Department of Health

ANDREW M. CUOMO
Governor

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

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

SEP 30 2015

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

Re: SPA #15-0005
Inpatient Hospital Services

Dear Mr. Cooley:

The State requests approval of the enclosed amendment #15-0005 to the Title XIX (Medicaid) State Plan for inpatient hospital services to be effective July 1, 2015 (Appendix I). This amendment is being submitted based upon enacted legislation. A summary of the proposed amendment is contained in Appendix II.

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

Notice of the changes in the methods and standards for setting payment rates for general hospital inpatient services were given in the New York State Register on June 24, 2015.

Copies of pertinent sections of enacted State statute are enclosed for your information (Appendix III). In addition, responses to the five standard funding questions are also enclosed (Appendix V).

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

Sincerely,

Jason A. Helgerson
Medicaid Director
Office of Health Insurance Programs

Enclosures
cc: Mr. Michael Melendez
Mr. Tom Brady

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: **15-0005**

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: **July 1, 2015**

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: **(in thousands)**
a. FFY 07/01/15-09/30/15 $ 212.50
b. FFY 10/01/15-09/30/16 $ 212.50

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-B: Page 1.9

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-B: Page 1.9

10. SUBJECT OF AMENDMENT:
Supplemental Physician Payments – Erie County Medical Center (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:

13. TYPED NAME: **Jason A. Helgerson**

14. TITLE: **Medicaid Director**
Department of Health

15. DATE SUBMITTED: SEP 3 0 2015

16. RETURN TO:
New York State Department of Health
Division of Finance and Rate Setting
99 Washington Ave – One Commerce Plaza
Suite 1460
Albany, NY 12210

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED:

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:

22. TITLE:

23. REMARKS:

Appendix I
2015 Title XIX State Plan
Third Quarter Amendment
Amended SPA Pages

Supplemental Medicaid Payments for Professional Services

3. Medicare Fee Equivalent Calculation

a. Effective April 1, 2011, supplemental payments will be made to physicians, nurse practitioners and physician assistants who are employed by a Public Benefit Corporation (PBC), or a non-state operated public general hospital operated by a PBC or who are providing professional services at a PBC facility as either a member of a practice plan or an employee of a professional corporation or limited liability corporation under contract to provide services to patients of such a public benefit corporation for those patients eligible for Medicaid. The supplemental payments will be applicable only to the professional component of the eligible services provided.

b. Eligible providers are affiliated with:

   i. New York City Health and Hospital Corporation (HHC), excluding facilities participating in the Medicare Teaching Election Amendment.

   ii. Nassau University Medical Center, [and]

   iii. Westchester Medical Center, and

   iv. Erie County Medical Center, effective July 1, 2015.

   Excluded facilities are Federal Qualified Health Centers and Rural Health Centers.

c. Supplemental payments for eligible services will equal the difference between the Medicare Part B fee schedule rate and the average Medicaid payment per unit otherwise made under this Attachment.

d. Supplemental payments will be made as an annual aggregate lump sum, and be based on the Medicaid data applicable to the calendar year. Initial payments will be based on claims processed within 3 months after the calendar year. A final payment will be made one year following the initial payment to capture those claims for the payment year dates of service processed subsequent to the initial payment. Supplemental payments will not be made prior to the delivery of services.

e. Services excluded are those utilizing procedure codes not reimbursed by Medicaid, clinical laboratory services, dual eligibles except where Medicaid becomes the primary payer, and Managed Care. Managed Care data will be included only when a separate fee-for-service payment has been made to an eligible provider. Non-commercial payers such as Medicare are excluded. Additionally, supplemental payment will not be allowed on all inclusive payments where the base payment includes the physician cost.

Appendix II
2015 Title XIX State Plan
Third Quarter Amendment
Summary

SUMMARY
SPA #15-0005

This State Plan Amendment proposes to add Erie County Medical Center to the list of providers that receive supplemental payments for professional services provided by physicians, nurse practitioners, and physician assistants. Those who will be eligible for such payments will be those practitioners who are employed or providing services for or through a public benefit corporation or at a public benefit corporation facility. Fees will increase in an amount equal to the Medicare rate for services supplied to patients eligible for Medicaid.

Appendix III
2015 Title XIX State Plan
Third Quarter Amendment
Authorizing Provisions

of transfer to existing child performer trust accounts. All documents related to this rule must be available for inspection by the Department, school attendance officers, the state education department or local school district, and the Comptroller.

The employer must notify the Department of its employment of the child performer in writing at least five business days prior to the start of the employment. The employer must report the name, address, and last four digits of the social security number of each child performer being employed, a description of each child performer's intended performance, the dates, location(s) and duration of such intended performance, and the name and contact information of the employer's representative who will be at the scene of the performance. Additionally, the employer must notify the Department of any additions, deletions, or other modifications to the information reported in such a notice within twenty-four hours of the change.

The rule also requires employers to provide a teacher for any child performer who is unable to fulfill his or her regular educational requirements due to work. The teacher must be available on any day the child performer is employed that his or her regular school is in session. The teacher must be certified or have credentials recognized by the child performer's state or nation of residence. Therefore, employers may be required to engage the services of professional educators to comply with this rule.

The rule also requires employers to provide a nurse for any child performer less than six (6) months of age. Child performers between the age of fifteen (15) days and six (6) weeks of age must have a nurse provided for each three (3) or few babies. Child performers between the six (6) weeks of age and to six (6) months of age must have a nurse provided for each ten (10) or few infants.

3. Costs:

Employers who are covered by this rule shall enter into contracts with professional educators and nurses in order to comply with this rule. The cost for individual employers will depend upon the number of hours their child performers are employed and the age of the child performers. Nurses are only required for child performers who are less than six (6) months of age. Employers may also be required to hire an additional staff to function as a responsible person, who will be present to represent the best interests of the child. Such responsible person may be a parent or guardian, however; so the cost of such staffing will be dependent on the extent to which the employer utilizes the availability of parents or guardians, as well as on the extent to which the employer utilizes child performers.

Other than staffing needs, costs associated with the rule will be administrative. Employers must prepare applications and notices, as well as regular transfers of a percentage of the child performer's gross income to a trust account. The fee to employers for an Employer Certificate of Eligibility shall be $350.00 for the initial Certificate and $200.00 for each renewal (such Certificates being valid for a period of three years), except that the fee to employers operating theaters containing fewer than 500 seats shall be $200.00 for the initial Certificate and $200.00 for each renewal. It is not anticipated that any child performer employer would have to retain additional outside professional services to prepare these documents and financial transfers, although most, if not all, likely retain accountants and other staff to manage payroll and financial transfers for other performers.

Legal services may be required to negotiate, draft or review contracts with individuals providing teaching services or acting as the responsible person. It is anticipated that a vast majority of child performer employers in the State already have procurement or legal staff who regularly work on such contracts.

The cost to comply with this rule is minimal for child performers and their parent or guardian. There is no cost to apply for or renew a Child Performer Permit. There may be minimal costs incurred in obtaining a physician's statement that the child performer is physically fit.

4. Minimizing adverse impact:

This rule is necessary to implement Labor Law § 154-a. This enabling legislation requires the promulgation of regulations to determine the hours and conditions of work necessary to safeguard the health, education, morals and general welfare of child performers. As discussed in the other SAPA documents related to this rule making, the Department included recommendations within the proposal to minimize adverse impact without jeopardizing the physical or mental health, education or general welfare of the children involved.

5. Rural area participation:

The Department sought input on these regulations from various employee representative groups which represent rural area employees. Additionally, the Department received input from various employer representative groups which also represent rural area employers.

Job Impact Statement

The rule will facilitate the orderly employment of child performers in New York by codifying procedures and policies that have applied to child performers for a number of years and further providing for the protection of child performers and assurances that the child performers will receive the education which is mandated under state law. This should increase the availability of child performers for the arts, entertainment, and advertising industries and bring more of this work to New York. It is apparent from the nature and purpose of the rule that it will not have a substantial adverse impact on jobs or employment opportunities, therefore no Job Impact Analysis is required.

Office of Mental Health

NOTICE OF ADOPTION

Correction of an Inaccurate State Agency Name

I.D. No. OMH-35-10-00023-A
Filing No. 1100
Filing Date: 2010-10-25
Effective Date: 2010-11-10

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

Action taken: Amendment of Part 505 of Title 14 NYCRR.

Statutory authority: Mental Hygiene Law, section 7.09

Subject: Correction of an inaccurate State agency name.

Purpose: To update the name of the Commission on Quality of Care and Advocacy for Persons with Disabilities within existing regulation.

Text or summary was published in the September 1, 2010 issue of the Register, I.D. No. OMH-35-10-00023-P.

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

Text of rule and any required statements and analyses may be obtained from: Joyce Donohue, NYS Office of Mental Health, 44 Holland Avenue, Albany, NY 12229, (518) 474-1331, email: cocbjdd@omh.state.ny.us

Assessment of Public Comment

The agency received no public comment.

NOTICE OF ADOPTION

Correction of an Inaccurate Address in Existing Regulation

I.D. No. OMH-35-10-00024-A
Filing No. 1101
Filing Date: 2010-10-25
Effective Date: 2010-11-10

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

Action taken: Amendment of Part 510 of Title 14 NYCRR.

Statutory authority: Mental Hygiene Law, sections 7.09 and 33.02; and Public Officers Law (Freedom of Information Law), art. 6

Subject: Correction of an inaccurate address in existing regulation.

Purpose: To correct the address of the Department of State, Committee on Open Government.

Text or summary was published in the September 1, 2010 issue of the Register, I.D. No. OMH-35-10-00024-P.

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

Text of rule and any required statements and analyses may be obtained from: Joyce Donohue, NYS Office of Mental Health, 44 Holland Avenue, Albany, NY 12229, (518) 474-1331, email: cocbjdd@omh.state.ny.us

Assessment of Public Comment

The agency received no public comment.

PROPOSED RULE MAKING
NO HEARING(S) SCHEDULED

Medical Assistance Rates of Payment for Residential Treatment Facilities for Children and Youth

I.D. No. OMH-45-10-00006-P

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

Proposed Action: This is a consensus rule making to amend Part 578 of Title 14 NYCRR.

Statutory authority: Mental Hygiene Law, sections 7.09 and 43.02

Subject: Medical Assistance Rates of Payment for Residential Treatment Facilities for Children and Youth.

Purpose: To carve out the cost of pharmaceuticals from the per diem reimbursement rate for Residential Treatment Facilities.

Text of proposed rule: A new subdivision (o) is added to Section 578.14 of Title 14 NYCRR to read as follows:

(o) Effective on or after January 1, 2011, and contingent upon federal approval, allowable operating costs shall not include the costs of pharmaceuticals listed on the New York State Medicaid formulary. Such costs may be reimbursed, as appropriate, on a fee-for-service basis by the Medicaid program.

Text of proposed rule and any required statements and analyses may be obtained from: Joyce Donohue, NYS Office of Mental Health, 44 Holland Avenue, Albany, NY 12229, (518) 474-1331, email: cocbjdd@omh.state.ny.us

Data, views or arguments may be submitted to: Same as above.

Public comment will be received until: 45 days after publication of this notice.

Consensus Rule Making Determination

This rule making is filed as a Consensus rule on the grounds that it is non-controversial and makes a technical correction. No person is likely to object to this rule since its purpose is to provide fiscal relief to residential treatment facility (RTF) providers and to improve access to services by children and adolescents who require the level of care provided in a RTF.

The amendment to Part 578 specifies that, on or after January 1, 2011, and contingent upon approval by the Centers for Medicare and Medicaid Services (CMS), allowable operating costs for RTFs for children and youth licensed by the Office shall not include the costs of pharmaceuticals listed on the New York State Medicaid formulary. These costs may be reimbursed, as appropriate, on a fee-for-service basis by the Medicaid program.

This amendment will provide financial relief to RTFs, as the costs of psychiatric medications have increased more rapidly than the rate of inflation. Currently, RTF providers are paid on an all-inclusive basis, and rates are set prospectively. The rates are based upon allowable costs reflected in the provider's cost report, which is submitted two fiscal years prior to the rate year. Thus, there is a significant lag before increased costs are reflected in the provider's rate. Because pharmaceutical costs are high, and tend to rise quickly, this lag can result in a serious cash flow problem for providers. This amendment will give fiscal relief to providers and ultimately reduce taxpayer costs.

In addition, this amendment should allow for an improvement in access to services by high-need children and adolescents who require the level of care provided in a RTF. Often, high-need individuals have complex health care problems, but some RTF providers have been unable to admit these patients due to the fact that the cost of purchasing the required drug treatments was found to be financially impossible for the provider. The carve out of the pharmaceutical costs included in the New York State Medicaid formulary will permit RTF providers to access medically necessary drugs, including HIV/AIDS-related medications, directly from the fee-for-service billing pharmacy.

Statutory Authority: Section 7.09 of the Mental Hygiene Law grants the Commissioner of the Office of Mental Health the authority and responsibility to adopt regulations that are necessary and proper to implement matters under his or her jurisdiction. Section 43.02 of the Mental Hygiene Law provides that the Commissioner has the power to establish standards and methods for determining rates of payment made by government agencies pursuant to Title 11 of Article 5 of the Social Services Law for services provided by facilities, including residential treatment facilities for children and youth licensed by the Office of Mental Health.

Job Impact Statement

A Job Impact Statement is not submitted with this notice because it is evident by the nature of the rule that there will be no adverse impact on jobs and employment opportunities. This rule specifies that, effective on or after January 1, 2011, and contingent upon the approval of the Centers for Medicare and Medicaid Services approval, allowable operating costs for residential treatment facilities (RTF) will not include the costs of pharmaceuticals listed on the New York State Medicaid formulary. These costs may, as appropriate, be reimbursed on a fee-for-service basis by the Medicaid program. This rule will provide financial relief to RTF providers and improve access to services provided in a RTF for children and adolescents.

PROPOSED RULE MAKING
NO HEARING(S) SCHEDULED

Operation of Residential Programs for Adults

I.D. No. OMH-45-10-00009-P

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

Proposed Action: This is a consensus rule making to amend section 595.9 of Title 14 NYCRR.

Statutory authority: Mental Hygiene Law, sections 7.09 and 31.04

Subject: Operation of Residential Programs for Adults.

Purpose: Clarify the due process protections of non-discharge ready residents who are no longer eligible for services.

Text of proposed rule: 1. Subdivision (c) of Section 595.9 of Title 14 NYCRR is amended to read as follows:

(c) A resident who is not discharge-ready *or who is no longer eligible for services* can be discharged provided discharge planning activities have been followed to the extent practicable under the circumstances, and one of the following conditions applies:

(1) the resident has permanently vacated the residence;

(2) the resident's condition has changed, as follows:

(i) the psychiatric or medical status of the resident has changed such that the resident requires inpatient hospital care; and/or

(ii) the resident's capacity for self preservation, as determined pursuant to section 595.16 of this Part, requires a level of care other than the residential program, or the resident is otherwise at risk due to requiring additional medical or psychiatric services or supports not available within the residential program; *or*

(iii) the psychiatric status of the resident has changed such that the services or support required can be provided in a less restrictive setting, and a clinically-appropriate less restrictive setting has been identified and is available;

(3) the resident fails to meet one or more material responsibilities for residency as described in section 595.10(a)(2) and (c) of this Part; or

(4) the resident's behavior poses an immediate and substantial threat to the health, safety and well-being of the resident or other individuals or creates a serious and ongoing disruption of the therapeutic environment of the residential program.

2. Subdivision (e) of Section 595.9 of Title 14 NYCRR is amended to read as follows:

(e) A discharge under paragraph (c)(2) of this section requires that a clinical assessment be conducted by clinical staff who are qualified by credentials, training and experience to conduct such assessments, *provided, however, that a determination under subparagraph (c)(2)(iii) of this section, such services and support required can be provided in a less restrictive setting, must be made by a physician.* If an individual is to be discharged because that individual is no longer capable of self preservation as determined pursuant to section 595.16 of this Part, or would be otherwise at risk due to requiring different or additional services, supports or physical environments not available within the residential program except to the extent required pursuant to the Federal Americans with Disabilities Act, the individual shall be notified in writing of the need for and intent to secure an appropriate alternative living arrangement.

3. Subdivision (f) of Section 595.9 of Title 14 NYCRR is amended to read as follows:

(f) A discharge under subparagraph (c)(2)(ii) *or (iii)* of this section, or a discharge under paragraph (c)(3) of this section, requires the following:

Text of proposed rule and any required statements and analyses may be obtained from: Joyce Donohue, NYS Office of Mental Health, 44 Holland Avenue, Albany, NY 12229, (518) 474-1331, email: cocbjdd@omh.state.ny.us

Data, views or arguments may be submitted to: Same as above.

Public comment will be received until: 45 days after publication of this notice.

the number and types of advisers that could be utilized by the Fund; (3) creates an inherent conflict between federal and state law that would make it impossible to do business with the Fund while complying with both; and (4) adds duplicative regulation in an area already substantially regulated at the state level and that is primed for further federal regulation through the imminent imposition of a federal pay-to-play regime on all registered broker-dealers acting as placement agents. In addition, SIFMA provided language that it believes would be consistent with the existing federal requirements on the use of placement agents. SIFMA requested that the Department either exclude from the proposed rule those placement agents who are registered as broker-dealers under the Securities Exchange Act of 1934 or delay the enactment of the proposed rule until the federal and state placement agent initiatives are finalized.

The Department does not have jurisdiction over placement agents, which makes it difficult to implement and enforce requirements on them. The Superintendent did consider other ways to limit the influence of placement agents, including a partial ban, increased disclosure requirements, and adopting alternative definitions of placement agent or intermediary. The Department considered limiting the ban to include intent on the part of the party using placement agents, or defining "placement agent" in more general terms. At the time, the Superintendent concluded that only an immediate, total ban on the use of placement agents could provide sufficient protection of the Fund's members and beneficiaries and safeguard the integrity of the Fund's investments.

The Department met with representatives from SIFMA on June 28th to gain further understanding of some of the issues raised in opposition to the proposed rule. We subsequently requested additional information from SIFMA. SIFMA provided the Department with additional information based upon actions taken and/or contemplated by pension fund regulators in other States. The Department will continue to assess the comments that have been received and any other information that may be submitted.

The Department is also evaluating the extent to which its proposed rule conforms with the Securities and Exchange Commission's "Pay-To-Play" regulation for financial advisors that was issued on July 1, 2010. This regulation is effective on September 13, 2010, with full compliance by March 14, 2011 for all affected investment advisers.

We are continuing to research best practices in use with large U.S. public pension funds before any further action will be taken with regards to the proposed rule. A number of policies/practices being researched include limits on the amount of business that may be placed through any single placement agent, and the feasibility of monetary penalties for investment managers/advisors who seek to circumvent procedures that are established to mitigate the risk of undue influence by politically connected persons.

Office of Mental Health

NOTICE OF ADOPTION

Medical Assistance Rates of Payment for Residential Treatment Facilities for Children and Youth

I.D. No. OMH-45-10-00006-A
Filing No. 57
Filing Date: 2011-01-12
Effective Date: 2011-02-02

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

Action taken: Amendment of Part 578 of Title 14 NYCRR.

Statutory authority: Mental Hygiene Law, sections 7.09 and 43.02

Subject: Medical Assistance Rates of Payment for Residential Treatment Facilities for Children and Youth.

Purpose: To carve out the cost of eligible pharmaceuticals from the per diem reimbursement rate for Residential Treatment Facilities.

Text or summary was published in the November 10, 2010 issue of the Register, I.D. No. OMH-45-10-00006-P.

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

Text of rule and any required statements and analyses may be obtained from: Joyce Donohue, NYS Office of Mental Health, 44 Holland Avenue, Albany, NY 12229, (518) 474-1331, email: cocbjdd@omh.state.ny.us

Assessment of Public Comment

The agency received no public comment.

NOTICE OF ADOPTION

Standards Pertaining to Payment for Hospitals Licensed by the Office of Mental Health

I.D. No. OMH-46-10-00017-A
Filing No. 58
Filing Date: 2011-01-13
Effective Date: 2011-02-02

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

Action taken: Amendment of Part 574 of Title 14 NYCRR.

Statutory authority: Mental Hygiene Law, sections 7.09, 31.04 and 43.02; Social Services Law, sections 364 and 364-a

Subject: Standards Pertaining to Payment for Hospitals Licensed by the Office of Mental Health.

Purpose: Make minor technical corrections to existing regulation and use "person-first" language.

Text or summary was published in the November 17, 2010 issue of the Register, I.D. No. OMH-46-10-00017-P.

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

Text of rule and any required statements and analyses may be obtained from: Joyce Donohue, NYS Office of Mental Health, 44 Holland Avenue, Albany, NY 12229, (518) 474-1331, email: cocbjdd@omh.state.ny.us

Assessment of Public Comment

The agency received no public comment.

Office of Parks, Recreation and Historic Preservation

PROPOSED RULE MAKING
NO HEARING(S) SCHEDULED

Navigation of Vessels, Conduct of Regattas and Placement of Navigation Aids and Floating Objects on Navigable Waters

I.D. No. PKR-05-11-00001-P

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

Proposed Action: This is a consensus rule making to repeal Appendix I-1 and Part 445; add new Part 445; and amend sections 377.1, 447.2, 447.3 and Part 448 of Title 9 NYCRR.

Statutory authority: Parks, Recreation and Historic Preservation Law, section 3.09(8); Navigation Law, sections 34, 34-a, 35, 35-a, 35-b, 36, 37, 41, 41(b), 43, 43(3), 45 and 46-aaaa

Subject: Navigation of vessels, conduct of regattas and placement of navigation aids and floating objects on navigable waters.

Purpose: To update obsolete state navigation rules or conform them to the U.S. Coast Guard Inland Navigation Rules.

Substance of proposed rule (Full text is posted at the following State website:www.nysparks.com): The Office of Parks, Recreation and Historic Preservation (OPRHP) is amending Title 9 NYCRR to update rules that address activities of its Bureau of Marine Services as follows:

Section 377.1(j) Regulated activities.

This section that pertains to the operation of vessels on Cuba Lake in Allegany County is repealed since the Office of Parks, Recreation and Historic Preservation (State Parks) no longer has jurisdiction over this Lake. The remaining subdivisions in this section are renumbered.

SPA 15-0005

Chapter 59 of the Law of 2011 (enacted budget)

S.2809-D/A.4009-D – Part H

§ 93. 1. Notwithstanding any inconsistent provision of law, rule or regulation to the contrary, and subject to the availability of federal financial participation, effective for the period April 1, 2011 through March 31, 2012, and each state fiscal year thereafter, the department of health is authorized to make supplemental Medicaid payments for professional services provided by physicians, nurse practitioners and physician assistants who are employed by a public benefit corporation or a non-state operated public general hospital operated by a public benefit corporation or who are providing professional services at a facility of such public benefit corporation as either a member of a practice plan or an employee of a professional corporation or limited liability corporation under contract to provide services to patients of such a public benefit corporation, in accordance with title 11 of article 5 of the social services law for patients eligible for federal financial participation under title XIX of the federal social security act, in amounts that will increase fees for such professional services to an amount equal to either the Medicare rate or the average commercial rate that would otherwise be received for such services rendered by such physicians, nurse practitioners and physician assistants, provided, however, that such supplemental fee payments shall not be available with regard to services provided at facilities participating in the Medicare Teaching Election Amendment. The calculation of such supplemental fee payments shall be made in accordance with applicable federal law and regulation and subject to the approval of the division of the budget. Such supplemental Medicaid fee payments may be added to the professional fees paid under the fee schedule or made as aggregate lump sum payments to entities authorized to receive professional fees.

2. The supplemental Medicaid payments for professional services authorized by subdivision one of this section may be made only at the election of the public benefit corporation or the local social services district in which the non-state operated public general hospital is located. The electing public benefit corporation or local social services district shall, notwithstanding the social services district Medicaid cap provisions of Part C of chapter 58 of the laws of 2005, be responsible for payment of one hundred percent of the non-federal share of such supplemental Medicaid payments, in accordance with section 365-a of the social services law, regardless of whether another social services district or the department of health may otherwise be responsible for furnishing medical assistance to the eligible persons receiving such services. Social services district or public benefit corporation funding of the non-federal share of any such payments shall be deemed to be voluntary for purposes of the increased federal medical assistance percentage provisions of the American Recovery and Reinvestment Act of 2009, provided, however, that in the event the federal Centers for Medicare and Medicaid Services determines that such non-federal share payments are not voluntary payments for purposes of such act, the provisions of this section shall be null and void.

Appendix IV
2015 Title XIX State Plan
Third Quarter Amendment
Public Notice

Responsible Fund (the "GSRF") investment option of the Plan. The objective of the GSRF is to meet or exceed the Morgan Stanley Capital International World Index. The Plan may construct the Global Socially Responsible Fund investment option using a global equity strategy or from the combination of US and non-US equity strategies. To be considered, vendors must submit their product information to Mercer Investment Consulting. Vendors should input or update their product information, as applicable, on Mercer's Global Investment Management Database (GIMD). The address for the website is: www.mercergimd.com. Vendors not already registered, please call (866) 657-6487 for a user I.D. and password to access the database. There is no fee for entering product information on the database. Please complete the submission of product information in the Mercer database no later than 4:30 P.M. Eastern Time on July 1, 2015.

PUBLIC NOTICE

New York City Deferred Compensation Plan

The New York City Deferred Compensation Plan (the "Plan") is seeking qualified vendors to provide third party foreign exchange services for certain investment options of the Plan. To be considered, qualified vendors must contact Mercer Investment Consulting to obtain and complete a Third Party Foreign Exchange Provider Questionnaire. There is no fee for requesting or completing the Third Party Foreign Exchange Provider Questionnaire. Please complete and submit the Questionnaire to Mercer Investment Consulting no later than 4:30 P.M. Eastern Time on July 1, 2015. The Plan also recommends that vendors interested in this procurement visit the Plan's website at www.nyc.gov/olr and download and review the applicable documents.

To request Mercer Investment Consulting's Third Party Foreign Exchange Provider Questionnaire or if you have any questions regarding the Questionnaire, please contact Mercer Investment Consulting. The primary contacts at Mercer Investment Consulting are: Paul G. Sachs (215) 982-4264 and Greg Cran (312) 917-0789.

The Third Party Foreign Exchange Provider Questionnaire should be submitted to Mercer via email at paul.sachs@mercer.com and greg.cran@mercer.com.

PUBLIC NOTICE

Department of Health

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

The Department of Health proposes to amend the Title XIX (Medicaid) State Plan for institutional services to comply with enacted statutory provisions. The following changes are proposed:

Effective July 1, 2015 and each state fiscal year thereafter, the current authority to make supplemental payments for services provided by physicians, nurse practitioners and physician assistants has now been extended by the Commissioner of Health to include Erie County Medical Center's Physician practice.

The estimated annual net aggregate in gross Medicaid savings attributable to this initiative for State fiscal year 2015-2016 is $850,000.

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, Division of Finance and Rate Setting, 99 Washington Ave. – One Commerce Plaza, Suite 1460, Albany, NY 12210, or e-mail: spa_inquiries@health.ny.gov

PUBLIC NOTICE

Office of Mental Health

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

The Office of Mental Health proposes to amend the Title XIX (Medicaid) State Plan long term care services to comply with regulatory changes. The following changes are proposed:

A regulatory change will be made to the pharmaceutical policy for Residential Treatment Facilities for Children and Youth (RTFs) will allow providers to utilize fee-for-service pharmacies beginning with the date a child is determined to be Medicaid eligible, as opposed to the current practice of waiting 90 days or the date a child is determined to be eligible. This proposed change will permit RTF providers to access medically necessary drugs, including HIV/AIDS related drugs directly from the fee-for-service billing pharmacy sooner, thereby reducing the fiscal disincentive of admitting children requiring an RTF level of care that also may require expensive pharmaceutical therapies. The proposed effective date is July 1, 2015.

The estimated annual net aggregate decrease in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2015/2016 is ($53,589).

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.

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:

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1916 Monterey Avenue
Bronx, New York 10457

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

Appendix V
2015 Title XIX State Plan
Third Quarter Amendment
Responses to Standard Funding Questions

APPENDIX V
HOSPITAL SERVICES
State Plan Amendment #15-0005

CMS Standard Funding Questions (NIRT Standard Funding Questions)

The following questions are being asked and should be answered in relation to all payments made to all providers under Attachment 4.19-A of your state plan.

1. **Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by States for services under the approved State plan. Do providers receive and retain the total Medicaid expenditures claimed by the State (includes normal per diem, supplemental, enhanced payments, other) or is any portion of the payments returned to the State, local governmental entity, or any other intermediary organization? If providers are required to return any portion of payments, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the amount or percentage of payments that are returned and the disposition and use of the funds once they are returned to the State (i.e., general fund, medical services account, etc.)**

   Response: Providers do retain the payments made pursuant to this amendment. However, this requirement in no way prohibits the public provider, including county providers, from reimbursing the sponsoring local government for appropriate expenses incurred by the local government on behalf of the public provider. The State does not regulate the financial relationships that exist between public health care providers and their sponsoring governments, which are extremely varied and complex. Local governments may provide direct and/or indirect monetary subsidies to their public providers to cover on-going unreimbursed operational expenses and assure achievement of their mission as primary safety net providers. Examples of appropriate expenses may include payments to the local government which include reimbursement for debt service paid on a provider's behalf, reimbursement for Medicare Part B premiums paid for a provider's retirees, reimbursement for contractually required health benefit fund payments made on a provider's behalf, and payment for overhead expenses as allocated per federal Office of Management and Budget Circular A-87 regarding Cost Principles for State, Local, and Indian Tribal Governments. The existence of such transfers should in no way negate the legitimacy of these facilities' Medicaid payments or result in reduced Medicaid federal financial participation for the State. This position was further supported by CMS in review and approval of SPA 07-07C when an on-site audit of these transactions for New York City's Health and Hospitals Corporation was completed with satisfactory results.

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

   Response: The supplemental payments to be made as a result of this SPA will be made only at the election of the PBC or the local social service district in which the non-state operated public general hospital is located. Funding of the supplemental payments by the social services district or PBC will be voluntary.

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 Medicaid payments authorized for this provision are supplemental payments. The total amount of the supplemental payment will be

approximately $850,000 a year for practice plans affiliated with Erie County Medical Center.

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

   Response: Physicians are not subject to the upper payment limit requirement. However, it should be noted that the proposed amendment provides a supplemental payment to reflect the difference between the average Medicaid payment and average Medicare payment.

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

   Response: The rate methodology included in the approved State Plan for institutional services is prospective payment. We are unaware of any requirement under current federal law or regulation that limits individual provider payments to their actual costs.

ACA Assurances:

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

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

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

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

   <u>Prior to January 1, 2014</u> States may potentially require contributions by local political subdivisions toward the non-Federal share of the States' expenditures at percentages <u>greater than</u> were required on December 31, 2009. <u>However</u>, 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 <u>anticipate potential violations and/or appropriate corrective actions</u> by the States and the Federal government.

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

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

   <u>Response:</u> This State does comply with the requirements of section 1902(a)(37) of the Act regarding prompt payment of claims.

<u>Tribal Assurance:</u>

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.