

**NEW YORK**  
state department of  
**HEALTH**

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

Sue Kelly  
Executive Deputy Commissioner

June 27, 2011

Mr. Michael Melendez  
Associate Regional Administrator  
Department of Health & Human Services  
Centers for Medicare & Medicaid Services  
New York Regional Office  
Division of Medicaid and Children's Health  
26 Federal Plaza - Room 3800  
New York, New York 10278

RE: SPA #11-76  
Non-Institutional Services

Dear Mr. Melendez:

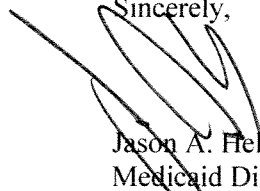
The State requests approval of the enclosed amendment #11-76 to the Title XIX (Medicaid) State Plan for non-institutional services to be effective April 1, 2011 (Appendix I). This amendment is being submitted based on enacted legislation. A summary of the plan amendment is provided in Appendix II.

The State of New York reimburses these services through the use of rates that are consistent with and promote efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area as required by §1902(a)(30) of the Social Security Act and 42 CFR §447.204.

Copies of pertinent sections of proposed State statute are enclosed for your information (Appendix III). A copy of the public notice of this plan amendment, which was given in the New York State Register on March 30, 2011, is also enclosed for your information (Appendix IV). In addition, responses to the five standard funding questions and the standard access questions are also enclosed (Appendix V and VI, respectively).

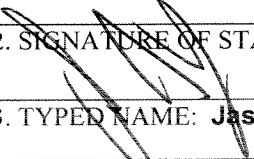
If you have any questions regarding this State Plan submission, please do not hesitate to contact John E. Ulberg Jr., Director, Division of Health Care Financing at (518) 474-6350.

Sincerely,



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

Enclosures

<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</b>  <b>FOR: HEALTH CARE FINANCING ADMINISTRATION</b>		1. TRANSMITTAL NUMBER: #11-76	2. STATE New York
		3. PROGRAM IDENTIFICATION: <b>TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)</b>	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE <b>April 1, 2011</b>	
5. TYPE OF PLAN MATERIAL ( <i>Check One</i> ):  <input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT ( <i>Separate Transmittal for each amendment</i> )			
6. FEDERAL STATUTE/REGULATION CITATION: <b>Section 1902(a) of the Social Security Act, and 42 CFR 447</b>		7. FEDERAL BUDGET IMPACT: a. FFY 04/1/11-9/30/11    \$ 2,271,200 b. FFY 10/1/11-9/30/12    \$ 9,925,000	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: <b>Attachment 4.19-B: Pages 1(A)(iii)(1), 1(c)(i)(B)(1), 1(c)(i)(F)(1)</b>		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT ( <i>If Applicable</i> ):	
10. SUBJECT OF AMENDMENT: <b>New Models of Payment for Patient-Centered Medical Homes (PCMH) (FMAP = 56.88% 4/1/11-6/30/11; 50% 7/1/11 forward)</b>			
11. GOVERNOR'S REVIEW ( <i>Check One</i> ): <input checked="" type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input type="checkbox"/> OTHER, AS SPECIFIED: <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL			
12. SIGNATURE OF STATE AGENCY OFFICIAL: 		16. RETURN TO: <b>New York State Department of Health Corning Tower Empire State Plaza Albany, New York 12237</b>	
13. TYPED NAME: <b>Jason A. Helgerson</b>			
14. TITLE: <b>Medicaid Director &amp; Deputy Commissioner Department of Health</b>			
15. DATE SUBMITTED: June 27, 2011			
<b>FOR REGIONAL OFFICE USE ONLY</b>			
17. DATE RECEIVED:		18. DATE APPROVED:	
<b>PLAN APPROVED - ONE COPY ATTACHED</b>			
19. EFFECTIVE DATE OF APPROVED MATERIAL:		20. SIGNATURE OF REGIONAL OFFICIAL:	
21. TYPED NAME:		22. TITLE:	
23. REMARKS:			

**Appendix I**  
**2011 Title XIX State Plan**  
**Second Quarter Amendment**  
**Non-Institutional Services**  
**Amended SPA Pages**

**New York  
1(A)(iii)(1)**

**Attachment 4.19-B  
(04/11)**

**New Models of Payment for Patient-Centered Medical Homes Program -  
Physicians/Nurse Practitioners**

Effective for periods on and after April 1, 2011, the Commissioner of Health is authorized to establish a patient-centered medical home program in order to test new models of payment to high-volume Medicaid primary care medical home practices which may incorporate the following: 1) risk-adjusted global payments including care management costs and/or 2) pay-for-performance enhancements payments. Risk-adjusted payments will be based on historical costs and risk adjusted for case mix using the most recent and accurate Medicaid claims available. Base rates will include costs associated with care management services. 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.

Medicaid physicians and/or nurse practitioners who are currently certified by the National Committee on Quality Assurance (NCQA) as Level 3 providers in the Physician Practice Connections®- Patient Centered Medical Home™ program will be eligible to participate in this demonstration for services rendered to recipients eligible for Medicaid fee-for-service. Reimbursement amounts for services provided to Medicaid fee-for-service recipients by physicians and/or nurse practitioners who are eligible for and participating in the Program will be developed by the New York State Department of Health and approved by the Division of the Budget. Such payments will be determined based on a market analysis of cost assumptions related to patient care and coordination, management information systems, quality performance, assumptions about the extent to which physicians and/or nurse practitioners will participate in the program, and the amounts appropriated for Patient Centered Medical Homes by the New York State Legislature.

Recipient and health care services participation is on a voluntary basis. Physicians and/or nurse practitioners currently participating in the Adirondack Medical Home Multi-payer Program established pursuant to this Amendment are ineligible to participate in the New Models of Payment for Patient Centered Medical Homes Program.

**TN   #11-76**

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

**Supersedes TN   New**

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

**New Models of Payment for Patient-Centered Medical Homes Program – Hospital Clinics**

Hospital clinic shall mean a general hospital providing outpatient care licensed under Article 28 of the New York State Public Health Law.

Effective for periods on and after April 1, 2011, the Commissioner of Health is authorized to establish a patient-centered medical home program in order to test new models of payment to high-volume Medicaid primary care medical home practices which may incorporate the following: 1) risk-adjusted global payments including care management costs and/or 2) pay-for-performance enhancements payments. Risk-adjusted payments will be based on historical costs and risk adjusted for case mix using the most recent and accurate Medicaid claims available. Base rates will include costs associated with care management services. 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.

Medicaid hospital clinics who are currently certified by the NCOA as Level 3 providers in the Physician Practice Connections®- Patient Centered Medical Home™ program will be eligible to participate in this demonstration for services rendered to recipients eligible for Medicaid fee-for-service. Reimbursement amounts for services provided to Medicaid fee-for-service recipients by hospital clinics who are eligible for and participating in the Program will be developed by the New York State Department of Health and approved by the Division of the Budget. Such payments will be determined based on a market analysis of cost assumptions related to patient care and coordination, management information systems, quality performance, assumptions about the extent to which hospital clinics will participate in the program, and the amounts appropriated for Patient Centered Medical Homes by the New York State Legislature.

Recipient and health care services participation is on a voluntary basis. Hospital clinics currently participating in the Adirondack Medical Home Multi-payer Program established pursuant to this Amendment are ineligible to participate in the New Models of Payment for Patient Centered Medical Homes Program.

**TN#:**     #11-76    

**Approval Date:** \_\_\_\_\_

**Supersedes TN#:**     New    

**Effective Date:** \_\_\_\_\_

**New Models of Payment for Patient-Centered Medical Homes Program -  
Freestanding Clinics**

Freestanding clinic shall mean a diagnostic and treatment center providing outpatient care licensed under Article 28 of the New York State Public Health Law.

Effective for periods on and after April 1, 2011, the Commissioner of Health is authorized to establish a patient-centered medical home program in order to test new models of payment to high-volume Medicaid primary care medical home practices which may incorporate the following: 1) risk-adjusted global payments including care management costs and/or 2) pay-for-performance enhancements payments. Risk-adjusted payments will be based on historical costs and risk adjusted for case mix using the most recent and accurate Medicaid claims available. Base rates will include costs associated with care management services. 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.

Freestanding clinics who are currently certified by the NCOA as Level 3 providers in the Physician Practice Connections®- Patient Centered Medical Home™ program will be eligible to participate in this demonstration for services rendered to recipients eligible for Medicaid fee-for-service. Reimbursement amounts for services provided to Medicaid fee-for-service recipients by hospital clinics who are eligible for and participating in the Program will be developed by the New York State Department of Health and approved by the Division of the Budget. Such payments will be determined based on a market analysis of cost assumptions related to patient care and coordination, management information systems, quality performance, assumptions about the extent to which free-standing clinics will participate in the program, and the amounts appropriated for Patient Centered Medical Homes by the New York State Legislature.

Recipient and health care services participation is on a voluntary basis. Freestanding clinics currently participating in the Adirondack Medical Home Multi-payer Program established pursuant to this Amendment are ineligible to participate in the New Models of Payment for Patient Centered Medical Homes Program.

**TN#:**           #11-76          

**Approval Date:** \_\_\_\_\_

**Supersedes TN#:**           New          

**Effective Date:** \_\_\_\_\_

**Appendix II**  
**2011 Title XIX State Plan**  
**Second Quarter Amendment**  
**Non-Institutional Services**  
**Summary**

**SUMMARY**  
**SPA #11-76**

This state plan amendment proposes that effective April 1, 2011 certain physicians and/or nurse practitioners and clinics that are certified as Level 3 providers in the NCQA Physician Practice Connections®- Patient Centered Medical Home™ program are eligible to participate in a program that will reimburse Medicaid providers for services rendered to Medicaid recipients using risk-adjusted global payments and pay-for-performance methodologies.



**Appendix III**  
**2011 Title XIX State Plan**  
**Second Quarter Amendment**  
**Non-Institutional Services**  
**Authorizing Provisions**

CHAPTER 59 OF THE LAWS OF 2011  
S.2009-D/A.4009-D - Part H - ENACTED

§ 35. The public health law is amended by adding a new article 29-AA to read as follows:

ARTICLE 29-AA

PATIENT CENTERED MEDICAL HOMES

Section 2959-a. Multipayor patient centered medical home program.

§ 2959-a. Multipayor patient centered medical home program. 1. (a) The commissioner is authorized to establish medical home multipayor programs (referred to in this section as a "program") whereby enhanced payments are made to primary care clinicians and clinics statewide that are certified as medical homes for the purpose of improving health care outcomes and efficiency through improved access, patient care continuity and coordination of health services.

(b) As used in this section:

(i) "clinic" means a general hospital providing outpatient care or diagnostic and treatment center, licensed under article twenty-eight of this chapter; and

(ii) "primary care clinician" means a physician, nurse practitioner, or midwife acting within his or her lawful scope of practice under title eight of the education law and who is practicing in a primary care specialty.

(iii) "primary care medical home collaborative" means an entity approved by the commissioner which shall include but not be limited to health care providers, which may include but not be limited to hospitals, diagnostic and treatment centers, private practices and independent practice associations, and payors of health care services, which may include but not be limited to employers, health plans and insurers.

2. (a) In order to promote improved quality of, and access to, health care services and promote improved clinical outcomes, it is the policy of the state to encourage cooperative, collaborative and integrative arrangements among payors of health care services and health care services providers who might otherwise be competitors, under the active supervision of the commissioner. It is the intent of the state to supplant competition with such arrangements and regulation only to the extent necessary to accomplish the purposes of this article, and to provide state action immunity under the state and federal antitrust laws to payors of health care services and health care services providers with respect to the planning, implementation and operation of the multipayor patient centered medical home program.

(b) The commissioner or his or her duly authorized representative may engage in appropriate state supervision necessary to promote state action immunity under the state and federal antitrust laws, and may inspect or request additional documentation from payors of health care services and health care services providers to verify that medical homes certified pursuant to this section operate in accordance with its intent and purpose.

3. The commissioner is authorized to participate in, actively supervise, facilitate and approve a primary care medical home collaborative for each program around the state to establish: (a) the boundaries of each program and the providers eligible to participate, provided that the boundaries of programs may overlap; (b) practice standards for each medical home program adopted with consideration of existing standards

developed by the National Committee for Quality Assurance ("NCQA"), the Joint Commission of Accreditation of Healthcare Organizations ("JCAHCO" or the "Joint Commission"), American Accreditation Healthcare Commission ("URAC"), American College of Physicians, the American Academy of Family Physicians, the American Academy of Pediatrics, and the American Osteopathic Association; the American Academy of Nurse Practitioners, and the American College of Nurse Practitioners; (c) standards for implementation and use of health information technology, including participation in health information exchanges through the statewide health information network; (d) methodologies by which payors will provide enhanced rates of payment to certified medical homes; (e) requirements for collecting data relating to the providing and paying for health care services under the program and providing of data to the commissioner, payors and health care providers under the program, to promote the effective operation and evaluation of the program, consistent with protection of the confidentiality of individual patient information; and (f) provisions under which the commissioner may terminate the program.

3-a. The commissioner may develop or approve (a) methodologies to pay additional amounts for medical homes that meet specific process or outcome standards established by each multipayor patient centered medical home collaborative; (b) alternative methodologies for payors of health care services to health care providers under the program; (c) provisions for payments to providers that may vary by size or form of organization of the provider, or patient case mix, to accommodate different levels of resources and difficulty to meet the standards of the program; (d) provisions for payments to entities that provide services to health care providers to assist them in meeting medical home standards under the program such as the services of community health workers.

4. The commissioner is authorized to establish an advisory group of state agencies and stakeholders, such as professional organizations and associations, and consumers, to identify legal and/or administrative barriers to the sharing of care management and care coordination services among participating health care services providers and to make recommendations for statutory and/or regulatory changes to address such barriers.

5. Patient, payor and health care services provider participation in the multipayor patient centered medical home program shall be on a voluntary basis.

6. Clinics and primary care clinicians participating in a program are not eligible for additional enhancements or bonuses under the statewide patient centered medical home program established pursuant to section three hundred sixty-four-m of the social services law. The commissioner shall develop or approve a method for determining payment under a program where a provider participates, or a patient is served, in an area where program boundaries overlap.

7. Subject to the availability of funding and federal financial participation, the commissioner is authorized:

(a) To pay enhanced rates of payment under Medicaid fee-for-service, Medicaid managed care, family health plus and child health plus to clinics and clinicians that are certified as patient centered medical homes under this title;

(b) To pay additional amounts for medical homes that meet specific process or outcome standards specified by the commissioner in consultation with each multipayor patient centered medical home collaborative;

(c) To authorize alternative payment methodologies under Medicaid fee-for-service, Medicaid managed care, family health plus and child

health plus for health care providers and to serve the purposes of the program, including payments to entities under paragraph (g) of subdivision three of this section; and

(d) To test new models of payment to high volume Medicaid primary care medical home practices that incorporate risk adjusted global payments combined with care management and pay for performance adjustments.

8. (a) The commissioner is authorized to contract with one or more entities to assist the state in implementing the provisions of this section. Such entity or entities shall be the same entity or entities chosen to assist in the implementation of the health home provisions of section three hundred sixty-five-1 of the social services law. Responsibilities of the contractor shall include but not be limited to: developing recommendations with respect to program policy, reimbursement, system requirements, reporting requirements, evaluation protocols, and provider and patient enrollment; providing technical assistance to potential medical home and health home providers; data collection; data sharing; program evaluation, and preparation of reports.

(b) Notwithstanding any inconsistent provision of sections one hundred twelve and one hundred sixty-three of the state finance law, or section one hundred forty-two of the economic development law, or any other law, the commissioner is authorized to enter into a contract or contracts under paragraph (a) of this subdivision without a request for proposal process, provided, however, that:

(i) The department shall post on its website, for a period of no less than thirty days:

(1) A description of the proposed services to be provided pursuant to the contract or contracts;

(2) The criteria for selection of a contractor or contractors;

(3) The period of time during which a prospective contractor may seek selection, which shall be no less than thirty days after such information is first posted on the website; and

(4) The manner by which a prospective contractor may seek such selection, which may include submission by electronic means;

(ii) All reasonable and responsive submissions that are received from prospective contractors in timely fashion shall be reviewed by the commissioner; and

(iii) The commissioner shall select such contractor or contractors that, in his or her discretion, are best suited to serve the purposes of this section.

9. The commissioner may directly, or by contract, provide:

(a) technical assistance to a primary care medical home collaborative in relation to establishing and operating a program;

(b) consumer assistance to patients participating in a program as to matters relating to the program;

(c) technical and other assistance to health care providers participating in a program as to matters relating to the program, including achieving medical home standards;

(d) care coordination provider technical and other assistance to individuals and entities providing care coordination services to health care providers under a program; and

(e) information sharing and other assistance among programs to improve the operation of programs, consistent with applicable laws relating to patient confidentiality.

10. The commissioner shall, to the extent necessary for the purpose of this section, submit the appropriate waivers and other applications, including, but not limited to, those authorized pursuant to sections eleven hundred fifteen and nineteen hundred fifteen of the federal

social security act, or successor provisions, and any other waivers or applications necessary to achieve the purposes of high quality, integrated, and cost effective care and integrated financial eligibility policies under Medicaid, family health plus and child health plus or Medicare. Copies of such original waiver and other applications shall be provided to the chairman of the senate finance committee and the chairman of the assembly ways and means committee simultaneously with their submission to the federal government.

11. The Adirondack medical home multipayor demonstration program (including the Adirondack medical home collaborative) previously established under section twenty-nine hundred fifty-nine of this chapter is continued and shall be deemed to be a program under this section.

12. The commissioner shall annually report to the governor and the legislature on the operation of the programs and their effectiveness in achieving the purposes of this section, with particular reference to the quality, cost, and outcomes for enrollees in Medicaid fee-for-service, Medicaid managed care, family health plus and child health plus.

**Appendix IV**  
**2011 Title XIX State Plan**  
**Second Quarter Amendment**  
**Non-Institutional 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](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 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](http://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 projec-

tions 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
<b>Additional Services Proposed for Copay</b>		
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 collocating 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](mailto: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:

**Appendix V**  
**2011 Title XIX State Plan**  
**Second Quarter Amendment**  
**Non-Institutional Services**  
**Responses to Standard Funding Questions**

**NON-INSTITUTIONAL SERVICES**  
**State Plan Amendment #11-76**

**CMS Standard Funding Questions**

The following questions are being asked and should be answered in relation to all payments made to all providers reimbursed pursuant to a methodology described in Attachment 4.19-B of this SPA. For SPAs that provide for changes to payments for clinic or outpatient hospital services or for enhanced or supplemental payments to physician or other practitioners, the questions must be answered for all payments made under the state plan for such service.

- 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 payments, a complete listing of providers that return a portion of their payments, 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 through 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 governmental 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. For clinic or outpatient hospital services 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.**

**Response:** Based on guidance from CMS, the State and CMS staff will engage in discussions to develop a strategic plan to complete the UPL demonstration for 2011.

- 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 methodologies included in the State Plan for outpatient hospital, and diagnostic and treatment center services are either cost-based subject to ceilings or based upon the Ambulatory Patient Group (APG) system. We are unaware of any requirement under current federal law or regulation that limits individual providers' payments to their actual costs.

#### **Assurances:**

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

**Response:** The State hereby provides assurances that it remains in compliance with the terms of the Recovery Act with regard to the requirements pertaining to the maintenance of effort, State or local match, prompt payment, rainy day funds, and eligible expenditures. In addition, the HHS Office of Inspector General has reviewed the State's compliance with the political subdivision requirement for increased FMAP under ARRA and found the State to be in compliance with this provision (Report A-02-09-01029).

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

**Response:** The rate methodology for Indian health clinics (also referred to as Tribal 638 clinics) is based on federal rules and methodology. These facilities are

paid using the outpatient per-visit rate published in the Federal Register, and as a result, none of the State's rate reductions affect these providers (i.e., trends, etc.).

In the case where a nation's clinic has opted to enter a formal relationship with an Article 28 facility to bill Medicaid on their behalf, Medicaid rates and related rate changes are not imposed on the clinic, rather, the clinic implicitly accepts the Medicaid rates by choosing to link or not to link with a facility in order to benefit from the payment arrangement.

One Indian nation operates a licensed Article 28 clinic that offers both health and dental services, and an Article 31 clinic that offers alcohol and substance abuse services. Though both clinics bill Medicaid for services provided to non Native Americans, the clinics receive the federal rate for services provided to Native Americans that reside on the reservation. Therefore, changes to State Medicaid reimbursement would not affect the Native American population receiving services at these clinics, and special consultation or notification is not necessary.