NEW YORK
state department of
HEALTH

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

Sue Kelly
Executive Deputy Commissioner

January 30, 2014

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 #13-70
Non-Institutional Services

Dear Mr. Melendez:

The State requests approval of the enclosed amendment #13-70 to the Title XIX (Medicaid) State Plan for non-institutional services to be effective January 1, 2014 (Appendix I). This amendment is being submitted based on 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.

Copies of pertinent sections of enacted regulation are 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 December 24, 2013, 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
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: **13-70**	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 **January 1, 2014**	

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION: **Section 1902(a) of the Social Security Act, and 42 CFR 447**	7. FEDERAL BUDGET IMPACT: **a. FFY 01/01/14-09/30/14 $7,648,437** **b. FFY 10/01/14-09-30/15 $3,589,700**
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: **Attachment 4.19-B Pages: 1(q), 1(q)(i)**	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: **Attachment 4.19-B Page: 1(q)**

10. SUBJECT OF AMENDMENT:
Safety Net/VAP – Non-Institutional (Hospital-Based Outpatient) – Phase 2 (FMAP = 50%)

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

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

12. SIGNATURE OF STATE AGENCY OFFICIAL:	16. RETURN TO: **New York State Department of Health** **Bureau of Federal Relations & Provider Assessments** **99 Washington Ave – One Commerce Plaza** **Suite 1430** **Albany, NY 12210**
13. TYPED NAME: **Jason A. Helgerson**	
14. TITLE: **Medicaid Director** **Department of Health**	
15. DATE SUBMITTED: January 30, 2014	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:	18. DATE APPROVED:
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL:	20. SIGNATURE OF REGIONAL OFFICIAL:
21. TYPED NAME:	22. TITLE:

23. REMARKS:

Appendix I
2013 Title XIX State Plan
Fourth Quarter Amendment
Non-Institutional Services
Amended SPA Pages

New York
1(q)

Temporary Rate Adjustments for Mergers, Acquisitions, Consolidations, Restructurings, and Closures – hospital-based outpatient

A temporary rate adjustment will be provided to eligible providers of outpatient services that are subject to or impacted by the closure, merger, and acquisition, consolidation, or restructuring of a health care provider. The rate adjustment is intended to:

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

Eligible providers, the annual amount of the temporary rate adjustment, and the duration of the adjustment shall be listed in the table which follows. The total annual adjustment amount will be paid quarterly with the amount of each quarterly payment being equal to one fourth of the total annual amount established for each provider. The quarterly payment made under this section will be an add-on to services payments made under this Attachment to such facilities during the quarter.

To remain eligible, providers must submit benchmarks and goals acceptable to the Commissioner and must submit periodic reports, as requested by the Commissioner, concerning the achievement of such benchmarks and goals. Failure to achieve satisfactory progress in accomplishing such benchmarks and goals will result in termination of the provider's temporary rate adjustment prior to the end of the specified timeframe. Once a provider's temporary rate adjustment ends, the provider will be reimbursed in accordance with the otherwise applicable rate-setting methodology as set forth in this Attachment.

Temporary rate adjustments have been approved for the following providers in the amounts and for the effective periods listed:

Outpatient Services:

Provider Name	Gross Medicaid Rate Adjustment	Rate Period Effective
Kingsbrook Jewish Medical Center	$7,600,000	11/01/2013 - 03/31-2014
	$2,800,000	04/01/2014 - 03/31/2015
Catskill Regional Medical Center	$889,105	01/01/2014 - 03/31/2014
	$1,040,305	04/01/2014 - 03/31/2015
	$1,164,505	04/01/2015 - 03/31/2016

New York
1(q)(i)

Provider Name	Gross Medicaid Rate Adjustment	Rate Period Effective
Aurelia Osborn Fox Memorial Hospital	$3,031,209	01/01/2014 – 03/31/2014
	$2,529,235	04/01/2014 – 03/31/2015
	$1,705,835	04/01/2015 – 03/31/2016
Canton/EJ Noble	$2,000,000	01/01/2014 – 03/31/2014
	$400,000	04/01/2014 – 03/31/2015
Clifton Fine Hospital	$1,225,000	01/01/2014 – 03/31/2014
Cortland Regional Medical Center	$577,633	01/01/2014 – 03/31/2014
	$1,114,173	04/01/2014 – 03/31/2015
	$496,666	04/01/2015 – 03/31/2016
Delaware Valley Hospital	$221,650	01/01/2014 – 03/31/2014
	$164,400	04/01/2014 – 03/31/2015
	$66,200	04/01/2015 – 03/31/2016
Ellenville Hospital	$219,780	01/01/2014 – 03/31/2014
	$224,176	04/01/2014 – 03/31/2015
	$699,788	04/01/2015 – 03/31/2016
Lewis County General Hospital	$788,798	01/01/2014 – 03/31/2014
	$356,650	04/01/2014 – 03/31/2015
	$170,360	04/01/2015 – 03/31/2016
Little Falls Hospital	$431,946	01/01/2014 – 03/31/2014
	$896,187	04/01/2014 – 03/31/2015
	$963,249	04/01/2015 – 03/31/2016
Oswego Hospital	$750,000	01/01/2014 – 03/31/2014
	$500,000	04/01/2014 – 03/31/2015
Rome Memorial Hospital	$855,125	01/01/2014 – 03/31/2014
	$740,330	04/01/2014 – 03/31/2015
	$686,025	04/01/2015 – 03/31/2016
Schuyler Hospital	$216,113	01/01/2014 – 03/31/2014
	$215,574	04/01/2014 – 03/31/2015
	$225,143	04/01/2015 – 03/31/2016

Appendix II
2013 Title XIX State Plan
Fourth Quarter Amendment
Non-Institutional Services
Summary

SUMMARY
SPA #13-70

This State Plan Amendment proposes to modify the listing of hospital-based outpatient providers previously approved to receive temporary rate adjustments under the closure, merger, consolidation, acquisition, or restructuring of a health care provider, which will be deemed Phase 2. The additional adjustments for the providers for which approval is being requested are: Catskill Regional Medical Center; A.O. Fox Memorial Hospital; Canton/EJ Noble; Clifton Fine Hospital; Cortland Regional Medical Center; Delaware Valley Hospital; Ellenville Hospital; Lewis County General Hospital; Little Falls Hospital; Oswego Hospital; Rome Memorial Hospital; and Schuyler Hospital.

Appendix III
2013 Title XIX State Plan
Fourth Quarter Amendment
Non-Institutional Services
Authorizing Provisions

achievement of benchmarks and goals that are established by the Commissioner and are in conformity with the provider's approved written proposal.

The rule will have no direct effect on local governments.

Professional Services:

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

Compliance Costs:

No initial capital costs will be imposed as a result of this rule, nor is there an annual cost of compliance.

Economic and Technological Feasibility:

Small businesses will be able to comply with the economic and technological aspects of this rule because there are no technological requirements other than the use of existing technology, and the overall economic aspect of complying with the requirements is expected to be minimal.

Minimizing Adverse Impact:

This regulation seeks to provide needed relief to eligible providers, thus a positive impact for small businesses that are eligible and no impact for the remainder. In addition, local districts' share of Medicaid costs is statutorily capped; therefore, there will be no adverse impact to local governments as a result of this proposal.

Small Business and Local Government Participation:

The State filed a Federal Public Notice, published in the State Register, prior to the effective date of the change. The Notice provided a summary of the action to be taken and instructions as to where the public, including small businesses and local governments, could locate copies of the corresponding proposed State Plan Amendment. The Notice further invited the public to review and comment on the related proposed State Plan Amendment. In addition, contact information for the Department of Health was provided for anyone interested in further information.

Rural Area Flexibility Analysis

Effect on Rural Areas:

Rural areas are defined as counties with populations less than 200,000 and, for counties with populations greater than 200,000, include towns with population densities of 150 persons or less per square mile. The following 43 counties have populations of less than 200,000:

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

The following nine counties have certain townships with population densities of 150 persons or less per square mile:

Albany	Erie	Oneida
Broome	Monroe	Onondaga
Dutchess	Niagara	Orange

Compliance Requirements:

For residential health care facilities that receive the temporary rate adjustment, periodic reports must be submitted concerning the achievement of benchmarks and goals as approved by the Commissioner.

Professional Services:

No new additional professional services are required in order for providers in rural areas to comply with the proposed amendments.

Compliance Costs:

No initial capital costs will be imposed as a result of this rule, nor is there an annual cost of compliance.

Minimizing Adverse Impact:

This regulation provides needed relief to eligible providers, thus a positive impact for small businesses that are eligible and no impact for the remainder. In addition, local districts' share of Medicaid costs is statutorily capped; therefore, there will be no adverse impact to local governments as a result of this proposal.

Rural Area Participation:

A concept paper was shared with the hospital and long-term care industry associations, both of which include members from rural areas. Comments were received and taken into consideration while drafting the regulations. In addition, a Federal Public Notice, published in the New York State Register invited comments and questions from the general public.

Job Impact Statement

A Job Impact Statement is not required pursuant to Section 201-a(2)(a) of the State Administrative Procedure Act. It is apparent, from the nature and purpose of the proposed rule, that it will not have a substantial adverse impact on jobs or employment opportunities. The proposed regulation provides a temporary rate adjustment to eligible residential health care facilities that are subject to or impacted by the closure, merger, acquisition, consolidation, or restructuring of a health care provider in its service delivery area. In addition, the proposed regulation sets forth the conditions under which a provider will be considered eligible, the requirements for requesting a temporary rate adjustment, and the conditions that must be met in order to receive a temporary rate adjustment. The proposed regulation has no implications for job opportunities.

EMERGENCY RULE MAKING

Temporary Rate Adjustment (TRA) - Licensed Ambulatory Care Facilities (LACF)

I.D. No. HLT-14-12-00008-E

Filing No. 449

Filing Date: 2012-05-11

Effective Date: 2012-05-11

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

Action taken: Addition of section 86-8.15 to Title 10 NYCRR.

Statutory authority: Public Health Law, section 2807(2-a)(e)

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

Specific reasons underlying the finding of necessity: Paragraph (e) of subdivision 2-a of Section 2807 of the Public Health Law (as added by Section 2 of Part C of Chapter 58 of the Laws of 2009) specifically provides the Commissioner of Health with authority to issue emergency regulations in order to compute rates of payment for Article 28 licensed ambulatory care providers as authorized in accordance with the provisions of such subdivision 2-a.

Subject: Temporary Rate Adjustment (TRA) - Licensed Ambulatory Care Facilities (LACF).

Purpose: Expand TRA to include Article 28 LACFs subject to or affected by closure, merger, acquisition, consolidation, or restructuring.

Text of emergency rule: Subpart 86-8 of title 10 of NYCRR is amended by adding a new section 86-8.15, to read as follows:

86-8.15 Closures, mergers, acquisitions, consolidations, restructurings and inpatient bed de-certifications. (a) The commissioner may grant approval of a temporary adjustment to the non-capital components of rates calculated pursuant to this subpart for eligible ambulatory care facilities licensed under article 28 of the Public Health Law ("PHL").

(b) Eligible facilities shall include:

(1) facilities undergoing closure;

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

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

(4) facilities impacted by the merger, acquisition, consolidation or restructuring of other health care facilities; or

(5) outpatient facilities of general hospitals which have entered into an agreement with the Department to permanently decertify a specified number of staffed hospital inpatient beds, as reported to the Department.

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

(1) protect or enhance access to care;

(2) protect or enhance quality of care;

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

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

(d)(1) Such written proposal shall be submitted to the commissioner at least sixty days prior to the requested effective date of the temporary rate adjustment and shall include a proposed budget to achieve the goals of the proposal. Any temporary rate adjustment issued pursuant to this section shall be in effect for a specified period of time as determined by the commissioner, of up to three years. At the end of the specified timeframe, the facility shall be reimbursed in accordance with the otherwise applicable rate-setting methodology as set forth in applicable statutes and this Subpart. The commissioner may establish, as a condition of receiving such a temporary rate adjustment, benchmarks and goals to be achieved in conformity with the facility's written proposal as approved by the commissioner and may also require that the facility submit such periodic reports concerning the achievement of such benchmarks and goals as the commissioner deems necessary. Failure to achieve satisfactory progress, as determined by the commissioner, in accomplishing such benchmarks and goals shall be a basis for ending the facility's temporary rate adjustment prior to the end of the specified timeframe.

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

(e) Federally qualified health centers with reimbursement rates issued pursuant to PHL § 2807(8) may apply for a temporary rate adjustment pursuant to this section as an alternative rate-setting methodology in accordance with the provisions of PHL § 2807(8)(f).

This notice is intended to serve only as a notice of emergency adoption. This agency intends to adopt the provisions of this emergency rule as a permanent rule, having previously submitted to the Department of State a notice of proposed rule making, I.D. No. HLT-14-12-00008-P, Issue of April 4, 2012. The emergency rule will expire July 9, 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 statutory authority for this regulation is contained in Section 2807(2-a)(e) of the Public Health Law (PHL) which authorizes the Commissioner to promulgate regulations, including emergency regulations, with regard to Medicaid reimbursement rates for outpatient services. Such outpatient rate regulations are set forth in Subpart 86-8 of Title 10 (Health) of the Official Compilation of Codes, Rules, and Regulation of the State of New York.

Legislative Objectives:

Subpart 86-8 of Title 10 (Health) of the Official Compilation of Codes, Rules and Regulation of the State of New York, will be amended to add this Section 8.15, which provides the commissioner authority to grant temporary rate adjustments to eligible Article 28 licensed ambulatory care providers subject to or affected by the closure, merger, acquisition consolidation, or restructuring of a health care provider in their service delivery area. In addition, the proposed regulation sets forth the conditions under which a provider will be considered eligible, the requirements for requesting a temporary rate adjustment, and the conditions that must be met in order to receive a temporary rate adjustment. The temporary rate adjustment shall be in effect for a specified period of time, as approved by the Commissioner, of up to three years. This regulation is necessary in order to maintain beneficiaries' access to services by providing needed relief to providers that meet the criteria.

Proposed section 86-8.15 requires providers seeking a temporary rate adjustment to submit a written proposal demonstrating that the additional resources provided by a temporary rate adjustment will achieve one or more of the following: (i) protect or enhance access to care; (ii) protect or enhance quality of care; (iii) improve the cost effectiveness of the delivery of health care services; or (iv) otherwise protect or enhance the health care delivery system, as determined by the Commissioner. The proposed amendment permits the Commissioner to establish benchmarks and goals, in conformity with a provider's written proposal as approved by the Commissioner, and to require the provider to submit periodic reports concerning its progress toward achievement of such. Failure to achieve satisfactory progress in accomplishing such benchmarks and goals, as determined by the Commissioner, shall be a basis for ending the provider's temporary rate adjustment prior to the end of the specified timeframe.

Needs and Benefits:

In the center of a changing health care delivery system, the closure, merger, acquisition, consolidation or restructuring of a health care provider within a community often happens without adequate planning of resources for the impact on health care providers in the service delivery area. In addition, maintaining access to needed services while also maintaining or improving quality becomes challenging for the impacted providers. The additional reimbursement provided by this adjustment will support the impacted Article 28 licensed ambulatory care providers in achieving these goals, thus improving quality while reducing health care costs.

Costs:

Costs to Private Regulated Parties:

There will be no additional costs to private regulated parties. The only additional data requested from providers would be periodic reports demonstrating progress against benchmarks and goals.

Costs to State Government:

There is no additional aggregate increase in Medicaid expenditures anticipated as a result of these regulations, as the cost of the temporary rate adjustment will be offset by the overall reduction in Medicaid expenditures due to the closure, merger, acquisition, consolidation or restructuring occurring in a particular service delivery area.

Costs to Local Government:

Local districts' share of Medicaid costs is statutorily capped; therefore, there will be no additional costs to local governments as a result of this proposed regulation.

Costs to the Department of Health:

There will be no additional costs to the Department of Health as a result of this proposed regulation.

Local Government Mandates:

The proposed regulation 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:

An eligible provider must submit a written proposal, including a proposed budget. If a temporary rate adjustment is approved for a provider, the provider must submit periodic reports, as determined by the Commissioner, concerning the achievement of benchmarks and goals that are established by the Commissioner and are in conformity with the provider's approved written proposal.

Duplication:

This is an amendment to an existing State regulation and does not duplicate any existing federal, state or local regulations.

Alternatives:

No significant alternatives are available. Any potential ambulatory care provider project that would otherwise qualify for funding pursuant to the revised regulation would, in the absence of this amendment, either not proceed or would require the use of existing provider resources.

Federal Standards:

The proposed regulation does not exceed any minimum standards of the federal government for the same or similar subject area.

Compliance Schedule:

The proposed regulation provides the Commissioner of Health the authority to grant approval of temporary adjustments to rates calculated for Article 28 licensed ambulatory care providers that are subject to or affected by the closure, merger, acquisition, consolidation, or restructuring of a health care provider, for a specified period of time, as determined by the Commissioner, of up to three years.

Regulatory Flexibility Analysis

Effect of Rule:

For the purpose of this regulatory flexibility analysis, small businesses were considered to be Article 28 licensed ambulatory care providers with 100 or fewer full-time equivalents. Based on recent financial and statistical data extracted from the Institutional Cost Report, 384 Article 28 licensed ambulatory care providers were identified as employing fewer than 100 employees.

No health care providers subject to this regulation will see a decrease in average per discharge Medicaid funding as a result of this regulation.

This rule will have no direct effect on local governments.

Compliance Requirements:

Article 28 licensed ambulatory care providers that receive the temporary rate adjustment under this regulation will be required to submit periodic reports demonstrating their progress toward benchmarks and goals established by the Commissioner.

The rule will have no direct effect on local governments.

Professional Services:

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

Compliance Costs:

No initial capital costs will be imposed as a result of this rule, nor will there be an annual cost of compliance.

Economic and Technological Feasibility:

Small businesses will be able to comply with the economic and technological aspects of this rule. The proposed amendments are techno-

logically feasible because it requires the use of existing technology. The overall economic impact to comply with the requirements of this regulation is expected to be minimal.

Minimizing Adverse Impact:

This regulation provides needed relief to eligible providers, thus a positive impact for small businesses that are eligible and no impact for the remainder. In addition, local districts' share of Medicaid costs is statutorily capped; therefore, there will be no adverse impact to local governments as a result of this proposal.

Small Business and Local Government Participation:

The State filed a Federal Public Notice, published in the State Register, prior to the effective date of the change. The Notice provided a summary of the action to be taken and instructions as to where the public, including small businesses and local governments, could locate copies of the corresponding proposed State Plan Amendment. The Notice further invited the public to review and comment on the related proposed State Plan Amendment. In addition, contact information for the Department of Health was provided for anyone interested in further information.

Rural Area Flexibility Analysis

Effect on Rural Areas:

Rural areas are defined as counties with populations less than 200,000 and, for counties with populations greater than 200,000, include towns with population densities of 150 persons or less per square mile. The following 43 counties have populations of less than 200,000:

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

The following nine counties have certain townships with population densities of 150 persons or less per square mile:

Albany	Erie	Oneida
Broome	Monroe	Onondaga
Dutchess	Niagara	Orange

Compliance Requirements:

For Article 28 licensed ambulatory care providers that receive the temporary rate adjustment, periodic reports must be submitted which demonstrate the achievement of benchmarks and goals set by the Commissioner.

Professional Services:

No new additional professional services are required in order for providers in rural areas to comply with the proposed amendments.

Compliance Costs:

No initial capital costs will be imposed as a result of this rule, nor is there an annual cost of compliance.

Minimizing Adverse Impact:

This regulation provides needed relief to eligible providers, thus a positive impact for small businesses that are eligible and no impact for the remainder. In addition, local districts' share of Medicaid costs is statutorily capped; therefore, there will be no adverse impact to local governments as a result of this proposal.

Rural Area Participation:

The proposal resulting in this regulation was endorsed by the Medicaid Redesign Team, which was established by the Governor. The Medicaid Redesign Team included members representing ambulatory care providers and rural areas and utilized a very public approach for soliciting both proposals and feedback from stakeholders and the public in general.

Job Impact Statement

A Job Impact Statement is not required pursuant to Section 201-a(2)(a) of the State Administrative Procedure Act. It is apparent, from the nature and purpose of the proposed rule, that it will not have a substantial adverse impact on jobs or employment opportunities. The proposed regulation provides for a temporary rate adjustment to eligible Article 28 ambulatory care providers subject to or affected by the closure, merger, acquisition, consolidation, or restructuring of a health care provider in its service delivery area. The proposed regulation has no implications for job opportunities.

PROPOSED RULE MAKING
NO HEARING(S) SCHEDULED

Limits on Executive Compensation and Administrative Expenses in Agency Procurements

I.D. No. HLT-22-12-00012-P

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

Proposed Action: Addition of Part 1002 to Title 10 NYCRR.

Statutory authority: Social Services Law, section 363-a(2); and Public Health Law, sections 201(1)(o), (p), 206(3) and (6)

Subject: Limits on Executive Compensation and Administrative Expenses in Agency Procurements.

Purpose: Ensure state funds and state authorized payments are expended in the most efficient manner and appropriate use of funds.

Substance of proposed rule (Full text is posted at the following State website:www.health.ny.gov): The Department proposes regulations to implement Governor Cuomo's Executive Order 38, which sets forth standards for executive compensation paid by, and administrative expenses paid to, covered providers receiving state funds or state authorized payments. The regulations define key terms including "administrative expenses," "program services expenses," and "covered provider," and provide standards to be used in determining whether a covered provider's executive compensation and administrative costs are within certain limits. The regulations further provide means for waivers with regard to the executive compensation and administrative cost limits under limited circumstances and subject to specific criteria. Finally, the regulations provide for review of decisions denying requests for waiver, penalties for failure to comply with applicable limitations, and covered entity reporting obligations.

Text of proposed 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

Data, views or arguments may be submitted to: Same as above.

Public comment will be received until: 45 days after publication of this notice.

This action was not under consideration at the time this agency's regulatory agenda was submitted.

Regulatory Impact Statement

Statutory Authority:

The authority for the promulgation of these regulations is contained section 363-a(2) of the Social Services law and in sections 201(1)(o), 201(1)(p), 206(3) and 206(6) of the Public Health Law.

Legislative Objectives:

This rule furthers the proper use of funds in furtherance of the Department's oversight of the various programs and procurements for which it pays, or authorizes payment.

Needs and Benefits:

The New York State Department of Health is proposing to adopt the following regulation because the State of New York directly or indirectly funds with taxpayer dollars a large number of tax exempt organizations and for-profit entities that provide critical services to New Yorkers in need and the goal is to ensure that taxpayers' dollars are used properly, efficiently, and effectively to improve the lives of New Yorkers. In certain instances, providers of services that receive State funds or State-authorized payments have used such funds to pay for excessive administrative costs or inflated compensation for their senior executives, rather than devoting a greater proportion of such funds to providing direct care or services to their clients. Such abuses involving public funds harm both the people of New York who are paying for such services, and those persons who must depend upon such services to be available and well-funded. These regulations, which are required by Executive Order No. 38, will ensure that State funds or State-authorized payments paid by this agency to providers are not used to support excessive compensation or unnecessary administrative costs.

Appendix IV
2013 Title XIX State Plan
Fourth Quarter Amendment
Non-Institutional 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 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 related to temporary rate adjustments to providers that are undergoing a closure, merger, consolidation, acquisition or restructuring themselves or other health care providers. These payments are authorized by current State statutory and regulatory provisions.

The temporary rate adjustment has been reviewed and approved for 36 providers with aggregate payment amounts totaling up to $138,672,342 for the period January 1, 2014 through March 31, 2016. The approved providers along with their individual estimated aggregate amounts include:

1. AHRC Health Care, Inc. (d/b/a ACCESS Comm. Health Center), up to $534,838;
2. Anthony L. Jordan Health Center, up to $2,459,842;
3. Aurelia Osborn Fox Memorial Hospital, up to $7,266,279;
4. Asian & Pacific Islander Coalition of HIV/AIDS (APICHA), up to $6,179,395;
5. Blue Line Group (comprised of Adirondack Tri-County Nursing and Rehabilitation Center, Inc.; Heritage Commons Residential Health Care Facility; Mercy Living Center; and Uihlein Living Center), up to $7,100,000;
6. Canton/EJ Noble, up to $2,400,000;
7. Catskill Regional Medical Center, up to $3,093,915;
8. Clifton-Fine Hospital, up to $1,225,000;
9. Cortland Regional Medical Center Inc., up to $2,188,472;
10. Crouse Community Center Inc., up to $1,420,000;
11. Delaware Valley Hospital, up to $452,250;
12. East Hill Family Medical Inc., up to $216,440;
13. Ellenville Regional Hospital, up to $1,143,744;
14. Elmwood Health Center, up to $752,909;
15. Finger Lakes Migrant Health Care Project (d/b/a Finger Lake Community Health), up to $2,240,982;
16. Hudson River HealthCare Inc., up to $1,019,400;
17. Jefferson County Public Health Service, up to $1,180,745;
18. Kings County Hospital Center, up to $1,000,000;
19. Lewis County General Hospital, up to $1,315,808;
20. Little Falls Hospital, up to $2,291,382;
21. Montefiore Medical Center, up to $59,000,000;
22. Morris Heights Health Center Inc., up to $1,311,114;
23. Mount Vernon Neighborhood Health Center Network, up to $749,599;
24. New York Methodist Hospital, up to $9,325,000;
25. Niagara Falls Memorial Medical Center, up to $795,566;
26. Oswego Hospital, up to $1,250,000;
27. Planned Parenthood of New York City Inc., up to $645,327;
28. Planned Parenthood of the Rochester/Syracuse Region Inc. up to $2,156,230;
29. Rochester Primary Care Network Inc./Rushville Health Center, Inc. Finger Lakes Regional, up to $2,218,340;
30. Rome Memorial Hospital Inc., up to $2,281,480;
31. Schuyler Hospital, up to $656,830;
32. The Floating Hospital Inc., up to $445,034;
33. The Institute for Family Health, up to $3,744,118;
34. Upper Hudson Planned Parenthood, up to $350,000;
35. Visiting Nurse Association of Long Island, up to $4,281,840; and
36. Wyckoff Heights Medical Center, up to $3,980,463.

An additional amount of up to $5,000,000 will be allocated to fund temporary rate adjustments for Critical Access Hospitals (CAHs), beyond that which is allocated for the individual providers listed. Total estimated aggregate expenditures for the 36 providers listed above and the CAHs is $143,672,342.

The estimated net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for State Fiscal Years 2013/2014, 2014/2015, and 2015/2016, by provider category, is as follows: institutional, $74,101,029; long term care, $8,520,000; non-institutional, $34,469,626 (includes CAHs); Federally Qualified Health Centers, $21,119,102; and Certified Home Health Agencies, $5,462,585.

The previously approved aggregate payment amounts for the periods January 1, 2014 through March 31, 2014 have been modified, and additional payments for the periods April 1, 2014 through March 31, 2016 have been approved. Such aggregate payments for all providers (including CAHs) will be: $39,523,157 for the period January 1, 2014 through March 31, 2014; $63,250,745 for the period April 1, 2014 through March 31, 2015; and $40,898,440 for the period April 1, 2015 through March 31, 2016.

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.

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

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

PUBLIC NOTICE

Department of 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 to remove coverage of barbiturates used in all medically accepted indications for dual eligible beneficiaries effective January 1, 2014.

Section 1927(d)(2) of the Act has been amended effective January 1, 2014, to remove barbiturates from the list of excludable drugs, thereby qualifying barbiturates as a covered Part D drug for all medically accepted indications. Currently, barbiturates are covered for dual eligible beneficiaries when used for indications other than epilepsy, cancer, and chronic mental health disorders.

Since the coverage of barbiturates under Part D is inclusive of all indications, New York State proposes to provide coverage for only non-dual eligible beneficiaries.

The estimated annual net aggregate decrease in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2013/14 is up to $22,000.

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.

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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 Federal Relations & Provider Assessments, 99 Washington Ave. – One Commerce Plaza, Suite 1430, Albany, NY 12210, (518) 474-1673, (518) 473-8825 (FAX), e-mail: spa_inquiries@health.state.ny.us

Appendix V
2013 Title XIX State Plan
Fourth Quarter Amendment
Non-Institutional Services
Responses to Standard Funding Questions

NON-INSTITUTIONAL SERVICES
State Plan Amendment #13-70

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: The State submitted the current outpatient UPL demonstration on September 30, 2013, which is currently under CMS review.

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 methodologies included in the State Plan for outpatient hospital services are either cost-based subject to ceilings or based upon the Ambulatory Patient Group (APG) system. We are unaware of any requirement under current federal law or regulation that limits individual provider's payments to their actual costs.

ACA Assurances:

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

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

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

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

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

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

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

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

Tribal Assurance:

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

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

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

Response: Tribal consultation was performed in accordance with the State's tribal consultation policy as approved in SPA 11-06, and documentation of such is included

with this submission. To date, no feedback has been received from any tribal representative in response to the proposed change in this SPA.