017	9.485290%

Subsequent revisions to the allowable costs percent reduction shall be published on the New York State Department of Health website at: http://www.health.ny.gov/

(q) Allowable costs for the indirect component of the rate shall include costs reported in the following functional cost centers on the facility's 2007 cost report (RHCF-4), or extracted from a hospital-based facility's 2007 cost report (RHCF-2) and the institutional cost report of its related hospital, from available certified cost reports as determined by the Commissioner, after first deducting costs attributable to specialty units, and the hospital by applying appropriate trace back percentages; and capital costs:

(1) fiscal services (004);
(2) administrative services (005);
(3) plant operations and maintenance (006) (with the exception of utilities and real estate and occupancy taxes);
;
(4) grounds (007);
(5) security (008);
(6) laundry and linen (009);

(7) housekeeping (010);
(8) patient food services (011);
(9) cafeteria (012);
(10) non-physician education (015);
(11) medical education (016);
(12) housing (018); and
(13) medical records (019).

(r) The indirect component of the price shall be adjusted by a Wage Equalization Factor (WEF). The WEF adjustment shall be calculated using cost and statistical data reported in each facility's 2009 cost report ((RHCF-4), or extracted from a hospital-based facility's 2009 costs report (RHCF-2) and the institutional cost report of its related hospital as applicable from available certified cost reports as determined by the Commissioner, subject to applicable trace back percentages. The WEF adjustment shall consist of 50% of a Facility Specific Indirect WEF and 50% of a Regional Indirect WEF.

(s) The Facility Specific Indirect WEF shall be calculated as follows:

1÷((Facility Specific Wage Ratio÷Wage Index)+ Facility Specific Non-Wage Ratio)

(1) The Facility Specific Wage Ratio shall be calculated by dividing facility-specific total salaries and fringes related to indirect cost centers for fiscal services (004), administrative services (005), plant operation and maintenance (006), grounds (007), security (008), laundry and linen (009), housekeeping (010), patient food service (011), cafeteria (012), non-physician education (015), medical education (016), housing (018), and medical records (019), by total indirect operating expenses for such cost centers.

(2) The Wage Index shall be calculated by dividing facility specific labor costs per hour by labor costs per hour for RNs, LPNs, aides and orderlies, therapists and therapist aides for all facilities from cost centers physical therapy (039), occupational therapy (040), speech/hearing (041) and residential health care facility (051).

(3) The Facility Specific Non-Wage Ratio shall be calculated by subtracting from 1 the Facility Specific Wage Ratio.

(t) A Regional Indirect WEF shall be calculated for each of the following 16 regions. The county geographic boundaries shall be the sole factor considered in determining which WEF region a facility is located in.

(1) Albany Region, consisting of the counties of Albany, Columbia, Fulton, Greene, Montgomery, Rensselaer, Saratoga, Schenectady and Schohaire

(2) Binghamton Region, consisting of the counties of Broome and Tioga

(3) Central Rural Region, consisting of the counties of Cayuga, Cortland, Seneca, Tompkins and Yates.

(4) Elmira Region, consisting of the counties of Chemung, Schuyler and Steuben.

(5) Erie Region, consisting of the counties of Cattaraugus, Chautaugua, Erie, Niagara and Orleans.

(6) Glens Falls Region, consisting of the counties of Essex, Warren and Washington.

(7) Long Island Region, consisting of the counties of Nassau and Suffolk.

(8) New York City Region, consisting of the counties of Bronx, Kings, New York, Queens and Richmond.

(9) Northern Rural Region, consisting of the counties of Clinton, Franklin, Hamilton and St. Lawrence.

(10) Orange Region, consisting of the counties of Chenango, Delaware, Orange, Otsego, Sullivan and Ulster.

(11) Poughkeepsie Region, consisting of the counties of Dutchess and Putnam.

(12) Rochester Region, consisting of the counties of Livingston, Monroe, Ontario and Wayne.

(13) Syracuse Region, consisting of the counties of Madison and Onondaga.

(14) Utica Region, consisting of the counties of Herkimer, Jefferson, Lewis, Oneida and Oswego.

(15) Westchester Region, consisting of the counties of Rockland and Westchester.

(16) Western Rural Region, consisting of the counties of Allegany, Genesee and Wyoming.

(u) The Regional Indirect WEF shall be calculated for each of the 16 regions, calculated as follows:

1÷((Regional Wage Ratio÷Region Wage Index)+ Regional Non-Wage Ratio)

(1) The Regional Indirect Wage Ratio shall be calculated by dividing total salaries and fringes related to indirect cost centers in each Region from cost centers for fiscal services (004), administrative services (005), plant operation and maintenance (006), grounds (007), security (008), laundry and linen (009), housekeeping (010), patient food service (011), cafeteria (012), non-physician education (015), medical education (016), housing (018), and medical records (019) for such indirect cost centers, by total indirect operating expenses in the Region for such cost centers.

(2) The Regional Wage Index shall be calculated by dividing labor costs per hour in the Region by labor costs per hour for RNs, LPNs, aides and orderlies, therapists and therapist

aides for all facilities from cost centers physical therapy (039), occupational therapy (040), speech/hearing therapy (041) and residential health care facility (051).

(3) The Regional Non-Wage Ratio shall be calculated by subtracting from 1 the Regional Wage Ratio.

(v) The Indirect WEF adjustment to the indirect component of the price for facilities for which 2009 cost report data is unavailable or insufficient to calculate the WEF as described above will be equal to 100% of the applicable regional WEF.

(w) The non- comparable component of the price shall be calculated using allowable operating costs and statistical data as reported in each facility's cost report for the 2007 calendar year, or from otherwise available certified cost reports as determined by the Commissioner, divided by total 2007 patient days, or divided by patient days derived from otherwise available certified cost reports as determined by the Commissioner.

(x) Allowable costs for the non-comparable component of the price shall include costs reported in the following functional cost centers on the facility's annual cost report (RHCF-4), or extracted from a hospital-based facility's annual costs report (RHCF-2) and the institutional cost report of its related hospital, or from otherwise available certified cost reports as determined by the Commissioner, after first deducting costs attributable to specialty units, and the hospital by applying appropriate trace back percentages; and capital costs:

(1) Laboratory services (031);
(2) ECG (032);
(3) EEG (033);
(4) Radiology (034);
(5) Inhalation therapy (035);
(6) Podiatry (036);
(7) Dental (037);
(8) Psychiatric (038);
(9) Speech and hearing therapy (041)) (hearing therapy only, including associated overhead);
;
(10) Medical directors office (017);
(11) Medical staff services (044);
(12) Utilization review (020);
(13) Other ancillary services (045, 046, 047);
(14) Costs of utilities associated with plant operations and maintenance; and

(15) Pharmacy costs pertaining to administrative overhead and costs of non-prescription drugs and supplies.

(y) The non-comparable component of the price for facilities for which 2007 cost report data is unavailable or insufficient to calculate the non-comparable component as described in this section shall initially receive a noncomparable rate which is calculated using the most recently available certified cost report, as determined by the Commissioner, and if no such report is available, the regional average shall be utilized until such time as a certified cost report is available.

(z) Per diem adjustments for certain patients. If applicable, and as updated pursuant to case mix adjustments made pursuant to paragraph (m) of this section, the operating component of the facility's price shall be adjusted to reflect the following:

(1) A per diem add-on in the amount of $8 for each patient that, (i) qualifies under both the RUG-III impaired cognition and the behavioral problems categories, or (ii) has been diagnosed with Alzheimer's disease or dementia, is classified in the reduced physical functions A, B, or C or in behavioral problems A or B categories, and has an activities of daily living index score of ten or less.

(2) A per diem add-on in the amount of $17 for each patient whose body mass index is greater than thirty-five.

(3) A per diem add-on in the amount of $36 for each patient requiring extended care for traumatic brain injury.

(aa) For the calendar year 2012, the operating component of the price of each facility that fails to submit to the Department data or reports on quality measures, as required and defined by regulation, shall be subject to a per diem reduction calculated by multiplying 50 million dollars by each facility's share of Medicaid days. Facilities determined by the Department to be subject to this adjustment may request an expedited administrative hearing with regard to such adjustment, provided, however, that such adjustment shall not be held in abeyance pending the completion of such a hearing.

(bb) Per diem transition adjustments. Over the five year period beginning January 1, 2012 and ending December 31, 2016, facilities shall be eligible for per diem transition rate adjustment, to be calculated as follows:

(1) In each year for each eligible facility computations shall be made by the Department pursuant to subparagraphs (i) and (ii) of this paragraph and per diem rate adjustments shall be made for each year such that the difference between such computations for each year is no greater than the percentage, as identified in subparagraph (iii) of this paragraph, of the total Medicaid revenue received from the facility's July 7, 2011 non-capital rate as communicated to facilities by the

Department in the letter dated November 9, 2011, and deemed not subject to subsequent reconciliation or adjustment.

(i) A facility's Medicaid revenue, calculated by summing the direct component, indirect component, non-comparable components of the price in effect for each eligible facility on January 1, 2012, and multiplying such total by the facility's 2010 Medicaid days or the most recently available Medicaid days as of October 24, 2011 as determined by the Commissioner.

(ii) A facility's Medicaid revenue calculated by multiplying the facility's July 7, 2011 rate (as communicated to facilities by Department letter dated November 9, 2011) by the facility's 2010 Medicaid days or the most recently available Medicaid days as of October 24, 2011 as determined by the Commissioner and deemed not subject to subsequent reconciliation or adjustment.

(iii) In year one the percentage shall be 1.75%, in year two it shall be 2.5%, in year three it shall be 5.0%, in year four it shall be 7.5% and in year five it shall be 10.0%. In year 6, the prices calculated in this section shall not be subject to per diem transition rate adjustments.

(iv) Facilities which do not have a July 7, 2011 rate as described above shall not be eligible for the per diem transition adjustment described herein.

(cc) Other Provisions:

(1) The appointment of a receiver or the establishment of a new operator or renovation of an existing facility on or after January 1, 2012 shall not result in a revision to the non-capital components of the price.

(2) For rate computation purposes, "patient days" shall include "reserved bed days", defined as the unit of measure denoting an overnight stay away from the facility for which the patient, or the patient's third-party payor, provides per diem reimbursement when the patient's absence is due to hospitalization or therapeutic leave.

(3) The base year used to calculate the direct and indirect price components , the base year used to calculate the direct and indirect wage equalization factor, and the Resource Utilization Groups System used to calculate case mix and described herein shall be periodically updated as determined by the Commissioner.

(dd) (1) Effective January 1, 2012, the non-capital components of the rate for specialty facilities and discrete specialty units of facilities (hereinafter "specialty facilities") shall be

the rates in effect for such facilities on January 1, 2009, as adjusted for inflation and rate appeals, in accordance with applicable statutes. Such rates of payment in effect January 1, 2009 for AIDS facilities or discrete AIDS units with facilities shall be reduced by the AIDS occupancy factor, as described in section 12 of part D of chapter 58 of the laws of 2009.

(2) The non-capital components of rates for new specialty facilities with initial rates issued for periods beginning after January 1, 2009, shall be in accordance with the following:

(i) For specialty facilities with an initial rate issued for periods beginning after January 1, 2009 but before April 1, 2009, the non-capital components of their rate effective for periods on and after January 1, 2012 shall be the rate in effect on the date the facility commenced operation.

(ii) For specialty facilities with an initial rate issued for periods beginning after March 31, 2009, but before July 8, 2011, the non-capital components of their rate effective for periods on and after January 1, 2012 shall be the rate in effect on July 7, 2011.

(iii) For specialty facilities with an initial rate issued for periods beginning after July 7, 2011, the non-capital components of their rate effective for periods on and after January 1, 2012 shall be based on budgeted costs, as submitted by the facility and approved by the Department and as issued by the Department effective on the facility's first day of operation, provided, however, that such specialty facilities shall file certified cost reports reflecting such specialty facility's first twelve months of operation at an occupancy level of 90% or more. The Department shall thereafter issue such facilities rates with non-capital components reflecting such cost reports and such rates shall be effective retroactive to the first day of such twelve month cost report. Nothing in this subparagraph shall be understood as exempting specialty facilities which have not yet achieved 90% occupancy from the generally applicable requirement to file annual calendar year cost reports.

(3) Effective for rate periods on and after January 1, 2012, there will be no case mix adjustments to rates for specialty facilities.

(ee) Administrative rate appeals from rates issued pursuant to this section shall be subject to otherwise applicable regulatory provisions of this Subpart and to applicable statutory provisions, including, but not limited to, Public Health Law sections 2808(11) and 2808(17).

Appendix IV
2012 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
Department of Civil Service

PURSUANT to the Open Meetings Law, the New York State Civil Service Commission hereby gives public notice of the following:

Please take notice that the regular monthly meeting of the State Civil Service Commission for April 2011 will be conducted on April 14 commencing at 10:00 a.m. This meeting will be conducted at New York Network, Suite 146, South Concourse, Empire State Plaza, Albany, NY. Directions and parking information available at (www.nyn.suny.edu).

For further information, contact: Office of Commission Operations, Department of Civil Service, Alfred E. Smith State Office Bldg., Albany, NY 12239, (518) 473-6598

PUBLIC NOTICE
Department of Health

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

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

All Services

• Effective on and after April 1, 2011, no annual trend factor will be applied pursuant to the provisions of Public Health Law § 2807-c(10)(c) to rates of payment for hospital inpatient, residential health care facilities, certified home health agencies, personal care services, and adult day health care services provided to patients diagnosed with AIDS. This includes the elimination of the 2011 trend factor effective for rates of payment April 1, 2011, and thereafter. In addition, the Department is authorized to promulgate regulations, to be effective April 1, 2011, such that no annual trend factor may be applied to rates of payment by the Department of Health for assisted living program services, adult day health care services or personal care services provided in those local social services districts, including New York City, whose rates of payment for services is established by such social services districts pursuant to a rate-setting exemption granted by the Department. This includes the elimination of the 2011 trend factor effective for rates of payment April 1, 2011, and thereafter.

- Effective for dates of service April 1, 2011, through March 31, 2012, and each state fiscal year thereafter, all non-exempt Medicaid payments as referenced below will be uniformly reduced by two percent. Such reductions will be applied only if an alternative method that achieves at least $345 million in Medicaid state share savings annually is not implemented.

- Medicaid administration costs paid to local governments, contractors and other such entities will also be reduced in the same manner as described above.

- Payments exempt from the uniform reduction based on federal law prohibitions include, but are not limited to, the following:

• Federally Qualified Health Center services;

• Indian Health Services and services provided to Native Americans;

• Supplemental Medical Insurance - Part A and Part B;

• State Contribution for Prescription Drug Benefit (aka Medicare Part D payments);

• Any local share cap payment required by the Federal Medical Assistance Percentage (FMAP) increase legislation;

• Required payments related to the School Supportive Health Services Program and Preschool Supportive Health Services Program settlement agreement;

• Services provided to American citizen repatriates; and

• Hospice Services.

- Payments exempt from the uniform reduction based on being funded exclusively with federal and/or local funds include, but are not limited to, the following:

• Upper payment limit payments to non-state owned or operated governmental providers certified under Article 28 of the NYS Public Health Law;

• Certified public expenditure payments to the NYC Health and Hospital Corporation;

• Certain disproportionate share payments to non-state operated or owned governmental hospitals;

• Certain managed care payments pursuant to section 3-d of Part B of the Chapter 58 of the Laws of 2010; and

• Services provided to inmates of local correctional facilities.

- Payments pursuant to the mental hygiene law will be exempt from the reduction;

- Court orders and judgments; and

- Payments where applying the reduction would result in a lower FMAP as determined by the Commissioner of Health and the Director of the Budget will be exempt.

• Medicaid expenditures will be held to a year to year rate of growth spending cap which does not exceed the rolling average of the preceding 10 years of the medical component of the Consumer Price Index (CPI) as published by the United States Department of Labor, Bureau of Labor Statistics.

- The Director of the Budget and the Commissioner of Health will periodically assess known and projected Medicaid expenditures to determine whether the Medicaid growth spending cap appears to be pierced. The cap may be adjusted to account for any revision in State Financial Plan projections due to a change in the FMAP amount, provider based revenues, and beginning April 1, 2012, the operational costs of the medical indemnity fund. In the event it is determined that Medicaid expenditures exceed the Medicaid spending cap, after any adjustment to the cap if needed, the Director of the Division of the Budget and the Commissioner of Health will develop a Medicaid savings allocation plan to limit the Medicaid expenditures by the amount of the projected overspending. The savings allocation plan will be in compliance with the following guidelines:

• The plan must be in compliance with the federal law;

• It must comply with the State's current Medicaid plan, amendment, or new plan that may be submitted;

• Reductions must be made uniformly among category of service, to the extent practicable, except where it is determined by the Commissioner of Health that there are grounds for non-uniformity; and

• The exceptions to uniformity include but are not limited to: sustaining safety net services in underserved communities, to ensuring that the quality and access to care is maintained, and to avoiding administrative burden to Medicaid applicants and recipients or providers.

Medicaid expenditures will be reduced through the Medicaid savings allocation plan by the amount of projected overspending through actions including, but not limited to: modifying or suspending reimbursement methods such as fees, premium levels, and rates of payment; modifying or discontinuing Medicaid program benefits; seeking new waivers or waiver amendments.

Institutional Services

• For the state fiscal year beginning April 1, 2011 through March 31, 2012, continues specialty hospital adjustments for hospital inpatient services provided on and after April 1, 2011, to public general hospitals, other than those operated by the State of New York or the State University of New York, located in a city with a population of over one million and receiving reimbursement of up to $1.08 billion annually. Payments to eligible public general hospitals may be added to rates of payment or made as aggregate payments.

• Effective for periods on and after January 1, 2011, for purposes of calculating maximum disproportionate share (DSH) payment distributions for a rate year or part thereof, costs incurred of furnishing hospital services net of medical assistance payments, other than DSH payments, and payments by uninsured patients shall for the 2011 calendar year, be determined initially based on each hospital's submission of a fully completed 2008 DSH hospital data collection tool, which is required to be submitted to the Department, and shall be subsequently revised to reflect each hospital's submission of a fully completed 2009 DSH hospital data collection tool, which is required to be submitted to the Department.

- For calendar years on and after 2012, such initial determinations shall reflect submission of data as required by the Commissioner on a specific date. All such initial determinations shall subsequently be revised to reflect actual rate period data and statistics. Indigent care payments will be withheld in instances when a hospital has not submitted required information by the due dates, provided, however, that such payments shall be made upon submission of such required data.

- For purposes of eligibility to receive DSH payments for a rate year or part thereof, the hospital inpatient utilization rate shall be determined based on the base year statistics and costs incurred of furnishing hospital services determined in accordance with the established methodology that is consistent with all federal requirements.

• Extends through December 31, 2014, the authorization to distribute Indigent Care and High Need Indigent Care disproportionate share payments in accordance with the previously approved methodology.

• For state fiscal years beginning April 1, 2011, and for each state fiscal year thereafter, additional medical assistance payments for inpatient hospital services may be made to public general hospitals operated by the State of New York or the State University of New York, or by a county which shall not include a city with a population over one million, and those public general hospitals located in the counties of Westchester, Erie, or Nassau, up to one hundred percent (100%) of each such public hospital's medical assistance and uninsured patient losses after all other medical assistance, including disproportionate share payments to such general hospitals. Payments may be added to rates of payment or made as aggregate payments. Payments will be based initially on reported reconciled data from the base year two years prior to the payment year adjusted for authorized Medicaid rate changes and further reconciled to actual reported data from such payment year.

• Public general hospitals, other than those operated by the State of New York or the State University of New York, that are located in a city with a population of over one million may receive additional medical assistance DSH payments for inpatient hospital services for the state fiscal year beginning April 1, 2011 through March 31, 2012, and annually thereafter, in the amount of up to $120 million, as further increased by up to the maximum payment amounts permitted under sections 1923(f) and (g) of the federal Social Security Act, as determined by the Commissioner of Health after application of all other disproportionate share hospital payments. Payments may be added to rates of payment or made as aggregate payments. Payments will be based initially on reported reconciled data from the base year two years prior to the payment year adjusted for authorized Medicaid rate changes and further reconciled to actual reported data from such payment year.

• Extends current provisions to services on and after April 1, 2011, the reimbursable operating cost component for general hospital inpatient rates will be established with the 2006 final trend factor equal to the final Consumer Price Index (CPI) for all urban consumers less 0.25%.

• The State proposes to extend, effective April 1, 2011, and thereafter, certain cost containment initiatives that were enacted in Chapter 81 of the Laws of 1995 and extended by subsequent legislation. The extended provisions are as follows: (1) hospital capital costs shall exclude 44% of major moveable equipment costs; (2) elimination of reimbursement of staff housing operating and capital costs; and (3) budgeted capital inpatient costs of a general hospital applicable to the rate year shall be decreased to reflect the percentage amount by which the budgeted costs for capital related inpatient costs of the hospital for the base year two years prior to the rate year exceeded actual costs.

• Per federal requirements, the Commissioner of Health shall promulgate regulations effective July 1, 2011 that will deny Medicaid payment for costs incurred for hospital acquired conditions (HACs). The regulations promulgated by the Commissioner shall incorporate the listing of Medicaid HACs in the yet to be issued final federal rule.

• The Commissioner of Health shall promulgate regulations to incorporate quality related measures pertaining to potentially preventable conditions and complications, including, but not limited to, diseases or complications of care acquired in the hospital and injuries sustained in the hospital.

• Effective April 1, 2011, hospital inpatient rates of payment for cesarean deliveries will be limited to the average Medicaid payment for vaginal deliveries. All cesarean claims will be subject to an appeal process to determine if the services were medically necessary thus warranting the higher Medicaid payment.

• Effective April 1, 2011, the Department is proposing to expand the current Patient Centered Medical Home (PCMH) to more payers and incorporate several provisions to improve medical care. Two provisions result in a change in the methods by which Medicaid fee-for-service (FFS) reimburses Medicaid providers who are designated by the National Committee for Quality Assurance as patient centered medical homes: 1) testing new models of payment to high-volume Medicaid primary care medical home practices which incorporate risk-adjusted global payments with care management and pay-for-performance, and 2) improving the relationship of FFS Medicaid members to medical homes by creating medical home payments only for FFS members who have evidence of ongoing continuity relationship with provider/practice and providing more reliable care manage-

ment payments to those providers which are independent of specific visit types. These provisions require the following changes to Medicaid:

- New models of reimbursement to high-volume Medicaid providers will be tested which may incorporate risk-adjusted global payments and pay-for-performance. Risk-adjusted payment models will differentially reimburse providers based on their historical case mix. Pay-for-performance will provide enhanced reimbursement to providers who provide high-quality care (such as improved preventative screenings) and/or reduce unnecessary utilization (such as a reduction in admissions for ambulatory sensitive conditions) as defined by standardized measures of performance; and

- Eligible Medicaid fee-for-service recipients, who are currently receiving care from a certified PCMH provider, as determined by an attribution methodology developed by the Commissioner of Health, will be assigned to this PCMH provider. Medicaid FFS will reimburse PCMH providers a per member per month (PMPM) capitation payment for FFS recipients attributed to their practices to provide the necessary care coordination and disease management services.

• Effective April 1, 2011, for inpatient hospital services the commissioner may grant approval of temporary adjustments to Medicaid rates to provide assistance to accommodate additional patient services requirements resulting from the closure, merger or reconfiguration of other hospitals in the area. Such rate increases would enable the surviving hospital to cover costs, including but not limited to additional staff, service reconfiguration, transfer of medical residents to other programs, increased patient volume, and enhancing information technology (IT) systems.

• The institutional cost report shall no longer be required to be certified by an independent licensed public accountant effective with cost reports filed with the Department of Health for cost reporting years ending on or after December 31, 2010. Effective for the same time periods, the Department will have authority to audit such cost reports.

Long Term Care Services

• Effective for periods on and after July 1, 2011, Medicaid rates of payments for inpatient services provided by residential health care facilities (RHCF), which as of April 1, 2011, operate discrete units for treatment of residents with Huntington's disease, and shall be increased by a rate add-on. The aggregate amount of such rate add-ons for the periods July 1, 2011 through December 31, 2011 shall be $850,000 and for calendar year 2012 and each year thereafter, shall be $1.7 million. Such amounts shall be allocated to each eligible RHCF proportionally, based on the number of beds in each facility's discrete unit for treatment of Huntington's disease relative to the total number of such beds in all such units. Such rate add-ons shall be computed utilizing reported Medicaid days from certified cost reports as submitted to the Department for the calendar year period two years prior to the applicable rate year and, further, such rate add-ons shall not be subject to subsequent adjustment or reconciliation.

• For state fiscal years beginning April 1, 2011, and thereafter, continues additional payments to non-state government operated public residential health care facilities, including public residential health care facilities located in Nassau, Westchester, and Erie counties, but excluding public residential health care facilities operated by a town or city within a county, in aggregate amounts of up to $300 million. The amount allocated to each eligible public RHCF will be in accordance with the previously approved methodology. Payments to eligible RHCF's may be added to rates of payment or made as aggregate payments.

• Continues, effective for periods on or after April 1, 2011, the total reimbursable state assessment on each residential health care facility's gross receipts received from all patient care services and other operating income on a cash basis for inpatient or health-related services, including adult day service, but excluding gross receipts attributable to payments received pursuant to Title XVIII of the federal Social Security Act (Medicare), at six percent. The extent to which a facility is reimbursed for the additional cost of the assessment is dependent upon Medicaid volume of services.

• Continues, effective April 1, 2011, and thereafter, the provision that rates of payment for RHCFs shall not reflect trend factor projections or adjustments for the period April 1, 1996 through March 31, 1997.

• Extends current provisions to services on and after April 1, 2011, the reimbursable operating cost component for RHCFs rates will be established with the final 2006 trend factor equal to the final Consumer Price Index (CPI) for all urban consumers less 0.25%.

• Continues, effective April 1, 2011, and thereafter, long-term care Medicare maximization initiatives.

• Effective April 1, 2011, for inpatient services provided by residential health care facilities (RHCFs), the commissioner may grant approval of temporary adjustments to Medicaid rates to provide assistance to accommodate additional patient services requirements resulting from the closure, merger or reconfiguration of other providers in the area. Such rate increases would enable the surviving RHCF to cover costs, including but not limited to additional staff, service reconfiguration, transfer of medical residents to other programs, increased patient volume, and enhancing information technology (IT) systems.

• The regional pricing methodology previously approved to be effective July 1, 2011 for inpatient services provided by residential health care facilities is repealed and replaced with a Statewide pricing methodology to be effective July 1, 2011.

- The Statewide pricing methodology for the non-capital component of the rates of payment for inpatient services provided by residential health care facilities shall utilize allowable operating costs for a base year, as determined by the Commissioner of Health by regulation, and shall reflect:

• A direct statewide price component adjusted by a wage equalization factor and subject to a Medicaid-only case mix adjustment.

• An indirect statewide price component adjusted by a wage equalization factor; and

• A facility specific non-comparable component.

- The non-capital component of the rates for AIDS facilities or discrete AIDS units within facilities; discrete units for residents receiving care in a long-term inpatient rehabilitation program for traumatic brain injured persons; discrete units providing specialized programs for residents requiring behavioral interventions; discrete units for long-term ventilator dependent residents; and facilities or discrete units within facilities that provide extensive nursing, medical, psychological and counseling support services solely to children shall be established pursuant to regulations.

The Commissioner of Health may promulgate regulations to implement the provisions of the methodology and such regulations may also include, but not be limited to, provisions for rate adjustments or payment enhancements to facilitate the transition of facilities to the rate-setting methodology and for facilitating quality improvements in residential health care facilities.

• Effective April 1, 2011, the capital cost component of Medicaid rates of payment for services provided by residential health care facilities shall not include any payment factor for return on or return of equity or for residual reimbursement.

• Effective January 1, 2012, payments for reserved bed days for temporary hospitalizations, for Medicaid eligible residents aged 21 and older, shall only be made to a residential health care facility if at least fifty percent of the facility's residents eligible to participate in a Medicare managed care plan are enrolled in such a plan. Payments for these reserved bed days will be consistent with current methodology.

Non-Institutional Services

• For State fiscal years beginning April 1, 2011 through March 31, 2012, continues hospital outpatient payment adjustments that increase the operating cost components of rates of payment for hospital outpatient and emergency departments for public general hospitals other than those operated by the State of new York or the State University of New York, which are located in a city with a population of over one million. The eligibility criteria remain unchanged. The amount to be paid will be up to $287 million annually. Payments to eligible public general hospitals may be added to rates of payment or made as aggregate payments.

• Effective April 1, 2011, the Office of Mental Health, the Office of

Alcoholism and Substance Abuse Services, and the Office for People with Developmental Disabilities will each establish utilization standards or thresholds for their voluntary-operated clinics. These standards or thresholds will target excessive utilization and will be either patient-specific or provider-specific, at the option of the controlling State agency. The standards or thresholds will be established based on normative provider visit volume for the clinic type, as determined by the controlling State agency. The Commissioner of Health may promulgate regulations, including emergency regulations, to implement these standards.

• Effective April 1, 2011, claims submitted by clinics licensed under Article 28 of New York State Public Health Law will receive an enhanced Medicaid payment for federally designated family planning services.

• Effective for the period April 1, 2011 through March 31, 2012 and each state fiscal year thereafter, the Department of Health is authorized to make supplemental payments for services provided by physicians, nurse practitioners and physician assistants who participate in a plan for the management of clinical practice at the State University of New York. Fees for these professional services shall be increased by an amount equal to the average commercial or Medicare rate that would otherwise be received for such services rendered by physicians, nurse practitioners and physician assistants. Such included payments may be added to such professional fees or made as aggregate lump sum payments made to eligible clinical practice plans.

• Effective for the period April 1, 2011 through March 31, 2012 and each state fiscal year thereafter, the Department of Health is authorized to make supplemental payments for services provided by physicians, nurse practitioners and physician assistants who are employed by non-state operated public general hospitals operated by a public benefit corporation located in a city of more than one million persons or at a facility of such public benefit corporation as a member of a practice plan under contract to provide services to patients of such a public benefit corporation. Fees for these professional services shall be increased by an amount equal to the average commercial or Medicare rate that would otherwise be received for such services rendered by physicians, nurse practitioners and physician assistants, provided, however, that such supplemental fee payments shall not be available with regard to services provided at facilities participating in the Medicare Teaching Election Amendment. Such included payments may be added to such professional fees or made as aggregate lump sum payments.

• Effective April 1, 2011, hospitals that voluntarily reduce excess staffed bed capacity in favor of expanding the State's outpatient, clinic, and ambulatory surgery services capacity may request and receive a temporary rate enhancement under the ambulatory patient groups (APG) methodology.

• Extends current provisions to services on and after April 1, 2011, the reimbursable operating cost component for general hospital outpatient rates and adult day health care services provided by RHCFs rates will be established with the final 2006 trend factor equal to the final consumer price index (CPI) for all urban consumers less 0.25%.

• Continues, effective April 1, 2011, and thereafter, certain cost containment initiatives currently in effect for Medicaid rates of payments. These are as follows: diagnostic and treatment center and certified home health agency administrative and general cost reimbursement limits; home health care Medicare maximization initiatives; hospital outpatient and emergency department reimbursement reductions attributable to exclusion of 44% of major moveable equipment capital costs; and elimination of staff housing costs.

• The current authority to adjust Medicaid rates of payment for personal care services, provided in local social services districts which include a city with a population of over one million persons and distributed in accordance with memorandums of understanding entered into between the State and such local districts for purpose of supporting recruitment and retention of personal care service workers has been extended for the period April 1, 2011 through March 31, 2014. Payments for the periods April 1, 2011 through March 31, 2012; April 1, 2012 through March 31, 2013; and April 1, 2013 through March 31, 2014, shall not exceed, in the aggregate, $340 million for each applicable period.

• The current authority to adjust Medicaid rates of payment for personal care services, provided in local social services districts which shall not include a city with a population of over one million persons, for purpose of supporting recruitment and retention of personal care service workers has been extended for the period April 1, 2011 through March 31, 2014. Payments for the period April 1, 2011 through March 31, 2012; April 1, 2012 through March 31, 2013; and April 1, 2013 through March 31, 2014, shall not exceed, in the aggregate, $28.5 million for each applicable period.

• The current authority to adjust Medicaid rates of payment for certified home health agencies, AIDS home care programs, and hospice programs for purposes of supporting recruitment and retention of non-supervisory health care workers or any worker with direct patient care responsibility has been extended for the period April 1, 2011 through March 31, 2014. Payments shall not exceed in the aggregate, $100 million for each of the following periods: April 1, 2011 through March 31, 2012; April 1, 2012 through March 31, 2013; and April 1, 2013 through March 31, 2014, and shall be calculated in accordance with the previously approved methodology. Such adjustments to rates of payment shall be allocated proportionally based on each certified home health agency's, AIDS home care and hospice programs' home health aide or other direct care services total annual hours of service provided to Medicaid patients, as reported in each such agency's most recently available cost report as submitted to the Department. Payments made shall not be subject to subsequent adjustment or reconciliation.

• Effective April 1, 2011, for the period April 1, 2011 through June 30, 2011, medical assistance rates of payment to residential health care facilities and diagnostic treatment centers licensed under Article 28 of the Public Health Law for adult day health care services provided to registrants with acquired immunodeficiency syndrome (AIDS) or other human immunodeficiency virus (HIV) related illnesses, shall be increased by an aggregated amount of $1,867,000. Such amount shall be allocated proportionally among such providers based on the medical assistance visits reported by each provider in the most recently available cost reports, submitted to the Department by January 1, 2011. Such adjustments shall be included as adjustments to each provider's daily rate of payment for such services and shall not be subject to subsequent adjustment or reconciliation.

- Effective April 1, 2011, for the period April 1, 2011 through June 30, 2011, rates of payment to residential health care facilities and diagnostic treatment centers licensed under Article 28 of the Public Health Law for adult day health care services provided to registrants with acquired immunodeficiency syndrome (AIDS) or other human immunodeficiency virus (HIV) related illnesses, shall reflect an adjustment to such rates of payment in an aggregate amount of $236,000. Such adjustments shall be distributed proportionally as rate add-ons, based on each eligible provider's Medicaid visits as reported in such provider's most recently available cost report as submitted to the Department prior to January 1, 2011, and provided further, such adjustments shall not be subject to subsequent adjustment or reconciliation.

• Effective April 1, 2011 through March 31, 2012, Medicaid rates of payment for services provided by certified home health agencies (except for such services provided to children under eighteen years of age and other discrete groups as may be determined by the Commissioner of Health) shall reflect agency ceiling limitations. In the alternative, and at the discretion of the Commissioner, such ceilings may be applied to payments for such services.

- The agency ceilings shall be applied to payments or rates of payment for certified home health agency services as established by applicable regulations and shall be based on a blend of:

• an agency's 2009 average per patient Medicaid claims, weighted at a percentage as determined by the Commissioner; and

• the 2009 statewide average per patient Medicaid claims adjusted by a regional wage index factor and an agency patient case mix index, weighted at a percentage as determined by the Commissioner.

- An interim payment or rate of payment adjustment effective April 1, 2011 shall be applied to agencies with projected average per patient Medicaid claims, as determined by the Commissioner, to be over their

ceilings. Such agencies shall have their payments or rates of payment reduced to reflect the amount by which such claims exceed their ceilings.

- The ceiling limitations shall be subject to retroactive reconciliation and shall be based on a blend of:

• agency's 2009 average per patient Medicaid claims adjusted by the percentage of increase or decrease in such agency's patient case mix from the 2009 calendar year to the annual period April 1, 2011 through March 31, 2012, weighted at a percentage as determined by the Commissioner, and

• the 2009 statewide average per patient Medicaid claims adjusted by a regional wage index factor and the agency's patient case mix index for the annual period April 1, 2011 through March 31, 2012, weighted at a percentage as determined by the Commissioner.

- Such adjusted agency ceiling shall be compared to actual Medicaid paid claims for the period April 1, 2011 through March 31, 2012. In those instances when:

• An agency's actual per patient Medicaid claims are determined to exceed the agency's adjusted ceiling, the amount of such excess shall be due from each such agency to the State and may be recouped by the Department in a lump sum amount or through reductions in the Medicaid payments due to the agency.

• An interim payment or rate of payment adjustment was applied to an agency as described above, and such agency's actual per patient Medicaid claims are determined to be less than the agency's adjusted ceiling, the amount by which such Medicaid claims are less than the agency's adjusted ceiling shall be remitted to each such agency by the Department in a lump sum amount or through an increase in the Medicaid payments due to the agency.

- In determining case mix, each patient shall be classified using a system based on measures which may include, but not be limited to, clinical and functional measures, as reported on the federal Outcome and Assessment Information Set (OASIS), as may be amended.

- The Commissioner may require agencies to collect and submit any data, and may promulgate regulations to implement the agency ceilings.

- The payments or rate of payment adjustments described above shall not, as determined by the Commissioner, result in an aggregate annual decrease in Medicaid payments to providers in excess of $200 million.

• Effective April 1, 2012, Medicaid payments for services provided by Certified Home Health Agencies (CHHAs), except for such services provided to children under 18 years of age and other discrete groups, as may be determined by the Commissioner of Health, will be based on episodic payments.

- To determine such episodic payments, a statewide base price will be established for each 60-day episode of care and shall be adjusted by a regional wage index factor and an individual patient case mix index. Such episodic payments may be further adjusted for low utilization cases and to reflect a percentage limitation of the cost for high-utilization cases that exceed outlier thresholds of such payments.

- To achieve savings comparable to the prior state fiscal year, the initial 2012 base year episodic payments will be based on 2009 Medicaid paid claims, as determined by the Commissioner. Such base year adjustments shall be made not less frequently than every three years. However, base year episodic payments subsequent to 2012 will be based on a year determined by the Commissioner that will be subsequent to 2009. Such base year adjustments shall be made not less frequently than every three years.

- In determining case mix, each patient shall be classified using a system based on measures which may include, but not be limited to, clinical and functional measures as reported on the federal Outcome and Assessment Information Set (OASIS).

- The Commissioner may require agencies to collect and submit any data determined to be necessary.

• Effective April 1, 2011, Medicaid rates for services provided by certified home health agencies, or by an AIDS home care program shall not reflect a separate payment for home care nursing services provided to patients diagnosed with Acquired Immune Deficiency Syndrome (AIDS).

• Effective for the period October 1, 2011 through September 30, 2013, pursuant to Section 2703 of the Patient Protection and Affordable Care Act, payments will be made to Managed Long Term Care Plans that have been designated as Health Home providers serving individuals with chronic conditions to cover comprehensive care management, care coordination and health promotion, comprehensive transitional care, patient and family support, referral to community and social support services and the use of health information technology to link services.

• Effective April 1, 2011, the Department is proposing to expand the current Patient Centered Medical Home (PCMH) to more payers and incorporate several provisions to improve medical care. Two provisions result in a change in the methods by which Medicaid fee-for-service (FFS) reimburses Medicaid providers who are designated by the National Committee for Quality Assurance as patient centered medical homes: 1) testing new models of payment to high-volume Medicaid primary care medical home practices which incorporate risk-adjusted global payments with care management and pay-for-performance, and 2) improving the relationship of FFS Medicaid members to medical homes by creating medical home payments only for FFS members who have evidence of ongoing continuity relationship with provider/practice and providing more reliable care management payments to those providers which are independent of specific visit types. These provisions require the following changes to Medicaid.

- New models of reimbursement to high-volume Medicaid providers will be tested which may incorporate risk-adjusted global payments and pay-for-performance. Risk-adjusted payment models will differentially reimburse providers based on their historical case mix. Pay-for-performance will provide enhanced reimbursement to providers who provide high-quality care (such as improved preventative screenings) and/or reduce unnecessary utilization (such as a reduction in admissions for ambulatory sensitive conditions) as defined by standardized measures of performance; and

- Eligible Medicaid fee-for-service recipients, who are currently receiving care from a certified PCMH provider, as determined by an attribution methodology developed by the Commissioner of Health, will be assigned to this PCMH provider. Medicaid FFS will reimburse PCMH providers a per member per month (PMPM) capitation payment for FFS recipients attributed to their practices to provide the necessary care coordination and disease management services.

• Effective October 1, 2011, the Department of Health will update rates paid for Medicaid coverage for preschool and school supportive health services (SSHS). SSHS are provided to Medicaid-eligible students with disabilities in school districts, counties, and State supported § 4201 schools. Payment will be based on a certified public expenditure reimbursement methodology, based on a statistically valid cost study for all school supportive health services and transportation. SSHS are authorized under § 1903(c) of the Social Security Act and include: physical therapy, occupational therapy, speech therapy, psychological evaluations, psychological counseling, skilled nursing services, medical evaluations, medical specialist evaluations, audiological evaluations, and special transportation services.

• Effective April 1, 2011, the Medicaid program is authorized to establish Behavioral Health Organizations (BHOs) to manage behavioral health services. BHOs will be authorized to manage mental health and substance abuse services not currently included in the managed care benefit for Medicaid enrollees in managed care and to facilitate the integration of such services with other health services. The BHOs will also be authorized to manage all mental health and substance abuse services for Medicaid enrollees not in managed care. Behavioral health management will be provided through a streamlined procurement process resulting in contracts with regional behavioral health organizations that will have responsibility for authorizing appropriate care and services based on criteria established by the Offices of Mental Health (OMH) and Alcohol and Substance Abuse Services (OASAS). OMH and OASAS will also be authorized, by April 1, 2013 to jointly designate on a regional basis, a limited number of special needs plans and/or

integrated physical and behavioral health provider systems capable of managing the physical and behavioral health needs of Medicaid enrollees with significant behavioral health needs.

• Effective October 1, 2011, Medicaid will expand coverage of smoking cessation counseling services so that it is available to all Medicaid enrollees. Reimbursement for these services will be available to office based providers, hospital outpatient departments and free-standing diagnostic and treatment centers.

• Effective October 1, 2011 the Department of Health is proposing a change in co-payment policy for Medicaid recipients as permitted in the federal regulations on cost sharing, 42 CFR 447.50 through 447.62. Under this proposal the current copayments will be increased and some services previously exempt from co-payments will be subject to co-payments. The chart below summarizes the current and proposed co-payment structure.

MEDICAID CO-PAYMENTS CURRENT AND PROPOSED

SERVICE OR ITEM	CURRENT AMOUNT	PROPOSED AMOUNT
Clinic Visits	$3.00	$3.40
Brand Name Prescription	$3.00	$3.40
Generic Drug Prescription, and Preferred Brand Name Prescription Drugs	$1.00	$1.15
Over-the-counter Medications	$0.50	$0.60
Lab Tests	$0.50	$0.60
X-Rays	$1.00	$1.15
Medical Supplies	$1.00	$1.15
Overnight Hospital Stays	$25.00 on the last day	$30.00
Emergency Room (for non-emergency room services)	$3.00	$6.40
Additional Services Proposed for Copay		
Eye Glasses	$0.00	$1.15
Eye Exams	$0.00	$1.15
Dental Services	$0.00	$3.40
Audiologist	$0.00	$2.30
Physician Services	$0.00	$3.40
Nurse Practitioner	$0.00	$2.30
Occupational Therapist	$0.00	$2.30
Physical Therapist	$0.00	$3.40
Speech Pathologist	$0.00	$3.40
Annual (SFY) Maximum Limit	$200.00	$300.00

- Other provisions on co-payments as stated in the § 360-7.12 of New York State Social Services Law remain unchanged. The providers of such services may charge recipients the co-payments. However, providers may not deny services to recipients because of their inability to pay the co-payments.

- The following recipients are exempt from co-payments:

• Recipients younger than 21 years of age;

• Recipients who are pregnant;

• Residents of an adult care facility licensed by the New York State Department of Health (for pharmacy services only);

• Residents of a nursing home;

• Residents of an Intermediate Care Facility for the Developmentally Disabled (ICF/DD);

• Residents of an Office of Mental Health (OMH) or Office of People with Developmental Disabilities (OPWDD) certified Community Residence;

• Enrollees in a Comprehensive Medicaid Case Management (CMCM) or Service Coordination Program;

• Enrollees in an OMH or OMRDD Home and Community Based Services (HCBS) Waiver Program; and

• Enrollees in a Department of Health HCBS Waiver Program for Persons with Traumatic Brain Injury (TBI).

- The following services are exempt from co-payments:

• Emergency services;

• Family Planning;

• Drugs to treat mental illness; and

• Services provided through managed care plans.

• Physical therapy, occupational therapy, and speech-language pathology are federal optional Medicaid services. New York State Medicaid presently covers these rehabilitation services with no limits. In order to eliminate delivery of excessive and/or unnecessary services, effective October 1, 2011, the New York State Medicaid Program is establishing utilization limits for the provision of these rehabilitation services. Enrollees will be permitted to receive up to a maximum of 20 visits in a 12 month period each for physical therapy, occupational therapy, and speech-language pathology. The utilization limits will apply to services provided by practitioners in private practice settings as well as for services provided in Article 28 certified hospital outpatient departments and diagnostic and treatment centers (free-standing clinics). The service limits will not apply to services provided in hospital inpatient settings, skilled nursing facilities, or in facilities operated by the Office of Mental Health or the Office of Persons with Developmental Disabilities. Additionally, the utilization limits will not apply for services provided to Medicaid enrollees less than 21 years of age enrollees who are developmentally disabled or to enrollees with specified chronic medical/physical conditions.

• Federal rules allow states the option of reducing coinsurance amounts at their discretion. Effective October 1, 2011, the Department of Health will change the cost-sharing basis for Medicare Part B payments. Currently, New York State Medicaid reimburses practitioners the full or partial Medicare Part B coinsurance amount for enrollees who have both Medicare and Medicaid coverage (the dually-eligible). Medicaid reimburses the Medicare Part B coinsurance, regardless of whether or not the service is covered by Medicaid. Upon federal approval of the proposed state plan change, Medicaid will no longer reimburse practitioners for the Medicare Part B coinsurance for those services that are not covered for a Medicaid-only enrollee. Medicaid presently reimburses Article 28 certified clinics (hospital outpatient departments and diagnostic and treatment centers) the full Medicare Part B coinsurance amount. The full coinsurance is paid by Medicaid, even if the total Medicare and Medicaid payment to the provider exceeds the amount that Medicaid would have paid if the enrollee did not have both Medicare and Medicaid coverage. Under the new reimbursement policy, Medicaid will provide payment for the Medicare Part B coinsurance amount, but the total Medicare/Medicaid payment to the provider will not exceed the amount that the provider would have received if the patient had Medicaid-only coverage. Therefore, if the Medicare payment exceeds what Medicaid would have paid for the service, no coinsurance will be paid by Medicaid. Practitioners and clinics will be required to accept the total Medicare and Medicaid payment (if any) as full payment for services. They will be prohibited from billing the Medicaid recipient.

• Effective October 1, 2011, the Department of Health, in collaboration with the Office of Mental Health, the Office of Alcohol and Substance Abuse Services, and the Office for People with Developmental Disabilities, will be authorized to begin Medicaid coverage for health home services to high cost, high need enrollees. Health home services include comprehensive care coordination for medical and behavioral health services, health promotion, transitional care, including appropriate follow-up from inpatient to other settings, patient and family support, referral to community and social support services, and use of health information technology to link services.

- High risk patients will be assigned to provider networks meeting state and federal health home standards (on a mandatory or opt out basis) for the provision of health home services.

- These services will range from lower intensity patient tracking to higher intensity care/service management depending on patient needs.

The provision of coordinated, integrated physical and behavioral health services will be critical components of the health home program. Strong linkages to community resources will be a health home requirement. Use of peer supports will be explored to help enrollees in the community cope with their medical and behavioral health conditions. The Managed Addiction Treatment Program (MATS), which manages access to treatment for high cost, chemically dependent Medicaid enrollees, will be expanded. Health home payment will be based on a variety of reimbursement methodologies including care coordination fees, partial and shared risk. The focus of the program will be reducing avoidable hospitalizations, institutionalizations, ER visits, and improving health outcomes.

- Payment methodologies for health home services shall be based on factors including, but not limited to, complexity of conditions providers will be managing, the anticipated amount of patient contact needed to manage such conditions, and the health care cost savings realized by provision of health home services.

- The Commissioner of Health is authorized to pay additional amounts to providers of health home services that meet process or outcomes standards specified by the Commissioner.

- Through a collaborative effort, the Department of Health, with the Office of Mental Health, Office of Alcohol and Substance Abuse Services, and the Office for People with Developmental Disabilities, will streamline existing program requirements that create barriers to co-locating medical and behavioral health services in licensed facilities to support improved coordination and integration of care.

• Effective for dates of service on and after April 1, 2011, coverage for prescription footwear and footwear inserts and components for adults age 21 and over will be limited to diabetic footwear or when the footwear is attached to a lower limb orthotic brace. This will reduce overutilization of footwear. Effective for dates of service on and after May 1, 2011, the DOH will establish maximum fees for prescription footwear, inserts and components. The fees will be based on an average of industry costs of generically equivalent products.

• Effective for dates of service on and after April 1, 2011, coverage of enteral formula for adults age 21 and over will be limited to formula administered by feeding tube or formula for treatment of an inborn metabolic disease. This will preserve coverage for medical need and eliminate coverage of orally consumed formulas for adults who can obtain nutrients through other means.

• Effective for dates of service on and after April 1, 2011, coverage of compression and support stockings will be limited to treatment of open wounds or for use as a pregnancy support. Coverage of stockings will not be available for comfort or convenience.

• Effective on and after July 1, 2011, the Department will choose selected transportation providers to deliver all necessary transportation of Medicaid enrollees to and from dialysis, at a per trip fee arrived through a competitive bid process. The Department will choose one or more transportation providers in a defined community to deliver necessary transportation of Medicaid enrollees to and from dialysis treatment. The enrollee's freedom to choose a transportation provider will be restricted to the selected provider(s) in the community. Medicaid enrollee access to necessary transportation to dialysis treatment will not be impacted by this change.

Prescription Drugs

• Effective April 1, 2011, the following is proposed:

- For sole or multi-source brand name drugs the Estimated Acquisition Cost (EAC) is defined as Average Wholesale Price (AWP) minus seventeen (17) percent and the Average Acquisition Cost (AAC) will be incorporated into the prescription drug reimbursement methodology;

- The dispensing fees paid for generic drugs will be $3.50; and

- Specialized HIV pharmacy reimbursement rates will be discontinued and a pharmacy previously designated as a specialized HIV pharmacy will receive the same reimbursement as all other pharmacies.

The estimated annual net aggregate decrease in gross Medicaid expenditures attributable to reform and other initiatives contained in the budget for state fiscal year 2011/2012 is $223 million; and the estimated annual net aggregate increase in gross Medicaid expenditures attributable to an extension of pertinent disproportionate share (DSH) and upper payment limit (UPL) payments for state fiscal year 2011/2012 is $1.9 billion.

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: Department of Health, Bureau of HCRA Operations & Financial Analysis, Corning Tower Bldg., Rm. 984, Empire State Plaza, Albany, NY 12237, (518) 474-1673, (518) 473-8825 (FAX), e-mail: spa_inquires@health.state.ny.us

SALE OF FOREST PRODUCTS

Chenango Reforestation Area No. 1
Contract No. X008135

Pursuant to Section 9-0505 of the Environmental Conservation Law, the Department of Environmental Conservation hereby gives Public Notice for the following:

Sealed bids for 21 tons more or less red pine, 32.6 MBF more or less white ash, 23.6 MBF more or less black cherry, 15.2 MBF more or less red maple, 10.0 MBF more or less sugar maple, 0.3 MBF more or less yellow birch, 0.5 MBF more or less basswood, 0.1 MBF more or less aspen, 233 cords more or less firewood, located on Chenango Reforestation Area No. 1, Stands C-27, D-25 and D-28, will be accepted at the Department of Environmental Conservation, Contract Unit, 625 Broadway, 10th Fl., Albany, NY 12233-5027 until 11:00 a.m. on Thursday, April 7, 2011.

For further information, contact: Robert Slavicek, Supervising Forester, Department of Environmental Conservation, Division of Lands and Forests, Region 7, 2715 State Hwy. 80, Sherburne, NY 13460-4507, (607) 674-4036

SALE OF FOREST PRODUCTS

Lewis Reforestation Area No. 20
Contract No. X008125

Pursuant to Section 9-0505 of the Environmental Conservation Law, the Department of Environmental Conservation hereby gives Public Notice of the following:

PUBLIC NOTICE
Department of Health

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

The Department of Health proposes to amend the Title XIX (Medicaid) State Plan with respect to the provision of targeted case management services in accordance with the Deficit Reduction Act of 2005 and regulations promulgated by the Centers for Medicare and Medicaid Services (CMS). The following changes are proposed:

Non-Institutional Services

- Case management services include assessment, development of a care plan, referral to needed services and monitoring. The proposed amendment will ensure that targeted case management services are provided in accordance with the statutory definition of case management adopted in the Deficit Reduction Act of 2005.
- The proposed amendment adds the county of Onondaga to the First-time Mothers/Newborns targeted case management program.
- The proposed amendment clarifies the requirement that all RNs are required to possess a Bachelor of Science in Nursing (BSN) degree for employment in the First-time Mothers/Newborns program, but adds that in limited circumstances, an RN who does not have a BSN but has a specific language competency may be hired to provide care to an under-served population with specific language needs. Specific criteria for this exception are described in this amendment.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this proposed initiative for State fiscal year 2011/2012 is $6 million.

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

Copies of the proposed state plan amendment 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: Department of Health, Bureau of HCRA Operations & Financial Analysis, Corning Tower Building, Rm. 984, Empire State Plaza, Albany, NY 12237, (518) 474-1673, (518) 473-8825 (fax), spa_inquiries@health.state.ny.us

PUBLIC NOTICE
Department of Health

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

The Department of Health proposes to amend the Title XIX (Medicaid) State Plan for long--term care services to comply with enacted statutory provisions. The following provides clarification to provisions previously noticed on April 27, 2011, and notification of new significant changes:

Long-Term Care Services

- The statewide pricing methodology for inpatient services provided by non-specialty residential health care facilities will be effective on January 1, 2012.
  - The statewide pricing methodology for the non-capital component of the rates of payment for inpatient services provided by non-specialty residential health care facilities shall reflect a direct statewide price, an indirect statewide price and a facility-specific non-comparable component, determined as follows:
    - A direct statewide price component, which shall consist of a blended price, to be determined as follows:
      - o 50% of the direct price component that is based upon 2007 allowable costs for all non-specialty facilities; and
      - o either 50% of a direct price component that is based upon 2007 allowable costs for hospital-based facilities and facilities with 300 or more beds, or 50% of a direct price component that is based upon 2007 allowable costs for all non-specialty facilities, excluding hospital-based facilities and facilities with 300 or more beds, as applicable.
      - o The direct statewide price shall be adjusted by a wage equalization factor which shall be a blend of 50% of a facility-specific wage equalization factor and 50% of regional wage equalization factor as determined by the Commissioner by regulation. As defined by regulation, there shall be 16 regions used to determine the regional wage equalization factor, and the facility-specific and regional wage equalization factor adjustments shall use data reported for 2009.
      - o The direct statewide price shall also be adjusted by a Medicaid-only case mix. The prices effective January 1, 2012 shall utilize case mix data for January 1, 2011. Thereafter, the direct statewide price shall be updated for a Medicaid-only case mix in July and January of each year, using the case mix data applicable to the previous period (e.g., July 2012 case mix adjustment shall use the January 1, 2012 case mix data, the January 1, 2013 case mix shall use the July 2012 case mix data, etc.).
    - An indirect statewide price component, which shall consist of a blended price, to be determined as follows:
      - o 50% of the indirect price component that is based upon 2007 allowable costs for all non-specialty facilities; and
      - o either 50% of a indirect price component that is based upon 2007 allowable costs for hospital-based facilities and facilities with 300 or more beds or 50% of a indirect price component that is based upon 2007 allowable costs for non-specialty facilities, excluding hospital-based facilities and facilities with 300 or more beds, as applicable.
      - o The indirect statewide price shall be adjusted by a wage equalization factor which shall be a blend of 50% of a facility-specific wage equalization factor and 50% of regional wage equalization factor as determined by the Commissioner by regulation. As defined by regulation, there shall be 16 regions used to determine the regional wage equalization factor, and the facility-specific and regional wage equalization factor adjustments shall use data reported for 2009.
  - The rate shall be adjusted to reflect per diem add-ons for dementia, bariatric, and traumatic brain injury patients, as defined by regulation, of $8 per day, $17 per day, and $36 per day, respectively. Such adjustments will be made using case mix data and will be made at the same time that the direct component of the rate is adjusted for case mix as described above.
  - The non-comparable component of the rate shall be based upon facility-specific 2007 allowable costs as determined by regulation.

- The statewide pricing methodology described above will reflect a six-year transition period.
- As determined by regulation, the Commissioner shall also establish an annual quality pool. In 2012, the rate shall include an adjustment for the reporting by facilities of data related to established quality indicators and benchmarks. Beginning in 2013, the Commissioner will develop regulations to annually distribute quality pool funds to facilities that improve or maintain quality against the indicators and benchmarks.
- The non-capital component of the "specialty" rates for AIDS facilities or discrete AIDS units within facilities; discrete units for residents receiving care in a long-term inpatient rehabilitation program for traumatic brain injured persons; discrete units providing specialized programs for residents requiring behavioral interventions; discrete units for long-term ventilator dependent residents; and facilities or discrete units within facilities that provide extensive nursing, medical, psychological and counseling support services solely to children shall be the rates in effect on January 1, 2009 and adjusted for applicable rate appeals. Such rates shall not be subject to case mix adjustments. The AIDS rates in effect January 1, 2009 shall be adjusted to reflect the elimination of the AIDS occupancy factor enacted in 2009.
- The Commissioner may promulgate regulations, including emergency regulations, to implement the provisions of the methodology.

The non-capital component of the rates described for non-specialty facilities under the statewide pricing methodology and for specialty facilities shall be subject to the residential health care facility cap, thus there is no increase or decrease in gross Medicaid expenditures for state fiscal year 2011-12.

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

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95 Central Avenue, St. George
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For further information and to review and comment, please contact: Department of Health, Bureau of HCRA Operations & Financial Analysis, Corning Tower Building, Rm. 984, Empire State Plaza, Albany, NY 12237, (518) 474-1673, (518) 473-8825 (fax), spa_inquiries@health.state.ny.us

PUBLIC NOTICE

Monroe County

Notice of Draft Request for Proposals (RFP)

NOTICE IS HEREBY GIVEN, that sealed proposals are sought and requested by the County of Monroe for the performance of the following contract, according to terms of the RFP:

PROPOSAL FOR THE OPERATION AND MAINTENANCE OF THE MONROE COUNTY RECYCLING CENTER AND PROGRAM

Monroe County is soliciting proposals for the Operation and Maintenance of the County Recycling Center and Program for a Contract with a minimum term of approximately six (6) years, unless Respondents can justify a longer-term Contract, such as by capital investment, up to a maximum of twenty-five (25) years. These operations include the receiving, processing, marketing and residual disposal associated with residential-generated recyclables collected by private and public haulers. Prospective Respondents must offer a proposal that will meet the scope of services, qualifications and general description of work activities identified in the Request for Proposals (RFP).

Prior to release of the final version of the RFP, the RFP will be available in draft form on December 30, 2011. This draft RFP is issued pursuant to the provisions of New York General Municipal Law (NY GML) § 120-w.

The draft RFP will be available for download from the Monroe County website, at http://www.monroecounty.gov/bid/rfps. Individuals must register through the Monroe County website to obtain the PDF version of the draft RFP. In addition, the draft RFP will be on file at the Monroe County Clerk's Office, 39 West Main Street, Room 101, Rochester, NY, 14614.

Monroe County is soliciting comments and questions on the draft by February 28, 2012. All comments and questions regarding the draft RFP from prospective Respondents and the public are due to the RFP Coordinator in accordance with the requirements listed in the draft RFP, and will be incorporated as appropriate into the final RFP, or filed with the final RFP, as set forth in the draft RFP. Any verbal or other communication sent or made to anyone other than to the RFP Coordinator will not be considered and may be cause for rejection of the Respondent's proposal.

A pre-proposal meeting and site tour will be conducted on January 24, 2011 at 1:00 PM. Individuals who would like to attend the tour must RSVP by January 20, 2011. Details regarding RSVPs and the pre-proposal meeting and site tour will be available in the draft RFP.

The final Request for Proposals (RFP) will be released in accordance with the timeline and regulations set forth in New York General Municipal Law (NY GML) § 120-w. Final RFP submissions from Respondents must be received in accordance with the specifications contained within the final RFP.

PUBLIC NOTICE

Village of Old Westbury

The Village of Old Westbury is soliciting 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 Village of Old Westbury meeting the requirements of Section 457 of the Internal Revenue Code and Section 5 of the New York State Finance Law, including all rules and regulations issued pursuant thereto.

A copy of the proposal questionnaire may be obtained from: Kenneth Callahan, Village Administrator, Village of Old Westbury, One Store Hill Road, Old Westbury, NY 11568

All proposals must be submitted not later than thirty (30) days from the date of publication in the New York State Register by 4:30 p.m.

PUBLIC NOTICE

Department of State

F-2011-0833a - Rescinding Public Notice F-2011-0833
Date of Issuance - December 28, 2011

The New York State Department of State (DOS) is rescinding the public notice issued December 14, 2011, for the activities described below, which are subject to the consistency provisions of the Federal Coastal Zone Management Act of 1972, as amended.

The applicant has certified that the proposed activity complies with and will be conducted in a manner consistent with the approved New

Appendix V
2012 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 #11-23-A

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 general appropriation received by the State agency that oversees medical assistance (Medicaid), which is the Department of Health. The source of the appropriation is the Local Assistance Account under the General Fund/Aid to Localities.

3. **Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan. If**

supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to each provider type.

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

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

   Response: Based on guidance from CMS, the State and CMS staff will engage in discussions to develop a strategic plan to complete the appropriate UPL demonstration for 2012.

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

   Response: The rate methodology included in the approved state plan for 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.

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.**

Does New York comply with the conditions of the MOE provision of section 1902(gg) of the Act for continued funding under the Medicaid program?

Response: The State 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.**

Would any existing approved plan provisions or State law violate these provisions, if they remained in effect on or after January 1, 2014?

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

12. **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.