NEW YORK
state department of
HEALTH

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

Sue Kelly
Executive Deputy Commissioner

June 4, 2012

Mr. Michael Melendez
Associate Regional Administrator
Department of Health & Human Services
Centers for Medicare & Medicaid Services
New York Regional Office
Division of Medicaid and Children's Health
26 Federal Plaza - Room 37-100 North
New York, NY 10278

RE: SPA #12-19
Non-Institutional Services

Dear Mr. Melendez:

The State requests approval of the enclosed amendment #12-19 to the Title XIX (Medicaid) State Plan for non-institutional services to be effective May 2, 2012 (Appendix I). This amendment is being submitted based on State regulation. A summary of the plan amendment is provided in Appendix II.

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

A copy of the regulations which were filed with the New York Department of State on and became effective on May 2, 2012 is enclosed for your information (Appendix III). Such regulations will be published in the May 23, 2012 New York State Register. A copy of the public notice for this plan amendment, which was given in the New York State Register on April 25, 2012, is 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 State Plan Amendment submission, please do not hesitate to contact John E. Ulberg, Jr., Medicaid Chief Financial Officer, Division of Finance and Rate Setting, at (518) 474-6350.

Sincerely,

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

Enclosures

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: **#12-19**	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 **MAY 2, 2012**	
5. TYPE OF PLAN MATERIAL *(Check One)*: ☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT		
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*		
6. FEDERAL STATUTE/REGULATION CITATION: **Section 1902(a) of the Social Security Act, and 42 CFR 447**	7. FEDERAL BUDGET IMPACT: **a. FFY 10/01/11-09/30/12: $125,000** **b. FFY 10/01/12-09/30/13: $300,000**	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: **Attachment 4.19-B: Pages 4(5)**	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: **Attachment 4.19-B: Page 4(5)**	
10. SUBJECT OF AMENDMENT: **Revisions to Episodic Pricing**		
11. GOVERNOR'S REVIEW *(Check One)*: ☒ GOVERNOR'S OFFICE REPORTED NO COMMENT ☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED ☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL	☐ OTHER, AS SPECIFIED:	
12. SIGNATURE OF STATE AGENCY OFFICIAL:	16. RETURN TO: **New York State Department of Health** **Corning Tower** **Empire State Plaza** **Albany, New York 12237**	
13. TYPED NAME: **Jason A. Helgerson**		
14. TITLE: **Medicaid Director & Deputy Commissioner Department of Health**		
15. DATE SUBMITTED: June 4, 2012		
FOR REGIONAL OFFICE USE ONLY		
17. DATE RECEIVED:	18. DATE APPROVED:	
PLAN APPROVED – ONE COPY ATTACHED		
19. EFFECTIVE DATE OF APPROVED MATERIAL:	20. SIGNATURE OF REGIONAL OFFICIAL:	
21. TYPED NAME:	22. TITLE:	
23. REMARKS:		

FORM HCFA-179 (07-92)

Appendix I
2012 Title XIX State Plan
Second Quarter Amendment
Non-Institutional Services
Amended SPA Pages

such agency to the state and will be recouped through reductions in the Medicaid payments due to the agency. In those instances where an interim payment adjustment was applied to an agency, 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 will be remitted to each such agency by the Department in a lump sum amount.

(f) Interim payment adjustments pursuant to this section will be based on Medicaid paid claims for services provided by agencies in the base year 2009. Amounts due from reconciling payment adjustments will be based on Medicaid paid claims for services provided by agencies in the base year 2009 and Medicaid paid claims for services provided by agencies in the reconciliation period April 1, 2011 through March 31, 2012.

(g) The payment adjustments will not result in an aggregate annual decrease in Medicaid payments to providers in excess of $200 million. If upon reconciliation it is determined that application of the calculated ceilings would result in an aggregate annual decrease of more than $200 million, all providers' ceilings would be adjusted proportionately to reduce the decrease to $200 million. Such reconciliation will not be subject to subsequent adjustment.

(h) The Commissioner may require agencies to collect and submit any data required to implement the provisions of this subdivision.

(i) Effective May 1, 2012, Medicaid payments for services provided by certified home health agencies, except for such services provided to children under 18 years of age and effective May 2, 2012, except for services provided to a special needs population of medically complex and fragile children, adolescents and young disabled adults by a CHHA operating under a pilot program approved by the Department, [shall] will be based on payment amounts calculated for 60-day episodes of care. The Commissioner will establish a base price for 60-day episodes of care, and this price will be adjusted for the case mix index, which applies to each patient, and for regional wage differences. Effective May 2, 2012, such case mix adjustments will include an adjustment factor for CHHAs providing care primarily to a special needs patient population coming under the jurisdiction of the Office for People With Developmental Disabilities (OPWDD) and consisting of no fewer than two hundred such patients.

The initial statewide episodic base price to be effective May 1, 2012, will be calculated based on paid Medicaid claims, as determined by the Department, for services provided by all certified home health agencies during the base year period of January 1, 2009 through December 31, 2009. The base price will be calculated by grouping all paid claims in the base period into 60-day episodes of care. All such 2009 episodes, which include episodes beginning in November or December of 2008 or ending in January or

Appendix II
2012 Title XIX State Plan
Second Quarter Amendment
Non-Institutional Services
Summary

SUMMARY
SPA #12-19

This State Plan Amendment proposes to amend the episodic pricing system for certified home health agencies (CHHAs) so that services provided to a special needs population of medically complex and fragile children, adolescents and young disabled adults by a CHHA operating under a pilot program approved by the Department are exempt from the episodic pricing system. In addition, case mix adjustments shall include an adjustment factor for CHHAs providing care primarily to a special needs patient population coming under the jurisdiction of the Office of People With Developmental Disabilities (OPWDD) and consisting of no fewer than two hundred such patients.

Appendix III
2012 Title XIX State Plan
Second Quarter Amendment
Non-Institutional Services
Authorizing Provisions

Fund), are consistent with the principles specified in the rule. Most among all affected parties, the State Comptroller, as a fiduciary whose responsibilities are clarified and broadened, is impacted by the rule. The State Comptroller is not a ''small business'' as defined in section 102(8) of the State Administrative Procedure Act.

This rule will affect investment managers and other intermediaries (other than OSC employees) who provide technical or professional services to the Fund related to Fund investments. The rule will prohibit investment managers from using the services of a placement agent unless such agent is a regular employee of the investment manager and is acting in a broader capacity than just providing specific investment advice to the Fund. In addition, the rule is also directed to placement agents, who as a result of this rule, will no longer be engaged directly or indirectly by investment managers that do business with the Fund. Some investment managers and placement agents may come within the definition of ''small business'' set forth in section 102(8) of the State Administrative Procedure Act, because they are independently owned and operated, and employ 100 or fewer individuals.

The rule bans the use of placement agents in connection with investments by the Fund. This may adversely affect the business of placement agents, who will lose opportunities to earn profits in connection with investments by the Fund. Nevertheless, as a result of recent allegations regarding ''pay to play'' practices, whereby politically connected individuals reportedly sold access to investment opportunities with the Fund, the Superintendent has concluded that an immediate ban on the use of placement agents is necessary to protect the Fund's members and beneficiaries and to safeguard the integrity of the Fund's investments.

This rule will not impose any adverse compliance requirements or result in any adverse impacts on local governments. The basis for this finding is that this rule is directed at the State Comptroller; employees of the Office of State Comptroller; and investment managers, placement agents, consultant or advisors - none of which are local governments.

2. Compliance requirements: None.

3. Professional services: Investment managers, consultants and advisors who provide services to the Fund, and are required to discontinue the use of placement agents in connection with investment services they provide to the Fund, may need to employ other professional services.

4. Compliance costs: The rule does not impose any additional requirements on the Comptroller, and no additional costs are expected to result from the implementation of the ban imposed by this rule. There are no costs to the Department of Financial Services or other state government agencies or local governments. However, investment managers, consultants and advisors who provide services to the Fund, which are required to discontinue the use of placement agents in connection with investment services they provide to the Fund, may lose opportunities to do business with the Fund.

5. Economic and technological feasibility: The rule does not impose any economic and technological requirements on affected parties, except for placement agents who will lose the opportunity to earn profits in connection with investments by the Fund.

6. Minimizing adverse impact: The costs to placement agents are lost opportunities to earn profits in connection with investments by the Fund. The Superintendent considered other ways to limit the influence of placement agents, including a partial ban, increased disclosure requirements, and adopting alternative definitions of placement agent or intermediary. But in the end, the Superintendent concluded that only an immediate total ban on the use of placement agents could provide sufficient protection of the Fund's members and beneficiaries and safeguard the integrity of the Fund's investments.

7. Small business and local government participation: In developing the rule, the Superintendent and State Comptroller not only consulted with one another, but also briefed representatives of: (1) New York State and New York City Public Employee Unions; (2) New York City Retirement and Pension Funds; (3) the Borough Presidents of the five counties of New York City; and (4) officials of the New York City Mayor's Office, Comptroller's Office and Finance Department.

A public hearing was held on April 28, 2010. Comments were received from two entities recommending that the total ban on the use of placement agents be modified. The Department will continue to assess the comments that have been received and any others that may be submitted.

Rural Area Flexibility Analysis

1. Types and estimated numbers of rural areas: Investment managers, placement agents, consultants or advisors that do business in rural areas as defined under State Administrative Procedure Act Section 102(10) will be affected by this rule. The rule bans the use of placement agents in connection with investments by the New York State Common Retirement Fund (''the Fund''), which may adversely affect the business of placement agents and of other entities that utilize placement agents and are involved in Fund investments.

2. Reporting, recordkeeping and other compliance requirements, and professional services: This rule will not impose any reporting, recordkeeping or other compliance requirements on public or private entities in rural areas, with the exception of requiring investment managers, consultants and advisors who provide services to the Fund to discontinue the use of placement agents.

3. Costs: The costs to placement agents are lost opportunities to earn profits in connection with investments by the Fund.

4. Minimizing adverse impact: The rule does not adversely impact rural areas.

5. Rural area participation: A public hearing was held on April 28, 2010. Comments were received from two entities recommending that the total ban on the use of placement agents be modified. The Department will continue to assess the comments that have been received and any others that may be submitted.

Job Impact Statement

The Department of Financial Services finds that this rule will have little or no impact on jobs and employment opportunities. The rule bans investment managers from using placement agents in connection with investments by the New York State Common Retirement Fund (''the Fund''). The rule may adversely affect the business of placement agents, who could lose the opportunity to earn profits in connection with investments by the Fund. Nevertheless, in view of recent events about how placement agents conduct business on behalf of their clients with regard to the Fund, the Superintendent has concluded that an immediate ban on the use of placement agents is necessary to protect the Fund's members and beneficiaries, and to safeguard the integrity of the Fund's investments.

Department of Health

EMERGENCY RULE MAKING

Episodic Pricing for Certified Home Health Agencies (CHHA)

I.D. No. HLT-21-12-00002-E
Filing No. 435
Filing Date: 2012-05-02
Effective Date: 2012-05-02

PURSUANT TO THE PROVISIONS OF THE State Administrative Procedure Act, NOTICE is hereby given of the following action:

Action taken: Amendment of section 86-1.44 of Title 10 NYCRR.

Statutory authority: Public Health Law, section 3614(13)

Finding of necessity for emergency rule: Preservation of public health.

Specific reasons underlying the finding of necessity: It is necessary to issue the proposed regulations on an emergency basis in order to ensure an appropriate level of reimbursement to those Certified Home Health Agencies (CHHAs) that provide services to a special needs population of medically complex children, adolescents and young disabled adults and to those CHHAs that serve primarily patients who are eligible for OPWDD services.

Section 111 of Part H of Chapter 59 of the Laws of 2011 provides the Commissioner of Health with authority to issue regulations such as these emergency regulations.

Further, there is compelling interest in enacting these regulations immediately in order to secure federal approval of the associated Medicaid State Plan Amendment.

Subject: Episodic Pricing for Certified Home Health Agencies (CHHA).

Purpose: To exempt services to a special needs population from the episodic payment system for CHHAs.

Text of emergency rule: Subdivisions (a) and (c) and the opening paragraph of subdivision (b) of section 86-1.44 of title 10 of NYCRR are amended to read as follows:

(a) Effective for services provided on and after [April 1] *May 2*, 2012, Medicaid payments for certified home health care agencies (''CHHA''), except for such services provided to children under eighteen years of age *and except for services provided to a special needs population of medically complex and fragile children, adolescents and young disabled adults by a CHHA operating under a pilot program approved by the Department*, shall be based on payment amounts calculated for 60-day episodes of care.

(b) An initial statewide episodic base price, to be effective [April 1]

May 2, 2012, will be calculated based on paid Medicaid claims, as determined by the Department, for services provided by all certified home health agencies in New York State during the base period of January 1, 2009 through December 31, 2009.

(c) The base price paid for 60-day episodes of care shall be adjusted by an individual patient case mix index as determined pursuant to subdivision (g) of this section; and also by a regional wage index factor as determined pursuant to subdivision (h) of this section. *Such case mix adjustments shall include an adjustment factor for CHHAs providing care primarily to a special needs patient population coming under the jurisdiction of the Office of People With Developmental Disabilities (OPWDD) and consisting of no fewer than two hundred such patients.*

This notice is intended to serve only as a notice of emergency adoption. This agency intends to adopt this emergency rule as a permanent rule and will publish a notice of proposed rule making in the *State Register* at some future date. The emergency rule will expire July 30, 2012.

Text of rule and any required statements and analyses may be obtained from: Katherine Ceroalo, DOH, Bureau of House Counsel, Reg. Affairs Unit, Room 2438, ESP Tower Building, Albany, NY 12237, (518) 473-7488, email: regsqna@health.state.ny.us

Regulatory Impact Statement

Statutory Authority:

The authority for implementation of an episodic payment system for Certified Home Health Agency services pursuant to regulations is set forth in section 3614(13) of the Public Health Law.

Legislative Objectives:

The Legislature chose to address the issue of over-utilization of Certified Home Health Agency services as a result of the recommendations submitted by the Medicaid Redesign Team and accepted by the Governor. Pursuant to statute, an episodic payment system based on 60-day episodes of care, with payments tied to patient acuity, was chosen as one of the vehicles to address this issue.

Needs and Benefits:

The proposed amendment will exempt services provided to a special needs population of medically complex children, adolescents and young disabled adults by a CHHA operating under a pilot program approved by the Department from the episodic payment system and will also provide for an adjustment of the case mix index for CHHAs serving primarily patients who are eligible for OPWDD services when such CHHAs have over 200 such patients. This amendment will help assure that agencies primarily serving certain special needs populations will receive a level of reimbursement from the Medicaid system to maintain both adequate access and quality of care for members of these populations.

Costs:

The regulated parties (providers) are not expected to incur any additional costs as a result of the proposed rule change. There are no additional costs to local governments for the implementation of and continuing compliance with this amendment. It is anticipated there will be a slight decrease to the total state fiscal savings which were budgeted for the Episodic Payment System.

Local Government Mandates:

The proposed amendment does not impose any new programs, services, duties or responsibilities upon any county, city, town, village, school district, fire district or other special district.

Paperwork:

There is no additional paperwork required of providers as a result of this amendment.

Duplication:

These regulations do not duplicate existing state or federal regulations.

Alternatives:

No significant alternatives are available. The Department is required by the Public Health Law section 3614(13) to promulgate implementing regulations.

Federal Standards:

This amendment does not exceed any minimum standards of the federal government for the same or similar subject areas.

Compliance Schedule:

There are no significant actions which are required by the affected providers to comply with the rule change.

Regulatory Flexibility Analysis

Effect of Rule:

The proposed rule is expected to initially affect two Certified Home Health Agencies. Neither agency is a small business and neither is government sponsored.

Compliance Requirements:

There are no additional reporting, recordkeeping or other affirmative acts that small businesses or local governments will need to undertake to comply with the proposed rule. A ''small business regulation guide'' is not required.

Professional Services:

No new or additional professional services are required in order to comply with the proposed amendments.

Compliance Costs:

The proposed rule will not require providers or local government to incur any additional compliance costs.

Economic and Technological Feasibility:

Compliance by small businesses and local governments is not expected to have economic or technological implications.

Minimizing Adverse Impact:

The proposed amendment reflects statutory intent and requirements.

Small Business and Local Government Participation:

The two affected Certified Home Health Agencies are not small businesses or government sponsored.

Rural Area Flexibility Analysis

Types and Estimated Numbers of Rural Areas:

This rule applies uniformly throughout the state, including rural areas. Rural areas are defined as counties with a population less than 200,000 and counties with a population of 200,000 or greater that have towns with population densities of 150 persons or fewer per square mile. The following 43 counties have a population of less than 200,000 based upon the United States Census estimated county populations for 2010 (http://quickfacts.census.gov). Approximately 17% of small health care facilities are located in rural areas.

Allegany County	Greene County	Schoharie County
Cattaraugus County	Hamilton County	Schuyler County
Cayuga County	Herkimer County	Seneca County
Chautauqua County	Jefferson County	St. Lawrence County
Chemung County	Lewis County	Steuben County
Chenango County	Livingston County	Sullivan County
Clinton County	Madison County	Tioga County
Columbia County	Montgomery County	Tompkins County
Cortland County	Ontario County	Ulster County
Delaware County	Orleans County	Warren County
Essex County	Oswego County	Washington County
Franklin County	Otsego County	Wayne County
Fulton County	Putnam County	Wyoming County
Genesee County	Rensselaer County	Yates County
	Schenectady	

The following counties have a population of 200,000 or greater and towns with population densities of 150 persons or fewer per square mile. Data is based upon the United States Census estimated county populations for 2010.

Albany County	Monroe County	Orange County
Broome County	Niagara County	Saratoga County
Dutchess County	Oneida County	Suffolk County
Erie County	Onondaga County	

Reporting, Recordkeeping and Other Compliance Requirements; and Professional Services:

No new reporting, recordkeeping, or other compliance requirements are being imposed as a result of this proposal. No additional professional services will be required for compliance.

Costs:

Certified Home Health Agencies are not expected to incur any significant costs as a result of this rule change.

Minimizing Adverse Impact:

The proposed amendment reflects statutory intent and requirements.

Rural Area Participation:

The two affected Certified Home Health Agencies are not rural providers.

Job Impact Statement

Nature of Impact:

The proposed rule change will exempt services to a special needs population of medically complex children, adolescents and young adults from the episodic payment system for Certified Home Health Agencies (CHHAs) and will provide for a positive adjustment of the case mix index for CHHAs serving primarily patients who are eligible for OPWDD services.

These changes are not expected to have a negative impact on jobs or

employment opportunities and could slightly increase employment levels at the impacted CHHAs due to higher Medicaid reimbursement levels.

Categories and Numbers Affected:

There are five categories of direct care workers at CHHAs: home health aides, nurses, physical therapists, occupational therapists and speech pathologists. Statewide, 84% of CHHA claims dollars are for home health aide services. The proposed rule changes are not expected to negatively impact any of these five categories.

Regions of Adverse Impact:

No adverse impact is anticipated as a result of this rule change.

Minimizing Adverse Impact:

No adverse impact is anticipated as a result of this rule change.

Self-Employment Opportunities:

Not applicable.

Office of Medicaid Inspector General

PROPOSED RULE MAKING NO HEARING(S) SCHEDULED

Withholding of Payments; Incorporation by Reference

I.D. No. MED-21-12-00001-P

PURSUANT TO THE PROVISIONS OF THE State Administrative Procedure Act, NOTICE is hereby given of the following proposed rule:

Proposed Action: Amendment of sections 518.7 and 518.9 of Title 18 NYCRR.

Statutory authority: Public Health Law, section 32

Subject: Withholding of payments; Incorporation by reference.

Purpose: To amend regulations governing the withholding of Medicaid payments in accordance with federal requirements.

Text of proposed rule: Section 518.7 of title 18 of NYCRR is amended to read as follows:

518.7 Withholding of payments.

(a) *Basis for withholding.*

(1) The department may withhold payments under the program, in whole or in part, when it has [reliable information that] *determined* that a provider [is involved in fraud or willful misrepresentation involving claims submitted to the program; or] *has* abused the program or *has* committed an unacceptable practice. [Reliable information] *The department's determination that a provider has abused the program, or has committed an unacceptable practice* may consist of preliminary findings by the department's audit or utilization review staff of unacceptable practices or significant overpayments, information from a State professional licensing or certifying agency of an ongoing investigation of a provider involving fraud, abuse, professional misconduct or unprofessional conduct, or information from a State investigating or prosecutorial agency or other law enforcement organization of an ongoing investigation of a provider for fraud or criminal conduct involving the program. The department may withhold payment of current and future claims to the provider and any affiliate.

(2) The department must withhold payments under the program, in whole or in part, when it has determined or has been notified that a provider is the subject of a pending investigation of a credible allegation of fraud unless the department finds good cause not to withhold payments in accordance with 42 C.F.R. 455.23. A credible allegation of fraud is an allegation that has indicia of reliability and has been verified by the department, or the Medicaid fraud control unit, or another State agency, or law enforcement organization.

(i) Whenever the department initiates a withholding, in whole or in part, in relation to a pending investigation of a credible allegation of fraud, the department must make a fraud referral to the Medicaid fraud control unit. If the Medicaid fraud control unit does not accept the referral, then the department may refer the matter to another law enforcement organization.

(ii) The fraud referral made under this paragraph must be in writing and provided to the Medicaid fraud control unit or other law enforcement organization not later than the next business day after the withhold is enacted.

(b) Notice of the withholding will [usually] be given [prior to or contemporaneously with the withholding; however, in no event will notice of the withholding be given more than] *within* five days of [after the withholding of payments] *taking such action unless requested in writing by a law enforcement organization to delay such notice.* The notice will describe the reasons for the action, but need not include specific information concerning an ongoing investigation.

(c) The notice of withholding must:

(1)*(i)* state that the payments are being withheld in accordance with [42 C.F.R. 455.23 and] this section; *and*

(ii) in cases where there is a pending investigation of a credible allegation of fraud state that the payments are being withheld in accordance with 42 C.F.R. 455.23;

(2) state that the withholding is for a temporary period only and recite the circumstances under which the withholding will be terminated;

(3) specify whether the withholding applies to all or only some claims and identify which claims if not all claims are involved; and

(4) advise of the right to submit written arguments and documentation in opposition to the withholding and how to submit them *in accordance with subdivision (e) of this section.*

(d) The withholding may continue only temporarily.

(1) When initiated by the department prior to issuance of a draft audit report or notice of proposed agency action, the withholding will not continue for more than 90 days unless a written draft audit report or notice of proposed agency action is sent to the provider. Issuance of the draft report or notice of proposed action may extend the withholding until an amount reasonably calculated to satisfy the overpayment is withheld, pending a final determination on the matter.

(2) When initiated by the department after issuance of a draft audit report or notice of proposed agency action, the withholding will not continue for more than 90 days unless a written final audit report or notice of agency action is sent to the provider. Issuance of the report or notice of action may extend the withholding until an amount reasonably calculated to satisfy the overpayment is withheld, pending a final determination on the matter.

(3) When initiated by another State agency or law enforcement organization, the withholding may continue until the agency or prosecuting authority determines that there is insufficient evidence to support an action against the provider or its affiliate, or until the agency or criminal proceedings are completed.

(4) When initiated by the department when it has determined or has been notified that a provider is the subject of a pending investigation of a credible allegation of fraud all withholding actions will be temporary and will not continue after either of the following:

(i) The department, or the Medicaid fraud control unit, or other law enforcement organization determines that there is insufficient evidence of fraud by the provider.

(ii) Legal proceedings related to the provider's alleged fraud are completed.

(e) Appeals.

(1) A provider or its affiliate that is the subject of the withholding is not entitled to an administrative hearing, but may, within 30 days of the date of the notice, submit written arguments and documentation that the withhold should be removed.

(2) Within 60 days of receiving written arguments or documentation in response to a withhold, the department will review the determination and notify the provider or its affiliate of the results of that review. After the review, the determination to impose a withhold may be affirmed, reversed or modified, in whole or in part.

(3) A decision by the department to affirm, reverse or modify a withhold on appeal shall not be a determination of the merits of any investigation initiated by another State agency, the Medicaid fraud control unit, or other law enforcement organization.

Section 518.9 of title 18 of NYCRR is amended to read as follows:

518.9 Incorporation by reference.

The provisions of the Code of Federal Regulations which have been incorporated by reference in this Part have been filed in the Office of the Secretary of State of the State of New York, the publication so filed being the booklet entitled: Code of Federal Regulations, title 42, Parts 455.23, revised as of October 1, [2008] *2011*, published by the Office of the Federal Register, National Archives and Records Administration, as a special edition of the Federal Register. The regulations incorporated by reference may be examined at the Office of the Department of State, 99 Washington Ave, Albany, NY 12231 at the law libraries of the New York State Supreme Court and the New York State, and at the Office of the Medicaid Inspector General, Office of Counsel, 800 N. Pearl Street, Albany, New York 12204. They may also be purchased from the Superintendent of Documents, Government Printing Office Washington, DC 20402. Copies of the Code of Federal Regulations are also available at many public libraries and bar association libraries.

Text of proposed rule and any required statements and analyses may be obtained from: Michael T. D'Allaird, Esq., Office of the Medicaid Inspector General, 800 North Pearl Street, Albany, New York 12204, (518) 402-1434, email: Michael.D'Allaird@omig.ny.gov

Appendix IV
2012 Title XIX State Plan
Second Quarter Amendment
Non-Institutional Services
Public Notice

- The Commissioner of Health will also provide for reimbursement of the cost of preadmission assessments conducted directly by ALPs, which previously would have been performed by and reimbursed to the CHHA. There is no annual increase or decrease in gross Medicaid dollars for this initiative in state fiscal year 2012/13.

Non-institutional Services

- Effective April 1, 2012, the APG investment for hospital outpatient payments will be reduced by $25 million.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to these initiatives contained in the budget for state fiscal year 2012/2013 is $26.4 million.

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

In addition, copies of the proposed state plan amendments will be on file and available for public review in each local (county) social services district.

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

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

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

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

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

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

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), spa_inquiries@health.state.ny.us

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 long term care services to comply with regulations authorized under existing State statute. The following significant changes are proposed:

Long Term Care Services

- Effective for services provided on and after May 1, 2012, Medicaid payments for certified home health care agencies (CHHA), except for such services provided to children under 18 years of age and except for services provided to a special needs population of medically complex and fragile children, adolescents and young disabled adults by a CHHA operating under a pilot program approved by the Department of Health, shall be based on payment amounts calculated for 60-day episodes of care.
  - The base price paid for 60-day episodes of care shall be adjusted by an individual patient case mix index, and also by a regional wage index factor. Such case mix adjustments shall include an adjustment factor for CHHAs providing care primarily to a special needs patient population coming under the jurisdiction of the Office of People with Developmental Disabilities (OPWDD) and consisting of no fewer than 200 such patients. The annual increase in gross Medicaid expenditures attributable to this initiative for state fiscal year 2012/13 is $600,000.
- Effective July 1, 2012 or upon the effective date of the applicable regulation, the capital cost component of the Medicaid rates of eligible residential health care facilities (RHCF) shall be adjusted, as determined by the Commissioner of Health, to reflect the costs of the annual debt service related to the financing of an automatic sprinkler system that will be in compliance with applicable federal regulations set forth in 42 CFR 483.70(a)(8).
  - Eligible facilities are those facilities which the Commissioner determines are financially distressed in terms of their being unable to finance the installation of automatic sprinkler systems as required by the federal regulations. In making such determinations of eligibility, the Commissioner shall consider information obtained from a facility's cost report, and such other information as may be required by the Commissioner, including, but not limited to:
    - operating profits and losses;
    - eligibility for funding pursuant to the capital cost reimbursement section of Subpart 86-2 of the Public Health Law;
    - unrestricted fund balances;
    - documentation demonstrating the inability of the facility to independently access the credit markets;
    - information related to the health and safety of a facility's residents;
    - other financial information as may be required from the facility by the Commissioner; and
    - the filing of Certificate of Need (CON) information, or the receipt of required CON approvals, as appropriate.
  - As a condition for the receipt of sprinkler funding, each eligible RHCF shall:
    - Prepare a schedule setting forth, by month, the estimated debt service payable, assuming level principal and interest payments over the life of the financing. Such schedule, along with such other information as may be required by the Commissioner, shall be provided to the Commissioner for review and approval at least 60 days prior to the due date of such first debt service payment (or such shorter period as the Commissioner may permit); and
    - Deposit into a separate account maintained by the facility, Medicaid revenues attributable to the capital rate adjustments for such sprinklers, and any other additional facility revenues needed to cover the scheduled debt service payments attributable to such sprinklers. All such deposits in such account shall be used solely for the purpose of satisfying such debt service payments.
  - The estimated annual increase in gross Medicaid expenditures attributable to this initiative for state fiscal year 2102/13 is $17 million.
- Effective for services provided on and after May 1, 2012, rates of payment for residential health care facilities which have received approval by the Commissioner of Health to provide services to more than 25 patients whose medical condition is HIV Infection Symptomatic, and the facility is not eligible for separate and distinct payment rates for AIDS facilities or discrete AIDS units, shall be adjusted by a per diem adjustment that shall not be in excess of the difference between such facility's 2010 allowable cost per day, as determined by the Commissioner, and the weighted average non-capital component of the rate in effect on and after January 1, 2012, and as subsequently updated by case mix adjustments made in July and January of each calendar year. The estimated annual increase in gross Medicaid expenditures attributable to this initiative for state fiscal year 2012/13 is $1 million.

Appendix V
2012 Title XIX State Plan
Second Quarter Amendment
Non-Institutional Services
Responses to Standard Funding Questions

NON-INSTITUTIONAL SERVICES
State Plan Amendment #12-19

CMS Standard Funding Questions

The following questions are being asked and should be answered in relation to all payments made to all providers reimbursed pursuant to a methodology described in Attachment 4.19-B of this SPA. For SPAs that provide for changes to payments for clinic or outpatient hospital services or for enhanced or supplemental payments to physician or other practitioners, the questions must be answered for all payments made under the state plan for such service.

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

   Response: 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 through an IGT or CPE. In this case, please identify the agency to which the funds are appropriated. Please provide an estimate of total expenditure and State share amounts for each type of Medicaid payment. If any of the non-federal share is being provided using IGTs or CPEs, please fully describe the matching arrangement including when the state agency receives the transferred amounts from the local governmental entity transferring the funds. If CPEs are used, please describe the methodology used by the state to verify that the total expenditures being certified are eligible for Federal matching funds in accordance with 42 CFR 433.51(b). For any payment funded by CPEs or IGTs, please provide the following:**

   (i) a complete list of the names of entities transferring or certifying funds;
   (ii) the operational nature of the entity (state, county, city, other);
   (iii) the total amounts transferred or certified by each entity;
   (iv) clarify whether the certifying or transferring entity has general taxing authority: and,
   (v) whether the certifying or transferring entity received appropriations (identify level of appropriations).

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

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

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

4. **For clinic or outpatient hospital services please provide a detailed description of the methodology used by the state to estimate the upper payment limit (UPL) for each class of providers (State owned or operated, non-state government owned or operated, and privately owned or operated). Please provide a current (i.e., applicable to the current rate year) UPL demonstration.**

   Response: This question is not applicable for this SPA, as CHHA services are not clinic or outpatient hospital services.

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

   Response: The State is unaware of any requirement under current federal law or regulation that limits individual provider payments to their actual costs.

Assurances:

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

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

   The State must assure that the SPA complies with the conditions of the MOE provision of section 1902(gg) of the Act for continued funding under the Medicaid program.

   Response: There are no eligibility provisions applicable for this SPA.

2. **Section 1905(y) and (z) of the Act provides for increased FMAPs for expenditures made on or after January 1, 2014 for individuals determined eligible under section 1902(a)(10)(A)(i)(VIII) of the Act.**

Under section 1905(cc) of the Act, the increased FMAP under sections 1905(y) and (z) would not be available for States that require local political subdivisions to contribute amounts toward the non-Federal share of the State's expenditures at a greater percentage than would have been required on December 31, 2009.

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

The State must assure that this SPA would [ ] / would not [ ] violate these provisions, if they remained in effect on or after January 1, 2014.

Response: The State assures that this SPA would not violate the above provisions if they remained in effect on or after January 1, 2014.

3. **The State must assure that this SPA complies with the requirements of section 1902(a)(37) of the Act regarding prompt payment of claims.**

   Response: The State assures that this SPA complies with the requirements of section 1902(a)(37) of the Act regarding prompt payment of claims.

4. **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: Documentation of tribal consultation is attached and was performed in accordance with the State's tribal consultation policy as approved in SPA 11-06. To date, no feedback has been received from any tribal representative in response to the proposed change in this SPA.