

**NEW YORK**  
state department of  
**HEALTH**

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

Sue Kelly  
Executive Deputy Commissioner

February 11, 2014

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

RE: SPA #13-71  
Non-Institutional Services

Dear Mr. Melendez:

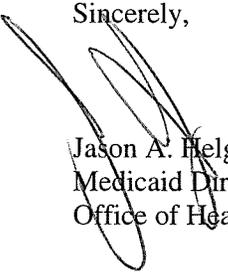
The State requests approval of the enclosed amendment #13-71 to the Title XIX (Medicaid) State Plan for non-institutional services to be effective January 1, 2014 (Appendix I). This amendment is being submitted based on regulation. A summary of the plan amendment is provided in Appendix II.

The State of New York reimburses these services through the use of rates that are consistent with and promote efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area as required by §1902(a)(30) of the Social Security Act and 42 CFR §447.204.

Copies of pertinent sections of enacted regulation are enclosed for your information (Appendix III). A copy of the public notice of this plan amendment, which was given in the New York State Register on December 24, 2013, is also enclosed for your information (Appendix IV). In addition, responses to the five standard funding questions are also enclosed (Appendix V).

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

Sincerely,

  
Jason A. Helgerson  
Medicaid Director  
Office of Health Insurance Programs

Enclosures

**TRANSMITTAL AND NOTICE OF APPROVAL OF  
STATE PLAN MATERIAL**

1. TRANSMITTAL NUMBER:  
**13-71**

2. STATE  
**New York**

**FOR: HEALTH CARE FINANCING ADMINISTRATION**

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

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

4. PROPOSED EFFECTIVE DATE  
**January 1, 2014**

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

NEW STATE PLAN       AMENDMENT TO BE CONSIDERED AS NEW PLAN       AMENDMENT

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

6. FEDERAL STATUTE/REGULATION CITATION:  
**Section 1902(a) of the Social Security Act, and 42 CFR 447**

7. FEDERAL BUDGET IMPACT:  
a. FFY 01/01/14-09/30/14 \$ 1,682,361  
b. FFY 10/01/14-09/30/15 \$ 1,323,718

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:  
**Attachment 4.19-B: Page 4(9)**

9. PAGE NUMBER OF THE SUPERSEDED PLAN  
SECTION OR ATTACHMENT (*If Applicable*):

10. SUBJECT OF AMENDMENT:  
**Safety Net/VAP – CHHA – Phase 2  
(FMAP = 50%)**

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

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

12. SIGNATURE OF STATE AGENCY OFFICIAL:

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

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

15. DATE SUBMITTED: **February 11, 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**  
**2013 Title XIX State Plan**  
**Fourth Quarter Amendment**  
**Non-Institutional Services**  
**Amended SPA Pages**

**New York  
4(9)**

**Temporary Rate Adjustments for Mergers, Acquisitions, Consolidations, Restructurings, and Closures – Certified Home Health Agencies (CHHAs)**

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

- Protect or enhance access to care;
- Protect or enhance quality of care;
- Improve the cost effectiveness; or
- Other protections or enhancements to the health care delivery system, as determined by the Commissioner.

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

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

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

**Certified Home Health Agencies:**

<b><u>Provider Name</u></b>	<b><u>Gross Medicaid Rate Adjustment</u></b>	<b><u>Rate Period Effective</u></b>
<u>Asian &amp; Pacific Islander Coalition on HIV/AIDS, Inc. (d/b/a APICHA Community Health Center)</u>	<u>\$1,682,405</u>	<u>01/01/2014 – 03/31/2014</u>
	<u>\$2,205,502</u>	<u>04/01/2014 – 03/31/2015</u>
	<u>\$2,291,488</u>	<u>04/01/2015 – 03/31/2016</u>
<u>Jefferson County Public Health Service</u>	<u>\$382,862</u>	<u>01/01/2014 – 03/31/2014</u>
	<u>\$393,408</u>	<u>04/01/2014 – 03/31/2015</u>
	<u>\$404,475</u>	<u>04/01/2015 – 03/31/2016</u>

TN   #13-71  

Approval Date \_\_\_\_\_

Supersedes TN   NEW  

Effective Date \_\_\_\_\_

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

**SUMMARY**  
**SPA #13-71**

This State Plan Amendment proposes to modify the listing of eligible certified health home agency (CHHA) providers previously approved to receive temporary adjustments to Medicaid rates under the closure, merger, acquisition, consolidation, or restructuring of a health care provider, which will be deemed Phase 2. The additional adjustments for providers for which approval is being requested are: Asian & Pacific Islander Coalition on HIV/AIDS, Inc. (d/b/a APICHA Community Health Center) and Jefferson County Public Health Service.

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

**Text of proposed rule:** Subdivision (d) of section 86-4.16 of 10 NYCRR is amended to read as follows:

(d) Documented increases in overall operating costs of a facility resulting from capital renovation, expansion, replacement or the inclusion of new programs, staff or services approved by the commissioner through the certificate of need (CON) process may be the basis for an application for revision of a certified rate, *provided, however, that such CON approval shall not be required with regard to such applications for rate revisions which are submitted by federally qualified health centers or rural health centers which are exempt from such CON approval pursuant to section 2807-z of the Public Health Law.* To receive consideration for reimbursement of such costs in the current rate year, a facility shall submit, at the time of appeal or as requested by the commissioner, detailed staffing documentation, proposed budgets and financial data, anticipated utilization expressed in terms of threshold visits and/or procedures and, where relevant, the final certified costs of construction approved by the department. An appeal may be submitted pursuant to this paragraph at any time throughout the rate period. Any modified rate certified or approved pursuant to this paragraph shall be effective on the date the new service or program is implemented or, in the case of capital renovation, expansion or replacement, on the date the project is completed and in use.

**Text of proposed rule and any required statements and analyses may be obtained from:** Katherine Ceroalo, DOH, Bureau of House Counsel, Reg. Affairs Unit, Room 2438, ESP Tower Building, Albany, NY 12237, (518) 473-7488, email: regsqa@health.state.ny.us

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

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

**Regulatory Impact Statement**

**Statutory Authority:**  
The statutory authority for this regulation is contained in Public Health Law (PHL) § 2807-z(9), which authorizes the Commissioner to promulgate regulations implementing the provisions of PHL § 2807-z, which, among other things, exempts diagnostic and treatment centers (DTCs) which are federally qualified health centers (FQHCs) from certificate of need (CON) requirements for capital projects which are budgeted at under \$3 million. The rate regulation revisions presented here are set forth in section 86-4.16(d) of Title 10 (Health) of the Official Compilation of Codes, Rules, and Regulations of the State of New York (NYCRR) and allows certain Medicaid rate adjustments related to such CON exempt capital projects.

**Legislative Objectives:**  
PHL § 2807-z exempts FQHCs from having to seek CON review and approval for certain capital projects with budgeted costs under \$3 million. This will allow such projects to go forward more quickly. The proposed regulation amendment implements this statute by deleting the requirement in § 86-4.16(d) for CON approval as a condition for FQHCs to secure Medicaid rate adjustments associated with such now CON exempt capital projects.

**Needs and Benefits:**  
The proposed regulation implements the provisions of PHL Section 2807-z, which exempts certain types of diagnostic and treatment centers from CON review for capital projects under \$3 million. As specified in PHL § 2807-z(6) and (7), the exempted facilities are those which receive federal grant funding reflecting their designation by the federal government as FQHCs or as rural health centers.

**COSTS:**  
**Costs to Private Regulated Parties:**  
There will be no additional costs to private regulated parties.  
**Costs to State Government:**

The enacted state budget for SFY 2012-13 does not include any state share annually to cover the anticipated 12 month total incremental cost to the Medicaid Program for providing reimbursement related to eligible capital projects. As the FQHC payment rate will not be effective until after January 1, 2013, less spending will occur in the current SFY due to the nine month delay in implementation.

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

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

**Local Government Mandates:**  
The proposed regulation does not impose any new programs, services, duties or responsibilities upon any county, city, town, village, school district, fire district or other special district.

**Paperwork:**  
No additional paperwork is required to be filed by FQHCs

**Duplication:**  
This regulation does not duplicate any existing federal, state or local government regulation.

**Alternatives:**  
No significant alternatives are available. The enhanced reimbursement available to FQHCs as a result of this proposed regulation ensures that their Medicaid rates reflect appropriate adjustments related to CON exempt capital projects and are therefore, are reasonable to meet the needs of the diverse patient populations they serve.

**Federal Standards:**  
The proposed regulation does not exceed any minimum standards of the federal government for the same or similar subject areas.

**Compliance Schedule:**  
The proposed regulation conforms Medicaid rate regulations with the provisions of enacted provisions of the Public Health Law. There is no period of time necessary for regulated parties to achieve compliance with the regulation.

**Regulatory Flexibility Analysis**  
No regulatory flexibility analysis is required pursuant to section 202-b(3)(a) of the State Administrative Procedure Act. The proposed amendment does not impose an adverse economic impact on small businesses or local governments, and it does not impose reporting, recordkeeping or other compliance requirements on small businesses or local governments.

**Rural Area Flexibility Analysis**  
No rural area flexibility analysis is required pursuant to section 202-bb(4)(a) of the State Administrative Procedure Act. The proposed amendment does not impose an adverse impact on rural areas, and it does not impose reporting, recordkeeping or other compliance requirements on public or private entities in rural areas.

**Job Impact Statement**  
A Job Impact Statement is not required pursuant to Section 201-a(2)(a) of the State Administrative Procedure Act. It is apparent from the nature and purpose of the proposed rule that it will not have a substantial adverse impact on jobs or employment opportunities. The proposed regulation establishes a Federally Qualified Health Center (FQHC) rate-setting methodology to reimburse Diagnostic and Treatment Centers for the capital costs of less than \$3 million which are not subject to the regulation regarding certificate of need process or requirements. The proposed regulation has no adverse implications for job opportunities. Rather, the additional revenue generated by FQHCs as a result of the new payment rate may provide them with the financial resources they need to add staff, thus enhancing their ability to provide expanded services.

**PROPOSED RULE MAKING  
NO HEARING(S) SCHEDULED**

**Episodic Pricing for Certified Home Health Agencies (CHHA)**

**I.D. No.** HLT-46-13-00006-P

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

**Proposed Action:** Amendment of section 86-1.44 of Title 10 NYCRR.

**Statutory authority:** Public Health Law, section 3614(13)

**Subject:** Episodic Pricing for Certified Home Health Agencies (CHHA).

**Purpose:** To exempt services to a special needs population from the episodic payment system for CHHAs.

**Text of proposed rule:** Subdivisions (a) and (c) and the opening paragraph of subdivision (b) of section 86-1.44 of title 10 of NYCRR are amended to read as follows:

(a) Effective for services provided on and after [April 1] May 2, 2012, Medicaid payments for certified home health care agencies ("CHHA"), except for such services provided to children under eighteen years of age and except for services provided to a special needs population of medically complex and fragile children, adolescents and young disabled adults by a CHHA operating under a pilot program approved by the Department, shall be based on payment amounts calculated for 60-day episodes of care.

(b) An initial statewide episodic base price, to be effective [April 1] May 2, 2012, will be calculated based on paid Medicaid claims, as determined by the Department, for services provided by all certified home health agencies in New York State during the base period of January 1, 2009 through December 31, 2009.

(c) The base price paid for 60-day episodes of care shall be adjusted by an individual patient case mix index as determined pursuant to subdivision (f) of this section; and also by a regional wage index factor as determined

pursuant to subdivision (h) of this section. *Such case mix adjustments shall include an adjustment factor for CHHAs providing care primarily to a special needs patient population coming under the jurisdiction of the Office of People With Developmental Disabilities (OPWDD) and consisting of no fewer than two hundred such patients.*

Section 86-1.44 of title 10 of NYCRR is amended by adding a new subdivision (k) to read as follows:

(k) *Closures, mergers, acquisitions, consolidations, and restructurings.*

(1) *The commissioner may grant approval of a temporary adjustment to rates calculated pursuant to this section for eligible certified home health agencies.*

(2) *Eligible certified home health agency providers shall include:*

(i) *providers undergoing closure;*

(ii) *providers impacted by the closure of other health care providers;*

(iii) *providers subject to mergers, acquisitions, consolidations or restructuring; or*

(iv) *providers impacted by the merger, acquisition, consolidation or restructuring of other health care facilities.*

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

(i) *protect or enhance access to care;*

(ii) *protect or enhance quality of care;*

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

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

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

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

**Text of proposed rule and any required statements and analyses may be obtained from:** Katherine Ceroalo, DOH, Bureau of House Counsel, Reg. Affairs Unit, Room 2438, ESP Tower Building, Albany, NY 12237, (518) 473-7488, email: regsqna@health.state.ny.us

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

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

**This rule was not under consideration at the time this agency submitted its Regulatory Agenda for publication in the Register.**

#### Regulatory Impact Statement

##### Statutory Authority:

The authority for implementation of an episodic payment system for Certified Home Health Agency services pursuant to regulations is set forth in section 3614(13) of the Public Health Law and in section 111(t) of part H of chapter 59 of the laws of 2011, which authorizes the Commissioner to promulgate regulations, including emergency regulations, with regard to Medicaid reimbursement rates for certified home health agencies. Section 3614(13) also exempts the application of the episodic payment system to Medicaid reimbursement for "children under eighteen years of age and other discrete groups as may be determined by the commissioner pursuant to regulations".

##### Legislative Objectives:

The Legislature chose to address the issue of over-utilization of Certified Home Health Agency services as a result of the recommendations submitted by the Medicaid Redesign Team and accepted by the Governor. Pursuant to statute, an episodic payment system based on 60-day episodes of care, with payments tied to patient acuity, was chosen as one of the vehicles to address this issue. The legislation also exempted Medicaid

payments for children from the new payment system and, further, gave the Commissioner of Health authority to exempt other discrete groups through regulation.

In addition, Section 86-1.44 of Title 10 (Health) of the Official Compilation of Codes, Rules and Regulation of the State of New York, will be amended to add subdivision (k), which provides the Commissioner authority to grant temporary rate adjustments to eligible Article 36 certified home health agency providers subject to or affected by the closure, merger, acquisition, consolidation, or restructuring of a health care provider in their service delivery area. In addition, the proposed regulation sets forth the conditions under which a provider will be considered eligible, the requirements for requesting a temporary rate adjustment, and the conditions that must be met in order to receive a temporary rate adjustment. The temporary rate adjustment shall be in effect for a specified period of time, as approved by the Commissioner, of up to three years. This regulation is necessary in order to maintain beneficiaries' access to services by providing needed relief to providers that meet the criteria.

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

##### Needs and Benefits:

The proposed amendments to subdivisions (a), (b), and (c) will exempt services provided to a special needs population of medically complex children, adolescents and young disabled adults by a CHHA operating under a pilot program approved by the Department from the episodic payment system and will also provide for an adjustment of the case mix index for CHHAs serving primarily patients who are eligible for OPWDD services when such CHHAs have over 200 such patients. These amendments reflect a Health Department determination that the more stringent cost containment mechanism of episodic pricing, already deemed by the legislature to be an inappropriate reimbursement mechanism for CHHA services for children, is also not appropriate for special needs populations consisting of young adults as well as children and adolescents being cared for pursuant to an approved pilot program. These amendments will thus help assure that agencies primarily serving certain special needs populations will receive a level of reimbursement from the Medicaid system to maintain both adequate access and quality of care for members of these populations.

With regard to the new subdivision (k), in the center of a changing health care delivery system, the closure, merger, acquisition, consolidation or restructuring of a health care provider within a community often happens without adequate planning of resources for the impact on health care providers in the service delivery area. In addition, maintaining access to needed services while also maintaining or improving quality becomes challenging for the impacted providers. The additional reimbursement provided by this adjustment will support the impacted Article 36 certified home health agency providers in achieving these goals, thus improving quality while reducing health care costs.

##### Costs:

The regulated parties (providers) are not expected to incur any additional costs as a result of the proposed rule change. There are no additional costs to local governments for the implementation of and continuing compliance with this amendment. It is anticipated there will be a slight decrease to the total state fiscal savings which were budgeted for the Episodic Payment System.

##### Local Government Mandates:

The proposed amendment does not impose any new programs, services, duties or responsibilities upon any county, city, town, village, school district, fire district or other special district.

##### Paperwork:

There is no additional paperwork required of providers as a result of this amendment.

##### Duplication:

These regulations do not duplicate existing state or federal regulations.

##### Alternatives:

No significant alternatives are available that will protect the special needs populations identified in this amendment. With regard to the new subdivision (k), no significant alternatives are available. Any potential certified home health agency provider project that would otherwise qualify for funding pursuant to the revised regulation would, in the absence of this

amendment, either not proceed or would require the use of existing provider resources.

**Federal Standards:**

This amendment does not exceed any minimum standards of the federal government for the same or similar subject areas.

**Compliance Schedule:**

There are no significant actions which are required by the affected providers to comply with the amendments to subdivisions (a), (b) and (c). With regard to the new subdivision (k), the proposed regulation provides the Commissioner of Health the authority to grant approval of temporary adjustments to rates calculated for Article 36 certified home health care providers that are subject to or affected by the closure, merger, acquisition, consolidation, or restructuring of a health care provider, for a specified period of time, as determined by the Commissioner, of up to three years.

**Regulatory Flexibility Analysis**

No regulatory flexibility analysis is required pursuant to section 202-(b)(3)(a) of the State Administrative Procedure Act. The proposed amendment does not impose an adverse economic impact on small businesses or local governments, and it does not impose reporting, record keeping or other compliance requirements on small businesses or local governments.

**Rural Area Flexibility Analysis**

No rural area flexibility analysis is required pursuant to section 202-bb(4)(a) of the State Administrative Procedure Act. The proposed amendment does not impose an adverse impact on facilities in rural areas, and it does not impose reporting, record keeping or other compliance requirements on facilities in rural areas.

**Job Impact Statement**

No Job Impact Statement is required pursuant to section 201 a(2)(a) of the State Administrative Procedure Act. It is apparent, from the nature of the proposed amendment, that it will not have an adverse impact on jobs and employment opportunities.

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## Justice Center for the Protection of People with Special Needs

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### NOTICE OF ADOPTION

**Procedures of the Surrogate Decision-Making Committees of the NYS Justice Center for the Protection of People with Special Needs**

**I.D. No.** JCP-35-13-00005-A

**Filing No.** 1059

**Filing Date:** 2013-10-25

**Effective Date:** 2013-11-13

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

**Action taken:** Amendment of sections 710.1, 710.2, 710.3, 710.4, 710.6, 710.7 and 710.8 of Title 14 NYCRR.

**Statutory authority:** Protection of People with Special Needs Act, L. 2012, ch. 501

**Subject:** Procedures of the Surrogate Decision-Making Committees of the NYS Justice Center for the Protection of People with Special Needs.

**Purpose:** Administer procedure to consent or refuse a nonemergency major medical treatment on behalf of a person with mental disabilities.

**Text or summary was published in** the August 28, 2013 issue of the Register, I.D. No. JCP-35-13-00005-P.

**Final rule as compared with last published rule:** No changes.

**Text of rule and any required statements and analyses may be obtained from:** David Cochran, Justice Center for Protection of People with Special Needs, 161 Delaware Avenue, Delmar, New York 12054-1310, (518) 549-0252, email: David.Cochran@Justicecenter.ny.gov

**Assessment of Public Comment**

The agency received no public comment.

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## Niagara Frontier Transportation Authority

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### PROPOSED RULE MAKING NO HEARING(S) SCHEDULED

**NFTA's Procurement Guidelines**

**I.D. No.** NFT-46-13-00004-P

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

**Proposed Action:** This is a consensus rule making to amend sections 1159.3 and 1159.5 of Title 21 NYCRR.

**Statutory authority:** Public Authorities Law, sections 1299-e(5) and 1299-t

**Subject:** The NFTA's Procurement Guidelines.

**Purpose:** To amend the NFTA's Procurement Guidelines regarding internal levels of approval.

**Text of proposed rule:** Subdivision (ae) of section 1159.3 is amended as follows:

(ae) Small Purchase. The acquisition of goods or services having an actual price less than \$[50,000] 100,000. [See section 1159.4(n) of this Part.]

Subdivision (af) of section 1159.3 is amended as follows:

(af) Small purchase formal bidding. A small purchases method of procuring goods or services under \$[50,000.00] 100,000.00, based upon competitive selection following the publication of a notice of procurement opportunity in the New York State Contract Reporter and the acceptance of sealed bids or proposals. [See section 1159.4(n)(2) of this Part.]

Subdivision (ag) of section 1159.3 is amended as follows:

(ag) Small purchase informal bidding. A small purchases method of procuring goods or services under \$[15,000.00] 50,000.00, based upon competitive selection which may be made on the basis of written or telephonic quotes and in accordance with the guidelines set forth in section 1159.4(n)(3) of this Part.

Subsection (1) to subdivision (a) of section 1159.4 is amended as follows:

(1) all contracts for goods or services in the actual or estimated value of \$[50,000] 100,000 or more;

Subsection (1) to subdivision (f) of section 1159.4 is amended as follows:

(1) Sealed bidding is the preferred procurement method for acquisitions of \$[15,000] 50,000 or more where the following factors are present:

Subsection (i) to subsection (2) to subdivision (f) of section 1159.4 is amended as follows:

(i) The purchase is under \$[15,000] 50,000 and an informal, small purchase procurement procedure is being followed;

Subsection (1) to subdivision (h) of section 1159.4 is amended as follows:

(1) Procurement by negotiation is the preferred procurement method for acquisitions of \$[15,000] 50,000 or more where one or more of the following factors are present:

Subsection (i) to subsection (2) to subdivision (h) of section 1159.4 is amended as follows:

(i) the purchase is under \$[15,000] 50,000 and an informal, small purchase procurement procedure is being followed;

Subdivision (k) of section 1159.4 is amended as follows:

(k) New York State Contract Reporter. All procurements of goods or services having an actual or estimated value of \$[15,000] or 50,000 or more shall be published in THE NEW YORK STATE CONTRACT REPORTER (NYSCR) The notice of procurement opportunity shall appear in the NYSCR at least 15 business days prior to the bid or proposal due date. However, advance publication shall not be required under emergency or exigency conditions, or when an expediency action has been adopted by the board, or if the procurement is being solicited within 45 business days after the date bids or proposals were originally due. At the time a determination of intent to award a procurement contract is made, the following information shall be submitted for publication in NYSCR: for procurement contracts obtained through the sealed bidding process, the result of the bid opening including the names of bidding firms and the amounts bid by each; for procurement contracts obtained through the negotiation and/or qualification-based processes, the names of firm submitting proposals and the proposal selected as the best value offer; and for all other procurement contracts, the name of the proposed awardee.

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

# MISCELLANEOUS NOTICES/HEARINGS

## Notice of Abandoned Property Received by the State Comptroller

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

1-800-221-9311  
or visit our web site at:  
[www.osc.state.ny.us](http://www.osc.state.ny.us)

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

## PUBLIC NOTICE Department of Health

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

The Department of Health proposes to amend the Title XIX (Medicaid) State Plan for institutional, long term care, and non-institutional services related to temporary rate adjustments to providers that are undergoing a closure, merger, consolidation, acquisition or restructuring themselves or other health care providers. These payments are authorized by current State statutory and regulatory provisions.

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

1. AHRC Health Care, Inc. (d/b/a ACCESS Comm. Health Center), up to \$534,838;
2. Anthony L. Jordan Health Center, up to \$2,459,842;
3. Aurelia Osborn Fox Memorial Hospital, up to \$7,266,279;
4. Asian & Pacific Islander Coalition of HIV/AIDS (APICHA), up to \$6,179,395;
5. Blue Line Group (comprised of Adirondack Tri-County Nursing and Rehabilitation Center, Inc.; Heritage Commons Residential Health Care Facility; Mercy Living Center; and Uihlein Living Center), up to \$7,100,000;
6. Canton/EJ Noble, up to \$2,400,000;
7. Catskill Regional Medical Center, up to \$3,093,915;
8. Clifton-Fine Hospital, up to \$1,225,000;
9. Cortland Regional Medical Center Inc., up to \$2,188,472;
10. Crouse Community Center Inc., up to \$1,420,000;
11. Delaware Valley Hospital, up to \$452,250;
12. East Hill Family Medical Inc., up to \$216,440;

13. Ellenville Regional Hospital, up to \$1,143,744;
14. Elmwood Health Center, up to \$752,909;
15. Finger Lakes Migrant Health Care Project (d/b/a Finger Lake Community Health), up to \$2,240,982;
16. Hudson River HealthCare Inc., up to \$1,019,400;
17. Jefferson County Public Health Service, up to \$1,180,745;
18. Kings County Hospital Center, up to \$1,000,000;
19. Lewis County General Hospital, up to \$1,315,808;
20. Little Falls Hospital, up to \$2,291,382;
21. Montefiore Medical Center, up to \$59,000,000;
22. Morris Heights Health Center Inc., up to \$1,311,114;
23. Mount Vernon Neighborhood Health Center Network, up to \$749,599;
24. New York Methodist Hospital, up to \$9,325,000;
25. Niagara Falls Memorial Medical Center, up to \$795,566;
26. Oswego Hospital, up to \$1,250,000;
27. Planned Parenthood of New York City Inc., up to \$645,327;
28. Planned Parenthood of the Rochester/Syracuse Region Inc. up to \$2,156,230;
29. Rochester Primary Care Network Inc./Rushville Health Center, Inc. Finger Lakes Regional, up to \$2,218,340;
30. Rome Memorial Hospital Inc., up to \$2,281,480;
31. Schuyler Hospital, up to \$656,830;
32. The Floating Hospital Inc., up to \$445,034;
33. The Institute for Family Health, up to \$3,744,118;
34. Upper Hudson Planned Parenthood, up to \$350,000;
35. Visiting Nurse Association of Long Island, up to \$4,281,840; and
36. Wyckoff Heights Medical Center, up to \$3,980,463.

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

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

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

The public is invited to review and comment on this proposed State Plan Amendment. Copies of which will be available for public review on the Department's website at [http://www.health.ny.gov/regulations/state\\_plans/status](http://www.health.ny.gov/regulations/state_plans/status).

Copies of the proposed State Plan Amendments will be on file in each local (county) social services district and available for public review.

For the New York City district, copies will be available at the following places:

New York County  
250 Church Street  
New York, New York 10018

Queens County, Queens Center  
3220 Northern Boulevard  
Long Island City, New York 11101

Kings County, Fulton Center  
114 Willoughby Street  
Brooklyn, New York 11201

Bronx County, Tremont Center  
1916 Monterey Avenue  
Bronx, New York 10457

Richmond County, Richmond Center  
95 Central Avenue, St. George  
Staten Island, New York 10301

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

## PUBLIC NOTICE

Department of Health

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

The Department of Health proposes to amend the Title XIX (Medicaid) State Plan to remove coverage of barbiturates used in all medically accepted indications for dual eligible beneficiaries effective January 1, 2014.

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

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

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

The public is invited to review and comment on this proposed State Plan Amendment. Copies of which will be available for public review on the Department's website at [http://www.health.ny.gov/regulations/state\\_plans/status](http://www.health.ny.gov/regulations/state_plans/status).

Copies of the proposed State Plan Amendments will be on file in each local (county) social services district and available for public review.

For the New York City district, copies will be available at the following places:

New York County  
250 Church Street  
New York, New York 10018  
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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

The public is invited to review and comment on this proposed State Plan Amendment.

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

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

## **NON-INSTITUTIONAL SERVICES State Plan Amendment #13-71**

### **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:** This question is not applicable for this SPA, as CHHA services are not clinic or outpatient hospital services.

- 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 State is 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.