NEW YORK
state department of
HEALTH

Howard A. Zucker, M.D., J.D.
Acting Commissioner of Health

Sue Kelly
Executive Deputy Commissioner

June 23, 2014

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

Re: SPA #14-26
Inpatient Hospital Services

Dear Mr. Cooley:

The State requests approval of the enclosed amendment #14-26 to the Title XIX (Medicaid) State Plan for inpatient hospital services to be effective April 1, 2014 (Appendix I). This amendment is being submitted based upon enacted legislation. A summary of the proposed amendment is contained in Appendix II.

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

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 were given in the New York State Register on March 26, 2014 and clarified on June 4, 2014.

It is estimated that the changes represented by 2014 payment rates for inpatient general hospital services will have 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.

Copies of pertinent sections of enacted State statute are enclosed for your information (Appendix III). In addition, responses to the five standard funding questions and the standard access questions are also enclosed (Appendix V and VII, respectively).

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
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: **14-26**	2. STATE **New York**
	3. PROGRAM IDENTIFICATION: **TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)**	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE **April 1, 2014**	

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 04/01/14-09/30/14 $ (12,750,000)** **b. FFY 10/01/14-03/31/15 $ (12,750,000)**
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: **Attachment 4.19-A: Pages 120(a)(ii), 120(a)(iv), 120(b), 120(b)(i), 120(b)(i), 120(b)(ii)**	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: **Attachment 4.19-A: Pages 120(a)(ii), 120(a)(iv), 120(b), 120(b)(i), 120(b)(i), 120(b)(ii)**

10. SUBJECT OF AMENDMENT:
PPNOs Extension
(FMAP = 50%)

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

12. SIGNATURE OF STATE AGENCY OFFICIAL:	16. RETURN TO: **New York State Department of Health** **Bureau of Federal Relations & Provider Assessments** **99 Washington Ave – One Commerce Plaza** **Suite 1430** **Albany, NY 12210**
13. TYPED NAME: **Jason A. Helgerson**	
14. TITLE: **Medicaid Director** **Department of Health**	
15. DATE SUBMITTED: June 23, 2014	

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
2014 Title XIX State Plan
Second Quarter Amendment
Amended SPA Pages

New York
120(a)(ii)

Potentially Preventable Negative Outcomes (PPNOs)

Potentially Preventable Complications (PPC)

For discharges occurring on and after July 1, 2011 through March 31, [2014] 2015, Medicaid rates of payment to hospitals that have higher than expected Medicaid payments related to potentially preventable complications, based on the criteria set forth in the Complication Criteria section, as determined by a risk adjusted comparison of the actual and expected Medicaid payments per case for each hospital as described by the Methodology section, will be reduced in accordance with the PPC Adjustment Factor section. Such rate adjustments will result in an aggregate reduction in Medicaid payments of up to $[20,500,000] 51,000,000 annually.

Definitions. As used in this Section, the following definitions shall apply:

1. **Potentially Preventable Complications** shall mean harmful events or negative outcomes that develop after hospital admission and may result from processes of care and treatment rather than from natural progression of the underlying illness, as defined under version 28 of the Potentially Preventable Complication grouping logic software developed and published by 3M Health Information Systems, Inc. (3M). The software identifies 1,450 ICD-9-CM diagnosis codes as a PPC diagnoses. Each ICD-9-CM code designated as a PPC diagnosis was assigned to one of 64 mutually exclusive complication groups called PPCs. A list of such PPCs are available on the following Department of Health website link:

   www.health.ny.gov/health_care/medicaid/quality/ppo/complications

2. **Hospital** shall mean a general hospital as defined pursuant to the Hospital Inpatient Reimbursement – Effective December 1, 2009 section, excluding, effective July 1, 2011, those hospitals exempt from the APR-DRG reimbursement methodology and critical access hospitals.
3. **Observed case** shall mean all non-Medicare acute care cases.
4. **PPC Coefficient** shall mean a dollar amount, the result of an indirect standardization, equal to the statewide average incremental Medicaid payment attributable to each of the 64 PPCs.
5. **Adjusted Admission APR-DRG** shall be defined as the assigned hospital admission APR-DRG SOI for each observed case using version 28 of the APR-DRG grouper and results from 3M's PPC grouping logic software. The software results identify each PPC per admission, which has been adjusted to reassign all secondary diagnosis, not identified as a PPC or the direct cause of a PPC, as present on admission.

New York
120(a)(iv)

PPC Adjustment Factor.

1. Effective for the period July 1, 2011 through March 31, [2014] 2015, rate adjustments for each hospital will be calculated using 2009 Medicaid claims data for discharges that occurred between January 1, 2009 and December 31, 2009.
2. The hospital-specific coefficient is multiplied by the total number of non-behavioral health Medicaid discharges to compute the PPC penalty. The PPC penalty is then multiplied by the hospital's wage equalization factor (WEF) and, for teaching hospitals, the indirect graduate medical education (IME) factor.
3. The Medicaid case payment rate for the applicable rate period shall be used to compute the total Medicaid operating payments for all non-behavioral health Medicaid discharges in each hospital.
4. For each hospital, a PPC adjustment factor will be computed as the ratio of the hospital's PPC penalty and the hospital's total Medicaid operating payments for all non-behavioral health Medicaid discharges in each hospital as determined pursuant to this section.

Adjustment for Hospitals With Unreliable Present On Admission (POA) Data.

Each hospital will be evaluated on five criteria for the reliability of the POA indicator in Medicaid discharge data. POA data was evaluated using 2009 Statewide Planning and Research Cooperative System (SPARCS) data. Two levels of POA quality will be established for each of the criteria, "red" and "grey" zones. The criteria and levels will be as follows:

1. The percent of pre-existing diagnoses that are coded as not present on admission: "red" will be greater than or equal to 7.5%, "grey" will be greater than or equal to 5%, but less than 7.5%.
2. Excluding pre-existing and exempt diagnoses, the percent of remaining diagnoses coded as uncertain: "red" will be greater than or equal to 10%, "grey" will be greater than or equal to 5%, but less than 10%.
3. Excluding pre-existing, exempt, and perinatal diagnoses, a high percentage of remaining diagnoses coded as present on admission: "red" will be greater than or equal to 96%, "grey" will be greater than or equal to 93%, but less than 96%.
4. Excluding pre-existing, exempt, and perinatal diagnoses, a low percentage of remaining diagnoses coded as present on admission: "red" will be less than or equal to 70%, "grey" will be greater than or equal to 70%, but less than 77%; and

New York
120(b)

Potentially Preventable Hospital Readmissions (PPR)

For discharges occurring on and after July 1, 2010 through March 31, [2014] 2015, Medicaid rates of payment to hospitals that have an excess number of readmissions based on the criteria set forth in the Readmission Criteria Section, as determined by a risk adjusted comparison of the actual and expected number of readmissions in a hospital as described by the Methodology Section, shall be reduced in accordance with the Payment Calculation Section. Such rate adjustments shall result in an aggregate reduction in Medicaid payments of $27.8 million for the period July 1, 2010 through March 31, 2011; $12 million for the period April 1, 2011 through March 31, 2012; [and] $13.7 million for the period April 1, 2012 through March 31, 2013 and $13.7 million for the period April 1, 2013 through March 31, 2014; and up to $51 million for the period April 1, 2014 through March 31, 2015.

Definitions. As used in this Section, the following definitions shall apply:

1. **Potentially Preventable Readmissions (PPR)** shall mean a readmission to a hospital that follows a prior admission from a hospital within 14 days, and that is clinically-related to the prior hospital admission, as defined under the PPR grouping logic software developed and published by 3M Health Information Systems, Inc. (3M), version 26.1 for the period July 1, 2010 through March 31, 2011; version 28 for the period April 1, 2011 through March 31, 2012; and version 29 for the period April 1, 2012 through March 31, [2014] 2015.
2. **Hospital** shall mean a general hospital as defined pursuant to the Hospital Inpatient Reimbursement – Effective December 1, 2009 Section, excluding, effective July 1, 2011, those hospitals exempt from the APR-DRG reimbursement methodology and critical access hospitals.
3. **Expected Potentially Preventable Readmissions**, for the period July 1, 2010 through June 30, 2011, are derived using a logistic regression analysis that produces a predicted probability (a number ranging from zero to one) that a hospital admission would be followed by at least one PPR. The total number of expected PPRs shall equal the sum of the expected probabilities of a PPR for all admissions at each hospital. Effective for the period July 1, 2011, through March 31, [2014] 2015, the Expected Potentially Preventable Readmissions shall be derived using 2009 SPARCS Medicaid data through an indirect standardization. A statewide PPR rate, the number of at-risk admissions followed by at least one PPR divided by the total number of at-risk admissions, for every APR-DRG severity of illness (SOI) combination will be multiplied by the number of at-risk admissions in that APR-DRG SOI at each hospital. The sum of all APR-DRG SOI combinations will be the Expected PPRs.
4. **Observed Rate of Readmission** shall mean the number of admissions in each hospital that were actually followed by at least one PPR divided by the total number of admissions.

New York
120(b)(i)

5. **Expected Rate of Readmission** shall mean a risk adjusted rate for each hospital that accounts for the severity of illness, APR-DRG, and age of patients at the time of discharge preceding the readmission. It shall equal the number of expected PPRs divided by the total number of at risk hospital admissions at that hospital.
6. **Excess Rate of Readmission** shall mean the difference between the observed rate of readmission and the expected rate of readmission for each hospital.
7. **Behavioral Health**, for the period July 1, 2010 through June 30, 2011, shall mean an admission that includes a primary or secondary diagnosis of a major mental health related condition. Effective for the period July 1, 2011 through March 31, [2014] 2015, Behavioral Health shall mean an admission that is assigned to a Major Diagnostic Category of 19-Mental Diseases and Disorders or 20-Alcohol/Drug Use and Alcohol/Drug Induced Organic Mental Disorders.
8. **Average Hospital Specific Payment** shall equal the Medicaid operating payment, using the applicable Medicaid rates for such period, of the total number of PPRs identified for each hospital divided by the total number of PPRs identified for each hospital.

Readmission Criteria.

1. A readmission is a return hospitalization following a prior discharge that meets all of the following criteria:
    a. The readmission could reasonably have been prevented by the provision of appropriate care consistent with accepted standards in the prior discharge or during the post discharge follow-up period.
    b. The readmission is for a condition or procedure related to the care during the prior discharge or the care during the period immediately following the prior discharge and including, but not limited to:
        i. the same or closely related condition or procedure as the prior discharge;
        ii. an infection or other complication of care;
        iii. a condition or procedure indicative of a failed surgical intervention; or
        iv. an acute decompensation of a coexisting chronic disease.
    c. The readmission is back to the same or to any other hospital.
2. Readmissions, for the purposes of determining PPRs, excludes the following circumstances:

New York
120(b)(ii)

a. The original discharge was a patient initiated discharge and was Against Medical Advice (AMA) and the circumstances of such discharge and readmission are documented in the patient's medical record.

b. For the period July 1, 2010 through June 30, 2011, the original discharge was for the purpose of securing treatment of a major or metastatic malignancy, multiple trauma, burns, neonatal and obstetrical admissions. Effective for the period July 1, 2011 through March 31, [2014] 2015, the original discharge was for the purpose of securing treatments of the admissions listed on the following Department of Health website link:

www.health.ny.gov/health_care/medicaid/quality/ppo/outcomes

c. The readmission was a planned readmission that occurred on or after 15 days following an initial admission.

d. For readmissions occurring during the period up through March 31, [2014] 2015, the readmissions involve a discharge determined to be behavioral health related.

Methodology.

1. For the period July 1, 2010 through June 30, 2011, rate adjustments for each hospital shall be calculated using 2007 Medicaid paid claims data for discharges that occurred between January 1, 2007 and December 31, 2007. Effective for the period July 1, 2011 through March 31, [2012] 2015, rate adjustments for each hospital will be calculated using 2009 Medicaid claims data for discharges that occurred between January 1, 2009 and December 31, 2009.

2. The expected rate of readmission shall be reduced by:

   (a) 24% for periods prior to September 30, 2010;

   (b) 38.5% for the period October 1, 2010 through December 31, 2010;

   (c) 33.3% for the period January 1, 2011 through June 30, 2011.

   (d) 11.4% for periods on and after July 1, 2011.

3. The excess rate of readmission is multiplied by the total number of at risk hospital admissions at each hospital to determine the total number of risk adjusted excess readmissions.

4. In the event the observed rate of readmission for a hospital is lower than the expected rate of readmission, after the expected rate of readmission has been reduced by the applicable percentage in accordance with this section, the risk adjusted excess readmissions shall be set at zero.

Appendix II
2014 Title XIX State Plan
Second Quarter Amendment
Summary

SUMMARY
SPA #14-26

This State Plan Amendment proposes to extend the provisions to update several components used in the potentially preventable readmission (PPRs) methodology, and establish quality related measures pertaining to potentially preventable conditions and complications of care acquired in the hospital, effective April 1, 2014 through March 31, 2015.

Appendix III
2014 Title XIX State Plan
Second Quarter Amendment
Authorizing Provisions

Authorization Provisions
SPA #14-26

Chapter 60 – Laws of 2014, Part C Section 67-a

§ 67-a. Subparagraph (v) of paragraph (b) of subdivision 35 of section 2807-c of the public health law, as amended by section 7 of part B of chapter 56 of the laws of 2013, is amended to read as follows:

(v) such regulations shall incorporate quality related measures, including, but not limited to, potentially preventable re-admissions (PPRs) and provide for rate adjustments or payment disallowances related to PPRs and other potentially preventable negative outcomes (PPNOs), which shall be calculated in accordance with methodologies as determined by the commissioner, provided, however, that such methodologies shall be 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 and provided further that such rate adjustments or payment disallowances shall result in an aggregate reduction in Medicaid payments of no less than thirty-five million dollars for the period July first, two thousand ten through March thirty-first, two thousand eleven and no less than fifty-one million dollars for annual periods beginning April first, two thousand eleven through March thirty-first, two thousand [~~**fourteen**~~] **fifteen**, provided further that such aggregate reductions shall be offset by Medicaid payment reductions occurring as a result of decreased PPRs during the period July first, two thousand ten through March thirty-first, two thousand eleven and the period April first, two thousand eleven through March thirty-first, two thousand [~~**fourteen**~~] **fifteen** and as a result of decreased PPNOs during the period April first, two thousand eleven through March thirty-first, two thousand [~~**fourteen**~~] **fifteen**; and provided further that for the period July first, two thousand ten through March thirty-first, two thousand [~~**fourteen**~~] **fifteen**, such rate adjustments or payment disallowances shall not apply to behavioral health PPRs; or to readmissions that occur on or after fifteen days following an initial admission. By no later than July first, two thousand eleven the commissioner shall enter into consultations with representatives of the health care facilities subject to this section regarding potential prospective revisions to applicable methodologies and benchmarks set forth in regulations issued pursuant to this subparagraph;

Appendix IV
2014 Title XIX State Plan
Second Quarter Amendment
Public Notice

registered limited liability partnerships which were duly included in proclamations declaring the registration of such registered limited liability partnerships to be revoked in the manner prescribed by Section 121-1500(g) of the Partnership Law, have complied with the provisions of Section 121-1500(g) of the Partnership Law, annulling all of the proceedings theretofore taken for the revocation of the registration of such registered limited liability partnerships. The appropriate entries have been made on the records of the Department of State.

ENTITY NAME: BODY-MIND HEALTH, LLP
REINSTATE: 12/04/13
REVOC OF REGIST: 03/30/05

ENTITY NAME: BORELLI & LI PUMA LLP
REINSTATE: 10/16/13
REVOC OF REGIST: 07/29/09

ENTITY NAME: DUNCAN, FISH & VOGEL, LLP
REINSTATE: 12/04/13
REVOC OF REGIST: 12/28/05

ENTITY NAME: ELLENOFF GROSSMAN & SCHOLE LLP
REINSTATE: 12/04/13
REVOC OF REGIST: 03/27/13

ENTITY NAME: GENSER, DUBOW, GENSER & CONA LLP
REINSTATE: 12/04/13
REVOC OF REGIST: 01/25/10

ENTITY NAME: HIGHWAY RADIOLOGY ASSOCIATES LLP
REINSTATE: 10/16/13
REVOC OF REGIST: 06/29/05

ENTITY NAME: JACQUES M. LEVY & CO., LLP
REINSTATE: 12/17/13
REVOC OF REGIST: 06/29/05

ENTITY NAME: KLINGER & KLINGER, LLP
REINSTATE: 10/17/13
REVOC OF REGIST: 07/25/12

ENTITY NAME: LEPATNER & ASSOCIATES LLP
REINSTATE: 12/04/13
REVOC OF REGIST: 07/25/12

ENTITY NAME: MCCORMICK & O'BRIEN LLP
REINSTATE: 12/04/13
REVOC OF REGIST: 01/26/11

ENTITY NAME: NEW YORK GROUP FOR PLASTIC SURGERY, LLP
REINSTATE: 12/04/13
REVOC OF REGIST: 07/29/10

ENTITY NAME: OLSEN & OLSEN LLP
REINSTATE: 12/04/13
REVOC OF REGIST: 12/26/07

ENTITY NAME: PARKER & CARMODY, LLP
REINSTATE: 12/04/13
REVOC OF REGIST: 04/25/12

ENTITY NAME: RUTHERFORD & CHRISTIE, LLP
REINSTATE: 12/04/13
REVOC OF REGIST: 12/26/12

ENTITY NAME: STOKES, VISCA & CO., LLP
REINSTATE: 12/04/13
REVOC OF REGIST: 12/26/12

ENTITY NAME: STULMAKER, KOHN & RICHARDSON, LLP
REINSTATE: 11/20/13
REVOC OF REGIST: 01/26/11

NOTICE OF THE ANNULMENT OF THE REVOCATION BY PROCLAMATION OF THE STATUS OF CERTAIN FOREIGN LIMITED LIABILITY PARTNERSHIPS AS NEW YORK REGISTERED FOREIGN LIMITED LIABILITY PARTNERSHIPS

Under the Provisions of Section 121-1502(f) of the Partnership Law, As Amended

The Secretary of State hereby provides notice that the following New York registered foreign limited liability partnerships which were duly included in proclamations declaring the status of such New York registered foreign limited liability partnerships to be revoked in the manner prescribed by Section 121-1502(f) of the Partnership Law, have complied with the provisions of Section 121-1502(f) of the Partnership Law annulling all of the proceedings theretofore taken for the revocation of the status of such New York registered foreign limited liability partnerships. The appropriate entries have been made on the records of the Department of State.

ENTITY NAME: NOERR LLP
JURIS: GERMANY
REINSTATE: 10/16/13
REVOC OF REGIST: 01/26/11

PUBLIC NOTICE
Office of General Services

Pursuant to Section 30-a of the Public Lands Law, the Office of General Services hereby gives notice to the following:

Notice is hereby given that the Office of People with Developmental Disabilities has declared 8972 Reed Hill Road, Town of East Otto in Cattaraugus County, New York State, improved with a two-story building, with tax identifier Section 27.016, Block 1, Lot 35.2, surplus, no longer useful or necessary for State program purposes, and has abandoned the property to the Commissioner of General Services for sale or other disposition as Unappropriated State Land.

For further information, please contact: Thomas Pohl, Esq., Office of General Services, Legal Services, 41st Fl., Corning Tower, Empire State Plaza, Albany, NY 12242, (518) 474-8831, (518) 473-4973 (fax)

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 and prescription drugs to comply with recently proposed statutory provisions. The following significant changes and clarifications are proposed:

All Services

• As previously noticed on March 26, 2014, the uniform reduction by two percent for all non-exempt Medicaid payments will terminate on March 31, 2014. Such notice incorrectly indicated this would result in an annual decrease in gross Medicaid expenditures attributable to the initiative, when the result will actually be an increase in gross Medicaid expenditures of up to $714 million for state fiscal year 2014/2015.

• To clarify previous notices related to temporary rate adjustments for providers, effective on or after April 1, 2014, the Commissioner of Health may grant approval of a temporary adjustment to the non-capital components of rates, or make temporary lump-sum Medicaid payments, within funds appropriated and subject to the availability of federal financial participation, to eligible general hospitals, skilled nursing facilities, clinics and home care providers.

- Eligible providers shall include providers: undergoing closure; impacted by the closure of other health care providers; subject to mergers, acquisitions, consolidations or restructuring or those impacted by the merger, acquisition, consolidation or restructuring of other health care providers.

- Providers seeking temporary rate adjustments must submit a written proposal to the Commissioner that demonstrates the additional resources provided will achieve one or more of the following:

• Protection or enhancement of access to care;

• Protection or enhancement of quality of care;

• Improvement in the costs effectiveness of the delivery of health care services; or

• Other protections or enhancements to the health care delivery system.

Such proposal will be submitted to the Commissioner at least 60 days prior to the requested effective date of such adjustment, and will include a proposed budget to achieve the goals of the proposal. Any such adjustment issued will be in effect for a specified period of time, not to exceed three years. At the end of the specified timeframe, such payments or adjustments to the non-capital component of rates will cease, and the provider will be reimbursed in accordance with the applicable rate-setting methodology as set forth in the State Plan. The Commissioner may establish benchmarks and goals to be achieved, and may require the facility to submit periodic reports concerning the achievement of such. Failure to achieve such benchmarks and goals shall be a basis for ending the facility's temporary rate adjustment prior to the end of the specified timeframe. General hospitals defined as critical access hospitals, pursuant to Title XVIII of the Federal Social Security Act shall be allocated no less than $5 million annually.

Institutional Services

• To correct the provision previously noticed on March 26, 2014, for the state fiscal year beginning April 1, 2014 through March 31, 2015, specialty hospital adjustments for hospital inpatient services provided on and after April 1, 2014, 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 will continue. Payments to eligible public general hospitals may be added to rates of payment or made as aggregate payments.

• As previously noticed on March 26, 2014, the Commissioner may make adjustments to inpatient and outpatient Medicaid rates of payment for general hospital services and to the methodology for computing such rates as is necessary to achieve no aggregate, increase or decrease, net growth in overall Medicaid expenditures related to the implementation of the International Classification of Diseases Version 10 (ICD-10) coding system beginning on or about October 1, 2014, as compared to such aggregate expenditures from the period immediately prior to such implementation. However, the State's 2014/2015 budget was enacted prior to the Federal government delaying the implementation of this provision to October 1, 2015. Consistent with the enacted statute, the Commissioner will make the necessary adjustments once ICD-10 goes into effect.

• As previously noticed on March 26, 2014, regulations for per diem rates for inpatient services of a general hospital or a distinct unit of a general hospital for services such as psychiatric, medical rehabilitation, chemical dependency detoxification, chemical dependency rehabilitation, Critical Access Hospitals, specialty long term acute care hospitals, cancer hospitals and exempt acute care children's hospitals may provide for periodic base year cost and statistic updates used to compute rates of payment. The first such base year update shall take effect no later than April 1, 2015, rather than January 1, 2015, as previously noticed. However, the Commissioner may make adjustments to the utilization and methodology for computing these rates as is necessary to achieve no aggregate, net growth in overall Medicaid expenditures related to these rates, as compared to the aggregate expenditures from the prior year. In determining the updated base years to be utilized, the Commissioner shall take into account the base years determined in accordance with Section 2807-c(35)(c).

There is no annual increase or decrease in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2014/2015.

• Extends the mandated cost savings associated with the current methodology establishing quality related measures, including, but not limited to potentially preventable re-admissions (PPRs) and providing for rate adjustments or payment disallowances related to PPRs and other potentially preventable negative outcomes (PPNOs). Such mandated cost savings of no less than $51 million a year are extended for the period April 1, 2014 through March 31, 2015.

- Such aggregate reductions shall be offset by Medicaid payment reductions occurring as a result of decreased PPRs during the period April 1, 2014 through March 31, 2015 and as a result of decreased PPNOs during the period April 1, 2014 through March 31, 2015. Such rate adjustments or payment disallowances will not apply to behavioral health PPRs or to readmissions that occur on or after 15 days following an initial admission.

Long Term Care Services

• For state fiscal years beginning April 1, 2014, continues additional payments to non-state government operated public residential health care facilities, including public residential health care facilities located in Nassau, Westchester, and Erie counties, but excluding public residential health care facilities operated by a town or city within a county, in aggregate amounts of up to $500 million. The amount allocated to each eligible public RHCF will be in accordance with the previously approved methodology, provided, however that patient days shall be utilized for such computation reflecting actual reported data for 2012 and each representative succeeding year as applicable. Payments to eligible RHCF's may be added to rates of payment or made as aggregate payments.

• For residential health care facilities (RHCFs), adjustments to Medicaid rates of payment based on changes to a facility's case mix index capping any change in such case mix index in excess of two percent for any six month period prior to periods beginning January 1, 2016, or such earlier date as determined by the Commissioner, previously noticed on March 26, 2014, shall not be implemented as a result of the final SFY 2014/15 Executive Budget.

Non-institutional Services

• 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, 2014 through March 31, 2017. Payments shall not exceed in the aggregate, $100 million for each of the following periods: April 1, 2014 through March 31, 2015; April 1, 2015 through March 31, 2016; and April 1, 2016 through March 31, 2017, 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, 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, 2014, the Commissioner may implement a Health Home rate add-on to provide resources to Health Homes for the following purposes: (1) member engagement and promotion of Health Homes; (2) workforce training and retraining; (3) health information technology (HIT) and clinical connectivity; and (4) joint governance technical assistance, start-up and other implementation costs, and other such purposes as the Commissioner of Health, in consultation with the Commissioners of the Office of Mental Health and the Office of Alcoholism and Substance Abuse Services, determines are necessary to facilitate the transition of Health Homes beyond their early stages of development. Total payments are estimated not to exceed $190.6 million. Health Homes will be required to submit reports, as required by the Department, on the uses of such funds.

The overall estimated annual net aggregate increase in gross Medicaid expenditures attributable to reform and other initiatives being clarified in this notice and contained in the budget for state fiscal

year 2014/2015 is $958.6 million; and the estimated annual net aggregate increase in gross Medicaid expenditures attributable to an extension upper payment limit (UPL) payments noticed herein for state fiscal year 2014/2015 is $1.58 billion.

The public is invited to review and comment on this proposed State Plan Amendment. Copies of which will be available for public review on the Department of Health's website at http://www.health.ny.gov/regulations/state_plans/status.

For the New York City district, copies will be available at the following places:

New York County
250 Church Street
New York, New York 10018

Queens County, Queens Center
3220 Northern Boulevard
Long Island City, New York 11101

Kings County, Fulton Center
114 Willoughby Street
Brooklyn, New York 11201

Bronx County, Tremont Center
1916 Monterey Avenue
Bronx, New York 10457

Richmond County, Richmond Center
95 Central Avenue, St. George
Staten Island, New York 10301

For further information and to review and comment, please contact: Department of Health, Bureau of Federal Relations & Provider Assessments, 99 Washington Ave. – One Commerce Plaza, Suite 1430, Albany, NY 12210, (518) 474-1673, (518) 473-8825 (FAX), e-mail: spa_inquiries@health.state.ny.us

PUBLIC NOTICE

Monroe County

The Monroe County Deferred Compensation Plan Committee is soliciting proposals from firms to provide investment advisory services for our Deferred Compensation 457 Plan. The Plan is subject to the Rules and Regulations of the New York State Deferred Compensation Board, Part 9000. A copy of the proposal questionnaire may be obtained from: www.monroecounty.gov/bids/rfps

Proposals should be received no later than 3:00 p.m. on June 27, 2014.

PUBLIC NOTICE

Department of State
F-2014-0209
Date of Issuance – June 4, 2014

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-2014-0209, Tappan Zee Constructors, LLC, with offices at 555 White Plains Road. Suite 400, Tarrytown, NY, has applied to the U.S. Army Corps of Engineers NY District for authorization to undertake improvements along the shoreline along the Hudson River at the Port of Coeymans Marine Terminal property, Hudson River Mile 116.0, Town of Coeymans, Albany County, for the purpose of the assembly and barge transportation of approach span frames for the New NY Bridge (New Tappan Zee Bridge). The proposed improvements include dredging of a new 56, 000 square foot area to a depth of -12' MLW, resulting in approximately 10, 000 cubic yards (cy) of material to be placed at an approved upland location to facilitate the barge import of materials and export of finished components; the installation of two parallel, 136' long temporary assembly sled finger trestles using forty 24" steel piles, and the installation of two parallel, 276' long temporary straddle crane finger trestles supported by sixty-two 24" steel piles to facilitate barge slip transport and delivery operations. All structures constructed below MHHW are proposed to be temporary and will be removed to at least 2 feet below the mudline within 36 months of installation.

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 this public notice or Friday, July 4, 2014.

Comments should be addressed to the New York State Department of State, Office of Planning and Development, One Commerce Plaza, 99 Washington Avenue, Albany, New York 12231. Telephone (518) 474-6000; Fax (518) 473-2464. Electronic submissions can be made at: CR@dos.ny.gov.

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

PUBLIC NOTICE

New York State and Local Retirement System

Pursuant to Retirement and Social Security Law, the New York State and Local Employees' Retirement System hereby gives public notice of the following:

The persons whose names and last known addresses are set forth below appear from records of the above named Retirement System to be entitled to accumulated contributions held by said retirement system whose membership terminated pursuant to Section 517-a of the Retirement and Social Security Law on or before May 10, 2013. This notice is published pursuant to Section 109 of the Retirement and Social Security Law of the State of New York. A list of the names contained in this notice is on file and open to public inspection at the office of the New York State and Local Retirement System located at the 110 State St., in the City of Albany, New York. At the expiration of six months from the date of the publication of this notice. The accumulated contributions of the persons so listed shall be deemed abandoned and shall be placed in the pension accumulation fund to be used for the purpose of said fund. Any accumulated contributions so deemed abandoned and transferred to the pension accumulation fund may be claimed by the persons who made such accumulated contributions or, in the event of his death, by his estate or such person as he shall have nominated to receive such accumulated contributions, by filing a claim with the State Comptroller in such form and in such a manner as may be prescribed by him, seeking the return of such abandoned contributions. In the event such claim is properly made the State Comptroller shall pay over to the person or persons or estate making the claim such amount of such accumulated contributions without interest.

Bloomfield, Gregory T - Staten Island, NY

Mc Field, John L - Brooklyn, NY

Minnies, Robin L - Stony Point, NY

For further information contact: Mary Ellen Kutey, Retirement Systems, 110 State St., Albany, NY 12244, (518) 474-3502

PUBLIC NOTICE

New York State and Local Retirement System

Pursuant to Retirement and Social Security Law, the New York State and Local Employees' Retirement System hereby gives public notice of the following:

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 2014 will be conducted on April 8 and April 9 commencing at 10:00 a.m. This meeting will be conducted at NYS Media Services Center, Suite 146, South Concourse, Empire State Plaza, Albany, NY.

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

PUBLIC NOTICE
Division of Criminal Justice Services
Commission on Forensic Science

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

DATE: Wednesday, March 26, 2014
TIME: 1:00-5:00 p.m.
PLACE: Division of Criminal Justice Services
80 S. Swan St.
Albany, NY 12210
CrimeStat Rm. 118

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

PUBLIC NOTICE
Department of Health

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

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

All Services

• For all non-exempt Medicaid payments subject to the uniform reduction by two percent, such reduction will terminate on March 31, 2014. Alternative methods of cost containment shall continue to be applied and maintained for periods on and after April 1, 2014, provided, however, the Commissioner of Health, in consultation with the Director of the Budget, is authorized to terminate such alternative methods upon a finding that they are no longer necessary to maintain essential cost savings.

The annual decrease in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2014/2015 is $714 million.

Institutional Services

• For the state fiscal year beginning April 1, 2014 through March 31, 2015, continues specialty hospital adjustments for hospital inpatient services provided on and after April 1, 2013, 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 April 1, 2014, continues the supplemental upper payment limit payments made to general hospitals, other than major public general hospitals of $339 million annually.

• Effective April 1, 2014, the Commissioner may make adjustments to inpatient and outpatient Medicaid rates of payment for general hospital services and to the methodology for computing such rates as is necessary to achieve no aggregate, net growth in overall Medicaid expenditures related to the implementation of the International Classification of Diseases Version 10 (ICD-10) coding system on or about October 1, 2014, as compared to such aggregate expenditures from the period immediately prior to such implementation.

• Effective April 1, 2014, regulations for per diem rates for inpatient services of a general hospital or a distinct unit of a general hospital for services such as psychiatric, medical rehabilitation, chemical dependency detoxification, chemical dependency rehabilitation, Critical Access Hospitals, specialty long term acute care hospitals, cancer hospitals and exempt acute care children's hospitals may provide for periodic base year cost and statistic updates used to compute rates of payment. The first such base year update shall take effect no later than January first, two thousand fifteen, however, the Commissioner may make adjustments to the utilization and methodology for computing these rates as is necessary to achieve no aggregate, net growth in overall Medicaid expenditures related to these rates, as compared to the aggregate expenditures from the prior year. In determining the updated base years to be utilized, the Commissioner shall take into account the base years determined in accordance with Section 2807-c(35)(c).

There is no annual increase or decrease in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2014/2015.

• Extends the mandated cost savings associated with the current methodology establishing quality related measures, including, but not limited to potentially preventable re-admissions (PPRs) and providing for rate adjustments or payment disallowances related to PPRs and other potentially preventable negative outcomes (PPNOs). Such mandated cost savings of no less than $51 million a year are extended for the period April 1, 2014 through March 31, 2017.

- Such aggregate reductions shall be offset by Medicaid payment reductions occurring as a result of decreased PPRs during the period April 1, 2014 through March 31, 2017 and as a result of decreased PPNOs during the period April 1, 2014 through March 31, 2017. Such rate adjustments or payment disallowances will not apply to behavioral health PPRs or to readmissions that occur on or after 15 days following an initial admission.

Long Term Care Services

• Effective April 1, 2014, medical assistance shall be furnished without consideration of the income and resources of an applicant's legally responsible relative if the applicant's eligibility would normally be determined by comparing the amount of available income and/or resources of the applicant, including amounts deemed available to the applicant from legally responsibility relatives, to an applicable eligibility standard, and:

- The legally responsibility relative is a community spouse;

- Such relative is refusing to make his/her income and/or resources avilable to meet the cost of necessary medical care, services and supplies; and

- The applicant executes an assignment of support from the community spouse in favor of the social services district and the Department of Health, unless the applicant is unable to execute such assignment due to physical or mental impairment or to deny assistance would create an undue hardship, as defined by the Commissioner of Health; or

- The legally responsible relative is absent from the applicant's household, and fails or refuses to make his/her income and/or resources available to meet the cost of necessary medical care, services and supplies.

In such cases, however, the furnishing of such assistance shall create an implied contract with such relative, and the cost thereof may be recovered from such relative in accordance with Title 6 of Article 3 and other applicable provisions of law.

The annual decrease in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2014/2015 is $20 million.

• For residential health care facilities (RHCFs), adjustments to Medicaid rates of payment base on changes to a facility's case mix index shall not reflect any change in such case mix index in excess of two percent for any six month period prior to periods beginning January 1,2016, or such earlier date as determined by the Commissioner.

The annual decrease in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2014/2015 is $42.9 million.

• For state fiscal years beginning April 1, 2014, 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, provided, however that patient days shall be utilized for such computation reflecting actual reported data for 2012 and each representative succeeding year as applicable. Payments to eligible RHCF's may be added to rates of payment or made as aggregate payments.

Non-institutional Services

• For state fiscal year beginning April 1, 2014 through March 31, 2015, 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. Payments to eligible public general hospitals may be added to rates of payment or made as aggregate payments.

• Effective for the period April 1, 2014 through March 31, 2015, and annually thereafter, upon the election of the social services district in which an eligible diagnostic and treatment center (DTC) is physically located, up to $12.6 million in additional annual Medicaid payments may be paid to public DTCs operated by the New York City Health and Hospitals Corporation. Such payments will be based on each DTC's proportionate share of the sum of all clinic visits for all facilities eligible for an adjustment for the base year two years prior to the rate year. The proportionate share payments may be added to rates of payment or made as aggregate payments to eligible DTCs.

• Effective for the periods April 1, 2014 through March 31, 2015, and annually thereafter, up to $5.4 million in additional annual Medicaid payments may be paid to county operated free-standing clinics, not including facilities operated by the New York City Health and Hospitals Corporation, for services provided by such DTC and those provided by a county operated freestanding mental health or substance abuse DTC. Distributions shall be based on each eligible facility's proportionate share of the sum of all DTC and clinic visits for all eligible facilities receiving payments for the base year two years prior to the rate year. The proportionate share payments may be added to rates of payment or made as aggregate payments to eligible facilities.

• Effective April 1, 2014, the Commissioner of Health, in consultation with the Commissioner of the Office of Mental Health, will update rates paid to clinics licensed under Article 28 of the Public Health Law who provide collaborative care services. The collaborative care clinical delivery model is an evidence-based service to improve detection of depression and other diagnosed mental or substance use disorders and provide treatment to such individuals in an integrated manner. Designated clinics will provide, at minimum, screening for depression, medical diagnosis of patients who screen positive, evidence-based depression care, ongoing tracking of patient progress, care management, and a designated psychiatric practitioner who will consult with the care manager and primary care physician.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2014/2015 is $10 million dollars.

• 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, 2014 through March 31, 2017. Payments for the period April 1, 2014 through March 31, 2015; April 1, 2015 through March 31, 2016; and April 1, 2016 through March 31, 2017 shall be up to $28.5 million for each applicable period.

• Effective April 1, 2014, the Commissioner is authorized, within amount appropriated, to distribute funds to local governmental units, pursuant to Mental Hygiene Law, to Medicaid managed care plans certified by the Department, health homes designated by the Department, and individual behavioral health providers and consortiums of such providers licensed or certified by the Office of Mental Health (OMH) or the Office of Alcoholism and Substance Abuse Services (OASAS) to prepare for the transition of adult and children's behavioral health providers and services into managed care.

- The use of such funds may include, but not be limited to, infrastructure and organizational modifications and investments in health information technology and training and technical assistance. Such funds shall be distributed pursuant to a plan to be developed by the Commissioner of Health, along with the Commissioners of the OMH and OASAS, taking into account the size and scope of a grantee's operations as a factor relevant to eligibility for, and the amount of, such funds.

- The Commissioner of Health is authorized to audit recipients of funds to ensure compliance and to recoup any funds determined to have been used for purposes other than previously described or otherwise approved by such Commissioners.

The estimated annual net increase in gross Medicaid expenditures attributable to this initiative for state fiscal year 2014/15 is $20 million.

• Effective April 1, 2014, Medicaid payments for services provided by Certified Home Health Agencies (CHHAs), except for such services provided to children under 18 years of age and those services provided to a special needs population of medically complex and fragile children, adolescents and young disable adults by a CHHA operating under a pilot program approved by the Department, for the purposes of improving recruitment, training and retention of home health aides or other personnel with direct patient care responsibility will cease.

There is no annual increase or decrease in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2014/2015.

• Effective April 1, 2014, the Commissioner may adjust Health Home payments to provide resources to Health Homes for the following purposes: (1) member engagement and promotion of Health Homes; (2) workforce training and retraining; (3) health information technology (HIT) and clinical connectivity; and (4) joint governance technical assistance, start-up and other implementation costs, and other such purposes as the Commissioner of Health, in consultation with the Commissioners of the Office of Mental Health and the Office of Alcoholism and Substance Abuse Services, determines are necessary to facilitate the transition of Health Homes beyond their early stages of development. Total payments are estimated not to exceed $525 million. Health Homes will be required to submit reports, as required by the Department, on the uses of such funds.

• Effective April 1, 2014, the Commissioner will expand access to tobacco counseling by reimbursing dentists. This program will provide greater access to effective, high quality smoking cessation treatment for members. Various analyses have found that smoking interventions delivered by non-physician clinicians are effective in increasing abstinence rates among smokers, which are associated with better health and lower cost.

The estimated annual net increase in gross Medicaid expenditures attributable to this initiative for state fiscal year 2014/15 is $3 million.

The overall estimated annual net aggregate increase in gross Medicaid expenditures attributable to reform and other initiatives contained in the budget for state fiscal year 2014/2015 is $528 million; and the estimated annual net aggregate increase in gross Medicaid expenditures attributable to an extension upper payment limit (UPL) payments for state fiscal year 2013/2014 is $2.0 billion.

The public is invited to review and comment on this proposed State Plan Amendment. Copies of which will be available for public review on the Department of Health's website at http://www.health.ny.gov/regulations/state_plans/status.

For the New York City district, copies will be available at the following places:

New York County
250 Church Street
New York, New York 10018

Queens County, Queens Center
3220 Northern Boulevard
Long Island City, New York 11101

Kings County, Fulton Center
114 Willoughby Street
Brooklyn, New York 11201

Bronx County, Tremont Center
1916 Monterey Avenue
Bronx, New York 10457
Richmond County, Richmond Center
95 Central Avenue, St. George
Staten Island, New York 10301

For further information and to review and comment, please contact: Department of Health, Bureau of Federal Relations & Provider Assessments, 99 Washington Ave. – One Commerce Plaza, Suite 1430, Albany, NY 12210, (518) 474-1673, (518) 473-8825 (Fax), e-mail: spa_inquiries@health.state.ny.us

PUBLIC NOTICE

Department of State
F-2014-0063 (DA)
Date of Issuance - March 11, 2014

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

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

Re-establish the beach profile along the eroded shoreline to the profile prior to damage sustained from Post-Tropical Storm Sandy. An existing upland and on site pile of material will be utilized for beach reconstruction. The new beach profile will be constructed between the mean high water (MHW) line and the upland grass area. The proposed activity will utilize approximately 1430 cubic yards of material. Following the reconstruction, american beach grass will be planted to facilitate shoreline stabilization.

Any interested parties and/or agencies desiring to express their views concerning the above proposed activities may do so by filing their comments, in writing, no later than 4:30 p.m., 15 days from the date of publication of this notice, or, March 26, 2014.

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

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

Appendix V
2014 Title XIX State Plan
Second Quarter Amendment
Responses to Standard Funding Questions

APPENDIX V
HOSPITAL SERVICES
State Plan Amendment #14-26

CMS Standard Funding Questions (NIRT Standard Funding Questions)

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

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

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

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

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

3. **Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan. If supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to each provider type.**

Response: The payments authorized for this provision are 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: Based on guidance from CMS, the State and CMS will engage in discussions to develop a strategic plan to complete the inpatient UPL demonstration for 2014 and submit it as soon as practicable.

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

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

ACA Assurances:

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

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

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

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

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

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

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

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

a) **Please describe the process the State uses to seek advice on a regular ongoing basis from federally recognized tribes Indian Health Programs and Urban Indian Organizations on matters related to Medicaid and CHIP programs and for consultation on State Plan Amendments waiver proposals waiver extensions waiver amendments**

waiver renewals and proposals for demonstration projects prior to submission to CMS.

b) **Please include information about the frequency inclusiveness and process for seeking such advice.**

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

Response: Tribal consultation was performed in accordance with the State's tribal consultation policy as approved in SPA 11-06, and documentation of such is included with this submission. To date, no feedback has been received from any tribal representative in response to the proposed change in this SPA.

Appendix VI
2014 Title XIX State Plan
Second Quarter Amendment
Responses to Standard Access Questions

INPATIENT SERVICES
State Plan Amendment #14-26

CMS Standard Access Questions

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

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

   Response: This amendment seeks to extend several components used in the potentially preventable readmission (PPRs) methodology, and establish quality related measures pertaining to potentially preventable conditions and complications of care acquired in the hospital to be effective April 1, 2014 through March 30, 2015. This plan will continue incentives for healthcare improvement by linking payment to quality measures as a way to focus quality improvement efforts to assist in the design of a safer health care delivery system. Therefore, the State feels it is compliant with the requirements of 1902(a)(30).

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

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

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

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

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

   Response: This change was enacted by the State Legislature as part of the negotiation of the 2014-15 Budget. The impact of this change was weighed in the context of the overall Budget in the State. The legislative process provides opportunities for all stakeholders to lobby their concerns, objections, or support for various legislative initiatives.

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

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

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

   Response: Beginning in 2008-09, the State undertook a massive reform initiative to better align reimbursement with care. The initiative invested over $600 million in the State's ambulatory care system (outpatient, ambulatory surgery, emergency department, clinic and physicians) to incentivize care in the most appropriate setting. The State has also increased its physician reimbursement schedule to resemble Medicare payments for similar services, thus ensuring continued access for Medicaid beneficiaries.

   On April 14, 2014, Governor Andrew M. Cuomo announced that New York has finalized terms and conditions with the Federal government for a groundbreaking waiver that will allow the State to reinvest $8 billion in Federal savings generated by the State's Medicaid Redesign Team (MRT) reforms. The MRT waiver amendment will transform the state's health care system, bend the Medicaid cost curve, and ensure access to quality care for all Medicaid members.

   The waiver amendment dollars will address critical issues throughout the State and allow for comprehensive reform through a Delivery System Reform Incentive Payment (DSRIP) program. The DSRIP program will promote community-level collaborations and focus on system reform, specifically a goal to achieve a 25 percent reduction in avoidable hospital use over five years. Safety net providers will be required to collaborate to implement innovative projects focusing on system transformation, clinical improvement and population health improvement. Single providers will be ineligible to apply. All DSRIP funds will be based on performance linked to achievement of project milestones.

While some of these initiatives are outside the scope of the State Plan, they represent some of the measures the State is taking to ensure quality care for the State's most vulnerable population.