NEW YORK
state department of
HEALTH

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

Sue Kelly
Executive Deputy Commissioner

June 9, 2011

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

RE: SPA #11-12
Long Term Care Facility Services

Dear Mr. Cooley:

The State requests approval of the enclosed amendment #11-12 to the Title XIX (Medicaid) State Plan for long term care facility services to be effective April 1, 2011 (Appendix I). This amendment is being submitted based on enacted legislation. A summary of the proposed amendment is provided in Appendix II.

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

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

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

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

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

In accordance with 42 CFR §447.272, New York assures that the aggregate Medicaid payments for inpatient services provided by nursing facilities for each prescribed category of providers does not exceed the upper payment limit for the particular category of providers.

A copy of the pertinent section of enacted state statute is enclosed for your information (Appendix III). Copies of the public notices of this proposed amendment, which were given in the New York State Register on March 30, 2011 and April 27, 2011, are also enclosed for your information (Appendix IV). In addition responses to the five standard funding questions are also enclosed (Appendix V).

If you have any questions regarding this matter, please do not hesitate to contact John E. Ulberg, Jr., Director, Division of Health Care Financing at (518) 474-6350.

Sincerely,

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

Enclosures

cc: Mr. Michael Melendez
Mr. Tom Brady

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: HEALTH CARE FINANCING ADMINISTRATION	1. TRANSMITTAL NUMBER: #11-12	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, 2011**	
5. TYPE OF PLAN MATERIAL *(Check One)*: ☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT		
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*		
6. FEDERAL STATUTE/REGULATION CITATION: **Section 1902(a) of the Social Security Act, and 42 CFR 447**	7. FEDERAL BUDGET IMPACT: a. FFY 04/01/11-09/30/11 **$48.4 million** b. FFY 10/01/11-09/30/12 **$90.5 million**	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: **Attachment 4.19-B: Pages 47(x)(9), 47(x)(11), 47(x)(12), 47(x)(13), 47(x)(14), 51(a)(1), 51(a)(1)(a), 110(E)(1)**	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: **Attachment 4.19-B: Pages 47(x)(9), 47(x)(11), 47(x)(12), 47(x)(13), 47(x)(14), 51(a)(1), 110(E)(1)**	
10. SUBJECT OF AMENDMENT: **2011 Cost Containment - LTC** **(FMAP = 56.88% 4/1/11-6/30/11; 50% 7/1/11 forward)**		
11. GOVERNOR'S REVIEW *(Check One)*: ☒ GOVERNOR'S OFFICE REPORTED NO COMMENT ☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED ☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL	☐ OTHER, AS SPECIFIED:	
12. SIGNATURE OF STATE AGENCY OFFICIAL:	16. RETURN TO:	
13. TYPED NAME: **Jason A. Helgerson**	**New York State Department of Health** **Corning Tower** **Empire State Plaza** **Albany, New York 12237**	
14. TITLE: **Medicaid Director & Deputy Commissioner Department of Health**		
15. DATE SUBMITTED: June 9, 2011		
FOR REGIONAL OFFICE USE ONLY		
17. DATE RECEIVED:	18. DATE APPROVED:	
PLAN APPROVED – ONE COPY ATTACHED		
19. EFFECTIVE DATE OF APPROVED MATERIAL:	20. SIGNATURE OF REGIONAL OFFICIAL:	
21. TYPED NAME:	22. TITLE:	
23. REMARKS:		

FORM HCFA-179 (07-92)

Appendix I
2011 Title XIX State Plan
Second Quarter Amendment
Long-Term Care Facility Services
Amended SPA Pages

facility days of care provided to beneficiaries of Title XVIII of the Social Security Act (Medicare), divided by the sum of such days of care plus days of care provided to residents eligible for payments pursuant to Title 11 of Article 5 of the Social Services Law minus the number of days provided to residents receiving hospice care, expressed as a percentage, for the period commencing January 1, 1999 through November 30, 1999, based on such data for such period. This value shall be called the 1999 statewide target percentage.

(f) Prior to February 1, 2001, February 1, 2002, February 1, 2003, February 1, 2004, February 1, 2005, February 1, 2006, February 1, 2007, February 1, 2008, February 1, 2009, February 1, 2010, [and] February 1, 2011, <u>February 1, 2012, and February 1, 2013,</u> the Commissioner of Health shall calculate the result of the statewide total of residential health care facility days of care provided to beneficiaries of Title XVIII of the Social Security Act (Medicare), divided by the sum of such days of care plus days of care provided to residents eligible for payments pursuant to Title 11 of Article 5 of the Social Services Law minus the number of days provided to residents receiving hospice care, expressed as a percentage, for the period commencing January 1, through November 30, of the prior year respectively, based on such data for such period. This value shall be called the 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, [and] 2011, <u>2012, and 2013,</u> statewide target percentage respectively.

(2) Prior to February 1, 1996, the Commissioner of Health shall calculate the results of the statewide total of health care facility

1996 statewide target percentage is at least two percentage points higher than the statewide base percentage, the 1996 statewide reduction percentage shall be zero.

(c) If the 1997, 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, [and] 2011, 2012, and 2013, statewide target percentages are not for each year at least three percentage points higher than the statewide base percentage, the Commissioner of Health shall determine the percentage by which the statewide target percentage for each year is not at least three percentage points higher than the statewide base percentage. The percentage calculated pursuant to this paragraph shall be called the 1997, 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, [and] 2011, 2012, and 2013, statewide reduction percentage respectively. If the 1997, 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, [and] 2011, 2012, and 2013, statewide target percentage for the respective year is at least three percentage points higher than the statewide base percentage, the statewide reduction percentage for the respective year shall be zero.

(d) If the 1999 statewide target percentage is not at least two and one-quarter percentage points higher than the statewide base percentage, the Commissioner of Health shall determine the percentage by which the 1999 statewide target percentage is not at least two and one-quarter percentage points higher than the statewide base percentage. The percentage calculated pursuant to this paragraph shall be called the 1999 statewide reduction percentage. If the 1999 statewide target percentage is at least two and one-quarter percentage points higher than the statewide base percentage, the 1999 statewide reduction percentage shall be zero.

(4) (a) The 1995 statewide reduction percentage shall be multiplied by $34 million to determine the 1995 statewide aggregate reduction amount. If the 1995 statewide reduction percentage shall be zero, there shall be no reduction amount.

(b) The 1996 statewide reduction percentage shall be multiplied by $68 million to determine the 1996 statewide aggregate reduction amount. If the 1996 statewide reduction percentage shall be zero, there shall be no reduction amount.

(c) The 1997 statewide reduction percentage shall be multiplied by $102 million to determine the 1997 statewide aggregate reduction amount. If the 1997 statewide reduction percentage shall be zero, there shall be no 1997 reduction amount.

(d) The 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, [and] 2011, 2012, and 2013, statewide reduction percentage shall be multiplied by $102 million respectively to determine the 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, [and] 2011, 2012, and 2013, statewide aggregate reduction amount. If the 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, [and] 2011, 2012, and 2013, statewide reduction percentage shall be zero respectively, there shall be no 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, [and] 2011, 2012, and 2013, statewide reduction amount.

(e) The 1999 statewide reduction percentage shall be multiplied by $76.5 million to determine the 1999 statewide aggregate reduction amount. If the 1999 statewide reduction percentage shall be zero, there shall be no 1999 reduction amount.

(5) (a) The 1995 statewide aggregate reduction amount shall be allocated by the Commissioner of Health among residential health care facilities that are eligible to provide services to Medicare beneficiaries and residents eligible for payments pursuant to Title 11 of Article 5 of the Social Services Law on the basis of the extent of each facility's failure to achieve a one percentage point increase in the 1995 target percentage compared to the base percentage, calculated on a facility specific basis for this purpose, compared to the statewide total of the extent of each facility's failure to achieve a one percentage point increase in the 1995 target percentage compared to the base percentage. This amount shall be called the 1995 facility specific reduction amount.

(b) The 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, [and] 2011, 2012, and 2013, statewide aggregate reduction amounts shall for each year be allocated by the Commissioner of Health among residential health care facilities that are eligible to provide services to Medicare beneficiaries and residents eligible for payments pursuant to Title 11 of Article 5 of the Social Services Law on the basis of the extent of each facility's failure to achieve a two percentage point increase in the 1996 target percentage, a three percentage point increase in the 1997, 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, [and] 2011, 2012, and 2013, target percentage and a two and one-quarter percentage point increase in the 1999 target percentage for each year, compared to the base percentage, calculated on a facility specific basis for this purpose, compared to the statewide total of the extent of each facility's failure to achieve a two percentage point increase in the 1996, a three percentage point increase in the 1997, and a

three percentage point increase in the 1998 and a two and one-quarter percentage point increase in the 1999 target percentage and a three percentage point increase in the 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, [and] 2011, 2012, and 2013, target percentage compared to the base percentage. These amounts shall be called the 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, [and] 2011, 2012, and 2013, facility specific reduction amounts respectively.

(6) The facility specific reduction amounts shall be due to

(g) For reimbursement of services provided to patients for the period April 1, 1995 through December 31, 1995, the trend factors established in accordance with subdivisions (d), (e) and (f) of this section shall reflect no trend factor projections applicable to the period January 1, 1995 other than those reflected in 1994 rates of payment and provide further, that this subdivision shall not apply to use of the trend factor for the January 1, 1995 through December 31, 1995 period, any interim adjustment to the trend factor for such period, or the final trend factor for such period for purposes of projection of allowable operating costs to subsequent rate periods. The Commissioner of Health shall adjust such rates of payment to reflect the exclusion of trend factor projections pursuant to this subdivision. For reimbursement of services provided to patients effective April 1, 1996 through March 31, 1997, the rates will be established by the Commissioner of Health without trend factor adjustments, but shall include the full or partial value of the retroactive impact of trend factor final adjustments for prior periods.* For reimbursement of services provided to patients on and after April 1, 1996 through March 31, 1999 and for payments made on and after July 1, 1999 through March 31, 2011, and on and after April 1, 2011 through March 31, 2013, the rates shall reflect no trend factor projections or adjustments for the period April 1, 1996 through March 31, 1997.

(h) For reimbursement of nursing home services provided to patients beginning on and after April 1, 2006 through March 31, 2011, and on and after April 1, 2011 through March 31, 2013, the Commissioner of Health shall apply a trend factor projection of 2.25% attributable to the period January 1, 2006 through December 31, 2006. Upon reconciliation of this trend factor in accordance with the previously approved state methodology, the final 2006 trend factor shall be the U.S. Consumer Price Index (CPI) for all Urban Consumers, as published by the U.S. Department of Labor, Bureau of Labor Statistics, minus 0.25%.

(i) For reimbursement of nursing home services provided on and after April 1, 2007, the Commissioner of Health shall apply a trend factor equal to 75% of the otherwise applicable trend factor for calendar year 2007 as calculated in accordance with paragraph (f) of this section.

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*This means that since the rates for the April 1, 1996 through March 31, 1997 period are based on 1983 base year costs trended to this period, the rate impacts of any differences between, say, the final value of the 1995 trend factor and the preliminary 1995 trend factor value that may have been used when initially calculating the rate, would be incorporated into the rates for the April 1, 1996 through March 31, 1997 rate period.

(j) For reimbursement of nursing home services provided on and after April 1, 2008, except for the nursing facilities which provide extensive nursing, medical, psychological, and counseling support services to children, the Commissioner of Health shall apply a trend factor equal to 65% of the otherwise applicable trend factor for calendar year 2008 as calculated in accordance with paragraph (f) of this section.

Effective January 1, 1997, the rates of payment will be adjusted to allow costs associated with a total State assessment of 5% of facility gross revenues which shall be a reimbursable cost to be included in calculating rates of payment. Effective March 1, 1997, the reimbursable assessment will be 3.1%. Effective April 1, 1997, the total reimbursable state assessment to be included in calculating rates of payment will be 4.8%. Effective April 1, 1999 through December 31, 1999, the total reimbursable state assessment of 2.4% of gross revenues as paid by facilities shall be included in calculating rates of payment. Effective April 1, 2002 through March 31, 2003, April 1, 2003 through March 31, 2005, and April 1, 2005 through March 31, [2011] 2013, 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 hospital or health-related services, including adult day service, but excluding, effective October 1, 2002, gross receipts attributable to payments received pursuant to Title XVIII of the federal Social Security Act (Medicare), shall be 6%, 5%, and 6%, respectively.

The reimbursable operating costs of facilities for purposes of calculating the reimbursement rates will be increased prospectively, beginning July 1, 1992, to reflect an estimate of the provider cost for the assessment for the period, provided, however, that effective October 1, 2002 the adjustment to rates of payment made pursuant to this paragraph shall be calculated on a per diem basis and based on total reported patient days of care minus reported days attributable to Title XVIII of the federal social security act (Medicare) units of service. As soon as practicable after the assessment period, an adjustment will be made to RHCF rates of payments applicable within the assessment period, based on a reconciliation of actual assessment payments to estimated payments.[1]

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[1]The extent to which a facility is reimbursed for the additional cost of the assessment is dependent upon Medicaid volume of services.

Appendix II
2011 Title XIX State Plan
Second Quarter Amendment
Long-Term Care Facility Services
Summary

SUMMARY
SPA #11-12

The State is proposing to extend through 2013 the following state plan provisions.

- Trend Factor - Continues the elimination of the trend factor for the period April 1, 1996 through March 31, 1997 in rates of payment;

- .25% reduction to the 2006 trend factor continues;

- Statewide Target Percentage – Continues the current calculation methodology for the statewide target percentage for Medicare maximization through 2013; and

- Extends the reimbursable assessment on RHCF gross receipts received from all patient care services and other operating income on a cash basis through March 31, 2013.

Appendix III
2011 Title XIX State Plan
Second Quarter Amendment
Long-Term Care Facility Services
Authorizing Provisions

CHAPTER 59 OF THE LAWS OF 2011

§ 9. Section 194 of chapter 474 of the laws of 1996, amending the education law and other laws relating to rates for residential health facilities, as amended by section 24 of part B of chapter 58 of the of 2009, is amended to read as follows:

§ 194. 1. Notwithstanding any inconsistent provision of law or regulation, the trend factors used to project reimbursable operating costs to the rate period for purposes of determining rates of payment pursuant to article 28 of the public health law for residential health care facilities for reimbursement of inpatient services provided to patients eligible for payments made by state governmental agencies on and after April 1, 1996 through March 31, 1999 and for payments made on and after July 1, 1999 through March 31, 2000 and on and after April 1, 2000 through March 31, 2003 and on and after April 1, 2003 through March 31, 2007 and on and after April 1, 2007 through March 31, 2009 and on and after April 1, 2009 through March 31, 2011 **and on and after April 1, 2011 through March 31, 2013** shall reflect no trend factor projections or adjustments for the period April 1, 1996, through March 31, 1997.

2. The commissioner of health shall adjust such rates of payment to reflect the exclusion pursuant to this section of such specified trend factor projections or adjustments.

§ 10. Subdivision 1 of section 89-a of part C of chapter 58 of the laws of 2007, amending the social services law and other laws relating to enacting the major components of legislation necessary to implement the health and mental hygiene budget for the 2007-2008 state fiscal year, as amended by section 25 of part B of chapter 58 of the laws of 2009, is amended to read as follows:

1. Notwithstanding paragraph (c) of subdivision 10 of section 2807-c of the public health law and section 21 of chapter 1 of the laws of 1999, as amended, and any other inconsistent provision of law or regulation to the contrary, in determining rates of payments by state governmental agencies effective for services provided beginning April 1, 2006, through March 31, 2009, and on and after April 1, 2009 through March 31, 2011**, and on and after April 1, 2011 through March 31, 2013** for inpatient and outpatient services provided by general hospitals and for inpatient services and outpatient adult day health care services provided by residential health care facilities pursuant to article 28 of the public health law, the commissioner of health shall apply a trend factor projection of two and twenty-five hundredths percent attributable to the period January 1, 2006 through December 31, 2006, and on and after January 1, 2007, provided, however, that on reconciliation of such trend factor for the period January 1, 2006 through December 31, 2006 pursuant to paragraph (c) of subdivision 10 of section 2807-c of the public health law, such trend factor shall be the final US Consumer Price Index (CPI) for all urban consumers, as published by the US Department of Labor, Bureau of Labor Statistics less twenty-five hundredths of a percentage point.

§ 11. Paragraph (f) of subdivision 1 of section 64 of chapter 81 of the laws of 1995, amending the public health law and other laws relating to medical reimbursement and welfare reform, as amended by section 26 of part B of chapter 58 of the laws of 2009, is amended to read as follows:

(f) Prior to February 1, 2001, February 1, 2002, February 1, 2003, February 1, 2004, February 1, 2005, February 1, 2006, February 1, 2007,

February 1, 2008, February 1, 2009, February 1, 2010, [~~and~~] February 1, 2011**, February 1, 2012, and February 1, 2013** the commissioner of health shall calculate the result of the statewide total of residential health care facility days of care provided to beneficiaries of title XVIII of the federal social security act (medicare), divided by the sum of such days of care plus days of care provided to residents eligible for payments pursuant to title 11 of article 5 of the social services law minus the number of days provided to residents receiving hospice care, expressed as a percentage, for the period commencing January 1, through November 30, of the prior year respectively, based on such data for such period. This value shall be called the 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010 [~~and~~], 2011**, 2012, and 2013** statewide target percentage respectively.

§ 12. Subparagraph (ii) of paragraph (b) of subdivision 3 of section 64 of chapter 81 of the laws of 1995, amending the public health law and other laws relating to medical reimbursement and welfare reform, as amended by section 27 of part B of chapter 58 of the laws of 2009, is amended to read as follows:

(ii) If the 1997, 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010 [~~and~~], 2011**, 2012, and 2013** statewide target percentages are not for each year at least three percentage points higher than the statewide base percentage, the commissioner of health shall determine the percentage by which the statewide target percentage for each year is not at least three percentage points higher than the statewide base percentage. The percentage calculated pursuant to this paragraph shall be called the 1997, 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010 [~~and~~], 2011**, 2012, and 2013** statewide reduction percentage respectively. If the 1997, 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010 [~~and~~], 2011**, 2012, and 2013** statewide target percentage for the respective year is at least three percentage points higher than the statewide base percentage, the statewide reduction percentage for the respective year shall be zero.

§ 13. Subparagraph (iii) of paragraph (b) of subdivision 4 of section 64 of chapter 81 of the laws of 1995, amending the public health law and other laws relating to medical reimbursement and welfare reform, as amended by section 28 of part B of chapter 58 of the laws of 2009, is amended to read as follows:

(iii) The 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010 [~~and~~], 2011**, 2012, and 2013** statewide reduction percentage shall be multiplied by one hundred two million dollars respectively to determine the 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010 [~~and~~], 2011**, 2012, and 2013** statewide aggregate reduction amount. If the 1998 and the 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010 [~~and~~], 2011**, 2012, and 2013** statewide reduction percentage shall be zero respectively, there shall be no 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010 [~~and~~], 2011**, 2012, and 2013** reduction amount.

§ 14. Paragraph (b) of subdivision 5 of section 64 of chapter 81 of the laws of 1995, amending the public health law and other laws relating to medical reimbursement and welfare reform, as amended by section 29 of part B of chapter 58 of the laws of 2009, is amended to read as follows:

(b) The 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010 [~~and~~], 2011**, 2012, and 2013** statewide aggregate reduction amounts shall for each year be allocated by the commissioner of health among residential health care facilities that are eligible to provide services to beneficiaries of title XVIII of the

federal social security act (medicare) and residents eligible for payments pursuant to title 11 of article 5 of the social services law on the basis of the extent of each facility's failure to achieve a two percentage points increase in the 1996 target percentage, a three percentage point increase in the 1997, 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010 [**~~and~~**], 2011**, 2012, and 2013** target percentage and a two and one-quarter percentage point increase in the 1999 target percentage for each year, compared to the base percentage, calculated on a facility specific basis for this purpose, compared to the statewide total of the extent of each facility's failure to achieve a two percentage points increase in the 1996 and a three percentage point increase in the 1997 and a three percentage point increase in the 1998 and a two and one-quarter percentage point increase in the 1999 target percentage and a three percentage point increase in the 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010 [**~~and~~**], 2011**, 2012, and 2013** target percentage compared to the base percentage. These amounts shall be called the 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010 [**~~and~~**], 2011**, 2012, and 2013** facility specific reduction amounts respectively.

SPA 11-12

CHAPTER 59 OF THE LAWS OF 2011
S.2809-D/A.4009-B - Part D

§ 102. Subparagraph (vi) of paragraph (b) of subdivision 2 of section 2807-d of the public health law, as amended by section 37 of part C of chapter 58 of the laws of 2007, is amended to read as follows:

(vi) Notwithstanding any contrary provision of this paragraph or any other provision of law or regulation to the contrary, for residential health care facilities the assessment shall be six percent of each residential health care facility's gross receipts received from all patient care services and other operating income on a cash basis for the period April first, two thousand two through March thirty-first, two thousand three for hospital or health-related services, including adult day services; provided, however, that residential health care facilities' gross receipts attributable to payments received pursuant to title XVIII of the federal social security act (medicare) shall be excluded from the assessment; provided, however, that for all such gross receipts received on or after April first, two thousand three through March thirty-first, two thousand five, such assessment shall be five percent, and further provided that for all such gross receipts received on or after April first, two thousand five through March thirty-first, two thousand nine, and on or after April first, two thousand nine through March thirty-first, two thousand eleven such assessment shall be six percent**, and further provided that for all such gross receipts received on or after April first, two thousand eleven through March thirty-first, two thousand thirteen such assessment shall be six percent**.

Appendix IV
2011 Title XIX State Plan
Second Quarter Amendment
Long-Term Care Facility 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 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:

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.

Appendix V
2011 Title XIX State Plan
Second Quarter Amendment
Long-Term Care Facility Services
Responses to Standard Funding Questions

LONG-TERM CARE FACILITY
SERVICES
State Plan Amendment #11-12

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: Based on guidance from CMS, the State and CMS staff will engage in discussions to develop a strategic plan to complete the UPL demonstration for 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 nursing facility services is a cost based prospective payment methodology subject to ceiling. We are unaware of any requirement under current federal law or regulation that limits individual provider payments to their actual costs.

Assurances:

1. **In compliance with provisions of the Recovery Act, the State should provide assurances that they are in compliance with the terms of the Recovery Act concerning (1) Maintenance of Effort (MOE); (2) State or local match; (3) Prompt payment; (4) Rainy day funds; and (5) Eligible expenditures (e.g. no DSH or other enhanced match payments).**

   Response: The State hereby provides assurances that it remains in compliance with the terms of the Recovery Act with regard to the requirements pertaining to the maintenance of effort, State or local match, prompt payment, rainy day funds, and eligible expenditures. In addition,

the HHS Office of Inspector General has reviewed the State's compliance with the political subdivision requirement for increased FMAP under ARRA and found the State to be in compliance with this provision (Report A-02-09-01029).

2. **The State needs to verify it is in compliance with the provisions of Section 5006 of the Recovery Act concerning tribal consultations for the SPA, or an explanation why the provisions did not apply in this instance.**

   Response: In New York State, Indian Health Programs and Urban Indian Organizations do not furnish long-term care services; therefore, solicitation of advice on this issue was not applicable.