NEW YORK
state department of
HEALTH

Howard A. Zucker, M.D., J.D.
Acting Commissioner of Health

Sue Kelly
Executive Deputy Commissioner

June 30, 2014

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 #14-25
Non-Institutional Services

Dear Mr. Melendez:

The State requests approval of the enclosed amendment #14-25 to the Title XIX (Medicaid) State Plan for non-institutional services to be effective April 1, 2014 (Appendix I). This amendment is being submitted based on enacted statute. 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 enacted 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 June 4, 2014 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: **#14-25**	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 **April 1, 2014**	

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

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

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

6. FEDERAL STATUTE/REGULATION CITATION: **Section 1902(a) of the Social Security Act, and 42 CFR 447**	7. FEDERAL BUDGET IMPACT: **a. FFY 04/01/14 –09/30/14 $ 7,319,000** **b. FFY 10/01/14 – 09/30/15 $14,638,000**
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: **Attachment 4.19-B: Pages 4(a)(i), 4(a)(viii)(1), 10**	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: **Attachment 4.19-B: Pages 4(a)(i), 4(a)(viii)(1), 10**

10. SUBJECT OF AMENDMENT:
Home Care R & R Extension (4/1/14-3/31/17)
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: June 30, 2014	

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
2014 Title XIX State Plan
Second Quarter Amendment
Amended SPA Pages

volume of services attributable to each contracted agency. Such agencies shall submit to providers with which they contract written certifications attesting that such funds will be used solely for the purposes of recruitment and retention of non-supervisory home care services workers or any worker with direct patient care responsibility and shall maintain in their files expenditure plans specifying how such funds will be used for such purposes. The Commissioner is authorized to audit such agencies to ensure compliance with such certifications and expenditure plans and shall recoup any funds determined to have been used for purposes other than those set forth in this section.

The Commissioner of Health will additionally adjust rates of payment for AIDS home care service providers, for the purpose of improving recruitment and retention of home health aides or other non-supervisory personnel with direct patient care responsibility.

These additional adjustments to rates of payments shall be calculated by allocating the available funding proportionally based on each AIDS home care service provider's, 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. The total aggregate available funding for AIDS home care service providers is as follows:

For the period June 1, 2006 through December 31, 2006 - $540,000.
For the period January 1, 2007 through June 30, 2007 - $540,000.
For the period July 1, 2007 through March 31, 2008 - $1,080,000.
For the period April 1, 2008 through March 31, 2009 - $1,080,000.
For the period April 1, 2009 through March 31, 2010 - $1,080,000.
For the period April 1, 2010 through March 31, 2011 - $1,080,000.
For the period April 1, 2011 through March 31, 2012 - $1,080,000.
For the period April 1, 2012 through March 31, 2013 - $1,080,000.
For the period April 1, 2013 through March 31, 2014 - $1,080,000.
For the period April 1, 2014 through March 31, 2015 - $1,080,000.
For the period April 1, 2015 through March 31, 2016 - $1,080,000
For the period April 1, 2016 through March 31, 2017 - $1,080,000.

Payments made pursuant to this section shall not be subject to subsequent adjustment or reconciliation.

For providers established after November 1, 2005, the Department utilizes Medicaid data from the initial cost report submitted to the Department, which would allow the inclusion of those providers in the distribution.

New York
4(a)(viii)(1)

Recruitment and Retention of Direct Patient Care Personnel

The Commissioner of Health will additionally adjust rates of payment for certified home health agencies, for purposes of improving recruitment and retention of home health aides or other non-supervisory personnel with direct patient care responsibility.

These additional adjustments to rates of payments shall be calculated by allocating the available funding proportionally based on each certified home health agency's, 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 .The total aggregate available funding for all eligible certified home health agency providers is as follows:

For the period June 1, 2006 through December 31, 2006 - $20,100,000.
For the period January 1, 2007 through June 30, 2007 - $20,100,000.
For the period July 1, 2007 through March 31, 2008 - $40,200,000.
For the period April 1, 2008 through March 31, 2009 - $40,200,000.
For the period April 1, 2009 through March 31, 2010 - $40,200,000.
For the period April 1, 2010 through March 31, 2011 - $40,200,000.
For the period April 1, 2011 through March 31, 2012 - $40,200,000.
For the period April 1, 2012 through March 31, 2013 - $40,200,000.
For the period April 1, 2013 through March 31, 2014 - $40,200,000.
For the period April 1, 2014 through March 31, 2015 - $26,736,000.
For the period April 1, 2015 through March 31, 2016 - $26,736,000.
For the period April 1, 2016 through March 31, 2017 - $26,736,000.

Payments made pursuant to this section will not be subject to subsequent adjustment or reconciliation.

For providers established after November 1, 2005, the Department utilizes Medicaid data from the initial cost report submitted to the Department, which would allow the inclusion of those providers in the distribution.

New York
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Types of Service

Hospice Services: Routine Home Care, Continuous Home Care, Inpatient Respite Care, And General Inpatient Care

Medicaid payment for hospice care will be in amounts no lower than the Medicare rates for: general inpatient, inpatient respite, routine home care and continuous home care using the same methodology as used under Part A of Title XVIII. Annual adjustments shall be made to these rates commencing October 1, 1990, using inflation factors developed by the State.

The Commissioner of Health will increase medical assistance rates of payment by three percent for hospice services provided on and after December first, two thousand two, for purposes of improving recruitment and retention of non-supervisory workers or workers with direct patient care responsibility.

For hospice services provided on or after June 1, 2006 through March 31, 2011, rates of payment will be additionally adjusted for the purpose of further enhancing the provider's ability to recruit and retain non-supervisory workers or workers with direct patient care responsibility. These additional adjustments to rates of payment will be allocated proportionally based on each hospice provider's non-supervisory workers' or direct patient care workers' total annual hours of service provided to Medicaid patients as reported in each such provider's most recently available cost report as submitted to the Department. The total aggregate available funding for all eligible hospice providers is as follows:

For the period June 1, 2006 through December 31, 2006 - $730,000.
For the period January 1, 2007 through June 30, 2007 - $730,000.
For the period July 1, 2007 through March 31, 2008 - $1,460,000.
For the period April 1, 2008 through March 31, 2009 - $1,460,000.
For the period April 1, 2009 through March 31, 2010 - $1,460,000.
For the period April 1, 2010 through March 31, 2011 - $1,460,000.
For the period April 1, 2011 through March 31, 2012 - $1,460,000.
For the period April 1, 2012 through March 31, 2013 - $1,460,000.
For the period April 1, 2013 through March 31, 2014 - $1,460,000.
For the period April 1, 2014 through March 31, 2015 - $1,460,000.
For the period April 1, 2015 through March 31, 2016 - $1,460,000.
For the period April 1, 2016 through March 31, 2017 - $1,460,000.

Hospice services providers that have their rates adjusted for this purpose shall use such funds solely for the purposes of recruitment and retention of non-supervisory workers or workers with direct patient care responsibility and are prohibited from using such funds for any other purposes. Each hospice provider receiving funds shall submit, at a time and in a manner determined by the Commissioner, a written certification attesting that such funds will be used solely for the purpose of recruitment and retention of non-supervisory workers or workers with

Appendix II
2014 Title XIX State Plan
Second Quarter Amendment
Summary

SUMMARY
SPA #14-25

This proposed state plan amendment provides funds to certified home health agencies, AIDS home care providers, and hospice service providers for the purpose of improving recruitment, training, and retention of home health aides or other personnel with direct patient care responsibility which has been extended for the period April 1, 2014 to March 31, 2017.

Appendix III
2014 Title XIX State Plan
Second Quarter Amendment
Authorizing Provisions

SPA # 14-25

Chapter 60 of the Laws of 2014

§ 13. Paragraph (i) of subdivision 9 of section 3614 of the public health law, as added by section 23 of part C of chapter 59 of the laws of 2011, is amended and three new paragraphs (j), (k) and (l) are added to read as follows:

(i) for the period April first, two thousand thirteen through March thirty-first, two thousand fourteen, up to one hundred million dollars[~~,~~]**;**

(j) for the period April first, two thousand fourteen through March thirty-first, two thousand fifteen, up to one hundred million dollars;

(k) for the period April first, two thousand fifteen through March thirty-first, two thousand sixteen, up to one hundred million dollars;

(l) for the period April first, two thousand sixteen through March thirty-first, two thousand seventeen, up to one hundred million dollars.

Appendix IV
2014 Title XIX State Plan
Second Quarter Amendment
Public Notice

registered limited liability partnerships which were duly included in proclamations declaring the registration of such registered limited liability partnerships to be revoked in the manner prescribed by Section 121-1500(g) of the Partnership Law, have complied with the provisions of Section 121-1500(g) of the Partnership Law, annulling all of the proceedings theretofore taken for the revocation of the registration of such registered limited liability partnerships. The appropriate entries have been made on the records of the Department of State.

ENTITY NAME: BODY-MIND HEALTH, LLP
REINSTATE: 12/04/13
REVOC OF REGIST: 03/30/05

ENTITY NAME: BORELLI & LI PUMA LLP
REINSTATE: 10/16/13
REVOC OF REGIST: 07/29/09

ENTITY NAME: DUNCAN, FISH & VOGEL, LLP
REINSTATE: 12/04/13
REVOC OF REGIST: 12/28/05

ENTITY NAME: ELLENOFF GROSSMAN & SCHOLE LLP
REINSTATE: 12/04/13
REVOC OF REGIST: 03/27/13

ENTITY NAME: GENSER, DUBOW, GENSER & CONA LLP
REINSTATE: 12/04/13
REVOC OF REGIST: 01/25/10

ENTITY NAME: HIGHWAY RADIOLOGY ASSOCIATES LLP
REINSTATE: 10/16/13
REVOC OF REGIST: 06/29/05

ENTITY NAME: JACQUES M. LEVY & CO., LLP
REINSTATE: 12/17/13
REVOC OF REGIST: 06/29/05

ENTITY NAME: KLINGER & KLINGER, LLP
REINSTATE: 10/17/13
REVOC OF REGIST: 07/25/12

ENTITY NAME: LEPATNER & ASSOCIATES LLP
REINSTATE: 12/04/13
REVOC OF REGIST: 07/25/12

ENTITY NAME: MCCORMICK & O'BRIEN LLP
REINSTATE: 12/04/13
REVOC OF REGIST: 01/26/11

ENTITY NAME: NEW YORK GROUP FOR PLASTIC SURGERY, LLP
REINSTATE: 12/04/13
REVOC OF REGIST: 07/29/10

ENTITY NAME: OLSEN & OLSEN LLP
REINSTATE: 12/04/13
REVOC OF REGIST: 12/26/07

ENTITY NAME: PARKER & CARMODY, LLP
REINSTATE: 12/04/13
REVOC OF REGIST: 04/25/12

ENTITY NAME: RUTHERFORD & CHRISTIE, LLP
REINSTATE: 12/04/13
REVOC OF REGIST: 12/26/12

ENTITY NAME: STOKES, VISCA & CO., LLP
REINSTATE: 12/04/13
REVOC OF REGIST: 12/26/12

ENTITY NAME: STULMAKER, KOHN & RICHARDSON, LLP
REINSTATE: 11/20/13
REVOC OF REGIST: 01/26/11

NOTICE OF THE ANNULMENT OF THE REVOCATION BY PROCLAMATION OF THE STATUS OF CERTAIN FOREIGN LIMITED LIABILITY PARTNERSHIPS AS NEW YORK REGISTERED FOREIGN LIMITED LIABILITY PARTNERSHIPS

Under the Provisions of Section 121-1502(f) of the Partnership Law, As Amended

The Secretary of State hereby provides notice that the following New York registered foreign limited liability partnerships which were duly included in proclamations declaring the status of such New York registered foreign limited liability partnerships to be revoked in the manner prescribed by Section 121-1502(f) of the Partnership Law, have complied with the provisions of Section 121-1502(f) of the Partnership Law annulling all of the proceedings theretofore taken for the revocation of the status of such New York registered foreign limited liability partnerships. The appropriate entries have been made on the records of the Department of State.

ENTITY NAME: NOERR LLP
JURIS: GERMANY
REINSTATE: 10/16/13
REVOC OF REGIST: 01/26/11

PUBLIC NOTICE
Office of General Services

Pursuant to Section 30-a of the Public Lands Law, the Office of General Services hereby gives notice to the following:

Notice is hereby given that the Office of People with Developmental Disabilities has declared 8972 Reed Hill Road, Town of East Otto in Cattaraugus County, New York State, improved with a two-story building, with tax identifier Section 27.016, Block 1, Lot 35.2, surplus, no longer useful or necessary for State program purposes, and has abandoned the property to the Commissioner of General Services for sale or other disposition as Unappropriated State Land.

For further information, please contact: Thomas Pohl, Esq., Office of General Services, Legal Services, 41st Fl., Corning Tower, Empire State Plaza, Albany, NY 12242, (518) 474-8831, (518) 473-4973 (fax)

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 and prescription drugs to comply with recently proposed statutory provisions. The following significant changes and clarifications are proposed:

All Services

• As previously noticed on March 26, 2014, the uniform reduction by two percent for all non-exempt Medicaid payments will terminate on March 31, 2014. Such notice incorrectly indicated this would result in an annual decrease in gross Medicaid expenditures attributable to the initiative, when the result will actually be an increase in gross Medicaid expenditures of up to $714 million for state fiscal year 2014/2015.

• To clarify previous notices related to temporary rate adjustments for providers, effective on or after April 1, 2014, the Commissioner of Health may grant approval of a temporary adjustment to the non-capital components of rates, or make temporary lump-sum Medicaid payments, within funds appropriated and subject to the availability of federal financial participation, to eligible general hospitals, skilled nursing facilities, clinics and home care providers.

- Eligible providers shall include providers: undergoing closure; impacted by the closure of other health care providers; subject to mergers, acquisitions, consolidations or restructuring or those impacted by the merger, acquisition, consolidation or restructuring of other health care providers.

- Providers seeking temporary rate adjustments must submit a written proposal to the Commissioner that demonstrates the additional resources provided will achieve one or more of the following:

• Protection or enhancement of access to care;

• Protection or enhancement of quality of care;

• Improvement in the costs effectiveness of the delivery of health care services; or

• Other protections or enhancements to the health care delivery system.

Such proposal will be submitted to the Commissioner at least 60 days prior to the requested effective date of such adjustment, and will include a proposed budget to achieve the goals of the proposal. Any such adjustment issued will be in effect for a specified period of time, not to exceed three years. At the end of the specified timeframe, such payments or adjustments to the non-capital component of rates will cease, and the provider will be reimbursed in accordance with the applicable rate-setting methodology as set forth in the State Plan. The Commissioner may establish benchmarks and goals to be achieved, and may require the facility to submit periodic reports concerning the achievement of such. Failure to achieve such benchmarks and goals shall be a basis for ending the facility's temporary rate adjustment prior to the end of the specified timeframe. General hospitals defined as critical access hospitals, pursuant to Title XVIII of the Federal Social Security Act shall be allocated no less than $5 million annually.

Institutional Services

• To correct the provision previously noticed on March 26, 2014, for the state fiscal year beginning April 1, 2014 through March 31, 2015, specialty hospital adjustments for hospital inpatient services provided on and after April 1, 2014, 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 will continue. Payments to eligible public general hospitals may be added to rates of payment or made as aggregate payments.

• As previously noticed on March 26, 2014, the Commissioner may make adjustments to inpatient and outpatient Medicaid rates of payment for general hospital services and to the methodology for computing such rates as is necessary to achieve no aggregate, increase or decrease, net growth in overall Medicaid expenditures related to the implementation of the International Classification of Diseases Version 10 (ICD-10) coding system beginning on or about October 1, 2014, as compared to such aggregate expenditures from the period immediately prior to such implementation. However, the State's 2014/2015 budget was enacted prior to the Federal government delaying the implementation of this provision to October 1, 2015. Consistent with the enacted statute, the Commissioner will make the necessary adjustments once ICD-10 goes into effect.

• As previously noticed on March 26, 2014, regulations for per diem rates for inpatient services of a general hospital or a distinct unit of a general hospital for services such as psychiatric, medical rehabilitation, chemical dependency detoxification, chemical dependency rehabilitation, Critical Access Hospitals, specialty long term acute care hospitals, cancer hospitals and exempt acute care children's hospitals may provide for periodic base year cost and statistic updates used to compute rates of payment. The first such base year update shall take effect no later than April 1, 2015, rather than January 1, 2015, as previously noticed. However, the Commissioner may make adjustments to the utilization and methodology for computing these rates as is necessary to achieve no aggregate, net growth in overall Medicaid expenditures related to these rates, as compared to the aggregate expenditures from the prior year. In determining the updated base years to be utilized, the Commissioner shall take into account the base years determined in accordance with Section 2807-c(35)(c).

There is no annual increase or decrease in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2014/2015.

• Extends the mandated cost savings associated with the current methodology establishing quality related measures, including, but not limited to potentially preventable re-admissions (PPRs) and providing for rate adjustments or payment disallowances related to PPRs and other potentially preventable negative outcomes (PPNOs). Such mandated cost savings of no less than $51 million a year are extended for the period April 1, 2014 through March 31, 2015.

- Such aggregate reductions shall be offset by Medicaid payment reductions occurring as a result of decreased PPRs during the period April 1, 2014 through March 31, 2015 and as a result of decreased PPNOs during the period April 1, 2014 through March 31, 2015. Such rate adjustments or payment disallowances will not apply to behavioral health PPRs or to readmissions that occur on or after 15 days following an initial admission.

Long Term Care Services

• For state fiscal years beginning April 1, 2014, continues additional payments to non-state government operated public residential health care facilities, including public residential health care facilities located in Nassau, Westchester, and Erie counties, but excluding public residential health care facilities operated by a town or city within a county, in aggregate amounts of up to $500 million. The amount allocated to each eligible public RHCF will be in accordance with the previously approved methodology, provided, however that patient days shall be utilized for such computation reflecting actual reported data for 2012 and each representative succeeding year as applicable. Payments to eligible RHCF's may be added to rates of payment or made as aggregate payments.

• For residential health care facilities (RHCFs), adjustments to Medicaid rates of payment based on changes to a facility's case mix index capping any change in such case mix index in excess of two percent for any six month period prior to periods beginning January 1, 2016, or such earlier date as determined by the Commissioner, previously noticed on March 26, 2014, shall not be implemented as a result of the final SFY 2014/15 Executive Budget.

Non-institutional Services

• 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, 2014 through March 31, 2017. Payments shall not exceed in the aggregate, $100 million for each of the following periods: April 1, 2014 through March 31, 2015; April 1, 2015 through March 31, 2016; and April 1, 2016 through March 31, 2017, 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, 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, 2014, the Commissioner may implement a Health Home rate add-on to provide resources to Health Homes for the following purposes: (1) member engagement and promotion of Health Homes; (2) workforce training and retraining; (3) health information technology (HIT) and clinical connectivity; and (4) joint governance technical assistance, start-up and other implementation costs, and other such purposes as the Commissioner of Health, in consultation with the Commissioners of the Office of Mental Health and the Office of Alcoholism and Substance Abuse Services, determines are necessary to facilitate the transition of Health Homes beyond their early stages of development. Total payments are estimated not to exceed $190.6 million. Health Homes will be required to submit reports, as required by the Department, on the uses of such funds.

The overall estimated annual net aggregate increase in gross Medicaid expenditures attributable to reform and other initiatives being clarified in this notice and contained in the budget for state fiscal

year 2014/2015 is $958.6 million; and the estimated annual net aggregate increase in gross Medicaid expenditures attributable to an extension upper payment limit (UPL) payments noticed herein for state fiscal year 2014/2015 is $1.58 billion.

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

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), e-mail: spa_inquiries@health.state.ny.us

PUBLIC NOTICE

Monroe County

The Monroe County Deferred Compensation Plan Committee is soliciting proposals from firms to provide investment advisory services for our Deferred Compensation 457 Plan. The Plan is subject to the Rules and Regulations of the New York State Deferred Compensation Board, Part 9000. A copy of the proposal questionnaire may be obtained from: www.monroecounty.gov/bids/rfps

Proposals should be received no later than 3:00 p.m. on June 27, 2014.

PUBLIC NOTICE

Department of State
F-2014-0209
Date of Issuance – June 4, 2014

The New York State Department of State (DOS) is required by Federal regulations to provide timely public notice for the activities described below, which are subject to the consistency provisions of the Federal Coastal Zone Management Act of 1972, as amended.

The applicant has certified that the proposed activity complies with and will be conducted in a manner consistent with the approved New York State Coastal Management Program. The applicant's consistency certification and accompanying public information and data are available for inspection at the New York State Department of State offices located at One Commerce Plaza, 99 Washington Avenue, in Albany, New York.

In F-2014-0209, Tappan Zee Constructors, LLC, with offices at 555 White Plains Road. Suite 400, Tarrytown, NY, has applied to the U.S. Army Corps of Engineers NY District for authorization to undertake improvements along the shoreline along the Hudson River at the Port of Coeymans Marine Terminal property, Hudson River Mile 116.0, Town of Coeymans, Albany County, for the purpose of the assembly and barge transportation of approach span frames for the New NY Bridge (New Tappan Zee Bridge). The proposed improvements include dredging of a new 56, 000 square foot area to a depth of -12' MLW, resulting in approximately 10, 000 cubic yards (cy) of material to be placed at an approved upland location to facilitate the barge import of materials and export of finished components; the installation of two parallel, 136' long temporary assembly sled finger trestles using forty 24" steel piles, and the installation of two parallel, 276' long temporary straddle crane finger trestles supported by sixty-two 24" steel piles to facilitate barge slip transport and delivery operations. All structures constructed below MHHW are proposed to be temporary and will be removed to at least 2 feet below the mudline within 36 months of installation.

Any interested parties and/or agencies desiring to express their views concerning the above proposed activities may do so by filing their comments, in writing, no later than 4:30 p.m., 30 days from the date of this public notice or Friday, July 4, 2014.

Comments should be addressed to the New York State Department of State, Office of Planning and Development, One Commerce Plaza, 99 Washington Avenue, Albany, New York 12231. Telephone (518) 474-6000; Fax (518) 473-2464. Electronic submissions can be made at: CR@dos.ny.gov.

This notice is promulgated in accordance with Title 15, Code of Federal Regulations, Part 930.

PUBLIC NOTICE

New York State and Local Retirement System

Pursuant to Retirement and Social Security Law, the New York State and Local Employees' Retirement System hereby gives public notice of the following:

The persons whose names and last known addresses are set forth below appear from records of the above named Retirement System to be entitled to accumulated contributions held by said retirement system whose membership terminated pursuant to Section 517-a of the Retirement and Social Security Law on or before May 10, 2013. This notice is published pursuant to Section 109 of the Retirement and Social Security Law of the State of New York. A list of the names contained in this notice is on file and open to public inspection at the office of the New York State and Local Retirement System located at the 110 State St., in the City of Albany, New York. At the expiration of six months from the date of the publication of this notice. The accumulated contributions of the persons so listed shall be deemed abandoned and shall be placed in the pension accumulation fund to be used for the purpose of said fund. Any accumulated contributions so deemed abandoned and transferred to the pension accumulation fund may be claimed by the persons who made such accumulated contributions or, in the event of his death, by his estate or such person as he shall have nominated to receive such accumulated contributions, by filing a claim with the State Comptroller in such form and in such a manner as may be prescribed by him, seeking the return of such abandoned contributions. In the event such claim is properly made the State Comptroller shall pay over to the person or persons or estate making the claim such amount of such accumulated contributions without interest.

Bloomfield, Gregory T - Staten Island, NY

Mc Field, John L - Brooklyn, NY

Minnies, Robin L - Stony Point, NY

For further information contact: Mary Ellen Kutey, Retirement Systems, 110 State St., Albany, NY 12244, (518) 474-3502

PUBLIC NOTICE

New York State and Local Retirement System

Pursuant to Retirement and Social Security Law, the New York State and Local Employees' Retirement System hereby gives public notice of the following:

Appendix V
2014 Title XIX State Plan
Second Quarter Amendment
Responses to Standard Funding Questions

NON-INSTITUTIONAL SERVICES
State Plan Amendment #14-25

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: Medicaid payments for home care services are not subject to the upper payment limit requirement.

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

   Response: The rate methodology included in the State Plan for home care services is cost based subject to ceilings. We are unaware of any requirement under current federal law or regulation that limits individual providers' 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.