



## Department of Health

**ANDREW M. CUOMO**  
Governor

**HOWARD A. ZUCKER, M.D., J.D.**  
Commissioner

**SALLY DRESLIN, M.S., R.N.**  
Executive Deputy Commissioner

FEB 18 2016

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 #16-0002  
Non-Institutional Services

Dear Mr. Melendez:

The State requests approval of the enclosed amendment #16-0002 to the Title XIX (Medicaid) State Plan for non-institutional services to be effective January 1, 2016 (Appendix I). This amendment is being submitted based on existing methodology. 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.

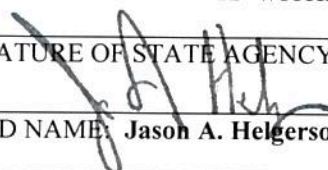
Copies of pertinent sections of proposed State statute are enclosed for your information (Appendix III). A copy of the public notice of this plan amendment, which was given in the New York State Register on December 31, 2014, is also enclosed for your information (Appendix IV). In addition, responses 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, Office of Health Insurance Programs at (518) 474-6350.

Sincerely,

  
Jason A. Helgeson  
Medicaid Director  
Office of Health Insurance Programs

Enclosures

<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</b>  <b>FOR: HEALTH CARE FINANCING ADMINISTRATION</b>		1. TRANSMITTAL NUMBER: <b>16-0002</b>	2. STATE <b>New York</b>
		3. PROGRAM IDENTIFICATION: <b>TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)</b>	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE <b>January 1, 2016</b>	
5. TYPE OF PLAN MATERIAL ( <i>Check One</i> ):  <input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT ( <i>Separate Transmittal for each amendment</i> )			
6. FEDERAL STATUTE/REGULATION CITATION: <b>§ 1902(a) of the Social Security Act, and 42 CFR 447</b>		7. FEDERAL BUDGET IMPACT: ( <i>in thousands</i> ) a. FFY 01/01/16-09/30/16 \$ 0 b. FFY 10/01/16-09/30/17 \$ 0	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:  <b>Attachment 4.19-B: Page 2(g)(1)</b>		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT ( <i>If Applicable</i> ):  <b>Attachment 4.19-B: Page 2(g)(1)</b>	
10. SUBJECT OF AMENDMENT: <b>APG Extension – Freestanding Clinics (FMAP = 50%)</b>			
11. GOVERNOR'S REVIEW ( <i>Check One</i> ): <input checked="" type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input type="checkbox"/> OTHER, AS SPECIFIED: <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL			
12. SIGNATURE OF STATE AGENCY OFFICIAL: 		16. RETURN TO: <b>New York State Department of Health Bureau of Federal Relations &amp; Provider Assessments 99 Washington Ave – One Commerce Plaza Suite 1460 Albany, NY 12210</b>	
13. TYPED NAME: <b>Jason A. Helgerson</b>			
14. TITLE: <b>Medicaid Director Department of Health</b>			
15. DATE SUBMITTED: <b>FEB 18 2016</b>			
<b>FOR REGIONAL OFFICE USE ONLY</b>			
17. DATE RECEIVED:		18. DATE APPROVED:	
<b>PLAN APPROVED – ONE COPY ATTACHED</b>			
19. EFFECTIVE DATE OF APPROVED MATERIAL:		20. SIGNATURE OF REGIONAL OFFICIAL:	
21. TYPED NAME:		22. TITLE:	
23. REMARKS:			

**Appendix I**  
**2016 Title XIX State Plan**  
**First Quarter Amendment**  
**Amended SPA Pages**



**New York  
2(g)(1)**

**APG Reimbursement Methodology – Freestanding Clinics**

For the purposes of sections pertaining to the Ambulatory Patient Group, and excepted as otherwise noted, the term freestanding clinics shall mean freestanding Diagnostic and Treatment Centers (D&TCs) and shall include freestanding ambulatory surgery centers.

For dates of service beginning September 1, 2009 through December 31, [2015] 2016, for freestanding Diagnostic and Treatment Center (D&TC) and ambulatory surgery center services, the operating component of rates shall be reimbursed using a methodology that is prospective and associated with resource utilization to ensure that ambulatory services are economically and efficiently provided. The methodology is based upon the Ambulatory Patient Group (APG) classification and reimbursement system. This methodology incorporates payments for the separate covered Medicaid benefits in accordance with the payment methods for these services. Reimbursement for the capital component of these rates shall be made as an add-on to the operating component as described in the APG Rate Computation section.

The Ambulatory Patient Group patient classification system is designed to explain the amount and type of resources used in an ambulatory visit by grouping patients with similar clinical characteristics and similar resource use into a specific APG. Each procedure code associated with a patient visit is assigned to an APG using the grouping logic developed by 3M Health Information Systems (3M). When evaluation and management codes are coded, the APG grouping logic also uses the diagnosis code to make the APG assignment. Ultimately, the procedures and diagnoses coded for a patient visit will result in a list of APGs that correspond on a one-for-one basis with each procedure coded for the visit.

**TN**           #16-0002                                **Approval Date** \_\_\_\_\_

**Supersedes TN**           #15-0010                                **Effective Date** \_\_\_\_\_

**Appendix II**  
**2016 Title XIX State Plan**  
**First Quarter Amendment**  
**Summary**

**SUMMARY**  
**SPA #16-0002**

This State Plan Amendment proposes to extend the Ambulatory Patient Group (APG) methodology for freestanding clinic and ambulatory surgery center services for the effective period January 1, 2016 through December 31, 2016.

**Appendix III**  
**2016 Title XIX State Plan**  
**First Quarter Amendment**  
**Authorizing Provisions**

CHAPTER 57 OF THE LAWS OF 2008 - PART C

§ 18. Section 2807 of the public health law is amended by adding a new subdivision 2-a to read as follows:

2-a. Notwithstanding any provision of which is inconsistent with or contrary to the structure established by this subdivision and subdivision thirty-three of section twenty-eight hundred seven-c of this article, and subject to the availability of federal financial participation, rates of payment by governmental agencies, established pursuant to this article, for general hospital outpatient services, general hospital emergency services, ambulatory surgical services provided by a hospital as defined by subdivision one of section twenty-eight hundred one of this article, and diagnostic and treatment center services, but excepting any facility whose reimbursement is governed by subdivision eight of this section or any payments made on behalf of persons enrolled in Medicaid managed care or in the family health plus program, shall be in accordance with the following:

(a) (i) for the period December first, two thousand eight through December thirty-first, two thousand nine, seventy-five percent of such rates of payment for each general hospital's outpatient services shall reflect the average Medicaid payment per claim, as determined by the commissioner, for services provided by that facility in the two thousand seven calendar year, but excluding any payments for services covered by the facility's licensure, if any, under the mental hygiene law, and twenty-five percent of such rates of payment shall, for the operating cost component, reflect the utilization of the ambulatory patient groups reimbursement methodology described in paragraph (e) of this subdivision;

(ii) for the period January first, two thousand ten through December thirty-first, two thousand ten, fifty percent of such rates for each facility shall reflect the average Medicaid payment per claim, as determined by the commissioner, for services provided by that facility in the two thousand seven calendar year, but excluding any payments for services covered by the facility's licensure, if any, under the mental hygiene law, and fifty percent of such rates of payment shall, for the operating cost component, reflect the utilization of the ambulatory patient groups reimbursement methodology described in paragraph (e) of this subdivision;

(iii) for the period January first, two thousand eleven through December thirty-first, two thousand eleven, twenty-five percent of such rates shall reflect the average Medicaid payment per claim, as determined by the commissioner, for services provided by that facility for the two thousand seven calendar year, but excluding any payments for services covered by the facility's licensure, if any, under the mental hygiene law, and seventy-five percent of such rates of payment shall, for the operating cost component, reflect the utilization of the ambulatory patient groups reimbursement methodology described in paragraph (e) of this subdivision; and

(iv) for periods on and after January first, two thousand twelve, one hundred percent of such rates of payment shall reflect the utilization of the ambulatory patient groups reimbursement methodology described in paragraph (e) of this subdivision.

(v) This paragraph shall be effective the later of: (i) December first, two thousand eight, or (ii) after the commissioner receives final approval of federal financial participation in payments made for beneficiaries eligible for medical assistance under title XIX of the federal social security act for the rate methodology established pursuant to subparagraph (i) of paragraph (a) of subdivision thirty-three of section twenty-eight hundred seven-c of this article.

(b) (i) for the period March first, two thousand nine through December thirty-first, two thousand nine, seventy-five percent of such rates of



payment for services provided by each diagnostic and treatment center and each free-standing ambulatory surgery center shall reflect the average Medicaid payment per claim, as determined by the commissioner, for services provided by that facility in the two thousand seven calendar year, but excluding any payments for services covered by the facility's licensure, if any, under the mental hygiene law, and twenty-five percent of such rates of payment shall, for the operating cost component, reflect the utilization of the ambulatory patient groups reimbursement methodology described in paragraph (e) of this subdivision;

(ii) for the period January first, two thousand ten through December thirty-first, two thousand ten, fifty percent of such rates for each facility shall reflect the average Medicaid payment per claim, as determined by the commissioner, for services provided by that facility in the two thousand seven calendar year, but excluding any payments for services covered by the facility's licensure, if any, under the mental hygiene law, and fifty percent of such rates of payment shall, for the operating cost component, reflect the utilization of the ambulatory patient groups reimbursement methodology described in paragraph (e) of this subdivision;

(iii) for the period January first, two thousand eleven through December thirty-first, two thousand eleven, twenty-five percent of such rates for each facility shall reflect the average Medicaid payment per claim, as determined by the commissioner, for services provided by that facility in the two thousand seven calendar year, but excluding any payments for services covered by the facility's licensure, if any, under the mental hygiene law, and seventy-five percent of such rates of payment shall, for the operating cost component, reflect the utilization of the ambulatory patient groups reimbursement methodology described in paragraph (e) of this subdivision; and

(iv) for periods on and after January first, two thousand twelve, one hundred percent of such rates of payment shall reflect the utilization of the ambulatory patient groups reimbursement methodology described in paragraph (e) of this subdivision.

(c) for periods on and after December first, two thousand eight, such rates of payment for ambulatory surgical services provided by general hospitals shall reflect the utilization of the ambulatory patient groups reimbursement methodology described in paragraph (e) of this subdivision, provided however, that the capital cost component for such rates shall be separately computed in accordance with regulations promulgated in accordance with paragraph (e) of this subdivision.

(d) for periods on and after January first, two thousand nine, the operating cost component of such rates of payment for general hospital emergency services shall reflect the utilization of the ambulatory patient groups reimbursement methodology described in paragraph (e) of this subdivision and shall not reflect any maximum payment amount as otherwise provided for in subparagraph (ii) of paragraph (g) of subdivision two of this section.

(e) notwithstanding any inconsistent provisions of this subdivision, the commissioner shall promulgate regulations establishing, subject to the approval of the state director of the budget, methodologies for determining rates of payment for the services described in this subdivision. Such regulations shall reflect utilization of the ambulatory patient group (APG) methodology, in which patients are grouped based on their diagnosis, the intensity of the services provided and the medical procedures performed, and with each APG assigned a weight reflecting the projected utilization of resources. Such regulations shall provide for the development of one or more base rates and the multiplication of such base rates by the assigned weight for each APG to establish the appropriate payment level for each such APG. Such regulations may also utilize bundling, packaging and discounting mechanisms.

(f) (i) The commissioner shall periodically measure the utilization and intensity of services provided to medical assistance recipients in ambulatory settings. Such analysis shall include, but not be limited to: measurement of the shift of surgical procedures from the inpatient



hospital setting to the ambulatory setting including measurement of the impact of any such shift on quality of care and outcomes; changes in the utilization and intensity of services provided in the outpatient hospital department and in diagnostic and treatment centers; and the change in the utilization and intensity of services provided in the emergency department.

(ii) notwithstanding the provisions of paragraphs (a) and (b) of this subdivision, for periods on and after January first, two thousand nine, the following services provided by general hospital outpatient departments and diagnostic and treatment centers shall be reimbursed with rates of payment based entirely upon the ambulatory patient group methodology as described in paragraph (e) of this subdivision:

(A) services provided in accordance with the provisions of paragraphs (q) and (r) of subdivision two of section three hundred sixty-five-a of the social services law; and

(B) all services, but only with regard to additional payment amounts, as determined in accordance with regulations issued in accordance with paragraph (e) of this subdivision, for the provision of such services during times outside the facility's normal hours of operation, as determined in accordance with criteria set forth in such regulations; and

(C) individual psychotherapy services provided by licensed social workers, in accordance with licensing criteria set forth in applicable regulations, to persons under the age of nineteen and to persons requiring such services as a result of or related to pregnancy or giving birth.

(D) individual psychotherapy services provided by licensed social workers, in accordance with licensing criteria set forth in applicable regulations, at diagnostic and treatment centers that provided, billed for, and received payment for these services between January first, two thousand seven and December thirty-first, two thousand seven.

(g) for the purposes set forth in paragraphs (a) and (b) of this subdivision, rates described as in effect for the two thousand seven calendar year shall mean those rates which are in effect for that year on the date this subdivision becomes effective and such rates shall not thereafter, for the purposes set forth in such paragraphs (a) and (b), be subject to further adjustment.

(h) (i) To the degree that rates of payment computed in accordance with paragraphs (a) and (d) of this subdivision reflect utilization of the ambulatory patient groups reimbursement methodology described in paragraph (e) of this subdivision for purposes of computing the operating component of such rates, the computation of the capital cost component of such rates shall remain subject to the provisions of subparagraphs

(i) and (ii) of paragraph (g) of subdivision two of this section, provided, however, that this subparagraph shall not be understood as applying to those portions of rates of payment computed pursuant to paragraph (a) of this subdivision which are based on average Medicaid payments per claim.

(ii) To the degree that rates of payment computed in accordance with paragraph (b) of this subdivision reflect utilization of the ambulatory patient groups reimbursement methodology described in paragraph (e) of this subdivision for purposes of computing the operating component of such rates, the computation of the capital cost component of such rates shall, for diagnostic and treatment centers, remain subject to the provisions of paragraph (b) of subdivision two of this section and shall, for free-standing ambulatory surgery centers, be separately computed in accordance with regulations promulgated in accordance with paragraph (e) of this subdivision, provided, however, that this subparagraph shall not be understood as applying to those portions of rates of payment which are based on average Medicaid payments per claim.

**Appendix IV  
2016 Title XIX State Plan  
First Quarter Amendment  
Public Notice**



# MISCELLANEOUS NOTICES/HEARINGS

## Notice of Abandoned Property Received by the State Comptroller

Pursuant to provisions of the Abandoned Property Law and related laws, the Office of the State Comptroller receives unclaimed monies and other property deemed abandoned. A list of the names and last known addresses of the entitled owners of this abandoned property is maintained by the office in accordance with Section 1401 of the Abandoned Property Law. Interested parties may inquire if they appear on the Abandoned Property Listing by contacting the Office of Unclaimed Funds, Monday through Friday from 8:00 a.m. to 4:30 p.m., at:

1-800-221-9311  
or visit our web site at:  
www.osc.state.ny.us

Claims for abandoned property must be filed with the New York State Comptroller's Office of Unclaimed Funds as provided in Section 1406 of the Abandoned Property Law. For further information contact: Office of the State Comptroller, Office of Unclaimed Funds, 110 State St., Albany, NY 12236.

## PUBLIC NOTICE

Department of Civil Service

PURSUANT to the Open Meetings Law, the New York State Civil Service Commission hereby gives public notice of the following:

Please take notice that the regular monthly meeting of the State Civil Service Commission for January 2015 will be conducted on January 13 and January 14 commencing at 10:00 a.m. This meeting will be conducted at NYS Media Services Center, Suite 146, South Concourse, Empire State Plaza, Albany, NY.

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

## PUBLIC NOTICE

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, non-institutional or long term care services to comply with enacted statutory provisions. The following changes are proposed:

### All Services

- Effective January 1, 2015, the Department of Health and Division of Budget will determine the extent of Medicaid savings available under the Medicaid Global Spending Cap for distribution among Medicaid providers and managed care plans prior to the last quarter of each state fiscal year. Funds up to the amount available under the Medicaid Global Spending Cap will be distributed through an allocation plan that utilizes three years of the most recently available system-wide expenditure data reflecting both MMIS and managed care encounters. The dividend will be allocated proportionately by the Medicaid expenditure data. Distributions to managed care plans will be calculated using the administrative outlays stemming from participation in the Medicaid program.

No greater than fifty percent of the funding available for a dividend will be made available for the purposes of ensuring a minimum level of assistance to financially distressed and critically needed providers.

There is no additional estimated annual change to gross Medicaid expenditures as a result of the proposed amendment.

### Non-Institutional Services

The Ambulatory Patient Group (APG) reimbursement methodology is extended for the period January 1, 2015 through March 31, 2017. Such methodology is revised to include recalculated weight and component updates that will become effective on or after January 1, 2015.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2014/2015 is \$1,944,230.

### Institutional Services

- Effective January 1, 2015 through March 31, 2016, the New York State Office of Mental Health hereby gives notice that it is proposing to amend its Medicaid State Plan for Residential Treatment Facilities for Children and Youth. The amendment will reflect the inclusion of a trend factor applied to allowable costs.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year (SFY) 2014/2015 is \$508,864 and for SFY 2015/2016 is \$2,035,457.

- Effective January 1, 2015 the State will change the methods and standards for determining payment rates for the services listed below to provide funding to support a two percent increase in annual salary and salary-related fringe benefits for direct care staff and direct support professionals, and in payment to foster parents and adoptive parents.

Effective April 1, 2015, a new two percent increase in annual salary and salary-related fringe benefits will be applied for direct care staff, direct support professionals and clinical staff, and in payment to foster parents and adoptive parents for the following programs:

- VOICF
- VOIRA – Supervised
- VOIRA – Supportive
- VO Day Habilitation
- VO Pre-Vocational
- VO Respite – Hourly
- VO Respite – Freestanding
- SO and VO Family Care
- VO Supported Employment
- VO Community Habilitation

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for SFY 2014/2015 is \$11,291,837.

- As previously noticed September 10, 2014 and October 8, 2014, the additional temporary rate adjustment for Arnot Ogden Medical Center related to general hospitals that are undergoing a closure, merger, consolidation, acquisition or restructuring of themselves or other health care providers incorrectly stated the name of the provider. This will clarify that the provider should be St. Joseph's Hospital, which is part of Arnot Health.



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](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 1460, Albany, NY 12210, [spa\\_inquiries@health.ny.gov](mailto:spa_inquiries@health.ny.gov)

## PUBLIC NOTICE

### New York State and Local Retirement System

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

The persons whose names and last known addresses are set forth below appear from records of the above named Retirement System to be entitled to accumulated contributions held by said retirement system whose membership terminated pursuant to Section 613 of the Retirement and Social Security Law on or before December 31, 2013. This notice is published pursuant to Section 109 of the Retirement and Social Security Law of the State of New York. A list of the names contained in this notice is on file and open to public inspection at the office of the New York State and Local Retirement System located at the 110 State St., in the City of Albany, New York. At the expiration of six months from the date of the publication of this notice. The accumulated contributions of the persons so listed shall be deemed abandoned and shall be placed in the pension accumulation fund to be used for the purpose of said fund. Any accumulated contributions so deemed abandoned and transferred to the pension accumulation fund may be claimed by the persons who made such accumulated contributions or, in the event of his death, by his estate or such person as he shall have nominated to receive such accumulated contributions, by filing a claim with the State Comptroller in such form and in such a manner as may be prescribed by him, seeking the return of such abandoned contributions. In the event such claim is properly made the State Comptroller shall pay over to the person or persons or estate making the claim such amount of such accumulated contributions without interest.

Frank, Bryan - Marion, NY

Vallabhaneni, Madhavi - West Nyack, NY

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

## PUBLIC NOTICE

### Uniform Code Regional Boards of Review

Pursuant to 19 NYCRR 1205, the petitions below have been received by the Department of State for action by the Uniform Code Regional Boards of Review. Unless otherwise indicated, they involve requests for relief from provisions of the New York State Uniform Fire Prevention and Building Code. Persons wishing to review any petitions, provide comments, or receive actual notices of any subsequent proceeding may contact Brian Tollsens, Building Standards And Codes, Department of State, One Commerce Plaza, 99 Washington Ave., Albany, NY 12231, (518) 474-4073 to make appropriate arrangements.

2014-0520 Matter of Dan Colaprete, 4853 W. Ridge Road, Spencerport, NY 14559, for a variance concerning safety requirements, including a required sprinkler system in a building, located at 4853 W. Ridge Road, Town of Sweden, County of Monro, State of New York.

2014-0586 Matter of Steven Carini, Carini Engineering Designs, 1387 Fairport Road-Suite 560, Fairport, NY 14617 for a variance concerning safety requirements, including emergency escape and rescue openings in a building, located at 6748 Falcons Point, Town of Victor, County of Ontario, State of New York.

2014-0614 James Wojotowicz, 8621 Clarence Center Road, Clarence Center, NY 14032 for a variance concerning requirements for maintaining existing emergency escape route in an existing building.

Involved is an existing three story, wood frame, building for permanent multiple dwelling occupancy with approximate gross floor area of 4000 square feet, located at 76 west Hazeltine Ave, City of Buffalo, County of Erie, State of New York.

2014-664 David A. Carr, P.E., 355 Randwood Drive, Williamsville, NY 14221 for NYS Parks & Recreation, for a variance concerning for sprinkler system, toilets and heating system.

Involved is the construction of a one story, wood frame building for assembly occupancy with approximate gross floor area of 2,800 square feet, located Allegany State Park, Town of Cold Springs, County of Cattaraugus, State of New York.

2014-0668 Matter of Michael Conforti, Violet Avenue Realty LLC, 547 Violet Avenue, Hyde Park, NY 12538 for a variance concerning fire code requirements, including parking of oil tank vehicles within 500 feet of a residential area.

Involved is vehicle parking area located at 547 Violet Avenue, Town of Hyde Park, County of Dutchess, State of New York.

2014-0670 Matter of Letchworth State Park Pinewood Lodge, 7 Letchworth State Park, Town of Castile, Wyoming County, New York 14427. The petitioner requests a variance concerning the relief from Automatic Sprinkler System as required by part 903.2.7 of Title 19 – Part 1221 Building Code.

**Appendix V**  
**2016 Title XIX State Plan**  
**First Quarter Amendment**  
**Responses to Standard Funding Questions**



**NON-INSTITUTIONAL SERVICES**  
**State Plan Amendment #16-0002**

**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 2012 and 2013 clinic UPL demonstration on March 21, 2014, the 2014 demonstration on July 11, 2014, and the 2015 demonstration on June 26, 2015. The State and CMS are having ongoing discussions to resolve remaining issues.

- 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 freestanding diagnostic and treatment and ambulatory surgery center 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 [✓] 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 State 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.