NEW YORK
state department of
HEALTH

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

Sue Kelly
Executive Deputy Commissioner

December 30, 2013

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 Operations
26 Federal Plaza - Room 37-100 North
New York, New York 10278

RE: SPA #13-61
Non-Institutional Services

Dear Mr. Melendez:

The State requests approval of the enclosed amendment #13-61 to the Title XIX (Medicaid) State Plan for non-institutional services to be effective October 1, 2013 (Appendix I). This amendment is being submitted based on statute and State regulation. 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 State regulation 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 September 25, 2013, is also enclosed for your information (Appendix IV). In addition, responses to the five standard funding questions are also enclosed (Appendix V).

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

Sincerely,

Jason A. Helgerson
Medicaid Director
Office of Health Insurance Programs

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: HEALTH CARE FINANCING ADMINISTRATION	1. TRANSMITTAL NUMBER: **13-61**	2. STATE **New York**
	3. PROGRAM IDENTIFICATION: **TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)**	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE **October 1, 2013**	

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 10/01/13-09/30/14 $2,500,000** **b. FFY 10/01/14-09/30/15 $2,500,000**
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: **Att 4.19-B: Pages 1(e)(2), 1(e)(2.1)**	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: **Att 4.19-B: Pages 1(e)(2), 1(e)(2.1)**

10. SUBJECT OF AMENDMENT:
October 2013 Hosp OP APG Weight Adjustments
(FMAP = 50%)

11. GOVERNOR'S REVIEW *(Check One)*:
☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:	16. RETURN TO: **New York State Department of Health** **Bureau of Federal Relations & Provider Assessments** **99 Washington Ave – One Commerce Plaza** **Suite 1430** **Albany, NY 12210**
13. TYPED NAME: **Jason A. Helgerson**	
14. TITLE: **Medicaid Director** **Department of Health**	
15. DATE SUBMITTED: December 30, 2013	

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
2013 Title XIX State Plan
Fourth Quarter Amendment
Non-Institutional Services
Amended SPA Pages

New York
1(e)(2)

APG Reimbursement Methodology – Hospital Outpatient

The following links direct users to the various definitions and factors that comprise the APG reimbursement methodology, which can also be found in aggregate on the APG website at http://www.health.ny.gov/health_care/medicaid/rates/apg/index.htm. In addition, prior period information associated with these links is available upon request to the Department of Health.

Contact Information:
http://www.health.ny.gov/health_care/medicaid/rates/apg/index.htm. Click on "Contacts."

3M APG Crosswalk, version [3.3] 3.8; updated as of 10/01/13:
http://www.health.ny.gov/health_care/medicaid/rates/crosswalk/index.htm
http://dashboard.emedny.org/CrossWalk/html/cwAgreement.html Click on "Accept" at bottom of page to gain access.

APG Alternative Payment Fee Schedule; updated as of 04/01/10:
http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm Click on "Alternative Payment Fee Schedule."

APG Consolidation Logic; logic is from the version of 4/01/08, updated as of 04/01/10:
http://www.health.ny.gov/health_care/medicaid/rates/bundling/2008/index.htm

APG 3M Definitions Manual Versions; updated as of [04/01/10] 10/01/13:
http://www.health.ny.gov/health_care/medicaid/rates/crosswalk/index.htm

APG Investments by Rate Period; updated as of 04/01/10:
http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm Click on "Investments by Rate Period."

APG Relative Weights; updated as of [07/01/13] 10/01/13:
http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm Click on "Weights, Proc Weights, and APG Fee Schedule Amounts" file.

Associated Ancillaries; updated as of 04/01/10:
http://www.health.ny.gov/health_care/medicaid/rates/apg/index.htm Click on "Ancillary Policy."

New York
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Base Rates, Hospital Outpatient Clinics, updated as of 04/01/10:
http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm Click on "APG Rates" and then "Hospital."

Carve-outs; updated as of 04/01/10:
http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm Click on "Carve Outs."

Coding Improvement Factors (CIF); updated as of 04/01/10:
http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm Click on "CIFs by Rate Period."

If Stand Alone, Do Not Pay APGs; updated as of [04/01/10] 10/01/13:
http://www.health.state.ny.us/health_care/medicaid/rates/methodology/index.htm Click on "If Stand Alone, Do Not Pay APGs."

If Stand Alone, Do Not Pay Procedures; updated as of 04/01/10:
http://www.health.state.ny.us/health_care/medicaid/rates/methodology/index.htm Click on "If Stand Alone, Do Not Pay Procedures."

Modifiers; updated as of [04/01/10] 10/01/13:
http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm Click on "Modifiers."

Never Pay APGs; updated as of 04/01/10:
http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm Click on "Never Pay APGs."

Never Pay Procedures; updated as of [07/01/13] 10/01/13:
http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm Click on "Never Pay Procedures."

No-Blend APGs; updated as of 04/01/10:
http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm Click on "No Blend APGs."

No-Blend Procedures; updated as of 04/01/10:
http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm Click on "No Blend Procedures."

Appendix II
2013 Title XIX State Plan
Fourth Quarter Amendment
Non-Institutional Services
Summary

SUMMARY
SPA #13-61

This State Plan Amendment proposes to revise the Ambulatory Patient Group (APG) methodology for hospital-based clinic and ambulatory surgery services, including emergency room services, to reflect the recalculated weights with component updates that will become effective October 1, 2013. Included in the weight update is the payment for direct admissions from physicians to hospital observation.

Appendix III
2013 Title XIX State Plan
Fourth Quarter Amendment
Non-Institutional Services
Authorizing Provisions

SPA 13-61

Public Health Law
Sections 2805-v

§ 2805-v. Observation services. 1. If a general hospital provides observation services, such services shall be provided in accordance with this section, and regulations adopted by the council and approved by the commissioner.

2. Observation services may be provided for such period of time as is permitted by the commissioner by regulation. Such regulations shall be consistent with federal policies for providing observation services to beneficiaries, as set forth in title XVIII of the federal social security act (medicare), except where necessary, in the discretion of the commissioner, to protect and promote patient care and safety.

3. Based on the clinical needs of the patient, which shall be determined in prompt fashion by appropriate staff, and the availability of services to meet those needs and patient safety, a general hospital shall determine (a) the proper clinical location for the care of a specific patient requiring observation services, including whether or not to provide such services in a distinct physical space, and (b) the appropriate oversight of observation services.

4. Every general hospital providing observation services shall develop and adopt policies and procedures for observation services, including: (a) assignment of a provider who will be responsible for the care of the patient and timely discharge from observation services; (b) clinical criteria for observation assignment and discharge; and (c) integration with quality assurance activities of the hospital.

5. The commissioner shall develop outpatient rates for observation services provided in accordance with this section to patients eligible for payments made by state governmental entities.

and there is no local share for administrative costs over and above the Medicaid administrative cap.

The Medicaid managed care program utilizes existing state systems for operation (Welfare Management System, eMedNY, etc.).

The Department provides ongoing technical assistance to counties to assist in all aspects of planning, implementing and operating the local program.

Rural Area Participation:

The proposed regulations do not reflect new policy. Rather, they codify current program policies and requirements and make the regulations consistent with section 364-j of the SSL. During the development of the 1115 waiver application and the design of the managed care program, input was obtained from many interested parties.

Job Impact Statement

Nature of Impact:

The rule will have no negative impact on jobs and employment opportunities. The mandatory Medicaid managed care program authorized by Section 364-j of the Social Services Law (SSL) will expand job opportunities by encouraging managed care plans to locate and expand in New York State.

Categories and Numbers Affected:

Not applicable.

Regions of Adverse Impact:

None.

Minimizing Adverse Impact:

Not applicable.

Self-Employment Opportunities:

Not applicable.

Assessment of Public Comment
The agency received no public comment since publication of the last assessment of public comment.

NOTICE OF ADOPTION

October 2011 Ambulatory Patient Groups (APGs) Payment Methodology

I.D. No. HLT-50-11-00015-A
Filing No. 172
Filing Date: 2012-02-28
Effective Date: 2012-03-14

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

Action taken: Amendment of Subpart 86-8 of Title 10 NYCRR.

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

Subject: October 2011 Ambulatory Patient Groups (APGs) Payment Methodology.

Purpose: To refine the APG payment methodology.

Text or summary was published in the December 14, 2011 issue of the Register, I.D. No. HLT-50-11-00015-P.

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

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

Assessment of Public Comment
The agency received no public comment.

Office of Mental Health

NOTICE OF ADOPTION

Clinic Treatment Programs

I.D. No. OMH-46-11-00006-A
Filing No. 169
Filing Date: 2012-02-27
Effective Date: 2012-03-14

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

Action taken: Amendment of Part 599 of Title 14 NYCRR.

Statutory authority: Mental Hygiene Law, sections 7.09, 31.04, 43.01 and 43.02; Social Services Law, art. 33, sections 364, 364-a and 365-m

Subject: Clinic Treatment Programs.

Purpose: Amend and clarify existing regulation and enable providers to seek reimbursement for certain services using State-only dollars.

Substance of final rule: This final adoption amends Part 599 of Title 14 NYCRR which governs the licensing, operation, and Medicaid fee-for-service funding of mental health clinics. 14 NYCRR Part 599 was originally adopted as final on October 1, 2010 and resulted in major changes in the delivery and financing of mental health clinic services. When the regulation was promulgated, the Office of Mental Health understood that there would be issues that might require clarification once providers and recipients of services had experience in operating under the new regulation. This rule making was designed to address those issues and add relatively minor program modifications that have occurred since the initial regulation was promulgated. Non-substantive changes were made to the final rule to further clarify the requirements found in 14 NYCRR Part 599. A summary of all changes, including those non-substantive changes that were made since publication of the Notice of Proposed Rule Making, are found in the narrative below.

- Clarification of the distinction between ''injectable psychotropic medication administration'' and ''injectable psychotropic medication administration with monitoring and education'' and the provisions regarding reimbursement for these services;

- Clarification of the definition of ''health monitoring'', ''hospital-based clinic'', ''modifiers'', and ''psychiatric assessment'', and inclusion of definitions for ''Behavioral Health Organization'' and ''concurrent review''. The final version of this regulation also expands the definitions of ''diagnostic and treatment center'', ''hospital-based clinic'' and ''heath monitoring''. The term ''smoking status'' has been changed to ''smoking cessation'' for both adults and children, and the definition of ''health monitoring'' now includes ''substance use'' as an indicator for both adults and children - see new Subdivisions (r), (w) and (ab) of Section 599.4;

- Repeal of provisions requiring a treating clinician to determine the need for continued clinic treatment beyond 40 visits for adults and children;

-Amendment of the provisions regarding screening of clinic treatment staff by the New York Statewide Central Register of Child Abuse and Maltreatment;

- Clarification of requirements regarding required signatures on treatment plans. The final version of the regulation further clarifies that, for recipients receiving services reimbursed by Medicaid on a fee-for-service basis, the signature of the physician is required on the treatment plan. For recipients receiving services that are not reimbursed by Medicaid on a fee-for-service basis, the signature of the physician, licensed psychologist, LCSW, or other licensed individual within his/her scope of practice involved in the treatment plan is required - see Section 599.10(j)(4);

- Addition of provisions regarding reimbursement modifications for visits in excess of 30 and 50 respectively (excluding crisis visits) for fiscal years commencing on or after April 1, 2011. Note - the final version of the regulation lists other services that are excluded from the 30/50 thresholds. These services, in addition to crisis visits, include off-site visits, complex care management and any services that are counted as health services - see Section 599.13(e);

Effective Date: 01/11/2012
Title: Section 405.19 - Emergency services

405.19 Emergency services.

(a) General.

(1) Emergency services shall be provided in accordance with this subdivision or subdivisions (b) through (e) of this section as appropriate.

(2) If emergency services are not provided as an organized service of the hospital, the governing body and the medical staff shall assure:

(i) prompt physician evaluation of patients presenting emergencies;

(ii) initial treatment and stabilization or management; and

(iii) transfer, where indicated, of patients to an appropriate receiving hospital. The hospital shall have a written agreement with local emergency medical services (EMS) to accommodate the need for timely inter-hospital transfer on a 24 hours a day, 7 days a week, 365 days a year basis.

(b) Organization. (1) The medical staff shall develop and implement written policies and procedures approved by the governing body that shall specify:

(i) the responsibility of the emergency services to evaluate, initially manage and treat, or admit or recommend admission, or transfer patients to another facility that can provide definitive treatment. Such policies and procedures shall include a written agreement with one or more local emergency medical services (EMS) to accommodate the need for timely inter-facility transport on a 24 hours a day, 7 days a week, 365 days a year basis;

(ii) the organizational structure of the emergency service, including the specification of authority and accountability for services; and

(iii) explicit prohibition on transfer of patients based on their ability or inability to pay for services.

(2) The emergency service shall be directed by a licensed and currently registered physician who is board-certified or board-admissible for a period not to exceed five years after the physician first attained board admissibility in emergency medicine, surgery, internal medicine, pediatrics or family practice, and who is currently certified in advanced trauma life support (ATLS) or has training and experience equivalent to ATLS. Such physician shall also have successfully completed a course in advanced cardiac life support (ACLS) or have had training and experience equivalent to ACLS. A licensed and currently registered physician who is board-certified or board-admissible in psychiatry for a period not to exceed five years after the physician first attained board-admissibility, in psychiatry may serve as psychiatrist director of a separately operated psychiatric emergency service. Directors of separately operated psychiatric emergency services need not be qualified to perform ACLS and ATLS.

(3) An emergency service shall have laboratory and X-ray capability, including both fixed and mobile equipment, available 24 hours a day, seven days a week, to provide test results to the service within a

time considered reasonable by accepted emergency medical standards.

(c) General policies and procedures. (1) The location and telephone number of the State Department of Health-designated poison control center, shall be maintained at the telephone switchboard and in the emergency service.

(2) All cases of suspected child abuse or neglect shall be treated and reported immediately to the New York State Central Register of Child Abuse and Maltreatment pursuant to procedures set forth in article 6, title 6 of the Social Services Law.

(3) Domestic violence. The emergency service shall develop and implement policies and procedures which provide for the management of cases of suspected or confirmed domestic violence victims in accordance with the requirements of section 405.9(e) of this Part.

(4) The emergency service shall establish and implement written policies and procedures for the maintenance of sexual offense evidence as part of the hospital-wide provisions required by this Part. An organized protocol for survivors of sexual offenses, including medical and psychological care shall be incorporated into such policies and procedures. These policies, procedures and protocols shall be consistent with the standards for patient care and evidence collection established in section 405.9(c) of this Part.

(5) The emergency service, in conjunction with the discharge planning program of the hospital, shall establish and implement written criteria and guidelines specifying the circumstances, the actions to be taken, and the appropriate contact agencies and individuals to accomplish adequate discharge planning for persons in need of post emergency treatment or services but not in need of inpatient hospital care.

(6) An admission and discharge register shall be current and shall include at least the following information for every individual seeking care:

(i) date, name, age, gender, ZIP code;

(ii) expected source of payment;

(iii) time and means of arrival, including name of ambulance service for patients arriving by ambulance;

(iv) complaint and disposition of the case; and

(v) time and means of departure, including name of ambulance service for patients transferred by ambulance.

(7) There shall be a medical record that meets the medical record requirements of this Part for every patient seen in the emergency service. Medical records shall be integrated or cross-referenced with the inpatient and outpatient medical records system to assure the timely availability of previous patient care information and shall contain the prehospital care report or equivalent report for patients who arrive by ambulance.

(8) Review of the hospital emergency service shall be conducted at least four times a year as a part of the hospital's overall quality assurance program. Receiving hospitals shall report to sending hospitals

and emergency medical systems, as appropriate, all patients that die unexpectedly within 24 hours upon arrival at the receiving hospitals. These patient mortalities shall be included in both hospitals' quality assurance review.

(d) Staffing. The following requirements are applicable to all organized emergency services:

(1) Emergency service physician services shall meet the following requirements:

(i) The emergency services attending physician shall meet the minimum qualifications set forth in either clauses (a) or (b) of this subparagraph.

(a) The emergency services attending physician shall be a licensed and currently registered physician who is board-certified in emergency medicine, surgery, internal medicine, pediatrics or family practice and who is currently certified in advanced trauma life support (ATLS) or has training and experience equivalent to ATLS. Such physician shall also have successfully completed a course in advanced cardiac life support (ACLS) or have had training and experience equivalent to ACLS. A licensed and currently registered physician who is board-certified in psychiatry may serve as psychiatrist attending in a separately operated psychiatric emergency service. A licensed and currently registered physician who is board-admissible in one of these specialty areas and is currently certified in ATLS or who has training and experience equivalent to ATLS and has successfully completed a course in ACLS or has had training and experience equivalent to ACLS may be designated as attending physician for a period not to exceed five years after the physician has first attained board-admissibility except that the requirement to be qualified to perform ATLS and ACLS shall not be applicable to qualified psychiatrist attendings in a separately operated psychiatric emergency service. Physicians who are board-certified or admissible, for a period not to exceed five years after the physician first attained board-admissibility, in other specialty areas may be designated as attending physicians for patients requiring their expertise.

(b) The emergency services attending physician shall be a physician who:

(1) is licensed and currently registered;

(2) has successfully completed one year of post-graduate training;

(3) has, within the past five years accumulated 7,000 documented patient contact hours or hours of teaching medical students, physicians-in-training, or physicians in emergency medicine. Up to 3,500 hours of documented experience in hospital-based settings or other settings in the specialties of internal medicine, family practice, surgery or pediatrics may be substituted for the required hours of emergency medicine experience on an hour-for-hour basis;

(4) has acquired in each of the last three years, an average of fifty hours or more per year of continuing medical education pertinent to emergency medicine or to the specialties of practice which contributed to meeting the 7,000 hours requirement specified in subclause (3) of this clause;

(5) is currently certified in ATLS or has training and experience equivalent to ATLS; and

(6) has successfully completed a course in advanced cardiac life support (ACLS) or has had training and experience equivalent to ACLS.

(ii) There shall be at least one emergency service attending physician on duty 24 hours a day, seven days a week. For hospitals that exceed 15,000 unscheduled visits annually, the attending physician shall be present and available to provide patient care and supervision in the emergency service. As necessitated by patient care needs, additional attending physicians shall be present and available to provide patient care and supervision. Appropriate subspecialty availability as demanded by the case mix shall be provided promptly in accordance with patient needs. For hospitals with less than 15,000 unscheduled emergency visits per year, the supervising or an attending physician need not be present but shall be available within thirty minutes, provided that at least one physician, nurse practitioner, or registered physician assistant shall be on duty in the emergency service 24 hours a day, seven days a week;

(iii) Other medical staff practitioner services provided in the emergency service shall be in accordance with the privileges granted the individual; and

(iv) Every medical-surgical specialty on the hospital's medical staff which is organized as a department or clinical service and where practitioner staffing is sufficient, shall have a schedule to provide coverage to the emergency service by attending physicians in a timely manner, 24 hours a day, seven days a week, in accordance with patient needs.

(2) Nursing services:

(i) There shall be at least one supervising emergency services registered professional nurse present and available to provide patient care services in the emergency service 24 hours a day, seven days a week;

(ii) Emergency services supervising nurses shall be licensed and currently registered and possess current, comprehensive knowledge and skills in emergency health care. They shall have at least one year of clinical experience, be able to demonstrate skills and knowledge necessary to perform basic life support measures, have successfully completed a course in ACLS or have had training and experience equivalent to ACLS and maintain current competence in ACLS as determined by the hospital;

(iii) Registered professional nurses in the emergency service shall be licensed and currently registered professional nurses who possess current, comprehensive knowledge and skills in emergency health care. They shall have at least one year of clinical experience, have successfully completed an emergency nursing orientation program and be able to demonstrate skills and knowledge necessary to perform basic life support measures. Within one year of assignment to the emergency service, each emergency service nurse shall have successfully completed a course in ACLS or have had training and experience equivalent to ACLS and shall maintain current competence in ACLS as determined by the hospital.

(iv) Additional registered professional nurses and nursing staff shall be assigned to the emergency service in accordance with patient needs. If, on average:

(a) the volume of patients per eight-hour shift is under 25, an additional registered professional nurse shall be available as needed to assist the supervising registered professional nurse with delivery of direct patient care; or

(b) the volume of patients per eight-hour shift is over 25, there shall be a minimum of two registered professional nurses per shift assigned to provide direct patient care. As patient volume and intensity increases, the total number of available registered professional nurses shall also be increased to meet

patient care needs;

(3) Registered physician's assistants and nurse practitioners:

(i) patient care services provided by registered physician's assistants shall be in accordance with section 405.4 of this Part;

(ii) patient care services provided by certified nurse practitioners shall be in collaboration with a licensed physician whose professional privileges include approval to work in the emergency service and in accordance with written practice protocols for these services; and

(iii) the registered physician assistants and the nurse practitioners shall meet the following standards:

(a) the registered physician assistants and the nurse practitioners in the emergency service shall have successfully completed a course in ACLS or have had training and experience equivalent to ACLS when determined necessary by the hospital to meet anticipated patient needs or when a physician assistant or nurse practitioner is serving as the sole practitioner on duty in a hospital with less than 15,000 unscheduled emergency visits per year;

(b) registered physician assistants and nurse practitioners in the emergency service shall have had training and experience equivalent to ATLS when determined necessary by the hospital to meet anticipated patient needs or when a physician assistant or nurse practitioner is serving as the sole practitioner on duty in a hospital with less than 15,000 unscheduled emergency visits per year.

(4) Support personnel. There shall be sufficient support personnel assigned to the emergency service to perform the following duties on a timely basis: patient registration, reception, messenger service, acquisition of supplies, equipment, delivery and labelling of laboratory specimens, responsible for the timely retrieval of laboratory reports, obtaining records, patient transport and other services as required.

(e) Patient care. (1) The hospital shall assure that all persons arriving at the emergency service for treatment receive emergency health care that meets generally accepted standards of medical care.

(2) Every person arriving at the emergency service for care shall be promptly examined, diagnosed and appropriately treated in accordance with triage and transfer policies and protocols adopted by the emergency service and approved by the hospital. Such protocols must include written agreements with local emergency medical services (EMS) in accordance with subparagraph (b)(1)(i) of this section. All patient care services shall be provided under the direction and control of the emergency services director or attending physician. In no event shall a patient be discharged or transferred to another facility, unless evaluated, initially managed, and treated as necessary by an appropriately privileged physician, physician assistant, or nurse practitioner. No later than eight hours after presenting in the emergency service, every person shall be admitted to the hospital, or assigned to an observation unit in accordance with subdivision (g) of this section, or transferred to another hospital in accordance with paragraph (6) of this subdivision, or discharged to self-care or the care of a physician or other appropriate follow-up service. Hospitals which elect to use physician assistants or nurse practitioners shall develop and implement written policies and treatment protocols subject to approval by the governing body that specify patient conditions that may be treated by a registered physician assistant or nurse practitioner without direct visual supervision of the emergency services attending physician.

(3) Hospitals that have limited capability for receiving and treating patients in need of specialized emergency care shall develop and implement standard descriptions of such patients, and have triage and treatment protocols and formal written transfer agreements with hospitals that are designated as being able to receive and provide definitive care for such patients. Patients in need of specialized emergency care shall include, but not be limited to:

(i) trauma patients and multiple injury patients;

(ii) burn patients with burns ranging from moderate uncomplicated to major burns as determined by use of generally acceptable methods for estimating total body surface area;

(iii) high risk maternity patients or neonates or pediatric patients in need of intensive care;

(iv) head-injured or spinal-cord injured patients;

(v) acute psychiatric patients;

(vi) replantation patients;

(vii) dialysis patients; and

(viii) acute myocardial infarction patients including but not limited to patients with ST elevation.

(4) Hospitals shall verbally request ambulance dispatcher services to divert patients with life threatening conditions to other hospitals only when the chief executive officer or designee appointed in writing, determines that acceptance of an additional critical patient would endanger the life of that patient or another patient. Request for diversion shall be documented in writing and, if warranted, renewed at the beginning of each shift.

(5) Reserved.

(6) Patients shall be transferred to another hospital only when:

(i) the patient's condition is stable or being managed;

(ii) the attending practitioner has authorized the transfer; and

(iii) administration of the receiving hospital is informed and can provide the necessary resources to care for the patient; or

(iv) when pursuant to paragraph (2) of this subdivision, the patient is in need of specialized emergency care at a hospital designated to receive and provide definitive care for such patients.

(7) Hospitals located within a city with a population of one million or more persons shall apply and, if accepted, participate to the full extent of their capability, in the emergency medical service which is operated by such city or such city's health and hospitals corporation.

(f) Quality assurance.

(1) Quality assurance activities of the emergency service shall be integrated with the hospital-wide quality assurance program and shall include review of:

(i) arrangements for medical control and direction of prehospital emergency medical services;

(ii) provisions for triage of persons in need of specialized emergency care to hospitals designated as capable of treating those patients;

(iii) emergency care provided to hospital patients, to be conducted at least four times a year, and to include prehospital care providers, emergency services personnel and emergency service physicians; and

(iv) adequacy of staff training and continuing education.

(2) hospitals as represented by emergency department practitioners and other clinical practitioners relevant to the care provided should also collaborate, as provided under Public Health Law Section 3006, in the quality improvement programs of their local EMS to review prehospital care issues including review of specific patient cases.

(g) *Observation units.* Observation units shall be under the direction and control of the emergency service and, unless a contrary requirement is specified in this subdivision, observation units shall be subject to all requirements of this section applicable to emergency services.

(1) Patient Care: An observation unit shall be used only for observation, diagnosis and stabilization of those patients for whom diagnosis and a determination concerning admission, discharge, or transfer cannot be accomplished within eight hours, but can reasonably be expected within twenty-four hours. Patients shall be assigned to the observation unit by physician order and within twenty-four hours of the issuance of an order assigning the patient to an observation unit, the patient must be admitted to the inpatient service, be transferred in accordance with paragraph (6) of subdivision (e) of this section, or be discharged to self-care or the care of a physician or other appropriate follow-up service.

(2) Physical Space:

(i) The total number of dedicated observation unit beds in a hospital shall be limited to five percent of the hospital's certified bed capacity, and shall not exceed forty, provided that in a hospital with less than 100 certified beds, an observation unit may have up to five beds.

(ii) The observation unit shall be located within a distinct physical space, except in a hospital designated as a critical access hospital pursuant to subpart F of part 485 of Title 42 of the Code of Federal Regulations or a sole community hospital pursuant to section 412.92 of Title 42 of the Code of Federal Regulations or any successor provisions.

(iii) The observation unit shall comply with the applicable provisions of Parts 711 and 712-2 and section 712-2.4 of this Title for construction projects approved or completed after January 1, 2011.

(iv) Observation unit beds shall not be counted within the state certified bed capacity of the hospital and

shall be exempt from the public need provisions of Part 709.

(v) The observation unit shall be marked with a clear and conspicuous sign that states: "This is an observation unit for visits of up to 24 hours. Patients in this unit are not admitted for inpatient services."

(3) Staffing.

(i) Patients in an observation unit shall be cared for, pursuant to a defined staffing plan, by staff, appropriately trained and in sufficient numbers to meet the needs of patients in the observation unit.

(ii) At a minimum, a physician, nurse practitioner, or physician assistant shall be responsible for oversight of the medical care of the patients assigned to the observation unit. Such physician, nurse practitioner, or physician assistant assigned to oversee the observation unit shall be immediately available to meet the needs of patients in the observation unit and shall not be assigned concurrent duties that will interfere with such availability.

(4) Organization. The medical staff shall develop and implement written policies and procedures approved by the governing body for the observation unit that shall include, but not be limited to:

(i) the integration of the observation unit and its services with the emergency service and other related services of the hospital; and

(ii) appropriate use of the observation unit, including documentation of the clinical reasons and indications that warrant the period of observation, rather than admission or discharge, consistent with section 405.10 of this Part.

(5) Opening and Closure.

(i) Any hospital seeking to establish an observation unit shall:

(a) if no construction, as defined in subdivision 5 of section 2801 of the Public Health Law, will be needed, and no service will be eliminated:

(1) submit a written notice to the Department on a form developed by the Department, not less than 90 days prior to opening the unit, indicating the hospital's intent to establish such a unit; the number of beds to be located in the unit; the location of the unit within the facility, and such other information as the Department may require; and

(2) submit a certification from a licensed architect or engineer, in the form specified by the Department, that the space complies with the applicable provisions of Parts 711 and 712-2 and section 712-2.4 of this Title for construction projects approved or completed after January 1, 2011; or

(b), if construction, as defined in subdivision 5 of section 2801 of the Public Health Law, will be needed or a service will be eliminated:

(1) comply with Part 710 of this Title, provided that for purposes of Part 710, a construction project involving only the creation of an observation unit and the addition of observation unit beds shall not be subject to review under section 710.1(c)(2) or (3) of this Title, unless the total project cost exceeds $15

million or $6 million respectively; and

(2) comply with the applicable provisions of Parts 711 and 712-2 and section 712-2.4 of this Title for construction projects approved or completed after January 1, 2011.

(ii) No hospital may discontinue operation of an observation unit without providing written notification to the Department of the impending closure not less than 90 days prior to the closure.

(6) Transition. A hospital operating an observation unit pursuant to a waiver granted by the Department shall be required to comply with the provisions of this subdivision within 24 months of its effective date.

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Appendix IV
2013 Title XIX State Plan
Fourth 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

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 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 revise provisions of the Ambulatory Patient Group (APG) reimbursement methodology on or after October 1, 2013.

The Ambulatory Patient Group (APG) reimbursement methodology is revised to include recalculated weight and component updates that will become effective on or after October 1, 2013. The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2013/2014 is $5,000,000.

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

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

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, Bureau of Federal Relations & Provider Assessments, 99 Washington Ave. – One Commerce Plaza, Suite 1430, Albany, NY 12210, (518) 474-1673, (518) 473-8825 (FAX), spa_inquiries@health.state.ny.us

PUBLIC NOTICE
Department of Health

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

The Department of Health proposes to amend the Title XIX (Medicaid) State Plan for long term care services pursuant to statutory provisions contained in the Patient Protection and Affordable Care Act (Public Law 111-148), Section 2401 (Community First Choice Option). The following changes are proposed:

The Affordable Care Act, PL 111-148, authorized states to expand access and availability of Medicaid-funded long term services and supports (LTSS) in non-institutional home and community-based settings by offering enhanced personal attendant services through the Community First Choice Option (CFCO) State Plan Amendment. Such services are required to provide assistance to eligible individuals to accomplish activities of daily living (ADLs), instrumental activities of daily living (IADLs) and/or health-related tasks through hands-on assistance, supervision and cueing. These services must be provided pursuant to a person-centered care plan developed after a comprehensive assessment of functional need in a community-based setting through an agency-provider or other model. Such services are to be consumer controlled to the greatest extent possible. Included in the services required under the CFCO are the acquisition, maintenance and enhancement of skills necessary for the individual to accomplish ADLs, IADLs, and health-related tasks; a backup system to assure continuity of care and voluntary training on selecting, managing and dismissing attendants. Excluded services include room and board, vocational or educational services, home modifications, medical supplies and equipment and assistive technology devices and services other than those specifically allowed under the plan.

Services under the CFCO must be provided across the disability spectrum including those who are elderly and those who have a physical, mental or developmental disability. Eligible individuals have demonstrated functional needs that can be addressed by CFCO LTSS, are Medicaid eligible, and require an institutional level of care.

New York State already offers personal care services as well as a Consumer Directed Personal Attendant Program (CDPAP) in its Medicaid State plan. The State also has an extensive array of waiver services that provide assistance with ADLs, IADLs and health-related tasks. These waiver programs and services are administered by vari-

Appendix V
2013 Title XIX State Plan
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Responses to Standard Funding Questions

NON-INSTITUTIONAL SERVICES
State Plan Amendment #13-61

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**

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: The State submitted 2012 and 2013 outpatient UPL demonstrations on September 30, 2013, which are currently under CMS review.

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 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 provider's payments to their actual costs.

ACA Assurances:

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

   MOE Period.
   - **Begins on: March 10, 2010, and**
   - **Ends on: The date the Secretary of the Federal Department of Health and Human Services determines an Exchange established by a State under the provisions of section 1311 of the Affordable Care Act is fully operational.**

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

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

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

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

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

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

Tribal Assurance:

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

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

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

Response: Tribal consultation was performed in accordance with the State's tribal consultation policy as approved in SPA 11-06, and documentation of such is included with this submission. To date, no feedback has been received from any tribal representative in response to the proposed change in this SPA.