NEW YORK
state department of
HEALTH

Nirav R. Shah, M.D., M.P.H.
Commissioner

Sue Kelly
Executive Deputy Commissioner

September 30, 2011

National Institutional Reimbursement Team
Attention: Mark Cooley
CMS, CMCS
7500 Security Boulevard, M/S 3-14-28
Baltimore, MD 21244-1850

RE: SPA #11-86
Specialty Hospital Services

Dear Mr. Cooley:

The State requests approval of the enclosed amendment #11-86 to the Title XIX (Medicaid) State Plan for Specialty Hospital services to be effective July 1, 2011 (Appendix I). This amendment is being submitted based on enacted legislation and adopted regulation. A summary of the proposed amendment is provided 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, Part 447, Subpart C, (42 CFR §447).

1. The State of New York pays for Specialty Hospital services using rates determined in accordance with methods and standards specified in an approved State Plan following a public process which complies with §1902(a)(13)(A) of the Social Security Act.

2. (a) It is estimated that the changes represented by the estimated average payment rates for Specialty Hospital services will have no noticeable short-term or long-term effect on the availability of services on a statewide and geographic area basis.

   (b) It is estimated that the changes represented by the estimated average payment rates for Specialty Hospital services will have no noticeable short-term or long-term effect on care furnished.

   (c) It is estimated that the changes represented by the estimated average payment rates for Specialty Hospital services will have no noticeable short-term or long-term effect on the extent of provider participation.

In accordance with 42 CFR §447.272(c), New York assures that its aggregate disproportionate share hospital payments do not exceed the disproportionate share hospital payment limit.

In accordance with §1923(g) of the Social Security Act, New York assures that it has calculated facility specific limits for disproportionate share payments for each disproportionate share hospital. New York assures that it will not make disproportionate share payments to a hospital in excess of the facility specific limits established for such hospital.

Copies of pertinent sections of enacted State statute and adopted regulations are enclosed for your information (Appendix III). 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 matter, please do not hesitate to contact John E. Ulberg, Jr., Director, Division of Health Care Financing at (518) 474-6350.

Sincerely,

Jason A. Helgerson
Medicaid Director
Deputy Commissioner
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: **11-86**	2. STATE **New York**
	3. PROGRAM IDENTIFICATION: **TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)**	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE **July 1, 2011**	

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

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

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

6. FEDERAL STATUTE/REGULATION CITATION: **Section 1902(a) of the Social Security Act, and 42 CFR 447**	7. FEDERAL BUDGET IMPACT: a. FFY **07/01/11-09/30/11 ($.087 million)** b. FFY **10/01/11-09/30/12 ($.346 million)**
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: **Attachment 4.19-A-Part VII: Pages 4, 6, 7, 12, 19, 20, 20a**	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: **Attachment 4.19-A-Part VII: Pages 4, 6, 7, 12, 19, 20, 20a**

10. SUBJECT OF AMENDMENT:
OPWDD Specialty Hospital Reimbursement (FMAP = 50% 7/1/11 forward)

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** **Corning Tower** **Empire State Plaza** **Albany, New York 12237**
13. TYPED NAME: **Jason A. Helgerson**	
14. TITLE: **Medicaid Director & Deputy Commissioner Department of Health**	
15. DATE SUBMITTED: September 30, 2011	

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
2011 Title XIX State Plan
Third Quarter Amendment
Non-Institutional Services
SPA Pages

a listing by client of the total number of days any client was on alternate care determination status as defined in section (a)(3). This data will correspond to the identical time period of the financial report.

(ii) Each provider shall, upon the request of [OMRDD] OPWDD, submit statistical data relevant to the administration and operation of the program as determined by the commissioner. Such data shall be submitted within the time frames specified in the request.

(3) Requirements for certification of financial reports and related statistical information.

(i) Each provider shall complete the required financial reports in accordance with generally accepted accounting principles, unless other principles are specified by this subpart or the Medicare Provider Reimbursement Manual, commonly referred to as HIM-15, published by the U.S. Department of Health and Human Services Health Care Financing Administration (HCFA). The HIM-15 document is available from:

Health Care Financing Administration
Division of Publication Management-SLL-12-15
7500 Security Boulevard
Baltimore, MD 21244-1850

(ii) The Medicare Provider Reimbursement Manual may be reviewed in person during regular business hours at the:

(a) NYS Department of State, 99 Washington Avenue, Albany, NY 12231; or by appointment at the

(b) NYS Office [of Mental Retardation and] for People With Developmental Disabilities, [Division of Revenue Management] Office of Counsel, 44 Holland Avenue, Albany, NY 12229-0001.

(iii) Financial reports information shall be certified for their compliance with section (b)(3)(i) by the provider's executive director or officer and by an independent licensed public accountant or certified public accountant who is not on the staff of the provider, on the staff of a program operated by the provider, and who has no financial interest in the provider nor is

time as [OMRDD] OPWDD can develop a new rate. The rate in existence on the last day of the rate period may be reduced by five percent according to the provisions of section (b)(4)(iii).

(v) When [OMRDD] OPWDD develops a new rate for a specialty hospital for which a rate was paid in accordance with section (b)(4)(iv) above, the rate developed will be effective on the first day of the first month following receipt of the required reports. The commissioner may, at his discretion and based upon his finding that the factor(s) causing the delay has/have been corrected, make the rate retroactive to the beginning of the rate period in question if the provider makes such a request within 60 days subsequent to submission of the delinquent report.

(5) Requirements for the revision of financial reports shall include the following:

(i) In the event that [OMRDD] OPWDD determines that the required financial report is incomplete, inaccurate, incorrect or otherwise unacceptable, the provider shall have 30 days from the date of its receipt of notification to submit revised financial reports or additional data. Such data or reports shall be certified by the provider's executive director or officer and an independent licensed public accountant or certified public accountant pursuant to the requirements stipulated in section(b)(3).

(ii) If the revised data referred to in section (b)(5)(i) is not received within 30 days of the provider's receipt of notification, the facility's existing rate may be reduced in accordance with section (b)(4)(iii) unless the commissioner has granted an extension pursuant to section (b)(4)(i) or (ii).

(iii) In the event the provider discovers that the financial reports it has submitted are incomplete, inaccurate, or incorrect prior to receiving its new rate, the provider must notify [OMRDD] OPWDD that such error exists. The provider will have 30 days from the date such notification is received by [OMRDD] OPWDD to submit revised reports or additional data. Such data or report shall meet the certification requirements of the report being corrected. If the corrected data or report is received within a reasonable time before the issuance of the

rate, [OMRDD] OPWDD shall incorporate the corrected data or report into its computation of the rate without the provider having to file an appeal application. However, OPWDD will not accept the resubmission of a January 1 – December 31, 2008 cost report subsequent to January 1, 2011 for the purposes of the calculation of the rate effective July 1, 2011 as described in clause (5)(ii)(f) of subdivision (d) of this section.

(iv) If the revised data or report referred to in section(b)(5)(iii) is not received within the time periods set forth in section(b)(5)(iii) above, the facility's existing rate may be reduced in accordance with section(b)(4)(iii).

(c) Requirements of Financial Records

(1) Each provider shall maintain financial records which reflect all expenditures made and revenues received for its operations.

(2) Each provider shall complete and file with the New York State Department of Health and/or its agent, annual financial and statistical report forms supplied by the New York State Department of Health and/or its agent.

(3) The financial records shall include separate accounts for each type of expense and revenue included on the annual budget or annual cost report. Such sub-accounts and control accounts as are necessary for effective financial management may be established by the specialty hospital. A separate expense and revenue account shall be established to properly identify the expense and revenues directly and indirectly attributable to ACD clients.

(4) All such financial records and any related records shall be subject to audit by the commissioner or his agent, the Office of the State Comptroller, the State Department of Social Services and by agencies of the federal government as provided by law.

(d) Rate Setting

(1) A client day shall be the unit of measure denoting lodging and services rendered to one client between the census taking hours of the facility on two successive days; the day of admission but not the day of discharge shall be counted. One client day shall be counted if the client is discharged on the same day that the client is admitted, providing that there was an expectation that the admission would have at least a 24-hour duration.

(d) Year 4-rate is established as the lower of either:

(1) the reimbursable operating component of the actual cost, as defined in section(a)(5), for the Year 4 rate period with the property costs added after trending; or

(2) the Year 3 rate, excluding property, trended with the property costs from the latest full-year cost report added after trending.

(e) For the period January 1, 1992 through December 31, 1992 and for each subsequent rate period through June 30, 2011, the [The] rate shall be equal to the reimbursable operating costs and appropriate appeal adjustments contained in the Year 4 rate calculated pursuant to 5(i)(d) and trended in accordance with Section(d)(4)(i)(b) of this Part. Appropriately approved property shall be added to this amount.

(f) For the period July 1, 2011 through December 31, 2011 and for each subsequent rate period, rates for other than newly-certified facilities for non-ACD clients and for ACD clients when the commissioner has determined that the occupancy of certified beds for the facility and the region is 80 percent or more shall be as follows. The operating component of the rate shall be equal to the allowable operating costs as reported by the provider in its 2008 annual cost report trended to the current rate period. For the period July 1, 2011 through December 31, 2011 and for each subsequent rate period, the capital component of the rate shall be equal to the allowable capital costs as reported in the provider's 2008 annual cost report. However, OPWDD shall update the capital component of the July 1, 2011 – December 31, 2011 rate based upon capital cost information reported in cost reports for years subsequent to the 2008 reporting year subject to a desk audit review by OPWDD.

(6) Payments attributable to a newly admitted client are subject to the commissioner's approval of that client's admission pursuant to section(b). Continued payments for each such client are subject to the facility's having obtained the approval of the commissioner on an annual basis for the retention of that client at the specialty hospital level of care.

(7) Reimbursement offsets.
If the costs of services not chargeable to the care of clients in accordance with 14 NYCRR as stated herein or HIM-15 are indeterminable and there is revenue derived therefrom, this revenue shall offset allowable cost.

(8) To be considered allowable, costs must be properly chargeable to necessary client care rendered in accordance with the requirements contained herein.

(9) To be considered allowable, costs must be in accordance with subdivision (j) General Rules for Capital Costs and Costs of Related Party Transactions, in the ICF/DD portion of this Plan, and subdivision (k) Glossary, also in the ICF/DD portion of this Plan.

(ix) Restricted funds are funds expended by the facility which include grants, gifts, and income from endowments, whether cash otherwise, which must be used only for a specific purpose as designated by the donor or grant instrument. Restricted funds are to be deducted from the designated costs when determining allowable costs. The commissioner may waive the provisions of this section at his discretion only in those instances where the provider makes a reasonable showing that the imposition of the requirements of this section would have a material adverse effect on the facility's capability to operate in an efficient and economical manner.

(10) All rates, and any adjustments to a facility's rates, shall not be considered final unless approved by the director of the Division of the Budget.

(11) For any rate period during which the reimbursement attributable to depreciation on a facility's real property, excluding equipment, exceeds the provider's principal repayment obligations on indebtedness attributable to such real property, such provider shall fund depreciation by depositing such difference in an interest-bearing checking account or other secure investment. If the provider operates more than one facility governed by section(d)(9), the provider may maintain one funded depreciation account for two or more facilities. The provider shall not commingle such funded depreciation account(s) with other monies of the provider. The provider shall not be required to fund depreciation attributable to the provider's equity in such real property. The provider may expend the funds in such account, including accrued interest, to retire all or a portion of the indebtedness attributable to such real property, or for building improvements and/or fixed equipment necessary to the Facility.

(e) Rate Appeals

(1) [First Level] Rate Appeals <u>and Corrections.</u>

<u>(i) First level rate appeals.</u>

<u>(a)</u> The commissioner shall consider first level rate appeals applications for revisions to the rate, if brought within 120 applications for revisions to the rate, if brought within 120 days of the provider's receipt of the initial rate computation sheet. However, if the appeal is to the ACD rate calculated in accordance with section(d)(4)(ii), the appeal must be from the ACD rate for a group of individuals residing in a physically distinct wing, unit or part of the facility, receiving similar services, having similar characteristics, and for whom the provider can identify discrete costs.

[(ii)](b) For any appeal, the provider must demonstrate that the rate requested in the appeal is necessary to ensure efficient and economic operation of the facility. If an appeal pursuant to this section is to the ACD rate, the provider must also show that clients to whom the appeal pertains require care for which the necessary cost of providing client care exceeds the ACD rate.

[(iii)](c) First level rate revision appeal applications shall be made in writing to the commissioner.

[(a)](1) The application shall set forth the basis for the appeal and the issues of fact. Appropriate documentation shall accompany the application and OMRDD may request such additional documentation as it deems necessary.

[(b)](2) Actions on first level rate appeal applications will be processed without unjustifiable delay.

[(iv)](d) A rate revised [by OMRDD] pursuant to an appeal shall not be considered final unless and until [the appeal is granted by OMRDD and] approved by the State Division of the Budget.

Except as provided in item [(vi)] (f) below, at the conclusion of the first level appeal process, [OMRDD] OPWDD shall notify the Specialty Hospital of any proposed revised rate or denial of same. [OMRDD] OPWDD shall inform the facility that the facility may either accept the proposed revised rate or request a second level appeal in accordance with Title 14 NYCRR section 602.9 in the event that the proposed revised rate fails to grant some or all of the relief requested.

(e) At no point in the first level appeal process shall the provider have a right to any form of interim report or determination made by [OMRDD] OPWDD or the State Division of the Budget.

[(vi)](f) If [OMRDD] OPWDD approves the revision to the rate and the State Division of the Budget denies the revision, the provider shall have no further right to administrative review pursuant to this section.

[(vii)](g) Any rate revised in accordance with section (d) shall be effective according to the dates indicated in the approval of rate appeal notification. Such notification shall be sent to the provider by certified mail, return receipt requested.

[(viii)](h) Any additional reimbursement received by the facility, pursuant to a rate revised in accordance with section (e), shall be restricted to the specific purpose set forth in the appeal decision.

[(2)] (ii) Second level rate appeals

[(i)](a) [OMRDD's] OPWDD's denial of the first level appeal of any or all of the relief requested in the appeals provided for in this section of the State Plan shall be final, unless the facility requests a second level appeal to the commissioner in writing within 30 days of notification of denial or proposed revised rate.

[(ii)](b) Second level appeals shall be brought and determined in accordance with the applicable provision of Title 14 NYCRR Part 602.

[(iii)](c) A rate revised by [OMRDD] OPWDD pursuant to a second level appeal shall not be considered final unless and until approved by the State Division of the Budget.

(2) Rate corrections for rate periods beginning on or after July 1, 2011.

The commissioner will correct rates in instances where there are material errors in the information submitted by the provider which OPWDD used to establish the rate or where there are material errors in the rate computation and only in instances which would result in an annual increase of $5,000 or more in a specialty hospital's allowable costs.

(3) Rate appeals for rate periods beginning on or after July 1, 2011.

(i) Threshold. The threshold is $5,000.

(ii) The only appeals that shall be considered are vacancy appeals.

(iii) The burden of proof on appeals shall be on the provider to demonstrate that the rate requested in the appeal is necessary to ensure efficient and economical operation of the specialty hospital.

(iv) OPWDD shall notify the provider of any revised rate or denial of the request. Once OPWDD has informed the provider of the appeal outcome, if the provider submits a revised cost report for the period reviewed, it shall not be entitled to an increase in the award determination based on that resubmission.

(v) Any rate revised in accordance with this paragraph shall be effective according to the dates indicated in the approval of the rate appeal notification.

(vi) Any additional reimbursement received by the provider pursuant to a rate revised in accordance with this paragraph shall be restricted to the specific purpose set forth in the appeal decision. If the provider does not spend such reimbursement on such specific purpose, OPWDD shall be entitled to recover such reimbursement.

Appendix II
2011 Title XIX State Plan
Third Quarter Amendment
Non-Institutional
Summary of Plan Provisions

SUMMARY
SPA #11-86

This state plan amendment implements changes to the reimbursement methodology for the Specialty Hospital certified by the Office for People With Developmental Disabilities consistent with regulations adopted effective on July 1, 2011.

Appendix III
2011 Title XIX State Plan
Third Quarter Amendment
Non-Institutional Services
Authorizing Provisions

Authorizing Provisions
SPA #11-86

New York State Mental Hygiene Law § 13.09 Powers of the office and commissioner; how exercised.

(a) The commissioner shall exercise all powers vested in the office. He may delegate any function, power, or duty assigned to him or to the office to any officer or employee of the office, unless otherwise provided by law. He may enter into agreements with other commissioners of the department in order to ensure that programs and services are provided for all of the mentally disabled.

New York State Mental Hygiene Law §43.02 Rates or methods of payment for services at facilities subject to licensure or certification by the office of mental health, the office for people with developmental disabilities or the office of alcoholism and substance abuse services.

(a) Notwithstanding any inconsistent provision of law, payment made by government agencies pursuant to title eleven of article five of the social services law for services provided by any facility . . . licensed or operated by the office for people with developmental disabilities pursuant to article sixteen of this chapter . . . shall be at rates or fees certified by the commissioner of the . . . office and approved by the director of the division of the budget . . . .

Reimbursement of Specialty Hospitals
Amendment of 14 NYCRR Section 680.12
Effective Date: July 1, 2011

- **Clause 680.12(b)(3)(ii)(*b*) is amended as follows:**

(*b*) NYS Office [of Mental Retardation and] for People With Developmental Disabilities, [Division of Revenue Management, 30 Russell Road] Office of Counsel, 44 Holland Avenue, Albany, NY [12206-1377] 12229.

- **Subparagraph 680.12(b)(5)(iii) is amended as follows:**

(iii) In the event the provider discovers that the financial reports it has submitted are incomplete, inaccurate or incorrect prior to receiving its new rate, the provider must notify [OMRDD] OPWDD that such error exists. The provider will have 30 days from the date such notification is received by [OMRDD] OPWDD to submit revised reports or additional data. Such data or report shall meet the certification requirements of the report being corrected. If the corrected data or report are received within a reasonable time before the issuance of the rate, [OMRDD] OPWDD shall incorporate the corrected data or report into its computation of the rate without the provider having to file an appeal application. However, OPWDD will not accept the resubmission of a January 1 – December 31, 2008 cost report subsequent to January 1, 2011 for the purposes of the calculation of the rate effective July 1, 2011 as described in clause (5)(ii)(*f*) of subdivision (d) of this section.

- **Clause 680.12(d)(5)(ii)(*e*) is amended as follows:**

(*e*) For the period January 1, 1992 through December 31, 1992 and for each subsequent rate period through June 30, 2011, the rate shall be equal to the reimbursable operating costs and appropriate appeal adjustments contained in the Year 4 rate calculated pursuant to clause (i)(*d*) of this paragraph, as trended, with the addition of appropriately approved property.

- **Subparagraph 680.12(d)(5)(ii) is amended by the addition of a new clause (*f*) as follows:**

(*f*) For the period July 1, 2011 through December 31, 2011 and for each subsequent rate period, rates for other than newly-certified facilities for non-ACD clients and for ACD clients when the commissioner has determined that the occupancy of certified beds for the facility and the region is 80 percent or more shall be as follows. The operating component of the rate shall be equal to the allowable operating costs as reported by the provider in its 2008 annual cost report trended to the current rate period. For the period July 1, 2011

Note: New material is underlined; deleted material is in [brackets].

through December 31, 2011 and for each subsequent rate period, the capital component of the rate shall be equal to the allowable capital costs as reported in the provider's 2008 annual cost report. However, OPWDD shall update the capital component of the July 1, 2011 – December 31, 2011 rate based upon capital cost information reported in cost reports for years subsequent to the 2008 reporting year subject to a desk audit review by OPWDD.

- **Subdivision 680.12(e) is amended as follows:**

(e) [*First level rate*] *Rate appeals and corrections*.

(1) Rate appeals for rate periods prior to July 1, 2011.

(i) First level rate appeals.

(*a*) The commissioner shall consider first level rate appeals applications for revisions to the rate, if brought within 120 days of the provider's receipt of the initial rate computation sheet. However, if the appeal is to the ACD rate calculated in accordance with section 680.12(d)(4)(ii) of this Part, the appeal must be from the ACD rate for a group of individuals residing in a physically distinct wing, unit or part of the facility, receiving similar services, having similar characteristics, and for whom the provider can identify discrete costs.

[(2)] (*b*) For any first level appeal, the provider must demonstrate that the rate requested in the appeal is necessary to ensure efficient and economic operation of the facility. If an appeal pursuant to this section is the ACD rate, the provider must also show that the individuals to whom the appeal pertains require care for which the necessary cost of providing [client] care to admitted individuals exceeds the ACD rate.

[(3)] (*c*) First level rate revision appeal applications shall be made in writing to the commissioner.

[(i)] (*1*) The application shall set forth the basis for the first level appeal and the issues of fact. Appropriate documentation shall accompany the application and [OMRDD] OPWDD may request such additional documentation as it deems necessary.

[(ii)] (*2*) Actions on first level rate appeal applications will be processed without unjustifiable delay.

Note: New material is underlined; deleted material is in [brackets].

[(4)] (*d*) A rate revised pursuant to an appeal shall not be considered final unless and until approved by the State Division of the Budget. At the conclusion of the first level appeal process [OMRDD] OPWDD shall notify the specialty hospital of any proposed revised rate or denial of same. [OMRDD] OPWDD shall inform the facility that the facility may either accept the proposed revised rate or request a second level appeal in accordance with section 602.9 of this Title in the event that the proposed revised rate fails to grant some or all of the relief requested.

[(5)] (*e*) At no point in the first level appeal process shall the provider have a right to any form of interim report or determination made by [OMRDD] OPWDD or the State Division of the Budget.

[(6)] (*f*) If [OMRDD] OPWDD approves the revision to the rate and the State Division of the Budget denies the revision, the provider shall have no further right to administrative review pursuant to this section.

[(7)] (*g*) Any rate revised in accordance with subdivision (d) of this section shall be effective according to the dates indicated in the approval of rate appeal notification. Such notification shall be sent to the provider by certified mail, return receipt requested.

[(8)] (*h*) Any additional reimbursement received by the facility, pursuant to a rate revised in accordance with this subdivision or section 602.9 of this Title, shall be restricted to the specific purpose set forth in the appeal decision.

[(9)] (ii) Second level rate appeals.

[(i)] (*a*) [OMRDD's] OPWDD's denial of the first level appeal of any or all of the relief requested in the appeals provided for in [paragraph (1) of this subdivision] subparagraph (i) of this paragraph shall be final, unless the facility requests a second level appeal to the commissioner in writing within 30 days of notification of denial or proposed revised rate.

[(ii)] (*b*) Second level appeals shall be brought and determined in accordance with the applicable provision of Part 602 of this Title.

(2) Rate corrections for rate periods beginning on or after July 1, 2011.

(i) The commissioner will correct rates in instances where there are material errors in the information submitted by the provider which OPWDD used to establish the rate or where there are material errors in the rate computation and only in instances

Note: New material is underlined; deleted material is in [brackets].

which would result in an annual increase of $5,000 or more in a specialty hospital's allowable costs.

(ii) In order to request a rate correction in accordance with subparagraph (i) of this paragraph, the provider must send to OPWDD its request by certified mail, return receipt requested, within 90 days of the provider receiving the rate computation or within 90 days of the first day of the rate period in question, whichever is later.

(3) Rate appeals for rate periods beginning on or after July 1, 2011.

(i) Threshold. The threshold is $5,000.

(ii) The only appeals that shall be considered are vacancy appeals.

(iii) First level rate appeals.

(*a*) Notification of first level appeal. In order to appeal a rate, the provider must send to OPWDD within one year of the close of the rate period in question, a first level appeal application by certified mail, return receipt requested.

(*b*) First level rate appeal applications shall be made in writing to the commissioner.

(*c*) The application shall set forth the issues of fact. Appropriate documentation shall accompany the application and OPWDD may request such additional documentation as it deems necessary.

(*d*) Actions on first level rate appeal applications will be processed without unjustifiable delay.

(*e*) The burden of proof on first level appeals shall be on the provider to demonstrate that the rate requested in the first level appeal is necessary to ensure efficient and economical operation of the specialty hospital.

(*f*) A rate revised by OPWDD pursuant to an appeal shall not be considered final unless and until approved by the State Division of the Budget.

(*g*) At no point in the first level appeal process shall the provider have a right to an interim report of any determinations made by any of the parties to the appeal. At the conclusion of the first level appeal process OPWDD shall

Note: New material is underlined; deleted material is in [brackets].

notify the provider of any proposed revised rate or denial of same. OPWDD shall inform the provider that it may either accept the proposed revised rate or request a second level appeal in accordance with the provisions of section 602.9 of this Title, in the event that the proposed revised rate fails to grant some or all of the relief requested.

(*h*) At the conclusion of the first level appeal process, OPWDD shall notify the provider of any revised rate or denial of the request. Once OPWDD has informed the provider of the appeal outcome, if the provider submits a revised cost report for the period reviewed, it shall not be entitled to an increase in the award determination based on that resubmission.

(*i*) If OPWDD approves the revision to the rate and the State Division of the Budget denies the revision, the provider shall have no further right to administrative review pursuant to this section.

(*j*) Any rate revised in accordance with this paragraph shall be effective according to the dates indicated in the approval of the rate appeal notification.

(*k*) Any additional reimbursement received by the provider pursuant to a rate revised in accordance with this paragraph shall be restricted to the specific purpose set forth in the first or second level appeal decision. If the provider does not spend such reimbursement on such specific purpose, OPWDD shall be entitled to recover such reimbursement.

(ii) Second level rate appeals.

(*a*) OPWDD's denial of the first level appeal of any or all of the relief requested shall be final, unless the provider requests a second level appeal to the commissioner in writing within 30 days of service of notification of denial or proposed revised rate.

(*b*) Second level appeals shall be brought and determined in accordance with the applicable provisions of Part 602 of this Title.

Note: New material is underlined; deleted material is in [brackets].

Appendix IV
2011 Title XIX State Plan
Third Quarter Amendment
Non-Institutional Services
Public Notice

The text of the proposed regulations may also be found on the OPWDD internet website at http://www.opwdd.ny.gov/regs/index.jsp or at the NYS Department of State website.

The public is invited to review and comment.

For further information and to review and comment, please contact: Barbara Brundage, Regulatory Affairs Unit, Office of Counsel, Office for People With Developmental Disabilities, 44 Holland Ave., Albany, NY 12229, (518) 474-1830, e-mail: Barbara.brundage@opwdd.ny.gov

PUBLIC NOTICE

Office for People with Developmental Disabilities and Department of Health

Pursuant to 42 CFR Section 447.205, the New York State Office for People With Developmental Disabilities (OPWDD) and the New York State Department of Health hereby give notice of the following:

New York State proposes to change it methods and standards for setting Medicaid payment rates (prices) for Supportive Individual Residential Alternatives and Supportive Community Residences certified or operated by OPWDD. This is consistent with New York State's efforts to achieve efficiencies in its Medicaid program including Medicaid funded services overseen by OPWDD. The proposed changes will effect a 2 percent reduction to the operating component of the price for supportive residential habilitation services. In reviewing subsequent budget projections for potential new sites, OPWDD will factor in the effects of this efficiency adjustment. The State estimates that the decrease in annual aggregate expenditures will be $2.1 million.

The proposed changes will become effective July 1, 2011. The new prices will apply to services delivered on or after that date.

Texts of regulations describing the proposed changes have been distributed to the offices of the local (county) Mental Hygiene Directors and are available for public review. To determine the location of your local Mental Hygiene Director including the office within Manhattan (New York County), you may access a list online at http://clmhd.org/about/countydirectory.aspx.

In New York City, the text of the proposed regulations will be available at the following Developmental Disabilities Services Office locations:

Metro New York DDSO
75 Morton Street
New York, New York 10014

Bernard M. Fineson DDSO
80-45 Winchester Blvd.
Administration Building 80-00
Queens Village, New York 11427

Brooklyn DDSO
888 Fountain Avenue
Brooklyn, New York 11208

Metro New York DDSO
2400 Halsey Street
Bronx, New York 10461

Staten Island DDSO
1150 Forest Hill Road
Staten Island, New York 10314

The text of the proposed regulations may also be found on the OPWDD internet website at http://www.opwdd.ny.gov/regs/index.jsp or at the NYS Department of State website.

The public is invited to review and comment. Public hearings will be held on the proposed changes as follows:

Tuesday, May 31, 2011 - 11:00am
Capital District DDSO
Building 3, Room 1
500 Balltown Road
Schenectady, NY

Thursday, June 2, 2011 - 11:00am
Metro DDSO
75 Morton Street
New York, NY

Persons who wish to present testimony at the public hearings must pre-register no later than Friday, May 20, 2011. Individuals who do not pre-register will not be able to present testimony. Individuals who want to attend the hearing but are not planning to present testimony do not need to pre-register. Attendees or presenters who need any special accommodations must make a request by the same date. In order to pre-register, to request special accommodations or to ask any questions about hearing logistics contact Darlene Mihill by email at Darlene.Mihill@opwdd.ny.gov or telephone at (518) 474-7403.

For further information and to review and comment, please contact: Barbara Brundage, Regulatory Affairs Unit, Office of Counsel, Office for People With Developmental Disabilities, 44 Holland Ave., Albany, NY 12229, (518) 474-1830, e-mail: Barbara.brundage@opwdd.ny.gov

PUBLIC NOTICE

Office for People with Developmental Disabilities and Department of Health

Pursuant to 42 CFR Section 447.205, the New York State Office for People With Developmental Disabilities (OPWDD) and the New York State Department of Health hereby give notice of the following:

The State proposes to change the reimbursement methodology for its Specialty Hospital certified by OPWDD. New York State is seeking to achieve efficiencies in its Medicaid program including Medicaid funded services overseen by OPWDD.

The Specialty Hospital rate will be changed by using more current cost information. The new methodology for the Specialty Hospital will base rates on actual 2008 costs for both the operating components and the capital components of the rate. This is expected to correct any misalignments between costs and reimbursements. Since the methodology change is structured to eliminate operating surpluses, OPWDD believes that the provider will be able to absorb this reduction while not reducing supports or services or service quality.

Additional changes will establish an appeal/corrections threshold of $5,000 and will limit grounds for appeals to vacancies. In addition, if the provider resubmits its cost report for a rate appeal period after OPWDD notified the provider of an appeal outcome, the provider will not be entitled to an increase in the appeal award based on the resubmitted cost data. The commissioner will continue to correct rates in instances where there are material errors in the information submitted by the provider which OPWDD used to establish the rate or where there are material errors in the rate computation.

The proposed changes will become effective July 1, 2011. The new methodology will apply to services delivered on or after that date. Changes to the appeals methodology will apply to rates calculated for rate periods beginning July 1, 2011 and thereafter.

The State estimates that the decrease in annual aggregate expenditures will be $1.1 million.

Texts of regulations describing the proposed changes have been distributed to the offices of the local (county) Mental Hygiene Directors and are available for public review. To determine the location of your local Mental Hygiene Director including the office within Manhattan (New York County), you may access a list online at http://clmhd.org/about/countydirectory.aspx.

In New York City, the text of the proposed regulations will be available at the following Developmental Disabilities Services Office locations:

Metro New York DDSO
75 Morton Street
New York, New York 10014

Bernard M. Fineson DDSO
80-45 Winchester Blvd.
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Brooklyn, New York 11208

Metro New York DDSO
2400 Halsey Street
Bronx, New York 10461

Staten Island DDSO
1150 Forest Hill Road
Staten Island, New York 10314

The text of the proposed regulations may also be found on the OPWDD internet website at http://www.opwdd.ny.gov/regs/index.jsp or at the NYS Department of State website.

The public is invited to review and comment on these proposed changes.

For further information and to review and comment, please contact: Barbara Brundage, Regulatory Affairs Unit, Office of Counsel, Office for People With Developmental Disabilities, 44 Holland Ave., Albany, NY 12229, (518) 474-1830, e-mail: Barbara.brundage@opwdd.ny.gov

PUBLIC NOTICE

City of Rochester
Request for Proposal
Investment Advisory Services for
Deferred Compensation Plan

The City of Rochester's Deferred Compensation Plan Committee is seeking written proposals from qualified investment advisors to provide investment advisory services for the Deferred Compensation Plan for City employees established pursuant to Section 457 of the Internal Revenue Code.

The City's Plan has two accounts, deferred compensation and deferred FICA (OBRA) with approximately 2,249 participants, of which 1,250 are active employees, and a total plan value of $133.7 million as of March 31, 2011.

Interested firms may request a copy of the complete Request for Proposal from Brian L. Roulin, CPA, Director of Finance, 30 Church Street, Room 109-A, Rochester, NY 14614, 585-428-7151, brian.roulin@cityofrochester.gov.

Proposals must be received by no later than 5:00 p.m. on June 17, 2011

PUBLIC NOTICE

Department of State
F-2011-0392 (DA)
Date of Issuance - June 01, 2011

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

The United States Fish and Wildlife Service has determined that the proposed activity will be undertaken in a manner consistent to the maximum extent practicable with the enforceable policies of the New York State Coastal Management Program. The applicant's consistency determination and accompanying supporting information and data are available for inspection at the New York State Department of State offices located at One Commerce Plaza, 99 Washington Avenue in Albany, New York.

In F-2011-0392, the Fish and Wildlife Service proposes to conduct a stream restoration project on North Sandy Creek in the Town of Ellisburg, Jefferson County, immediately upstream of the Route 3 Bridge. The proposed project includes the realignment of a series of braided stream channel into a single stream channel, the installation of various re-directive structures including J-hooks, log vanes and channel blocks, the re-grading of various areas and the installation of various vegetative stabilization controls.

The stated purpose of the proposed project is "The stream has extensive braiding just upstream of the NYS Rte 3 Bridge which has led to excessive soil loss due to erosion and has allowed ice sheeting action to build up and pose a safety hazard to NYS Rte 3 during the winter months. This project addresses these issues."

Any interested parties and/or agencies desiring to express their views concerning the above proposed activities may do so by filing their comments, in writing, no later than 4:30 p.m., 15 days from the date of publication of this notice, or June 16, 2011

Comments should be addressed to: Department of State, Division of Coastal Resources, One Commerce Plaza, 99 Washington Ave., Suite, 1010, Albany, NY 12231, (518) 474-6000, Fax (518) 473-2464

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

PUBLIC NOTICE

Uniform Code Regional Boards of Review

Pursuant to 19 NYCRR 1205, the petitions below have been received by the Department of State for action by the Uniform Code Regional Boards of Review. Unless otherwise indicated, they involve requests for relief from provisions of the New York State Uniform Fire Prevention and Building Code. Persons wishing to review any petitions, provide comments, or receive actual notices of any subsequent proceeding may contact Steven Rocklin, Codes Division, Department of State, One Commerce Plaza, 99 Washington Ave., Albany, NY 12231, (518) 474-4073 to make appropriate arrangements.

2011-0147 Matter of SUNY Cortland, attn: Jeffrey Lallas, Director of Facilities Planning, Pasley Dr, Cortland, NY for a variance concerning fire safety and building code requirements including the required minimum number of plumbing fixtures based on occupancy calculations.

Involved is the construction of a student recreational and fitness center known as the "Student Life Center" located at Pashley Drive, City of Cortland, Cortland County, State of New York.

2011-0153 Matter of Tanrackin Farm, LLC, PO Box 901 Bedford Village, NY 10506 for a variance concerning building area, fire sprinklering, exiting, plumbing.

Involved is a new building, A3 occupancy classification located at 145 Broad Brook Road, Bedford Village, Town/Village of Bedford, County of Westchester, State of New York.

2011-0164 Matter of Chris Tucker, 151 Martling Ave., Tarrytown, New York, 10591, for a variance concerning handicapped accessibility and exiting, including 19 NYCRR 1101.2 and 19 NYCRR 1009.1. The petition pertains to the installation of a stairlift in a public hallway of an existing 2-story garden apartment building, R2 occupancy, located at 141 E Hartsdale Avenue, Hartsdale, Town of Greenburgh, County of Westchester, State of New York.

2011-0172 Matter of Kathryn Teal, 36 Willet Street, Albany NY 12210 for a variance concerning fire safety issues including the code requirement for the location of a boiler power exhauster to be located 10 feet from a lot line.

Involved is the replacement of a conventional gas fired boiler and hot water heater with new high efficiency units. The code requires a 10 foot distance from the discharge port of the equipment to a lot line. The building contains an R-2 (multiple dwelling) occupancy, is 4 stories in height, of Type IIIB (ordinary) construction having a cumulative gross floor area of 5,500 square feet. The building is located at 36 Willet St., City of Albany, Albany County, State of New York.

Appendix V
2011 Title XIX State Plan
Third Quarter Amendment
Non-Institutional Services
Responses to Standard Funding Questions

NON-INSTITUTIONAL SERVICES
State Plan Amendment #11-86

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-A of this SPA. For SPAs that provide for changes to payments for clinic or outpatient hospital services or for enhanced or supplemental payments to physician or other practitioners, the questions must be answered for all payments made under the state plan for such service.

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

   Response: Specialty hospitals receive and retain the total Medicaid expenditures claimed by the State.

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: The source of funds for the State share of payments made to the Specialty Hospital is tax revenues appropriated to OPWDD. When the Specialty Hospital bills eMedNY for payment, the Department of Health covers the non-federal share expenditures in the first instance. Throughout the state fiscal year, such expenditures are applied against OPWDD appropriations by the transfer of funds from OPWDD to DOH. The total amount to be transferred to DOH for the current fiscal year is projected at approximately $8.2 million.

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: No supplemental or enhanced payments are made to the Specialty Hospital.

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: This plan amendment does not concern clinic or outpatient hospital services.

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: There is only one specialty hospital certified by OPWDD and is it privately operated.

Appendix VI
2011 Title XIX State Plan
Third Quarter Amendment
Non-Institutional Services
Responses to Standard Access Questions

Specialty Hospital SERVICES
State Plan Amendment #11-86

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-A 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: The State determined that 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) because the changes were structured to eliminate operating surpluses.

   The changes use 2008 cost information, establish a $5,000 appeal threshold, and limit grounds for appeals to vacancies. In addition, the changes eliminate an entitlement to appeal based on resubmitted cost data for a rate appeal period, following OPWDD's notification to the provider of the outcome of an earlier appeal.

   Before July 1, 2011, the operating components of the specialty hospital rate were based, in part, on 1987 budget costs. Using actual costs from 2008 to establish rates will eliminate some of the reimbursement the specialty hospital was receiving in excess of its actual costs. Moreover, since the specialty hospital will receive funding based on its actual spending from a more recent base year (2008), the new rates will still reimburse the hospital based on its costs.

   The changes regarding appeals will only prevent the specialty hospital from submitting appeals for unlimited reasons, and from revising cost reports to increase revenue. The specialty hospital will no longer be able to simply spend more than its revenues and look to OPWDD for compensation.

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: There is only one OPWDD-licensed specialty hospital and Medicaid is the major funding source available for this facility.

   The specialty hospital is a long term residential setting and it is operating at full capacity. When there is a vacancy at the specialty hospital, it is filled. Because of this, the State does not anticipate any decrease in capacity in specialty hospital services.

   The State will continue to collect cost reports from the Specialty Hospital. If the specialty hospital experiences Medicaid revenue issues that would threaten its ability to continue

operating, OPWDD would actively work with it to explore the situation and discuss possible solutions.

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: OPWDD published these changes as proposed amendments to regulations in the State Register on April 20, 2011. A public notice describing the changes was published in the June 1, 2011 State Register. The proposed regulations appeared on OPWDD's website, and were mailed to the specialty hospital, other providers of services to persons with developmental disabilities, self-advocates, family members, advocates, provider associations, advocacy associations (e.g. Self Advocacy Association of New York State), and all members of the public who have requested to be on the mailing list. The public was invited to comment on these proposed changes.

   There were no public comments on the change in methodology for the specialty hospital.

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 the specialty hospital experience Medicaid revenue issues that would threaten its ability to continue operating, OPWDD would actively work with the provider to explore the situation and discuss possible solutions.

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: No. OPWDD does not expect there to be any change in access to specialty hospital services.