NEW YORK STATE OF OPPORTUNITY. Department of Health

ANDREW M. CUOMO
Governor

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

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

MAR 1 5 2016

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

Re: SPA #16-0022
Inpatient Hospital Services

Dear Mr. Cooley:

The State requests approval of the enclosed amendment #16-0022 to the Title XIX (Medicaid) State Plan for inpatient hospital services to be effective March 1, 2016 (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 February 24, 2016.

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: **16-0022**	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 **March 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 03/01/16-09/30/16 $ 5,685.00** **b. FFY 10/01/16-09/30/17 $ 1,895.00**
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: **Attachment 4.19-A – 136(d); 136(d.1); 136(d.2); 136(d.3); 136(d.4)**	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

10. SUBJECT OF AMENDMENT:
Safety Net VAP - $10M Essential Community Provider-IP Hospital (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** **Division of Finance and Rate Setting** **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: MAR 1 5 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:	

FORM HCFA-179 (07-92)

Appendix I
2016 Title XIX State Plan
First Quarter Amendment
Amended SPA Pages

New York
136(d)

c. Temporary rate adjustments have been approved for the following essential community providers in the amounts and for the effective periods listed:

Essential Community Providers:

Provider Name	Gross Medicaid Rate Adjustment	Rate Period Effective
A.O. Fox Memorial Hospital	$255,000	03/01/2016 – 03/31/2016
	$255,000	04/01/2016 – 03/31/2017
Adirondack Medical Center	$75,000	03/01/2016 – 03/31/2016
	$75,000	04/01/2016 – 03/31/2017
Alice Hyde Hospital Association	$130,000	03/01/2016 – 03/31/2016
	$130,000	04/01/2016 - 03/31/2017
Auburn Memorial Hospital	$75,000	03/01/2016 – 03/31/2016
	$75,000	04/01/2016 – 03/31/2017
Bassett Hospital of Schoharie County-Cobleskill Reg.	$75,000	03/01/2016 – 03/31/2016
	$75,000	04/01/2016 – 03/31/2017
Brooks Memorial Hospital	$245,000	03/01/2016 – 03/31/2016
	$245,000	04/01/2016 – 03/31/2017
Canton-Potsdam Hospital	$65,000	03/01/2016 – 03/31/2016
	$65,000	04/01/2016 – 03/31/2017
Carthage Area Hospital	$275,000	03/01/2016 – 03/31/2016
	$275,000	04/01/2016 – 03/31/2017
Catskill Regional Hospital-Sullivan	$255,000	03/01/2016 - 03/31/2016
	$255,000	04/01/2016 – 03/31/2017
Catskill Regional Medical Center – Hermann Division	$ 85,000	03/01/2016 – 03/31/2016
	$ 85,000	04/01/2016 – 03/31/2017
Cayuga Medical Center-Ithaca	$120,000	03/01/2016 – 03/31/2016
	$120,000	04/01/2016 – 03/31/2017
Champlain Valley Physicians HMC	$75,000	03/01/2016 - 03/31/2016
	$75,000	04/01/2016 – 03/31/2017

New York
136(d.1)

Essential Community Providers (cont'd):

Provider Name	Gross Medicaid Rate Adjustment	Rate Period Effective
Chenango Memorial Hospital	$ 75,000	03/01/2016 – 03/31/2016
	$75,000	04/01/2016 – 03/31/2017
Claxton Hepburn Hospital	$ 85,000	03/01/2016 – 03/31/2016
	$ 85,000	04/01/2016 – 03/31/2017
Clifton-Fine Hospital	$275,000	03/01/2016 – 03/31/2016
	$275,000	04/01/2016 – 03/31/2017
Columbia Memorial Hospital	$120,000	03/01/2016 – 03/31/2016
	$120,000	04/01/2016 - 03/31/2017
Community Memorial Hospital	$130,000	03/01/2016 – 03/31/2016
	$130,000	04/01/2016 – 03/31/2017
Corning Hospital	$ 65,000	03/01/2016 – 03/31/2016
	$ 65,000	04/01/2016 – 03/31/2017
Cortland Memorial Hospital	$255,000	03/01/2016 – 03/31/2016
	$255,000	04/01/2016 – 03/31/2017
Cuba Memorial Hospital	$245,000	03/01/2016 – 03/31/2016
	$245,000	04/01/2016 – 03/31/2017
Delaware Valley Hospital	$ 85,000	03/01/2016 – 03/31/2016
	$ 85,000	04/01/2016 – 03/31/2017
Elizabethtown Community Hospital	$ 85,000	03/01/2016 - 03/31/2016
	$ 85,000	04/01/2016 – 03/31/2017
Ellenville Community Hospital	$ 85,000	03/01/2016 – 03/31/2016
	$ 85,000	04/01/2016 – 03/31/2017
Gouvernor Hospital	$275,000	03/01/2016 - 03/31/2016
	$275,000	04/01/2016 – 03/31/2017
Ira Davenport Memorial Hospital	$275,000	03/01/2016 - 03/31/2016
	$275,000	04/01/2016 – 03/31/2017

New York
136(d.2)

Essential Community Providers (cont'd):

Provider Name	Gross Medicaid Rate Adjustment	Rate Period Effective
Jones Memorial Hospital	$120,000	03/01/2016 – 03/31/2016
	$120,000	04/01/2016 – 03/31/2017
Lewis County General Hospital	$245,000	03/01/2016 – 03/31/2016
	$245,000	04/01/2016 – 03/31/2017
Little Falls Hospital	$ 85,000	03/01/2016 – 03/31/2016
	$ 85,000	04/01/2016 – 03/31/2017
Margaretville Memorial Hospital	$255,000	03/01/2016 – 03/31/2016
	$255,000	04/01/2016 - 03/31/2017
Mary Imogene Bassett Hospital	$ 65,000	03/01/2016 – 03/31/2016
	$ 65,000	04/01/2016 – 03/31/2017
Massena Memorial Hospital	$205,000	03/01/2016 – 03/31/2016
	$205,000	04/01/2016 – 03/31/2017
Medina Memorial Hospital	$ 85,000	03/01/2016 – 03/31/2016
	$ 85,000	04/01/2016 – 03/31/2017
Moses-Ludington Hospital	$205,000	03/01/2016 – 03/31/2016
	$205,000	04/01/2016 – 03/31/2017
Nathan Littauer Hospital	$ 75,000	03/01/2016 – 03/31/2016
	$ 75,000	04/01/2016 – 03/31/2017
Northern Dutchess Hospital	$ 65,000	03/01/2016 - 03/31/2016
	$ 65,000	04/01/2016 – 03/31/2017
Noyes Memorial Hospital	$ 85,000	03/01/2016 – 03/31/2016
	$ 85,000	04/01/2016 – 03/31/2017
O'Connor Hospital	$105,000	03/01/2016 - 03/31/2016
	$105,000	04/01/2016 – 03/31/2017
Olean General Hospital-Main	$ 85,000	03/01/2016 - 03/31/2016
	$ 85,000	04/01/2016 – 03/31/2017

New York
136(d.3)

Essential Community Providers (cont'd):

Provider Name	Gross Medicaid Rate Adjustment	Rate Period Effective
Oneida City Hospital	$120,000	03/01/2016 – 03/31/2016
	$120,000	04/01/2016 – 03/31/2017
Oswego Hospital	$85,000	03/01/2016 – 03/31/2016
	$85,000	04/01/2016 – 03/31/2017
River Hospital	$275,000	03/01/2016 – 03/31/2016
	$275,000	04/01/2016 - 03/31/2017
Samaritan Medical Center	$ 65,000	03/01/2016 – 03/31/2016
	$ 65,000	04/01/2016 – 03/31/2017
Schuyler Hospital	$150,000	03/01/2016 – 03/31/2016
	$150,000	04/01/2016 – 03/31/2017
Soldiers and Sailors Memorial Hospital	$120,000	03/01/2016 – 03/31/2016
	$120,000	04/01/2016 – 03/31/2017
St. James Mercy Hospital	$255,000	03/01/2016 – 03/31/2016
	$255,000	04/01/2016 – 03/31/2017
St. Mary's Healthcare-St. Mary's Hospital	$105,000	03/01/2016 – 03/31/2016
	$105,000	04/01/2016 – 03/31/2017
TLC Health Network	$275,000	03/01/2016 – 03/31/2016
	$275,000	04/01/2016 – 03/31/2017
Tri Town Regional	$ 65,000	03/01/2016 - 03/31/2016
	$ 65,000	04/01/2016 – 03/31/2017
United Memorial Medical Center – North Street Division	$75,000	03/01/2016 – 03/31/2016
	$75,000	04/01/2016 – 03/31/2017
Westfield Memorial Hospital	$275,000	03/01/2016 – 03/31/2016
	$275,000	04/01/2016 – 03/31/2017
Wyoming County Community Hospital	$130,000	03/01/2016 - 03/31/2016
	$130,000	04/01/2016 – 03/31/2017

New York
136(d.4)

Essential Community Providers (cont'd):

Provider Name	Gross Medicaid Rate Adjustment	Rate Period Effective
WCA Hospital	$120,000	03/01/2016 – 03/31/2016
	$120,000	04/01/2016 – 03/31/2017

Appendix II
2016 Title XIX State Plan
First Quarter Amendment
Summary

SUMMARY
SPA #16-0022

This State Plan Amendment proposes to modify the listing of hospitals previously approved to receive temporary rate adjustments under the closure, merger, consolidation, acquisition, or restructuring of a health care provider. The additional adjustments for providers for which approval is being requested are listed below:

1. A.O Fox Memorial Hospital
2. Adirondack Medical Center
3. Alice Hyde Hospital Association
4. Auburn Memorial Hospital
5. Bassett Hospital of Schoharie County- Cobleskill Regional
6. Brooks Memorial Hospital
7. Canton-Potsdam Hospital
8. Carthage Area Hospital
9. Catskill Regional Hospital - Sullivan
10. Catskill Regional Medical Center-Hermann Division
11. Cayuga Medical Center-Ithaca
12. Champlain Valley Physicians HMC
13. Chenango Memorial Hospital
14. Claxton Hepburn Hospital
15. Clifton-Fine Hospital
16. Columbia Memorial Hospital
17. Community Memorial Hospital
18. Corning Hospital
19. Cortland Memorial Hospital
20. Cuba Memorial Hospital
21. Delaware Valley Hospital
22. Elizabethtown Community Hospital
23. Ellenville Community Hospital
24. Gouvernor Hospital
25. Ira Davenport Memorial Hospital
26. Jones Memorial Hospital
27. Lewis County General Hospital
28. Little Falls Hospital
29. Margaretville Memorial Hospital
30. Mary Imogene Bassett Hospital
31. Massena Memorial Hospital
32. Medina Memorial Hospital
33. Moses-Ludington Hospital
34. Nathan Littauer Hospital
35. Northern Dutchess Hospital

36. Noyes Memorial Hospital
37. O'Connor Hospital
38. Olean General Hospital - Main
39. Oneida City Hospital
40. Oswego Hospital
41. River Hospital
42. Samaritan Medical Center
43. Schuyler Hospital
44. Soldiers and Sailors Memorial Hospital
45. St. James Mercy Hospital
46. St. Mary's Healthcare -- St. Mary's Hospital
47. TLC Health Network
48. Tri Town Regional
49. United Memorial Medical Center -- North Street Division
50. WCA Hospital
51. Westfield Memorial Hospital; and
52. Wyoming County Community Hospital

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

SPA 16-0022

Public Health Law

§ 2826. Temporary adjustment to reimbursement rates. (a) Notwithstanding any provision of law to the contrary, within funds appropriated and subject to the availability of federal financial participation, the commissioner may grant approval of a temporary adjustment to the non-capital components of rates, or make temporary lump-sum Medicaid payments, to eligible general hospitals, skilled nursing facilities, clinics and home care providers, provided however, that should federal financial participation not be available for any eligible provider, then payments pursuant to this subdivision may be made as grants and shall not be deemed to be medical assistance payments.

(b) Eligible providers shall include:

(i) providers undergoing closure;

(ii) providers impacted by the closure of other health care providers;

(iii) providers subject to mergers, acquisitions, consolidations or restructuring; or

(iv) providers impacted by the merger, acquisition, consolidation or restructuring of other health care providers.

(c) Providers seeking temporary rate adjustments under this section shall demonstrate through submission of a written proposal to the commissioner that the additional resources provided by a temporary rate adjustment will achieve one or more of the following:

(i) protect or enhance access to care;

(ii) protect or enhance quality of care;

(iii) improve the cost effectiveness of the delivery of health care services; or

(iv) otherwise protect or enhance the health care delivery system, as determined by the commissioner.

(c-1) The commissioner, under applications submitted to the department pursuant to subdivision (d) of this section, shall consider criteria that includes, but is not limited to:

(i) Such applicant's financial condition as evidenced by operating margins, negative fund balance or negative equity position;

(ii) The extent to which such applicant fulfills or will fulfill an unmet health care need for acute inpatient, outpatient, primary or residential health care services in a community;

(iii) The extent to which such application will involve savings to the Medicaid program;

(iv) The quality of the application as evidenced by such application's long term solutions for such applicant to achieve sustainable health care services, improving the quality of patient care, and/or transforming the delivery of health care services to meet community needs;

(v) The extent to which such applicant is geographically isolated in relation to other providers; or

(vi) The extent to which such applicant provides services to an underserved area in relation to other providers.

(d) (i) Such written proposal shall be submitted to the commissioner at least sixty days prior to the requested effective date of the temporary rate adjustment, and shall include a proposed budget to achieve the goals of the proposal. Any Medicaid payment issued pursuant to this section shall be in effect for a specified period of time as

determined by the commissioner, of up to three years. At the end of the specified timeframe such payments or adjustments to the non-capital component of rates shall cease, and the provider shall be reimbursed in accordance with the otherwise applicable rate-setting methodology as set forth in applicable statutes and regulations. The commissioner may establish, as a condition of receiving such temporary rate adjustments or grants, benchmarks and goals to be achieved in conformity with the provider's written proposal as approved by the commissioner and may also require that the facility submit such periodic reports concerning the achievement of such benchmarks and goals as the commissioner deems necessary. Failure to achieve satisfactory progress, as determined by the commissioner, in accomplishing such benchmarks and goals shall be a basis for ending the facility's temporary rate adjustment or grant prior to the end of the specified timeframe. (ii) The commissioner may require that applications submitted pursuant to this section be submitted in response to and in accordance with a Request For Applications or a Request For Proposals issued by the commissioner.

(e) Notwithstanding any law to the contrary, general hospitals defined as critical access hospitals pursuant to title XVIII of the federal social security act shall be allocated no less than seven million five hundred thousand dollars annually pursuant to this section. The department of health shall provide a report to the governor and legislature no later than June first, two thousand fifteen providing recommendations on how to ensure the financial stability of, and preserve patient access to, critical access hospitals, including an examination of permanent Medicaid rate methodology changes.

(e-1) Thirty days prior to executing an allocation or modification to an allocation made pursuant to this section, the commissioner shall provide written notice to the chair of the senate finance committee and the chair of the assembly ways and means committee with regards to the intent to distribute such funds. Such notice shall include, but not be limited to, information on the methodology used to distribute the funds, the facility specific allocations of the funds, any facility specific project descriptions or requirements for receiving such funds, the multi-year impacts of these allocations, and the availability of federal matching funds. The commissioner shall provide quarterly reports to the chair of the senate finance committee and the chair of the assembly ways and means committee on the distribution and disbursement of such funds. Within sixty days of the effectiveness of this subdivision, the commissioner shall provide a written report to the chair of the senate finance committee and the chair of the assembly ways and means committee on all awards made pursuant to this section prior to the effectiveness of this subdivision, including all information that is required to be included in the notice requirements of this subdivision.

(f) Notwithstanding any provision of law to the contrary, and subject to federal financial participation, no less than ten million dollars shall be allocated to providers described in this subdivision; provided, however that if federal financial participation is unavailable for any eligible provider, or for any potential investment under this subdivision then the non-federal share of payments pursuant to this subdivision may be made as state grants.

(i) Providers serving rural areas as such term is defined in section two thousand nine hundred fifty-one of this chapter, including but not limited to hospitals, residential health care facilities, diagnostic and treatment centers, ambulatory surgery centers and clinics shall be eligible for enhanced payments or reimbursement under a supplemental rate methodology for the purpose of promoting access and improving the

quality of care.

(ii) Notwithstanding any provision of law to the contrary, and subject to federal financial participation, essential community providers, which, for the purposes of this section, shall mean a provider that offers health services within a defined and isolated geographic region where such services would otherwise be unavailable to the population of such region, shall be eligible for enhanced payments or reimbursement under a supplemental rate methodology for the purpose of promoting access and improving quality of care. Eligible providers under this paragraph may include, but are not limited to, hospitals, residential health care facilities, diagnostic and treatment centers, ambulatory surgery centers and clinics.

(iii) In making such payments the commissioner may contemplate the extent to which any such provider receives assistance under subdivision (a) of this section and may require such provider to submit a written proposal demonstrating that the need for monies under this subdivision exceeds monies otherwise distributed pursuant to this section.

(iv) Payments under this subdivision may include, but not be limited to, temporary rate adjustments, lump sum Medicaid payments, supplemental rate methodologies and any other payments as determined by the commissioner.

(v) Payments under this subdivision shall be subject to approval by the director of the budget.

(vi) The commissioner may promulgate regulations to effectuate the provisions of this subdivision.

(vii) Thirty days prior to adopting or applying a methodology or procedure for making an allocation or modification to an allocation made pursuant to this subdivision, the commissioner shall provide written notice to the chairs of the senate finance committee, the assembly ways and means committee, and the senate and assembly health committees with regard to the intent to adopt or apply the methodology or procedure, including a detailed explanation of the methodology or procedure.

(viii) Thirty days prior to executing an allocation or modification to an allocation made pursuant to this subdivision, the commissioner shall provide written notice to the chairs of the senate finance committee, the assembly ways and means committee, and the senate and assembly health committees with regard to the intent to distribute such funds. Such notice shall include, but not be limited to, information on the methodology used to distribute the funds, the facility specific allocations of the funds, any facility specific project descriptions or requirements for receiving such funds, the multi-year impacts of these allocations, and the availability of federal matching funds. The commissioner shall provide quarterly reports to the chair of the senate finance committee and the chair of the assembly ways and means committee on the distribution and disbursement of such funds.

(g) Notwithstanding subdivision (a) of this section, and within amounts appropriated for such purposes as described herein, for the period of April first, two thousand fifteen through March thirty-first, two thousand sixteen, the commissioner may award a temporary adjustment to the non-capital components of rates, or make temporary lump-sum Medicaid payments to eligible general hospitals in severe financial distress to enable such facilities to maintain operations and vital services while such facilities establish long term solutions to achieve sustainable health services.

(i) Eligible general hospitals shall include:

(A) a public hospital, which for purposes of this subdivision, shall mean a general hospital operated by a county or municipality, but shall

exclude any such hospital operated by a public benefit corporation;

(B) a federally designated critical access hospital;

(C) a federally designated sole community hospital; or

(D) a general hospital that is a safety net hospital, which for purposes of this subdivision shall mean:

(1) such hospital has at least thirty percent of its inpatient discharges made up of Medicaid eligible individuals, uninsured individuals or Medicaid dually eligible individuals and with at least thirty-five percent of its outpatient visits made up of Medicaid eligible individuals, uninsured individuals or Medicaid dually-eligible individuals; or

(2) such hospital serves at least thirty percent of the residents of a county or a multi-county area who are Medicaid eligible individuals, uninsured individuals or Medicaid dually-eligible individuals.

(ii) Eligible applicants must demonstrate that without such award, they will be in severe financial distress through March thirty-first, two thousand sixteen, as evidenced by:

(A) certification that such applicant has less than fifteen days cash and equivalents;

(B) such applicant has no assets that can be monetized other than those vital to operations; and

(C) such applicant has exhausted all efforts to obtain resources from corporate parents and affiliated entities to sustain operations.

(iii) Awards under this subdivision shall be made upon application to the department.

(A) Applications under this subdivision shall include a multi-year transformation plan that is aligned with the delivery system reform incentive payment ("DSRIP") program goals and objectives. Such plan shall be approved by the department and shall demonstrate a path towards long term sustainability and improved patient care.

(B) The department may authorize initial award payments to eligible applicants based solely on the criteria pursuant to paragraphs (i) and (ii) of this subdivision.

(C) Notwithstanding subparagraph (B) of this paragraph, the department may suspend or repeal an award if an eligible applicant fails to submit a multi-year transformation plan pursuant to subparagraph (A) of this paragraph that is acceptable to the department by no later than the thirtieth day of September two thousand fifteen.

(D) Applicants under this subdivision shall detail the extent to which the affected community has been engaged and consulted on potential projects of such application, as well as any outreach to stakeholders and health plans.

(E) The department shall review all applications under this subdivision, and a determine:

(1) applicant eligibility;

(2) each applicant's projected financial status;

(3) each applicant's proposed use of funds to maintain critical services needed by its community; and

(4) the anticipated impact of the loss of such services.

(F) After review of all applications under this subdivision, and a determination of the aggregate amount of requested funds, the department shall make awards to eligible applicants; provided, however, that such awards may be in an amount lower than such requested funding, on a per applicant or aggregate basis.

(iv) Awards under this subdivision may not be used for:

(A) capital expenditures, including, but not limited to: construction, renovation and acquisition of capital equipment, including major medical

equipment;

(B) consultant fees;

(C) retirement of long term debt; or

(D) bankruptcy-related costs.

(v) Payments made to awardees pursuant to this subdivision shall be made on a monthly basis. Such payments will be based on the applicant's actual monthly financial performance during such period and the reasonable cash amount necessary to sustain operations for the following month. The applicant's monthly financial performance shall be measured by such applicant's monthly financial and activity reports, which shall include, but not be limited to, actual revenue and expenses for the prior month, projected cash need for the current month, and projected cash need for the following month.

(vi) The department shall provide a report on a quarterly basis to the chairs of the senate finance, assembly ways and means, senate health and assembly health committees. Such reports shall be submitted no later than sixty days after the close of the quarter, and shall include for each award, the name of the applicant, the amount of the award, payments to date, and a description of the status of the multi-year transformation plan pursuant to paragraph (iii) of this subdivision.

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 March 2016 will be conducted on March 8 and March 9 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
Education Department

EDU-06-16-00004-P

School Counseling, Certification Requirements for School Counselors and School Counselor Program Registration Requirements

In the February 10, 2016 edition of the State Register, and pursuant to the requirements of the State Administrative Procedure Act, the State Education Department provided notice of a proposed rulemaking that would make amendments to 52.21, Part 80 and 100.2(j) to Title 8 NYCRR. Since the rulemaking was over 2,000 words, the State Education Department was required to provide a link to the full text. The notice provided that the full text is posted at the following website (http://www.regents.nysed.gov/). The full link is available at: http://www.regents.nysed.gov/meetings/2015/2015-09/p-12-educationhigher-education-joint-meeting.

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 temporary rate adjustments to providers that are undergoing a closure, merger, consolidation, acquisition or restructuring themselves or other health care providers. These payments are authorized by § 2826 of the New York Public Health Law.

The temporary rate adjustment has been reviewed and approved for 52 providers with aggregate payment amounts totaling up to $7,580,000 for the period March 1, 2016 through March 31, 2016 and $7,580,000 for the period April 1, 2016 through March 31, 2017. The approved providers along with their individual estimated aggregate amounts include:

1. A.O Fox Memorial Hospital, up to $255,000 SFY 15/16 and $255,000 for SFY 16/17;

2. Adirondack Medical Center, up to $75,000 SFY 15/16 and $75,000 for SFY 16/17;

3. Alice Hyde Hospital Association, up to $130,000 SFY 15/16 and $130,000 for SFY 16/17;

4. Auburn Memorial Hospital, up to $75,000 SFY 15/16 and $75,000 for SFY 16/17;

5. Bassett Hospital of Schoharie County- Cobleskill Reg, up to $75,000 SFY 15/16 and $75,000 for SFY 16/17;

6. Brooks Memorial Hospital, up to $245,000 SFY 15/16 and $245,000 for SFY 16/17;

7. Canton-Potsdam Hospital, up to $65,000 SFY 15/16 and $65,000 for SFY 16/17;

8. Carthage Area Hospital, up to $275,000 SFY 15/16 and $275,000 for SFY 16/17;

9. Catskill Regional Hospital - Sullivan, up to $255,000 SFY 15/16 and $255,000 for SFY 16/17;

10. Catskill Regional Medical Center-Hermann Div, up to $85,000 SFY 15/16 and $85,000 for SFY 16/17;

11. Cayuga Medical Center-Ithaca, up to $120,000 SFY 15/16 and $120,000 for SFY 16/17;

12. Champlain Valley Physicians HMC, up to $75,000 SFY 15/16 and $75,000 for SFY 16/17;

13. Chenango Memorial Hospital, up to $75,000 SFY 15/16 and $75,000 for SFY 16/17;

14. Claxton Hepburn Hospital, up to $85,000 SFY 15/16 and $85,000 for SFY 16/17;

15. Clifton-Fine Hospital, up to $275,000 SFY 15/16 and $275,000 for SFY 16/17;

16. Columbia Memorial Hospital, up to $120,000 SFY 15/16 and $120,000 for SFY 16/17;

17. Community Memorial Hospital, up to $130,000 SFY 15/16 and $130,000 for SFY 16/17;

18. Corning Hospital, up to $65,000 SFY 15/16 and $65,000 for SFY 16/17;

19. Cortland Memorial Hospital, up to $255,000 SFY 15/16 and $255,000 for SFY 16/17;

20. Cuba Memorial Hospital, up to $245,000 SFY 15/16 and $245,000 for SFY 16/17;

21. Delaware Valley Hospital, up to $85,000 SFY 15/16 and $85,000 for SFY 16/17;

22. Elizabethtown Community Hospital, up to $85,000 SFY 15/16 and $85,000 for SFY 16/17;

23. Ellenville Community Hospital, up to $85,000 SFY 15/16 and $85,000 for SFY 16/17;

24. Gouvernor Hospital, up to $275,000 SFY 15/16 and $275,000 for SFY 16/17;

25. Ira Davenport Memorial Hospital, up to $275,000 SFY 15/16 and $275,000 for SFY 16/17;

26. Jones Memorial Hospital, up to $120,000 SFY 15/16 and $120,000 for SFY 16/17;

27. Lewis County General Hospital, up to $245,000 SFY 15/16 and $245,000 for SFY 16/17;

28. Little Falls Hospital, up to $85,000 SFY 15/16 and $85,000 for SFY 16/17;

29. Margaretville Memorial Hospital, up to $255,000 SFY 15/16 and $255,000 for SFY 16/17;

30. Mary Imogene Bassett Hospital, up to $65,000 SFY 15/16 and $65,000 for SFY 16/17;

31. Massena Memorial Hospital, up to $205,000 SFY 15/16 and $205,000 for SFY 16/17;

32. Medina Memorial Hospital, up to $85,000 SFY 15/16 and $85,000 for SFY 16/17;

33. Moses-Ludington Hospital, up to $205,000 SFY 15/16 and $205,000 for SFY 16/17;

34. Nathan Littauer Hospital, up to $75,000 SFY 15/16 and $75,000 for SFY 16/17;

35. Northern Dutchess Hospital, up to $65,000 SFY 15/16 and $65,000 for SFY 16/17;

36. Noyes Memorial Hospital, up to $85,000 SFY 15/16 and $85,000 for SFY 16/17;

37. O'Connor Hospital, up to $105,000 SFY 15/16 and $105,000 for SFY 16/17;

38. Olean General Hospital - Main, up to $85,000 SFY 15/16 and $85,000 for SFY 16/17;

39. Oneida City Hospital, up to $120,000 SFY 15/16 and $120,000 for SFY 16/17;

40. Oswego Hospital, up to $85,000 SFY 15/16 and $85,000 for SFY 16/17;

41. River Hospital, up to $275,000 SFY 15/16 and $275,000 for SFY 16/17;

42. Samaritan Medical Center, up to $65,000 SFY 15/16 and $65,000 for SFY 16/17;

43. Schuyler Hospital, up to $150,000 SFY 15/16 and $150,000 for SFY 16/17;

44. Soldiers and Sailors Memorial Hospital, up to $120,000 SFY 15/16 and $120,000 for SFY 16/17;

45. St. James Mercy Hospital, up to $255,000 SFY 15/16 and $255,000 for SFY 16/17;

46. TLC Health Network, up to $275,000 SFY 15/16 and $275,000 for SFY 16/17;

47. Tri Town Regional, up to $65,000 SFY 15/16 and $65,000 for SFY 16/17;

48. Westfield Memorial Hospital, up to $275,000 SFY 15/16 and $275,000 for SFY 16/17;

49. Wyoming County Community Hospital, up to $130,000 SFY 15/16 and $130,000 for SFY 16/17;

50. WCA Hospital, up to $120,000 SFY 15/16 and $120,000 for SFY 16/17;

51. United Memorial Medical Center -- North Street Division, up to $75,000 SFY 15/16 and $75,000 for SFY 16/17;

52. St. Mary's Healthcare -- St. Mary's Hospital, up to $105,000 SFY 15/16 and $105,000 for SFY 16/17.

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, e-mail: spa_inquiries@health.ny.gov

PUBLIC NOTICE

Office of Mental Health and Department of Health

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

The Office of Mental Health and the Department of Health propose to amend the Title XIX (Medicaid) State Plan for non-institutional services related to temporary rate adjustments to Article 31 Freestanding Clinics that are undergoing a closure, merger, consolidation, acquisition or restructuring of themselves or other health care providers. These payments are currently authorized by current State statutory and regulatory provisions. The following changes are proposed:

Additional temporary rate adjustments have been reviewed and approved for the following clinics:

- Albany County of Mental Health
- Astor Children and Family Services
- Catholic Charities of Rockville Center
- Catholic Family Center of the Diocese of Rochester
- Central Nassau Guidance and Counseling Services, Inc.
- Chenango County Community Service Board
- Lexington Center for Mental Health Services, Inc.
- Mental Health Association of Westchester County
- Northshore Child & Family Guidance Association, Inc.
- Northside Center for Child Development Inc.
- Occupation Now Access Support for the Living
- Safe Space NY
- Schuyler County of Mental Health
- Steuben County Community Mental Health Center
- Suffolk County Department of Health Services
- Sullivan County Department of Community Services
- The Children's Home of Jefferson County

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

APPENDIX V
HOSPITAL SERVICES
State Plan Amendment #16-0022

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: 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 add-on services payments made to those providers listed who will receive temporary rate adjustments to be paid quarterly during each period in equal installments.

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: The State and CMS are having ongoing discussions to resolve issues with the 2015 inpatient UPL, which the 2016 UPL is contingent upon.

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.**

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

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

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

   Response: This 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.