NEW YORK
state department of
HEALTH

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

Sue Kelly
Executive Deputy Commissioner

June 30, 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 Operations
26 Federal Plaza - Room 37-100 North
New York, New York 10278

RE: SPA #12-31
Non-Institutional Services

Dear Mr. Melendez:

The State requests approval of the enclosed amendment #12-31 to the Title XIX (Medicaid) State Plan for non-institutional services to be effective May 1, 2012 (Appendix I). This amendment is being submitted based on enacted legislation. 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 pertinent section of enacted legislation is enclosed for your information (Appendix III). A copy of the public notice of 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 and the standard access questions are also enclosed (Appendix V and VI, respectively).

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: **12-31**	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 1, 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 447.204**	7. FEDERAL BUDGET IMPACT: **a. FFY 05/01/12 – 09/30/12 $ 5,681,818** **b. FFY 10/01/12 – 09/30/13 $12,500,000**	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: **Attachment 4.19-B: Page 1(j)**	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: **Attachment 4.19-B: Page 1(j)**	
10. SUBJECT OF AMENDMENT: **$25M Reduction to Hospital APG Investment (FMAP = 50%)**		
11. GOVERNOR'S REVIEW *(Check One)*: ☒ GOVERNOR'S OFFICE REPORTED NO COMMENT ☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED ☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL	☐ OTHER, AS SPECIFIED:	
12. SIGNATURE OF STATE AGENCY OFFICIAL:	16. RETURN TO: **New York State Department of Health** **Corning Tower** **Empire State Plaza** **Albany, New York 12237**	
13. TYPED NAME: **Jason A. Helgerson**		
14. TITLE: **Medicaid Director & Deputy Commissioner Department of Health**		
15. DATE SUBMITTED: June 30, 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

III. The APG base rates shall be updated at least annually. Updates for periods prior to January 1, 2010 will be based on claims data from the December 1, 2008 through April 30, 2009 period. The January 1, 2010, update will be based on claims data for the period December 1, 2008, through September 30, 2009. Subsequent updates will be based on Medicaid claims data from the most recent twelve-month period, and will be based on complete and accurate billing data. APG base rates shall be rebased each time the APG relative weights are reweighted.

a. If it is determined by the Department that an APG base rate is materially incorrect, the Department shall correct that base rate prospectively so as to align aggregate reimbursement with total available funding.

IV. APG base rates shall initially be calculated using the total operating reimbursement for services and associated ancillaries and the associated number of visits for services moving to APG reimbursement for the period January 1, 2007 to December 31, 2007. APG payments shall also reflect an investment of $178 million on an annualized basis for periods prior to December 1, 2009, [and] $270 million on an annualized basis <u>for the period December 1, 2009, through April 30, 2012, and $245 million for the period May 1, 2012, through March 31, 2013, and $245 million on an annualized basis for periods</u> thereafter. APG investment shall be allocated among the peer groups based on targeted reimbursement levels (e.g. percent of operating cost) and negotiated with the hospital associations. A link to the allocation of all APG investments across peer groups for all periods is available in the APG Reimbursement Methodology – Hospital Outpatient section. The case mix index shall initially be calculated using 2005 claims data.

a. Re-estimations of total operating reimbursement and associated ancillaries and the estimated number of visits shall be calculated based on historical claims data. Re-estimations for periods prior to January 1, 2010, will be based on claims data from the December 1, 2008 through April 30, 2009 period. The January 1, 2010, re-estimation shall be based on claims data from the December 1, 2008, through September 30, 2009, period. Subsequent re-estimations will be based on Medicaid claims data from the most recent twelve-month period, and will be based on complete and accurate data.

b. The estimated case mix index shall be calculated using the appropriate version of the 3M APG software based on claims data. Re-estimations for periods prior to January 1, 2009, will be based on claims data from the December 1, 2008 through April 30, 2009 period. The January 1, 2010, re-estimation shall be based on Medicaid data for the period December 1, 2008, through September 30, 2009. Subsequent re-estimations will be based on Medicaid claims data from the most recent twelve-month period, and will be based on complete and accurate line level procedure and charge data and ratio of cost to charge data.

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

SUMMARY
SPA #12-31

This State Plan Amendment proposes to reduce the APG investment for hospital outpatient payments by $25 million.

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

participating in the medicare drug benefit authorized by P.L. 108-173.

Notwithstanding any inconsistent provision of law, the moneys hereby appropriated shall not be used for any existing rates, fees, fee schedule, or procedures which may affect the cost of care and services provided by personal care providers, case managers, health maintenance organizations, out of state medical facilities which provide care and services to residents of the state, providers of transportation services, that are altered, amended, adjusted or otherwise changed by a local social services district unless previously approved by the department of health and the director of the budget.

For services and expenses of the medical assistance program including hospital inpatient services.

Notwithstanding any provision of law to the contrary, the portion of this appropriation covering fiscal year 2012-13 shall supersede and replace any duplicative (i) reappropriation for this item covering fiscal year 2012-13, and (ii) appropriation for this item covering fiscal year 2012-13 set forth in chapter 53 of the laws of 2011 559,019,000

For services and expenses of the medical assistance program including hospital outpatient and emergency room services.

Notwithstanding any provision of law to the contrary, the portion of this appropriation covering fiscal year 2012-13 shall supersede and replace any duplicative (i) reappropriation for this item covering fiscal year 2012-13, and (ii) appropriation for this item covering fiscal year 2012-13 set forth in chapter 53 of the laws of 2011 546,420,000

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

An application for a waiver of the requirements of paragraph a of subdivision 7 of section 176-b of the Town Law, which limits the membership of volunteer fire companies to forty-five per centum of the actual membership of the fire company, has been submitted by the Sauquoit Fire District #1, County of Oneida.

Pursuant to section 176-b of the Town Law, the non-resident membership limit shall be waived provided that no adjacent fire department objects within sixty days of the publication of this notice.

Objections shall be made in writing, setting forth the reasons such waiver should not be granted, and shall be submitted to: Bryant D. Stevens, State Fire Administrator, Office of Fire Prevention and Control, 99 Washington Ave., Suite 500, Albany, NY 12210-2833

Objections must be received by the State Fire Administrator within sixty days of the date of publication of this notice.

In cases where an objection is properly filed, the State Fire Administrator shall have the authority to grant a waiver upon consideration of (1) the difficulty of the fire company or district in retaining and recruiting adequate personnel; (2) any alternative means available to the fire company or district to address such difficulties; and (3) the impact of the waiver on adjacent fire departments.

For further information, please contact: Deputy Chief Donald Fischer, Office of Fire Prevention and Control, 99 Washington Ave., Suite 500, Albany, NY 12210-2833, (518) 474-6746, Dfischer@dhses.ny.gov

PUBLIC NOTICE

City of Glen Cove
Transfer Station Operation & Maintenance
Solid Waste Transport
Recycling and Disposal Services
Final Request for Proposals (FRFP)

PLEASE TAKE NOTICE, that pursuant to, and accordance with, Subdivision 4 of Section 120-w of the General Municipal Law, the City of Glen Cove hereby gives notice of its Final Request for Proposals (FRFP) for the financing, provision of transportation means and services and the facilities, having to do with the operation and maintenance of the City of Glen Cove solid waste transfer station and for the transportation, recycling and disposal of City of Glen Cove municipal solid waste. The means, services and facilities are expected to include: certain capital improvements to the City of Glen Cove solid waste transfer station; the operation and maintenance of the City of Glen Cove solid waste transfer station; transfer haul vehicles; the processing, transportation, recycling and disposal of solid waste; administrative management; maintenance support; and customer service support to perform services as specified in FRFP. Issued with the FRFP, may be comments filed in relation to the previously released Draft Request for Proposals (DRFP), and the City's findings related to the substantive elements of such comments.

Copies of the FRFP may be obtained at the City of Glen Cove Finance Department, Purchasing Division, Attn: Ms. Nancy Andreiev, City Purchasing Agent, City of Glen Cove City Hall, First Floor, 9 Glen Street, Glen Cove, New York 11542 between the hours of 9:00 A.M., 4:30 P.M., except Saturdays, Sundays and Holidays, on and after Monday, April 30, 2012 for a nonrefundable fee of ONE HUNDRED DOLLARS ($100.00), until Tuesday, May 22, 2012.

One (1) original and 4 (four) copies of the FRFP must be received at the office of William Archambault, Director of Public Works, City of Glen Cove City Hall, Room 301, 9 Glen Street, Glen Cove, New York 11542, no later than 3:00 p.m. on Tuesday, May 22, 2012.

The City of Glen Cove shall also provide a copy of the FRFP for review on or after April 30, 2012 until May 22, 2012, at the following two locations: (1) the Office of the City Clerk, City Hall, 9 Glen Street, New York 11542, and (2) the Glen Cove Public Library, 4 Glen Cove Avenue, Glen Cove, New York 11542.

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 institutional, 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, 2012, and notification of new significant changes:

All Services

- The amount appropriated for previously noticed provisions regarding the Essential Community Provider Network and the Vital Access Providers initiatives in the enacted budget is now $86.4 million, which is a reduction of $13.6 million for state fiscal year 2012/13; however, the annual increase in state fiscal year 2013/14 remains $100 million.
- To clarify, effective April 1, 2012, regularly scheduled phased reductions to hospital inpatient Transition II funding of $25 million will be redirected to the Safety Net/VAP funding instead of the development of the inpatient statewide base price.

The annual increase in gross Medicaid expenditures for both initiatives for state fiscal year 2012/13 is $86.4, including the redirection of the hospital inpatient Phase II funding.

Institutional Services

- Effective May 1, 2012, the statewide base price will be reduced by $19.2 million for state fiscal year 2012/13 and $19.2 million for state fiscal year 2013/14 as compared to the $24.2 million in state fiscal year 2011/12.

Long Term Care Services

- Effective on and after April 1, 2012, for rate periods on and after July 1, 2012, for services provided to residential health care facility residents 21 years of age and older, the Commissioner of Health shall implement a methodology which establishes reimbursement rates for reserved bed days.
  - Such methodology shall, for each Medicaid patient for any 12-month period, provide for reimbursement for reserved bed days for up to an aggregate of 14 days for hospitalizations and for other therapeutic leave of absences consistent with a plan of care ordered by such patient's treating health care professional, and up to an aggregate of 10 days of other leaves of absence.
  - If the Commissioner, in consultation with the Director of the Budget, determines that such methodology shall achieve projected aggregate Medicaid savings of less than $40 million for state fiscal year beginning April 1, 2012, and each state fiscal year thereafter, the Commissioner shall establish a prospective per diem rate adjustment for all nursing homes, other than those providing services primarily to children under the age of 21, sufficient to achieve such $40 million in savings for each such state fiscal year.
- Effective April 1, 2012, an assisted living program (ALP), that is not itself a certified home health agency (CHHA), shall contract with one or more CHHAs for the provision of services pursuant to Article 36 of the Public Health Law.
  - An ALP shall, either directly or through contract with a certified home health agency, conduct an initial assessment to determine whether a person would otherwise require placement in a residential health care facility if not for the availability of the ALP and is appropriate for admission to an ALP.
  - No person shall be determined eligible for and admitted to an ALP unless the ALP finds that the person meets the criteria provided above.
  - Appropriate services shall be provided to an eligible person only in accordance with a plan of care which is based upon an initial assessment and periodic reassessments conducted by an ALP, either directly or through contract with a CHHA. A reassessment shall be conducted as frequently as is required to respond to changes in the resident's condition and ensure immediate access to necessary and appropriate services by the resident, but in no event less frequently than once every six months. No person shall be admitted to or retained in an ALP unless the person can be safely and adequately cared for with the provision of services determined by such assessment or reassessment.

- 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 #12-31

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: 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 2012.

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 State Plan for hospital outpatient services is based upon the Ambulatory Patient Group (APG) system with the exception of Federally Qualified Health Centers who have the option to opt into the APG system or remain on the Prospective Payment Methodology (PPS) as approved by CMS in SPA 01-03. We are unaware of any requirement under current federal law or regulation that limits individual providers' payments to their actual costs.

ACA Assurances:

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

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

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

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

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

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

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

   Response: This SPA does comply with the requirements of section 1902(a)(37) of the Act regarding prompt payment of claims.

Tribal Assurance:

Section 1902(a)(73) of the Social Security Act the Act requires a State in which one or more Indian Health Programs or Urban Indian Organizations furnish health care services to establish a process for the State Medicaid agency to seek advice on a regular ongoing basis from designees of Indian health programs whether operated by the Indian Health Service HIS Tribes or Tribal organizations under the Indian Self Determination and Education Assistance Act ISDEAA or Urban Indian Organizations under the Indian Health Care Improvement Act.

IHCIA Section 2107(e)(I) of the Act was also amended to apply these requirements to the Children's Health Insurance Program CHIP. Consultation is required concerning Medicaid and CHIP matters having a direct impact on Indian health programs and Urban Indian organizations.

a) **Please describe the process the State uses to seek advice on a regular ongoing basis from federally recognized tribes Indian Health Programs and Urban Indian Organizations on matters related to Medicaid and CHIP programs and for consultation on State Plan Amendments waiver proposals waiver extensions waiver amendments waiver renewals and proposals for demonstration projects prior to submission to CMS.**
b) **Please include information about the frequency inclusiveness and process for seeking such advice.**
c) **Please describe the consultation process that occurred specifically for the development and submission of this State Plan Amendment when it occurred and who was involved.**

Response: The process that New York State uses is detailed in SPA #11-06, which was approved by CMS on 8/4/11. The tribal leaders were sent information regarding the SPA via postal mail, and the health clinic administrators were emailed the same information. Copies of tribal consultation are enclosed.

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

APPENDIX VI
NON-INSTITUTIONAL SERVICES
State Plan Amendment 12-31

CMS Standard Access Questions

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

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

   Response: This amendment seeks to reduce the APG investment for hospital outpatient payments by $25 million. The reduction in the APG investment will assist to ensure that the Medicaid program remains sustainable and affordable to taxpayers. It also allows the State to have a viable program which avoids scaling back essential benefits to needy patients while working to address fiscal short falls. As the reduction will be spread over all hospital APG payments affected by the investment, the actual affect on each provider will not be excessive.

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

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

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

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

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

Response: This change was enacted by the State Legislature as part of the negotiation of the 2012-13 Budget. The impact of this change was weighed in the context of the overall Budget in the State. The legislative process provides opportunities for all stakeholders to lobby their concerns, objections, or support for various legislative initiatives.

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

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

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

Response: Over the course of the past three years, the State has undertaken a massive reform initiative to better align reimbursement with care. When fully implemented, the initiative will invest over $600 million in the State's ambulatory care system (outpatient, ambulatory surgery, emergency department, clinic and physicians) to incentivize care in the most appropriate setting. The State has also increased its physician reimbursement schedule to resemble Medicare payments for similar services, thus ensuring continued access for Medicaid beneficiaries. Further, the State is implementing initiatives that will award $600 million annually, over five years, to providers who promote efficiency and quality care through the Federal-State Health Reform Partnership(F-SHRP)/ NYS Healthcare Efficiency and Affordability Law (HEAL). While some of these initiatives are outside the scope of the State Plan, they represent some of the measures the State is taking to ensure quality care for the State's most vulnerable population.