



## Department of Health

**ANDREW M. CUOMO**  
Governor

**HOWARD A. ZUCKER, M.D., J.D.**  
Commissioner

**SALLY DRESLIN, M.S., R.N.**  
Executive Deputy Commissioner

DEC 3 1 2018

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

RE: SPA #18-0042  
Long Term Care

Dear Mr. Cooley:

The State requests approval of the enclosed amendment #18-0042 to the Title XIX (Medicaid) State Plan for long term care facility services to be effective January 1, 2019 (Appendix I). This amendment is being submitted based on proposed legislation. A summary of the proposed amendment is provided in Appendix II.

This amendment is submitted pursuant to §1902(a) of the Social Security Act (42 USC 1396a(a)) and Title 42 of the Code of Federal Regulations, Part 447, Subpart C, (42 CFR §447).

A copy of the pertinent section of proposed State legislation is enclosed for your information (Appendix III). Copies of the public notice of this proposed amendment, which was given in the New York State Register on March 29, 2017 and May 10, 2017, is also enclosed for your information (Appendix IV). In addition, responses to the five standard funding questions and standard access questions are also enclosed (Appendix V and VI, respectively).

If you have any questions regarding this State Plan Amendment submission, please do not hesitate to contact Regina Deyette, Medicaid State Plan Coordinator, Division of Finance and Rate Setting, Office of Health Insurance Programs at (518) 473-3658.

Sincerely,

Donna Frescatore  
Medicaid Director  
Office of Health Insurance Programs

Enclosures  
cc: Mr. Michael Melendez  
Mr. Tom Brady

**TRANSMITTAL AND NOTICE OF APPROVAL OF  
STATE PLAN MATERIAL  
FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES**

1. TRANSMITTAL NUMBER  
1 8 — 0 0 4 2

2. STATE  
New York

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

TO: REGIONAL ADMINISTRATOR  
CENTERS FOR MEDICARE & MEDICAID SERVICES  
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE  
January 1, 2019

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

NEW STATE PLAN       AMENDMENT TO BE CONSIDERED AS NEW PLAN       AMENDMENT

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

6. FEDERAL STATUTE/REGULATION CITATION  
§1902(a) of the Social Security Act, and 42 CFR 447

7. FEDERAL BUDGET IMPACT  
a. FFY 01/01/19-09/30/19 \$ (5,268)  
b. FFY 10/01/19-09/30/20 \$ (7,024)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT  
Attachment 4.19-C – Page 1, Page 1.1  
Attachment 4.19-D – Page 110(d)(23)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (*If Applicable*)  
Attachment 4.19-C – Page 1  
Attachment 4.19-D – Page 110(d)(23)

10. SUBJECT OF AMENDMENT  
Elimination of LTC Bed Hold  
(FMAP=50%)

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

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

12. SIGNATURE OF STATE AGENCY OFFICIAL

13. TYPED NAME  
Donna Frescatore

14. TITLE  
Medicaid Director, Department of Health

15. DATE SUBMITTED  
DEC 31 2018

16. RETURN TO  
New York State Department of Health  
Division of Finance and Rate Setting  
99 Washington Ave – One Commerce Plaza  
Suite 1432  
Albany, NY 12210

**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED

18. DATE APPROVED

**PLAN APPROVED - ONE COPY ATTACHED**

19. EFFECTIVE DATE OF APPROVED MATERIAL

20. SIGNATURE OF REGIONAL OFFICIAL

21. TYPED NAME

22. TITLE

23. REMARKS

**Appendix I**  
**2018 Title XIX State Plan**  
**Second Quarter Amendment**  
**Amended SPA Pages**

**PAYMENT FOR RESERVED BEDS IN MEDICAL INSTITUTIONS****LIMITATIONS**

**A. RESERVED BEDS DURING LEAVES OF ABSENCE** (Defined to mean overnight absences including visits with relatives/friends, or leaves to participate in medically acceptable therapeutic or rehabilitative plans of care).

When patient's/resident's plan of care provides for leaves of absence:

**General Hospital Patients**

Eligibility restricted to patients receiving care in certified psychiatric or rehabilitation units, without consideration of any vacancy rate. A psychiatric patient must be institutionalized for 15 days during a current spell of illness; a rehabilitation patient must be institutionalized for 30 days. Leaves must be for therapeutic reasons only and carry a general limitation of no more than 18 days in any 12 month period, and 2 days per any single absence. Broader special limits are possible when physicians can justify them, subject to prior approval.

**Nursing Facility (NF) Patients**

A reserved bed day is a day for which a governmental agency pays a residential health care facility to reserve a bed for a person eligible for medical assistance while he or she is temporarily hospitalized or on leave of absence from the facility. All such reserve bed days during leaves of absences [shall] will be pursuant to the residents' plan of care.

All recipients are eligible after 30 days in the facility, subject to a facility vacancy rate, on the first day of the patient's/resident's absence of no more than 5%.

Effective July 1, 2012, for reserved bed days provided on behalf of persons 21 years of age or older:

- (i) payments for reserved bed days related to hospitalization will be made at 50% of the Medicaid rate, and payments for reserved bed days related to non-hospitalization leaves of absence will be made at 95% of the Medicaid rate otherwise payable to the facility for services provided to such person;
- (ii) payment to a facility for reserved bed days provided for such person for hospitalizations and therapeutic leave that is consistent with a plan of care ordered by the patient's treating health care professional for visits to a health care professional that is expected to improve the patients' physical condition or quality of life may not exceed 14 days in any 12-month period; and
- (iii) payment to a facility for reserved bed days for patients on leave for purposes other than hospitalization or eligible therapeutic leave may not exceed 10 days in any 12-month period.
- (iv) Broader special limits are possible when physicians can justify them, subject to prior approval.

The above payment methodology will sunset effective December 31, 2018.

[Reserved bed days provided on behalf of persons younger than 21 years of age will be made at 100% of the Medicaid rate.

In computing reserved bed days, the day of discharge from the residential health care facility shall be counted, but not day of readmission.]

TN     #18-0042    

Approval Date \_\_\_\_\_

Supersedes TN     #12-0024    

Effective Date \_\_\_\_\_

New York  
Page 1.1

Effective January 1, 2019, for reserved bed days provided on behalf of persons 21 years of age or older:

(i) payments for reserved bed days for patients on hospice will be made at 50% of the Medicaid rate otherwise payable to the facility for the services provided to such person.

(a) payment to a facility for reserved bed days provided on behalf of such person for leaves of absences may not exceed 14 days in any 12 – month period.

(ii) payments for reserved bed days related to therapeutic leaves of absence will be made at 95% of the Medicaid rate otherwise payable to the facility for services provided to such person.

(a) payment to a facility for reserved bed days provided on behalf of such person for therapeutic leaves of absences may not exceed 10 days in any 12-month period.

Reserved bed days provided on behalf of persons younger than 21 years of age will be made at 100% of the Medicaid rate.

In computing reserved bed days, the day of discharge from the residential health care facility will be counted, but not day of readmission.

TN # 18-0042 \_\_\_\_\_

Approval Date \_\_\_\_\_

Supersedes TN NEW \_\_\_\_\_

Effective Date \_\_\_\_\_

New York  
110(d)(23)

**Per Diem Reduction to all qualified facilities.**

- (a) Qualified facilities are residential health care facilities other than those facilities or units within facilities that provide extensive nursing, medical, psychological and counseling support services solely to children.
- (b) Effective January 1, 2013, all qualified residential health care facilities will be subject to a per diem adjustment that is calculated to reduce Medicaid payments by \$24 million for the period January 1, 2013 through March 31, 2013.

Effective April 1, 2013, all qualified residential health care facilities will be subject to a per diem adjustment that is calculated to reduce Medicaid payments by \$19 million for each state fiscal year beginning April 1, 2013.

- (c) An interim per diem adjustment for each facility will be calculated as follows:
  - (1) For each such facility, facility Medicaid revenues, calculated by multiplying each facility's promulgated rate in effect for such period by reported Medicaid days as reported in a facility's most recently available cost report, will be divided by total Medicaid revenues of all qualified facilities. The result will be multiplied by the amount of savings identified above for each such fiscal year, and divided by each facility's most recently reported Medicaid days.
  - [ (2) Following the close of each fiscal year, the interim per diem adjustment effective January 1, 2013 through March 31, 2013, and April 1, 2013 through March 31, 2014 and in each state fiscal year thereafter will be reconciled using actual Medicaid claims data to determine the actual combined savings from the per diem adjustment and from the reduction in the payment for reserve bed days for hospitalizations from 95% to 50% of the Medicaid rate for such fiscal year. To the extent that such interim savings is greater than or less than \$40 million, the per diem adjustment for each eligible provider in effect during such prior fiscal year will be adjusted proportionately such that \$40 million in savings is achieved.]

TN # 18-0042 \_\_\_\_\_

Approval Date \_\_\_\_\_

Supersedes TN #12-0024 \_\_\_\_\_

Effective Date \_\_\_\_\_

**Appendix II**  
**2018 Title XIX State Plan**  
**Second Quarter Amendment**  
**Summary**

**SUMMARY**  
**SPA #18-0042**

This State Plan Amendment proposes to clarify rates of payment for LTC bed reservation.



**Appendix III**  
**2018 Title XIX State Plan**  
**Second Quarter Amendment**  
**Authorizing Provisions**

SPA #18-0042

CHAPTER 56 OF THE LAWS OF 2018 - Part D

25. Reserved bed days. (a) For purposes of this subdivision, a "reserved bed day" is a day for which a governmental agency pays a residential health care facility to reserve a bed for a person eligible for medical assistance pursuant to title eleven of article five of the social services law while he or she is on therapeutic leave of absence from the facility.

(b) Notwithstanding any other provisions of this section or any other law or regulation to the contrary, for reserved bed days provided on behalf of persons twenty-one years of age or older:

(i) payments for reserved bed days shall be made at ninety-five percent of the Medicaid rate otherwise payable to the facility for services provided on behalf of such person; and

(ii) payment to a facility for reserved bed days provided on behalf of such person for therapeutic leaves of absence may not exceed ten days in any twelve month period.

**Appendix IV**  
**2018 Title XIX State Plan**  
**Second Quarter Amendment**  
**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](http://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 2017 will be conducted on April 11 and April 12 commencing at 10:00 a.m. This meeting will be conducted at NYS Media Services Center, Suite 146, South Concourse, Empire State Plaza, Albany, NY with live coverage available at <https://www.cs.ny.gov/commission/>.

For further information, contact: Office of Commission Operations, Department of Civil Service, Empire State Plaza, Agency Bldg. 1, Albany, NY 12239, (518) 473-6598

## PUBLIC NOTICE Division of Criminal Justice Services Commission on Forensic Science

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

Date: April 12, 2017  
Time: 9:00 a.m.-1:00 p.m.  
Place: Division of Criminal Justice Services  
Alfred E. Smith Office Bldg.  
CrimeStat Rm. 118  
80 S. Swan St.  
Albany, NY

Video Conference with:  
Empire State Development Corporation  
(ESDC)

633 3rd Ave.  
37th Fl./Conference Rm.  
New York, NY

\*Identification and sign-in is required at this location. For further information, or if you need a reasonable accommodation to attend this meeting, contact: Catherine White, Division of Criminal Justice Services, Office of Forensic Services, 80 S. Swan St., Albany, NY 12210, (518) 485-5052

## PUBLIC NOTICE Division of Criminal Justice Services DNA Subcommittee

Pursuant to Public Officers Law section 104, the Division of Criminal Justice Services gives notice of a meeting of the DNA Subcommittee to be held on:

Date: March 27, 2017  
Time: 8:30 a.m.-1:00 p.m.  
Place: Empire State Development Corporation  
(ESDC)  
633 3rd Ave.  
37th Fl. Board Rm.  
New York, NY

Identification and sign-in are required at this location. For further information, or if you need a reasonable accommodation to attend this meeting, contact: Catherine White, Division of Criminal Justice Services, Office of Forensic Services, 80 S. Swan St., Albany, NY, (518) 485-5052

## PUBLIC NOTICE Department of Health

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

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

### All Services

- Effective on and after April 1, 2017, no greater than zero trend factors attributable to services through March 31, 2020 pursuant to the provisions of Public Health Law § 2807-c(10)(c) to rates of payment for hospital inpatient and outpatient services, inpatient and adult day health care outpatient services provided by residential health care facilities pursuant to Article 28 of the Public Health Law, except for residential health care facilities or units of such facilities providing services primarily to children under 21 year of age, certified home health agencies, AIDS home care programs, and for personal care services pursuant to section 365-a of the Social Services Law, including 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, and assisted living program services.

The annual decrease in gross Medicaid expenditures for state fiscal year 2017/2018 is (\$208.8) million.

#### Institutional Services

- For the state fiscal year beginning April 1, 2017 through March 31, 2018, continues specialty hospital adjustments for hospital inpatient services provided on and after April 1, 2012, to public general hospitals, other than those operated by the State of New York or the State University of New York, located in a city with a population of over one million and receiving reimbursement of up to \$1.08 billion annually based on criteria and methodology set by the Commissioner of Health, which the Commissioner may periodically set through a memorandum of understanding with the New York City Health and Hospitals Corporation. Payments to eligible public general hospitals may be added to rates of payment or made as aggregate payments.

- Extends current provisions for services on and after April 1, 2017 through March 30, 2020, 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 estimated annual net decrease in gross Medicaid expenditures attributable to these cost containment initiatives contained in the budget for state fiscal year 2017/2018 is (\$114.5) million.

- Effective April 1, 2017, continues the supplemental upper payment limit payments made to general hospitals, other than major public general hospitals under institutional services of \$339 million annually.

- Capital related costs of a general hospital excluding 44% of the major movable costs and excluding staff housing costs will continue effective April 1, 2017 through March 31, 2020.

The estimated gross annual decrease in Medicaid expenditures for state fiscal year 2017/2018 for this initiative is (\$48.4) million.

- Budgeted capital inpatient costs of a general hospital applicable to the rate year will be decreased to reflect the percentage amount by which the budget for the base year two years prior to the rate year for capital related inpatient expenses of the hospital exceeded actual expenses will continue effective April 1, 2017 through March 31, 2020.

The estimated gross annual decrease in Medicaid expenditures for state fiscal year 2017/2018 for this initiative is (\$15.9) million.

#### Long Term Care Services

- For state fiscal year beginning April 1, 2017, 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 \$500 million. The amount allocated to each eligible public RHCF will be in accordance with the previously approved methodology, provided, however that patient days shall be utilized for such computation reflecting actual reported data for 2014 and each representative succeeding year as applicable. Payments to eligible RHCF's may be added to rates of payment or made as aggregate payments.

- The quality incentive program for non-specialty nursing homes will continue for the 2017 rate year to recognize improvement in performance as an element in the program and provide for other minor modifications.

There is no additional estimated annual change to gross Medicaid expenditures attributable to this initiative for state fiscal year 2017/2018.

- This proposal eliminates the reimbursement to Nursing Homes for bed hold days through the repeal of PHL § 2808(25).

The estimated annual net decrease in gross Medicaid expenditures attributable to these cost containment initiatives contained in the budget for state fiscal year 2017/2018 is (\$22) million.

- Continues, effective for periods on and after April 1, 2017, 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.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2017/2018 is \$513 million.

- The following is notice of the continuation of the Advanced Training Program (ATI). First introduced in State fiscal year 2015/2016, ATI is a training program aimed at teaching staff to detect early changes in a resident's physical, mental, or functional status that could lead to hospitalization. Clinical findings show early detection of patient decline by front line workers, couple with clinical care models aimed at fostering consistent and continuous care between care givers and patients results in better care outcomes.

Training programs and their curricula from the previous ATI program may be used by facilities, new training programs will be submitted for Department review. In addition to offering a training program, eligible facilities must also have direct care staff retention above the statewide median. Hospital-based facilities and those receiving VAP funds will not be eligible to participate.

The estimated net aggregate cost contained in the budget for the continuation of the ATI program for 2017/2018 is \$46 million.

- The rates of payment for RHCFS shall not reflect trend factor projections or adjustments for the period April 1, 1996 through March 31, 1997 and continues the provision effective on and after April 1, 2017 through March 31, 2020.

The estimated annual net aggregate decrease in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2017/2018 is (\$12,749,000) million.

- Extends current provisions to services on and after April 1, 2017, 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%.

The estimated annual net decrease in gross Medicaid expenditures attributable to these cost containment initiatives contained in the budget for state fiscal year 2017/2018 is (\$15,355,637) million.

#### Non-Institutional Services

- For state fiscal year beginning April 1, 2017 through March 31, 2018, continues hospital outpatient payment adjustments that increase the operating cost components of rates of payment for hospital outpatient and emergency departments on and after April 1, 2011, 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 amount to be paid will be up to \$287 million annually based on criteria and methodology set by the Commissioner of Health, which the Commissioner may periodically set through a memorandum of understanding with the New York City Health and Hospitals Corporation. Payments may be added to rates of payment or made as aggregate payments.

- For the state fiscal year beginning April 1, 2017 through March 31, 2018, continues upon the election of the social services district in which an eligible diagnostic and treatment center (DTC) is physically located, up to \$12.6 million in additional annual Medicaid payments may be paid to public DTCs operated by the New York City Health and Hospitals Corporation. Such payments will be based on each DTC's proportionate share of the sum of all clinic visits for all facilities eligible for an adjustment for the base year two years prior to the rate year. The proportionate share payments may be added to rates of payment or made as aggregate payments to eligible DTCs.

- For the state fiscal year beginning April 1, 2017 through March 31, 2018, continues up to \$5.4 million in additional annual Medicaid payments may be paid to county operated free-standing clinics, not including facilities operated by the New York City Health and Hospitals Corporation, for services provided by such DTC and those

provided by a county operated freestanding mental health or substance abuse DTC. Distributions shall be based on each eligible facility's proportionate share of the sum of all DTC and clinic visits for all eligible facilities receiving payments for the base year two years prior to the rate year. The proportionate share payments may be added to rates of payment or made as aggregate payments to eligible facilities.

- Effective on or after April 1, 2017, eliminates supplemental medical assistance payments of up to \$6 million annually made to providers of emergency medical transportation.

- Continues, effective for periods on and after April 1, 2017, funds to certified home health agencies, AIDS home care providers, and hospice service providers for the purpose of improving recruitment, training, and retention of home health aides or other personnel with direct patient care responsibility.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2017/2018 is \$26 million.

- Extends current provisions to services on and after April 1, 2017 through March 30, 2020, the reimbursable operating cost component for general hospital outpatient rates and adult day health care services provided by RHCs 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%.

- Extends current provisions for certified home health agency administrative and general cost reimbursement limits for the periods April 1, 2017 through March 31, 2020.

- Effective April 1, 2017, continues the supplemental upper payment limit payments made to general hospitals, other than major public general hospitals under non-institutional services of \$339 million annually.

- Capital related costs of a general hospital excluding 44% of the major movable costs and excluding staff housing costs will continue effective April 1, 2017 through March 31, 2020.

The estimated gross annual decrease in Medicaid expenditures for state fiscal year 2017/2018 for this initiative is (\$35.1) million.

#### Prescription Drugs:

- Effective April 1, 2017, in an effort to mitigate high drug costs, the Department proposes to establish requirements for manufacturers to pay a penalty in the form of a rebate, as well as impose a surcharge on wholesalers and manufacturers for certain high priced drugs.

- o The Department will collect confidential information from drug manufacturers related to drug costs and prices, and with the assistance of the drug utilization review board (DURB), identify for review drugs which: are first introduced to market at prohibitively expensive prices, experience a large increase in price not explained by a relevant factor, or are priced disproportionately given limited therapeutic benefits. If a manufacturer's price exceeds the reasonable value of the drug, as determined by the DURB, the Board would recommend that a benchmark price be established and the excess amount would be subject to a Medicaid rebate and a surcharge.

- o A list of such designated high priced drugs shall be published on the Department's website, along with the date on which each drug first appeared on the list, and its associated benchmark price.

- o A surcharge of 60% shall be imposed on the excess charge amount of the gross receipt from the first in-state sale of a high priced drug. The surcharge shall be deposited into a designated High Priced Drug Reimbursement Fund, and paid out through the Department of Financial Services to health insurers and the Medicaid program in proportion to their respective costs attributable to the drug.

The estimated annual aggregate decrease in Medicaid expenditures for state fiscal year 2017/2018 for this initiative is \$110 million.

- The Department proposes to amend the reimbursement for prescription drugs dispensed, effective April 1, 2017. These changes will bring the reimbursement methodology into compliance with Federal regulations.

- o Reimbursement for prescribed drugs will be the lower of ingredient cost (plus a professional dispensing fee when a covered outpatient drug), or the billing pharmacy's usual and customary charge.

- o For brand name drugs, the ingredient cost will be the National Average Drug Acquisition Cost (NADAC); or, in the event of no NADAC pricing available, Wholesale Acquisition Cost (WAC) less 3.3%.

- o For generic drugs, ingredient cost will be the lower of NADAC; or the Federal Upper Limit (FUL); or the State Maximum Acquisition Cost (SMAC). In the event of no NADAC pricing available, ingredient cost is the lower of WAC less 17.5%; or the FUL; or SMAC.

- o For over-the-counter drugs, ingredient cost will be the lower of NADAC; or FUL; or SMAC. In the event of no NADAC pricing available, ingredient cost is the lower of WAC; FUL; or SMAC.

- o The professional dispensing fee for brand name, generic, and OTC covered outpatient drugs will be \$10.00.

The estimated annual aggregate increase in Medicaid expenditures for state fiscal year 2017/2018 for this initiative is \$11 million.

- Effective July 1, 2017, the co-pay for over-the-counter (OTC) non-prescription drug/items will be increased from \$0.50 to \$1.00. In addition, modifications to the list of covered drug/items in this category may be filed as regulations by the commissioner of health without prior notice and comment.

The estimated annual aggregate decrease in Medicaid expenditures for state fiscal year 2017/2018 for this initiative is \$12.6 million.

- Effective July 1, 2017, the Department proposes to amend the copayment for brand name prescription drugs dispensed in order to eliminate the difference in co-pay between a preferred drug and a non-preferred drug, in accordance with federal requirements:

- o The co-pay for brand-name prescription drugs will be changed to \$2.50, regardless of their status on or off the preferred drug list; provided, however, that the copayments for brand name prescriptions drugs in the Fee-for-Service Brand Less Than Generic program will continue to be \$1.00.

There is no additional estimated annual change to gross Medicaid expenditures as a result of the clarifying proposed amendments.

The overall estimated annual net aggregate decrease in gross Medicaid expenditures attributable to reform and other initiatives contained in the budget for state fiscal year 2017/2018 is \$282,506,637 million; and the estimated annual net aggregate increase in gross Medicaid expenditures attributable to an extension of upper payment limit (UPL) payments for state fiscal year 2017/2018 in \$2.5 billion.

The public is invited to review and comment on this proposed State Plan Amendment. Copies of which will be available for public review on the Department's website at [http://www.health.ny.gov/regulations/state\\_plans/status](http://www.health.ny.gov/regulations/state_plans/status).

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

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

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

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

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

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

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

**For further information and to review and comment, please contact:**  
 Department of Health, Division of Finance and Rate Setting, 99  
 Washington Ave., One Commerce Plaza, Suite 1460, Albany, NY,  
 12210, spa\_inquiries@health.ny.gov

## PUBLIC NOTICE

Department of Health

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

The Department of Health proposes to amend the Title XIX (Medicaid) State Plan for Non-Institutional Services to comply with Section 5006 of the American Recovery and Reinvestment Act of 2009. The following changes are proposed:

### Non-Institutional Services

Effective on or after April 1, 2017, in accordance with Section 5006 of the American Recovery and Reinvestment Act of 2009 which amended the Social Security Act to provide Indian health care providers that are not FQHCs with the right to wrap around payments from the State, in the event that the amount paid by a managed care plan is less than what is due to the Indian health care provider as stated in the State Plan, the difference will be provided.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2017/2018 is approximately \$450,000.

The public is invited to review and comment on this proposed State Plan Amendment, a copy of which will be available for public review on the Department's website at [http://www.health.ny.gov/regulations/state\\_plans/status](http://www.health.ny.gov/regulations/state_plans/status). In addition, approved SPA's beginning in 2011, are also available for viewing on this website.

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

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

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

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

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

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

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

**For further information and to review and comment, please contact:**  
 Department of Health, Division of Finance and Rate Setting, 99  
 Washington Ave., One Commerce Plaza, Suite 1432, Albany, NY  
 12210, spa\_inquiries@health.ny.gov

## PUBLIC NOTICE

City of Oswego

The City of Oswego is soliciting proposals from Administrative Service Agencies, Trustees, and Financial Organizations for services in connection with a Deferred Compensation Plan that will meet the

requirements of Section 457 of the Internal Revenue Code and Section 5 of the State Finance Law, including all rules and regulations issued pursuant thereto.

A copy of the proposal questionnaire may be obtained from: Nancy C. Sterio, Personnel Director, nsterio@oswegony.org

All proposals must be submitted not later than 30 days from the date of publication in the New York State Register.

## PUBLIC NOTICE

Susquehanna River Basin Commission

Projects Approved for Consumptive Uses of Water

SUMMARY: This notice lists the projects approved by rule by the Susquehanna River Basin Commission during the period set forth in "DATES."

DATES: February 1-28, 2017.

ADDRESSES: Susquehanna River Basin Commission, 4423 North Front St., Harrisburg, PA 17110-1788.

FOR FURTHER INFORMATION CONTACT: Jason E. Oyler, General Counsel, telephone: (717) 238-0423, ext. 1312; fax: (717) 238-2436; e-mail: joyler@srbc.net. Regular mail inquiries may be sent to the above address.

SUPPLEMENTARY INFORMATION: This notice lists the projects, described below, receiving approval for the consumptive use of water pursuant to the Commission's approval by rule process set forth in 18 CFR § 806.22(f) for the time period specified above:

Approvals By Rule Issued Under 18 CFR 806.22(f):

1. Chesapeake Appalachia, LLC, Pad ID: Maple Ln Farms, ABR-201202021.R1, Athens Township, Bradford County, PA; Consumptive Use of Up to 7.5000 mgd; Approval Date: February 6, 2017.

2. SWEPI, LP, Pad ID: My TB INV LLC 6076, ABR-201702001, Deerfield Township, Tioga County, PA; Consumptive Use of Up to 4.0000 mgd; Approval Date: February 6, 2017.

3. Range Resources – Appalachia, LLC, Pad ID: Bobst Mtn Hunting Club 30H-33H, ABR-201202017.R1, Cogan House Township, Lycoming County, PA; Consumptive Use of Up to 1.0000 mgd; Approval Date: February 8, 2017.

4. Range Resources – Appalachia, LLC, Pad ID: Bobst A Unit 25H-27H, ABR-201202018.R1, Cogan House Township, Lycoming County, PA; Consumptive Use of Up to 1.0000 mgd; Approval Date: February 8, 2017.

5. SWN Production Company, LLC, Pad ID: HEBDA-VANDEMARK, ABR-201201025.R1, Stevens Township, Bradford County, PA; Consumptive Use of Up to 4.9990 mgd; Approval Date: February 10, 2017.

6. Cabot Oil & Gas Corporation, Pad ID: Jeffers Farms P2, ABR-201702002, Harford Township, Susquehanna County, PA; Consumptive Use of Up to 4.2500 mgd; Approval Date: February 14, 2017.

7. Cabot Oil & Gas Corporation, Pad ID: FoltzJ P2, ABR-201702003, Brooklyn Township, Susquehanna County, PA; Consumptive Use of Up to 4.2500 mgd; Approval Date: February 14, 2017.

8. Carrizo (Marcellus), LLC, Pad ID: EP Bender B (CC-03) Pad (2), ABR-201201030.R1, Reade Township, Cambria County, PA; Consumptive Use of Up to 2.1000 mgd; Approval Date: February 14, 2017.

9. EXCO Resources (PA), LLC, Pad ID: Warner North Unit Pad, ABR-201202001.R1, Penn Township, Lycoming County, PA; Consumptive Use of Up to 8.0000 mgd; Approval Date: February 14, 2017.

10. Infection Energy, (PA), LLC, Pad ID: Eichenlaub B Pad, ABR-201206013.R1, Upper Fairfield Township, Lycoming County, PA; Consumptive Use of Up to 4.0000 mgd; Approval Date: February 16, 2017.

11. Chief Oil & Gas, LLC, Pad ID: Boy Scouts Drilling Pad, ABR-201207023.R1, Elkland Township, Sullivan County, PA; Consumptive Use of Up to 2.0000 mgd; Approval Date: February 17, 2017.

12. Cabot Oil & Gas Corporation, Pad ID: ManzerA P1, ABR-201203013.R1, Gibson Township, Susquehanna County, PA; Consumptive Use of Up to 3.5750 mgd; Approval Date: February 20, 2017.

- 2-14197 Commercial and Residential Real Estate Agents and Brokers and Property Management Services Policies covering the liability of real estate agents and brokers and property managers who are engaged in large commercial and residential real estate projects. The policies would include, but are not limited to, liability coverage for acts arising out of the brokerage of sales and lease of real estate, property management, construction management and consulting, general consulting, franchising, joint ventures, mortgage brokering, appraisals, auction, referrals, business brokerage activities and the development of owned commercial and residential real estate.
- 2-22002 [Automobile] Motorsports Racing Liability Liability coverage for owners or lessors of motorsports racing venues (e.g. race tracks for oval track events, drag races, monster truck rallies, motocross, motorcycle, boat or snowmobile racing, and other types of motorized vehicle competitive events).
- 2-22003 [Auto] Motorsports Racing and [Automobile Race Track] Motorsports Liability Coverage for claims of spectators, participants or other third parties in connection with the operation of [an automobile race track or drag strip] motorsports venues, or the staging or conduct of [an automobile race] motorsports events or participation therein by teams and individuals.
- 2-02038 Television Broadcast Interruption [Breakdown-Closed Circuits] Covers the reduction in gross admission fees caused by interruption by breakdown, failure, malfunctioning or any disorder of equipment lines and appurtenances thereto, which prevents presentation of the audio or showing of [the] a telecast.

For further information you may contact: Hoda Nairooz by email at hoda.nairooz@dfs.ny.gov, by mail at Department of Financial Services, Property Bureau, One State St., New York, NY 10004, or by calling (212) 480-5595

### PUBLIC NOTICE Department of Health

The New York State Department of Health (DOH) is required by the provisions of the federal Beaches Environmental Assessment and Coastal Health (BEACH) Act to provide for public review and comment on the Department's beach monitoring and notification plan. The BEACH Act (Section 406(b) of the Clean Water Act) enacted a federal Environmental Protection Agency grant program available to states, such as New York, with coastal recreational waters. Coastal recreational waters include the Great Lakes and marine coastal waters that are designated for swimming, bathing, surfing, or similar water contact activities. The Act is not applicable to inland waters or waters upstream of the mouth of a river or stream having an unimpaired natural connection with the open sea.

The beach monitoring and public notification plan also includes information on the beach evaluation and classification process, including a list of waters to be monitored and beach ranking. Also included in this plan, is the sampling design and monitoring plan, including sampling location and sampling frequency. Lastly, the plan contains information on procedures for public notification and risk communication, including methods to notify the public of a swimming advisory or beach closure.

Any interested parties and/or agencies desiring to review and/or comment on the beach monitoring and notification plan for coastal recreational waters may do so by writing to: Timothy M. Shay, Assistant Bureau Director, Department of Health, Center for Environmental Health, Bureau of Community Environmental Health and Food Protection, Empire State Plaza, Corning Tower Bldg., Rm. 1395, Albany, NY 12237, Fax: (518) 402-7609

### PUBLIC NOTICE Department of Health

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

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

#### All Services

- Payments to Critical Access Hospitals based on criteria as determined by the Commissioner of Health.

The estimated annual increase in gross Medicaid expenditures for this initiative is \$20 million.

#### Institutional Services

- Payments to hospitals that meet the criteria as an enhanced safety net hospital. The criteria are as follows: In any of the previous three calendar years, the hospital has had not less than fifty percent of the patients it treats receive Medicaid or be medically uninsured; not less than forty percent of its inpatient discharges are covered by Medicaid; twenty-five percent or less of its discharged patients are commercially insured; not less than three percent of the services are attributed to the care of uninsured patients; it provides care to uninsured patients in its emergency room, hospital based clinics and community based clinics, including the provision of important community services such as dental care and prenatal care.

The estimated annual increase in gross Medicaid expenditures for this initiative is \$20 million.

#### Long Term Care Services

- The Enacted Budget limits reimbursement to Nursing Homes for bed hold days to therapeutic leaves of absence.

The estimated annual net decrease in gross Medicaid expenditures attributable to this cost containment initiative contained in the budget for state fiscal year 2017/2018 is (\$20) million.

#### Non-Institutional Services

- The initiative previously noticed regarding the elimination of supplemental medical assistance payments of up to \$6 million annually made to providers of emergency medical transportation was not included in the Enacted Budget for state fiscal year 2017/2018.

#### Prescription Drugs:

- The initiative previously noticed regarding the co-pay for over-the-counter (OTC) non-prescription drug/items increased from \$0.50 to \$1.00 was eliminated from the budget for state fiscal year 2017/2018.

Effective April 1, 2017, to mitigate high drug costs, the Department will establish a Medicaid prescription drug cap as a separate component of the Medicaid global cap with year to year spending targets. Drug expenditures will be reviewed quarterly. If it is determined that expenditures will exceed annual growth limitation, the Commissioner may identify and refer drugs to the Drug Utilization Review Board (DURB) for a recommended target supplemental rebate. The Department shall notify affected manufacturers prior to referring drug(s) to DURB, and attempt to reach a rebate agreement.

When determining whether to recommend a drug to the DURB for a target supplemental rate, the department shall consider the actual cost of a drug to the state, including current rebate amounts, taking into consideration whether the drug manufacturer provides significant discounts relative to other covered drugs. When considering whether to recommend a target supplemental rate for a drug, the DURB shall consider the actual cost of the drug to the Medicaid program including state and federal rebates, and may consider:

- o Impact on spending target, capitation rates and affordability and value to the program;
- o Significant and unjustified price increases;
- o Whether the drug may be priced disproportionately to its therapeutic benefits.

If a target rebate is recommended by the DURB, and the department is unable to negotiate a rebate of at least 75% of the target rebate



amount with the manufacturer(s), the “prescriber prevails” provision (if applicable), may be waived for the target drug(s).

If a target rebate is recommended by the DURB, and the department is unable to negotiate a rebate which it deems satisfactory, the Department may collect additional cost information from the manufacturer.

If, regardless of rebates, total Medicaid drug expenditures are still projected to exceed the prescription drug cap, the department may invoke prior authorization on the targeted drug(s) or other drugs made by the same manufacturer, direct Medicaid managed care plans to remove the target drug(s) from their formularies, or promote the use of alternative cost and clinically effective drugs.

The estimated annual aggregate decrease in Medicaid expenditures for state fiscal year 2017-18 for this initiative is \$110 million.

The overall estimated annual net aggregate increase in gross Medicaid expenditures attributable to reform and other initiatives contained in the budget for state fiscal year 2017/2018 is \$233,906,637.

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](http://www.health.ny.gov/regulations/state_plans/status).

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

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

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

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

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

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

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

For further information and to review and comment, please contact: Department of Health, Division of Finance and Rate Setting, 99 Washington Ave., One Commerce Plaza, Suite 1460, Albany, NY 12210, [spa\\_inquiries@health.ny.gov](mailto:spa_inquiries@health.ny.gov)

**PUBLIC NOTICE**

Office of Parks, Recreation and Historic Preservation

Pursuant to section 14.07 of the Parks, Recreation and Historic Preservation Law, the Office of Parks, Recreation and Historic Preservation hereby gives notice of the following:

In accordance with subdivision (c) of section 427.4 of title 9 NYCRR notice is hereby given that the New York State Board for Historic Preservation will be considering nomination proposals for listing of properties in the State and National Register of Historic Places at a meeting to be held on Thursday, June 15, 2017 at Peebles Island State Park, 1 Delaware Avenue, Cohoes, NY 12188.

The following properties will be considered:

1. Delaware Avenue Baptist Church, Buffalo, Erie County
2. Newberry Building, Batavia, Genesee County

3. Linde Air Products Factory, Buffalo, Erie County
4. Springville Baptist Church (Boundary Expansion), Springville, Erie County
5. Allegany Council House, Jimmersonstown, Allegany Indian Territories (AIR), Cattaraugus County
6. Morgan Dunne House, Syracuse, Onondaga County
7. West High School, Auburn, Cayuga County
8. Congregation Ohab Zedek, New York County
9. Swan River Schoolhouse, East Patchogue, Suffolk County
10. Second & Ostrander Historic District, Riverhead, Suffolk County
11. Charles & Anna Bates House, Greenport, Suffolk County
12. 390 Ocean Avenue, Massapequa, Nassau County
13. George Sumner Kellogg House, Baldwin, Nassau County
14. Oak Hill Historic District, Durham, Greene County
15. Gumaer Cemetery, Deerpark, Orange County
16. Crandell Theatre, Chatham, Columbia County
17. Phillipsport Methodist Church and Phillipsport District 16 Schoolhouse, Phillipsport, Sullivan County
18. Oneida Downtown Commercial Historic District, Oneida, Madison County
19. Sagamore Apartment House, Syracuse, Onondaga County
20. Oswego & Syracuse Railroad Freighthouse, Oswego, Oswego County
21. First Lewis County Clerk’s Office, Martinsburg, Lewis County
22. Lady Tree Lodge, Saranac Inn, Franklin County
23. Stillwater Fire Observation Station, Webb, Herkimer County
24. St. Matthew’s Episcopal Church, Horseheads, Chemung County
25. House at 5680 Seneca Point Rd., South Bristol vic., Ontario County
26. Coeymans Landing Historic District, Coeymans, Albany County

To be considered by the board, comments may be submitted to Michael F. Lynch, P.E., A.I.A., Deputy State Historic Preservation Officer and Director, Division for Historic Preservation, Peebles Island, P.O. Box 189, Waterford, New York 12188-0189, no later than Wednesday, June 14, 2017 or may be submitted in person at the meeting by contacting Michael F. Lynch at the same address no later than June 14.

For further information, contact: Michael F. Lynch, P.E., A.I.A., Deputy State Historic Preservation Officer and Director, Division for Historic Preservation, Peebles Island, P.O. Box 189, Waterford, NY 12188-0189, (518) 268-2130

**PUBLIC NOTICE**

County of Seneca

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

A copy of the proposal questionnaire may be obtained from: Kathy Corona, Personnel Officer, Seneca County Personnel Office, One DiPronio Dr., Waterloo, NY 13165, (315) 539-1712, Fax (315) 539-1658, e-mail: [kcorona@co.seneca.ny.us](mailto:kcorona@co.seneca.ny.us)

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

**PUBLIC NOTICE**

Department of State  
F-2016-0130

Date of Issuance – May 10, 2017

The New York State Department of State (DOS) is required by Federal regulations to provide timely public notice for the activities

**Appendix V**  
**2018 Title XIX State Plan**  
**Second Quarter Amendment**  
**Responses to Standard Funding Questions**

**APPENDIX V**  
**LONG TERM CARE SERVICES**  
**State Plan Amendment #18-0042**

**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-D of the 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 at 2 CFR 200 regarding Cost Principles for State, Local, and Indian Tribal Governments. The existence of such transfers should in no way negate the legitimacy of these facilities' Medicaid payments or result in reduced Medicaid federal financial participation for the State. This position was further supported by CMS in review and approval of SPA 07-07C when an on-site audit of these transactions for New York City's Health and Hospitals Corporation was completed with satisfactory results.

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

**Response:** Payments made to service providers under the provisions of this SPA are funded through a budget appropriation received by the State agency that oversees medical assistance (Medicaid), which is the Department of Health.

The source of the appropriation is the Medicaid General Fund Local Assistance Account, which is part of the Global Cap. The Global Cap is funded by General Fund and HCRA resources.

There have been no new provider taxes and no existing taxes have been modified.

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 447.272, States are prohibited from setting payment rates for Medicaid inpatient services that exceed a reasonable estimate of the amount that would be paid under Medicare payment principals.**

**Response:** The State will be working with CMS in the coming months for the 2018 nursing home UPL.

- 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:** Effective January 1, 2012, the rate methodology included in the approved State Plan for non-specialty nursing facility services for the operating component of the rate is a blended statewide/peer group price adjusted for case mix and wage differentials wage equalization factor. Specialty nursing facility and units are paid the operating rate in effect on January 1, 2009. The capital component of the rate for all specialty and non-specialty facilities is based upon a cost based methodology. We are unaware of any requirement under current federal law or regulation that limits individual provider payments to their actual costs.

#### **ACA Assurances:**

- 1. Maintenance of Effort (MOE). Under section 1902(gg) of the Social Security Act (the Act), as amended by the Affordable Care Act, as a condition of receiving any Federal payments under the Medicaid program during the MOE period indicated below, the State shall not have in effect any eligibility standards, methodologies, or procedures in its Medicaid program which are more restrictive than such eligibility provisions as in effect in its Medicaid program on March 10, 2010.**

#### **MOE Period.**

- **Begins on: March 10, 2010, and**

- **Ends on:** The date the Secretary of the Federal Department of Health and Human Services determines an Exchange established by a State under the provisions of section 1311 of the Affordable Care Act is fully operational.

**Response:** This SPA complies with the conditions of the MOE provision of section 1902(gg) of the Act for continued funding under the Medicaid program.

2. **Section 1905(y) and (z) of the Act provides for increased FMAPs for expenditures made on or after January 1, 2014 for individuals determined eligible under section 1902(a)(10)(A)(i)(VIII) of the Act. Under section 1905(cc) of the Act, the increased FMAP under sections 1905(y) and (z) would not be available for States that require local political subdivisions to contribute amounts toward the non-Federal share of the State's expenditures at a greater percentage than would have been required on December 31, 2009.**

**Prior to January 1, 2014** States may potentially require contributions by local political subdivisions toward the non-Federal share of the States' expenditures at percentages **greater than** were required on December 31, 2009. **However**, because of the provisions of section 1905(cc) of the Act, it is important to determine and document/flag any SPAs/State plans which have such greater percentages prior to the January 1, 2014 date in order to **anticipate potential violations and/or appropriate corrective actions** by the States and the Federal government.

**Response:** This SPA would [ ] / would not [✓] violate these provisions, if they remained in effect on or after January 1, 2015.

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

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

**Tribal Assurance:**

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

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

- a) Please describe the process the State uses to seek advice on a regular ongoing basis from federally recognized tribes Indian Health Programs and Urban Indian Organizations on matters related to Medicaid and CHIP programs and for consultation on State Plan Amendments waiver proposals waiver extensions waiver amendments waiver renewals and proposals for demonstration projects prior to submission to CMS.**
- b) Please include information about the frequency inclusiveness and process for seeking such advice.**
- c) Please describe the consultation process that occurred specifically for the development and submission of this State Plan Amendment when it occurred and who was involved.**

**Response:** Tribal consultation was performed in accordance with the State's tribal consultation policy as approved in SPA 17-0065, and documentation of such is included with the original submission. To date, no feedback has been received from any tribal representative in response to the proposed change in this SPA.

**Appendix VI**  
**2018 Title XIX State Plan**  
**Second Quarter Amendment**  
**Responses to Standard Access Questions**



**APPENDIX VI  
LONG TERM CARE SERVICES  
State Plan Amendment 18-0042**

**CMS Standard Access Questions**

The following questions have been asked by CMS and are answered by the State in relation to all payments made to all providers under Attachment 4.19-D of the state plan.

- 1. Specifically, how did the State determine that the Medicaid provider payments that will result from the change in this amendment are sufficient to comply with the requirements of 1902(a)(30)?**

**Response:** This amendment seeks to

- Eliminate the payment to nursing homes for bed reserve days for hospitalizations for all residents aged over 21 years with the exception of persons on hospice.
- This change will not impact access to care.

- 2. How does the State intend to monitor the impact of the new rates and implement a remedy should rates be insufficient to guarantee required access levels?**

**Response:** The State has various ways to ensure that access levels in the Medicaid program are retained and is currently not aware of any access issues, particularly since there is excess bed capacity for both hospitals and nursing homes. Additionally, hospital and nursing home providers must notify and receive approval from the Department's Office of Health Systems Management (OHSM) in order to discontinue services. This Office monitors and considers such requests in the context of access as they approve/deny changes in services. Finally, providers cannot discriminate based on source of payment.

The State will continue to monitor provider complaint hotlines to identify geographic areas of concern and/or service type needs. If Medicaid beneficiaries begin to encounter access issues, the Department would expect to see a marked increase in complaints. These complaints will be identified and analyzed in light of the changes proposed in this State Plan Amendment.

Finally, the State ensures that there is sufficient provider capacity for Medicaid Managed Care plans as part of its process to approve managed care rates and plans. Should sufficient access to services be compromised, the State would be alerted and would take appropriate action to ensure retention of access to such services.

- 3. How were providers, advocates and beneficiaries engaged in the discussion around rate modifications? What were their concerns and how did the State address these concerns?**

**Response:** This change was enacted by the State Legislature as part of the negotiation of the 2018-2019 Budget. The impact of this change was weighed in the context of the overall Budget in the State. The legislative process provides opportunities for all stakeholders to lobby their concerns, objections, or support for various legislative initiatives.

4. **What action(s) does the State plan to implement after the rate change takes place to counter any decrease to access if the rate decrease is found to prevent sufficient access to care?**

**Response:** Should any essential community provider experience Medicaid or other revenue issues that would prevent access to needed community services, per usual practice, the State would meet with them to explore the situation and discuss possible solutions, if necessary.

5. **Is the State modifying anything else in the State Plan which will counterbalance any impact on access that may be caused by the decrease in rates (e.g. increasing scope of services that other provider types may provide or providing care in other settings)?**

**Response:** The State has undertaken initiatives to provide continued access and quality of care to Nursing Homes. Such initiatives are the Vital Access Program (VAP), Minimum Wage increase, 1% Supplemental Payment, Advanced Training Initiative and Refinanced Shared Savings. While some of these initiatives are outside the scope of the State Plan, they represent some of the measures the State is taking to ensure quality care for the State's most vulnerable population.