NEW YORK STATE OF OPPORTUNITY. Department of Health

ANDREW M. CUOMO
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Commissioner

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

FEB 18 2016

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 #16-0017
Non-Institutional Services

Dear Mr. Melendez:

The State requests approval of the enclosed amendment #16-0017 to the Title XIX (Medicaid) State Plan for non-institutional services to be effective January 1, 2016 (Appendix I). This amendment is being submitted based on State regulations. A summary of the plan amendment is provided in Appendix II.

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

Copies of pertinent sections of proposed State statute are enclosed for your information (Appendix III). A copy of the public notice of this plan amendment, which was given in the New York State Register on December 30, 2015, 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, Office of Health Insurance Programs 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: **16-0017**	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 **January 1, 2016**	

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 01/01/16-09/30/16 ($ 17.95)** **b. FFY 10/01/16-09/30/17 ($ 23.93)**
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: **Attachment 4.19-B Pages: 2(g)(2), 2(g)(3)**	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: **Attachment 4.19-B Pages: 2(g)(2), 2(g)(3)**

10. SUBJECT OF AMENDMENT:
January 2016 APG Updates – Freestanding Clinics
(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 1460** **Albany, NY 12210**
13. TYPED NAME: **Jason A. Helgerson**	
14. TITLE: **Medicaid Director** **Department of Health**	
15. DATE SUBMITTED: FEB 1 8 2016	

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
2016 Title XIX State Plan
First Quarter Amendment
Amended SPA Pages

New York
2(g)(2)

APG Reimbursement Methodology – Freestanding Clinics

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

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

3M APG Crosswalk, version 3.[10]11; updated as of [07/01/15] 01/01/16:
http://www.health.ny.gov/health_care/medicaid/rates/apg/index.htm Click on "3M Versions and Crosswalks," then on "3M APG Crosswalk" toward bottom of page, and finally on "Accept" at bottom of page.

APG Alternative Payment Fee Schedule; updated as of 01/01/11:
http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm Click on "Alternative Payment Fee Schedule."

APG Consolidation Logic; logic is from version of 4/1/08, updated as of 10/01/11:
http://www.health.ny.gov/health_care/medicaid/rates/bundling/ Click on "2011"

APG 3M Definitions Manual Versions; updated as of [07/01/15] 01/01/16:
http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm Click on "3M Versions and Crosswalk."

APG Investments by Rate Period; updated as of 07/01/10:
http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm Click on "Investments by Rate Period."

APG Relative Weights; updated as of [07/01/15] 01/01/16:
http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm Click on "Weights, Proc Weights, and APG Fee Schedule Amounts."

Associated Ancillaries; updated as of 07/01/15:
http://www.health.ny.gov/health_care/medicaid/rates/apg/index.htm Click on "Ancillary Policy."

New York
2(g)(3)

Carve-outs; updated as of 01/01/11:
http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm Click on "Carve Outs."

Coding Improvement Factors (CIF); updated as of 07/01/12:
http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm Click on "CIFs by Rate Period."

If Stand Alone, Do Not Pay APGs; updated as of 01/01/15:
http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm Click on "If Stand Alone, Do Not Pay APGs."

If Stand Alone, Do Not Pay Procedures; updated as of 07/01/14:
http://www.health.state.ny.us/health_care/medicaid/rates/methodology/index.htm Click on "If Stand Alone, Do Not Pay Procedures."

Modifiers; updated as of 01/01/15:
http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm Click on "Modifiers."

Never Pay APGs; updated as of [07/01/12] 01/01/16:
http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm Click on "Never Pay APGs."

Never Pay Procedures; updated as of [01/01/15] 01/01/16:
http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm Click on "Never Pay Procedures."

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

No-Blend Procedures; updated as of 01/01/11:
http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm Click on "No-Blend Procedures."

No Capital Add-on APGs: updated as of 07/01/13:
http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm Click on "No Capital Add-on APGs."

Appendix II
2016 Title XIX State Plan
First Quarter Amendment
Summary

SUMMARY
SPA #16-0017

This State Plan Amendment proposes to revise the Ambulatory Patient Group (APG) methodology for freestanding clinic and ambulatory surgery center services to reflect the recalculated weights with component updates to become effective January 1, 2016.

Appendix III
2016 Title XIX State Plan
First Quarter Amendment
Authorizing Provisions

EMERGENCY RULE MAKING

October 2011 Ambulatory Patient Groups (APGs) Payment Methodology

I.D. No. HLT-41-11-00005-E
Filing No. 851
Filing Date: 2011-09-27
Effective Date: 2011-09-27

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

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

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

Finding of necessity for emergency rule: Preservation of public health.

Specific reasons underlying the finding of necessity: It is necessary to issue the proposed regulation on an emergency basis in order to meet the regulatory requirement found within the regulation itself to update the Ambulatory Patient Group (APG) weights at least once a year. To meet that requirement, the weights needed to be revised and published in the regulation for January 2010 and updated thereafter. Additionally, the regulation needs to reflect the many software changes made to the APG payment software, known as the APG grouper-pricer, which is a subcomponent of the eMedNY Medicaid payment system. These changes include revised lists of payable and non-payable APGs, a new list of APGs that are not eligible for a capital add-on, and a list of APGs that are not subject to having their payment "blended" with provider-specific historical payment amounts. Finally, a brand new payment software enhancement, which allows payment on a procedure code-specific basis rather than an APG basis, needs to be reflected in the regulation.

There is a compelling interest in enacting these amendments immediately in order to secure federal approval of associated Medicaid State Plan amendments and assure there are no delays in implementation of these provisions. APGs represent the cornerstone to health care reform. Their continued refinement is necessary to assure access to preventive services for all Medicaid recipients.

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

Purpose: To refine the APG payment methodology.

Text of emergency rule: Section 86-8.2 subdivision (r) is hereby repealed:

[(r) Ambulatory surgery permissible procedures shall mean those surgical procedures designated by the Department as reimbursable as ambulatory surgery pursuant to this Subpart.]

Section 86-8.7 is hereby repealed effective October 1, 2011 and a new section 86-8.7 is added to read as follows:

(a) The table of APG Weights, Procedure Based Weights and units, and APG Fee Schedule Fees and units for each effective period are published on the New York State Department of Health website at: http://www.health.state.ny.us/health_care/medicaid/rates/apg/docs/apg_payment_components.xls

Subdivision (c) of section 86-8.9 is repealed and a new subdivision (c) is added, to read as follows:

[(c) The Department's written billing and reporting instructions shall set forth a complete listing of all ambulatory surgery permissible procedures which are reimbursable pursuant to this Subpart. No visits may be billed as ambulatory surgery unless at least one procedure designated as ambulatory surgery permissible appears on the claim for the date of service for the visit.]

(c) Drugs purchased under the 340B drug benefit program and billed under the APG reimbursement methodology shall be reimbursed at a reduced rate comparable to the reduced cost of drugs purchased through the 340B drug benefit program.

Subdivision (d) of section 86-8.9 is amended to add the following APG and to read as follows:

451 SMOKING CESSATION TREATMENT

Subdivision (h) of section 86-8.10 is amended to add the following APG and to read as follows:

465 CLASS XIII COMBINED CHEMOTHERAPY AND PHARMACOTHERAPY

Subdivision (i) of section 86-8.10 is amended to add the following APG and to read as follows:

490 INCIDENTAL TO MEDICAL, SIGNIFICANT PROCEDURE OR THERAPY VISIT

This notice is intended to serve only as a notice of emergency adoption. This agency intends to adopt this emergency rule as a permanent rule and will publish a notice of proposed rule making in the *State Register* at some future date. The emergency rule will expire December 25, 2011.

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

Regulatory Impact Statement

Statutory Authority:

Authority for the promulgation of these regulations is contained in section 2807(2-a)(e) of the Public Health Law, as amended by Part C of Chapter 58 of the Laws of 2008 and Part C of Chapter 58 of the Laws of 2009, which authorize the Commissioner of Health to adopt and amend rules and regulations, subject to the approval of the State Director of the Budget, establishing an Ambulatory Patient Groups methodology for determining Medicaid rates of payment for diagnostic and treatment center services, free-standing ambulatory surgery services and general hospital outpatient clinics, emergency departments and ambulatory surgery services.

Legislative Objective:

The Legislature's mandate is to convert, where appropriate, Medicaid reimbursement of ambulatory care services to a system that pays differential amounts based on the resources required for each patient visit, as determined through Ambulatory Patient Groups ("APGs"). The APGs refer to the Enhanced Ambulatory Patient Grouping classification system which is owned and maintained by 3M Health Information Systems. The Enhanced Ambulatory Group classification system and the clinical logic underlying that classification system, the EAPG software, and the Definitions Manual associated with that classification system, are all proprietary to 3M Health Information Systems. APG-based Medicaid Fee For Service payment systems have been implemented in several states including: Massachusetts, New Hampshire, and Maryland.

Needs and Benefits:

This amendment replaces the actual APG weights, APG procedure based weights, and the APG fee schedule amounts listed in section 86-8.7 with a link to the New York State Department of Health website where all of the APG weights, APG procedure based weights, and the APG fee schedule amounts are posted for all periods. Removing this specificity from the regulation text obviates the need for quarterly amendments to the APG regulation.

COSTS

Costs for the Implementation of, and Continuing Compliance with this Regulation to the Regulated Entity:

There will be no additional costs to providers as a result of these amendments.

Costs to Local Governments:

There will be no additional costs to local governments as a result of these amendments.

Costs to State Governments:

There will be no additional costs to NYS as a result of these amendments. All expenditures under this regulation are fully budgeted in the SFY 2009-10 and 2010-11 enacted budgets.

Costs to the Department of Health:

There will be no additional costs to the Department of Health as a result of these amendments.

Local Government Mandates:

There are no local government mandates.

Paperwork:

There is no additional paperwork required of providers as a result of these amendments.

Duplication:

This regulation does not duplicate other state or federal regulations.

Alternatives:

These regulations are in conformance with Public Health Law section 2807(2-(a)(e)). Although the 2009 amendments to PHL 2807 (2-a) authorize the Commissioner to adopt rules to establish alternative payment methodologies or to continue to utilize existing payment methodologies where the APG is not yet appropriate or practical for certain services, the utilization of the APG methodology is in its relative infancy and is otherwise continually monitored, adjusted and evaluated for appropriateness by the Department and the providers. This rulemaking is in response to this continually evaluative process.

Federal Standards:

This amendment does not exceed any minimum standards of the federal government for the same or similar subject areas.

Compliance Schedule:

The proposed amendment will become effective upon filing with the Department of State.

Regulatory Flexibility Analysis

Effect on Small Business and Local Governments:

For the purpose of this regulatory flexibility analysis, small businesses

were considered to be general hospitals, diagnostic and treatment centers, and free-standing ambulatory surgery centers. Based on recent data extracted from providers' submitted cost reports, seven hospitals and 245 DTCs were identified as employing fewer than 100 employees.

Compliance Requirements:

No new reporting, recordkeeping or other compliance requirements are being imposed as a result of these rules.

Professional Services:

No new or additional professional services are required in order to comply with the proposed amendments.

Compliance Costs:

No initial capital costs will be imposed as a result of this rule, nor is there an annual cost of compliance.

Economic and Technological Feasibility:

Small businesses will be able to comply with the economic and technological aspects of this rule. The proposed amendments are intended to further reform the outpatient/ambulatory care fee-for-service Medicaid payment system, which is intended to benefit health care providers, including those with fewer than 100 employees.

Minimizing Adverse Impact:

The proposed amendments apply to certain services of general hospitals, diagnostic and treatment centers and freestanding ambulatory surgery centers. The Department of Health considered approaches specified in section 202-b(1) of the State Administrative Procedure Act in drafting the proposed amendments and rejected them as inappropriate given that this reimbursement system is mandated in statute.

Small Business and Local Government Participation:

Local governments and small businesses were given notice of these proposals by their inclusion in the SFY 2009-10 enacted budget and the Department's issuance in the *State Register* of federal public notices on February 25, 2009, June 10, 2009 and January 20, 2010.

Rural Area Flexibility Analysis

Effect on Rural Areas:

Rural areas are defined as counties with a population less than 200,000 and, for counties with a population greater than 200,000, includes towns with population densities of 150 persons or less per square mile. The following 43 counties have a population less than 200,000:

Allegany	Hamilton	Schenectady
Cattaraugus	Herkimer	Schoharie
Cayuga	Jefferson	Schuyler
Chautauqua	Lewis	Seneca
Chemung	Livingston	Steuben
Chenango	Madison	Sullivan
Clinton	Montgomery	Tioga
Columbia	Ontario	Tompkins
Cortland	Orleans	Ulster
Delaware	Oswego	Warren
Essex	Otsego	Washington
Franklin	Putnam	Wayne
Fulton	Rensselaer	Wyoming
Genesee	St. Lawrence	Yates
Greene		

The following 9 counties have certain townships with population densities of 150 persons or less per square mile:

Albany	Erie	Oneida
Broome	Monroe	Onondaga
Dutchess	Niagara	Orange

Compliance Requirements:

No new reporting, recordkeeping, or other compliance requirements are being imposed as a result of this proposal.

Professional Services:

No new additional professional services are required in order for providers in rural areas to comply with the proposed amendments.

Compliance Costs:

No initial capital costs will be imposed as a result of this rule, nor is there an annual cost of compliance.

Minimizing Adverse Impact:

The proposed amendments apply to certain services of general hospitals, diagnostic and treatment centers and freestanding ambulatory surgery centers. The Department of Health considered approaches specified in section 202-bb(2) of the State Administrative Procedure Act in drafting the proposed amendments and rejected them as inappropriate given that the reimbursement system is mandated in statute.

Opportunity for Rural Area Participation:

Local governments and small businesses were given notice of these proposals by their inclusion in the SFY 2009-10 enacted budget and the Department's issuance in the *State Register* of federal public notices on February 25, 2009, June 10, 2009 and January 20, 2010.

Job Impact Statement

A Job Impact Statement is not required pursuant to Section 201-a(2)(a) of the State Administrative Procedure Act. It is apparent, from the nature and purpose of the proposed regulations, that they will not have a substantial adverse impact on jobs or employment opportunities.

Department of Labor

NOTICE OF ADOPTION

Restrictions on the Consecutive Hours of Work for Nurses As Enacted in Section 167 of the Labor Law

I.D. No. LAB-43-10-00003-A
Filing No. 855
Filing Date: 2011-09-27
Effective Date: 2011-10-12

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

Action taken: Addition of Part 177 to Title 12 NYCRR.

Statutory authority: Labor Law, section 21

Subject: Restrictions on the consecutive hours of work for nurses as enacted in Section 167 of the Labor Law.

Purpose: To clarify the emergency circumstances under which an employer may require overtime for nurses.

Text or summary was published in the October 27, 2010 issue of the Register, I.D. No. LAB-43-10-00003-EP.

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

Text of rule and any required statements and analyses may be obtained from: Joan Connell, Esq., New York State Department of Labor, State Office Campus, Building 12, Room 509, Albany, NY 12240, (518) 457-4380, email: teresa.stoklosa@labor.ny.gov

Assessment of Public Comment

The agency received no public comment.

Office of Mental Health

EMERGENCY RULE MAKING

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

I.D. No. OMH-32-11-00004-E
Filing No. 852
Filing Date: 2011-09-27
Effective Date: 2011-09-27

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

Finding of necessity for emergency rule: Preservation of general welfare.

Specific reasons underlying the finding of necessity: The rulemaking serves to amend two separate provisions within 14 NYCRR Part 578. The first amendment provides consistency with the enacted State budget by

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

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

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

Rural Area Participation:

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

Job Impact Statement

Nature of Impact:

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

Categories and Numbers Affected:

Not applicable.

Regions of Adverse Impact:

None.

Minimizing Adverse Impact:

Not applicable.

Self-Employment Opportunities:

Not applicable.

Assessment of Public Comment

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

NOTICE OF ADOPTION

October 2011 Ambulatory Patient Groups (APGs) Payment Methodology

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

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

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

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

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

Purpose: To refine the APG payment methodology.

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

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

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

Assessment of Public Comment

The agency received no public comment.

Office of Mental Health

NOTICE OF ADOPTION

Clinic Treatment Programs

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

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

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

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

Subject: Clinic Treatment Programs.

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

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

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

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

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

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

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

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

Appendix IV
2016 Title XIX State Plan
First Quarter Amendment
Public Notice

MISCELLANEOUS NOTICES/HEARINGS

Notice of Abandoned Property Received by the State Comptroller

Pursuant to provisions of the Abandoned Property Law and related laws, the Office of the State Comptroller receives unclaimed monies and other property deemed abandoned. A list of the names and last known addresses of the entitled owners of this abandoned property is maintained by the office in accordance with Section 1401 of the Abandoned Property Law. Interested parties may inquire if they appear on the Abandoned Property Listing by contacting the Office of Unclaimed Funds, Monday through Friday from 8:00 a.m. to 4:30 p.m., at:

1-800-221-9311
or visit our web site at:
www.osc.state.ny.us

Claims for abandoned property must be filed with the New York State Comptroller's Office of Unclaimed Funds as provided in Section 1406 of the Abandoned Property Law. For further information contact: Office of the State Comptroller, Office of Unclaimed Funds, 110 State St., Albany, NY 12236.

PUBLIC NOTICE
Department of Civil Service

PURSUANT to the Open Meetings Law, the New York State Civil Service Commission hereby gives public notice of the following:

Please take notice that the regular monthly meeting of the State Civil Service Commission for January 2016 will be conducted on January 12 and January 13 commencing at 10:00 a.m. This meeting will be conducted at NYS Media Services Center, Suite 146, South Concourse, Empire State Plaza, Albany, NY.

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

PUBLIC NOTICE
Department of Health

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

The Department of Health proposes to amend the Title XIX (Medicaid) State Plan for non-institutional services to revise provisions of the Ambulatory Patient Group (APG) reimbursement methodology on or after January 1, 2016. The following changes are proposed:

The Ambulatory Patient Group (APG) reimbursement methodology is revised to include recalculated weight and component updates that will become effective on or after January 1, 2016. The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2015/2016 is $317,339.

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 & Rate Setting, 99 Washington Ave. – One Commerce Plaza, Suite 1460, Albany, NY 12210, or e-mail: spa_inquiries@health.state.ny.us

PUBLIC NOTICE
Long Island Power Authority
and
PSEG Long Island

On December 15, 2015, pursuant to New York Public Authorities Law Section 1020-f(cc), the Long Island Power Authority (Authority) and PSEG Long Island filed with the New York State Department of Public Service (Department) an emergency response plan (2016 Electric Emergency Response Plan for PSEG Long Island (Plan)) to assure the reasonably prompt restoration of service in the case of a storm or other cause beyond the control of the Authority and PSEG Long Island. The Plan was prepared in accordance with Section 66(21)(a) of the New York State Public Service Law (PSL) and the regulations of the Public Service Commission adopted thereunder.

Subject to review and recommendation by the Department in accordance with PSL Section 3-b(3)(c), the Authority may adopt, amend, or reject the Plan, in whole or in part.

Copies of the Plan are posted on the website of the Long Island Power Authority (http://www.lipower.org/); the website of PSEG Long Island (https://www.psegliny.com/); and the website of the New York State Department of Public Service (Matter number 15-02577). Comments may be submitted via mail or email to the Department of Public Service and PSEG Long Island (at the addresses immediately below) within 45 days of the date of publication of this notice. Comments submitted to the Department should refer to Matter No. 15-02577 - In the Matter of the 2016 Emergency Response Plan of PSEG Long Island.

Appendix V
2016 Title XIX State Plan
First Quarter Amendment
Responses to Standard Funding Questions

NON-INSTITUTIONAL SERVICES
State Plan Amendment #16-0017

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: The State submitted the 2012 and 2013 clinic UPL demonstration on March 21, 2014, the 2014 demonstration on July 11, 2014, and the 2015 demonstration on June 26, 2015. The State and CMS are having ongoing discussions to resolve remaining issues.

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 freestanding diagnostic and treatment and ambulatory surgery center services is based upon the Ambulatory Patient Group (APG) system with the exception of Federally Qualified Health Centers who have the option to opt into the APG system or remain on the Prospective Payment Methodology (PPS) as approved by CMS in SPA 01-03. 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: The State does comply with the requirements of section 1902(a)(37) of the Act regarding prompt payment of claims.

Tribal Assurance:

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

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

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

c) Please describe the consultation process that occurred specifically for the development and submission of this State Plan Amendment when it occurred and who was involved.

Response: Tribal consultation was performed in accordance with the State's tribal consultation policy as approved in SPA 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.

Appendix VI
2016 Title XIX State Plan
First Quarter Amendment
Responses to Standard Access Questions

APPENDIX VI
NON-INSTITUTIONAL SERVICES
State Plan Amendment #16-0017

CMS Standard Access Questions

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

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

   Response: This amendment seeks to accurately pay providers for the services they performed. As the impact is insignificant as compared to the Medicaid program and this category of service, it is not expected that this implementation of APGs will affect the State's compliance with the requirements of 1902(a)(30).

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

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

   For providers that are not subject to an approval process, the State will continue to monitor provider complaint hotlines to identify geographic areas of concern and/or service type needs. If Medicaid beneficiaries begin to encounter access issues, the Department would expect to see a marked increase in complaints. These complaints will be identified and analyzed in light of the changes proposed in this State Plan Amendment.

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

the State would be alerted and would take appropriate action to ensure retention of access to such services.

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

   Response: Any major changes are discussed at a monthly association meeting. This change is due to a review of payments to providers in order to accurately reflect Medicaid policy and is insignificant as compared to the Medicaid program and this category of service.

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

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

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

   Response: Over the course of the past three years, the State has undertaken a massive reform initiative to better align reimbursement with care. When fully implemented, the initiative will invest over $600 million in the State's ambulatory care system (outpatient, ambulatory surgery, emergency department, clinic and physicians) to incentivize care in the most appropriate setting. The State has also increased its physician reimbursement schedule to resemble Medicare payments for similar services, thus ensuring continued access for Medicaid beneficiaries. While some of these initiatives are outside the scope of the State Plan, they represent some of the measures the State is taking to ensure quality care for the State's most vulnerable population.