NEW YORK
state department of
HEALTH

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

Sue Kelly
Executive Deputy Commissioner

April 24, 2013

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

RE: SPA #13-46
Non-Institutional Services

Dear Mr. Melendez:

The State requests approval of the enclosed amendment #13-46 to the Title XIX (Medicaid) State Plan for non-institutional services to be effective April 1, 2013 (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 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 April 3, 2013, is also enclosed for your information (Appendix IV). In addition, responses to the five standard funding questions are also enclosed (Appendix V).

If you have any questions regarding this State Plan submission, please do not hesitate to contact John E. Ulberg, Jr., Medicaid Chief Financial Officer, Division of Finance and Rate Setting at (518) 474-6350.

Sincerely,

Jason A. Helgerson
Medicaid Director
Office of Health Insurance Programs

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL **FOR: HEALTH CARE FINANCING ADMINISTRATION**	1. TRANSMITTAL NUMBER: **13-46**	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, 2013**	

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

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

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

6. FEDERAL STATUTE/REGULATION CITATION: **Section 1902(a) of the Social Security Act, and 42 CFR 447.204**	7. FEDERAL BUDGET IMPACT: a. FFY **04/01/13-09/30/13 $0** b. FFY **10/01/13-09/31/14 $0**
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: **Attachment 4.19-B: Page 1(e)(1)**	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: **Attachment 4.19-B: Page 1(e)(1)**

10. SUBJECT OF AMENDMENT:
Extend APG methodology

11. GOVERNOR'S REVIEW *(Check One)*:
☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:	16. RETURN TO: **New York State Department of Health** **Bureau of HCRA Operations & Financial Analysis** **99 Washington Ave – One Commerce Plaza** **Suite 810** **Albany, NY 12210**
13. TYPED NAME: **Jason A. Helgerson**	
14. TITLE: **Medicaid Director** **Department of Health**	
15. DATE SUBMITTED: April 24, 2013	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:	18. DATE APPROVED:

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:	20. SIGNATURE OF REGIONAL OFFICIAL:
21. TYPED NAME:	22. TITLE:

23. REMARKS:

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

New York
1(e)(1)

Ambulatory Patient Group System: Hospital-Based Outpatient

For dates of service beginning December 1, 2008, for hospital outpatient clinic and ambulatory surgery services, and beginning January 1, 2009, for emergency department services, through March 31, [2013] 2015, the operating component of rates for hospital based outpatient services 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. 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.

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

SUMMARY
SPA #13-46

This State Plan Amendment proposes to extend the APG methodology for an additional two years through March 31, 2015.

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

CHAPTER 57 OF THE LAWS OF 2008 - PART C

§ 12. Section 2807-c of the public health law is amended by adding a new subdivision 33 to read as follows:

33. Notwithstanding any provision of law which is inconsistent with or contrary to the structure established by this subdivision and subdivision two-a of section twenty-eight hundred seven of this article in order to transition from nineteen hundred eighty-one base year costs to two thousand five base year costs by no later than December thirty-first, two thousand twelve, and subject to the availability of federal financial participation, medicaid per diem and per discharge rates of payment for general hospital inpatient services for discharges and days occurring on and after December first, two thousand eight, shall be computed in accordance with the following:

(a)(i) for the period December first, two thousand eight through March thirty-first, two thousand nine, such rates shall be subject to a uniform transition adjustment which shall be based on each general hospital's proportional share of projected medicaid reimbursable inpatient operating costs and result in an aggregate reduction in such rates equal to fifty-one million five hundred thousand dollars, as determined by the commissioner, provided, however, that such transition adjustment shall not apply to rates computed pursuant to paragraph (1) of subdivision four of this section; and

(ii) for the period April first, two thousand nine through March thirty-first, two thousand ten, such rates shall be revised pursuant to a chapter of the laws of two thousand nine and as reflecting the findings and recommendations of the commissioner as issued pursuant to the provisions of paragraph (b) of this subdivision, provided, however, that such revisions shall reflect an aggregate reduction in such rates of no less than one hundred fifty-four million five hundred thousand dollars; and

(iii) for the periods April first, two thousand ten through March thirty-first, two thousand twelve, rates shall reflect prior year rate reductions and such additional reductions as are required to establish rates based on two thousand five reported allowable Medicaid costs pursuant to a chapter of the laws of two thousand ten.

(b) In consultation with the chairs of the senate and assembly health committees, the commissioner shall, by no later than July first, two thousand eight, establish a technical advisory committee for the purposes of examining data and evaluating rate-setting methodological issues, including the impact on hospitals of different methodologies in preparation for the phased transition to the utilization of reported allowable two thousand five operating costs for the purpose of setting inpatient rates of payment for periods on and after April first, two thousand nine, which phased transition shall be authorized in accordance with a chapter of the laws of two thousand nine. The technical advisory committee shall consist of three representatives of hospital associations, two representatives of the health care industry and three representatives of community providers and consumers as determined by the commissioner. By no later than August first, two thousand eight, the commissioner shall make available to the technical advisory committee updated data and documentation relevant to the projected phased transition to utilization of reported allowable two thousand five operating costs for rate-setting purposes. The issues to be examined by the technical advisory committee shall include, but not be limited to, hospital re-basing, workforce recruitment and retention funding, graduate medical education funding, peer group pricing, wage equalization factors, case mix and such other related elements of the general hospital inpatient reimbursement system as deemed appropriate by the commissioner. The technical advisory committee shall also examine the scope and volume of hospital out-patient services. By no later than November first, two thousand eight the commissioner shall issue a report setting forth find-

ings and recommendations, including divergent views of members of the technical advisory committee members concerning the matters examined by the technical advisory committee and the projected phased transition to utilization of two thousand five base year reported allowable operating costs for inpatient rates of payments on and after April first, two thousand nine.

(c) Paragraph (a) of this subdivision shall be effective the later of: (i) December first, two thousand eight; (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 subdivision two-a of section twenty-eight hundred seven of this article; or (iii) after the commissioner determines that the department of health has the capability, for payments made pursuant to subdivision two-a of section twenty-eight hundred seven of this article, to electronically receive and process claims and transmit payments with remittance statements. Prior to the commissioner making such a determination, the department shall provide training sessions on the rate methodology and billing requirements for services pursuant to subdivision two-a of section twenty-eight hundred seven of this article and opportunity for hospitals to perform end-to-end testing on claims submission, processing and payment.

§ 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 subdivi-

sion 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.

CHAPTER 57 OF THE LAWS OF 2008 - PART OO

§ 19. Subdivision 2-a of section 2807 of the public health law, as added by section 18 of part C of a chapter of the laws of 2008 amending provisions of law implementing the health and mental hygiene budget for the 2008-2009 state fiscal year, as proposed in legislative bill numbers S.6808-C and A.9808-C, is amended by adding a new paragraph (i) to read as follows:

(i) Notwithstanding any provision of law to the contrary, rates of payment by governmental agencies for general hospital outpatient services, general hospital emergency services and ambulatory surgical services provided by a general hospital established pursuant to paragraphs (a), (c) and (d) of this subdivision shall result in an aggregate increase in such rates of payment of fifty-six million dollars for the period December first, two thousand eight through March thirty-first, two thousand nine and one hundred seventy-eight million dollars for periods after April first, two thousand nine.

Appendix IV
2013 Title XIX State Plan
Second Quarter Amendment
Non-Institutional Services
Public Notice

MISCELLANEOUS NOTICES/HEARINGS

Notice of Abandoned Property Received by the State Comptroller

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

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

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

NOTICE OF PUBLIC HEARING

Commission on Quality of Care and Advocacy for Persons with Disabilities

Pursuant to 42 U.S.C. § 15043 and 29 U.S.C. § 732, the New York State Commission on Quality of Care and Advocacy for Persons with Disabilities hereby gives notice of a public hearing to receive testimony regarding the notice of intent released by the Governor on February 15, 2013 to designate a not-for-profit corporation, Disability Advocates, Inc. (DAI), as the P&A and CAP.

Subject: The proposed re-designation of the New York Protection and Advocacy (P&A) System and Client Assistance Program (CAP) for people with disabilities.

Purpose: To receive testimony regarding the notice of intent released by the Governor on February 15, 2013 to designate a not-for-profit corporation, Disability Advocates, Inc. (DAI), as the P&A and CAP.

Date: Tuesday, April 9, 2013

Time: 1:00 p.m. – 4:00 p.m.

Location: Meeting Rooms 3 and 4, Empire State Plaza, Concourse Level, Albany, NY and as a live video-conference at eight additional locations statewide. See below for video conference locations.

Registration: Register online at www.cqc.ny.gov. If assistance is required with registration,call 1-800-624-4143 (Voice/Relay/TTY).

Registration to attend the public hearing is highly recommended as there is limited seating at the video conference locations. Oral testimony will be limited to three (3) minutes. Anyone wishing to submit written testimony may give it to the registration representative at the hearing site.

For individuals with disabilities, accommodations will be provided upon reasonable request. Accommodation requests are included in the online registration. Please make all requests by Monday, April 1st at 5:00 p.m.

Video Conference Locations:

Broome DDSO- Theater, 249 Glenwood Road, Binghamton, NY 13905

Central NY DDSO- VC Room, 1001 West Fayette Street, Suite 5B, Syracuse, NY 13204

Finger Lakes DDSO-Room 3/4, 620 Westfall Road, Rochester, NY 14620

Hudson Valley DDSO- OMEGA Room 123, 9 Wilbur Road, Thiells, NY 10984

Long Island DDSO- Large Conference Room, 45 Mall Drive Suite 1, Commack, NY 11725

Metro NY DDSO- 1st Floor Activities Center, 75 Morton Street, New York, NY 10014

Sunmount DDSO- Bldg. 3, 2nd Floor Conference Room, 2445 State Rte 30, Tupper Lake, NY 12986

Western NY DDSO- Room 1-153, 1200 East & West Road, Building 16, West Seneca, NY 14224

For further information, contact: Commission on Quality of Care & Advocacy for Persons with Disabilities, 401 State St., Schenectady, NY 12305, (518) 388-0698, e-mail: greg.jones@cqc.ny.gov

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 non-institutional services to revise provisions of the Ambulatory Patient Group (APG) reimbursement methodology on or after April 1, 2013:

- The Ambulatory Patient Group (APG) reimbursement methodology is extended for the period April 1, 2013 through March 31, 2015. Such methodology is revised to include recalculated weights that will become effective on or after April 1, 2013.

There is no estimated annual change to gross Medicaid expenditures as a result of this proposal.

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

Copies of the proposed state plan amendment will also 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, or to review and comment, please contact: Department of Health, Bureau of HCRA Operations & Financial Analysis, 99 Washington Ave. – One Commerce Plaza, Suite 810, Albany, NY 12210, (518) 474-1673, (518) 473-8825 (FAX), e-mail: spa__inquiries@health.state.ny.us

PUBLIC NOTICE

New York City Deferred Compensation Plan/NYCE IRA

The New York City Deferred Compensation Plan/NYCE IRA (the "Plan") is seeking qualified vendors to provide daily or as necessary liquidity through the use of a low duration wrapped bond portfolio, an insurance company separate account portfolio and/or a commingled stable value fund for the Stable Income Fund investment option of the Plan. To be considered, vendors must submit their product information to Mercer Investment Consulting. Vendors should input or update their product information, as applicable, on Mercer's Global Investment Management Database (GIMD). The address for the website is: www.mercergimd.com. Vendors not already registered, please call Jay Livnat at (212) 345-2719 for a user I.D. and password to access the database. There is no fee for entering product information on the database. Please complete the submission of product information in the Mercer database no later than 4:30 P.M. Eastern Time on Friday, April 19, 2013. Also, please visit the Plan's website at www.nyc.gov/olr and review the participant communications regarding the Stable Income Fund. The Plan also recommends that vendors interested in this procurement download and review the applicable documents from the Plan's website.

If you have any questions regarding the materials on the Plan's website, please fax your questions to (212) 306-7376. Please contact Beth Ripston of Mercer Investment Consulting at (212) 345-4992, if you have any investment-related questions.

PUBLIC NOTICE

Department of State

Proclamation

Revoking Limited Liability Partnerships

W*HEREAS,* Article 8-B of the Partnership Law, requires registered limited liability partnerships and New York registered foreign limited liability partnerships to furnish the Department of State with a statement every five years updating specified information, and

W*HEREAS*, the following registered limited liability partnerships and New York registered foreign limited liability partnerships have not furnished the department with the required statement, and

W*HEREAS*, such registered limited liability partnerships and New York registered foreign limited liability partnerships have been provided with 60 days notice of this action;

N*OW, THEREFORE*, I, Cesar A. Perales, Secretary of State of the State of New York, do declare and proclaim that the registrations of the following registered limited liability partnerships are hereby revoked and the status of the following New York foreign limited liability partnerships are hereby revoked pursuant to the provisions of Article 8-B of the Partnership Law, as amended:

DOMESTIC REGISTERED LIMITED LIABILITY PARTNERSHIPS

B

BERGEN & SCHIFFMACHER, LLP (07)
BOIES & MCINNIS L.L.P. (97)
BOIES & SCHILLER L.L.P. (97)

C

CAHN & CAHN, LLP (02)
CANTANNO & ASSOCIATES, LLP (02)
CONDON RESNICK, LLP (02)
CUMMINGS & FORSON, LLP (07)

D

DALRYMPLE & DALRYMPLE, LLP (02)
DONOVAN & GIANNUZZI, LLP (02)
DREIER & BARITZ LLP (97)
DREIER LLP (97)

E

ELLENOFF GROSSMAN & SCHOLE LLP (97)
EMPIRE STATE PODISTRY, LLP (02)

F

FINGER LAKES IMAGING ASSOCIATES LLP (07)

G

GAINSBURG & HIRSCH LLP (97)
GERIATRIC ASSOCIATES, LLP (02)
GOLDBURD & LOKETCH, LLP (97)
GREENSTEIN & SCHWELL, LLP (07)

K

KELLY AND LEONARD, LLP (07)
KING PERRY BONNER MCMILLAN ROGERS, LLP (07)

L

LAW OFFICE OF K.E. RICHMAN, LLP (07)
LEVI & KORSINSKY, LLP (07)

M

MACKAY & BRADY, LLP (07)

N

NEUROLOGY CONSULTANTS OF ROCHESTER, LLP (07)
NEWMAN FERRARA LLP (07)
NY FACIAL SURGICAL FACILITY, LLP (07)

P

PADDU & ASSOCIATES, LLP (07)
PHYSICIANS MRI, LLP (97)

R

RAINES AND FISCHER LLP (02)
REISS & ARCURI, L.L.P. (07)
ROCHLIN GREENBLATT GALLO LLP (97)

S

SEJONG, LIMITED LIABILITY PARTNERSHIP (02)
SMITH & FLYNN, LLP (07)
STAHL LAW ASSOCIATES, LLP (02)

FOREIGN REGISTERED LIMITED LIABILITY PARTNERSHIPS

A

ASHURST LLP (07) (EW)

C

CAPIN CROUSE, LLP (02) (IL)

S

STRASBURGER & PRICE LLP (07) (TX)

T

THE HUDSON LAW GROUP, LLP (07) (NJ)

[SEAL]

WITNESS my hand and the official seal of the Department of State at its office in the City of Albany this third day of April in the year two thousand thirteen.

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

NON-INSTITUTIONAL SERVICES
State Plan Amendment #13-46

CMS Standard Funding Questions

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

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

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

2. **Section 1902(a)(2) provides that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan. Please describe how the state share of each type of Medicaid payment (normal per diem, supplemental, enhanced, other) is funded. Please describe whether the state share is from appropriations from the legislature to the Medicaid agency, through intergovernmental transfer agreements (IGTs), certified public expenditures (CPEs), provider taxes, or any other mechanism used by the state to provide state share. Note that, if the appropriation is not to the Medicaid agency, the source of the state share would necessarily be derived through either through an IGT or CPE. In this case, please identify the agency to which the funds are appropriated. Please provide an estimate of total expenditure and State share amounts for each type of Medicaid payment. If any of the non-federal share is being provided using IGTs or CPEs, please fully describe the matching arrangement including when the state agency receives the transferred amounts from the local governmental entity transferring the funds. If CPEs are used, please describe the methodology used by the state to verify that the total expenditures being certified are eligible for Federal matching funds in accordance with 42 CFR 433.51(b). For any payment funded by CPEs or IGTs, please provide the following:**
   - **(i) a complete list of the names of entities transferring or certifying funds;**
   - **(ii) the operational nature of the entity (state, county, city, other);**
   - **(iii) the total amounts transferred or certified by each entity;**
   - **(iv) clarify whether the certifying or transferring entity has general taxing authority: and,**
   - **(v) whether the certifying or transferring entity received appropriations (identify level of appropriations).**

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

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

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

4. **For clinic or outpatient hospital services please provide a detailed description of the methodology used by the state to estimate the upper payment limit (UPL) for each class of providers (State owned or operated,**

non-state government owned or operated, and privately owned or operated). Please provide a current (i.e., applicable to the current rate year) UPL demonstration.

Response: Based on guidance from CMS, the State will submit a current hospital outpatient UPL demonstration by June 30, 2013 and a current clinic UPL demonstration by March 31, 2014.

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

ACA Assurances:

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

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

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

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

expenditures at a greater percentage than would have been required on December 31, 2009.

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

Response: This SPA would [ ] / would not [✓] 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 will be forwarded to CMS. To date, no feedback has been received from any tribal representative in response to the proposed change in this SPA.