NEW YORK
state department of
HEALTH

Howard A. Zucker, M.D., J.D.
Acting Commissioner of Health

Sue Kelly
Executive Deputy Commissioner

June 23, 2014

National Institutional Reimbursement Team
Attention: Mark Cooley
CMS, CMCS
7500 Security Boulevard, M/S S3-14-28
Baltimore, MD 21244-1850

Re: SPA #14-04
Inpatient Hospital Services

Dear Mr. Cooley:

The State requests approval of the enclosed amendment #14-04 to the Title XIX (Medicaid) State Plan for inpatient hospital services to be effective April 1, 2014 (Appendix I). This amendment is being submitted based upon State statute. A summary of the proposed amendment is contained in Appendix II.

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

The State of New York pays for inpatient general hospital services using rates determined in accordance with methods and standards specified in an approved State Plan, following a public process, which complies with Social Security Act §1902(a)(13)(A).

Notice of the changes in the methods and standards for setting payment rates for general hospital inpatient services were given in the New York State Register on March 26, 2014.

It is estimated that the changes represented by 2014 payment rates for inpatient general hospital services will have no noticeable short-term or long-term effect on the availability of services on a statewide or geographic area basis, the type of care furnished, or the extent of provider participation.

In accordance with 42 CFR §447.272(c), New York assures that its aggregate disproportionate share hospital payments do not exceed the disproportionate share hospital payment limit.

In accordance with §1923(g) of the Social Security Act, New York assures that it has calculated facility specific limits for disproportionate share payments for each disproportionate share hospital. New York assures that it will not make disproportionate share payments to a hospital in excess of the facility specific limits established for such hospital.

Copies of pertinent sections of State statute are enclosed for your information (Appendix III). In addition, responses to the five standard funding questions are also enclosed (Appendix V).

If you have any questions regarding this matter, please do not hesitate to contact John E. Ulberg, Jr., 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

cc: Mr. Michael Melendez
Mr. Tom Brady

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: **14-04**

2. STATE **New York**

3. PROGRAM IDENTIFICATION: **TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)**

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE **April 1, 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 04/01/14-09/30/14 $ 200,944,248
b. FFY 10/01/14-03/31/15 $ 200,944,248

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-A: Pages 161, 161(1)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-A: Pages 161, 161(1)

10. SUBJECT OF AMENDMENT:
2014 Inpatient UPL Payments
(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:

13. TYPED NAME: **Jason A. Helgerson**

14. TITLE: **Medicaid Director**
Department of Health

15. DATE SUBMITTED: June 23, 2014

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

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
2014 Title XIX State Plan
Second Quarter Amendment
Amended SPA Pages

Additional Inpatient Hospital Payments

Effective for the state fiscal years beginning April 1, 2001 and ending March 31, 2009, specialty hospital adjustments for services provided on or after April 1, 2001, are authorized to government general hospitals, other than those operated by the State of New York or the State University of New York, receiving reimbursement for all inpatient services under Title XIX of the federal Social Security Act (Medicaid) pursuant to this Attachment of this State Plan and located in a city with a population of over one million, of up to $286 million annually, as medical assistance payments. For the period beginning April 1, 2008 through March 31, 2009, and April 1, 2009 through March 31, 2010, such payments shall total $232.1 million and $380,935,268 million, respectively. For the period beginning April 1, 2010 through March 31, 2011 such payments shall total $445,115,542. For the period beginning April 1, 2011 through March 31, 2012 such payments shall total $464,776,992. For state fiscal year beginning April 1, 2012 through March 31, 2013, the amount to be paid will be $464,776,992. For state fiscal year beginning April 1, 2013 through March 31, 2014, the amount to be paid will be $464,776,992. For state fiscal year beginning April 1, 2014 through March 31, 2015, the amount to be paid will be $464,776,992. Such payments, when aggregated with other medical assistance payments, shall not exceed 100% of a reasonable estimate of the amount that would be paid for such services under Medicare payment principles for non-state government owned or operated government general hospitals for the respective periods and shall be based on each such hospital's proportionate share of the sum of all inpatient discharges for all facilities eligible for an adjustment pursuant to this section for the base year two years prior to the rate year. Such proportionate share payment may be added to rates of payment or made as aggregate payments to eligible government general hospitals.

Effective for the period September 1, 2001 through March 31, 2002 and state fiscal years beginning April 1, 2002 and ending March 31, 2008, additional specialty hospital adjustments for services provided on or after September 1, 2001 are authorized to government general hospitals, other than those operated by the State of New York or the State University of New York, receiving reimbursement for all inpatient services under Title XIX of the federal social security act (Medicaid) pursuant to this Attachment of this State Plan and located in a city with a population of over one million, of up to $463 million for the period September 1, 2001 through March 31, 2002 and $794 million annually for state fiscal years, beginning April 1, 2002 and ending March 31, 2008, as medical assistance payments based on each such hospital's proportionate share of the sum of all inpatient discharges for all facilities eligible for an adjustment pursuant to this section for the base year two years prior to the rate year. Such proportionate share payments may be added to rates of payment or made as aggregate payments to eligible government general hospitals.

Voluntary Supplemental Inpatient Payments

Effective for the period July 1, 2010 through March 31, 2011, additional inpatient hospital payments are authorized to voluntary sector hospitals, excluding government general hospitals, for inpatient hospital services after all other medical assistance payments, of $235.5M for the period July 1, 2010 through March 31, 2011; $314M for the period April 1, 2011 through March 31, 2012; $314M for the period April 1, 2012 through March 31, 2013; [and] $314M for the period April 1, 2013 through March 31, 2014 and $339M for the period April 1, 2014 through March 31, 2015 subject to the requirements of 42 CFR 447.272 (upper payment limit). Such payments may be added to rates of payment or made as aggregate payments to eligible voluntary sector owned or operated general hospitals, excluding government general hospitals.

Eligibility to receive such additional payments will be based on data from the period two years prior to the rate year, as reported on the Institutional Cost Report (ICR) submitted to the Department as of October 1 of the prior rate year.

(a) Thirty percent of such payments will be allocated to safety net hospitals based on each eligible hospital's proportionate share of all eligible safety net hospitals' Medicaid discharges for inpatient hospital services, including both Medicaid fee-for-service and managed care discharges for acute and exempt services;

(i) Safety net hospitals are defined as non-government owned or operated hospitals which provide emergency room services having either: a Medicaid share of total inpatient hospital discharges of at least 35%, including both fee-for-service and managed care discharges for acute and exempt services; or a Medicaid share of total discharges of at least 30%, including both fee-for-service and managed care discharges for acute and exempt services, and also providing obstetrical services.

(b) Seventy percent of such payments will be allocated to eligible general hospitals, which provide emergency room services, based on each such hospital's proportionate share of all eligible hospitals' Medicaid discharges for inpatient hospital services, including both Medicaid fee-for-service and managed care discharges for acute and exempt services;

(c) No eligible general hospital's annual payment amount will exceed the lower of the sum of the annual amounts due that hospital in accordance with the Medicaid Disproportionate Share Section, the Supplemental Indigent Care Distributions Section, and the High Need Indigent Care Adjustment Pool Section of this Attachment, or the hospital's facility specific projected disproportionate share hospital payment ceiling

Appendix II
2014 Title XIX State Plan
Second Quarter Amendment
Summary

SUMMARY
SPA #14-04

This State Plan Amendment proposes to extend supplemental payments made for inpatient hospital services to voluntary sector hospitals and in non-state public hospitals in cities with more than one million persons. These payments reflect specialty adjustments to qualifying hospitals, for the period April 1, 2014 through March 31, 2015.

Appendix III
2014 Title XIX State Plan
Second Quarter Amendment
Authorizing Provisions

Section 12 of Part A of Chapter 1 of the Laws of 2002

§ 12. Notwithstanding any inconsistent provision of law or regulation to the contrary, and subject to the availability of federal financial participation pursuant to title XIX of the federal social security act, effective for the period September 1, 2001 through March 31, 2002, and state fiscal years thereafter, the department of health is authorized to pay a specialty hospital adjustment to public general hospitals, as defined in subdivision 10 of section 2801 of the public health law, other than those operated by the state of New York or the state university of New York, receiving reimbursement for all inpatient services under title XIX of the federal social security act pursuant to paragraph (e) of subdivision 4 of section 2807-c of the public health law, and located in a city with a population of over 1 million, of up to four hundred sixty-three million dollars for the period September 1, 2001 through March 31, 2002 and up to seven hundred ninety-four million dollars annually for state fiscal years thereafter as medical assistance payments for inpatient services pursuant to title 11 of article 5 of the social services law for patients eligible for federal financial participation under title XIX of the federal social security act based on each such hospital's proportionate share of the sum of all inpatient discharges for all facilities eligible for an adjustment pursuant to this section for the base year two years prior to the rate year. Such proportionate share payment may be added to rates of payment or made as aggregate payments to eligible public general hospitals.

Section 13 of Part B of Chapter 1 of the Laws of 2002

§ 13. Notwithstanding any inconsistent provision of law or regulation to the contrary, and subject to the availability of federal financial participation pursuant to title XIX of the federal social security act, effective for the period April 1, 2002 through March 31, 2003, and state fiscal years thereafter, the department of health is authorized to pay a specialty hospital adjustment to public general hospitals, as defined in subdivision 10 of section 2801 of the public health law, other than those operated by the state of New York or the state university of New York, receiving reimbursement for all inpatient services under title XIX of the federal social security act pursuant to paragraph (e) of subdivision 4 of section 2807-c of the public health law, and located in a city with a population of over one million, of up to two hundred eighty-six million dollars as medical assistance payments for inpatient services pursuant to title 11 of article 5 of the social services law for patients eligible for federal financial participation under title XIX of the federal social security act based on each such hospital's proportionate share of the sum of all inpatient discharges for all facilities eligible for an adjustment pursuant to this section for the base year two years prior to the rate year. Such proportionate share payment may be added to rates of payment or made as aggregate payments to eligible hospitals.

Public Health Law section 35(i)(i)

§35(i)(i) Notwithstanding any inconsistent provision of this subdivision or any other contrary provision of law and subject to the availability of federal financial participation, for the period July first, two thousand ten through March thirty-first, two thousand eleven, and each state fiscal year period thereafter, the commissioner shall make additional inpatient hospital payments up to the aggregate upper payment limit for inpatient hospital services after all other medical assistance payments, but not to exceed two hundred thirty-five million five hundred thousand dollars for the period July first, two thousand ten through March thirty-first, two thousand eleven, three hundred fourteen million dollars for each state fiscal year beginning April first, two thousand eleven, through March thirty-first, two thousand thirteen, and no less than three hundred thirty-nine million dollars for each state fiscal year thereafter, to general hospitals, other than major public general hospitals, providing emergency room services and including safety net hospitals, which shall, for the purpose of this paragraph, be defined as having either: a Medicaid share of total inpatient hospital discharges of at least thirty-five percent, including both fee-for-service and managed care discharges for acute and exempt services; or a Medicaid share of total discharges of at least thirty percent, including both fee-for-service and managed care discharges for acute and exempt services, and also providing obstetrical services. Eligibility to receive such additional payments shall be based on data from the period two years prior to the rate year, as reported on the institutional cost report submitted to the department as of October first of the prior rate year. Such payments shall be made as medical assistance payments for fee-for-service inpatient hospital services pursuant to title eleven of article five of the social services law for patients eligible for federal financial participation under title XIX of the federal social security act and in accordance with the following:

(A) Thirty percent of such payments shall be allocated to safety net hospitals based on each eligible hospital's proportionate share of all eligible safety net hospitals' Medicaid discharges for inpatient hospital services, including both Medicaid fee-for-service and managed care discharges for acute and exempt services, based on data from the period two years prior to the rate year, as reported on the institutional cost report submitted to the department as of October first of the prior rate year;

(B) Seventy percent of such payments shall be allocated to eligible general hospitals based on each such hospital's proportionate share of all eligible hospitals' Medicaid discharges for inpatient hospital services, including both Medicaid fee-for-service and managed care discharges for acute and exempt services, based on data from the period two years prior to the rate year, as reported on the institutional cost report submitted to the department as of October first of the prior rate year;

(C) No eligible general hospital's annual payment amount pursuant to this paragraph shall exceed the lower of the sum of the annual amounts due that hospital pursuant to section twenty-eight hundred seven-k and section twenty-eight hundred seven-w of this article; or the hospital's facility specific projected disproportionate share hospital payment ceiling established pursuant to federal law, provided, however, that payment amounts to eligible hospitals pursuant to clauses (A) and (B) of

this subparagraph in excess of the lower of such sum or payment ceiling shall be reallocated to eligible hospitals that do not have excess payment amounts. Such reallocations shall be proportional to each such hospital's aggregate payment amount pursuant to clauses (A) and (B) of this subparagraph to the total of all payment amounts for such eligible hospitals;

(D) Subject to the availability of federal financial participation, the payment methodology set forth in this subparagraph may be further revised by the commissioner on an annual basis pursuant to regulations issued pursuant to this subdivision for periods on and after April first, two thousand eleven; and

(E) Subject to the availability of federal financial participation and in conformance with all applicable federal statutes and regulations, such payments shall be made as upper payment limit payments and, further, such payments shall be made as aggregate monthly payments to eligible general hospitals.

(ii) In the event that the commissioner determines that federal financial participation will not be available for aggregate payments made in accordance with clause (E) of subparagraph (i) of this paragraph, payments pursuant to this paragraph shall be included as rate add-ons to medical assistance inpatient rates of payment established pursuant to this subdivision based on data from the period two years prior to the rate year, as reported on the institutional cost report submitted to the department as of October first of the prior rate year, provided, however, that if such payments are made as rate add-ons, the commissioner shall establish a procedure to reconcile payment amounts to reflect changes in medical assistance utilization from the period two years prior to the rate year and the actual rate year based on data as reported on each hospital's annual institutional cost report for the respective rate year, as submitted to the department as of October first of the year following the rate year.

(iii) Notwithstanding any other law, rule or regulation to the contrary, projections of each general hospital's disproportionate share limitations as computed by the commissioner pursuant to applicable regulations shall be adjusted to reflect any additional revenue received or anticipated to be received by each such general hospital pursuant to this paragraph.

Appendix IV
2014 Title XIX State Plan
Second 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 April 2014 will be conducted on April 8 and April 9 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

Division of Criminal Justice Services
Commission on Forensic Science

Pursuant to Public Officers Law section 104, the Division of Criminal Justice Services gives notice of a meeting of the New York State Commission on Forensic Science to be held on:

DATE: Wednesday, March 26, 2014
TIME: 1:00-5:00 p.m.
PLACE: Division of Criminal Justice Services
80 S. Swan St.
Albany, NY 12210
CrimeStat Rm. 118

Sign-in is required at this location. *For further information, or if you need a reasonable accommodation to attend this meeting, contact*: Cathy White, Division of Criminal Justice Services, Office of Forensic Services, 80 Swan St., Albany NY 12210, (518) 485-5052

PUBLIC NOTICE

Department of Health

Pursuant to 42 CFR Section 447.205, the Department of Health hereby gives public notice of the following:

The Department of Health proposes to amend the Title XIX (Medicaid) State Plan for inpatient, long term care, and non-institutional services and prescription drugs to comply with recently proposed statutory provisions. The following significant changes and clarifications are proposed:

All Services

- For all non-exempt Medicaid payments subject to the uniform reduction by two percent, such reduction will terminate on March 31, 2014. Alternative methods of cost containment shall continue to be applied and maintained for periods on and after April 1, 2014, provided, however, the Commissioner of Health, in consultation with the Director of the Budget, is authorized to terminate such alternative methods upon a finding that they are no longer necessary to maintain essential cost savings.

The annual decrease in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2014/2015 is $714 million.

Institutional Services

- For the state fiscal year beginning April 1, 2014 through March 31, 2015, continues specialty hospital adjustments for hospital inpatient services provided on and after April 1, 2013, to public general hospitals, other than those operated by the State of New York or the State University of New York, located in a city with a population of over one million and receiving reimbursement of up to $1.08 billion annually. Payments to eligible public general hospitals may be added to rates of payment or made as aggregate payments.
- Effective April 1, 2014, continues the supplemental upper payment limit payments made to general hospitals, other than major public general hospitals of $339 million annually.
- Effective April 1, 2014, the Commissioner may make adjustments to inpatient and outpatient Medicaid rates of payment for general hospital services and to the methodology for computing such rates as is necessary to achieve no aggregate, net growth in overall Medicaid expenditures related to the implementation of the International Classification of Diseases Version 10 (ICD-10) coding system on or about October 1, 2014, as compared to such aggregate expenditures from the period immediately prior to such implementation.
- Effective April 1, 2014, regulations for per diem rates for inpatient services of a general hospital or a distinct unit of a general hospital for services such as psychiatric, medical rehabilitation, chemical dependency detoxification, chemical dependency rehabilitation, Critical Access Hospitals, specialty long term acute care hospitals, cancer hospitals and exempt acute care children's hospitals may provide for periodic base year cost and statistic updates used to compute rates of payment. The first such base year update shall take effect no later than January first, two thousand fifteen, however, the Commissioner may make adjustments to the utilization and methodology for computing these rates as is necessary to achieve no aggregate, net growth in overall Medicaid expenditures related to these rates, as compared to the aggregate expenditures from the prior year. In determining the updated base years to be utilized, the Commissioner shall take into account the base years determined in accordance with Section 2807-c(35)(c).

There is no annual increase or decrease in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2014/2015.

• Extends the mandated cost savings associated with the current methodology establishing quality related measures, including, but not limited to potentially preventable re-admissions (PPRs) and providing for rate adjustments or payment disallowances related to PPRs and other potentially preventable negative outcomes (PPNOs). Such mandated cost savings of no less than $51 million a year are extended for the period April 1, 2014 through March 31, 2017.

- Such aggregate reductions shall be offset by Medicaid payment reductions occurring as a result of decreased PPRs during the period April 1, 2014 through March 31, 2017 and as a result of decreased PPNOs during the period April 1, 2014 through March 31, 2017. Such rate adjustments or payment disallowances will not apply to behavioral health PPRs or to readmissions that occur on or after 15 days following an initial admission.

Long Term Care Services

• Effective April 1, 2014, medical assistance shall be furnished without consideration of the income and resources of an applicant's legally responsible relative if the applicant's eligibility would normally be determined by comparing the amount of available income and/or resources of the applicant, including amounts deemed available to the applicant from legally responsibility relatives, to an applicable eligibility standard, and:

- The legally responsibility relative is a community spouse;

- Such relative is refusing to make his/her income and/or resources avilable to meet the cost of necessary medical care, services and supplies; and

- The applicant executes an assignment of support from the community spouse in favor of the social services district and the Department of Health, unless the applicant is unable to execute such assignment due to physical or mental impairment or to deny assistance would create an undue hardship, as defined by the Commissioner of Health; or

- The legally responsible relative is absent from the applicant's household, and fails or refuses to make his/her income and/or resources available to meet the cost of necessary medical care, services and supplies.

In such cases, however, the furnishing of such assistance shall create an implied contract with such relative, and the cost thereof may be recovered from such relative in accordance with Title 6 of Article 3 and other applicable provisions of law.

The annual decrease in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2014/2015 is $20 million.

• For residential health care facilities (RHCFs), adjustments to Medicaid rates of payment base on changes to a facility's case mix index shall not reflect any change in such case mix index in excess of two percent for any six month period prior to periods beginning January 1,2016, or such earlier date as determined by the Commissioner.

The annual decrease in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2014/2015 is $42.9 million.

• For state fiscal years beginning April 1, 2014, continues additional payments to non-state government operated public residential health care facilities, including public residential health care facilities located in Nassau, Westchester, and Erie counties, but excluding public residential health care facilities operated by a town or city within a county, in aggregate amounts of up to $300 million. The amount allocated to each eligible public RHCF will be in accordance with the previously approved methodology, provided, however that patient days shall be utilized for such computation reflecting actual reported data for 2012 and each representative succeeding year as applicable. Payments to eligible RHCF's may be added to rates of payment or made as aggregate payments.

Non-institutional Services

• For state fiscal year beginning April 1, 2014 through March 31, 2015, continues hospital outpatient payment adjustments that increase the operating cost components of rates of payment for hospital outpatient and emergency departments for public general hospitals other than those operated by the State of new York or the State University of New York, which are located in a city with a population of over one million. The eligibility criteria remain unchanged. The amount to be paid will be up to $287 million. Payments to eligible public general hospitals may be added to rates of payment or made as aggregate payments.

• Effective for the period April 1, 2014 through March 31, 2015, and annually thereafter, upon the election of the social services district in which an eligible diagnostic and treatment center (DTC) is physically located, up to $12.6 million in additional annual Medicaid payments may be paid to public DTCs operated by the New York City Health and Hospitals Corporation. Such payments will be based on each DTC's proportionate share of the sum of all clinic visits for all facilities eligible for an adjustment for the base year two years prior to the rate year. The proportionate share payments may be added to rates of payment or made as aggregate payments to eligible DTCs.

• Effective for the periods April 1, 2014 through March 31, 2015, and annually thereafter, up to $5.4 million in additional annual Medicaid payments may be paid to county operated free-standing clinics, not including facilities operated by the New York City Health and Hospitals Corporation, for services provided by such DTC and those provided by a county operated freestanding mental health or substance abuse DTC. Distributions shall be based on each eligible facility's proportionate share of the sum of all DTC and clinic visits for all eligible facilities receiving payments for the base year two years prior to the rate year. The proportionate share payments may be added to rates of payment or made as aggregate payments to eligible facilities.

• Effective April 1, 2014, the Commissioner of Health, in consultation with the Commissioner of the Office of Mental Health, will update rates paid to clinics licensed under Article 28 of the Public Health Law who provide collaborative care services. The collaborative care clinical delivery model is an evidence-based service to improve detection of depression and other diagnosed mental or substance use disorders and provide treatment to such individuals in an integrated manner. Designated clinics will provide, at minimum, screening for depression, medical diagnosis of patients who screen positive, evidence-based depression care, ongoing tracking of patient progress, care management, and a designated psychiatric practitioner who will consult with the care manager and primary care physician.

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 $10 million dollars.

• The current authority to adjust Medicaid rates of payment for personal care services provided in local social services districts which shall not include a city with a population of over one million persons, for purpose of supporting recruitment and retention of personal care service workers has been extended for the period April 1, 2014 through March 31, 2017. Payments for the period April 1, 2014 through March 31, 2015; April 1, 2015 through March 31, 2016; and April 1, 2016 through March 31, 2017 shall be up to $28.5 million for each applicable period.

• Effective April 1, 2014, the Commissioner is authorized, within amount appropriated, to distribute funds to local governmental units, pursuant to Mental Hygiene Law, to Medicaid managed care plans certified by the Department, health homes designated by the Department, and individual behavioral health providers and consortiums of such providers licensed or certified by the Office of Mental Health (OMH) or the Office of Alcoholism and Substance Abuse Services (OASAS) to prepare for the transition of adult and children's behavioral health providers and services into managed care.

- The use of such funds may include, but not be limited to, infrastructure and organizational modifications and investments in health information technology and training and technical assistance. Such funds shall be distributed pursuant to a plan to be developed by the Commissioner of Health, along with the Commissioners of the OMH and OASAS, taking into account the size and scope of a grantee's operations as a factor relevant to eligibility for, and the amount of, such funds.

- The Commissioner of Health is authorized to audit recipients of funds to ensure compliance and to recoup any funds determined to have been used for purposes other than previously described or otherwise approved by such Commissioners.

The estimated annual net increase in gross Medicaid expenditures attributable to this initiative for state fiscal year 2014/15 is $20 million.

• Effective April 1, 2014, Medicaid payments for services provided by Certified Home Health Agencies (CHHAs), except for such services provided to children under 18 years of age and those services provided to a special needs population of medically complex and fragile children, adolescents and young disable adults by a CHHA operating under a pilot program approved by the Department, for the purposes of improving recruitment, training and retention of home health aides or other personnel with direct patient care responsibility will cease.

There is no annual increase or decrease in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2014/2015.

• Effective April 1, 2014, the Commissioner may adjust Health Home payments to provide resources to Health Homes for the following purposes: (1) member engagement and promotion of Health Homes; (2) workforce training and retraining; (3) health information technology (HIT) and clinical connectivity; and (4) joint governance technical assistance, start-up and other implementation costs, and other such purposes as the Commissioner of Health, in consultation with the Commissioners of the Office of Mental Health and the Office of Alcoholism and Substance Abuse Services, determines are necessary to facilitate the transition of Health Homes beyond their early stages of development. Total payments are estimated not to exceed $525 million. Health Homes will be required to submit reports, as required by the Department, on the uses of such funds.

• Effective April 1, 2014, the Commissioner will expand access to tobacco counseling by reimbursing dentists. This program will provide greater access to effective, high quality smoking cessation treatment for members. Various analyses have found that smoking interventions delivered by non-physician clinicians are effective in increasing abstinence rates among smokers, which are associated with better health and lower cost.

The estimated annual net increase in gross Medicaid expenditures attributable to this initiative for state fiscal year 2014/15 is $3 million.

The overall estimated annual net aggregate increase in gross Medicaid expenditures attributable to reform and other initiatives contained in the budget for state fiscal year 2014/2015 is $528 million; and the estimated annual net aggregate increase in gross Medicaid expenditures attributable to an extension upper payment limit (UPL) payments for state fiscal year 2013/2014 is $2.0 billion.

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 of Health's website at http://www.health.ny.gov/regulations/state_plans/status.

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 State
F-2014-0063 (DA)
Date of Issuance - March 11, 2014

The New York State Department of State (DOS) is required by Federal regulations to provide timely public notice for the activities described below, which are subject to the consistency provisions of the Federal Coastal Zone Management Act of 1972, as amended.

The United States Coast Guard has determined that the proposed activity will be undertaken in a manner consistent to the maximum extent practicable with the enforceable policies of the New York State Coastal Management Program. The applicant's consistency determination and accompanying supporting information and data are available for inspection at the New York State Department of State offices located at One Commerce Plaza, 99 Washington Avenue in Albany, New York.

Re-establish the beach profile along the eroded shoreline to the profile prior to damage sustained from Post-Tropical Storm Sandy. An existing upland and on site pile of material will be utilized for beach reconstruction. The new beach profile will be constructed between the mean high water (MHW) line and the upland grass area. The proposed activity will utilize approximately 1430 cubic yards of material. Following the reconstruction, american beach grass will be planted to facilitate shoreline stabilization.

Any interested parties and/or agencies desiring to express their views concerning the above proposed activities may do so by filing their comments, in writing, no later than 4:30 p.m., 15 days from the date of publication of this notice, or, March 26, 2014.

Comments should be addressed to: Department of State, Office of Coastal, Local Government and Community Sustainability, One Commerce Plaza, 99 Washington Ave., Suite 1010, Albany, NY 12231, (518) 474-6000, (518) 473-2464 (Fax)

This notice is promulgated in accordance with Title 15, Code of Federal Regulations, Part 930.

Appendix V
2014 Title XIX State Plan
Second Quarter Amendment
Responses to Standard Funding Questions

HOSPITAL SERVICES
State Plan Amendment #14-04

CMS Standard Funding Questions (NIRT Standard Funding Questions)

The following questions are being asked and should be answered in relation to all payments made to all providers under Attachment 4.19-A of your state plan.

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

   Response: Providers do retain the payments made pursuant to this amendment. However, this requirement in no way prohibits the public provider, including county providers, from reimbursing the sponsoring local government for appropriate expenses incurred by the local government on behalf of the public provider. The State does not regulate the financial relationships that exist between public health care providers and their sponsoring governments, which are extremely varied and complex. Local governments may provide direct and/or indirect monetary subsidies to their public providers to cover on-going unreimbursed operational expenses and assure achievement of their mission as primary safety net providers. Examples of appropriate expenses may include payments to the local government which include reimbursement for debt service paid on a provider's behalf, reimbursement for Medicare Part B premiums paid for a provider's retirees, reimbursement for contractually required health benefit fund payments made on a provider's behalf, and payment for overhead expenses as allocated per federal Office of Management and Budget Circular A-87 regarding Cost Principles for State, Local, and Indian Tribal Governments. The existence of such transfers should in no way negate the legitimacy of these facilities' Medicaid payments or result in reduced Medicaid federal financial participation for the State. This position was further supported by CMS in review and approval of SPA 07-07C when an on-site audit of these transactions for New York City's Health and Hospitals Corporation was completed with satisfactory results.

2. **Section 1902(a)(2) provides that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan. Please describe how the state share of each type of Medicaid payment (normal per diem,**

supplemental, enhanced, other) is funded. Please describe whether the state share is from appropriations from the legislature to the Medicaid agency, through intergovernmental transfer agreements (IGTs), certified public expenditures (CPEs), provider taxes, or any other mechanism used by the state to provide state share. Note that, if the appropriation is not to the Medicaid agency, the source of the state share would necessarily be derived through either an IGT or CPE. In this case, please identify the agency to which the funds are appropriated. Please provide an estimate of total expenditure and State share amounts for each type of Medicaid payment. If any of the non-federal share is being provided using IGTs or CPEs, please fully describe the matching arrangement including when the state agency receives the transferred amounts from the local government entity transferring the funds. If CPEs are used, please describe the methodology used by the state to verify that the total expenditures being certified are eligible for Federal matching funds in accordance with 42 CFR 433.51(b). For any payment funded by CPEs or IGTs, please provide the following:

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

Response: UPL payments made to governmental providers under the provision of this SPA for the period April 1, 2014 through March 31, 2015 will be paid to providers of services in an amount totaling $464,776,992. These payments will be made to the non-state government owned or operated provider category. The non-federal share of these payments will be funded via an IGT payment from the local government (New York City). This transfer of funds must take place prior to the State making the payment to the eligible providers. New York City does have general taxing authority.

UPL payments made to non-governmental providers under the provisions of this SPA are funded through a budget 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 Medicaid payments authorized for this provision are supplemental payments. The amount of the supplemental payment for government hospitals for the period April 1, 2014, through March 31, 2015, is $464,776,992. These payments will be made to the non-state owned or operated provider category. The amount of the supplemental payment for voluntary hospitals for the period April 1, 2014 through March 31, 2015 is $339M.

4. **Please provide a detailed description of the methodology used by the state to estimate the upper payment limit (UPL) for each class of providers (State owned or operated, non-state government owned or operated, and privately owned or operated). Please provide a current (i.e. applicable to the current rate year) UPL demonstration. Under regulations at 42 CFR 4447.272, States are prohibited from setting payment rates for Medicaid inpatient services that exceed a reasonable estimate of the amount that would be paid under Medicare payment principals.**

   Response: Based on guidance from CMS, the State and CMS will engage in discussions to develop a strategic plan to complete the inpatient UPL demonstration for 2014 and submit it as soon as practicable.

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

   Response: The rate methodology included in the approved State Plan for hospital inpatient services is prospective payment methodology. We are unaware of any requirement under current federal law or regulation that limits individual provider 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.