NEW YORK
state department of
HEALTH

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

Sue Kelly
Executive Deputy Commissioner

September 28, 2012

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

RE: SPA #12-24
Long-Term Care Facility Services

Dear Mr. Cooley:

The State requests approval of the enclosed amendment #12-24 to the Title XIX (Medicaid) State Plan for long-term care facility services to be effective July 1, 2012 (Appendix I). This amendment is being submitted based on enacted legislation and draft regulation. A summary of the proposed amendment is provided in Appendix II.

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

1. The State of New York pays for long-term care services using rates determined in accordance with methods and standards specified in an approved State Plan following a public process which complies with §1902(a)(13)(A) of the Social Security Act.

2. (a) It is estimated that the changes represented by the estimated average payment rates for long-term care facility services will have no noticeable short-term or long-term effect on the availability of services on a statewide and geographic area basis.

   (b) It is estimated that the changes represented by the estimated average payment rates for long-term care facility services will have no noticeable short-term or long-term effect on care furnished.

   (c) It is estimated that the changes represented by the estimated average payment rates for long-term care facility services will have no noticeable short-term or long-term effect on the extent of provider participation.

In accordance with 42 CFR §447.272, New York assures that the aggregate Medicaid payments for inpatient services provided by nursing facilities for each prescribed category of providers does not exceed the upper payment limit for the particular category of providers.

Copies of pertinent sections of enacted State statute and draft regulation are enclosed for your information (Appendix III). Copies of the public notices for this proposed amendment, which were given in the New York State Register on March 28, 2012, and April 25, 2012, are also enclosed for your information (Appendix IV). In addition, responses to the standard funding questions and standard access questions are also enclosed (Appendix V and VI, respectively).

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

Sincerely,

Jason A. Helgerson
Medicaid Director
Office of Health Insurance Programs

Enclosures

cc: Mr. Michael Melendez
Mr. Tom Brady

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: HEALTH CARE FINANCING ADMINISTRATION	1. TRANSMITTAL NUMBER: **12-24**	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 **July 1, 2012**	
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 07/01/12 – 09/30/12 ($ 4,800,000)** **b. FFY 10/01/12 – 09/30/13 ($28,400,000)**	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: **Attachment 4.19-C: Page 1**	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: **Attachment 4.19-C: Page 1**	
10. SUBJECT OF AMENDMENT: **Nursing Home Bedhold Revisions (effective 7/1/12) & Per Diem Adjustment (effective 12/1/12) (FMAP = 50%)**		
11. GOVERNOR'S REVIEW *(Check One)*: ☒ GOVERNOR'S OFFICE REPORTED NO COMMENT ☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED ☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL ☐ OTHER, AS SPECIFIED:		
12. SIGNATURE OF STATE AGENCY OFFICIAL: 13. TYPED NAME: **Jason A. Helgerson** 14. TITLE: **Medicaid Director** **Department of Health** 15. DATE SUBMITTED: September 28, 2012	16. RETURN TO: **New York State Department of Health** **Bureau of HCRA Oper & Financial Analysis** **99 Washington Ave – One Commerce Plaza** **Suite 810** **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:		

FORM HCFA-179 (07-92)

Appendix II
2012 Title XIX State Plan
Third Quarter Amendment
Long-Term Care Facility Services
Summary

SUMMARY
SPA #12-24

This State Plan Amendment proposes to lower the rate of payment for reserved bed days related to hospitalizations from 95% of the Medicaid rate to 50% of the Medicaid rate payable to the nursing home for patients 21 years or older, effective July 1, 2012. The total number of reserved bed days provided for the resident for temporary hospitalizations and therapeutic leaves of absences that are consistent with a plan of care ordered by the resident's treating health care professional will to be limited to 14 days in any 12-month period.

In addition, a per diem adjustment will be made to the Medicaid rate of payment, excluding nursing homes providing services primarily to children under the age of 21, effective December 1, 2012, when necessary to achieve a total aggregate savings for each State fiscal year of $40 million.

Appendix I
2012 Title XIX State Plan
Third Quarter Amendment
Long-Term Care Facility Services
Amended SPA Pages

New York
Page 1

PAYMENT FOR RESERVED BEDS IN MEDICAL INSTITUTIONS

LIMITATIONS

A. RESERVED BEDS DURING LEAVES OF ABSENCE (Defined to mean overnight absences including visits with relatives/friends, or leaves to participate in medically acceptable therapeutic or rehabilitative plans of care).

When patient's/resident's plan of care provides for leaves of absence:

General Hospital Patients
Eligibility restricted to patients receiving care in certified psychiatric or rehabilitation units, without consideration of any vacancy rate. A psychiatric patient must be institutionalized for 15 days during a current spell of illness; a rehabilitation patient must be institutionalized for 30 days. Leaves must be for therapeutic reasons only and carry a general limitation of no more than 18 days in any 12 month period, and 2 days per any single absence. Broader special limits are possible physicians can justify them, subject to prior approval.

Nursing Facility (NF) Patients
A reserved bed day is a day for which a governmental agency pays a residential health care facility to reserve a bed for a person eligible for medical assistance while he or she is temporarily hospitalized or on leave of absence from the facility.

All recipients eligible after 30 days in the facility, subject to a facility vacancy rate, on the first day of the patient's/resident's absence of no more than 5%. General limitations of no more than 18 days in any 12 month period with broader special limits possible when physicians can justify them, subject to prior approval.

Effective July [19, 2010] 1, 2012, for reserved bed days provided on behalf of persons 21 years of age or older:

(i) payments for reserved bed days related to hospitalization will be made at [95%] 50% of the Medicaid rate, and payments for reserved bed days related to non-hospitalization leaves of absence will be made at 95% of the Medicaid rate otherwise payable to the facility for services provided [on behalf of] to such person;

(ii) payment to a facility for reserved bed days provided [on behalf of] for such person for [temporary] hospitalizations and therapeutic leave that is consistent with a plan of care ordered by the patient's treating health care professional may not exceed 14 days in any 12-month period; and

(iii) payment to a facility for reserved bed days provided [on behalf of such person for non-hospitalization leaves of absence] for patients on leave for purposes other than hospitalization or eligible therapeutic leave may not exceed 10 days in any 12-month period.

In computing reserved bed days, the day of discharge from the residential health care facility shall be counted, but not day of readmission.

For each state fiscal year in which the reserved bed day provision does not realize $40,000,000 in gross savings, effective December 1, 2012, a per diem adjustment will be applied for all nursing homes, other than those providing services primarily to children under the age of twenty-one, sufficient to increase the gross savings to $40,000,000 for that state fiscal year.

Appendix III
2012 Title XIX State Plan
Third Quarter Amendment
Long-Term Care Facility Services
Authorizing Provisions

SPA 12-24

Chapter 56 of the Laws of 2012 – section 34 of Part D

§ 34. Subdivision 25 of section 2808 of the public health law, as added by section 31 of part B of chapter 109 of the laws of 2010, subparagraph (iii) of paragraph (b) as amended and subparagraph (iv) of paragraph (b) as added by section 69 of part H of chapter 59 of the laws of 2011, is amended to read as follows:

25. Reserved bed days. (a) For purposes of this subdivision, a "reserved bed day" is a day for which a governmental agency pays a residential health care facility to reserve a bed for a person eligible for medical assistance pursuant to title eleven of article five of the social services law while he or she is temporarily hospitalized or on leave of absence from the facility.

(b) Notwithstanding any other provisions of this section or any other law or regulation to the contrary, for reserved bed days provided on behalf of persons twenty-one years of age or older:

(i) payments for reserved bed days shall be made at ninety-five percent of the Medicaid rate otherwise payable to the facility for services provided on behalf of such person;

(ii) payment to a facility for reserved bed days provided on behalf of such person for temporary hospitalizations may not exceed fourteen days in any twelve month period;

(iii) payment to a facility for reserved bed days provided on behalf of such person for non-hospitalization leaves of absence may not exceed ten days in any twelve month period[~~; and~~

~~(iv) payments for reserved bed days for temporary hospitalizations shall only be made to a residential health care facility if at least fifty percent of the facility's residents eligible to participate in a Medicare managed care plan are enrolled in such a plan~~].

(c)(i) Notwithstanding any contrary provision of this subdivision or any other law and subject to the availability of federal financial participation, for rate periods on and after April first, two thousand twelve, with regard to services provided to residential health care facility residents twenty-one years of age and older, the commissioner shall promulgate regulations, and may promulgate emergency regulations, effective for periods on and after April first, two thousand twelve, establishing reimbursement rates for reserved bed days, provided, however, that such regulations shall achieve an aggregate annualized reduction in reimbursement for such reserved bed days of no less than forty million dollars, as determined by the commissioner.

(ii) In the event the commissioner determines that federal financial participation will not be available for rate adjustments made pursuant to subparagraph (i) of this paragraph or regulations promulgated thereunder, then, for rate periods on and after April first, two thousand twelve, Medicaid rates for inpatient services shall not include any factor or payment amount for such reserved bed days with regard to residents twenty-one years of age and older.

(iii) In the event the provisions of subparagraph (ii) of this paragraph are invoked and implemented by the commissioner, then the commissioner shall promulgate regulations, and may promulgate emergency regulations, effective for rate periods on or after April first, two thousand twelve, providing upward revisions to Medicaid rates issued pursuant to subdivision two-c of this section, provided, however, that such upward revisions shall not in aggregate, as determined by the commissioner, exceed, on an annual basis, an amount equal to current annual Medicaid payments for reserved bed days, less forty million dollars.

86-2.40(ac)(4) -- reserved beds days reim – veino 9/10/12

Subdivision (ac) of section 86-2.40 of Subpart 86-2 of 10 NYCRR is amended by adding a new paragraph (4), to read as follows:

(4)(i) Subject to the availability of federal financial participation, for services provided on and after July 1, 2012, Medicaid payments for reserved bed days, as defined in paragraph (2) of this subdivision, which are related to a patient's hospitalization shall be made at 50% of the Medicaid rate otherwise payable to the facility with regard to such days of care.

(ii) Subject to the availability of federal financial participation, for services provided on and after July 1, 2012, Medicaid payments for reserved bed days, as defined in paragraph (2) of this subdivision, which do not involve the patient's hospitalization and which are *(a)* related to a patient's therapeutic leave of absence that is consistent with a plan of care ordered by such patient's treating health care professional, or *(b)* are other leaves of absences, shall be made at 95% of the Medicaid rate otherwise payable to the facility with regard to such days of care.

(iii) Subject to the availability of federal financial participation, in the event the commissioner determines, in consultation with the director of the budget, that the provisions of subparagraphs (i) and (ii) of this paragraph shall achieve projected aggregate Medicaid savings, as determined by the commissioner, of less than forty million dollars for the state fiscal year beginning April first, two thousand twelve, and each state fiscal year thereafter, the commissioner shall establish a prospective per diem rate adjustment for all nursing homes, other than nursing homes providing services primarily to children under the age of twenty-one, sufficient to achieve such forty million dollars in savings for each such state fiscal year.

86-2.40(ac)(2) -- reserved beds days definition – veino 8/28/12

Paragraph (2) of subdivision (ac) of section 86-2.40 of Subpart 86-2 of 10 NYCRR is amended, to read as follows:

(2) For rate computation purposes, "patient days" shall include "reserved bed days", defined as the unit of measure denoting an overnight stay away from the facility for which the patient, or the patient's third-party payor, provides per diem reimbursement when the patient's absence is due to hospitalization or therapeutic leave **consistent with a plan of care ordered by such patient's treating health care professional or due to other leaves of absences**.

Appendix IV
2012 Title XIX State Plan
Third Quarter Amendment
Long-Term Care Facility Services
Public Notice

MISCELLANEOUS NOTICES/HEARINGS

Notice of Abandoned Property Received by the State Comptroller

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

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

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

PUBLIC NOTICE
Department of Health

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

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

All Services

- Effective April 1, 2012, the Essential Community Provider Network and the Vital Access Providers initiatives will be established to ensure access to care for patients.

Essential Community Provider Network: New York State will assume an active role in ensuring certain essential community providers (hospitals, nursing homes, D&TCs or home health providers) be eligible to receive short-term funding to achieve defined operational goals such as a facility closure, merger, integration or reconfiguration of services.

- To receive funding under this initiative, providers must apply to the Department of Health for consideration and present a plan with clearly defined benchmarks for achieving well-articulated goals, including improved quality, efficiency, and the alignment of health care resources with community health needs. The plan must also include a budget that will be the basis for reimbursement and for identifying required financial resources. Failure to meet goals articulated in the plan within the defined timelines (no more than 2-3 years) will result in the immediate termination of the rate enhancement. The facility must also demonstrate how its plan and the investment will ultimately return savings long term for the Medicaid program.
- The Commissioner of Health will make the final decision concerning which facilities are eligible by applying the following criteria:
  - Demonstration of integration of services with other providers and improved quality, access, and efficiency;
  - Engagement with community stakeholders and responsiveness of plan to community health needs;
  - Financial viability based upon certain metrics (profitability, debt load, and liquidity);
  - Provision of care to financially and medically vulnerable populations;
  - Provision of essential health services; and/or
  - Provision of an otherwise unmet health care need (e.g., behavioral health services).
- Benchmarks that must be present in any acceptable plan are key to the success of this initiative. Such measures might include:
  - Administrative and operational efficiencies;
  - Quality and population health standards;
  - Provision of essential services;
  - Improved integration or collaboration with other entities; and/or
  - Achieving health care cost savings.
- Furthermore, as part of the requirement for a provider to receive funds through this initiative, the Department of Health must approve of the applicant's governance structure and the ability of its board and executive leadership to implement the plan and take decisive steps to stabilize the financial condition of the facility, while improving quality and efficiency. In addition, it is also possible restructuring officers and new board members (with expertise in certain areas) could be recruited to replace or enhance the existing leadership as a means to ensure the plan's fruition.

Vital Access Providers (VAP): This initiative will be established to provide ongoing rate enhancement to a small group of hospitals, nursing homes, D&TCs, and home care providers, under more stringent basis over a longer term. These facilities will be required to submit a plan and a budget for meeting defined goals, which would include approaches to advance community care, but the purpose of these funds is to provide longer term operational support. Examples of providers that could receive this designation and enhancement could include efficient hospitals and other providers in rural communities that have already reconfigured services to create integrated systems of care and that require a rate enhancement to remain financially viable and continue to provide a service not offered elsewhere in the community (e.g., emergency department, trauma care, obstetrics). Furthermore, in urban areas, qualifying providers will be unique in that they serve a very high proportion of Medicaid and financially vulnerable populations, provide unique services that are not offered by other providers within the community, and have serious financial problems.

- The VAP provider designation and any allocation of funds are subject to approval by the Commissioner of Health and are pursuant to a dynamic plan to better the health of the community.
- Facilities will be required to demonstrate satisfaction of benchmarks specified by the Commissioner.
- Effective April 1, 2012, regularly scheduled phased reductions to hospital inpatient Transition II funding will be redirected to the Safety Net/VAP funding instead of the development of the inpatient statewide base price.

The annual increase in gross Medicaid expenditures for both initia-

tives for state fiscal year 2012/13 is $100 million, including the redirection of the hospital inpatient Phase II funding.

- Continues Ambulatory Patient Group (APG) rates of payment for Medicaid services for outpatient hospital services, general hospital emergency services, ambulatory surgical services, for dates of service on and after April 1, 2012, and for diagnostic and treatment center services, for dates of services on and after July 1, 2012, except those payments made on behalf of persons enrolled in Medicaid HMO or Family Health Plus.
- For state fiscal year beginning April 1, 2012 and forward provide Medicaid reimbursement to hospitals for inpatient and ambulatory care services, and to free standing diagnostic and treatment centers through modification of APG payments, for the provision of interpretation services for patients with limited English proficiency (LEP) and communication services for people who are deaf and hard of hearing. The increase in gross Medicaid expenditures for state fiscal year 2012/13 is $2.70 million.

Institutional Services

- For the state fiscal year beginning April 1, 2012 through March 31, 2013, continues specialty hospital adjustments for hospital inpatient services provided on and after April 1, 2012, to public general hospitals, other than those operated by the State of New York or the State University of New York, located in a city with a population of over one million and receiving reimbursement of up to $1.08 billion annually. Payments to eligible public general hospitals may be added to rates of payment or made as aggregate payments.
- Effective April 1, 2012, the Commissioner of Health shall incorporate quality related measures including, potentially preventable re-admissions (PPRs) and other potentially preventable negative outcomes (PPNOs) and provide for rate adjustments or payment disallowances related to same. Such rate adjustments or payment disallowances will be calculated in accordance with methodologies, as determined by the Commissioner of Health, and based on a comparison of the actual and risk adjusted expected number of PPRs and other PPNOs in a given hospital and with benchmarks established by the Commissioner. Such adjustments or disallowances for PPRs and other PPNOs will result in an aggregate reduction in Medicaid payments of no less than $51 million annually for periods beginning April 1, 2012 through March 31, 2013, provided that such aggregate reductions shall be offset by Medicaid payment reductions occurring as a result of decreased PPRs for the periods April 1, 2012 through March 31, 2013, and as a result of decreased PPRs and PPNOs for the period April 1, 2012 through March 31, 2013. Such rate adjustments or payment disallowances shall not apply to behavioral health PPRs or to readmissions that occur on or after 15 days following an initial admission. The annual decrease in gross Medicaid expenditures for state fiscal year 2012/13 is $51 million.

Long Term Care Services

- Effective April 1, 2012, for rate periods on and after April 1, 2012, for services provided to residential health care facility residents 21 years of age and older, the Commissioner of Health shall promulgate regulations, which may be emergency regulations, establishing reimbursement rates for reserved bed days, provided, however, that such regulations shall achieve an aggregate annualized reduction in reimbursement for such reserved bed days of no less than $40 million, as determined by the Commissioner.
  - If federal financial participation is not available for rate adjustments, or regulations promulgated thereunder, then, for such rate periods, Medicaid rates for inpatient services shall not include any factor or payment amount for such reserved bed days with regard to residents 21 years of age or older. In addition, for such rate periods upward revisions to Medicaid rates shall be provided, however, such upward revisions shall not in the aggregate, as determined by the Commissioner, exceed, on an annual basis, an amount equal to current annual Medicaid payments for reserved bed days, less than $40 million.
- To clarify the previously noticed provisions of March 30, 2011, December 28, 2011 and March 14, 2012, related to Certified Home Health Agencies (CHHA) episodic pricing, Medicaid payments for services provided by CHHAs will be effective May 1, 2012.
- The current authority to adjust Medicaid rates of payment for personal care services, provided in local social services districts which include a city with a population of over one million persons and distributed in accordance with memorandums of understanding entered into between the State and such local districts for purpose of supporting recruitment and retention of personal care service workers has been extended for the period April 1, 2012 through March 31, 2014. Payments for the periods April 1, 2012 through March 31, 2013; and April 1, 2013 through March 31, 2014, shall not exceed, in the aggregate, $340 million for each applicable period.
- The current authority to adjust Medicaid rates of payment for personal care services provided in local social services districts which shall not include a city with a population of over one million persons, for purpose of supporting recruitment and retention of personal care service workers has been extended for the period April 1, 2012 through March 31, 2014. Payments for the period April 1, 2012 through March 31, 2013; and April 1, 2013 through March 31, 2014, shall be up to $28.5 million for each applicable period.
- The current authority to adjust Medicaid rates of payment for certified home health agencies, AIDS home care programs, and hospice programs for purposes of supporting recruitment and retention of non-supervisory health care workers or any worker with direct patient care responsibility has been extended for the period April 1, 2012 through March 31, 2014. Payments shall not exceed in the aggregate, $100 million for each of the following periods: April 1, 2012 through March 31, 2013; and April 1, 2013 through March 31, 2014, and shall be calculated in accordance with the previously approved methodology. Such adjustments to rates of payment shall be allocated proportionally based on each certified home health agency's, AIDS home care and hospice programs' home health aide or other direct care services total annual hours of service provided to Medicaid patients, as reported in each such agency's most recently available cost report as submitted to the Department. Payments made shall not be subject to subsequent adjustment or reconciliation.

Non-institutional Services

- For State fiscal years beginning April 1, 2012 through March 31, 2013, continues hospital outpatient payment adjustments that increase the operating cost components of rates of payment for hospital outpatient and emergency departments for public general hospitals other than those operated by the State of New York or the State University of New York, which are located in a city with a population of over one million. The eligibility criteria remain unchanged. Payments to eligible public general hospitals may be added to rates of payment or made as aggregate payments. The increase in Medicaid expenditures for state fiscal year 2012/13 is $287 million.
- The Ambulatory Patient Group (APG) reimbursement methodology is revised to include recalculated weights that will become effective on or after April 1, 2012. There is no estimated annual change to gross Medicaid expenditures as a result of this proposal.
- Effective on or after April 1, 2012, adults, age 21 and older, with a diagnosis of diabetes mellitus may obtain podiatry services from podiatrists in private practice. The decrease in gross Medicaid expenditures for state fiscal year 2012/13 is $4.40 million.
- Effective on or after April 1, 2012, lactation counseling services for pregnant and postpartum women will be provided when such services are ordered by a physician, registered physician's assistant, registered nurse practitioner, or licensed midwife and provided by a certified lactation consultant, as determined by the Commissioner of Health. The decrease in gross Medicaid expenditures for state fiscal year 2012/13 is $8.40 million.

An application for a waiver of the requirements of paragraph a of subdivision 7 of section 176-b of the Town Law, which limits the membership of volunteer fire companies to forty-five per centum of the actual membership of the fire company, has been submitted by the Sauquoit Fire District #1, County of Oneida.

Pursuant to section 176-b of the Town Law, the non-resident membership limit shall be waived provided that no adjacent fire department objects within sixty days of the publication of this notice.

Objections shall be made in writing, setting forth the reasons such waiver should not be granted, and shall be submitted to: Bryant D. Stevens, State Fire Administrator, Office of Fire Prevention and Control, 99 Washington Ave., Suite 500, Albany, NY 12210-2833

Objections must be received by the State Fire Administrator within sixty days of the date of publication of this notice.

In cases where an objection is properly filed, the State Fire Administrator shall have the authority to grant a waiver upon consideration of (1) the difficulty of the fire company or district in retaining and recruiting adequate personnel; (2) any alternative means available to the fire company or district to address such difficulties; and (3) the impact of the waiver on adjacent fire departments.

For further information, please contact: Deputy Chief Donald Fischer, Office of Fire Prevention and Control, 99 Washington Ave., Suite 500, Albany, NY 12210-2833, (518) 474-6746, Dfischer@dhses.ny.gov

PUBLIC NOTICE

City of Glen Cove
Transfer Station Operation & Maintenance
Solid Waste Transport
Recycling and Disposal Services
Final Request for Proposals (FRFP)

PLEASE TAKE NOTICE, that pursuant to, and accordance with, Subdivision 4 of Section 120-w of the General Municipal Law, the City of Glen Cove hereby gives notice of its Final Request for Proposals (FRFP) for the financing, provision of transportation means and services and the facilities, having to do with the operation and maintenance of the City of Glen Cove solid waste transfer station and for the transportation, recycling and disposal of City of Glen Cove municipal solid waste. The means, services and facilities are expected to include: certain capital improvements to the City of Glen Cove solid waste transfer station; the operation and maintenance of the City of Glen Cove solid waste transfer station; transfer haul vehicles; the processing, transportation, recycling and disposal of solid waste; administrative management; maintenance support; and customer service support to perform services as specified in FRFP. Issued with the FRFP, may be comments filed in relation to the previously released Draft Request for Proposals (DRFP), and the City's findings related to the substantive elements of such comments.

Copies of the FRFP may be obtained at the City of Glen Cove Finance Department, Purchasing Division, Attn: Ms. Nancy Andreiev, City Purchasing Agent, City of Glen Cove City Hall, First Floor, 9 Glen Street, Glen Cove, New York 11542 between the hours of 9:00 A.M., 4:30 P.M., except Saturdays, Sundays and Holidays, on and after Monday, April 30, 2012 for a nonrefundable fee of ONE HUNDRED DOLLARS ($100.00), until Tuesday, May 22, 2012.

One (1) original and 4 (four) copies of the FRFP must be received at the office of William Archambault, Director of Public Works, City of Glen Cove City Hall, Room 301, 9 Glen Street, Glen Cove, New York 11542, no later than 3:00 p.m. on Tuesday, May 22, 2012.

The City of Glen Cove shall also provide a copy of the FRFP for review on or after April 30, 2012 until May 22, 2012, at the following two locations: (1) the Office of the City Clerk, City Hall, 9 Glen Street, New York 11542, and (2) the Glen Cove Public Library, 4 Glen Cove Avenue, Glen Cove, New York 11542.

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 to comply with recently enacted statutory provisions. The following provides clarification to provisions previously noticed on March 30, 2012, and notification of new significant changes:

All Services

- The amount appropriated for previously noticed provisions regarding the Essential Community Provider Network and the Vital Access Providers initiatives in the enacted budget is now $86.4 million, which is a reduction of $13.6 million for state fiscal year 2012/13; however, the annual increase in state fiscal year 2013/14 remains $100 million.
- To clarify, effective April 1, 2012, regularly scheduled phased reductions to hospital inpatient Transition II funding of $25 million will be redirected to the Safety Net/VAP funding instead of the development of the inpatient statewide base price.

The annual increase in gross Medicaid expenditures for both initiatives for state fiscal year 2012/13 is $86.4, including the redirection of the hospital inpatient Phase II funding.

Institutional Services

- Effective May 1, 2012, the statewide base price will be reduced by $19.2 million for state fiscal year 2012/13 and $19.2 million for state fiscal year 2013/14 as compared to the $24.2 million in state fiscal year 2011/12.

Long Term Care Services

- Effective on and after April 1, 2012, for rate periods on and after July 1, 2012, for services provided to residential health care facility residents 21 years of age and older, the Commissioner of Health shall implement a methodology which establishes reimbursement rates for reserved bed days.
  - Such methodology shall, for each Medicaid patient for any 12-month period, provide for reimbursement for reserved bed days for up to an aggregate of 14 days for hospitalizations and for other therapeutic leave of absences consistent with a plan of care ordered by such patient's treating health care professional, and up to an aggregate of 10 days of other leaves of absence.
  - If the Commissioner, in consultation with the Director of the Budget, determines that such methodology shall achieve projected aggregate Medicaid savings of less than $40 million for state fiscal year beginning April 1, 2012, and each state fiscal year thereafter, the Commissioner shall establish a prospective per diem rate adjustment for all nursing homes, other than those providing services primarily to children under the age of 21, sufficient to achieve such $40 million in savings for each such state fiscal year.
- Effective April 1, 2012, an assisted living program (ALP), that is not itself a certified home health agency (CHHA), shall contract with one or more CHHAs for the provision of services pursuant to Article 36 of the Public Health Law.
  - An ALP shall, either directly or through contract with a certified home health agency, conduct an initial assessment to determine whether a person would otherwise require placement in a residential health care facility if not for the availability of the ALP and is appropriate for admission to an ALP.
  - No person shall be determined eligible for and admitted to an ALP unless the ALP finds that the person meets the criteria provided above.
  - Appropriate services shall be provided to an eligible person only in accordance with a plan of care which is based upon an initial assessment and periodic reassessments conducted by an ALP, either directly or through contract with a CHHA. A reassessment shall be conducted as frequently as is required to respond to changes in the resident's condition and ensure immediate access to necessary and appropriate services by the resident, but in no event less frequently than once every six months. No person shall be admitted to or retained in an ALP unless the person can be safely and adequately cared for with the provision of services determined by such assessment or reassessment.

Appendix V
2012 Title XIX State Plan
Third Quarter Amendment
Long-Term Care Facility Services
Responses to Standard Funding Questions

LONG-TERM CARE FACILITY SERVICES
State Plan Amendment #12-24

CMS Standard Funding Questions (NIRT Standard Funding Questions)

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

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

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

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

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

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

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

Response: Based on guidance from CMS, the State and CMS staff will engage in discussions to develop a strategic plan to complete the UPL demonstration for 2012.

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 e 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: The consultation process that New York State uses is detailed in SPA #11-06, which was approved by CMS on 8/4/11. On 4/29/11, and again on 6/28/11, tribal leaders and health clinic administrators were sent information regarding this SPA (see attached) in accordance with the State's approved procedure. To date, no comments have been received.

Appendix VI
2012 Title XIX State Plan
Third Quarter Amendment
Long-Term Care Facility Services
Responses to Standard Access Questions

APPENDIX VI
NON-INSTITUTIONAL SERVICES
State Plan Amendment 12-24

CMS Standard Access Questions

The following questions have been asked by CMS and are answered by the State in relation to all payments made to all providers under Attachment 4.19-B of the state plan.

1. **Specifically, how did the State determine that the Medicaid provider payments that will result from the change in this amendment are sufficient to comply with the requirements of 1902(a)(30)?**

- **Response:** This amendment seeks to update the State's reserved bed day reimbursement policy, as required by changes enacted in the 2012-13 New York State Budget. Specifically, the rate of payment for reserved bed days related to temporary hospitalizations will be lowered from 95% to 50% of the Medicaid rate payable to the facility. The total number of reserved bed days provided on behalf of the resident for temporary hospitalization and other therapeutic leaves of absences that are consistent with a plan of care ordered by the resident's treating health care professional will be limited to 14 days in any 12-month period. In addition, effective December 1, 2012, a per diem adjustment will be made to the Medicaid rate of payment, excluding nursing homes providing services primarily to children under the age of 21, as necessary to achieve a net savings of $40 million for each State fiscal year.

  This amendment is expected to reduce Medicaid costs by reducing unnecessary hospitalization and improving the quality of care for nursing home residents.

2. **How does the State intend to monitor the impact of the new rates and implement a remedy should rates be insufficient to guarantee required access levels?**

   Response: The State has various ways to ensure that access levels in the Medicaid program are retained and is currently not aware of any access issues, particularly since there is excess bed capacity for both hospitals and nursing homes. Additionally, hospital and nursing home providers must notify and receive approval from the Department's Office of Health Systems Management (OHSM) in order to discontinue services. This Office monitors and considers such requests in the context of access as they approve/deny changes in services. Finally, providers cannot discriminate based on source of payment.

For providers that are not subject to an approval process, the State will continue to monitor provider complaint hotlines to identify geographic areas of concern and/or service type needs. If Medicaid beneficiaries begin to encounter access issues, the Department would expect to see a marked increase in complaints. These complaints will be identified and analyzed in light of the changes proposed in this State Plan Amendment.

Finally, the State ensures that there is sufficient provider capacity for Medicaid Managed Care plans as part of its process to approve managed care rates and plans. Should sufficient access to services be compromised, the State would be alerted and would take appropriate action to ensure retention of access to such services.

3. **How were providers, advocates and beneficiaries engaged in the discussion around rate modifications? What were their concerns and how did the State address these concerns?**

   Response: This change was enacted by the State Legislature as part of the negotiation of the 2012-13 Budget. The impact of this change was weighed in the context of the overall Budget in the State. The legislative process provides opportunities for all stakeholders to lobby their concerns, objections, or support for various legislative initiatives.

4. **What action(s) does the State plan to implement after the rate change takes place to counter any decrease to access if the rate decrease is found to prevent sufficient access to care?**

   Response: Should any essential community provider experience Medicaid or other revenue issues that would prevent access to needed community services, per usual practice, the State would meet with them to explore the situation and discuss possible solutions, if necessary.

5. **Is the State modifying anything else in the State Plan which will counterbalance any impact on access that may be caused by the decrease in rates (e.g. increasing scope of services that other provider types may provide or providing care in other settings)?**

   Response: Over the course of the past three years, the State has undertaken a massive reform initiative to better align reimbursement with care. When fully implemented, the initiative will invest over $600 million in the State's ambulatory care system (outpatient, ambulatory surgery, emergency department, clinic and physicians) to incentivize care in the most appropriate setting. The State has also increased its physician reimbursement schedule to resemble Medicare payments for similar services, thus ensuring continued access for Medicaid beneficiaries. Further, the State is implementing initiatives that will award $600 million annually, over five years, to providers

who promote efficiency and quality care through the Federal-State Health Reform Partnership(F-SHRP)/ NYS Healthcare Efficiency and Affordability Law (HEAL). While some of these initiatives are outside the scope of the State Plan, they represent some of the measures the State is taking to ensure quality care for the State's most vulnerable population.