Department of Health

ANDREW M. CUOMO
Governor

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

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

JUN 30 2017

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 #17-0034
Non-Institutional Services

Dear Mr. Melendez:

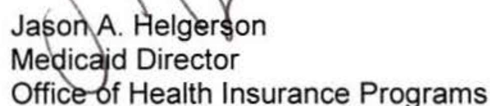
The State requests approval of the enclosed amendment #17-0034 to the Title XIX (Medicaid) State Plan for non-institutional services to be effective April 1, 2017 (Appendix I). This amendment is being submitted based on enacted legislation. A summary of the plan amendment is provided in Appendix II.

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

Copies of pertinent sections of enacted State legislation 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 March 29, 2017, is also enclosed for your information (Appendix IV). In addition, responses to the five standard funding questions and the standard access questions are also enclosed (Appendix V and VI, respectively).

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.

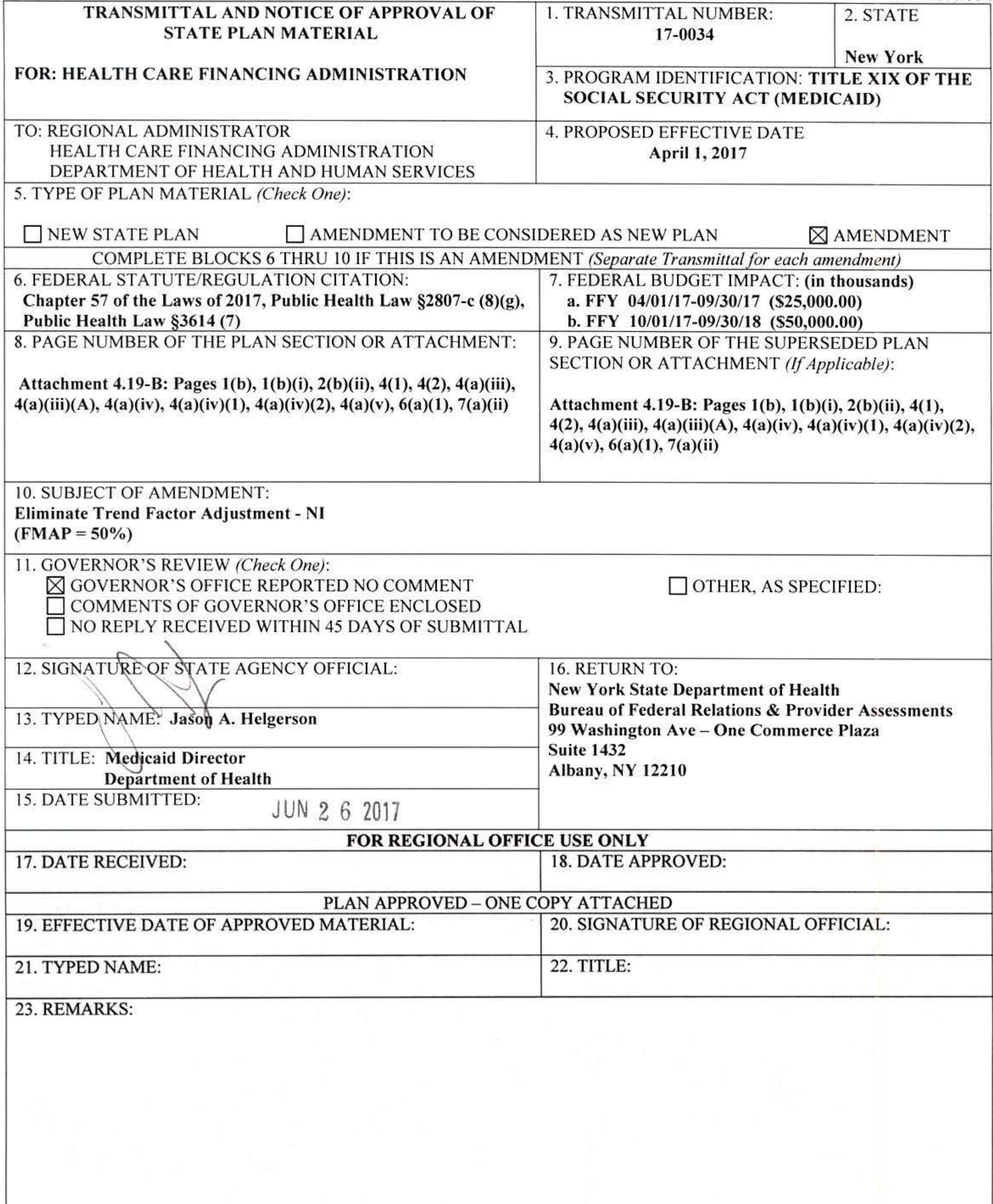
Sincerely,



Jason A. Helgerson
Medicaid Director
Office of Health Insurance Programs

Enclosures

FORM APPROVED
OMB NO. 0938-0193



TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: **17-0034**

2. STATE **New York**

3. PROGRAM IDENTIFICATION: **TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)**

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE **April 1, 2017**

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:
Chapter 57 of the Laws of 2017, Public Health Law §2807-c (8)(g), Public Health Law §3614 (7)

7. FEDERAL BUDGET IMPACT: **(in thousands)**
a. FFY 04/01/17-09/30/17 ($25,000.00)
b. FFY 10/01/17-09/30/18 ($50,000.00)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-B: Pages 1(b), 1(b)(i), 2(b)(ii), 4(1), 4(2), 4(a)(iii), 4(a)(iii)(A), 4(a)(iv), 4(a)(iv)(1), 4(a)(iv)(2), 4(a)(v), 6(a)(1), 7(a)(ii)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-B: Pages 1(b), 1(b)(i), 2(b)(ii), 4(1), 4(2), 4(a)(iii), 4(a)(iii)(A), 4(a)(iv), 4(a)(iv)(1), 4(a)(iv)(2), 4(a)(v), 6(a)(1), 7(a)(ii)

10. SUBJECT OF AMENDMENT:
Eliminate Trend Factor Adjustment - NI
(FMAP = 50%)

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

12. SIGNATURE OF STATE AGENCY OFFICIAL:

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

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

15. DATE SUBMITTED: JUN 2 6 2017

16. RETURN TO:
New York State Department of Health
Bureau of Federal Relations & Provider Assessments
99 Washington Ave – One Commerce Plaza
Suite 1432
Albany, NY 12210

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED:

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:

22. TITLE:

23. REMARKS:

Appendix I
2017 Title XIX State Plan
Second Quarter Amendment
Amended SPA Pages

(two year trend movement) on a per visit basis, except that commencing April 1, 1995 through March 31, 1999 and on and after July 1, 1999 through March 31, 2000 and on and after April 1, 2000 through March 31, 2003, and on and after April 1, 2003 through March 31, 2009, and on and after April 1, 2009 through March 31, 2011, and on and after April 1, 2011 through March 31, 2013, and on and after April 1, 2013 through March 31, 2015, and on and after April 1, 2015 through March 31, 2017, and on and after April 1, 2017 through March 31, 2019, for rates of payment for patients eligible for payments made by state governmental agencies, the capital cost per visit components will be adjusted by the Commissioner to exclude such expenses related to 1) forty-four percent of the costs of major moveable equipment and 2) staff housing. A return on equity is recognized in those instances where the hospital is organized under the auspices of proprietary sponsorship. MMTP services may be reimbursed on a uniform fixed weekly fee per enrolled patient basis. Renal dialysis services are reimbursed on the lower of a facility's actual cost or statewide ceiling of $150.00 per procedure. Payment rates for renal dialysis services are adjusted to reflect utilization patterns for CAPD, CCPD, hemodialysis and extended peritoneal dialysis services. Effective October 1, 1995, the rate for primary care clinic services provided in primary care hospitals, will be a per visit rate based on allowable reportable operating costs subject to a cap on operating costs of $67.50 per visit. For dates of service beginning on December 1, 2008 through March 31, 2010, primary care clinic and renal dialysis services will be reimbursed using the Ambulatory Patient Group classification and reimbursement system. Allowable reportable capital costs will be reimbursed on a per visit basis not subject to a ceiling on reimbursement, provided however that for the period October 1, 1995 through March 31, 1999 and on and after July 1, 1999 through March 31, 2000 and on and after April 1, 2000 through March 31, 2003, and on and after April 1, 2003 through March 31, 2009, and on and after April 1, 2009 through March 31, 2011, and on and after April 1, 2011 through March 31, 2013, and on and after April 1, 2013 through March 31, 2015, and on and after April 1, 2015 through March 31, 2017, and on and after April 1, 2017 through March 31, 2019, the capital cost per visit components will be adjusted by the Commissioner to exclude such expenses related to 1) forty-four percent of the cost of major movable equipment and 2) staff housing. A return on equity is recognized in those instances where the hospital is organized under the auspices of proprietary sponsorship.

Effective October 1, 1995, the rate for emergency services provided in primary care hospitals, will be a per visit rate based upon allowable reportable operating costs and limited to a cap on operating costs of $95 per visit provided however, that for the period January 1, 2007 through December 31, 2007 the maximum payment for the operating component will be $125 per visit; and during the period January 1, 2008 through December 31, 2008, the maximum payment for the operating cost component will be $140 per visit; and during the period January 1, 2009 through March 31, 2010 emergency department services will be reimbursed through the Ambulatory Patient Group (APG) classification and reimbursement system. Allowable reportable capital costs will be reimbursed on a per visit basis not subject to a ceiling on reimbursement, provided however, that for the period of October 1, 1995 through March 31, 1999 and on and after July 1, 1999 through March 31, 2000, and on and after April 1, 2000 through March 31, 2003, and on and after April 1, 2003 through March 31, 2009, and on and after April 1, 2009 through March 31, 2011, and on and after April 1, 2011 through March 31, 2013, and on and after April 1, 2013 through March 31, 2015, and on and after April 1, 2015 through March 31, 2017, and on and after April 1, 2017 through March 31, 2019, the capital costs per visit components will be adjusted by the Commissioner to exclude such expenses related to 1) forty-four percent of the cost of major movable equipment and 2) staff housing. A return on equity is recognized in those instances where the hospital is organized under the auspices of proprietary sponsorship.

For outpatient services provided by general hospitals as noted in the proceeding paragraphs of this Section, beginning on and after April 1, 2006, the Commissioner of Health shall apply a trend factor projection of 2.25% attributable to the period January 1, 2006 through December 31, 2006. Upon reconciliation of this trend factor, in accordance with the previously approved state methodology, the final 2006 trend factor shall be the U.S. Consumer Price Index (CPI) for all Urban Consumers, as published by the U.S. Department of Labor, Bureau of Labor Statistics, minus 0.25%.

For reimbursement of outpatient hospital services provided on and after April 1, 2007, the Commissioner of Health shall apply a trend factor projection equal to 75% of the otherwise applicable trend factor for calendar year 2007.

For reimbursement of outpatient hospital services provided on and after April 1, 2008, the Commissioner of Health shall apply a trend factor projection equal to 65% of the otherwise applicable trend factor for calendar year 2008, as calculated in accordance with the general Trend Factor section of this Attachment.

For rates of payment effective for outpatient hospital services provided on and after January 1, 2009 through March 31, 2009, the otherwise applicable final trend factor attributable to the 2008 calendar year period shall be adjusted such that any increase to the average trend factor for the period April 1, 2008 through December 31, 2008 shall be reduced, on an annualized basis, by 1.3%. However, no retroactive adjustment to such trend factor will be made for the period April 1, 2008 through December 31, 2008. Effective on and after April 1, 2009, the otherwise applicable final trend factor attributable to the 2008 calendar year period shall be zero.

For rates of payment effective for outpatient hospital services provided on and after January 1, 2009 through March 31, 2009, a trend factor equal to the otherwise applicable trend factor attributable to the period January 1, 2009 through December 31, 2009, less 1% shall be applied. Effective on and after April 1, 2009, the otherwise applicable final trend factor attributable to the 2009 calendar year period shall be zero.

For rates of payment effective for outpatient hospital services provided on and after January 1, 2010 through March 31, 2010, the otherwise applicable final trend factor attributable to the 2010 calendar year period shall be zero.

For rates of payment effective for outpatient hospital services provided on and after April 1, 2010, the otherwise applicable trend factor attributable to the 2010 calendar year period shall be zero.

For rates of payment effective for outpatient hospital services provided on and after April 1, 2011, the otherwise applicable trend factors attributable to the 2011 through 2014 calendar year periods shall be no greater than zero. For such rates effective for the period January 1, 2015 through March 31, 2015 and for the period April 23, 2015 through December 31, 2015 otherwise applicable trend factors attributable to the 2015 calendar year period shall be no greater than zero. For rates of payment effective for outpatient hospital services provided on and after January 1, 2016 through March 31, 2017 and for the period April 1, 2017 through December 31, 2017, the otherwise applicable final trend factor attributable to the 2016 and 2017 calendar year periods shall be zero. For rates of payment effective for outpatient hospital services provided on and after January 1, 2018 through March 31, 2019, the otherwise applicable final trend factor attributable to the 2018 and 2019 calendar year periods shall be zero.

New York
2(b)(ii)

For rates of payment effective for outpatient hospital services provided on and after January 1, 2009 through March 31, 2009, the otherwise applicable final trend factor attributable to the 2008 calendar year period shall be adjusted such that any increase to the average trend factor for the period April 1, 2008 through December 31, 2008 shall be reduced, on an annualized basis, by 1.3%. However, no retroactive adjustment to such trend factor will be made for the period April 1, 2008 through December 31, 2008. Effective on and after April 1, 2009, the otherwise applicable final trend factor attributable to the 2008 calendar year period shall be zero.

For rates of payment effective for outpatient hospital services provided on and after January 1, 2009 through March 31, 2009, a trend factor equal to the otherwise applicable trend factor attributable to the period January 1, 2009 through December 31, 2009, less 1% shall be applied. Effective on and after April 1, 2009, the otherwise applicable final trend factor attributable to the 2009 calendar year period shall be zero.

For rates of payment effective for outpatient hospital services provided on and after January 1, 2010 through March 31, 2010, the otherwise applicable final trend factor attributable to the 2010 calendar year period shall be zero.

For rates of payment effective for outpatient hospital services provided on and after April 1, 2010, the otherwise applicable trend factor attributable to the 2010 calendar year period shall be zero.

For rates of payment effective for outpatient hospital services provided on and after April 1, 2011, the otherwise applicable trend factors attributable to the 2011 through 2014 calendar year periods shall be no greater than zero. For such rates effective for the period January 1, 2015 through March 31, 2015 and for the period April 23, 2015 through December 31, 2015 otherwise applicable trend factors attributable to the 2015 calendar year period shall be no greater than zero. For rates of payment effective for outpatient hospital services provided on and after January 1, 2016 through March 31, 2017 and for the period April 1, 2017 through December 31, 2017, the otherwise applicable final trend factor attributable to the 2016 and 2017 calendar year periods shall be zero. For rates of payment effective for outpatient hospital services provided on and after January 1, 2018 through March 31, 2019, the otherwise applicable final trend factor attributable to the 2018 and 2019 calendar year periods shall be zero.

Home Health Services/Certified Home Health Agencies

Prospective, cost based hourly and per visit rates for five services shall be calculated by the Department of Health and approved by Division of the Budget. Rates are based on the lower of cost or ceiling, trended or, if lower, the charge provided, however, for services on and after April 1, 2008, the Commissioner of Health shall apply a trend factor projection equal to 65% of the otherwise applicable trend factor for calendar year 2008, as calculated in accordance with the general Trend Factor section of this Attachment.

For rates of payment effective for services provided on and after January 1, 2009 through March 31, 2009, the otherwise applicable final trend factor attributable to the 2008 calendar year period shall be adjusted such that any increase to the average trend factor for the period April 1, 2008 through December 31, 2008 shall be reduced, on an annualized basis, by 1.3%. However, no retroactive adjustment to such trend factor will be made for the period April 1, 2008 through December 31, 2008. Effective on and after April 1, 2009, the otherwise applicable final trend factor attributable to the 2008 calendar year period shall be zero.

For rates of payment effective for services provided on and after January 1, 2009 through March 31, 2009, a trend factor equal to the otherwise applicable trend factor attributable to the period January 1, 2009 through December 31, 2009, less 1% shall be applied. Effective on and after April 1, 2009 the otherwise applicable final trend factor attributable to the 2009 calendar year period shall be zero.

For rates of payment effective for services provided on and after January 1, 2010 through March 31, 2010, the otherwise applicable final trend factor attributable to the 2010 calendar year period shall be zero.

For rates of payment effective for services provided on and after April 1, 2010, the otherwise applicable trend factor attributable to the 2010 calendar year period shall be zero.

For rates of payment effective for services provided on and after April 1, 2011, the otherwise applicable trend factors attributable to the 2011 through 2014 calendar year periods shall be no greater than zero. For such rates effective for the period January 1, 2015 through March 31, 2015 and for the period April 23, 2015 through December 31, 2015 otherwise applicable trend factors attributable to the 2015 calendar year period shall be no greater than zero. For rates of payment effective for services provided on and after January 1, 2016 through March 31, 2017 and for the period April 1, 2017 through December 31, 2017, the otherwise applicable final trend factor attributable to the 2016 and 2017 calendar year periods shall be zero. For rates of payment effective for services provided on and after January 1, 2018 through March 31, 2019, the otherwise applicable final trend factor attributable to the 2018 and 2019 calendar year periods shall be zero.

New York
4(2)

Providers are grouped geographically into upstate/downstate and by sponsorship, public/voluntary. Ceilings are calculated using the group cost experience. For purposes of establishing rates of payment by governmental agencies for certified home health agencies for the period April 1, 1995 through December 31, 1995, and for rate periods beginning on or after January 1, 1996 through March 31, 1999, and on July 1, 1999 through March 31, 2000, and on and after April 1, 2000 through March 31, 2003, and on and after April 1, 2003 through March 31, 2009, and on and after April 1, 2009 through March 31, 2011, and on and after April 1, 2011 through March 31, 2013, and on and after April 1, 2013 through March 31, 2015, and on and after April 1, 2015 through March 31, 2017, and on and after April 1, 2017 through March 31, 2019, the reimbursable base year administrative and general costs of a provider of services, excluding a provider of services reimbursed on an initial budget basis, and a new provider, excluding changes in ownership or changes in name, who begins operations in the year prior to the year which is used as base year in determining rates of payment, will not exceed the statewide average of total reimbursable base year administrative and general costs of such providers of services. In the 1996, 1997, 1998, 1999, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, and 2009, rate periods respectively the amount of such reduction in certified home health agency rates of payments made during the twelve month period running from April 1, of the year prior to the respective rate period through March 31, of such respective rate period will be adjusted in the respective rate period on a pro-rate basis, if it is determined upon post-audit review by June 15, of the respective rate period and reconciliation, that the savings for the state share, excluding the federal and local government shares, of medical assistance payments is in excess of one million five hundred thousand dollars or is less than one million five hundred thousand dollars for payments made on or before March 31, of the applicable twelve month period to reflect the amount by which such savings are in excess of or lower than one million five hundred thousand dollars. The amount of such reduction in certified home health agency rates of payment made during the period July 1, 1999 through March 31, 2000, will be adjusted in the 2000 rate period on a pro-rate basis, if it is determined upon post-audit review by June 15, 2000 and reconciliation, that the savings for the state share, excluding the federal and local government shares, of medical assistance payments is in excess of one million one hundred twenty-five thousand dollars or is less than one million one hundred twenty-five thousand dollars for payments made on or before March 31, 2000, to reflect the amount by which such savings are in excess of or lower than one million one hundred twenty-five thousand dollars.

New York
4(a)(iii)

Effective for the period August 1, 1996 through November 30, 2009, certified home health agencies (CHHAs) will be required to increase their Medicare revenues relative to their Medicaid revenues measured from a base period (calendar year 1995) to a target period (the 1996 target period is August 1, 1996 through March 31, 1997, the 1997 target period is January 1, 1997 through November 30, 1997, the 1998 target period will mean January 1, 1998 through November 30, 1998, the 1999 target period will mean January 1, 1999 through November 30, 1999, the 2000 target period will mean January 1, 2000 through November 30, 2000, the 2001 target period will mean January 1, 2001 through November 30, 2001, the 2002 target period will mean January 1, 2002 through November 30, 2002, the 2003 target period will mean January 1, 2003 through November 30, 2003, the 2004 target period will mean January 1, 2004 through November 30, 2004, the 2005 target period will mean January 1, 2005 through November 30, 2005, the 2006 target period will mean January 1, 2006 through November 30, 2006, the 2007 target period will mean January 1, 2007 through November 30, 2007, the 2008 target period will mean January 1, 2008 through November 30, 2008, and the 2009 target period will mean January 1, 2009 through November 30, 2009, and the 2010 target period will mean January 1, 2010 through November 30, 2010, and the 2011 target period will mean January 1, 2011 through November 30, 2011, and the 2012 target period will mean January 1, 2012 through November 30, 2012 and the 2013 target period will mean January 1, 2013 through November 30, 2013, and the 2014 target period will mean January 1, 2014 through November 30, 2014, and the 2015 target period will mean January 1, 2015 through November 30, 2015, and the 2016 target will mean January 1, 2016 through November 30, 2016, and the 2017 target period will mean January 1, 2017 through November 30, 2017, and the 2018 target will mean January 1, 2018 through November 30, 2018, and the 2019 target period will mean January 1, 2019 through November 30, 2019 or receive a reduction in their Medicaid payments. For this purpose, regions will consist of a downstate region comprised of Kings, New York, Richmond, Queens, Bronx, Nassau and Suffolk counties and an upstate region comprised of all other New York State counties. A certified home health agency will be located in the same county utilized by the Commissioner of Health for the establishment of rates pursuant to Article 36 of the Public Health Law. Regional group will mean all those CHHAs located within a region. Medicaid revenue percentage will mean CHHA revenues attributable to services provided to persons eligible for payments pursuant to Title 11 of Article 5 of the Social Services law divided by such revenues plus CHHA revenues attributable to services provided to beneficiaries of Title XVIII of the Federal Social Security Act (Medicare).

New York
4(a)(iii)(A)

Prior to February 1, 1997, for each regional group, 1996 Medicaid revenue percentage for the period commencing August 1, 1996, to the last date for which such data is available and reasonably accurate will be calculated. Prior to February 1, 1998, prior to February 1, 1999, prior to February 1, 2000, prior to February 1, 2001, prior to February 1, 2002, prior to February 1, 2003, prior to February 1, 2004, prior to February 1, 2005, prior to February 1, 2006, prior to February 1, 2007, prior to February 1, 2008, prior to February 1, 2009, prior to February 1, 2010, prior to February 1, 2011, prior to February 1, 2012, prior to February 1, 2013, prior to February 1, 2014, prior to February 1, 2015, prior to February 1, 2016, [and] prior to February 1, 2017, prior to February 1, 2018, and prior to February 1, 2019, for each regional group, the Commissioner of Health will calculate the prior years Medicaid revenue percentages for the period beginning January 1 through November 30 of such prior year. By September 15, 1996, for each regional group, the base period Medicaid revenue percentage will be calculated.

For each regional group, the 1996 target Medicaid revenue percentage will be calculated by subtracting the 1996 Medicaid revenue reduction percentages from the base period Medicaid revenue percentages. The 1996 Medicaid revenue reduction percentage, taking into account regional and program differences in utilization of Medicaid and Medicare services, for the following regional groups will be equal to:

one and one-tenth percentage points for CHHAs located within the downstate region; and,

six-tenths of one percentage point for CHHAs located within the upstate region.

New York
4(a)(iv)

For 1997, 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, [and] 2017, 2018, and 2019, for each regional group, the target Medicaid revenue percentage for the respective year will be calculated by subtracting the respective year's Medicaid revenue reduction percentage from the base period Medicaid revenue percentage. The Medicaid revenue reduction percentages for 1997, 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, [and] 2017, 2018, and 2019, taking into account regional and program differences in utilization of Medicaid and Medicare services, for the following regional groups will be equal to:

one and one-tenth percentage points for CHHAs located within the downstate region; and,

six-tenths of one percentage point for CHHAs located within the upstage region.

For each regional group, the 1999 target Medicaid revenue percentage will be calculated by subtracting the 1999 Medicaid revenue reduction percentage from the base period Medicaid revenue percentage. The 1999 Medicaid revenue reduction percentages, taking into account regional and program differences in utilization of Medicaid and Medicare services, for the following regional groups will be equal to:

eight hundred twenty-five thousandths (.825) of one percentage point for CHHAs located within the downstate region;

forty-five hundredths (.45) of one percentage point for CHHAs located within the upstate region;

For each regional group, if the 1996 Medicaid revenue percentage is not equal to or less than the 1996 target Medicaid revenue percentage, a 1996 reduction factor will be calculated by comparing the 1996 Medicaid revenue percentage to the 1996 target Medicaid revenue percentage to determine the amount of the shortfall and dividing such shortfall by the 1996 Medicaid revenue reduction percentage. These amounts, expressed as a percentage, will not exceed one hundred percent. If the 1996 Medicaid revenue percentage is equal to or less than 1996 target Medicaid revenue percentage, the 1996 reduction factor will be zero. For each regional group, the 1996 reduction factor will be multiplied by the following amounts to determine each regional group's applicable 1996 state share reduction amount.

two million three hundred ninety thousand dollars ($2,390,000) for CHHAs located within the downstate region;

seven hundred fifty thousand dollars ($750,000) for CHHAs located within the upstate region.

New York
4(a)(iv)(1)

For each regional group reduction, if the 1996 reduction factor will be zero, there will be no 1996 state share reduction amount.

For 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, [and] 2017, 2018, and 2019, for each regional group, if the Medicaid revenue percentage for the respective year is not equal to or less than the target Medicaid revenue percentage for such respective year, the Commissioner of Health will compare such respective year's Medicaid revenue percentage to such respective year's target Medicaid revenue percentage to determine the amount of the shortfall which, when divided by the respective year's Medicaid revenue reduction percentage, will be called the reduction factor for such respective year. These amounts, expressed as a percentage, will not exceed one hundred percent. If the Medicaid revenue percentage for a particular year is equal to or less than the target Medicaid revenue percentage for that year, the reduction factor for that year will be zero.

For 1997, 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, [and] 2017, 2018, and 2019, for each regional group, the reduction factor for the respective year will be multiplied by the following amounts to determine each regional group's applicable state share reduction amount for such respective year.

New York
4(a)(iv)(2)

two million three hundred ninety thousand dollars ($2,390,000) for CHHAs located within the downstate region;

seven hundred fifty thousand dollars ($750,000) for CHHAs located within the upstate region;

For each regional group reduction, if the reduction factor for a particular year is zero, there will be no state share reduction amount for such year.

For each regional group, the 1999 reduction factor will be multiplied by the following amounts to determine each regional group's applicable 1999 state share reduction amount:

one million seven hundred ninety-two thousand five hundred dollars ($1,792,500) for CHHAs located within the downstate region;

five hundred sixty-two thousand five hundred dollars ($562,500) for CHHAs located within the upstate region;

For each regional group reduction, if the 1999 reduction factor is zero, there will be no 1999 state share reduction amount.

For each regional group, the 1996 state share reduction amount will be allocated among CHHAs on the basis of the extent of each CHHA's failure to achieve the 1996 target Medicaid revenue percentage, calculated on a provider specific basis utilizing revenues for this purpose, expressed as a proportion of the total of each CHHA's failure to achieve the 1996 target Medicaid revenue percentage within the applicable regional group. This proportion will be multiplied by the applicable 1996 state share reduction amount. This amount will be called the 1996 provider specific state share reduction amount.

The 1996 provider specific state share reduction amount will be due to the state from each CHHA and may be recouped by the State by March 31, 1997, in a lump sum amount or amounts from payments due to the CHHA pursuant to Title 11 of Article 5 of the Social Services Law.

For 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, [and] 2017, 2018, and 2019, for each regional group, the state share reduction amount for the respective year will be allocated among CHHAs on the basis of the extent of each CHHA's failure to achieve the target Medicaid revenue percentage for the applicable year, calculated on a provider specific basis utilizing revenues for this purpose, expressed as a proportion of the total of each CHHA's failure to achieve the target Medicaid revenue percentage for the applicable year within the applicable regional group. This proportion will be multiplied by the applicable year's state share reduction amount for the applicable regional group. This amount will be called the provider specific state share reduction amount for the applicable year.

New York
4(a)(v)

The provider specific state share reduction amount for 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, [and] 2017, 2018, and 2019, respectively, will be due to the state from each CHHA and the amount due for each respective year may be recouped by the state by March 31 of the following year in a lump sum amount or amounts from payments due to the CHHA pursuant to Title 11 of Article 5 of the Social Services Law.

CHHAs will submit such data and information at such times as the Commissioner of Health may require. The Commissioner of Health may use data available from third party payors.

On or about June 1, 1997, for each regional group, the Commissioner of Health will calculate for the period of August 1, 1996 through March 31, 1997, a Medicaid revenue percentage, a reduction factor, a state share reduction amount, and a provider specific state share reduction amount in accordance with the methodology provided herein for calculating such amounts for the 1996 target period. The provider specific state share reduction amount calculated will be compared to the 1996 provider specific state share reduction amount. Any amount in excess of the 1996 provider specific state share reduction amount will be due to the state from each CHHA and may be recouped. If the amount is less than the 1996 provider specific state share reduction amount, the difference will be refunded to the CHHA by the state no later than July 15, 1997. CHHAs will submit data for the period August 1, 1996 through March 31, 1997, to the Commissioner of Health by April 15, 1997.

If a CHHA fails to submit data and information as required, such CHHA will be presumed to have no decrease in Medicaid revenue percentage between the base period and the applicable target period for purposes of the calculations described herein and the Commissioner of Health will reduce the current rate paid to such CHHA by state governmental agencies pursuant to Article 36 of the Public Health Law by one percent for the period beginning on the first day of the calendar month following the applicable due date as established by the Commissioner of Health and continuing until the last day of the calendar month in which the required data and information are submitted.

Notwithstanding any inconsistent provision set forth herein, the annual percentage reductions as set forth above, will be prorated by the Commissioner of Health for the period April 1, 2007 through March 31, 2009.

Personal Care Services

For personal care services provided pursuant to a contract between a social services district and a voluntary, proprietary or public personal care services provider, payment is made at the lower of the provider's charge to the general public for personal care services or a rate the Department establishes for the provider, subject to the approval of the Director of the Budget, in accordance with a cost-based methodology. Under the cost-based methodology, the Department determines a provider's rate based upon the provider's reported allowable costs, as adjusted by annual trend factors provided, however, for services on and after April 1, 2008, the Commissioner of Health shall apply a trend factor projection equal to 65% of the otherwise applicable trend factor for calendar year 2008, as calculated in accordance with the general trend factor methodology contained on page 1(c)(i) in this Attachment.

For rates of payment effective for personal care services provided on and after January 1, 2009 through March 31, 2009, the otherwise applicable final trend factor attributable to the 2008 calendar year period shall be adjusted such that any increase to the average trend factor for the period April 1, 2008 through December 31, 2008 shall be reduced, on an annualized basis, by 1.3%. However, no retroactive adjustment to such trend factor will be made for the period April 1, 2008 through December 31, 2008. Effective on and after April 1, 2009, the otherwise applicable final trend factor attributable to the 2008 calendar year period shall be zero.

For rates of payment effective for personal care services provided on and after January 1, 2009 through March 31, 2009, a trend factor equal to the otherwise applicable trend factor attributable to the period January 1, 2009 through December 31, 2009, less 1% shall be applied. Effective on and after April 1, 2009 the otherwise applicable trend factor attributable to the 2009 calendar year period shall be zero.

For rates of payment effective for services provided on and after January 1, 2010 through March 31, 2010, the otherwise applicable final trend factor attributable to the 2010 calendar year period shall be zero.

For rates of payment effective for personal care services provided on and after April 1, 2010, the otherwise applicable trend factor attributable to the 2010 calendar year period shall be zero.

For rates of payment effective for personal care services provided on and after April 1, 2011, the otherwise applicable trend factors attributable to the 2011 through 2014 calendar year periods shall be no greater than zero. For such rates effective for the period January 1, 2015 through March 31, 2015 and for the period April 23, 2015 through December 31, 2015 otherwise applicable trend factors attributable to the 2015 calendar year period shall be no greater than zero. For rates of payment effective for services provided on and after January 1, 2016 through March 31, 2017 and for the period April 1, 2017 through December 31, 2017, the otherwise applicable final trend factor attributable to the 2016 and 2017 calendar year periods shall be zero. For rates of payment effective for services provided on and after January 1, 2018 through March 31, 2019, the otherwise applicable final trend factor attributable to the 2018 and 2019 calendar year periods shall be zero.

For rates of payment effective for adult day health care services provided on and after January 1, 2009 through March 31, 2009, the otherwise applicable final trend factor attributable to the 2008 calendar year period shall be adjusted such that any increase to the average trend factor for the period April 1, 2008 through December 31, 2008 shall be reduced, on an annualized basis, by 1.3%. However, no retroactive adjustment to such trend factor will be made for the period April 1, 2008 through December 31, 2008. Effective on and after April 1, 2009, the otherwise applicable final trend factor attributable to the 2008 calendar year period shall be zero.

For rates of payment effective for adult day health care services provided on and after January 1, 2009 through March 31, 2009, a trend factor equal to the otherwise applicable trend factor attributable to the period January 1, 2009 through December 31, 2009, less 1% shall be applied. Effective on and after April 1, 2009 the otherwise applicable trend factor attributable to the 2009 calendar year period shall be zero.

For rates of payment effective for services provided on and after January 1, 2010 through March 31, 2010, the otherwise applicable final trend factor attributable to the 2010 calendar year period shall be zero.

For rates of payment effective for adult day health care services provided on and after April 1, 2010, the otherwise applicable trend factor attributable to the 2010 calendar year period shall be zero.

For rates of payment effective for adult day health care services provided on and after April 1, 2011, the otherwise applicable trend factors attributable to the 2011 through 2014 calendar year periods shall be no greater than zero. For such rates effective for the period January 1, 2015 through March 31, 2015 and for the period April 23, 2015 through December 31, 2015 otherwise applicable trend factors attributable to the 2015 calendar year period shall be no greater than zero. For rates of payment effective for adult day health care services provided on and after January 1, 2016 through March 31, 2017 and for the period April 1, 2017 through December 31, 2017, the otherwise applicable trend factor attributable to the 2016 and 2017 calendar year periods shall be zero. For rates of payment effective for adult day health care services provided on and after January 1, 2018 through March 31, 2019, the otherwise applicable trend factor attributable to the 2018 and 2019 calendar year periods shall be zero.

Appendix II
2017 Title XIX State Plan
Second Quarter Amendment
Summary

SUMMARY
SPA #17-0034

This State Plan Amendment proposes to continue, for the periods April 1, 2017 through March 31, 2019, the following previously enacted cost containment measures:

- limit the trend factor to an amount no greater than zero for outpatient services provided by general hospitals, home health services including services provided to home care patients diagnosed with AIDS, personal care services and adult day health care services provided;
- the cap on administrative and general component of rates for certified home health agencies;
- continues to appropriately allocate capital costs for outpatient and emergency department rates, and
- continues home health care maximization initiatives.

Appendix III
2017 Title XIX State Plan
Second Quarter Amendment
Authorizing Provisions

Authorizing Provisions
SPA #17-0034

Chapter 57 of the Laws of 2017

19 § 9. Section 4-a of part A of chapter 56 of the laws of 2013 amending
20 chapter 59 of the laws of 2011 amending the public health law and other
21 laws relating to general hospital reimbursement for annual rates relat-
22 ing to the cap on local Medicaid expenditures, as amended by section 29
23 of part D of chapter 57 of the laws of 2015, is amended to read as
24 follows:
25 § 4-a. Notwithstanding paragraph (c) of subdivision 10 of section
26 2807-c of the public health law, section 21 of chapter 1 of the laws of
27 1999, or any other contrary provision of law, in determining rates of
28 payments by state governmental agencies effective for services provided
29 on and after January 1, [~~2017~~] **2019** through March 31, [~~2017~~] **2019**, for
30 inpatient and outpatient services provided by general hospitals, for
31 inpatient services and adult day health care outpatient services
32 provided by residential health care facilities pursuant to article 28 of
33 the public health law, except for residential health care facilities or
34 units of such facilities providing services primarily to children under
35 twenty-one years of age, for home health care services provided pursuant
36 to article 36 of the public health law by certified home health agen-
37 cies, long term home health care programs and AIDS home care programs,
38 and for personal care services provided pursuant to section 365-a of the
39 social services law, the commissioner of health shall apply no greater
40 than zero trend factors attributable to the [~~2017~~] **2019** calendar year in
41 accordance with paragraph (c) of subdivision 10 of section 2807-c of the
42 public health law, provided, however, that such no greater than zero
43 trend factors attributable to such [~~2017~~] **2019** calendar year shall also
44 be applied to rates of payment provided on and after January 1, [~~2017~~]
45 **2019** through March 31, [~~2017~~] **2019** for personal care services provided
46 in those local social services districts, including New York city, whose
47 rates of payment for such services are established by such local social
48 services districts pursuant to a rate-setting exemption issued by the
49 commissioner of health to such local social services districts in
50 accordance with applicable regulations, and provided further, however,
51 that for rates of payment for assisted living program services provided
52 on and after January 1, [~~2017~~] **2019** through March 31, [~~2017~~] **2019**, such
53 trend factors attributable to the [~~2017~~] **2019** calendar year shall be
54 established at no greater than zero percent.

Public Health Law §3614 (7)

7. * Notwithstanding any inconsistent provision of law or regulation, for purposes of establishing rates of payment by governmental agencies for certified home health agencies for the period April first, nineteen hundred ninety-five through December thirty-first, nineteen hundred ninety-five and for rate periods beginning on or after January first, nineteen hundred ninety-six, the reimbursable base year administrative and general costs of a provider of services shall not exceed the statewide average of total reimbursable base year administrative and general costs of such providers of services. The amount of such reduction in certified home health agency rates of payments made during the period April first, nineteen hundred ninety-five through March thirty-first, nineteen hundred ninety-six shall be adjusted in the nineteen hundred ninety-six rate period on a pro-rata basis, if it is determined upon post-audit review by June fifteenth, nineteen hundred ninety-six and reconciliation that the savings for the state share,

excluding the federal and local government shares, of medical assistance payments pursuant to title eleven of article five of the social services law based on the limitation of such payment pursuant to this subdivision is in excess of one million five hundred thousand dollars or is less than one million five hundred thousand dollars for payments made on or before March thirty-first, nineteen hundred ninety-six to reflect the amount by which such savings are in excess of or lower than one million five hundred thousand dollars. For rate periods on and after January first, two thousand five through December thirty-first, two thousand six, there shall be no such reconciliation of the amount of savings in excess of or lower than one million five hundred thousand dollars.

* NB Effective until March 31, 2019

Public Health Law §2807-c (8)(g)

* (g) Notwithstanding any inconsistent provision of this article, commencing April first, nineteen hundred ninety-five for rates of payment for patients eligible for payments made by state governmental agencies, the capital related inpatient expenses component determined in accordance with paragraph (a) of this subdivision and the capital cost per visit components determined in accordance with subparagraphs (i) and (ii) of paragraph (g) of subdivision two of section twenty-eight hundred seven of this article shall be adjusted by the commissioner to exclude such expenses related to:

(i) forty-four percent of the costs of major movable equipment; and

(ii) staff housing.

* NB Effective through March 31, 2019

Chapter 57 of the Laws of 2017

§ 6. Subdivision 5-a of section 246 of chapter 81 of the laws of 1995, amending the public health law and other laws relating to medical reimbursement and welfare reform, as amended by section 11 of part D of chapter 57 of the laws of 2015, is amended to read as follows:

5-a. Section sixty-four-a of this act shall be deemed to have been in full force and effect on and after April 1, 1995 through March 31, 1999 and on and after July 1, 1999 through March 31, 2000 and on and after April 1, 2000 through March 31, 2003 and on and after April 1, 2003 through March 31, 2007, and on and after April 1, 2007 through March 31, 2009, and on and after April 1, 2009 through March 31, 2011, and on and after April 1, 2011 through March 31, 2013, and on and after April 1, 2013 through March 31, 2015, and on and after April 1, 2015 through March 31, 2017 **and on and after April 1, 2017 through March 31, 2019**;

Appendix IV
2017 Title XIX State Plan
Second 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 April 2017 will be conducted on April 11 and April 12 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 with live coverage available at https://www.cs.ny.gov/commission/.

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

Division of Criminal Justice Services
Commission on Forensic Science

Pursuant to Public Officers Law section 104, the Division of Criminal Justice Services gives notice of a meeting of the New York State Commission on Forensic Science to be held on:

Date: April 12, 2017
Time: 9:00 a.m.-1:00 p.m.
Place: Division of Criminal Justice Services
Alfred E. Smith Office Bldg.
CrimeStat Rm. 118
80 S. Swan St.
Albany, NY

Video Conference with:
Empire State Development Corporation (ESDC)
633 3rd Ave.
37th Fl./Conference Rm.
New York, NY

*Identification and sign-in is required at this location. *For further information, or if you need a reasonable accommodation to attend this meeting, contact:* Catherine White, Division of Criminal Justice Services, Office of Forensic Services, 80 S. Swan St., Albany, NY 12210, (518) 485-5052

PUBLIC NOTICE

Division of Criminal Justice Services
DNA Subcommittee

Pursuant to Public Officers Law section 104, the Division of Criminal Justice Services gives notice of a meeting of the DNA Subcommittee to be held on:

Date: March 27, 2017
Time: 8:30 a.m.-1:00 p.m.
Place: Empire State Development Corporation (ESDC)
633 3rd Ave.
37th Fl. Board Rm.
New York, NY

Identification and sign-in are required at this location. *For further information, or if you need a reasonable accommodation to attend this meeting, contact:* Catherine White, Division of Criminal Justice Services, Office of Forensic Services, 80 S. Swan St., Albany, NY, (518) 485-5052

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, non-institutional, long term care, and prescription drug services to comply with proposed statutory provisions. The following changes are proposed:

All Services

• Effective on and after April 1, 2017, no greater than zero trend factors attributable to services through March 31, 2020 pursuant to the provisions of Public Health Law § 2807-c(10)(c) to rates of payment for hospital inpatient and outpatient services, inpatient and adult day health care outpatient services provided by residential health care facilities pursuant to Article 28 of the Public Health Law, except for residential health care facilities or units of such facilities providing services primarily to children under 21 year of age, certified home health agencies, AIDS home care programs, and for personal care services pursuant to section 365-a of the Social Services Law, including personal care services provided in those local social services districts, including New York City, whose rates of payment for services is

established by such social services districts pursuant to a rate-setting exemption granted by the Department, and assisted living program services.

The annual decrease in gross Medicaid expenditures for state fiscal year 2017/2018 is ($208.8) million.

Institutional Services

• For the state fiscal year beginning April 1, 2017 through March 31, 2018, continues specialty hospital adjustments for hospital inpatient services provided on and after April 1, 2012, to public general hospitals, other than those operated by the State of New York or the State University of New York, located in a city with a population of over one million and receiving reimbursement of up to $1.08 billion annually based on criteria and methodology set by the Commissioner of Health, which the Commissioner may periodically set through a memorandum of understanding with the New York City Health and Hospitals Corporation. Payments to eligible public general hospitals may be added to rates of payment or made as aggregate payments.

• Extends current provisions for services on and after April 1, 2017 through March 30, 2020, the reimbursable operating cost component for general hospital inpatient rates will be established with the 2006 final trend factor equal to the final Consumer Price Index (CPI) for all urban consumers less 0.25%.

The estimated annual net decrease in gross Medicaid expenditures attributable to these cost containment initiatives contained in the budget for state fiscal year 2017/2018 is ($114.5) million.

• Effective April 1, 2017, continues the supplemental upper payment limit payments made to general hospitals, other than major public general hospitals under institutional services of $339 million annually.

• Capital related costs of a general hospital excluding 44% of the major movable costs and excluding staff housing costs will continue effective April 1, 2017 through March 31, 2020.

The estimated gross annual decrease in Medicaid expenditures for state fiscal year 2017/2018 for this initiative is ($48.4) million.

• Budgeted capital inpatient costs of a general hospital applicable to the rate year will be decreased to reflect the percentage amount by which the budget for the base year two years prior to the rate year for capital related inpatient expenses of the hospital exceeded actual expenses will continue effective April 1, 2017 through March 31, 2020.

The estimated gross annual decrease in Medicaid expenditures for state fiscal year 2017/2018 for this initiative is ($15.9) million.

Long Term Care Services

• For state fiscal year beginning April 1, 2017, continues additional payments to non-state government operated public residential health care facilities, including public residential health care facilities located in Nassau, Westchester, and Erie counties, but excluding public residential health care facilities operated by a town or city within a county, in aggregate amounts of up to $500 million. The amount allocated to each eligible public RHCF will be in accordance with the previously approved methodology, provided, however that patient days shall be utilized for such computation reflecting actual reported data for 2014 and each representative succeeding year as applicable. Payments to eligible RHCF's may be added to rates of payment or made as aggregate payments.

• The quality incentive program for non-specialty nursing homes will continue for the 2017 rate year to recognize improvement in performance as an element in the program and provide for other minor modifications.

There is no additional estimated annual change to gross Medicaid expenditures attributable to this initiative for state fiscal year 2017/2018.

• This proposal eliminates the reimbursement to Nursing Homes for bed hold days through the repeal of PHL § 2808(25).

The estimated annual net decrease in gross Medicaid expenditures attributable to these cost containment initiatives contained in the budget for state fiscal year 2017/2018 is ($22) million.

• Continues, effective for periods on and after April 1, 2017, the total reimbursable state assessment on each residential health care facility's gross receipts received from all patient care services and other operating income on a cash basis for inpatient or health-related services, including adult day service, but excluding gross receipts attributable to payments received pursuant to Title XVIII of the federal Social Security Act (Medicare), at six percent. The extent to which a facility is reimbursed for the additional cost of the assessment is dependent upon Medicaid volume of services.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2017/2018 is $513 million.

• The following is notice of the continuation of the Advanced Training Program (ATI). First introduced in State fiscal year 2015/2016, ATI is a training program aimed at teaching staff to detect early changes in a resident's physical, mental, or functional status that could lead to hospitalization. Clinical findings show early detection of patient decline by front line workers, couple with clinical care models aimed at fostering consistent and continuous care between care givers and patients results in better care outcomes.

Training programs and their curricula from the previous ATI program may be used by facilities, new training programs will be submitted for Department review. In addition to offering a training program, eligible facilities must also have direct care staff retention above the statewide median. Hospital-based facilities and those receiving VAP funds will not be eligible to participate.

The estimated net aggregate cost contained in the budget for the continuation of the ATI program for 2017/2018 is $46 million.

• The rates of payment for RHCFs shall not reflect trend factor projections or adjustments for the period April 1, 1996 through March 31, 1997 and continues the provision effective on and after April 1, 2017 through March 31, 2020.

The estimated annual net aggregate decrease in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2017/2018 is ($12,749,000) million.

• Extends current provisions to services on and after April 1, 2017, the reimbursable operating cost component for RHCFs rates will be established with the final 2006 trend factor equal to the final Consumer Price Index (CPI) for all urban consumers less 0.25%.

The estimated annual net decrease in gross Medicaid expenditures attributable to these cost containment initiatives contained in the budget for state fiscal year 2017/2018 is ($15,355,637) million.

Non-Institutional Services

• For state fiscal year beginning April 1, 2017 through March 31, 2018, continues hospital outpatient payment adjustments that increase the operating cost components of rates of payment for hospital outpatient and emergency departments on and after April 1, 2011, for public general hospitals other than those operated by the State of New York or the State University of New York, which are located in a city with a population of over one million. The amount to be paid will be up to $287 million annually based on criteria and methodology set by the Commissioner of Health, which the Commissioner may periodically set through a memorandum of understanding with the New York City Health and Hospitals Corporation. Payments may be added to rates of payment or made as aggregate payments.

• For the state fiscal year beginning April 1, 2017 through March 31, 2018, continues upon the election of the social services district in which an eligible diagnostic and treatment center (DTC) is physically located, up to $12.6 million in additional annual Medicaid payments may be paid to public DTCs operated by the New York City Health and Hospitals Corporation. Such payments will be based on each DTC's proportionate share of the sum of all clinic visits for all facilities eligible for an adjustment for the base year two years prior to the rate year. The proportionate share payments may be added to rates of payment or made as aggregate payments to eligible DTCs.

• For the state fiscal year beginning April 1, 2017 through March 31, 2018, continues up to $5.4 million in additional annual Medicaid payments may be paid to county operated free-standing clinics, not including facilities operated by the New York City Health and Hospitals Corporation, for services provided by such DTC and those

provided by a county operated freestanding mental health or substance abuse DTC. Distributions shall be based on each eligible facility's proportionate share of the sum of all DTC and clinic visits for all eligible facilities receiving payments for the base year two years prior to the rate year. The proportionate share payments may be added to rates of payment or made as aggregate payments to eligible facilities.

• Effective on or after April 1, 2017, eliminates supplemental medical assistance payments of up to $6 million annually made to providers of emergency medical transportation.

• Continues, effective for periods on and after April 1, 2017, funds to certified home health agencies, AIDS home care providers, and hospice service providers for the purpose of improving recruitment, training, and retention of home health aides or other personnel with direct patient care responsibility.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2017/2018 is $26 million.

• Extends current provisions to services on and after April 1, 2017 through March 30, 2020, the reimbursable operating cost component for general hospital outpatient rates and adult day health care services provided by RHCFs rates will be established with the final 2006 trend factor equal to the final consumer price index (CPI) for all urban consumers less 0.25%.

• Extends current provisions for certified home health agency administrative and general cost reimbursement limits for the periods April 1, 2017 through March 31, 2020.

• Effective April 1, 2017, continues the supplemental upper payment limit payments made to general hospitals, other than major public general hospitals under non-institutional services of $339 million annually.

• Capital related costs of a general hospital excluding 44% of the major movable costs and excluding staff housing costs will continue effective April 1, 2017 through March 31, 2020.

The estimated gross annual decrease in Medicaid expenditures for state fiscal year 2017/2018 for this initiative is ($35.1) million.

Prescription Drugs:

• Effective April 1, 2017, in an effort to mitigate high drug costs, the Department proposes to establish requirements for manufacturers to pay a penalty in the form of a rebate, as well as impose a surcharge on wholesalers and manufacturers for certain high priced drugs.

o The Department will collect confidential information from drug manufacturers related to drug costs and prices, and with the assistance of the drug utilization review board (DURB), identify for review drugs which: are first introduced to market at prohibitively expensive prices, experience a large increase in price not explained by a relevant factor, or are priced disproportionally given limited therapeutic benefits. If a manufacturer's price exceeds the reasonable value of the drug, as determined by the DURB, the Board would recommend that a benchmark price be established and the excess amount would be subject to a Medicaid rebate and a surcharge.

o A list of such designated high priced drugs shall be published on the Department's website, along with the date on which each drug first appeared on the list, and its associated benchmark price.

o A surcharge of 60% shall be imposed on the excess charge amount of the gross receipt from the first in-state sale of a high priced drug. The surcharge shall be deposited into a designated High Priced Drug Reimbursement Fund, and paid out through the Department of Financial Services to health insurers and the Medicaid program in proportion to their respective costs attributable to the drug.

The estimated annual aggregate decrease in Medicaid expenditures for state fiscal year 2017/2018 for this initiative is $110 million.

• The Department proposes to amend the reimbursement for prescription drugs dispensed, effective April 1, 2017. These changes will bring the reimbursement methodology into compliance with Federal regulations.

o Reimbursement for prescribed drugs will be the lower of ingredient cost (plus a professional dispensing fee when a covered outpatient drug), or the billing pharmacy's usual and customary charge.

o For brand name drugs, the ingredient cost will be the National Average Drug Acquisition Cost (NADAC); or, in the event of no NADAC pricing available, Wholesale Acquisition Cost (WAC) less 3.3%.

o For generic drugs, ingredient cost will be the lower of NADAC; or the Federal Upper Limit (FUL); or the State Maximum Acquisition Cost (SMAC). In the event of no NADAC pricing available, ingredient cost is the lower of WAC less 17.5%; or the FUL; or SMAC.

o For over-the-counter drugs, ingredient cost will be the lower of NADAC; or FUL; or SMAC. In the event of no NADAC pricing available, ingredient cost is the lower of WAC; FUL; or SMAC.

o The professional dispensing fee for brand name, generic, and OTC covered outpatient drugs will be $10.00.

The estimated annual aggregate increase in Medicaid expenditures for state fiscal year 2017/2018 for this initiative is $11 million.

• Effective July 1, 2017, the co-pay for over-the-counter (OTC) non-prescription drug/items will be increased from $0.50 to $1.00. In addition, modifications to the list of covered drug/items in this category may be filed as regulations by the commissioner of health without prior notice and comment.

The estimated annual aggregate decrease in Medicaid expenditures for state fiscal year 2017/2018 for this initiative is $12.6 million.

• Effective July 1, 2017, the Department proposes to amend the copayment for brand name prescription drugs dispensed in order to eliminate the difference in co-pay between a preferred drug and a non-preferred drug, in accordance with federal requirements:

o The co-pay for brand-name prescription drugs will be changed to $2.50, regardless of their status on or off the preferred drug list; provided, however, that the copayments for brand name prescriptions drugs in the Fee-for-Service Brand Less Than Generic program will continue to be $1.00.

There is no additional estimated annual change to gross Medicaid expenditures as a result of the clarifying proposed amendments.

The overall estimated annual net aggregate decrease in gross Medicaid expenditures attributable to reform and other initiatives contained in the budget for state fiscal year 2017/2018 is $282,506,637 million; and the estimated annual net aggregate increase in gross Medicaid expenditures attributable to an extension of upper payment limit (UPL) payments for state fiscal year 2017/2018 in $2.5 billion.

The public is invited to review and comment on this proposed State Plan Amendment. Copies of which will be available for public review on the Department'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, spa_inquiries@health.ny.gov

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 comply with Section 5006 of the American Recovery and Reinvestment Act of 2009. The following changes are proposed:

Non-Institutional Services

Effective on or after April 1, 2017, in accordance with Section 5006 of the American Recovery and Reinvestment Act of 2009 which amended the Social Security Act to provide Indian health care providers that are not FQHCs with the right to wrap around payments from the State, in the event that the amount paid by a managed care plan is less than what is due to the Indian health care provider as stated in the State Plan, the difference will be provided.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2017/2018 is approximately $450,000.

The public is invited to review and comment on this proposed State Plan Amendment, a copy of which will be available for public review on the Department's website at http://www.health.ny.gov/regulations/state_plans/status. In addition, approved SPA's beginning in 2011, are also available for viewing on this website.

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 1432, Albany, NY 12210, spa_inquiries@health.ny.gov

PUBLIC NOTICE

City of Oswego

The City of Oswego is soliciting proposals from Administrative Service Agencies, Trustees, and Financial Organizations for services in connection with a Deferred Compensation Plan that will meet the requirements of Section 457 of the Internal Revenue Code and Section 5 of the State Finance Law, including all rules and regulations issued pursuant thereto.

A copy of the proposal questionnaire may be obtained from: Nancy C. Sterio, Personnel Director, nsterio@oswegony.org

All proposals must be submitted not later than 30 days from the date of publication in the New York State Register.

PUBLIC NOTICE

Susquehanna River Basin Commission

Projects Approved for Consumptive Uses of Water

SUMMARY: This notice lists the projects approved by rule by the Susquehanna River Basin Commission during the period set forth in "DATES."

DATES: February 1-28, 2017.

ADDRESSES: Susquehanna River Basin Commission, 4423 North Front St., Harrisburg, PA 17110-1788.

FOR FURTHER INFORMATION CONTACT: Jason E. Oyler, General Counsel, telephone: (717) 238-0423, ext. 1312; fax: (717) 238-2436; e-mail: joyler@srbc.net. Regular mail inquiries may be sent to the above address.

SUPPLEMENTARY INFORMATION: This notice lists the projects, described below, receiving approval for the consumptive use of water pursuant to the Commission's approval by rule process set forth in 18 CFR § 806.22(f) for the time period specified above:

Approvals By Rule Issued Under 18 CFR 806.22(f):

1. Chesapeake Appalachia, LLC, Pad ID: Maple Ln Farms, ABR-201202021.R1, Athens Township, Bradford County, PA; Consumptive Use of Up to 7.5000 mgd; Approval Date: February 6, 2017.

2. SWEPI, LP, Pad ID: My TB INV LLC 6076, ABR-201702001, Deerfield Township, Tioga County, PA; Consumptive Use of Up to 4.0000 mgd; Approval Date: February 6, 2017.

3. Range Resources – Appalachia, LLC, Pad ID: Bobst Mtn Hunting Club 30H-33H, ABR-201202017.R1, Cogan House Township, Lycoming County, PA; Consumptive Use of Up to 1.0000 mgd; Approval Date: February 8, 2017.

4. Range Resources – Appalachia, LLC, Pad ID: Bobst A Unit 25H-27H, ABR-201202018.R1, Cogan House Township, Lycoming County, PA; Consumptive Use of Up to 1.0000 mgd; Approval Date: February 8, 2017.

5. SWN Production Company, LLC, Pad ID: HEBDA-VANDEMARK, ABR-201201025.R1, Stevens Township, Bradford County, PA; Consumptive Use of Up to 4.9990 mgd; Approval Date: February 10, 2017.

6. Cabot Oil & Gas Corporation, Pad ID: Jeffers Farms P2, ABR-201702002, Harford Township, Susquehanna County, PA; Consumptive Use of Up to 4.2500 mgd; Approval Date: February 14, 2017.

7. Cabot Oil & Gas Corporation, Pad ID: FoltzJ P2, ABR-201702003, Brooklyn Township, Susquehanna County, PA; Consumptive Use of Up to 4.2500 mgd; Approval Date: February 14, 2017.

8. Carrizo (Marcellus), LLC, Pad ID: EP Bender B (CC-03) Pad (2), ABR-201201030.R1, Reade Township, Cambria County, PA; Consumptive Use of Up to 2.1000 mgd; Approval Date: February 14, 2017.

9. EXCO Resources (PA), LLC, Pad ID: Warner North Unit Pad, ABR-201202001.R1, Penn Township, Lycoming County, PA; Consumptive Use of Up to 8.0000 mgd; Approval Date: February 14, 2017.

10. Inflection Energy, (PA), LLC, Pad ID: Eichenlaub B Pad, ABR-201206013.R1, Upper Fairfield Township, Lycoming County, PA; Consumptive Use of Up to 4.0000 mgd; Approval Date: February 16, 2017.

11. Chief Oil & Gas, LLC, Pad ID: Boy Scouts Drilling Pad, ABR-201207023.R1, Elkland Township, Sullivan County, PA; Consumptive Use of Up to 2.0000 mgd; Approval Date: February 17, 2017.

12. Cabot Oil & Gas Corporation, Pad ID: ManzerA P1, ABR-201203013.R1, Gibson Township, Susquehanna County, PA; Consumptive Use of Up to 3.5750 mgd; Approval Date: February 20, 2017.

Appendix V
2017 Title XIX State Plan
Second Quarter Amendment
Responses to Standard Funding Questions

NON-INSTITUTIONAL SERVICES
State Plan Amendment #17-0034

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 the state plan. 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 2 CFR 200 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 and CMS are having ongoing discussions related to prior years' outpatient UPL demonstrations, of which the 2017 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 methodologies included in the State Plan for outpatient hospital, home health services including services provided to home care patients diagnosed with AIDS, personal care services, and adult day health care services are either cost-based subject to ceilings or based upon the Ambulatory Patient Group (APG) system. We are unaware of any requirement under current federal law or regulation that limits individual providers' payments to their actual costs.

ACA Assurances:

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

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

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

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

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

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

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

   Response: This 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
2017 Title XIX State Plan
Second Quarter Amendment
Responses to Standard Access Questions

APPENDIX VI
NON-INSTITUTIONAL SERVICES
State Plan Amendment #17-0034

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 continue cost saving measures previously enacted. This is an overall effort to control Medicaid spending resulting from the 2017-18 New York State Budget. The change should not significantly impact providers since overall reimbursement rates are being held constant, not being reduced.

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: This change was enacted by the State Legislature as part of the negotiation of the 2017-18 Budget. The impact of this change was weighed in the context of the overall Budget in the State. The legislative process provides opportunities for all stakeholders to lobby their concerns, objections, or support for various legislative initiatives.

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. In addition, the State is implementing initiatives that will award $600 million annually, over the next few years, to providers who promote efficiency and quality care through the Federal-State Health Reform Partnership(F-SHRP)/ NYS Healthcare Efficiency and Affordability Law (HEAL). Further, the New York State Budget provides for a Quality Pool for hospital inpatient services for up to $57.8M for SFY 2017/2018 which will be paid through the Medicaid Managed Care Health Plan rates. The State Budget also provides for a $20M investment in Critical Access Hospitals, as well as a $20M investment in Enhanced Safety Net facilities. DOH is also in the process of implementing the Delivery System Reform Incentive Payment (DSRIP) program whereby up to $6.42 billion is being reinvested in the Medicaid program over a five-year period. The State

also offers a number of other programs to hospitals such as the Vital Access Provider (VAP) program and the Vital Access Provider Assurance Program (VAPAP) to help sustain key health care services. 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.