NEW YORK
state department of
HEALTH

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

Sue Kelly
Executive Deputy Commissioner

February 21, 2012

Mr. Frank Walsh
Chief Budget Examiner
Division of the Budget
Health and Higher Education Unit
State Capitol
Albany, New York 12224

Dear Mr. Walsh:

Enclosed for your review and assistance in obtaining the Governor's approval is submittal #11-24, which is an amendment to this Department's State Plan under Title XIX (Medical Assistance).

This amendment proposes to revise the State Plan for hospital inpatient services to provide for expansion of the temporary rate adjustment to providers subject to or impacted by the closure, merger, consolidation, acquisition or restructuring of a health care provider.

To assist in your review of this submittal, enclosed are copies of the following: (1) submittal #11-24, (2) a fiscal analysis, and (3) the formal State Plan Amendment submittal form. We are requesting an effective date of February 13, 2012.

If you or your staff have any questions or need assistance, please contact Karla Knuth of my staff at 473-8822.

Sincerely,

Jason A. Helgerson
Medicaid Director
Deputy Commissioner
Office of Health Insurance Programs

Enclosures

NEW YORK
state department of
HEALTH

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

Sue Kelly
Executive Deputy Commissioner

February 27, 2012

National Institutional Reimbursement Team
Attention: Mark Cooley
CMS, CMCS
7500 Security Boulevard, M/S S2-01-16
Baltimore, MD 21244-1850

Re: SPA #11-24
Inpatient Hospital Services

Dear Mr. Cooley:

The State requests approval of the enclosed amendment #11-24 to the Title XIX (Medicaid) State Plan for inpatient hospital services to be effective February 13, 2012 (Appendix I). This amendment is being submitted based upon regulations. A summary of the proposed amendment is contained in Appendix II.

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

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

Notice of the changes in the methods and standards for setting payment rates for general hospital inpatient services appeared in the March 30, 2011, edition of the *New York State Register*, with clarifications appearing in the November 23, 2011, edition. (Appendix IV).

The changes to payment rates for inpatient general hospital services resulting from this amendment are critical to ensuring that there will be no noticeable short-term or long-term effect on the availability of services on a statewide or geographic area basis, the type of care furnished, or 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.

A copy of the pertinent regulation is enclosed for your information (Appendix III). In addition, responses to the five standard funding questions (Appendix V) and evidence of tribal consultation are also enclosed.

If you have any questions regarding this matter, please do not hesitate to contact John E. Ulberg, Jr., Medicaid Chief Financial Officer, Division of Finance and Rate Setting, 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: **#11-24**	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 **February 13, 2012**	

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 02/13/12-09/30/12 $0** **b. FFY 10/01/12-09/30/13 $0**
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: **Attachment 4.19-A: Pages 136, 136(a)**	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: **Attachment 4.19-A: Pages 136, 136(a)**

10. SUBJECT OF AMENDMENT:
Assist Preservation of Essential Safety-Nets – IP
(FMAP = 50%)

11. GOVERNOR'S REVIEW *(Check One)*:

☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:	16. RETURN TO: **New York State Department of Health** **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: February 27, 2012	

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
2012 Title XIX State Plan
First Quarter Amendment
Inpatient Hospital Services
Amended SPA Pages

Mergers, acquisitions, [and] consolidations, restructurings, and closures.

1. *Rates of Payment.* As used in this Section, the terms merger, acquisition and consolidation shall mean the combining of two or more general hospitals where such combination is consistent with the public need, would create a new, more economical entity, reduce the costs of operation, result in the reduction of beds and/or improve service delivery and approved through the Department's Certificate of Need process. Payments for hospitals subject to a merger, acquisition or consolidation for inpatient acute care services that are not otherwise exempt from DRG case-based rates of payment will be effective on the date the transaction is effected and shall be computed in accordance with this Section except as follows:

   a. The WEF used to adjust the statewide base price shall be calculated by combining all components used in the calculation pursuant to the WEF Section for all hospitals subject to the merger, acquisition or consolidation.

   b. The direct GME payment per discharge added to the case payment rates of teaching hospitals shall be calculated by dividing the total reported Medicaid direct GME costs for all teaching hospitals subject to the merger, acquisition, or consolidation by the total reported Medicaid discharges reported by such hospitals in the applicable base period.

   c. The indirect GME payment per discharge added to the case payment rates of teaching hospitals shall be calculated in accordance with the Add-ons to the Case Payment Rate Per Discharge Section, except the ratio of residents to beds used in the calculation shall be based on the total residents and beds of all such hospitals subject to the merger, acquisition, or consolidation.

   d. The non-comparable payment per discharge added to the case payment rates shall be calculated by dividing the total reported Medicaid costs for qualifying non-comparable cost categories for all hospitals subject to the merger, acquisition, or consolidation by the total reported Medicaid discharges reported by such hospitals in the applicable base period.

[2. Temporary rate adjustment.

   a. The Commissioner may grant approval of a temporary adjustment to rates calculated pursuant to this Section for hospitals that complete a merger, acquisition or consolidation provided such hospitals demonstrate through submission of a written proposal that the merger, acquisition or consolidation will result in an improvement to (i) cost effectiveness of service delivery, (ii) quality of care, and (iii) factors deemed appropriate by the Commissioner. Such written proposal shall be submitted to the Department sixty days prior to the requested effective date of the temporary rate adjustment. The temporary rate adjustment shall be in effect for no longer than such time as base year costs are updated for the development of these temporary rates or such time as statewide base year costs are updated for the development of rates,]

[whichever is earlier, and shall consist of the various operating rate components of the surviving entity. At the end of the specified timeframe, the hospital will be reimbursed in accordance with the statewide methodology set forth in this Attachment. The Commissioner may establish, as a condition of receiving such a temporary rate adjustment, benchmarks and goals to be achieved as a result of the ongoing consolidation efforts and may also require that the hospital submit such periodic reports concerning the achievement of such benchmarks and goals as the Commissioner deems necessary. Failure to achieve satisfactory progress, as determined by the Commissioner, in accomplishing such benchmarks and goals shall be a basis for ending the hospital's temporary rate adjustment prior to the end of the specified timeframe.]

2. Temporary rate adjustment.

a. The Commissioner may grant approval of a temporary adjustment to rates calculated pursuant to this Section for general hospitals certified under Article 28 of the Public Health Law that are undergoing or impacted by the closure, merger, acquisition, consolidation or restructuring of a health care provider. Providers seeking rate adjustments under this section must submit for approval a written proposal to the Commissioner at least 60 days prior to the requested effective date of the temporary adjustment. The proposal must demonstrate that one or more of the following will be achieved as a result of such additional financial resources:

- Protect or enhance access to care;
- Protect or enhance quality of care; or
- Improve the cost effectiveness of the delivery of health care services.

Such proposals must provide a budget, details of the need for the adjustment, the purpose and benefits of receiving the adjustment, the timeframes for implementing actions supported by the adjustment, and the deliverables resulting from receipt of the adjustment. Any adjustment issued pursuant to this section will be a DRG payment-based rate adjustment in accordance with the existing Medicaid rate methodology and will be in effect for a specified period of time, as determined by the Commissioner and based upon the plans identified in the proposal, of up to three years. The Commissioner will establish, as a condition of receiving the temporary rate adjustment, benchmarks and goals to be achieved in conformity with the provider's approved proposal, and the provider must submit periodic reports, as requested by the Commissioner, concerning the achievement of such benchmarks and goals. Failure to achieve satisfactory progress in accomplishing such benchmarks and goals shall be a basis for ending the provider's temporary rate adjustment prior to the end of the specified timeframe. Once a provider's temporary rate adjustment ends, the provider shall be reimbursed in accordance with the otherwise applicable rate-setting methodology as set forth in applicable statutes and this Attachment.

[b. The Commissioner shall withdraw approval of a temporary rate adjustment for hospitals which (i) fail to demonstrate compliance with and continual improvement on the approved proposal or (ii) an update to the base year is made by the Department.]

Appendix II
2012 Title XIX State Plan
First Quarter Amendment
Inpatient Hospital Services
Summary

SUMMARY
SPA #11-24

This State Plan Amendment proposes to modify the temporary rate adjustment for hospitals to include hospitals subject to closure, merger, consolidation, acquisition, or restructuring, as well as hospitals impacted by the closure, merger, consolidation, acquisition, or restructuring of a health care provider. This amendment also details the specific requirements for receiving such an adjustment.

This plan amendment is budget neutral because the temporary rate adjustment for eligible hospitals will be funded by the reduction in expenditures resulting from the overall restructuring of the health care delivery system.

Appendix III
2012 Title XIX State Plan
First Quarter Amendment
Inpatient Hospital Services
Authorizing Provisions

Filed 2/13/12
Effective 2/13/12
To be published 2/29/12

Pursuant to the authority vested in the Commissioner of Health by section 2807-c(35) of the Public Health Law, subdivision (b) of Section 86-1.31 of Subpart 86-1 of Title 10 (Health) of the Official Compilation of Codes, Rules, and Regulation of the State of New York, is hereby repealed and a new subdivision (b) is added, to be effective upon filing with the Secretary of State, as follows:

Subdivision (b) of section 86-1.31 of title 10 of NYCRR is hereby REPEALED and a new subdivision (b) is added, to read as follows:

(b) Closures, mergers, acquisitions, consolidations and restructurings.

(1) The commissioner may grant approval of a temporary adjustment to the non-capital components of rates calculated pursuant to this subpart for eligible general hospitals.

(2) Eligible facilities shall include:

(i) facilities undergoing closure;

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

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

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

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

(i) protect or enhance access to care;

(ii) protect or enhance quality of care;

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

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

(4) (i) Such written proposal shall be submitted to the commissioner at least sixty days prior to the requested effective date of the temporary rate adjustment and shall include a proposed budget to achieve the goals of the proposal. Any temporary rate adjustment issued pursuant to this section shall be in effect for a specified period of time as determined by the commissioner, of up to three years. At the end of the specified timeframe, the facility shall be reimbursed in accordance with the otherwise applicable rate-setting methodology as set forth in applicable statutes and this Subpart. The commissioner may establish, as a condition of receiving such a temporary rate adjustment, benchmarks and goals to be achieved in conformity with the facility's written proposal as approved by the commissioner and may also require that the facility submit such periodic reports concerning the achievement of such benchmarks and goals as the commissioner deems necessary. Failure to achieve satisfactory progress, as determined by the commissioner, in accomplishing such benchmarks and goals shall be a basis for ending the facility's temporary rate adjustment prior to the end of the specified timeframe.

(ii) The commissioner may require that applications submitted pursuant to this section be submitted in response to and in accordance with a Request For Applications or a Request For Proposals issued by the commissioner.

Appendix IV
2012 Title XIX State Plan
First Quarter Amendment
Inpatient Hospital Services
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 Environmental Conservation

Pursuant to Title 3, Article 49 of the Environmental Conservation Law, the Department of Environmental Conservation hereby gives public notice of the following:

Notice is hereby given, pursuant to Section 49-0305(9) of the Environmental Conservation Law, of the Department's intent to acquire a Conservation Easement from Adam Hochschild, et al., over certain lands located in the Town of Indian Lake, Hamilton County, New York.

For further information contact: Keith Matteson, Superintendent, Bureau of Real Property, Dept. of Environmental Conservation, 625 Broadway, 5th Fl., Albany, NY 12233-4256, (518) 402-9442

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 inpatient and non-institutional services to comply with enacted State statute. The following significant changes are proposed:

Inpatient Services

Effective December 1, 2011, the temporary rate adjustment for general hospital inpatient rates that the commissioner may grant to hospitals undergoing a merger, consolidation or acquisition will be modified and expanded to include a temporary rate adjustment for those general hospitals that are undergoing a closure, merger, consolidation, acquisition, or restructuring, and for those general hospitals that are impacted by the closure, merger, consolidation, acquisition or restructuring of other health care providers. The temporary rate adjustment will apply to inpatient services provided by hospitals certified under Article 28 of the Public Health Law. Hospitals must submit for approval a written proposal to the Commissioner, at least 60 days prior to the requested effective date of the adjustment, which demonstrates that one or more of the following will be achieved as a result of such additional financial resources:

- Protection or enhancement of access to care;
- Protection or enhancement of quality of care;
- Improvement in the cost effectiveness of the delivery of health care services; or
- Other protections or enhancements to the health care delivery system.

Proposals must also include a budget, details of the need for the adjustment, the purpose and benefits of receiving the adjustment, the timeframes for implementing actions supported by the adjustment, and the deliverables resulting from receipt of the adjustment. Any such adjustment issued will be in effect for a specified period of time, not to exceed three years, after which the hospital will be reimbursed in accordance with the statewide methodology set forth in the State Plan. The Commissioner may establish benchmarks and goals to be achieved, and the hospital must submit periodic reports demonstrating achievement of such. Failure to achieve such benchmarks and goals shall be a basis for ending the hospital's temporary rate adjustment prior to the end of the specified timeframe.

The estimated annual net aggregate change in gross Medicaid expenditures attributable to this change for state fiscal year 2011/2012 is $0.

Non-Institutional Services

Effective December 1, 2011, the commissioner may grant a temporary rate adjustment for certified home health agencies (CHHAs) that are undergoing a closure, merger, consolidation, acquisition, or restructuring, and for those CHHAs that are impacted by the closure, merger, consolidation, acquisition or restructuring of other health care providers. CHHAs must submit for approval a written proposal to the Commissioner, at least 60 days prior to the requested effective date of the adjustment, which demonstrates that one or more of the following will be achieved as a result of such additional financial resources:

- Protection or enhancement of access to care;
- Protection or enhancement of quality of care;
- Improvement in the cost effectiveness of the delivery of health care services; or
- Other protections or enhancements to the health care delivery system.

Proposals must also include a budget, details of the need for the adjustment, the purpose and benefits of receiving the adjustment, the timeframes for implementing actions supported by the adjustment, and the deliverables resulting from receipt of the adjustment. Any such adjustment issued will be in effect for a specified period of time, not to exceed three years, after which the CHHA will be reimbursed in accordance with the statewide methodology set forth in the State Plan. The Commissioner may establish benchmarks and goals to be achieved, and the CHHA must submit periodic reports demonstrating achievement of such. Failure to achieve such benchmarks and goals shall be a basis for ending the CHHA's temporary rate adjustment prior to the end of the specified timeframe.

The estimated annual net aggregate change in gross Medicaid expenditures attributable to this change for state fiscal year 2011/2012 is $0.

Copies of the proposed state plan amendment will be available for public review on the Department's website at: http://www.health.ny.gov/regulations/state_plans/status

In addition, copies will be on file in each local (county) social services district. 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

The public is invited to review and comment on this proposed state plan amendment. *For further information or to submit a comment, please contact*: Department of Health, Bureau of HCRA Operations & Financial Analysis, Corning Tower Bldg., Rm. 984, Empire State Plaza, Albany, NY 12237, (518) 474-1673, (518) 473-8825 (FAX), e-mail: spa_inquiries@health.state.ny.us

PUBLIC NOTICE

Department of Taxation and Finance
Interest Rates

The Commissioner of Taxation and Finance hereby sets the interest rates for the months of January, February, March, 2012 pursuant to sections 697(j) and 1096(e) of the Tax Law, as follows:

For purposes of section 697(j) the overpayment rate of interest is set at 2 percent per annum, and the underpayment rate of interest is set at 7-1/2 percent per annum. For purposes of section 1096(e), the overpayment rate of interest is set at 2 percent per annum, and the underpayment rate of interest is set at 7.5 percent per annum. (The underpayment rates set pursuant to sections 697(j) and 1096(e) may not be less than 7-1/2 percent per annum.) Pursuant to section 1145(a)(1) of the Tax Law, the underpayment rate for State and local sales and use taxes administered by the Commissioner of Taxation and Finance is 14-1/2 percent per annum. The underpayment rate for the special assessments on hazardous waste imposed by section 27-0923 of the Environmental Conservation Law is 15 percent.

For the interest rates applicable to overpayments (refunds) and underpayments (late payments and assessments) of the following taxes administered by the Commissioner of Taxation and Finance for the period January 1, 2012 through March 31, 2012, see the table below:

1/1/12 - 3/31/12
Interest Rate Per
Annum
Compounded Daily

Commonly viewed tax types	Refunds	Late Payments & Assessments
Income **	2%	7.5%
Sales and use	2%	14.5% *
Withholding	2%	7.5%
Corporation **	2%	7.5%
All other tax types	**Refunds**	**Late Payments & Assessments**
Alcoholic Beverage	2%	7.5%
Beverage Container Deposits	2%	7.5%
Boxing & Wrestling	2%	7.5%
Cigarette	NA	7.5%
Diesel Motor Fuel	2%	7.5%
Estate	2%	7.5%
Fuel Use Tax	12%	12%
Generation-Skipping Transfer	2%	7.5%
Hazardous Waste	2%	15%
Highway Use	2%	7.5%
Metropolitan Commuter Transportation Medallion Taxicab Ride	2%	7.5%
Metropolitan Commuter Transportation Mobility Tax	2%	7.5%
Mortgage Recording	2%	7.5%
Motor Fuel	2%	7.5%
Petroleum Business	2%	7.5%
Real Estate Transfer	2%	7.5%
Tobacco Products	NA	7.5%
Waste Tire Fee	2%	7.5%

* The Tax Law requires the interest rate on sales tax assessments or late payments to be set at 14-1/2% for this quarter. However, if the Commissioner determines that the failure to pay or the delay in payment is due to reasonable cause and not willful neglect, the Commissioner may impose interest at the corporation tax late payment and assessment rate. That rate is 7.5% for this quarter.

** There are a number of state and local governmental bodies that have interest rates tied to the overpayment and underpayment rates contained in either section 697(j) (Income Tax) or section 1096(e) (Corporation Tax) of the Tax Law. For purposes of section 697(j) and section 1096(e) of the Tax Law, the overpayment rate for this period is 2%. For purposes of section 697(j) of the Tax Law, the underpayment rate for this period is 7.5%. For purposes of section 1096(e) of the Tax Law, the underpayment rate for this period is also 7.5%.

For further information contact: John W. Bartlett, Taxpayer Guidance Division, Department of Taxation and Finance, W. A. Harriman Campus, Albany, NY 12227, (518) 457-2554

For rates for previous periods, visit the Department of Taxation and Finance website: www.tax.ny.gov/taxnews/int_curr.htm

SALE OF FOREST PRODUCTS

Jefferson Reforestation Area No.7
Contract No. X008461

Pursuant to Section 9-0505 of the Environmental Conservation Law, the Department of Environmental Conservation hereby gives Public Notice of the following:

Sealed bids for red pine - 209.0 MBF more or less, white pine - 0.4 MBF more or less, white ash - 1.6 MBF more or less, black cherry - 0.5 MBF more or less, red maple - 0.3 MBF more or less, hard maple - 0.07 MBF more or less, pine pulp - 583.0 cords more or less, firewood - 88.0 cords more or less, located on Jefferson Reforestation Area No. 7, Goulds Corners State Forest, Stands A-2 and A-3, will be accepted at the Department of Environmental Conservation, Contract Unit, 625 Broadway, 10th Fl., Albany, NY 12233-5027 until 11:00 a.m., Thursday, Dec. 1, 2011.

For further information, contact: Edwin Sykes, Senior Forester, Department of Environmental Conservation, Division of Lands and Forests, Region 6, 7327 State Rte. 812, Lowville, NY 13367, (315) 376-3521

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 2011 will be conducted on April 14 commencing at 10:00 a.m. This meeting will be conducted at New York Network, Suite 146, South Concourse, Empire State Plaza, Albany, NY. Directions and parking information available at (www.nyn.suny.edu).

For further information, contact: Office of Commission Operations, Department of Civil Service, Alfred E. Smith State Office Bldg., Albany, NY 12239, (518) 473-6598

PUBLIC NOTICE

Department of Health

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

The Department of Health proposes to amend the Title XIX (Medicaid) State Plan for inpatient, long term care, and non-institutional services to comply with recently proposed statutory provisions. The following significant changes are proposed:

All Services

• Effective on and after April 1, 2011, no annual trend factor will be applied pursuant to the provisions of Public Health Law § 2807-c(10)(c) to rates of payment for hospital inpatient, residential health care facilities, certified home health agencies, personal care services, and adult day health care services provided to patients diagnosed with AIDS. This includes the elimination of the 2011 trend factor effective for rates of payment April 1, 2011, and thereafter. In addition, the Department is authorized to promulgate regulations, to be effective April 1, 2011, such that no annual trend factor may be applied to rates of payment by the Department of Health for assisted living program services, adult day health care services or 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. This includes the elimination of the 2011 trend factor effective for rates of payment April 1, 2011, and thereafter.

- Effective for dates of service April 1, 2011, through March 31, 2012, and each state fiscal year thereafter, all non-exempt Medicaid payments as referenced below will be uniformly reduced by two percent. Such reductions will be applied only if an alternative method that achieves at least $345 million in Medicaid state share savings annually is not implemented.

- Medicaid administration costs paid to local governments, contractors and other such entities will also be reduced in the same manner as described above.

- Payments exempt from the uniform reduction based on federal law prohibitions include, but are not limited to, the following:

• Federally Qualified Health Center services;

• Indian Health Services and services provided to Native Americans;

• Supplemental Medical Insurance - Part A and Part B;

• State Contribution for Prescription Drug Benefit (aka Medicare Part D payments);

• Any local share cap payment required by the Federal Medical Assistance Percentage (FMAP) increase legislation;

• Required payments related to the School Supportive Health Services Program and Preschool Supportive Health Services Program settlement agreement;

• Services provided to American citizen repatriates; and

• Hospice Services.

- Payments exempt from the uniform reduction based on being funded exclusively with federal and/or local funds include, but are not limited to, the following:

• Upper payment limit payments to non-state owned or operated governmental providers certified under Article 28 of the NYS Public Health Law;

• Certified public expenditure payments to the NYC Health and Hospital Corporation;

• Certain disproportionate share payments to non-state operated or owned governmental hospitals;

• Certain managed care payments pursuant to section 3-d of Part B of the Chapter 58 of the Laws of 2010; and

• Services provided to inmates of local correctional facilities.

- Payments pursuant to the mental hygiene law will be exempt from the reduction;

- Court orders and judgments; and

- Payments where applying the reduction would result in a lower FMAP as determined by the Commissioner of Health and the Director of the Budget will be exempt.

• Medicaid expenditures will be held to a year to year rate of growth spending cap which does not exceed the rolling average of the preceding 10 years of the medical component of the Consumer Price Index (CPI) as published by the United States Department of Labor, Bureau of Labor Statistics.

- The Director of the Budget and the Commissioner of Health will periodically assess known and projected Medicaid expenditures to determine whether the Medicaid growth spending cap appears to be pierced. The cap may be adjusted to account for any revision in State Financial Plan projections due to a change in the FMAP amount, provider based revenues, and beginning April 1, 2012, the operational costs of the medical indemnity fund. In the event it is determined that Medicaid expenditures exceed the Medicaid spending cap, after any adjustment to the cap if needed, the Director of the Division of the Budget and the Commissioner of Health will develop a Medicaid savings allocation plan to limit the Medicaid expenditures by the amount of the projected overspending. The savings allocation plan will be in compliance with the following guidelines:

• The plan must be in compliance with the federal law;

• It must comply with the State's current Medicaid plan, amendment, or new plan that may be submitted;

• Reductions must be made uniformly among category of service, to the extent practicable, except where it is determined by the Commissioner of Health that there are grounds for non-uniformity; and

• The exceptions to uniformity include but are not limited to: sustaining safety net services in underserved communities, to ensuring that the quality and access to care is maintained, and to avoiding administrative burden to Medicaid applicants and recipients or providers.

Medicaid expenditures will be reduced through the Medicaid savings allocation plan by the amount of projected overspending through actions including, but not limited to: modifying or suspending reimbursement methods such as fees, premium levels, and rates of payment; modifying or discontinuing Medicaid program benefits; seeking new waivers or waiver amendments.

Institutional Services

• For the state fiscal year beginning April 1, 2011 through March 31, 2012, continues specialty hospital adjustments for hospital inpatient services provided on and after April 1, 2011, 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. Payments to eligible public general hospitals may be added to rates of payment or made as aggregate payments.

• Effective for periods on and after January 1, 2011, for purposes of calculating maximum disproportionate share (DSH) payment distributions for a rate year or part thereof, costs incurred of furnishing hospital services net of medical assistance payments, other than DSH payments, and payments by uninsured patients shall for the 2011 calendar year, be determined initially based on each hospital's submission of a fully completed 2008 DSH hospital data collection tool, which is required to be submitted to the Department, and shall be subsequently revised to reflect each hospital's submission of a fully completed 2009 DSH hospital data collection tool, which is required to be submitted to the Department.

- For calendar years on and after 2012, such initial determinations shall reflect submission of data as required by the Commissioner on a specific date. All such initial determinations shall subsequently be revised to reflect actual rate period data and statistics. Indigent care payments will be withheld in instances when a hospital has not submitted required information by the due dates, provided, however, that such payments shall be made upon submission of such required data.

- For purposes of eligibility to receive DSH payments for a rate year or part thereof, the hospital inpatient utilization rate shall be determined based on the base year statistics and costs incurred of furnishing hospital services determined in accordance with the established methodology that is consistent with all federal requirements.

• Extends through December 31, 2014, the authorization to distribute Indigent Care and High Need Indigent Care disproportionate share payments in accordance with the previously approved methodology.

• For state fiscal years beginning April 1, 2011, and for each state fiscal year thereafter, additional medical assistance payments for inpatient hospital services may be made to public general hospitals operated by the State of New York or the State University of New York, or by a county which shall not include a city with a population over one million, and those public general hospitals located in the counties of Westchester, Erie, or Nassau, up to one hundred percent (100%) of each such public hospital's medical assistance and uninsured patient losses after all other medical assistance, including disproportionate share payments to such general hospitals. Payments may be added to rates of payment or made as aggregate payments. Payments will be based initially on reported reconciled data from the base year two years prior to the payment year adjusted for authorized Medicaid rate changes and further reconciled to actual reported data from such payment year.

• Public general hospitals, other than those operated by the State of New York or the State University of New York, that are located in a city with a population of over one million may receive additional medical assistance DSH payments for inpatient hospital services for the state fiscal year beginning April 1, 2011 through March 31, 2012, and annually thereafter, in the amount of up to $120 million, as further increased by up to the maximum payment amounts permitted under sections 1923(f) and (g) of the federal Social Security Act, as determined by the Commissioner of Health after application of all other disproportionate share hospital payments. Payments may be added to rates of payment or made as aggregate payments. Payments will be based initially on reported reconciled data from the base year two years prior to the payment year adjusted for authorized Medicaid rate changes and further reconciled to actual reported data from such payment year.

• Extends current provisions to services on and after April 1, 2011, 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 State proposes to extend, effective April 1, 2011, and thereafter, certain cost containment initiatives that were enacted in Chapter 81 of the Laws of 1995 and extended by subsequent legislation. The extended provisions are as follows: (1) hospital capital costs shall exclude 44% of major moveable equipment costs; (2) elimination of reimbursement of staff housing operating and capital costs; and (3) budgeted capital inpatient costs of a general hospital applicable to the rate year shall be decreased to reflect the percentage amount by which the budgeted costs for capital related inpatient costs of the hospital for the base year two years prior to the rate year exceeded actual costs.

• Per federal requirements, the Commissioner of Health shall promulgate regulations effective July 1, 2011 that will deny Medicaid payment for costs incurred for hospital acquired conditions (HACs). The regulations promulgated by the Commissioner shall incorporate the listing of Medicaid HACs in the yet to be issued final federal rule.

• The Commissioner of Health shall promulgate regulations to incorporate quality related measures pertaining to potentially preventable conditions and complications, including, but not limited to, diseases or complications of care acquired in the hospital and injuries sustained in the hospital.

• Effective April 1, 2011, hospital inpatient rates of payment for cesarean deliveries will be limited to the average Medicaid payment for vaginal deliveries. All cesarean claims will be subject to an appeal process to determine if the services were medically necessary thus warranting the higher Medicaid payment.

• Effective April 1, 2011, the Department is proposing to expand the current Patient Centered Medical Home (PCMH) to more payers and incorporate several provisions to improve medical care. Two provisions result in a change in the methods by which Medicaid fee-for-service (FFS) reimburses Medicaid providers who are designated by the National Committee for Quality Assurance as patient centered medical homes: 1) testing new models of payment to high-volume Medicaid primary care medical home practices which incorporate risk-adjusted global payments with care management and pay-for-performance, and 2) improving the relationship of FFS Medicaid members to medical homes by creating medical home payments only for FFS members who have evidence of ongoing continuity relationship with provider/practice and providing more reliable care manage-

ment payments to those providers which are independent of specific visit types. These provisions require the following changes to Medicaid:

- New models of reimbursement to high-volume Medicaid providers will be tested which may incorporate risk-adjusted global payments and pay-for-performance. Risk-adjusted payment models will differentially reimburse providers based on their historical case mix. Pay-for-performance will provide enhanced reimbursement to providers who provide high-quality care (such as improved preventative screenings) and/or reduce unnecessary utilization (such as a reduction in admissions for ambulatory sensitive conditions) as defined by standardized measures of performance; and

- Eligible Medicaid fee-for-service recipients, who are currently receiving care from a certified PCMH provider, as determined by an attribution methodology developed by the Commissioner of Health, will be assigned to this PCMH provider. Medicaid FFS will reimburse PCMH providers a per member per month (PMPM) capitation payment for FFS recipients attributed to their practices to provide the necessary care coordination and disease management services.

• Effective April 1, 2011, for inpatient hospital services the commissioner may grant approval of temporary adjustments to Medicaid rates to provide assistance to accommodate additional patient services requirements resulting from the closure, merger or reconfiguration of other hospitals in the area. Such rate increases would enable the surviving hospital to cover costs, including but not limited to additional staff, service reconfiguration, transfer of medical residents to other programs, increased patient volume, and enhancing information technology (IT) systems.

• The institutional cost report shall no longer be required to be certified by an independent licensed public accountant effective with cost reports filed with the Department of Health for cost reporting years ending on or after December 31, 2010. Effective for the same time periods, the Department will have authority to audit such cost reports.

Long Term Care Services

• Effective for periods on and after July 1, 2011, Medicaid rates of payments for inpatient services provided by residential health care facilities (RHCF), which as of April 1, 2011, operate discrete units for treatment of residents with Huntington's disease, and shall be increased by a rate add-on. The aggregate amount of such rate add-ons for the periods July 1, 2011 through December 31, 2011 shall be $850,000 and for calendar year 2012 and each year thereafter, shall be $1.7 million. Such amounts shall be allocated to each eligible RHCF proportionally, based on the number of beds in each facility's discrete unit for treatment of Huntington's disease relative to the total number of such beds in all such units. Such rate add-ons shall be computed utilizing reported Medicaid days from certified cost reports as submitted to the Department for the calendar year period two years prior to the applicable rate year and, further, such rate add-ons shall not be subject to subsequent adjustment or reconciliation.

• For state fiscal years beginning April 1, 2011, and thereafter, 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 $300 million. The amount allocated to each eligible public RHCF will be in accordance with the previously approved methodology. Payments to eligible RHCF's may be added to rates of payment or made as aggregate payments.

• Continues, effective for periods on or after April 1, 2011, 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.

• Continues, effective April 1, 2011, and thereafter, the provision that rates of payment for RHCFs shall not reflect trend factor projections or adjustments for the period April 1, 1996 through March 31, 1997.

• Extends current provisions to services on and after April 1, 2011, 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%.

• Continues, effective April 1, 2011, and thereafter, long-term care Medicare maximization initiatives.

• Effective April 1, 2011, for inpatient services provided by residential health care facilities (RHCFs), the commissioner may grant approval of temporary adjustments to Medicaid rates to provide assistance to accommodate additional patient services requirements resulting from the closure, merger or reconfiguration of other providers in the area. Such rate increases would enable the surviving RHCF to cover costs, including but not limited to additional staff, service reconfiguration, transfer of medical residents to other programs, increased patient volume, and enhancing information technology (IT) systems.

• The regional pricing methodology previously approved to be effective July 1, 2011 for inpatient services provided by residential health care facilities is repealed and replaced with a Statewide pricing methodology to be effective July 1, 2011.

- The Statewide pricing methodology for the non-capital component of the rates of payment for inpatient services provided by residential health care facilities shall utilize allowable operating costs for a base year, as determined by the Commissioner of Health by regulation, and shall reflect:

• A direct statewide price component adjusted by a wage equalization factor and subject to a Medicaid-only case mix adjustment.

• An indirect statewide price component adjusted by a wage equalization factor; and

• A facility specific non-comparable component.

- The non-capital component of the rates for AIDS facilities or discrete AIDS units within facilities; discrete units for residents receiving care in a long-term inpatient rehabilitation program for traumatic brain injured persons; discrete units providing specialized programs for residents requiring behavioral interventions; discrete units for long-term ventilator dependent residents; and facilities or discrete units within facilities that provide extensive nursing, medical, psychological and counseling support services solely to children shall be established pursuant to regulations.

The Commissioner of Health may promulgate regulations to implement the provisions of the methodology and such regulations may also include, but not be limited to, provisions for rate adjustments or payment enhancements to facilitate the transition of facilities to the rate-setting methodology and for facilitating quality improvements in residential health care facilities.

• Effective April 1, 2011, the capital cost component of Medicaid rates of payment for services provided by residential health care facilities shall not include any payment factor for return on or return of equity or for residual reimbursement.

• Effective January 1, 2012, payments for reserved bed days for temporary hospitalizations, for Medicaid eligible residents aged 21 and older, shall only be made to a residential health care facility if at least fifty percent of the facility's residents eligible to participate in a Medicare managed care plan are enrolled in such a plan. Payments for these reserved bed days will be consistent with current methodology.

Non-Institutional Services

• For State fiscal years beginning April 1, 2011 through March 31, 2012, continues hospital outpatient payment adjustments that increase the operating cost components of rates of payment for hospital outpatient and emergency departments 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 eligibility criteria remain unchanged. The amount to be paid will be up to $287 million annually. Payments to eligible public general hospitals may be added to rates of payment or made as aggregate payments.

• Effective April 1, 2011, the Office of Mental Health, the Office of

Alcoholism and Substance Abuse Services, and the Office for People with Developmental Disabilities will each establish utilization standards or thresholds for their voluntary-operated clinics. These standards or thresholds will target excessive utilization and will be either patient-specific or provider-specific, at the option of the controlling State agency. The standards or thresholds will be established based on normative provider visit volume for the clinic type, as determined by the controlling State agency. The Commissioner of Health may promulgate regulations, including emergency regulations, to implement these standards.

• Effective April 1, 2011, claims submitted by clinics licensed under Article 28 of New York State Public Health Law will receive an enhanced Medicaid payment for federally designated family planning services.

• Effective for the period April 1, 2011 through March 31, 2012 and each state fiscal year thereafter, the Department of Health is authorized to make supplemental payments for services provided by physicians, nurse practitioners and physician assistants who participate in a plan for the management of clinical practice at the State University of New York. Fees for these professional services shall be increased by an amount equal to the average commercial or Medicare rate that would otherwise be received for such services rendered by physicians, nurse practitioners and physician assistants. Such included payments may be added to such professional fees or made as aggregate lump sum payments made to eligible clinical practice plans.

• Effective for the period April 1, 2011 through March 31, 2012 and each state fiscal year thereafter, the Department of Health is authorized to make supplemental payments for services provided by physicians, nurse practitioners and physician assistants who are employed by non-state operated public general hospitals operated by a public benefit corporation located in a city of more than one million persons or at a facility of such public benefit corporation as a member of a practice plan under contract to provide services to patients of such a public benefit corporation. Fees for these professional services shall be increased by an amount equal to the average commercial or Medicare rate that would otherwise be received for such services rendered by physicians, nurse practitioners and physician assistants, provided, however, that such supplemental fee payments shall not be available with regard to services provided at facilities participating in the Medicare Teaching Election Amendment. Such included payments may be added to such professional fees or made as aggregate lump sum payments.

• Effective April 1, 2011, hospitals that voluntarily reduce excess staffed bed capacity in favor of expanding the State's outpatient, clinic, and ambulatory surgery services capacity may request and receive a temporary rate enhancement under the ambulatory patient groups (APG) methodology.

• Extends current provisions to services on and after April 1, 2011, 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%.

• Continues, effective April 1, 2011, and thereafter, certain cost containment initiatives currently in effect for Medicaid rates of payments. These are as follows: diagnostic and treatment center and certified home health agency administrative and general cost reimbursement limits; home health care Medicare maximization initiatives; hospital outpatient and emergency department reimbursement reductions attributable to exclusion of 44% of major moveable equipment capital costs; and elimination of staff housing costs.

• The current authority to adjust Medicaid rates of payment for personal care services, provided in local social services districts which include a city with a population of over one million persons and distributed in accordance with memorandums of understanding entered into between the State and such local districts for purpose of supporting recruitment and retention of personal care service workers has been extended for the period April 1, 2011 through March 31, 2014. Payments for the periods April 1, 2011 through March 31, 2012; April 1, 2012 through March 31, 2013; and April 1, 2013 through March 31, 2014, shall not exceed, in the aggregate, $340 million for each applicable period.

• The current authority to adjust Medicaid rates of payment for personal care services, provided in local social services districts which shall not include a city with a population of over one million persons, for purpose of supporting recruitment and retention of personal care service workers has been extended for the period April 1, 2011 through March 31, 2014. Payments for the period April 1, 2011 through March 31, 2012; April 1, 2012 through March 31, 2013; and April 1, 2013 through March 31, 2014, shall not exceed, in the aggregate, $28.5 million for each applicable period.

• The current authority to adjust Medicaid rates of payment for certified home health agencies, AIDS home care programs, and hospice programs for purposes of supporting recruitment and retention of non-supervisory health care workers or any worker with direct patient care responsibility has been extended for the period April 1, 2011 through March 31, 2014. Payments shall not exceed in the aggregate, $100 million for each of the following periods: April 1, 2011 through March 31, 2012; April 1, 2012 through March 31, 2013; and April 1, 2013 through March 31, 2014, and shall be calculated in accordance with the previously approved methodology. Such adjustments to rates of payment shall be allocated proportionally based on each certified home health agency's, AIDS home care and hospice programs' home health aide or other direct care services total annual hours of service provided to Medicaid patients, as reported in each such agency's most recently available cost report as submitted to the Department. Payments made shall not be subject to subsequent adjustment or reconciliation.

• Effective April 1, 2011, for the period April 1, 2011 through June 30, 2011, medical assistance rates of payment to residential health care facilities and diagnostic treatment centers licensed under Article 28 of the Public Health Law for adult day health care services provided to registrants with acquired immunodeficiency syndrome (AIDS) or other human immunodeficiency virus (HIV) related illnesses, shall be increased by an aggregated amount of $1,867,000. Such amount shall be allocated proportionally among such providers based on the medical assistance visits reported by each provider in the most recently available cost reports, submitted to the Department by January 1, 2011. Such adjustments shall be included as adjustments to each provider's daily rate of payment for such services and shall not be subject to subsequent adjustment or reconciliation.

- Effective April 1, 2011, for the period April 1, 2011 through June 30, 2011, rates of payment to residential health care facilities and diagnostic treatment centers licensed under Article 28 of the Public Health Law for adult day health care services provided to registrants with acquired immunodeficiency syndrome (AIDS) or other human immunodeficiency virus (HIV) related illnesses, shall reflect an adjustment to such rates of payment in an aggregate amount of $236,000. Such adjustments shall be distributed proportionally as rate add-ons, based on each eligible provider's Medicaid visits as reported in such provider's most recently available cost report as submitted to the Department prior to January 1, 2011, and provided further, such adjustments shall not be subject to subsequent adjustment or reconciliation.

• Effective April 1, 2011 through March 31, 2012, Medicaid rates of payment for services provided by certified home health agencies (except for such services provided to children under eighteen years of age and other discrete groups as may be determined by the Commissioner of Health) shall reflect agency ceiling limitations. In the alternative, and at the discretion of the Commissioner, such ceilings may be applied to payments for such services.

- The agency ceilings shall be applied to payments or rates of payment for certified home health agency services as established by applicable regulations and shall be based on a blend of:

• an agency's 2009 average per patient Medicaid claims, weighted at a percentage as determined by the Commissioner; and

• the 2009 statewide average per patient Medicaid claims adjusted by a regional wage index factor and an agency patient case mix index, weighted at a percentage as determined by the Commissioner.

- An interim payment or rate of payment adjustment effective April 1, 2011 shall be applied to agencies with projected average per patient Medicaid claims, as determined by the Commissioner, to be over their

ceilings. Such agencies shall have their payments or rates of payment reduced to reflect the amount by which such claims exceed their ceilings.

- The ceiling limitations shall be subject to retroactive reconciliation and shall be based on a blend of:

• agency's 2009 average per patient Medicaid claims adjusted by the percentage of increase or decrease in such agency's patient case mix from the 2009 calendar year to the annual period April 1, 2011 through March 31, 2012, weighted at a percentage as determined by the Commissioner, and

• the 2009 statewide average per patient Medicaid claims adjusted by a regional wage index factor and the agency's patient case mix index for the annual period April 1, 2011 through March 31, 2012, weighted at a percentage as determined by the Commissioner.

- Such adjusted agency ceiling shall be compared to actual Medicaid paid claims for the period April 1, 2011 through March 31, 2012. In those instances when:

• An agency's actual per patient Medicaid claims are determined to exceed the agency's adjusted ceiling, the amount of such excess shall be due from each such agency to the State and may be recouped by the Department in a lump sum amount or through reductions in the Medicaid payments due to the agency.

• An interim payment or rate of payment adjustment was applied to an agency as described above, and such agency's actual per patient Medicaid claims are determined to be less than the agency's adjusted ceiling, the amount by which such Medicaid claims are less than the agency's adjusted ceiling shall be remitted to each such agency by the Department in a lump sum amount or through an increase in the Medicaid payments due to the agency.

- In determining case mix, each patient shall be classified using a system based on measures which may include, but not be limited to, clinical and functional measures, as reported on the federal Outcome and Assessment Information Set (OASIS), as may be amended.

- The Commissioner may require agencies to collect and submit any data, and may promulgate regulations to implement the agency ceilings.

- The payments or rate of payment adjustments described above shall not, as determined by the Commissioner, result in an aggregate annual decrease in Medicaid payments to providers in excess of $200 million.

• Effective April 1, 2012, Medicaid payments for services provided by Certified Home Health Agencies (CHHAs), except for such services provided to children under 18 years of age and other discrete groups, as may be determined by the Commissioner of Health, will be based on episodic payments.

- To determine such episodic payments, a statewide base price will be established for each 60-day episode of care and shall be adjusted by a regional wage index factor and an individual patient case mix index. Such episodic payments may be further adjusted for low utilization cases and to reflect a percentage limitation of the cost for high-utilization cases that exceed outlier thresholds of such payments.

- To achieve savings comparable to the prior state fiscal year, the initial 2012 base year episodic payments will be based on 2009 Medicaid paid claims, as determined by the Commissioner. Such base year adjustments shall be made not less frequently than every three years. However, base year episodic payments subsequent to 2012 will be based on a year determined by the Commissioner that will be subsequent to 2009. Such base year adjustments shall be made not less frequently than every three years.

- In determining case mix, each patient shall be classified using a system based on measures which may include, but not be limited to, clinical and functional measures as reported on the federal Outcome and Assessment Information Set (OASIS).

- The Commissioner may require agencies to collect and submit any data determined to be necessary.

• Effective April 1, 2011, Medicaid rates for services provided by certified home health agencies, or by an AIDS home care program shall not reflect a separate payment for home care nursing services provided to patients diagnosed with Acquired Immune Deficiency Syndrome (AIDS).

• Effective for the period October 1, 2011 through September 30, 2013, pursuant to Section 2703 of the Patient Protection and Affordable Care Act, payments will be made to Managed Long Term Care Plans that have been designated as Health Home providers serving individuals with chronic conditions to cover comprehensive care management, care coordination and health promotion, comprehensive transitional care, patient and family support, referral to community and social support services and the use of health information technology to link services.

• Effective April 1, 2011, the Department is proposing to expand the current Patient Centered Medical Home (PCMH) to more payers and incorporate several provisions to improve medical care. Two provisions result in a change in the methods by which Medicaid fee-for-service (FFS) reimburses Medicaid providers who are designated by the National Committee for Quality Assurance as patient centered medical homes: 1) testing new models of payment to high-volume Medicaid primary care medical home practices which incorporate risk-adjusted global payments with care management and pay-for-performance, and 2) improving the relationship of FFS Medicaid members to medical homes by creating medical home payments only for FFS members who have evidence of ongoing continuity relationship with provider/practice and providing more reliable care management payments to those providers which are independent of specific visit types. These provisions require the following changes to Medicaid.

- New models of reimbursement to high-volume Medicaid providers will be tested which may incorporate risk-adjusted global payments and pay-for-performance. Risk-adjusted payment models will differentially reimburse providers based on their historical case mix. Pay-for-performance will provide enhanced reimbursement to providers who provide high-quality care (such as improved preventative screenings) and/or reduce unnecessary utilization (such as a reduction in admissions for ambulatory sensitive conditions) as defined by standardized measures of performance; and

- Eligible Medicaid fee-for-service recipients, who are currently receiving care from a certified PCMH provider, as determined by an attribution methodology developed by the Commissioner of Health, will be assigned to this PCMH provider. Medicaid FFS will reimburse PCMH providers a per member per month (PMPM) capitation payment for FFS recipients attributed to their practices to provide the necessary care coordination and disease management services.

• Effective October 1, 2011, the Department of Health will update rates paid for Medicaid coverage for preschool and school supportive health services (SSHS). SSHS are provided to Medicaid-eligible students with disabilities in school districts, counties, and State supported § 4201 schools. Payment will be based on a certified public expenditure reimbursement methodology, based on a statistically valid cost study for all school supportive health services and transportation. SSHS are authorized under § 1903(c) of the Social Security Act and include: physical therapy, occupational therapy, speech therapy, psychological evaluations, psychological counseling, skilled nursing services, medical evaluations, medical specialist evaluations, audiological evaluations, and special transportation services.

• Effective April 1, 2011, the Medicaid program is authorized to establish Behavioral Health Organizations (BHOs) to manage behavioral health services. BHOs will be authorized to manage mental health and substance abuse services not currently included in the managed care benefit for Medicaid enrollees in managed care and to facilitate the integration of such services with other health services. The BHOs will also be authorized to manage all mental health and substance abuse services for Medicaid enrollees not in managed care. Behavioral health management will be provided through a streamlined procurement process resulting in contracts with regional behavioral health organizations that will have responsibility for authorizing appropriate care and services based on criteria established by the Offices of Mental Health (OMH) and Alcohol and Substance Abuse Services (OASAS). OMH and OASAS will also be authorized, by April 1, 2013 to jointly designate on a regional basis, a limited number of special needs plans and/or

integrated physical and behavioral health provider systems capable of managing the physical and behavioral health needs of Medicaid enrollees with significant behavioral health needs.

• Effective October 1, 2011, Medicaid will expand coverage of smoking cessation counseling services so that it is available to all Medicaid enrollees. Reimbursement for these services will be available to office based providers, hospital outpatient departments and free-standing diagnostic and treatment centers.

• Effective October 1, 2011 the Department of Health is proposing a change in co-payment policy for Medicaid recipients as permitted in the federal regulations on cost sharing, 42 CFR 447.50 through 447.62. Under this proposal the current copayments will be increased and some services previously exempt from co-payments will be subject to co-payments. The chart below summarizes the current and proposed co-payment structure.

MEDICAID CO-PAYMENTS CURRENT AND PROPOSED

SERVICE OR ITEM	CURRENT AMOUNT	PROPOSED AMOUNT
Clinic Visits	$3.00	$3.40
Brand Name Prescription	$3.00	$3.40
Generic Drug Prescription, and Preferred Brand Name Prescription Drugs	$1.00	$1.15
Over-the-counter Medications	$0.50	$0.60
Lab Tests	$0.50	$0.60
X-Rays	$1.00	$1.15
Medical Supplies	$1.00	$1.15
Overnight Hospital Stays	$25.00 on the last day	$30.00
Emergency Room (for non-emergency room services)	$3.00	$6.40
Additional Services Proposed for Copay		
Eye Glasses	$0.00	$1.15
Eye Exams	$0.00	$1.15
Dental Services	$0.00	$3.40
Audiologist	$0.00	$2.30
Physician Services	$0.00	$3.40
Nurse Practitioner	$0.00	$2.30
Occupational Therapist	$0.00	$2.30
Physical Therapist	$0.00	$3.40
Speech Pathologist	$0.00	$3.40
Annual (SFY) Maximum Limit	$200.00	$300.00

- Other provisions on co-payments as stated in the § 360-7.12 of New York State Social Services Law remain unchanged. The providers of such services may charge recipients the co-payments. However, providers may not deny services to recipients because of their inability to pay the co-payments.

- The following recipients are exempt from co-payments:

• Recipients younger than 21 years of age;

• Recipients who are pregnant;

• Residents of an adult care facility licensed by the New York State Department of Health (for pharmacy services only);

• Residents of a nursing home;

• Residents of an Intermediate Care Facility for the Developmentally Disabled (ICF/DD);

• Residents of an Office of Mental Health (OMH) or Office of People with Developmental Disabilities (OPWDD) certified Community Residence;

• Enrollees in a Comprehensive Medicaid Case Management (CMCM) or Service Coordination Program;

• Enrollees in an OMH or OMRDD Home and Community Based Services (HCBS) Waiver Program; and

• Enrollees in a Department of Health HCBS Waiver Program for Persons with Traumatic Brain Injury (TBI).

- The following services are exempt from co-payments:

• Emergency services;

• Family Planning;

• Drugs to treat mental illness; and

• Services provided through managed care plans.

• Physical therapy, occupational therapy, and speech-language pathology are federal optional Medicaid services. New York State Medicaid presently covers these rehabilitation services with no limits. In order to eliminate delivery of excessive and/or unnecessary services, effective October 1, 2011, the New York State Medicaid Program is establishing utilization limits for the provision of these rehabilitation services. Enrollees will be permitted to receive up to a maximum of 20 visits in a 12 month period each for physical therapy, occupational therapy, and speech-language pathology. The utilization limits will apply to services provided by practitioners in private practice settings as well as for services provided in Article 28 certified hospital outpatient departments and diagnostic and treatment centers (free-standing clinics). The service limits will not apply to services provided in hospital inpatient settings, skilled nursing facilities, or in facilities operated by the Office of Mental Health or the Office of Persons with Developmental Disabilities. Additionally, the utilization limits will not apply for services provided to Medicaid enrollees less than 21 years of age enrollees who are developmentally disabled or to enrollees with specified chronic medical/physical conditions.

• Federal rules allow states the option of reducing coinsurance amounts at their discretion. Effective October 1, 2011, the Department of Health will change the cost-sharing basis for Medicare Part B payments. Currently, New York State Medicaid reimburses practitioners the full or partial Medicare Part B coinsurance amount for enrollees who have both Medicare and Medicaid coverage (the dually-eligible). Medicaid reimburses the Medicare Part B coinsurance, regardless of whether or not the service is covered by Medicaid. Upon federal approval of the proposed state plan change, Medicaid will no longer reimburse practitioners for the Medicare Part B coinsurance for those services that are not covered for a Medicaid-only enrollee. Medicaid presently reimburses Article 28 certified clinics (hospital outpatient departments and diagnostic and treatment centers) the full Medicare Part B coinsurance amount. The full coinsurance is paid by Medicaid, even if the total Medicare and Medicaid payment to the provider exceeds the amount that Medicaid would have paid if the enrollee did not have both Medicare and Medicaid coverage. Under the new reimbursement policy, Medicaid will provide payment for the Medicare Part B coinsurance amount, but the total Medicare/Medicaid payment to the provider will not exceed the amount that the provider would have received if the patient had Medicaid-only coverage. Therefore, if the Medicare payment exceeds what Medicaid would have paid for the service, no coinsurance will be paid by Medicaid. Practitioners and clinics will be required to accept the total Medicare and Medicaid payment (if any) as full payment for services. They will be prohibited from billing the Medicaid recipient.

• Effective October 1, 2011, the Department of Health, in collaboration with the Office of Mental Health, the Office of Alcohol and Substance Abuse Services, and the Office for People with Developmental Disabilities, will be authorized to begin Medicaid coverage for health home services to high cost, high need enrollees. Health home services include comprehensive care coordination for medical and behavioral health services, health promotion, transitional care, including appropriate follow-up from inpatient to other settings, patient and family support, referral to community and social support services, and use of health information technology to link services.

- High risk patients will be assigned to provider networks meeting state and federal health home standards (on a mandatory or opt out basis) for the provision of health home services.

- These services will range from lower intensity patient tracking to higher intensity care/service management depending on patient needs.

The provision of coordinated, integrated physical and behavioral health services will be critical components of the health home program. Strong linkages to community resources will be a health home requirement. Use of peer supports will be explored to help enrollees in the community cope with their medical and behavioral health conditions. The Managed Addiction Treatment Program (MATS), which manages access to treatment for high cost, chemically dependent Medicaid enrollees, will be expanded. Health home payment will be based on a variety of reimbursement methodologies including care coordination fees, partial and shared risk. The focus of the program will be reducing avoidable hospitalizations, institutionalizations, ER visits, and improving health outcomes.

- Payment methodologies for health home services shall be based on factors including, but not limited to, complexity of conditions providers will be managing, the anticipated amount of patient contact needed to manage such conditions, and the health care cost savings realized by provision of health home services.

- The Commissioner of Health is authorized to pay additional amounts to providers of health home services that meet process or outcomes standards specified by the Commissioner.

- Through a collaborative effort, the Department of Health, with the Office of Mental Health, Office of Alcohol and Substance Abuse Services, and the Office for People with Developmental Disabilities, will streamline existing program requirements that create barriers to co-locating medical and behavioral health services in licensed facilities to support improved coordination and integration of care.

• Effective for dates of service on and after April 1, 2011, coverage for prescription footwear and footwear inserts and components for adults age 21 and over will be limited to diabetic footwear or when the footwear is attached to a lower limb orthotic brace. This will reduce overutilization of footwear. Effective for dates of service on and after May 1, 2011, the DOH will establish maximum fees for prescription footwear, inserts and components. The fees will be based on an average of industry costs of generically equivalent products.

• Effective for dates of service on and after April 1, 2011, coverage of enteral formula for adults age 21 and over will be limited to formula administered by feeding tube or formula for treatment of an inborn metabolic disease. This will preserve coverage for medical need and eliminate coverage of orally consumed formulas for adults who can obtain nutrients through other means.

• Effective for dates of service on and after April 1, 2011, coverage of compression and support stockings will be limited to treatment of open wounds or for use as a pregnancy support. Coverage of stockings will not be available for comfort or convenience.

• Effective on and after July 1, 2011, the Department will choose selected transportation providers to deliver all necessary transportation of Medicaid enrollees to and from dialysis, at a per trip fee arrived through a competitive bid process. The Department will choose one or more transportation providers in a defined community to deliver necessary transportation of Medicaid enrollees to and from dialysis treatment. The enrollee's freedom to choose a transportation provider will be restricted to the selected provider(s) in the community. Medicaid enrollee access to necessary transportation to dialysis treatment will not be impacted by this change.

Prescription Drugs

• Effective April 1, 2011, the following is proposed:

- For sole or multi-source brand name drugs the Estimated Acquisition Cost (EAC) is defined as Average Wholesale Price (AWP) minus seventeen (17) percent and the Average Acquisition Cost (AAC) will be incorporated into the prescription drug reimbursement methodology;

- The dispensing fees paid for generic drugs will be $3.50; and

- Specialized HIV pharmacy reimbursement rates will be discontinued and a pharmacy previously designated as a specialized HIV pharmacy will receive the same reimbursement as all other pharmacies.

The estimated annual net aggregate decrease in gross Medicaid expenditures attributable to reform and other initiatives contained in the budget for state fiscal year 2011/2012 is $223 million; and the estimated annual net aggregate increase in gross Medicaid expenditures attributable to an extension of pertinent disproportionate share (DSH) and upper payment limit (UPL) payments for state fiscal year 2011/2012 is $1.9 billion.

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

The public is invited to review and comment on this proposed state plan amendment.

For further information and to review and comment, please contact: Department of Health, Bureau of HCRA Operations & Financial Analysis, Corning Tower Bldg., Rm. 984, Empire State Plaza, Albany, NY 12237, (518) 474-1673, (518) 473-8825 (FAX), e-mail: spa_inquires@health.state.ny.us

SALE OF FOREST PRODUCTS

Chenango Reforestation Area No. 1
Contract No. X008135

Pursuant to Section 9-0505 of the Environmental Conservation Law, the Department of Environmental Conservation hereby gives Public Notice for the following:

Sealed bids for 21 tons more or less red pine, 32.6 MBF more or less white ash, 23.6 MBF more or less black cherry, 15.2 MBF more or less red maple, 10.0 MBF more or less sugar maple, 0.3 MBF more or less yellow birch, 0.5 MBF more or less basswood, 0.1 MBF more or less aspen, 233 cords more or less firewood, located on Chenango Reforestation Area No. 1, Stands C-27, D-25 and D-28, will be accepted at the Department of Environmental Conservation, Contract Unit, 625 Broadway, 10th Fl., Albany, NY 12233-5027 until 11:00 a.m. on Thursday, April 7, 2011.

For further information, contact: Robert Slavicek, Supervising Forester, Department of Environmental Conservation, Division of Lands and Forests, Region 7, 2715 State Hwy. 80, Sherburne, NY 13460-4507, (607) 674-4036

SALE OF FOREST PRODUCTS

Lewis Reforestation Area No. 20
Contract No. X008125

Pursuant to Section 9-0505 of the Environmental Conservation Law, the Department of Environmental Conservation hereby gives Public Notice of the following:

Sealed bids for hard maple ST - 134.6 MBF more or less, black cherry ST - 29.5 MBF more or less, white ash ST - 30.9 MBF more or less, red maple ST - 7.7 MBF more or less, yellow birch ST - 5.8 MBF more or less, basswood ST - 6.9 MBF more or less, red oak ST - 2.5 MBF more or less, hemlock - 0.8 MBF more or less, pine pulp - 13 cords more or less, firewood - 626.6 cords more or less, located on Lewis Reforestation Area No. 20, Stands A-7, 8, 15, 17 & 21, will be accepted at the Department of Environmental Conservation, Contract Unit, 625 Broadway, 10th Fl., Albany, NY 12233-5027 until 11:00 a.m., Thursday, April 7, 2011.

For further information, contact: Andrea Mercurio, Senior Forester, Department of Environmental Conservation, Division of Lands and Forests, Region 6, 7327 State Rte. 812, Lowville, NY 13367, (315) 376-3521

Appendix V
2012 Title XIX State Plan
First Quarter Amendment
Inpatient Hospital Services
Responses to Standard Funding Questions

HOSPITAL SERVICES
State Plan Amendment #11-24

CMS Standard Funding Questions (NIRT Standard Funding Questions)

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

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

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

07C when an on-site audit of these transactions for New York City's Health and Hospitals Corporation was completed with satisfactory results.

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

   Response: Payments made to service providers under the provisions of this SPA are funded through a general appropriation received by the State agency that oversees medical assistance (Medicaid), which is the Department of Health. The source of the appropriation is the Local Assistance Account under the General Fund/Aid to Localities.

3. **Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan. If**

supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to each provider type.

Response: The payments authorized for this provision are not supplemental or enhanced payments.

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

   Response: The State submitted the 2011 inpatient UPL to CMS for review and approval on September 9, 2011.

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

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

ACA Assurances:

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

   MOE Period.
   - Begins on: **March 10, 2010, and**
   - Ends on: **The date the Secretary of the Federal Department of Health and Human Services determines an Exchange established by a State**

under the provisions of section 1311 of the Affordable Care Act is fully operational.

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

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

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

   Response: This SPA would [ ] / would not **[XX]** 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 SPA 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)(l) 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: The consultation process that New York State uses is detailed in SPA #11-06, which was approved by CMS on 8/4/11. On 4/29/11, and again on 6/28/11, tribal leaders and health clinic administrators were sent information regarding this SPA (see attached) in accordance with the State's approved procedure. To date, no comments have been received.

SPA 11-24
Response to CMS Comments of 7/14/11

Question:

This SPA would provide for temporary rate adjustments that would be conditioned upon a hospital being impacted by a closure.

As a general comment, based on the preliminary discussions we have had so far, we wonder if the rate adjustment contemplated by this amendment might be better placed in the State plan under its own section. At least our sense is that the purpose and need for and the amount and distribution of the higher payments may be different that what the current approved provision relating to mergers and acquisitions contemplate.

The determination of whether Medicaid will pay a higher rate hinges on whether or not a hospital is impacted. Does this mean the hospital has to be a party to the transaction? If that is the case, wouldn't the current plan provisions entitle them to a rate adjustment? If this is intended to have a broader application, a complexity will be defining the standard—as presumably some mergers will occur naturally in the market, without any apparent value to the Medicaid program to justify a higher rate adjustment while others will benefit Medicaid and might justify different treatment. While the State is free to use impact to define the target group, it is also free to consider other approaches.

Response: Keeping this temporary adjustment as a component in the general Medicaid rate setting methodology will allow the consolidation of the various rate setting methodologies; therefore, it has not been moved to a section of its own.

A provider does not have to be a party to the transaction in order to be impacted. A provider who takes on employees, services, or patient volume from another provider who is party to a transaction in the same service delivery area is also an example of one who is impacted. Providing support to such a provider will help maintain access to needed healthcare services in that community.

Providers seeking the temporary rate adjustment will be required to submit a written proposal that includes a budget, details of the need for the adjustment, the purpose and benefits of receiving the adjustment, the timeframes for implementing actions supported by the adjustment, and the deliverables resulting from receipt of the adjustment. Together, these must demonstrate that the additional resources will result in the protection or enhancement of access to care, and/or the protection or enhancement of quality of care, and/or improvement in the cost effectiveness of the delivery of health care services, and/or other protections or enhancements to the health care delivery system.

Question:

This SPA proposes to expand effective 4/1/2011, the circumstances under which Medicaid will temporarily increase payments rates to include inpatient hospital services furnish by a hospital subject to or impacted by a hospital closure.

It is not clear if this adjustment will be to the DRG prices paid to the impacted hospital or determined based on Medicaid service utilization, but paid separate from the DRG payment. The amount of the payment and how it will be determined is not clear either. We also wonder if the duration, till rebasing will make sense in all instances? If a transaction occurred near the end of the 4-year rebasing cycle, does that have any impact that would undercut the From a rate methodology perspective, we would be looking for clarity regarding, the amount of the adjustments, how does a provider qualify to receive the higher payment, the duration of entitlement, how will the higher amount be paid to providers etc?

From a rate methodology perspective, we would be looking for clarity regarding:

- **the amount of the adjustments**
- **how a provider would qualify to receive the higher payment**
- **the duration of entitlement**
- **how the higher amount will actually be paid t providers**
- **etc.**

And, while w appreciate the State's might desire flexibility and discretion, the plan language has to be definitive enough to meet the comprehensive language requirements of 42 CFR 447.252(b).

Response: The Department has deferred the effective date of this new provision to 12/1/2011 to allow for appropriate public notice and regulation development based upon a more defined program and rate setting methodology.

Any adjustment issued pursuant to this section will be a DRG payment based rate adjustment in accordance with the existing Medicaid rate methodology and will be in effect for a specified period of time, as determined by the Commissioner and based upon the plans identified in the provider's proposal, of up to three years. As discussed in the previous answer, in order to receive an adjustment, a provider must first submit a plan to DOH, which shall include the goals of the proposal and a budget necessary to achieve those goals, and receive approval of the plan from DOH.

The attached proposed regulations provide specific details on the process and the duration of a temporary rate adjustment. The amount of the rate adjustment will be based upon the plan submitted by the hospital and approved by the Commissioner. The process will be collaborative and will involve dialogue with affected providers to determine the appropriateness of a particular plan and its effect on the healthcare delivery system in the community, as well as the effect on the Medicaid population.

Other Comments:

We would note too that the upper payment limit is in part a function of Medicaid services furnished and we generally view this proposal as trying to provide the existing level of services more efficiently, but if for some reason, utilization dropped or shifted to non inpatient hospital services the UPL for inpatient services may be impacted.

Response: Yes, the UPL may be affected by this proposal. Any increased Medicaid expenditures related to this temporary adjustment will be reflected in the UPL calculations and will be within those limits.

Pending Amendment: The SPA 11-24 submission consists of revised Attachment 4.19-A, Page 136(a). However, Page 136(a) is part of SPA 10-45, which is under active review, but as a matter of procedure, the prior SPA will need to be processed before a final action can be taken on 11-24.

Response: Since the time these comments were received by the State, SPA 10-45 has been approved (8/26/11).

Form 179: While this amendment has a proposed effective date of 4/1/2011, the estimated fiscal impact indicates that no fiscal impact is expected in FY 2011 or 2012. Is this because the State does not expect any provider to be impacted by a closure during this period? We understand more information about this proposal will be forthcoming and in the interim, the State has asked for our preliminary analysis on the materials submitted, but this is one area we would like a better understanding.

Response: The State anticipates that the expenses associated with any temporary rate adjustments will be counterbalanced by gross savings to the Medicaid program realized through the cost efficiencies resulting from closures, mergers, acquisitions, consolidations and/or restructurings; therefore, the State has reflected a zero impact. As part of the application for a temporary rate adjustment, providers must describe how activities supported by the adjustment will result in cost savings to the health care system and the Medicaid program through improved efficiency, more appropriate levels of care, and the like. Recipient providers will be held to demonstrating the achievement of established benchmarks and goals in order to continue to receive funding throughout the time period specified for each such provider.

On the 179, for Block 7b, the State indicates, "FFY 10/01/11-09/30/11" Should that be "FFY 10/1/11-09/30/12"?

Response: Yes, the draft 179 that was previously submitted is incorrect. A new effective date of December 1, 2011 has been established; therefore, a revised 179 will be submitted and will reflect the period 12/1/11 – 9/30/12 and FFY 10/1/12 – 9/30/13.

NEW YORK
state department of
HEALTH

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

Sue Kelly
Executive Deputy Commissioner

June 28, 2011

Oneida Indian Nation
Ray Halbritter
Nation Representative
528 Patrick Road
Verona, NY 13478

Dear Mr. Halbritter:

Pursuant to our recently developed tribal consultation policy, I am enclosing two packets of information for your review and comment. The first packet contains summary descriptions of proposed changes to New York's Medicaid State Plan, along with draft State Plan pages showing the corresponding proposed changes (deletions in brackets and new language underlined). After consultation with the federal Centers for Medicare and Medicaid Services (CMS), the State believes that this packet contains changes that are likely to impact upon Indians or Indian health care providers. The second packet is being included for informational purposes; nonetheless, I encourage you to review both packets and provide any comments or request a personal meeting to discuss the proposed changes within two weeks of the date of this letter.

I appreciate the opportunity to share this information with you and look forward to responding to any comments or concerns that you may have. I can be reached at (518) 474-1673.

Sincerely,

Philip N. Mossman

Philip N. Mossman, Director
Bureau of HCRA Operations
& Financial Analysis

Enclosures

cc: Michael Melendez
Centers for Medicare and Medicaid Services

Wendy Stoddart
NYSDOH American Indian Health Program

NEW YORK
state department of
HEALTH

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

Sue Kelly
Executive Deputy Commissioner

June 28, 2011

Onondaga Nation
Chief Irving Powless, Jr.
Box 319-B
Nedrow, NY 13120

Dear Chief Irving Powless:

Pursuant to our recently developed tribal consultation policy, I am enclosing two packets of information for your review and comment. The first packet contains summary descriptions of proposed changes to New York's Medicaid State Plan, along with draft State Plan pages showing the corresponding proposed changes (deletions in brackets and new language underlined). After consultation with the federal Centers for Medicare and Medicaid Services (CMS), the State believes that this packet contains changes that are likely to impact upon Indians or Indian health care providers. The second packet is being included for informational purposes; nonetheless, I encourage you to review both packets and provide any comments or request a personal meeting to discuss the proposed changes within two weeks of the date of this letter.

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Sincerely,

Philip N. Mossman

Philip N. Mossman, Director
Bureau of HCRA Operations
& Financial Analysis

Enclosures

cc: Michael Melendez
Centers for Medicare and Medicaid Services

Wendy Stoddart
NYSDOH American Indian Health Program

NEW YORK
state department of
HEALTH

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

Sue Kelly
Executive Deputy Commissioner

June 28, 2011

Shinnecock Indian Nation Tribal Office
Randy King
Chairman of the Board of Trustees
P.O. Box 5006
Southampton, NY 11969

Dear Mr. King:

Pursuant to our recently developed tribal consultation policy, I am enclosing two packets of information for your review and comment. The first packet contains summary descriptions of proposed changes to New York's Medicaid State Plan, along with draft State Plan pages showing the corresponding proposed changes (deletions in brackets and new language underlined). After consultation with the federal Centers for Medicare and Medicaid Services (CMS), the State believes that this packet contains changes that are likely to impact upon Indians or Indian health care providers. The second packet is being included for informational purposes; nonetheless, I encourage you to review both packets and provide any comments or request a personal meeting to discuss the proposed changes within two weeks of the date of this letter.

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Sincerely,

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Philip N. Mossman, Director
Bureau of HCRA Operations
& Financial Analysis

Enclosures

cc: Michael Melendez
Centers for Medicare and Medicaid Services

Wendy Stoddart
NYSDOH American Indian Health Program

NEW YORK
state department of
HEALTH

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

Sue Kelly
Executive Deputy Commissioner

June 28, 2011

Tonawanda Seneca Indian Nation
Chief Roger Hill, Council Chairman
Administration Office
7027 Meadville Road
Basom, NY 14013

Dear Chief Roger Hill:

Pursuant to our recently developed tribal consultation policy, I am enclosing two packets of information for your review and comment. The first packet contains summary descriptions of proposed changes to New York's Medicaid State Plan, along with draft State Plan pages showing the corresponding proposed changes (deletions in brackets and new language underlined). After consultation with the federal Centers for Medicare and Medicaid Services (CMS), the State believes that this packet contains changes that are likely to impact upon Indians or Indian health care providers. The second packet is being included for informational purposes; nonetheless, I encourage you to review both packets and provide any comments or request a personal meeting to discuss the proposed changes within two weeks of the date of this letter.

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Philip N. Mossman, Director
Bureau of HCRA Operations
& Financial Analysis

Enclosures

cc: Michael Melendez
Centers for Medicare and Medicaid Services

Wendy Stoddart
NYSDOH American Indian Health Program

NEW YORK
state department of
HEALTH

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

Sue Kelly
Executive Deputy Commissioner

June 28, 2011

Tuscarora Indian Nation
Chief Leo Henry, Clerk
2006 Mount Hope Road
Lewiston, NY 14092

Dear Chief Leo Henry:

Pursuant to our recently developed tribal consultation policy, I am enclosing two packets of information for your review and comment. The first packet contains summary descriptions of proposed changes to New York's Medicaid State Plan, along with draft State Plan pages showing the corresponding proposed changes (deletions in brackets and new language underlined). After consultation with the federal Centers for Medicare and Medicaid Services (CMS), the State believes that this packet contains changes that are likely to impact upon Indians or Indian health care providers. The second packet is being included for informational purposes; nonetheless, I encourage you to review both packets and provide any comments or request a personal meeting to discuss the proposed changes within two weeks of the date of this letter.

I appreciate the opportunity to share this information with you and look forward to responding to any comments or concerns that you may have. I can be reached at (518) 474-1673.

Sincerely,

Philip N. Mossman

Philip N. Mossman, Director
Bureau of HCRA Operations
& Financial Analysis

Enclosures

cc: Michael Melendez
Centers for Medicare and Medicaid Services

Wendy Stoddart
NYSDOH American Indian Health Program

NEW YORK
state department of
HEALTH

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

Sue Kelly
Executive Deputy Commissioner

June 28, 2011

Tuscarora Indian Nation
Chief Kenneth Patterson
1967 Upper Mountain Road
Lewiston, NY 14092

Dear Chief Kenneth Patterson:

Pursuant to our recently developed tribal consultation policy, I am enclosing two packets of information for your review and comment. The first packet contains summary descriptions of proposed changes to New York's Medicaid State Plan, along with draft State Plan pages showing the corresponding proposed changes (deletions in brackets and new language underlined). After consultation with the federal Centers for Medicare and Medicaid Services (CMS), the State believes that this packet contains changes that are likely to impact upon Indians or Indian health care providers. The second packet is being included for informational purposes; nonetheless, I encourage you to review both packets and provide any comments or request a personal meeting to discuss the proposed changes within two weeks of the date of this letter.

I appreciate the opportunity to share this information with you and look forward to responding to any comments or concerns that you may have. I can be reached at (518) 474-1673.

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Bureau of HCRA Operations
& Financial Analysis

Enclosures

cc: Michael Melendez
Centers for Medicare and Medicaid Services

Wendy Stoddart
NYSDOH American Indian Health Program

NEW YORK
state department of
HEALTH

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

Sue Kelly
Executive Deputy Commissioner

June 28, 2011

American Indian Community House
L. Buddy Gwin, Executive Director
11 Broadway, 2nd Floor
New York, NY 10004-1303

Dear Mr. Gwin:

Pursuant to our recently developed tribal consultation policy, I am enclosing two packets of information for your review and comment. The first packet contains summary descriptions of proposed changes to New York's Medicaid State Plan, along with draft State Plan pages showing the corresponding proposed changes (deletions in brackets and new language underlined). After consultation with the federal Centers for Medicare and Medicaid Services (CMS), the State believes that this packet contains changes that are likely to impact upon Indians or Indian health care providers. The second packet is being included for informational purposes; nonetheless, I encourage you to review both packets and provide any comments or request a personal meeting to discuss the proposed changes within two weeks of the date of this letter.

I appreciate the opportunity to share this information with you and look forward to responding to any comments or concerns that you may have. I can be reached at (518) 474-1673.

Sincerely,

Philip N. Mossman

Philip N. Mossman, Director
Bureau of HCRA Operations
& Financial Analysis

Enclosures

cc: Michael Melendez
Centers for Medicare and Medicaid Services

Wendy Stoddart
NYSDOH American Indian Health Program

NEW YORK
state department of
HEALTH

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

Sue Kelly
Executive Deputy Commissioner

June 28, 2011

Cayuga Nation
Mr. Clinton Halftown
Nation Representative
P.O. Box 803
Seneca Falls, NY 13148

Dear Mr. Halftown:

Pursuant to our recently developed tribal consultation policy, I am enclosing two packets of information for your review and comment. The first packet contains summary descriptions of proposed changes to New York's Medicaid State Plan, along with draft State Plan pages showing the corresponding proposed changes (deletions in brackets and new language underlined). After consultation with the federal Centers for Medicare and Medicaid Services (CMS), the State believes that this packet contains changes that are likely to impact upon Indians or Indian health care providers. The second packet is being included for informational purposes; nonetheless, I encourage you to review both packets and provide any comments or request a personal meeting to discuss the proposed changes within two weeks of the date of this letter.

I appreciate the opportunity to share this information with you and look forward to responding to any comments or concerns that you may have. I can be reached at (518) 474-1673.

Sincerely,

Philip N. Mossman

Philip N. Mossman, Director
Bureau of HCRA Operations
& Financial Analysis

Enclosures

cc: Michael Melendez
Centers for Medicare and Medicaid Services

Wendy Stoddart
NYSDOH American Indian Health Program

NEW YORK
state department of
HEALTH

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

Sue Kelly
Executive Deputy Commissioner

June 28, 2011

Ukechaug Indian Territory
Chief Harry B. Wallace
207 Poospatuck Lane
Mastic, NY 11950

Dear Chief Harry Wallace:

Pursuant to our recently developed tribal consultation policy, I am enclosing two packets of information for your review and comment. The first packet contains summary descriptions of proposed changes to New York's Medicaid State Plan, along with draft State Plan pages showing the corresponding proposed changes (deletions in brackets and new language underlined). After consultation with the federal Centers for Medicare and Medicaid Services (CMS), the State believes that this packet contains changes that are likely to impact upon Indians or Indian health care providers. The second packet is being included for informational purposes; nonetheless, I encourage you to review both packets and provide any comments or request a personal meeting to discuss the proposed changes within two weeks of the date of this letter.

I appreciate the opportunity to share this information with you and look forward to responding to any comments or concerns that you may have. I can be reached at (518) 474-1673.

Sincerely,

Philip N. Mossman

Philip N. Mossman, Director
Bureau of HCRA Operations
& Financial Analysis

Enclosures

cc: Michael Melendez
Centers for Medicare and Medicaid Services

Wendy Stoddart
NYSDOH American Indian Health Program

NEW YORK
state department of
HEALTH

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

Sue Kelly
Executive Deputy Commissioner

June 28, 2011

Seneca Nation of Indians
Robert Odawi Porter
President
P.O. Box 231
Salamanca, NY 14779

Dear Mr. Porter:

Pursuant to our recently developed tribal consultation policy, I am enclosing two packets of information for your review and comment. The first packet contains summary descriptions of proposed changes to New York's Medicaid State Plan, along with draft State Plan pages showing the corresponding proposed changes (deletions in brackets and new language underlined). After consultation with the federal Centers for Medicare and Medicaid Services (CMS), the State believes that this packet contains changes that are likely to impact upon Indians or Indian health care providers. The second packet is being included for informational purposes; nonetheless, I encourage you to review both packets and provide any comments or request a personal meeting to discuss the proposed changes within two weeks of the date of this letter.

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Bureau of HCRA Operations
& Financial Analysis

Enclosures

cc: Michael Melendez
Centers for Medicare and Medicaid Services

Wendy Stoddart
NYSDOH American Indian Health Program

NEW YORK
state department of
HEALTH

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

Sue Kelly
Executive Deputy Commissioner

June 28, 2011

St. Regis Mohawk Tribe
Chief Monica Jacobs
412 State Route 37
Akwesasne, NY 13655

Dear Chief Monica Jacobs:

Pursuant to our recently developed tribal consultation policy, I am enclosing two packets of information for your review and comment. The first packet contains summary descriptions of proposed changes to New York's Medicaid State Plan, along with draft State Plan pages showing the corresponding proposed changes (deletions in brackets and new language underlined). After consultation with the federal Centers for Medicare and Medicaid Services (CMS), the State believes that this packet contains changes that are likely to impact upon Indians or Indian health care providers. The second packet is being included for informational purposes; nonetheless, I encourage you to review both packets and provide any comments or request a personal meeting to discuss the proposed changes within two weeks of the date of this letter.

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Sincerely,

Philip N. Mossman

Philip N. Mossman, Director
Bureau of HCRA Operations
& Financial Analysis

Enclosures

cc: Michael Melendez
Centers for Medicare and Medicaid Services

Wendy Stoddart
NYSDOH American Indian Health Program

NEW YORK
state department of
HEALTH

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

Sue Kelly
Executive Deputy Commissioner

June 28, 2011

St. Regis Mohawk Tribe
Chief Mark Garrow
412 State Route 37
Akwesasne, NY 13655

Dear Chief Mark Garrow:

Pursuant to our recently developed tribal consultation policy, I am enclosing two packets of information for your review and comment. The first packet contains summary descriptions of proposed changes to New York's Medicaid State Plan, along with draft State Plan pages showing the corresponding proposed changes (deletions in brackets and new language underlined). After consultation with the federal Centers for Medicare and Medicaid Services (CMS), the State believes that this packet contains changes that are likely to impact upon Indians or Indian health care providers. The second packet is being included for informational purposes; nonetheless, I encourage you to review both packets and provide any comments or request a personal meeting to discuss the proposed changes within two weeks of the date of this letter.

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Sincerely,

Philip N. Mossman

Philip N. Mossman, Director
Bureau of HCRA Operations
& Financial Analysis

Enclosures

cc: Michael Melendez
Centers for Medicare and Medicaid Services

Wendy Stoddart
NYSDOH American Indian Health Program

NEW YORK
state department of
HEALTH

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

Sue Kelly
Executive Deputy Commissioner

June 28, 2011

St. Regis Mohawk Tribe
Chief Randy Hart
412 State Route 37
Akwesasne, NY 13655

Dear Chief Randy Hart:

Pursuant to our recently developed tribal consultation policy, I am enclosing two packets of information for your review and comment. The first packet contains summary descriptions of proposed changes to New York's Medicaid State Plan, along with draft State Plan pages showing the corresponding proposed changes (deletions in brackets and new language underlined). After consultation with the federal Centers for Medicare and Medicaid Services (CMS), the State believes that this packet contains changes that are likely to impact upon Indians or Indian health care providers. The second packet is being included for informational purposes; nonetheless, I encourage you to review both packets and provide any comments or request a personal meeting to discuss the proposed changes within two weeks of the date of this letter.

I appreciate the opportunity to share this information with you and look forward to responding to any comments or concerns that you may have. I can be reached at (518) 474-1673.

Sincerely,

Philip N. Mossman

Philip N. Mossman, Director
Bureau of HCRA Operations
& Financial Analysis

Enclosures

cc: Michael Melendez
Centers for Medicare and Medicaid Services

Wendy Stoddart
NYSDOH American Indian Health Program

NEW YORK
state department of
HEALTH

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

Sue Kelly
Executive Deputy Commissioner

June 28, 2011

American Indian Community House
Larenia Felix, Interim Acting Manager
Health Department
11 Broadway, 2nd Floor
New York, NY 10004-1303

Dear Ms. Felix:

Pursuant to our recently developed tribal consultation policy, I am enclosing two packets of information for your review and comment. The first packet contains summary descriptions of proposed changes to New York's Medicaid State Plan, along with draft State Plan pages showing the corresponding proposed changes (deletions in brackets and new language underlined). After consultation with the federal Centers for Medicare and Medicaid Services (CMS), the State believes that this packet contains changes that are likely to impact upon Indians or Indian health care providers. The second packet is being included for informational purposes; nonetheless, I encourage you to review both packets and provide any comments or request a personal meeting to discuss the proposed changes within two weeks of the date of this letter.

I appreciate the opportunity to share this information with you and look forward to responding to any comments or concerns that you may have. I can be reached at (518) 474-1673.

Sincerely,

Philip N. Mossman

Philip N. Mossman, Director
Bureau of HCRA Operations
& Financial Analysis

Enclosures

cc: Michael Melendez
Centers for Medicare and Medicaid Services

Wendy Stoddart
NYSDOH American Indian Health Program

Packet Two

Informational Purposes Only

SUMMARY
SPA #11-24

This state plan amendment proposes to modify the temporary rate adjustment for hospitals as set forth in the approved state plan to recognize closures in addition to mergers, consolidations and acquisitions as a basis for this adjustment. This adjustment will be allowed if a hospital submits a required written plan which receives approval by the Commissioner. The temporary adjustment will also allow for the protection and enhancement of quality and access to the communities served by the effected hospitals.

This plan amendment is budget neutral because the temporary rate adjustment for hospital closures will be funded by the reduction in expenditures as the result of the hospital(s) that close.

Contact: Philip N. Mossman
(518) 474-1673

2. Temporary rate adjustment.

a. The Commissioner may grant approval of a temporary adjustment to rates calculated pursuant to this Section for hospitals subject to or impacted by closures, mergers, acquisitions or consolidations provided such hospitals demonstrate through submission of a written proposal that the [merger, acquisition or consolidation] additional resources provided by such temporary rate adjustment will result in an improvement to (i) cost effectiveness of service delivery, (ii) protect or enhancement of quality of care, and (iii) [other] factors deemed appropriate by the Commissioner. Such written proposal shall be submitted to the Department sixty days prior to the requested effective date of the temporary rate adjustment. The temporary rate adjustment shall consist of the various operating rate components of that portion of the facility originally associated with the surviving provider number or such other operating component determined by the Commissioner based upon the approved plan and shall be in effect for a specified amount of time as approved by the Commissioner. At the end of the specified timeframe, the hospital will be reimbursed in accordance with the statewide methodology set forth in this Subpart. The Commissioner may establish, as a condition of receiving such a temporary rate adjustment, benchmarks and goals to be achieved as a result of the closure, ongoing merger, consolidation or acquisition efforts and may [also] require that the hospital submit such periodic reports concerning the achievement of such benchmarks and goals as the Commissioner deems necessary. Failure to achieve satisfactory progress, as determined by the Commissioner, in accomplishing such benchmarks and goals shall be a basis for ending the hospital's temporary rate adjustment prior to the end of the specified timeframe.

b. The Commissioner shall withdraw approval of a temporary rate adjustment for hospitals which (i) fail to demonstrate compliance with and continual improvement on the approved proposal or (ii) an update to the base year is made by the Department.

Pertinent excerpts from tribal mailing containing FPNs of 3/30/11 and 4/27/11.

NEW YORK
state department of
HEALTH

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

Sue Kelly
Executive Deputy Commissioner

April 29, 2011

Shinnecock Indian Nation
Randy King, Trustee-Chairman
P.O. Box 59
Church Street
Southampton, NY 11969

Dear Mr. King:

On March 29th, I had the pleasure of attending the 2011 Annual Tribal Consultation Session in Verona and presenting information about New York State's Medicaid State Plan, the draft policy for tribal consultation related to the Plan, and proposed changes to the Plan. Following the presentation, attendees had the opportunity to ask questions and comment on the information that was presented, all of which will be taken into consideration as we move forward with drafting and finalizing the proposed changes.

For your information, I am enclosing a copy of the PowerPoint that was used for that presentation, along with a copy of the *Federal Public Notice* (FPN) dated March 30, 2011, which provides brief descriptions of the proposed changes, and the FPN dated April 27, 2011, which provides clarification to the March 30th FPN, along with information about new initiatives that were not previously noticed but were contained in New York's enacted budget.

For many of the proposed changes, a formal State Plan Amendment (SPA) must be written and submitted to the federal Centers for Medicare and Medicaid Services for approval. Once the SPAs associated with these proposed changes are drafted, copies will be forwarded to you for your review and comment. It is important that, as part of the tribal consultation process, the draft SPAs be reviewed and all comments or questions raised be addressed by the State. If you have any comments regarding the enclosed information or would like to request a personal meeting to discuss it, please contact me within two weeks from the date of this letter at the number below.

Also for your information, the next meeting of the New York State Medicaid Redesign Team (MRT) will take place on Thursday, May 12, beginning at 10:30 a.m. and running until approximately 1:30 p.m. The meeting will be held in Manhattan at:

The William and Anita Newman Conference Center
Baruch College
151 East 25th Street - Room 750
(Closest Intersection - Lexington & 25th)

This will be a team work session, so there will be no public comment period. However, limited audience seating will be available, and the meeting will be webcast. Although no agenda is available at this point, the team will be discussing the enacted budget and the proposed next steps of the MRT.

As further information about MRT activities becomes available, it will be posted to the Department of Health's website at health.ny.gov/health_care/medicaid/redesign/. Information and a link for the webcast will be available on the website approximately one week before the meeting. To sign up for automatic e-mail updates regarding the MRT, please also visit health.ny.gov/health_care/medicaid/redesign/listserv.htm.

Again, if you have any questions or comments concerning the information in this letter, please feel free to contact me at (518) 474-1673.

Sincerely,

Philip N. Mossman

Philip N. Mossman, Director
Bureau of HCRA Operations
and Financial Analysis

Enclosures

cc: Michael Melendez
Associate Regional Administrator
Centers for Medicare and Medicaid Services

Wendy Stoddart
New York State Department of Health
American Indian Health Program

NEW YORK
state department of
HEALTH

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

Sue Kelly
Executive Deputy Commissioner

April 29, 2011

Tonawanda Seneca Indian Nation
Chief Roger Hill, Council Chairman
Administration Office
7027 Meadville Road
Basom, NY 14013

Dear Chief Roger Hill:

On March 29th, I had the pleasure of attending the 2011 Annual Tribal Consultation Session in Verona and presenting information about New York State's Medicaid State Plan, the draft policy for tribal consultation related to the Plan, and proposed changes to the Plan. Following the presentation, attendees had the opportunity to ask questions and comment on the information that was presented, all of which will be taken into consideration as we move forward with drafting and finalizing the proposed changes.

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Sincerely,

Philip N. Mossman

Philip N. Mossman, Director
Bureau of HCRA Operations
and Financial Analysis

Enclosures

cc: Michael Melendez
Associate Regional Administrator
Centers for Medicare and Medicaid Services

Wendy Stoddart
New York State Department of Health
American Indian Health Program

NEW YORK
state department of
HEALTH

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

Sue Kelly
Executive Deputy Commissioner

April 29, 2011

Tuscarora Indian Nation
Chief Leo Henry, Clerk
2006 Mount Hope Road
Lewiston, NY 14092

Dear Chief Leo Henry:

On March 29th, I had the pleasure of attending the 2011 Annual Tribal Consultation Session in Verona and presenting information about New York State's Medicaid State Plan, the draft policy for tribal consultation related to the Plan, and proposed changes to the Plan. Following the presentation, attendees had the opportunity to ask questions and comment on the information that was presented, all of which will be taken into consideration as we move forward with drafting and finalizing the proposed changes.

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Sincerely,

Philip N. Mossman

Philip N. Mossman, Director
Bureau of HCRA Operations
and Financial Analysis

Enclosures

cc: Michael Melendez
Associate Regional Administrator
Centers for Medicare and Medicaid Services

Wendy Stoddart
New York State Department of Health
American Indian Health Program

NEW YORK
state department of
HEALTH

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

Sue Kelly
Executive Deputy Commissioner

April 29, 2011

Tuscarora Indian Nation
Chief Kenneth Patterson
1967 Upper Mountain Road
Lewiston, NY 14092

Dear Chief Kenneth Patterson:

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Sincerely,

Philip N. Mossman

Philip N. Mossman, Director
Bureau of HCRA Operations
and Financial Analysis

Enclosures

cc: Michael Melendez
Associate Regional Administrator
Centers for Medicare and Medicaid Services

Wendy Stoddart
New York State Department of Health
American Indian Health Program

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 2011 will be conducted on April 14 commencing at 10:00 a.m. This meeting will be conducted at New York Network, Suite 146, South Concourse, Empire State Plaza, Albany, NY. Directions and parking information available at (www.nyn.suny.edu).

For further information, contact: Office of Commission Operations, Department of Civil Service, Alfred E. Smith State Office Bldg., Albany, NY 12239, (518) 473-6598

PUBLIC NOTICE
Department of Health

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

The Department of Health proposes to amend the Title XIX (Medicaid) State Plan for inpatient, long term care, and non-institutional services to comply with recently proposed statutory provisions. The following significant changes are proposed:

All Services

• Effective on and after April 1, 2011, no annual trend factor will be applied pursuant to the provisions of Public Health Law § 2807-c(10)(c) to rates of payment for hospital inpatient, residential health care facilities, certified home health agencies, personal care services, and adult day health care services provided to patients diagnosed with AIDS. This includes the elimination of the 2011 trend factor effective for rates of payment April 1, 2011, and thereafter. In addition, the Department is authorized to promulgate regulations, to be effective April 1, 2011, such that no annual trend factor may be applied to rates of payment by the Department of Health for assisted living program services, adult day health care services or 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. This includes the elimination of the 2011 trend factor effective for rates of payment April 1, 2011, and thereafter.

- Effective for dates of service April 1, 2011, through March 31, 2012, and each state fiscal year thereafter, all non-exempt Medicaid payments as referenced below will be uniformly reduced by two percent. Such reductions will be applied only if an alternative method that achieves at least $345 million in Medicaid state share savings annually is not implemented.

- Medicaid administration costs paid to local governments, contractors and other such entities will also be reduced in the same manner as described above.

- Payments exempt from the uniform reduction based on federal law prohibitions include, but are not limited to, the following:

• Federally Qualified Health Center services;

• Indian Health Services and services provided to Native Americans;

• Supplemental Medical Insurance - Part A and Part B;

• State Contribution for Prescription Drug Benefit (aka Medicare Part D payments);

• Any local share cap payment required by the Federal Medical Assistance Percentage (FMAP) increase legislation;

• Required payments related to the School Supportive Health Services Program and Preschool Supportive Health Services Program settlement agreement;

• Services provided to American citizen repatriates; and

• Hospice Services.

- Payments exempt from the uniform reduction based on being funded exclusively with federal and/or local funds include, but are not limited to, the following:

• Upper payment limit payments to non-state owned or operated governmental providers certified under Article 28 of the NYS Public Health Law;

• Certified public expenditure payments to the NYC Health and Hospital Corporation;

• Certain disproportionate share payments to non-state operated or owned governmental hospitals;

• Certain managed care payments pursuant to section 3-d of Part B of the Chapter 58 of the Laws of 2010; and

• Services provided to inmates of local correctional facilities.

- Payments pursuant to the mental hygiene law will be exempt from the reduction;

- Court orders and judgments; and

- Payments where applying the reduction would result in a lower FMAP as determined by the Commissioner of Health and the Director of the Budget will be exempt.

• Medicaid expenditures will be held to a year to year rate of growth spending cap which does not exceed the rolling average of the preceding 10 years of the medical component of the Consumer Price Index (CPI) as published by the United States Department of Labor, Bureau of Labor Statistics.

- The Director of the Budget and the Commissioner of Health will periodically assess known and projected Medicaid expenditures to determine whether the Medicaid growth spending cap appears to be pierced. The cap may be adjusted to account for any revision in State Financial Plan projections due to a change in the FMAP amount, provider based revenues, and beginning April 1, 2012, the operational costs of the medical indemnity fund. In the event it is determined that Medicaid expenditures exceed the Medicaid spending cap, after any adjustment to the cap if needed, the Director of the Division of the Budget and the Commissioner of Health will develop a Medicaid savings allocation plan to limit the Medicaid expenditures by the amount of the projected overspending. The savings allocation plan will be in compliance with the following guidelines:

• The plan must be in compliance with the federal law;

• It must comply with the State's current Medicaid plan, amendment, or new plan that may be submitted;

• Reductions must be made uniformly among category of service, to the extent practicable, except where it is determined by the Commissioner of Health that there are grounds for non-uniformity; and

• The exceptions to uniformity include but are not limited to: sustaining safety net services in underserved communities, to ensuring that the quality and access to care is maintained, and to avoiding administrative burden to Medicaid applicants and recipients or providers.

Medicaid expenditures will be reduced through the Medicaid savings allocation plan by the amount of projected overspending through actions including, but not limited to: modifying or suspending reimbursement methods such as fees, premium levels, and rates of payment; modifying or discontinuing Medicaid program benefits; seeking new waivers or waiver amendments.

Institutional Services

• For the state fiscal year beginning April 1, 2011 through March 31, 2012, continues specialty hospital adjustments for hospital inpatient services provided on and after April 1, 2011, 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. Payments to eligible public general hospitals may be added to rates of payment or made as aggregate payments.

• Effective for periods on and after January 1, 2011, for purposes of calculating maximum disproportionate share (DSH) payment distributions for a rate year or part thereof, costs incurred of furnishing hospital services net of medical assistance payments, other than DSH payments, and payments by uninsured patients shall for the 2011 calendar year, be determined initially based on each hospital's submission of a fully completed 2008 DSH hospital data collection tool, which is required to be submitted to the Department, and shall be subsequently revised to reflect each hospital's submission of a fully completed 2009 DSH hospital data collection tool, which is required to be submitted to the Department.

- For calendar years on and after 2012, such initial determinations shall reflect submission of data as required by the Commissioner on a specific date. All such initial determinations shall subsequently be revised to reflect actual rate period data and statistics. Indigent care payments will be withheld in instances when a hospital has not submitted required information by the due dates, provided, however, that such payments shall be made upon submission of such required data.

- For purposes of eligibility to receive DSH payments for a rate year or part thereof, the hospital inpatient utilization rate shall be determined based on the base year statistics and costs incurred of furnishing hospital services determined in accordance with the established methodology that is consistent with all federal requirements.

• Extends through December 31, 2014, the authorization to distribute Indigent Care and High Need Indigent Care disproportionate share payments in accordance with the previously approved methodology.

• For state fiscal years beginning April 1, 2011, and for each state fiscal year thereafter, additional medical assistance payments for inpatient hospital services may be made to public general hospitals operated by the State of New York or the State University of New York, or by a county which shall not include a city with a population over one million, and those public general hospitals located in the counties of Westchester, Erie, or Nassau, up to one hundred percent (100%) of each such public hospital's medical assistance and uninsured patient losses after all other medical assistance, including disproportionate share payments to such general hospitals. Payments may be added to rates of payment or made as aggregate payments. Payments will be based initially on reported reconciled data from the base year two years prior to the payment year adjusted for authorized Medicaid rate changes and further reconciled to actual reported data from such payment year.

• Public general hospitals, other than those operated by the State of New York or the State University of New York, that are located in a city with a population of over one million may receive additional medical assistance DSH payments for inpatient hospital services for the state fiscal year beginning April 1, 2011 through March 31, 2012, and annually thereafter, in the amount of up to $120 million, as further increased by up to the maximum payment amounts permitted under sections 1923(f) and (g) of the federal Social Security Act, as determined by the Commissioner of Health after application of all other disproportionate share hospital payments. Payments may be added to rates of payment or made as aggregate payments. Payments will be based initially on reported reconciled data from the base year two years prior to the payment year adjusted for authorized Medicaid rate changes and further reconciled to actual reported data from such payment year.

• Extends current provisions to services on and after April 1, 2011, 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 State proposes to extend, effective April 1, 2011, and thereafter, certain cost containment initiatives that were enacted in Chapter 81 of the Laws of 1995 and extended by subsequent legislation. The extended provisions are as follows: (1) hospital capital costs shall exclude 44% of major moveable equipment costs; (2) elimination of reimbursement of staff housing operating and capital costs; and (3) budgeted capital inpatient costs of a general hospital applicable to the rate year shall be decreased to reflect the percentage amount by which the budgeted costs for capital related inpatient costs of the hospital for the base year two years prior to the rate year exceeded actual costs.

• Per federal requirements, the Commissioner of Health shall promulgate regulations effective July 1, 2011 that will deny Medicaid payment for costs incurred for hospital acquired conditions (HACs). The regulations promulgated by the Commissioner shall incorporate the listing of Medicaid HACs in the yet to be issued final federal rule.

• The Commissioner of Health shall promulgate regulations to incorporate quality related measures pertaining to potentially preventable conditions and complications, including, but not limited to, diseases or complications of care acquired in the hospital and injuries sustained in the hospital.

• Effective April 1, 2011, hospital inpatient rates of payment for cesarean deliveries will be limited to the average Medicaid payment for vaginal deliveries. All cesarean claims will be subject to an appeal process to determine if the services were medically necessary thus warranting the higher Medicaid payment.

• Effective April 1, 2011, the Department is proposing to expand the current Patient Centered Medical Home (PCMH) to more payers and incorporate several provisions to improve medical care. Two provisions result in a change in the methods by which Medicaid fee-for-service (FFS) reimburses Medicaid providers who are designated by the National Committee for Quality Assurance as patient centered medical homes: 1) testing new models of payment to high-volume Medicaid primary care medical home practices which incorporate risk-adjusted global payments with care management and pay-for-performance, and 2) improving the relationship of FFS Medicaid members to medical homes by creating medical home payments only for FFS members who have evidence of ongoing continuity relationship with provider/practice and providing more reliable care manage-

ment payments to those providers which are independent of specific visit types. These provisions require the following changes to Medicaid:

- New models of reimbursement to high-volume Medicaid providers will be tested which may incorporate risk-adjusted global payments and pay-for-performance. Risk-adjusted payment models will differentially reimburse providers based on their historical case mix. Pay-for-performance will provide enhanced reimbursement to providers who provide high-quality care (such as improved preventative screenings) and/or reduce unnecessary utilization (such as a reduction in admissions for ambulatory sensitive conditions) as defined by standardized measures of performance; and

- Eligible Medicaid fee-for-service recipients, who are currently receiving care from a certified PCMH provider, as determined by an attribution methodology developed by the Commissioner of Health, will be assigned to this PCMH provider. Medicaid FFS will reimburse PCMH providers a per member per month (PMPM) capitation payment for FFS recipients attributed to their practices to provide the necessary care coordination and disease management services.

• Effective April 1, 2011, for inpatient hospital services the commissioner may grant approval of temporary adjustments to Medicaid rates to provide assistance to accommodate additional patient services requirements resulting from the closure, merger or reconfiguration of other hospitals in the area. Such rate increases would enable the surviving hospital to cover costs, including but not limited to additional staff, service reconfiguration, transfer of medical residents to other programs, increased patient volume, and enhancing information technology (IT) systems.

• The institutional cost report shall no longer be required to be certified by an independent licensed public accountant effective with cost reports filed with the Department of Health for cost reporting years ending on or after December 31, 2010. Effective for the same time periods, the Department will have authority to audit such cost reports.

Long Term Care Services

• Effective for periods on and after July 1, 2011, Medicaid rates of payments for inpatient services provided by residential health care facilities (RHCF), which as of April 1, 2011, operate discrete units for treatment of residents with Huntington's disease, and shall be increased by a rate add-on. The aggregate amount of such rate add-ons for the periods July 1, 2011 through December 31, 2011 shall be $850,000 and for calendar year 2012 and each year thereafter, shall be $1.7 million. Such amounts shall be allocated to each eligible RHCF proportionally, based on the number of beds in each facility's discrete unit for treatment of Huntington's disease relative to the total number of such beds in all such units. Such rate add-ons shall be computed utilizing reported Medicaid days from certified cost reports as submitted to the Department for the calendar year period two years prior to the applicable rate year and, further, such rate add-ons shall not be subject to subsequent adjustment or reconciliation.

• For state fiscal years beginning April 1, 2011, and thereafter, 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 $300 million. The amount allocated to each eligible public RHCF will be in accordance with the previously approved methodology. Payments to eligible RHCF's may be added to rates of payment or made as aggregate payments.

• Continues, effective for periods on or after April 1, 2011, 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.

• Continues, effective April 1, 2011, and thereafter, the provision that rates of payment for RHCFs shall not reflect trend factor projections or adjustments for the period April 1, 1996 through March 31, 1997.

• Extends current provisions to services on and after April 1, 2011, 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%.

• Continues, effective April 1, 2011, and thereafter, long-term care Medicare maximization initiatives.

• Effective April 1, 2011, for inpatient services provided by residential health care facilities (RHCFs), the commissioner may grant approval of temporary adjustments to Medicaid rates to provide assistance to accommodate additional patient services requirements resulting from the closure, merger or reconfiguration of other providers in the area. Such rate increases would enable the surviving RHCF to cover costs, including but not limited to additional staff, service reconfiguration, transfer of medical residents to other programs, increased patient volume, and enhancing information technology (IT) systems.

• The regional pricing methodology previously approved to be effective July 1, 2011 for inpatient services provided by residential health care facilities is repealed and replaced with a Statewide pricing methodology to be effective July 1, 2011.

- The Statewide pricing methodology for the non-capital component of the rates of payment for inpatient services provided by residential health care facilities shall utilize allowable operating costs for a base year, as determined by the Commissioner of Health by regulation, and shall reflect:

• A direct statewide price component adjusted by a wage equalization factor and subject to a Medicaid-only case mix adjustment.

• An indirect statewide price component adjusted by a wage equalization factor; and

• A facility specific non-comparable component.

- The non-capital component of the rates for AIDS facilities or discrete AIDS units within facilities; discrete units for residents receiving care in a long-term inpatient rehabilitation program for traumatic brain injured persons; discrete units providing specialized programs for residents requiring behavioral interventions; discrete units for long-term ventilator dependent residents; and facilities or discrete units within facilities that provide extensive nursing, medical, psychological and counseling support services solely to children shall be established pursuant to regulations.

The Commissioner of Health may promulgate regulations to implement the provisions of the methodology and such regulations may also include, but not be limited to, provisions for rate adjustments or payment enhancements to facilitate the transition of facilities to the rate-setting methodology and for facilitating quality improvements in residential health care facilities.

• Effective April 1, 2011, the capital cost component of Medicaid rates of payment for services provided by residential health care facilities shall not include any payment factor for return on or return of equity or for residual reimbursement.

• Effective January 1, 2012, payments for reserved bed days for temporary hospitalizations, for Medicaid eligible residents aged 21 and older, shall only be made to a residential health care facility if at least fifty percent of the facility's residents eligible to participate in a Medicare managed care plan are enrolled in such a plan. Payments for these reserved bed days will be consistent with current methodology.

Non-Institutional Services

• For State fiscal years beginning April 1, 2011 through March 31, 2012, continues hospital outpatient payment adjustments that increase the operating cost components of rates of payment for hospital outpatient and emergency departments 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 eligibility criteria remain unchanged. The amount to be paid will be up to $287 million annually. Payments to eligible public general hospitals may be added to rates of payment or made as aggregate payments.

• Effective April 1, 2011, the Office of Mental Health, the Office of

Alcoholism and Substance Abuse Services, and the Office for People with Developmental Disabilities will each establish utilization standards or thresholds for their voluntary-operated clinics. These standards or thresholds will target excessive utilization and will be either patient-specific or provider-specific, at the option of the controlling State agency. The standards or thresholds will be established based on normative provider visit volume for the clinic type, as determined by the controlling State agency. The Commissioner of Health may promulgate regulations, including emergency regulations, to implement these standards.

• Effective April 1, 2011, claims submitted by clinics licensed under Article 28 of New York State Public Health Law will receive an enhanced Medicaid payment for federally designated family planning services.

• Effective for the period April 1, 2011 through March 31, 2012 and each state fiscal year thereafter, the Department of Health is authorized to make supplemental payments for services provided by physicians, nurse practitioners and physician assistants who participate in a plan for the management of clinical practice at the State University of New York. Fees for these professional services shall be increased by an amount equal to the average commercial or Medicare rate that would otherwise be received for such services rendered by physicians, nurse practitioners and physician assistants. Such included payments may be added to such professional fees or made as aggregate lump sum payments made to eligible clinical practice plans.

• Effective for the period April 1, 2011 through March 31, 2012 and each state fiscal year thereafter, the Department of Health is authorized to make supplemental payments for services provided by physicians, nurse practitioners and physician assistants who are employed by non-state operated public general hospitals operated by a public benefit corporation located in a city of more than one million persons or at a facility of such public benefit corporation as a member of a practice plan under contract to provide services to patients of such a public benefit corporation. Fees for these professional services shall be increased by an amount equal to the average commercial or Medicare rate that would otherwise be received for such services rendered by physicians, nurse practitioners and physician assistants, provided, however, that such supplemental fee payments shall not be available with regard to services provided at facilities participating in the Medicare Teaching Election Amendment. Such included payments may be added to such professional fees or made as aggregate lump sum payments.

• Effective April 1, 2011, hospitals that voluntarily reduce excess staffed bed capacity in favor of expanding the State's outpatient, clinic, and ambulatory surgery services capacity may request and receive a temporary rate enhancement under the ambulatory patient groups (APG) methodology.

• Extends current provisions to services on and after April 1, 2011, 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%.

• Continues, effective April 1, 2011, and thereafter, certain cost containment initiatives currently in effect for Medicaid rates of payments. These are as follows: diagnostic and treatment center and certified home health agency administrative and general cost reimbursement limits; home health care Medicare maximization initiatives; hospital outpatient and emergency department reimbursement reductions attributable to exclusion of 44% of major moveable equipment capital costs; and elimination of staff housing costs.

• The current authority to adjust Medicaid rates of payment for personal care services, provided in local social services districts which include a city with a population of over one million persons and distributed in accordance with memorandums of understanding entered into between the State and such local districts for purpose of supporting recruitment and retention of personal care service workers has been extended for the period April 1, 2011 through March 31, 2014. Payments for the periods April 1, 2011 through March 31, 2012; April 1, 2012 through March 31, 2013; and April 1, 2013 through March 31, 2014, shall not exceed, in the aggregate, $340 million for each applicable period.

• The current authority to adjust Medicaid rates of payment for personal care services, provided in local social services districts which shall not include a city with a population of over one million persons, for purpose of supporting recruitment and retention of personal care service workers has been extended for the period April 1, 2011 through March 31, 2014. Payments for the period April 1, 2011 through March 31, 2012; April 1, 2012 through March 31, 2013; and April 1, 2013 through March 31, 2014, shall not exceed, in the aggregate, $28.5 million for each applicable period.

• The current authority to adjust Medicaid rates of payment for certified home health agencies, AIDS home care programs, and hospice programs for purposes of supporting recruitment and retention of non-supervisory health care workers or any worker with direct patient care responsibility has been extended for the period April 1, 2011 through March 31, 2014. Payments shall not exceed in the aggregate, $100 million for each of the following periods: April 1, 2011 through March 31, 2012; April 1, 2012 through March 31, 2013; and April 1, 2013 through March 31, 2014, and shall be calculated in accordance with the previously approved methodology. Such adjustments to rates of payment shall be allocated proportionally based on each certified home health agency's, AIDS home care and hospice programs' home health aide or other direct care services total annual hours of service provided to Medicaid patients, as reported in each such agency's most recently available cost report as submitted to the Department. Payments made shall not be subject to subsequent adjustment or reconciliation.

• Effective April 1, 2011, for the period April 1, 2011 through June 30, 2011, medical assistance rates of payment to residential health care facilities and diagnostic treatment centers licensed under Article 28 of the Public Health Law for adult day health care services provided to registrants with acquired immunodeficiency syndrome (AIDS) or other human immunodeficiency virus (HIV) related illnesses, shall be increased by an aggregated amount of $1,867,000. Such amount shall be allocated proportionally among such providers based on the medical assistance visits reported by each provider in the most recently available cost reports, submitted to the Department by January 1, 2011. Such adjustments shall be included as adjustments to each provider's daily rate of payment for such services and shall not be subject to subsequent adjustment or reconciliation.

- Effective April 1, 2011, for the period April 1, 2011 through June 30, 2011, rates of payment to residential health care facilities and diagnostic treatment centers licensed under Article 28 of the Public Health Law for adult day health care services provided to registrants with acquired immunodeficiency syndrome (AIDS) or other human immunodeficiency virus (HIV) related illnesses, shall reflect an adjustment to such rates of payment in an aggregate amount of $236,000. Such adjustments shall be distributed proportionally as rate add-ons, based on each eligible provider's Medicaid visits as reported in such provider's most recently available cost report as submitted to the Department prior to January 1, 2011, and provided further, such adjustments shall not be subject to subsequent adjustment or reconciliation.

• Effective April 1, 2011 through March 31, 2012, Medicaid rates of payment for services provided by certified home health agencies (except for such services provided to children under eighteen years of age and other discrete groups as may be determined by the Commissioner of Health) shall reflect agency ceiling limitations. In the alternative, and at the discretion of the Commissioner, such ceilings may be applied to payments for such services.

- The agency ceilings shall be applied to payments or rates of payment for certified home health agency services as established by applicable regulations and shall be based on a blend of:

• an agency's 2009 average per patient Medicaid claims, weighted at a percentage as determined by the Commissioner; and

• the 2009 statewide average per patient Medicaid claims adjusted by a regional wage index factor and an agency patient case mix index, weighted at a percentage as determined by the Commissioner.

- An interim payment or rate of payment adjustment effective April 1, 2011 shall be applied to agencies with projected average per patient Medicaid claims, as determined by the Commissioner, to be over their

ceilings. Such agencies shall have their payments or rates of payment reduced to reflect the amount by which such claims exceed their ceilings.

- The ceiling limitations shall be subject to retroactive reconciliation and shall be based on a blend of:

• agency's 2009 average per patient Medicaid claims adjusted by the percentage of increase or decrease in such agency's patient case mix from the 2009 calendar year to the annual period April 1, 2011 through March 31, 2012, weighted at a percentage as determined by the Commissioner, and

• the 2009 statewide average per patient Medicaid claims adjusted by a regional wage index factor and the agency's patient case mix index for the annual period April 1, 2011 through March 31, 2012, weighted at a percentage as determined by the Commissioner.

- Such adjusted agency ceiling shall be compared to actual Medicaid paid claims for the period April 1, 2011 through March 31, 2012. In those instances when:

• An agency's actual per patient Medicaid claims are determined to exceed the agency's adjusted ceiling, the amount of such excess shall be due from each such agency to the State and may be recouped by the Department in a lump sum amount or through reductions in the Medicaid payments due to the agency.

• An interim payment or rate of payment adjustment was applied to an agency as described above, and such agency's actual per patient Medicaid claims are determined to be less than the agency's adjusted ceiling, the amount by which such Medicaid claims are less than the agency's adjusted ceiling shall be remitted to each such agency by the Department in a lump sum amount or through an increase in the Medicaid payments due to the agency.

- In determining case mix, each patient shall be classified using a system based on measures which may include, but not be limited to, clinical and functional measures, as reported on the federal Outcome and Assessment Information Set (OASIS), as may be amended.

- The Commissioner may require agencies to collect and submit any data, and may promulgate regulations to implement the agency ceilings.

- The payments or rate of payment adjustments described above shall not, as determined by the Commissioner, result in an aggregate annual decrease in Medicaid payments to providers in excess of $200 million.

• Effective April 1, 2012, Medicaid payments for services provided by Certified Home Health Agencies (CHHAs), except for such services provided to children under 18 years of age and other discrete groups, as may be determined by the Commissioner of Health, will be based on episodic payments.

- To determine such episodic payments, a statewide base price will be established for each 60-day episode of care and shall be adjusted by a regional wage index factor and an individual patient case mix index. Such episodic payments may be further adjusted for low utilization cases and to reflect a percentage limitation of the cost for high-utilization cases that exceed outlier thresholds of such payments.

- To achieve savings comparable to the prior state fiscal year, the initial 2012 base year episodic payments will be based on 2009 Medicaid paid claims, as determined by the Commissioner. Such base year adjustments shall be made not less frequently than every three years. However, base year episodic payments subsequent to 2012 will be based on a year determined by the Commissioner that will be subsequent to 2009. Such base year adjustments shall be made not less frequently than every three years.

- In determining case mix, each patient shall be classified using a system based on measures which may include, but not be limited to, clinical and functional measures as reported on the federal Outcome and Assessment Information Set (OASIS).

- The Commissioner may require agencies to collect and submit any data determined to be necessary.

• Effective April 1, 2011, Medicaid rates for services provided by certified home health agencies, or by an AIDS home care program shall not reflect a separate payment for home care nursing services provided to patients diagnosed with Acquired Immune Deficiency Syndrome (AIDS).

• Effective for the period October 1, 2011 through September 30, 2013, pursuant to Section 2703 of the Patient Protection and Affordable Care Act, payments will be made to Managed Long Term Care Plans that have been designated as Health Home providers serving individuals with chronic conditions to cover comprehensive care management, care coordination and health promotion, comprehensive transitional care, patient and family support, referral to community and social support services and the use of health information technology to link services.

• Effective April 1, 2011, the Department is proposing to expand the current Patient Centered Medical Home (PCMH) to more payers and incorporate several provisions to improve medical care. Two provisions result in a change in the methods by which Medicaid fee-for-service (FFS) reimburses Medicaid providers who are designated by the National Committee for Quality Assurance as patient centered medical homes: 1) testing new models of payment to high-volume Medicaid primary care medical home practices which incorporate risk-adjusted global payments with care management and pay-for-performance, and 2) improving the relationship of FFS Medicaid members to medical homes by creating medical home payments only for FFS members who have evidence of ongoing continuity relationship with provider/practice and providing more reliable care management payments to those providers which are independent of specific visit types. These provisions require the following changes to Medicaid.

- New models of reimbursement to high-volume Medicaid providers will be tested which may incorporate risk-adjusted global payments and pay-for-performance. Risk-adjusted payment models will differentially reimburse providers based on their historical case mix. Pay-for-performance will provide enhanced reimbursement to providers who provide high-quality care (such as improved preventative screenings) and/or reduce unnecessary utilization (such as a reduction in admissions for ambulatory sensitive conditions) as defined by standardized measures of performance; and

- Eligible Medicaid fee-for-service recipients, who are currently receiving care from a certified PCMH provider, as determined by an attribution methodology developed by the Commissioner of Health, will be assigned to this PCMH provider. Medicaid FFS will reimburse PCMH providers a per member per month (PMPM) capitation payment for FFS recipients attributed to their practices to provide the necessary care coordination and disease management services.

• Effective October 1, 2011, the Department of Health will update rates paid for Medicaid coverage for preschool and school supportive health services (SSHS). SSHS are provided to Medicaid-eligible students with disabilities in school districts, counties, and State supported § 4201 schools. Payment will be based on a certified public expenditure reimbursement methodology, based on a statistically valid cost study for all school supportive health services and transportation. SSHS are authorized under § 1903(c) of the Social Security Act and include: physical therapy, occupational therapy, speech therapy, psychological evaluations, psychological counseling, skilled nursing services, medical evaluations, medical specialist evaluations, audiological evaluations, and special transportation services.

• Effective April 1, 2011, the Medicaid program is authorized to establish Behavioral Health Organizations (BHOs) to manage behavioral health services. BHOs will be authorized to manage mental health and substance abuse services not currently included in the managed care benefit for Medicaid enrollees in managed care and to facilitate the integration of such services with other health services. The BHOs will also be authorized to manage all mental health and substance abuse services for Medicaid enrollees not in managed care. Behavioral health management will be provided through a streamlined procurement process resulting in contracts with regional behavioral health organizations that will have responsibility for authorizing appropriate care and services based on criteria established by the Offices of Mental Health (OMH) and Alcohol and Substance Abuse Services (OASAS). OMH and OASAS will also be authorized, by April 1, 2013 to jointly designate on a regional basis, a limited number of special needs plans and/or

integrated physical and behavioral health provider systems capable of managing the physical and behavioral health needs of Medicaid enrollees with significant behavioral health needs.

• Effective October 1, 2011, Medicaid will expand coverage of smoking cessation counseling services so that it is available to all Medicaid enrollees. Reimbursement for these services will be available to office based providers, hospital outpatient departments and free-standing diagnostic and treatment centers.

• Effective October 1, 2011 the Department of Health is proposing a change in co-payment policy for Medicaid recipients as permitted in the federal regulations on cost sharing, 42 CFR 447.50 through 447.62. Under this proposal the current copayments will be increased and some services previously exempt from co-payments will be subject to co-payments. The chart below summarizes the current and proposed co-payment structure.

MEDICAID CO-PAYMENTS CURRENT AND PROPOSED

SERVICE OR ITEM	CURRENT AMOUNT	PROPOSED AMOUNT
Clinic Visits	$3.00	$3.40
Brand Name Prescription	$3.00	$3.40
Generic Drug Prescription, and Preferred Brand Name Prescription Drugs	$1.00	$1.15
Over-the-counter Medications	$0.50	$0.60
Lab Tests	$0.50	$0.60
X-Rays	$1.00	$1.15
Medical Supplies	$1.00	$1.15
Overnight Hospital Stays	$25.00 on the last day	$30.00
Emergency Room (for non-emergency room services)	$3.00	$6.40
Additional Services Proposed for Copay		
Eye Glasses	$0.00	$1.15
Eye Exams	$0.00	$1.15
Dental Services	$0.00	$3.40
Audiologist	$0.00	$2.30
Physician Services	$0.00	$3.40
Nurse Practitioner	$0.00	$2.30
Occupational Therapist	$0.00	$2.30
Physical Therapist	$0.00	$3.40
Speech Pathologist	$0.00	$3.40
Annual (SFY) Maximum Limit	$200.00	$300.00

- Other provisions on co-payments as stated in the § 360-7.12 of New York State Social Services Law remain unchanged. The providers of such services may charge recipients the co-payments. However, providers may not deny services to recipients because of their inability to pay the co-payments.

- The following recipients are exempt from co-payments:

• Recipients younger than 21 years of age;

• Recipients who are pregnant;

• Residents of an adult care facility licensed by the New York State Department of Health (for pharmacy services only);

• Residents of a nursing home;

• Residents of an Intermediate Care Facility for the Developmentally Disabled (ICF/DD);

• Residents of an Office of Mental Health (OMH) or Office of People with Developmental Disabilities (OPWDD) certified Community Residence;

• Enrollees in a Comprehensive Medicaid Case Management (CMCM) or Service Coordination Program;

• Enrollees in an OMH or OMRDD Home and Community Based Services (HCBS) Waiver Program; and

• Enrollees in a Department of Health HCBS Waiver Program for Persons with Traumatic Brain Injury (TBI).

- The following services are exempt from co-payments:

• Emergency services;

• Family Planning;

• Drugs to treat mental illness; and

• Services provided through managed care plans.

• Physical therapy, occupational therapy, and speech-language pathology are federal optional Medicaid services. New York State Medicaid presently covers these rehabilitation services with no limits. In order to eliminate delivery of excessive and/or unnecessary services, effective October 1, 2011, the New York State Medicaid Program is establishing utilization limits for the provision of these rehabilitation services. Enrollees will be permitted to receive up to a maximum of 20 visits in a 12 month period each for physical therapy, occupational therapy, and speech-language pathology. The utilization limits will apply to services provided by practitioners in private practice settings as well as for services provided in Article 28 certified hospital outpatient departments and diagnostic and treatment centers (free-standing clinics). The service limits will not apply to services provided in hospital inpatient settings, skilled nursing facilities, or in facilities operated by the Office of Mental Health or the Office of Persons with Developmental Disabilities. Additionally, the utilization limits will not apply for services provided to Medicaid enrollees less than 21 years of age enrollees who are developmentally disabled or to enrollees with specified chronic medical/physical conditions.

• Federal rules allow states the option of reducing coinsurance amounts at their discretion. Effective October 1, 2011, the Department of Health will change the cost-sharing basis for Medicare Part B payments. Currently, New York State Medicaid reimburses practitioners the full or partial Medicare Part B coinsurance amount for enrollees who have both Medicare and Medicaid coverage (the dually-eligible). Medicaid reimburses the Medicare Part B coinsurance, regardless of whether or not the service is covered by Medicaid. Upon federal approval of the proposed state plan change, Medicaid will no longer reimburse practitioners for the Medicare Part B coinsurance for those services that are not covered for a Medicaid-only enrollee. Medicaid presently reimburses Article 28 certified clinics (hospital outpatient departments and diagnostic and treatment centers) the full Medicare Part B coinsurance amount. The full coinsurance is paid by Medicaid, even if the total Medicare and Medicaid payment to the provider exceeds the amount that Medicaid would have paid if the enrollee did not have both Medicare and Medicaid coverage. Under the new reimbursement policy, Medicaid will provide payment for the Medicare Part B coinsurance amount, but the total Medicare/Medicaid payment to the provider will not exceed the amount that the provider would have received if the patient had Medicaid-only coverage. Therefore, if the Medicare payment exceeds what Medicaid would have paid for the service, no coinsurance will be paid by Medicaid. Practitioners and clinics will be required to accept the total Medicare and Medicaid payment (if any) as full payment for services. They will be prohibited from billing the Medicaid recipient.

• Effective October 1, 2011, the Department of Health, in collaboration with the Office of Mental Health, the Office of Alcohol and Substance Abuse Services, and the Office for People with Developmental Disabilities, will be authorized to begin Medicaid coverage for health home services to high cost, high need enrollees. Health home services include comprehensive care coordination for medical and behavioral health services, health promotion, transitional care, including appropriate follow-up from inpatient to other settings, patient and family support, referral to community and social support services, and use of health information technology to link services.

- High risk patients will be assigned to provider networks meeting state and federal health home standards (on a mandatory or opt out basis) for the provision of health home services.

- These services will range from lower intensity patient tracking to higher intensity care/service management depending on patient needs.

The provision of coordinated, integrated physical and behavioral health services will be critical components of the health home program. Strong linkages to community resources will be a health home requirement. Use of peer supports will be explored to help enrollees in the community cope with their medical and behavioral health conditions. The Managed Addiction Treatment Program (MATS), which manages access to treatment for high cost, chemically dependent Medicaid enrollees, will be expanded. Health home payment will be based on a variety of reimbursement methodologies including care coordination fees, partial and shared risk. The focus of the program will be reducing avoidable hospitalizations, institutionalizations, ER visits, and improving health outcomes.

- Payment methodologies for health home services shall be based on factors including, but not limited to, complexity of conditions providers will be managing, the anticipated amount of patient contact needed to manage such conditions, and the health care cost savings realized by provision of health home services.

- The Commissioner of Health is authorized to pay additional amounts to providers of health home services that meet process or outcomes standards specified by the Commissioner.

- Through a collaborative effort, the Department of Health, with the Office of Mental Health, Office of Alcohol and Substance Abuse Services, and the Office for People with Developmental Disabilities, will streamline existing program requirements that create barriers to co-locating medical and behavioral health services in licensed facilities to support improved coordination and integration of care.

• Effective for dates of service on and after April 1, 2011, coverage for prescription footwear and footwear inserts and components for adults age 21 and over will be limited to diabetic footwear or when the footwear is attached to a lower limb orthotic brace. This will reduce overutilization of footwear. Effective for dates of service on and after May 1, 2011, the DOH will establish maximum fees for prescription footwear, inserts and components. The fees will be based on an average of industry costs of generically equivalent products.

• Effective for dates of service on and after April 1, 2011, coverage of enteral formula for adults age 21 and over will be limited to formula administered by feeding tube or formula for treatment of an inborn metabolic disease. This will preserve coverage for medical need and eliminate coverage of orally consumed formulas for adults who can obtain nutrients through other means.

• Effective for dates of service on and after April 1, 2011, coverage of compression and support stockings will be limited to treatment of open wounds or for use as a pregnancy support. Coverage of stockings will not be available for comfort or convenience.

• Effective on and after July 1, 2011, the Department will choose selected transportation providers to deliver all necessary transportation of Medicaid enrollees to and from dialysis, at a per trip fee arrived through a competitive bid process. The Department will choose one or more transportation providers in a defined community to deliver necessary transportation of Medicaid enrollees to and from dialysis treatment. The enrollee's freedom to choose a transportation provider will be restricted to the selected provider(s) in the community. Medicaid enrollee access to necessary transportation to dialysis treatment will not be impacted by this change.

Prescription Drugs

• Effective April 1, 2011, the following is proposed:

- For sole or multi-source brand name drugs the Estimated Acquisition Cost (EAC) is defined as Average Wholesale Price (AWP) minus seventeen (17) percent and the Average Acquisition Cost (AAC) will be incorporated into the prescription drug reimbursement methodology;

- The dispensing fees paid for generic drugs will be $3.50; and

- Specialized HIV pharmacy reimbursement rates will be discontinued and a pharmacy previously designated as a specialized HIV pharmacy will receive the same reimbursement as all other pharmacies.

The estimated annual net aggregate decrease in gross Medicaid expenditures attributable to reform and other initiatives contained in the budget for state fiscal year 2011/2012 is $223 million; and the estimated annual net aggregate increase in gross Medicaid expenditures attributable to an extension of pertinent disproportionate share (DSH) and upper payment limit (UPL) payments for state fiscal year 2011/2012 is $1.9 billion.

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

The public is invited to review and comment on this proposed state plan amendment.

For further information and to review and comment, please contact: Department of Health, Bureau of HCRA Operations & Financial Analysis, Corning Tower Bldg., Rm. 984, Empire State Plaza, Albany, NY 12237, (518) 474-1673, (518) 473-8825 (FAX), e-mail: spa_inquires@health.state.ny.us

SALE OF FOREST PRODUCTS

Chenango Reforestation Area No. 1
Contract No. X008135

Pursuant to Section 9-0505 of the Environmental Conservation Law, the Department of Environmental Conservation hereby gives Public Notice for the following:

Sealed bids for 21 tons more or less red pine, 32.6 MBF more or less white ash, 23.6 MBF more or less black cherry, 15.2 MBF more or less red maple, 10.0 MBF more or less sugar maple, 0.3 MBF more or less yellow birch, 0.5 MBF more or less basswood, 0.1 MBF more or less aspen, 233 cords more or less firewood, located on Chenango Reforestation Area No. 1, Stands C-27, D-25 and D-28, will be accepted at the Department of Environmental Conservation, Contract Unit, 625 Broadway, 10th Fl., Albany, NY 12233-5027 until 11:00 a.m. on Thursday, April 7, 2011.

For further information, contact: Robert Slavicek, Supervising Forester, Department of Environmental Conservation, Division of Lands and Forests, Region 7, 2715 State Hwy. 80, Sherburne, NY 13460-4507, (607) 674-4036

SALE OF FOREST PRODUCTS

Lewis Reforestation Area No. 20
Contract No. X008125

Pursuant to Section 9-0505 of the Environmental Conservation Law, the Department of Environmental Conservation hereby gives Public Notice of the following:

Sealed bids for hard maple ST - 134.6 MBF more or less, black cherry ST - 29.5 MBF more or less, white ash ST - 30.9 MBF more or less, red maple ST - 7.7 MBF more or less, yellow birch ST - 5.8 MBF more or less, basswood ST - 6.9 MBF more or less, red oak ST - 2.5 MBF more or less, hemlock - 0.8 MBF more or less, pine pulp - 13 cords more or less, firewood - 626.6 cords more or less, located on Lewis Reforestation Area No. 20, Stands A-7, 8, 15, 17 & 21, will be accepted at the Department of Environmental Conservation, Contract Unit, 625 Broadway, 10th Fl., Albany, NY 12233-5027 until 11:00 a.m., Thursday, April 7, 2011.

For further information, contact: Andrea Mercurio, Senior Forester, Department of Environmental Conservation, Division of Lands and Forests, Region 6, 7327 State Rte. 812, Lowville, NY 13367, (315) 376-3521

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 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 inpatient, long term care, and non-institutional services to comply with recently enacted statutory provisions. The following provides clarification to provisions previously noticed on March 30, 2011, and notification of new significant changes:

All Services

• To clarify the previously noticed provision, the elimination of the trend factor has been revised to be effective on and after April 1, 2011 through March 31, 2013 and no greater than zero trend factors shall be applied. This is also revised to exclude residential health care facilities or units of such facilities that provide services primarily to children under 21 years of age, and to include hospital outpatient services. The annual decrease in gross Medicaid expenditures for state fiscal year 2011/12 is ($56) million.

• To clarify the previously noticed provision regarding the uniform two percent Medicaid payment reduction, the effective period is now April 1, 2011 through March 31, 2013. The annual decrease in gross Medicaid expenditures for state fiscal year 2011/12 is ($517.80) million.

Institutional Services

• Extends current provisions to services for the periods April 1, 2011 through March 31, 2013, 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 State proposes to extend, effective April 1, 2011 through March 31, 2013, certain cost containment initiatives that were enacted in Chapter 81 of the Laws of 1995 and extended by subsequent legislation. The extended provisions are as follows: (1) hospital capital costs shall exclude 44% of major moveable equipment costs; (2) elimination of reimbursement of staff housing operating and capital costs; and (3) budgeted capital inpatient costs of a general hospital applicable to the rate year shall be decreased to reflect the percentage amount by which the budgeted costs for capital related inpatient costs of the hospital for the base year two years prior to the rate year exceeded actual costs.

The annual decrease in gross Medicaid expenditures for state fiscal year 2011/12 is ($7.85) million.

• The Commissioner of Health shall incorporate quality related measures including, potentially preventable re-admissions (PPRs) and other potentially preventable negative outcomes (PPNOs) and provide for rate adjustments or payment disallowances related to same. Such rate adjustments or payment disallowances will be calculated in accordance with methodologies, as determined by the Commissioner of Health, and based on a comparison of the actual and risk adjusted expected number of PPRs and other PPNOs in a given hospital and with benchmarks established by the Commissioner. Such adjustments or disallowances for PPRs and other PPNOs will result in an aggregate reduction in Medicaid payments of no less than $51 million for the period April 1, 2011 through March 31, 2012, provided that such aggregate reductions shall be offset by Medicaid payment reductions occurring as a result of decreased PPRs for the period July 1, 2011 through March 31, 2011, and as a result of decreased PPRs and PPNOs for the period April 1, 2011 through March 31, 2012. The annual decrease in gross Medicaid expenditures, not previously noticed, for state fiscal year 2011/12 is ($4) million.

Long Term Care Services

• Continues, effective April 1, 2011 through March 31, 2013, the provision that rates of payment for RHCFs shall not reflect trend factor projections or adjustments for the period April 1, 1996 through March 31, 1997.

Extends current provisions to services for the periods April 1, 2011 through March 31, 2013, 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%.

Continues, effective April 1, 2011 through March 31, 2013, the long-term care Medicare maximization initiatives.

The annual decrease in gross Medicaid expenditures for state fiscal year 2011/12 is ($214) million.

• Effective April 1, 2011, for inpatient services provided by residential health care facilities (RHCFs), the Commissioner of Health may grant approval of temporary adjustments to Medicaid rates to provide short term assistance to eligible facilities to accommodate additional patient services requirements resulting from the closure of other facilities in the area, including but not limited to additional staff, service reconfiguration, and enhancing information technology (IT) systems.

– Eligible facilities shall submit written proposals demonstrating the need for additional short-term resources and how such additional resources will result in improvements to the cost effectiveness of service delivery; quality of care; and other factors. Written proposals must be submitted to the department at least sixty days prior to the requested effective date of the temporary rate adjustment. The temporary rate adjustment shall be in effect for a specified period of

time and at the end of the specified timeframe, the facility will be reimbursed in accordance with otherwise applicable rate-setting methodologies. The commissioner may establish, as a condition of receiving such a temporary rate adjustment, benchmarks and goals to be achieved in accordance with the facility's approved proposals and may also require that the facility submit periodic reports evaluating the progress made in achieving the benchmarks and goals. Failure to achieve satisfactory progress, as determined by the commissioner, in accomplishing such benchmarks and goals shall be a basis for ending the facility's temporary rate adjustment. The estimated increase in Medicaid expenditures for the rate increases will be offset by the decrease in Medicaid expenditures resulting from the closure of other providers.

• The 2002 rebasing methodology and the 2002 wage equalization factor methodology will be extended and will remain in effect until such time as the Statewide pricing methodology takes effect. Case mix adjustments as scheduled for July 2011 will not be made.

– The regional pricing methodology previously approved to be effective July 1, 2011 for inpatient services provided by residential health care facilities is replaced with a Statewide pricing methodology to be effective on or after October 1, 2011 but no later than January 1, 2012.

– The Statewide pricing methodology for the non-capital component of the rates of payment for inpatient services provided by residential health care facilities shall utilize allowable operating costs for a base year, determined by the Commissioner of Health by regulation, and shall reflect:

•A direct statewide price component adjusted by a wage equalization factor (which shall be periodically updated to reflect current labor market conditions) and other factors to recognize other cost differentials. The direct statewide price shall also be subject to a Medicaid-only case mix adjustment.

•An indirect statewide price component adjusted by a wage equalization factor (which shall be periodically updated to reflect current labor market conditions); and

•A facility specific non-comparable component.

– Such rate components shall be periodically updated to reflect changes in operating costs.

– The non-capital component of the "specialty" rates for AIDS facilities or discrete AIDS units within facilities; discrete units for residents receiving care in a long-term inpatient rehabilitation program for traumatic brain injured persons; discrete units providing specialized programs for residents requiring behavioral interventions; discrete units for long-term ventilator dependent residents; and facilities or discrete units within facilities that provide extensive nursing, medical, psychological and counseling support services solely to children shall be the rates in effect on January 1, 2009, as adjusted for inflation and rate appeals. The AIDS rates in effect January 1, 2009 shall be adjusted to reflect the elimination of the AIDS occupancy factor enacted in 2009. In addition, the trend factors attributable to 2008 and 2009 and included in such specialty rates shall be subject to the residential health care facility cap. The Commissioner may promulgate regulations, including emergency regulations, to implement the provisions of the methodology. The regulations will include provisions for rate adjustments or payment enhancements to facilitate a minimum four year transition of facilities to the methodology and may also include provisions for rate adjustments or payment enhancements to facilitate the transition of facilities to the rate-setting methodology and for facilitating quality improvements in residential health care facilities. The regulations will be developed in consultation with the nursing home industry and advocates for residential health care facility residents. The Commissioner shall notify the Chairs of the Legislative Fiscal Committees and Health Committees in the Senate and the Assembly of such regulations. There is no increase or decrease in gross Medicaid expenditures for state fiscal year 2011/12 (including the $210 million cap).

For the period May 1, 2011 through May 31, 2011, supplemental payments in an amount not to exceed $221.3 million will be made to eligible residential health care facilities as determined by the Commissioner of Health, which experienced a net reduction in their payment rate for the period April 1, 2009 through March 31, 2011 as a result of the 2002 rebasing methodology, Medicaid only case mix methodology, and the application of proportional adjustments required to be made by the application of the residential health care facility (RHCF) cap. In determining the net reduction, the impact of case mix adjustments applicable to July 2010 and certain rate adjustments processed for payment after October 19, 2010 will be disregarded by the Commissioner. The following facilities, as determined by the Commissioner, are eligible for such supplemental payments.

– Facilities which were eligible for Financially Disadvantaged distributions for the 2009 period; non- government owned or operated facilities whose total operating losses equal or exceed five percent of total operating revenue and whose Medicaid utilization equals or exceeds 70 percent (based on either their 2009 cost report or their most recently available cost report); and pediatric facilities or distinct units, which will receive a supplemental payment that is equal to 100 percent of the net reduction determined above.

– Eligible facilities, other than those described in the previous paragraph above will receive supplemental payments equal to 50 percent of their net reduction. Eligible facilities which after the application of these rate adjustments that remain subject to a net reduction in their inpatient Medicaid revenue which is in excess of two percent (as measured with regard to the non-capital components of facility inpatient rates in effect on March 31, 2009 computed prior to the application of trend factor adjustments attributable to the 2008 and 2009 calendar years), will have their payments further adjusted so that the net reduction does not exceed two percent. Eligible facilities which have experienced a net reduction in their inpatient rates of more than $6 million over the period April 1, 2009 through March 31, 2011, as a result of the application of proportional adjustments required to be made by the application of the RHCF cap, will have their payments further adjusted so that their net reduction is reduced to zero.

The supplemental payments previously described will not be subject to subsequent adjustment or reconciliation and will be disregarded for purposes of calculating the limitations on Medicaid rates required by the application of the residential health care facility cap.

Additional rate adjustments, in the form of rate add-ons, will be made to the eligible facilities previously described for the period May 1, 2011 through May 31, 2011 in an aggregate amount equal to 25% of the payments previously described (or 25% of $221.3 million which equals $55.3 million). The payments will be distributed to eligible facilities in the same proportion as the total $221.3 million of distributions made to each eligible facility.

The Commissioner may, with the approval of the Director of the Budget, and subject to the identification of sufficient nursing home related Medicaid savings to offset the expenditures authorized by this paragraph, make additional rate adjustments, in the form of rate add-ons, to the eligible facilities previously described, for the rate periods December 1, 2011 through December 31, 2012 in an aggregate amount equal to 12.5% of the payments previously described (or 12.5% of $221.3 million which equals about $27.7 million).

The annual increase in gross Medicaid expenditures for state fiscal year 2011/12 is $304.30 million.

• For the rate period April 1, 2011 through June 30, 2011 the non-capital component of residential health care facility rates will be subject to a uniform percentage reduction sufficient to reduce rates by $27.1 million. The dollar amount of this uniform reduction will be disregarded for purposes of calculating the limitations on Medicaid rates required by the application of the RHCF cap. The annual decrease in gross Medicaid expenditures for state fiscal year 2011/12 is ($27.1) million.

• Facilities that receive a Financially Disadvantaged (FD) payment, for the period May 1, 2010 through April 30, 2011, shall have their Medicaid rates for the rate period December 1, 2011 through December 31, 2011 reduced by an amount equal to such FD payments. FD payments made for the annual period May 1, 2011 through April 30, 2012, shall not be made. The annual decrease in gross Medicaid expenditures for state fiscal year 2011/12 is ($60) million.

• Effective April 1, 2011, the capital cost component of Medicaid rates of payment for services provided by RHCFs may not include any

payment factor for return on or return of equity, or for residual reimbursement. In addition, provisions authorizing adjustments to the capital cost component of rates for proprietary facilities that would otherwise be eligible for residual reimbursement to take into account any capital improvements and/or renovations made to the facility's existing infrastructure for the purpose of converting beds to alternative long-term care uses or protecting the health and safety of patients are repealed. The annual decrease in gross Medicaid expenditures for state fiscal year 2011/12 is ($64) million.

Non-institutional Services

• Revision to the methodology used to establish peer groups for Federally Qualified Health Centers (FQHC's) to align the counties considered upstate and downstate with those used for the ambulatory care groups' methodology. The grouping methodology is used to determine reasonable costs for FQHC's in their respective region. The downstate region is defined as all counties comprising New York City, Nassau, Suffolk, Richmond, Westchester, Rockland, Putnam, Orange and Dutchess. All other counties are considered upstate. The annual increase in gross Medicaid expenditures for state fiscal year 2011/12 is $4.8M.

• Effective for the period April 1, 2011 through March 31, 2012, early intervention program rates for approved services rendered on and after April 1, 2011 shall be reduced by five percent. The annual decrease in gross Medicaid expenditures for state fiscal year 2011/12 is ($13) million.

Effective for the period April 1, 2011 through March 31, 2012, early intervention program rates for home and community based rates for approved services rendered on and after April 1, 2011 shall be adjusted to reflect updated wage equalization factors and overhead adjustments. The annual decrease in gross Medicaid expenditures for state fiscal year 2011/12 is ($2) million.

Effective July 1, 2011 early intervention program rates for home and community based rates for approved services rendered on and after July 1, 2011 shall be adjusted to reflect 15 minute billing increments. The annual decrease in gross Medicaid expenditures for state fiscal year 2011/12 is ($3) million.

• To clarify the previously noticed provision, the uniform payment reduction will not apply to physicians, nurse practitioners, midwives and dentists in the office setting; or to free-standing clinics and free-standing ambulatory surgery centers. The $37.5M balance of the ambulatory patient group investment will be reduced on April 1, 2011 to cover the cost of this exemption. The annual decrease in gross Medicaid expenditures for state fiscal year 2011/12 is ($12.3) million, and is included in the overall fiscal cited for the uniform across the board reduction under all services.

• Extends current provisions to services for the periods April 1, 2011 through March 31, 2011, 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%.

Continues, effective April 1, 2011 through March 31, 2011, certain cost containment initiatives currently in effect for Medicaid rates of payments. These are as follows: diagnostic and treatment center and certified home health agency administrative and general cost reimbursement limits; home health care Medicare maximization initiatives; hospital outpatient and emergency department reimbursement reductions attributable to exclusion of 44% of major moveable equipment capital costs; and elimination of staff housing costs.

The annual decrease in gross Medicaid expenditures for state fiscal year 2011/12 is ($53.73) million.

• Physical therapy, occupational therapy, and speech-language pathology are federal optional Medicaid services. New York State Medicaid presently covers these rehabilitation services with no limits. In order to eliminate delivery of excessive and/or unnecessary services, effective October 1, 2011, the New York State Medicaid Program is establishing utilization limits for the provision of these rehabilitation services. Enrollees will be permitted to receive up to a maximum of 20 visits in a 12 month period each for physical therapy, occupational therapy, and speech-language pathology. The utilization limits will apply to services provided by practitioners in private practice settings as well as for services provided in Article 28 certified hospital outpatient departments and diagnostic and treatment centers (free-standing clinics). The service limits will not apply to services provided in hospital inpatient settings, skilled nursing facilities, or in facilities operated by the Office of Mental Health or the Office of Persons with Developmental Disabilities. Additionally, the utilization limits will not apply for services provided to Medicaid enrollees less than 21 years of age or to enrollees who are developmentally disabled. The annual decrease in gross Medicaid expenditures for state fiscal year 2011/12 is ($4.94) million.

• Effective for dates of service on and after May 1, 2011, coverage of enteral formula and nutritional supplements for adults age 21 and over will be limited to formula administered by feeding tube or formula for treatment of an inborn metabolic disease, or to address growth and development problems in children. This will preserve coverage for medical need and eliminate coverage of orally consumed formulas for adults who can obtain nutrients through other means. The annual decrease in gross Medicaid expenditures for state fiscal year 2011/12 is ($30.8) million.

The estimated annual net aggregate decrease in gross Medicaid expenditures attributable to reform and other initiatives contained in the budget for state fiscal year 2011/2012 is ($749.12) million.

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

The public is invited to review and comment on this proposed state plan amendment.

For further information and to review and comment, please contact: Department of Health, Bureau of HCRA Operations and Financial Analysis, Corning Tower Building, Rm. 984, Empire State Plaza, Albany, NY 12237, (518) 474-1673, (518) 473-8825 (FAX), e-mail: spa__inquiries@health.state.ny.us

PUBLIC NOTICE

Department of Health

The Department of Health is proposing to modify its two 1115 waivers, the Partnership Plan (PP) 11-W-00114/2 and the Federal-State Health Reform Partnership (F-SHRP) 11-W-00234/2, as part of a major redesign of New York State's Medicaid program. Changes affecting the State's waiver programs are intended to streamline and maximize enrollment in managed care programs, simplify the program, improve quality of care and reduce costs.

Changes are effective on or after April 1, 2011, as indicated.

A. Expand Medicaid Managed Care Enrollment of Non-duals

The State is proposing to amend its federal Social Security Act Section 1115 waivers, the Partnership Plan (PP) 11-W-00114/2 and the Federal-State Health Reform Partnership (F-SHRP) 11-W-00234/2, to expand enrollment in Medicaid managed care programs by requiring some of the populations previously exempt or excluded to enroll in a managed care organization (MCO). Enrollment of the new populations will be phased in over three years beginning July 2011.

Beginning 7/1/11, the following individuals will be required to enroll in a managed care plan:

• Individuals in the Recipient Restriction Program

Beginning 10/1/11, the following individuals will be required to enroll in a managed care plan:

• Individuals who have a relationship with a primary care provider not participating in any MCOs

• Individuals living with HIV (outside of New York City)

• Individuals without a choice of primary care provider within 30 miles or 30 minutes

• Non-SSI adults diagnosed as seriously and persistently mentally ill and non-SSI children diagnosed as severely emotionally disturbed

• Individuals temporarily living outside of their home district

• Pregnant women whose prenatal provider does not participate in any MCOs

• Persons receiving Mental Health Family Care

• Individuals who cannot be served by a managed care provider due to a language barrier.

Beginning 10/1/11, the following exemption from enrollment will be limited to 6 months or the completion of a course of treatment, whichever occurs first:

• Individuals with chronic medical issues under the care of a specialist provider not participating in any MCOs

Beginning 4/1/12, the following individuals will be required to enroll in a managed care plan:

• Individuals enrolled in the Long Term Home Health Care Program (LTHHCP) where capacity exists will have the option to opt out of Mainstream Managed Care and enroll in the Managed Long Term Care program

• Individuals with characteristics and needs similar to those in the LTHHCP

• Individuals with end stage renal disease

• Individuals receiving services through the Chronic Illness Demonstration Program

• Homeless persons

• Infants under 6 months of age who were born weighing under 1200 grams or are disabled

• Adolescents admitted to Residential Rehabilitation Services for Youth (RRSY) programs

Beginning 10/1/12

• Residents of residential health care facilities (nursing homes)

Beginning 4/1/13, the following individuals will be required to enroll in a managed care plan providing program features are in place:

• Residents of an intermediate care facility for the mentally retarded or developmentally disabled (ICF/MR or ICF/DD)

• Individuals with characteristics and needs similar to residents of an ICF/MR

• Individuals receiving services through the Nursing Home Diversion and Transition waiver

• Residents of Long Term Chemical Dependence programs

• Children enrolled in the Bridges to Health (B2H) foster care waiver program

• Non-institutionalized foster care children living in the community

• Individuals receiving services through a Medicaid Home and Community-based Services Waiver (these individuals may enroll while remaining in the waiver program)

• Individuals with characteristics and needs similar to those receiving services through a Medicaid Home and Community-based Services waiver

• Individuals receiving services through a Medicaid Model Waiver waiver (Care at Home) Program (these individuals may enroll while remaining in the waiver program)

• Individuals with characteristics and needs similar to those receiving services through a Medicaid Model Waiver (Care at Home) Program

• Individuals eligible through the Medicaid Buy-In for the Working Disabled (those who pay a premium and those who pay no premium)

• Residents of State-operated psychiatric centers

• Blind or disabled children living separate and apart from their parents for 30 days or more

• Institutional foster care children

B. Streamline the Enrollment Process

Effective on or after 10/1/2011, the State proposes to streamline the enrollment process by standardizing the period during which all beneficiaries may select a plan. New applicants will be required to indicate their choice of plan at the time of application for Medical Assistance (MA), and if they do not choose a plan, they will be auto-assigned to a plan using the existing process. Persons already in receipt of MA will have 30 days from the day the local district or State indicates to choose a plan. If they do not choose a plan within that 30 day window, they will be auto-assigned to a plan. Pregnant women will be required to choose a plan when they apply for presumptive eligibility and will be auto-assigned after 30 days if they fail to do so.

C. Pharmacy "Carve-in" and Other Benefit Changes

Effective on or after 10/1/2011, pharmacy services will be included in the Medicaid managed care and FHPlus benefit packages. For Medicaid managed care only, personal care agency services will become the responsibility of Medicaid managed care plans effective 7/1/2011, and effective 10/1/2012, nursing facility care will be included in the benefit package.

D. Mandatory Enrollment of Medicaid Eligibles in Managed Long Term Care

Effective April 1, 2012 the State will require the transition and enrollment of people who meet the following criteria into Managed Long Term Care (MLTC) plans or other care coordination models approved by the Commissioner of Health: age 21 and older; eligible for Medicare and Medicaid; and, in need of community-based long term care services for more than 120 days. Non-dually eligible disabled adults who meet these criteria will have the option of joining a MLTCP in lieu of an MMC plan. Three MLTC models now operate in New York – the Program of All-Inclusive Care for the Elderly (PACE), Medicaid Advantage Plus (MAP) and partially-capitated plans. Partially capitated plans are expected to be the primary type of plan these individuals will enroll in because there is no requirement for concurrent Medicare enrollment. However, where available and when additional plan-specific enrollment criteria are met, people will have an option to select PACE or MAP as well.

Mandatory enrollment will begin in New York City and be phased-in throughout the rest of the State as plan capacity is developed. People who are in the Assisted Living Program, Nursing Home Transition and Diversion waiver, Traumatic Brain Injury waiver and those served through the Office People with Developmental Disabilities would be exempted from mandatory enrollment in a MLTC program until the State develops appropriate program features for these populations.

Additional information concerning the Partnership Plan and the proposal can be obtained by writing to: Department of Health, Division of Managed Care. Empire State Plaza, Corning Tower, Rm. 1927, Albany, NY 12237

1115 waiver information is also available to the public on–line at www.nyhealth.gov

Written comments concerning extension of the program will be accepted at the above address for a period of thirty (30) days from the date of this notice.

PUBLIC NOTICE

Town of Oyster Bay

On April 12, 2011, by Resolution 365-2011, the Town of Oyster Bay awarded a contract to Winters MSW Holdings, LLC pursuant to section one hundred twenty-w of the general municipal law for the transfer, haul and disposal of solid wastes from the Town of Oyster Bay Solid Waste Disposal District. The validity of this contract or the procedures which led to its award may be hereafter contested only by action, suit or proceeding commenced within sixty days after the date of this notice and only upon the ground or grounds that: (1) such award or procedure was not authorized pursuant to that section, or (2) any of the provisions of that section which should be complied with at the date of this publication have not been substantially complied with, or (3) a conflict of interest can be shown in the manner in which the contract was awarded; or by action, suit or proceeding commenced on the grounds that such contract was awarded in violation of the provisions of the Constitution.

PUBLIC NOTICE

Department of State

F-2011-0008

Date of Issuance - April 27, 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 applicant has certified that the proposed activity complies with and will be conducted in a manner consistent with the approved New York State Coastal Management Program. The applicant's consistency certification and accompanying public 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-2011-0008, Verdant Power, LLC (Verdant) has applied to the Federal Energy Regulatory Commission (FERC), for a ten year hydrokinetic pilot license to install, operate and maintain up to 30, 5 meter diameter kinetic hydropower system 35 kW generators mounted on ten triframe mounts, as well as associated facilities, in the East Channel of the East River at Roosevelt Island, City of New York, New York County. Verdant Power, LLC proposes a phased approach and anticipates installing 3 units on 1 triframe during the third quarter of 2012, 6-9 additional units on 2-3 triframes during the third quarter of 2013 and the remaining units and triframes during the third quarter of 2014.

The stated purpose of the above mentioned proposal is "to generate up to 1 MW of emission-free electricity from the tides of the East River for delivery to New York City customers."

Verdant Power LLC's application materials are available at the Department of State's Albany office. Verdant's federal application materials are available at http://www.ferc.gov/docs-filing/elibrary.asp under docket # P-12611.

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., 30 days from the date of publication of this notice, or, May 27, 2011.

Comments should be addressed to: Division of Coastal Resources, Department of State, 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

Department of State

Notice of Review for the Town of Southold

Draft Local Waterfront Revitalization Program Amendment

A draft amendment to the Town of Southold Local Waterfront Revitalization Program (LWRP) has been prepared pursuant to provisions of the New York State Waterfront Revitalization of Coastal Areas and Inland Waterways Act and the New York State Coastal Management Program (NYS CMP).

The LWRP serves as a comprehensive management program for the Town's Long Island Sound, Fishers Island Sound, Block Island Sound, Gardiners Bay and Peconic Bay waterfront resources, and was approved by the New York State Secretary of State on May 10, 2005 and incorporated into the State Coastal Management Program on November 2, 2005.

A major component of the State's CMP and the Waterfront Revitalization and Coastal Resources Act (Article 42 of the NYS Executive Law) involves designation of coastal fish and wildlife habitats which are significant due to ecosystem rarity, vulnerable species, human use, population levels, or replaceability. The CMP calls for areas so designated to be protected, preserved, and where practical, restored so as to maintain their viability as habitats.

In 2005, upon approval of the Secretary of State, the descriptions and narratives for a number of existing Significant Coastal Fish and Wildlife Habitats (SCFWH) located in Long Island Sound and Peconic Bay were revised to better reflect current conditions, and new SCFWHs were also designated. All of the changes to the Long Island Sound and Peconic Bay SCFWHs were incorporated into the New York State Coastal Management Program (CMP), as a Routine Program Implementation Action. This LWRP amendment reflects the modifications to the SCFWHs located within the Town of Southold's coastal area, such as revisions to the habitat narratives and boundaries of the Mattituck Inlet Wetlands and Beaches, and Fishers Island Beaches/ Pine Islands and Shallows SCFWHs, and the inclusion of the Goldsmith Inlet and Beach, Pipes Cove Creek and Moores Drain, and Dumpling Islands and Flat Hammock as new SCFWHs. This amendment also reflects revisions to Chapter 268 of Southold's Town Code (Waterfront Consistency Review) which will strengthen the ability of the Town to implement the LWRP by assuring that Town actions are undertaken in a manner consistent to the maximum extent practicable with the LWRP.

Upon approval by the Secretary of State, the Department of State intends to request the incorporation of the Southold LWRP amendment into the NYS CMP.

To approve this amendment to the Southold LWRP, pursuant Article 42 of the NYS Executive Law, it is required that potentially affected State, federal, and local agencies be consulted to assure that it does not conflict with existing policies and programs. For this purpose, the draft Southold LWRP amendment is available online, at http://nyswaterfronts.com/LWRP.asp. The draft LWRP amendment was accepted by the New York State Department of State as complete and is now available for review by potentially affected State, federal, and local agencies and the general public. Comments on the draft LWRP amendment are due by May 20, 2011.

Comments on the Draft Town of Southold LWRP amendment should be submitted by May 20, 2011 to: Kevin Millington, Department of State, Office of Coastal, Local Government and Community Sustainability, 99 Washington Ave., Suite 1010, Albany, NY 12231-0001, (518) 473-2479

PUBLIC NOTICE

Department of State

Proclamation

Revoking Limited Liability Partnerships

WHEREAS, Article 8-B of the Partnership Law, requires registered limited liability partnerships and New York registered foreign limited liability partnerships to furnish the Department of State with a statement every five years updating specified information, and

WHEREAS, the following registered limited liability partnerships and New York registered foreign limited liability partnerships have not furnished the department with the required statement, and

WHEREAS, such registered limited liability partnerships and New York registered foreign limited liability partnerships have been provided with 60 days notice of this action;

NOW, THEREFORE, I, Ruth Noemi Colón, Acting Secretary of State of the State of New York, do declare and proclaim that the registrations of the following registered limited liability partnerships are hereby revoked and the status of the following New York foreign limited liability partnerships are hereby revoked pursuant to the provisions of Article 8-B of the Partnership Law, as amended:

DOMESTIC REGISTERED LIMITED REGISTERED LIMITED LIABILITY PARTNERSHIP REVOCATION OF REGISTRATION

A

A. JAMES DE BRUIN & SONS, LLP (95)
ALLEN JOHNSON & LONERGAN, LLP (95)
ANDREAS ESBERG & COMPANY, LLP (95)
ANDREOZZI & FICKESS, LLP (04)
ANESTHESIA ASSOCIATES OF BAY RIDGE, LLP (00)
ANTONUCCI LAW FIRM LLP (95)
ATKINSON & HEFFRON, LLP (05)
AURORA PET HOSPITAL, LLP (05)

B

B FIVE STUDIO LLP (95)
BART AND SCHWARTZ, LLP (00)
BATH AVENUE ANIMAL CLINIC, L.L.P. (00)
BECKHARD RICHLAN SZERBATY + ASSOCIATES, LLP (95)
BELDING, FRANCO, GLEASON, DRAGONE & O'BRIEN, LLP (95)
BELKIN BURDEN WENIG & GOLDMAN, LLP (95)
BENDER, CICCOTTO & CO., C.P.A.'S, L.L.P. (95)
BENTEL & BENTEL, ARCHITECTS/PLANNERS, LLP (95)
BERWITZ & DITATA LLP (00)
BLATT & DAUMAN LLP (04)
BLOOM & CO., LLP (00)
BRAND BRAND NOMBERG & ROSENBAUM, LLP (04)
BRATSAFOLIS & FEINERMAN, LLP (05)
BRONSTEIN, VAN VEEN & SCHUCK, LLP (05)
BUFFALO EMERGENCY ASSOCIATES, L.L.P. (00)
BURKE, ALBRIGHT, HARTER, & REDDY, LLP (95)

C

CAMERON ERSKINE LLP (05)
CAMPBELL & SHELTON LLP (04)
CARABBA, LOCKE LLP (99)
CARLOS M. VELAZQUEZ & ASSOCIATES, LLP (05)
CASPER & FISCHER, LLP (05)
CASTLE HILL MEDICAL CARE LLP (05)
CASTRO & KARTEN LLP (00)
CATSKILL NEUROSCIENCES & RADIOLOGY ASSOCIATES, LLP (00)
CHEHEBAR & DEVENEY LLP (05)
CHRISTOPHER CHIROPRACTIC CENTER, L.L.P. (00)
CLARK, CUYLER, MAFFEI & MEDEROS, LLP (05)
COFFINAS & COFFINAS, LLP (00)
COLAMARINO & SOHNS, LLP (95)
COLEMAN, RHINE & GOODWIN LLP (95)
CONDOR ROCK CONSULTING, LLP (04)
COSTAS KONDYLIS AND PARTNERS LLP (00)
CRONIN & VRIS, LLP (00)
CUSACK & STILES LLP (95)

D

D&K CHIROPRACTIC OF NEW YORK, LLP (05)
DECKER, DECKER, DITO & INTERNICOLA, LLP (05)
DEERPARK ANESTHESIA GROUP, LLP (05)
DELANNEY & ASSOCIATES, LLP (05)
DELANNEY & ASSOCIATES, LLP (05)
DELAWARE PEDIATRIC ASSOCIATES, LLP (05)
DEMASCO, SENA & JAHELKA LLP (00)
DENTAL ARTS OF GLEN COVE, LLP (05)
DENTO FACIAL ASSOCIATES OF NEW YORK, LLP (95)
DEVINE & MCCORMICK LLP (00)
DICKERSON TOMASELLI & MULLEN LLP (05)
DRAGA EYE CARE & SURGERY ASSOCIATES, LLP (95)
DURBEN & TOSTI, LLP (95)

E

E, R AND O TELE COMMUNICATIONS, LLP (05)
EARYES ALU, LLP (05)
EE&K RESIDENTIAL ARCHITECTURE, RLLP (05)
EISENBERG & MARGOLIS, LLP (05)
EISENBERG & SCHNELL, LLP (00)
ELEFANTE & PERSANIS, LLP (00)
ELHILOW & MAIOCCHI, LLP (95)
ELMWOOD PEDIATRIC GROUP, LLP (95)
ENGEL, MCCARNEY & KENNEY LLP (05)

F

FARBER, P.T., L.L.P. (05)
FERGUSON & JOSEPH, LLP (05)
FISCHETTI & PESCE, LLP (00)
FLANAGAN, COOKE & FRENCH, LLP (00)
FLEISCHMAN & BEKERMAN, LLP (05)
FORENSIC PSYCHOLOGY ASSOCIATES, LLP (05)
FRANK & ZIMMERMAN & COMPANY, LLP (95)
FRIEDMAN, HIRSCHEN & MILLER LLP (05)
FULVIO & ASSOCIATES, L.L.P. (95)

G

G.R. REID ASSOCIATES, LLP (05)
GABER, BERARD & DONAHUE LLP (00)
GALLO & DARMANIAN, LLP (05)
GARGUILO & ORZECHOWSKI LLP (99)
GAUTHIER & MARTIAN LLP (00)
GENSER, DUBOW, GENSER & CONA LLP (99)
GIAIMO ASSOCIATES, L.L.P. (05)
GIOVANNIELLO & UDELL CPAS LLP (95)
GOLDSTEIN, BULAN & CHIARI, LLP (95)
GORDON, HUIE & FEIGENBAUM LLP (95)
GOSHOW ARCHITECTS, L.L.P. (00)
GOSMAN & DIAMOND, LLP (00)
GREENFIELD IMAGING ASSOCIATES WEST LLP (00)
GROUPS FOR GROWTH, LLP (95)
GULLACE & WELD LLP (00)

H

H. BRADLEY DAVIDSON, D.D.S. AND MICHAEL K. KEATING, D.D.S., (95)
HALKET WEITZ, LLP (05)
HALL DICKLER LLP (95)
HAMILTON ANESTHESIA ASSOCIATES, LLP (95)
HANDSMAN & KAMINSKY LLP (95)
HEARD & O'TOOLE LLP (00)
HEART RHYTHM CONSULTANTS OF NEW YORK LLP (05)
HIA-BENSONHURST IMAGING ASSOCIATES LLP (95)
HINCKLEY & HEISENBERG LLP (00)
HIRSCH, LEVINE, GREENE, INDRIOLO & HISIGER, L.L.P. (99)
HOFFMAN & ROTH, LLP (95)
HOLLYER BRADY BARRETT & HINES LLP (95)

HUDSON VALLEY BONE AND JOINT SURGEONS LLP (95)
I
IRIS SCHOENBERGER OTR LLP (05)
ISLAND HEIGHTS PEDIATRICS, LLP (95)
J
JACKSON & JACKSON LLP (05)
JACKSON & NASH, LLP (95)
JFM DENTAL, L.L.P. (95)
JOSEPH & TERRACCIANO, LLP (05)
JOSEPH M. SIMANTOV & ASSOCIATES, LLP (05)
JOSEPH, RENNIE & ASSOCIATES, LLP (05)
K
KANTER & KANTER LLP (05)
KAPLAN FOX & KILSHEIMER LLP (95)
KAPLOWITZ DAVIS, L.L.P. (05)
KAPLOWITZ FIRM, LLP (05)
KARASYK AND MOSCHELLA, LLP (04)
KAUFMANN & KAUFMANN PH.D'S., LLP (00)
KELLY MASSAD LLP (95)
KIERNAN, ANGIULO & HOROWITZ, LLP (00)
KILLIAN, LEGAKIS & VETERE LLP (99)
KUCZINSKI, VILA & ASSOCIATES, LLP (05)
KUHARSKI & LEVITZ, L.L.P. (00)
L
LAW OFFICE OF MURACA & KELLY, L.L.P. (95)
LAW OFFICES OF BROGDON & BUNCH, LLP (04)
LAW OFFICES OF CLIFFORD S. NELSON, LLP (00)
LAW OFFICES OF THOMAS L. COSTA, LLP (95)
LAWLER, MATUSKY & SKELLY ENGINEERS LLP (95)
LAZAR SANDERS THALER & ASSOCIATES, LLP (05)
LAZAR SANDERS, LLP (95)
LEFKOWITZ, LOUIS, SULLIVAN & HOGAN, L.L.P. (00)
LEHR CONSULTANTS INTERNATIONAL LLP (05)
LENSON LAW GROUP, LLP (04)
LEVINE SAMUEL, LLP (95)
LEVITT & VOGEL LLP (95)
LIFE CARE NEPHROLOGY GROUP, LLP (95)
LOCKE PARTNERSHIP, LLP (00)
LONG ISLAND NEUROSCIENCE SPECIALISTS, L.L.P. (04)
LONG POND PEDIATRICS, LLP (00)
LOUGEN, VALENTI, BOOKBINDER & WEINTRAUB, LLP (00)
LUTHRA AND GUPTA, M.D., LLP (04)
M
MALCOLM S. TAUB LLP (00)
MANHASSET ALLERGY & ASTHMA ASSOC., LLP (95)
MARCOS & NEGRON, L.L.P. (95)
MARCUS, OLLMAN & KOMMER LLP (05)
MAYER & COMPANY LLP (04)
MCCORMICK & O'BRIEN LLP (05)
MCCULLOUGH,GOLDBERGER & STAUDT, LLP (00)
MCGREEVY & HENLE, LLP (05)
MEDINA & KETOVER, LLP (05)
MENTZER & HIGGINS, LLP (99)
MICHAEL F. WEISS, M.D. AND SHERYL S. COHEN, M.D., LLP (00)
MICHAEL TARTELL, M.D. AND SPYROS A. HARISIADIS, M.D., LLP (95)
MISTUR RIEBE ARCHITECTS LLP (05)
MITOFSKY SHAPIRO NEVILLE & HAZEN, LLP (00)
MORDOWITZ & LEMBERG LLP (00)
MOREA SCHWARTZ LLP (05)
MORRIS DUFFY ALONSO & FALEY, LLP (95)
MULRY & SHAUB, LLP (00)
MUSCATO & BOGULSKI, LLP (05)
N
NANGIA & KAZANSKY L.L.P. (00)
NASSAU NEPHROLOGY LLP (99)
NELSON & POPE, LLP (95)
NEW YORK GROUP FOR PLASTIC SURGERY, LLP (95)
NEW YORK MEDICAL MASSAGE PRACTICE L.L.P. (99)
NIMKOFF ROSENFELD & SCHECHTER, LLP (95)
NORTHERN WESTCHESTER SURGICAL ASSOCIATES, LLP (05)
O
O'NEILL & THATCHER, LLP (95)
O'SHEA PARTNERS LLP (05)
P
PADELL NADELL FINE WEINBERGER LLP (00)
PALL AND PALL, LLP (05)
PAYKIN MAHON ROONEY & KRIEG LLP (95)
PEDIATRIC ASSOCIATES OF BATAVIA, LLP (04)
PEIX & MARCHETTI, ARCHITECTS, L.L.P. (95)
PELAGALLI, WEINER, RENCH & THOMPSON, LLP (95)
PENN & VAN METER ARCHITECTS, LLP (95)
PERRY & CAMPANELLI, LLP (00)
PITCHFORD SEMERDJIAN LLP (05)
POLON & GLICKSMAN, L.L.P. (00)
POTTISH FREYBERG MARCUS & VELAZQUEZ, LLP (95)
POWERS SHAPIRO STEIN LLP (05)
PROKIDS, LLP (95)
R
R & J MANAGEMENT, LLP (05)
REDNISS MOODY LLP (05)
REINACH WOLF, ROTHMAN & STERN, LLP (05)
RICHMOND RADIOLOGY ASSOCIATES, LLP (00)
ROBINSON BREIT & CO, LLP (05)
ROBSON & MILLER LLP (95)
RODGERS & COPPOLA LLP (95)
RODMAN & RODMAN, LLP (95)
ROGOVIN GOLUB BERNSTEIN & WEXLER, L.L.P. (95)
ROMEO & SCHMITT, LLP (05)
ROSENBERG FELDMAN SMITH LLP (05)
ROTHFELD & POHL, LLP (95)
ROUZARD & ROUZARD, LLP (05)
RUFOLO & BARBERESI LLP (05)
RUSSO, KEANE & TONER, LLP (00)
RYAN & STANTON LLP (00)
S
SAGA SPORTS MEDICINE CENTER LLP (99)
SALE & GROOTHIUS, LLP (00)
SAMSON FINK & DUBOW LLP (95)
SASSON BLAIVAS LLP (05)
SCARCELLA AND LA TORRE, LLP (04)
SCHIFFERLI & MARTIN, LLP (05)
SCHNEIDER & LEVINE LLP (00)
SCHNEIDER & PFAHL, LLP (99)
SCHRADER & ISRAELY, LLP (04)
SCHUYLER EMERGENCY PHYSICIANS ASSOCIATES, RLLP (05)

SEIDEL & GIANTURCO, LLP (00)
SESSLER & CHILEWICH, L.L.P. (99)
SHANDELL, BLITZ, BLITZ & ASHLEY, LLP (95)
SHAW, PERELSON, MAY & LAMBERT, LLP (95)
SHELDON ZUCKERMAN, M.D. AND ALBERT J. FERRARA, D.O., L.L.P. (05)
SHERESKY ARONSON MAYEFSKY & SLOAN, LLP (95)
SHOLES & MILLER, LLP (00)
SIEGEL, SOMMERS & SCHWARTZ, LLP (95)
SIFRE, INIGUEZ & VITARELLI, LLP (05)
SILBERBERG & SCHERER, LLP (95)
SIMMONS, JANNACE & STAGG, L.L.P. (95)
SIX CENTURY HILL PARTNERSHIP, L.L.P. (99)
SMITH & NEWMAN, LLP (05)
SMOLIN & ALTAMURA LLP (05)
SOFER & HAROUN, L.L.P. (95)
SOTO, SANCHEZ & NEGRON, LLP (04)
SPACE SMITH LLP (05)
SPORTS MEDICINE ARTHROSCOPIC RECONSTRUCTIVE JOINT AND TRAUMA (95)
SPRITZER, KAUFMAN & COMPANY LLP (05)
SRA & ASSOCIATES LLP (95)
STEIN RISO MANTEL, LLP (95)
STEPHEN H. GREEN M.D., F.A.C.S. & STANLEY K. KLAUSNER M.D., (95)
STULMAKER, KOHN & RICHARDSON, LLP (95)
SUFFOLK CHEST PHYSICIANS, L.L.P. (95)
SYLVOR & RICHMAN, LLP (95)
T
TABAT, COHEN & BLUM, LLP (00)
TAYLOR & MRSICH, LLP (05)
TEPEDINO & COMPANY LLP (95)
THE HERMES GROUP LLP (95)
THE LAW FIRM OF CARL STEIN & ASSOCIATES, LLP (05)
THE LAW OFFICE OF JANE B. PULLEN, L.L.P. (05)
THE LAW OFFICES OF KRAUSE & MAUSER, LLP (05)
THE MAURO LAW FIRM, LLP (05)
THE MCDONOUGH LAW FIRM, L.L.P. (95)
THEOBALD AND ATANASIO, LLP (05)
THOMAS & GRAHAM, LLP (95)
THREE BY THE SEA ASSOCIATES, LLP (05)
TILEM & CAMPBELL, LLP (04)
TOOLS FOR LANGUAGE & COMMUNICATION LLP (05)
TOWNSEND & VALENTE, LLP (95)
TRATNER, MOLLOY & GOODSTEIN LLP (05)
TREUHAFT & ZAKARIN, LLP (05)
U
UNCYK, BORENKIND & NADLER, LLP (95)
UNIVERSITY PAIN CENTER, LLP (95)
UPPER MAIN STREET & MCCHESNEY, LLP (00)
USA PAIN, LLP (05)
V
VOLGENAU & BOSSE, LLP (00)
W
WALL STREET FOOT GROUP, L.L.P. (05)
WALLACH & ELEFANT, LLP (00)
WATKINS & WATKINS, L.L.P. (05)
WEISS & RANALDO, L.L.P. (05)
WELBY, BRADY & GREENBLATT, LLP (95)
WELT, GABRIELS, SCHUNK & DALY, LLP (95)
WESTERN NEW YORK PEDIATRIC ASSOCIATES LLP (95)
WHITE, FLEISCHNER & FINO LLP (00)
WHITTEMORE DOWEN LLP (95)
WOLMAN, BABITT & KING, L.L.P. (95)
X
XYLAS & ZICCARDI, LLP (95)
Y
YOUR FAVORITE CONSTRUCTION LLP (05)
Z
ZWANGER-PESIRI-LIDI, LLP (05)

FOREIGN REGISTERED LIMITED

NY REGISTERED FOREIGN LIMITED LIABILITY PARTNERSHIP REVOCATION OF REGISTRATION

A
A.M. PEISCH & COMPANY, LLP (05) (VT)
B
BARITZ & COLMAN LLP (05) (FL)
C
CAPITAL LAW GROUP, LLP (05) (DC)
D
DPK&A ARCHITECTS, LLP (00) (PA)
H
H2L2 ARCHITECTS/PLANNERS LLP (00) (PA)
L
LINEBARGER GOGGAN BLAIR & SAMPSON, LLP (05) (TX)
M
MATSON, DRISCOLL & DAMICO, LLP (00) (GA)
N
NOERR LLP (05) (GE)
O
OLENDERFELDMAN, LLP (05) (NJ)
R
RAICE, PAYKIN, GREENBLATT, LESSER & KRIEG, LLP (05) (NJ)

[SEAL]

WITNESS my hand and the official seal of the Department of State at its office in the City of Albany this twenty-seventh day of April in the year two thousand eleven.

RUTH NOEMÍ COLÓN
Acting Secretary of State

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.

2011-0108 Matter of Mario Vigliotta, Jabez Expiditing, 648 Horseblock Road, Farmingville, NY 11738, for a variance concerning life-safety requirements with ceiling heights in conjunction with alterations to a basement in a single-family dwelling.

Involved is a one-family dwelling, approximately 3,000 square feet in area, two stories in height of type VB construction, located at 93 Aspen Road, Mastic Beach, Town of Brookhaven, Suffolk County, New York.

2011-0113 Matter of Calamar- Jolelyn BOS, c/o Richard A. Molnar, VP, 3949 Forest Pkwy. for a variance concerning requirements for number of and handicap accessible toilets.

Involved is the construction of a two-story building of wood frame construction for permanent multiple dwelling occupancy, located at 100 Weiss Ave., Town of Orchard Park, County of Erie, State of New York.

2011-0118 Matter of William F. Cronin Jr., 116 Rosemary Lane, Centereach, NY 11720, for a variance concerning fire-safety requirements for door width to a dwelling unit, dwelling unit separation and minimum height under beams in conjunction with alterations to a basement in a single-family dwelling.

Involved is a single-family dwelling, of approximately 2,314 square feet in area, two stories in height of type VB construction, located at, 116 Rosemary Lane, Centereach, Town of Brookhaven, Suffolk County, New York.

2011-0126 Matter of Roger P. Smith, A.I.A., BBS Architecture and Engineering, 244 East Main Street, Patchogue, NY 11772, for a variance concerning fire-safety requirements for minimum design flood elevation heights in conjunction with the construction of a new Ferry Terminal.

Involved is a proposed Ferry Terminal, of a mixed B/S-2/A-3 (Business/Storage/Assembly) occupancy, approximately 5,825 square feet in area, one story in height of type VB construction, located at, Bayberry Walk, Village of Ocean Beach, Suffolk County, New York.

2011-0128 Matter of Bruce Dumbauld for Bergmann Associates, 200 First Federal Plaza, 28 East Main Street, Rochester, NY 14614, for a variance concerning Uniform Code requirements including relief from a required smoke control system. The subject building is classified as a B (business occupancy) college building three stories in height, of Type IIB (unprotected non-combustible) construction, and approximately 1000,000 square feet in gross area. The building is located at SUNY Oswego, Wilber Hall and Park Hall, in the City of Oswego, Oswego County, State of New York.

2011-0129 Matter of James P. Brasley, Architect, 10 Cambridge Court, Fairport, NY 14450, for a variance concerning Uniform Code requirements including relief from maintaining a required sprinkler system. The subject building is classified as an S1 (Moderate hazard storage occupancy) warehouse, three stories in height, of Type III (unprotected Ordinary) construction, and is approximately 161,091 square feet in gross area. The building is located at 243 Gorham Street, in the City of Canandaigua, Ontario County, State of New York.

2011-0130 Matter of David and Betty Thompson, 808 3rd Avenue, 106, Bradenton, FL 34205, for a variance concerning Uniform Code requirements including relief from sprinkler requirements. The subject building is classified as an R2 (Permanent occupancy residential) apartment building, four stories in height, of mixed Type Vb (unprotected wood frame) construction. The building is located at 409 South Main Street, in the City of Geneva, Ontario County, State of New York.

2011-0134 Matter of Adam Richter for T.Y. Lin International Engineering, Architecture & Land Surveying, PC, 255 East Avenue, Rochester, NY 14604, for an appeal of the code enforcement official's determination regarding distance of travel and the common path of egress travel. There are eight subject buildings which are classified as R-2 (residential permanent occupancy) townhouse buildings, three stories in height, of Type 5B (unprotected wood frame) construction, approximately 14,548 square feet in gross area. The buildings are located at Erie Harbor, 205-375 Mount Hope Avenue, in the City of Rochester, Monroe County, State of New York.

SALE OF FOREST PRODUCTS

Madison Reforestation Area No. 1
Contract No. X008189

Pursuant to Section 9-0505 of the Environmental Conservation Law, the Department of Environmental Conservation hereby gives Public Notice of the following:

Sealed bids for 2,506 tons more or less red pine, 1.6 MBF more or less white ash, 0.2 MBF more or less black cherry, 0.1 MBF more or less hard maple, 6 cords more or less misc. hardwood, located on Madison Reforestation Area No. 1, Stand(s) E-33, 51, 56, 60, 61 and 64, will be accepted at the Department of Environmental Conservation, Contract Unit, 625 Broadway, 10th Fl., Albany, NY, 12233-5027 until 11:00 a.m., Thursday, May 5, 2011.

For further information, contact: Robert Slavicek, Supervising Forester, Department of Environmental Conservation, Division of Lands and Forests, Region 7, 2715 State Hwy. 80, Sherburne, NY 13460-4507, (607) 674-4036