

NEW YORK
state department of
HEALTH

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

Sue Kelly
Executive Deputy Commissioner

January 25, 2012

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
26 Federal Plaza - Room 37-100 North
New York, NY 10278

RE: SPA #11-51
Non-Institutional Services

Dear Mr. Melendez:

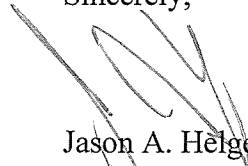
The State requests approval of the enclosed amendment #11-51 to the Title XIX (Medicaid) State Plan for non-institutional services to be effective April 1, 2012 (Appendix I). This amendment is being submitted based on enacted legislation and State regulation. A summary of the plan amendment is provided 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 the pertinent section of enacted State statute and draft regulations are enclosed for your information (Appendix III). Copies of the public notices for this plan amendment, which were given in the New York State Register on March 30, 2011, and December 28, 2011, are also enclosed for your information (Appendix IV). In addition, responses to the five standard funding questions and the standard access questions are also enclosed (Appendix V and VI, respectively).


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,

A handwritten signature in black ink, appearing to read "Jason A. Helgeson", written over the typed name.

Jason A. Helgeson
Medicaid Director
Deputy Commissioner
Office of Health Insurance Programs

Enclosures

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL		1. TRANSMITTAL NUMBER: #11-51	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 April 1, 2012	
5. TYPE OF PLAN MATERIAL (<i>Check One</i>): <input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (<i>Separate Transmittal for each amendment</i>)			
6. FEDERAL STATUTE/REGULATION CITATION: Section 1902(a) of the Social Security Act, and 42 CFR 447		7. FEDERAL BUDGET IMPACT: a. FFY 04/01/12 – 09/30/12 (\$35M) b. FFY 10/01/12 – 09/30/13 (\$50.5M)	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-B: Pages 4(5), 4(6), 4(7)		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (<i>If Applicable</i>): Attachment 4.19-B: Page 4(5)	
10. SUBJECT OF AMENDMENT: CHHA Episodic Pricing			
11. GOVERNOR'S REVIEW (<i>Check One</i>): <input checked="" type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input type="checkbox"/> OTHER, AS SPECIFIED: <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL			
12. SIGNATURE OF STATE AGENCY OFFICIAL: 		16. RETURN TO: New York State Department of Health Corning Tower Empire State Plaza Albany, New York 12237	
13. TYPED NAME: Jason A. Helgerson			
14. TITLE: Medicaid Director & Deputy Commissioner Department of Health			
15. DATE SUBMITTED: January 25, 2012			
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
2012 Title XIX State Plan
First Quarter Amendment
Non-Institutional Services
Amended SPA Pages

New York
4(5)

Attachment 4.19-B
(04/12)

such agency to the state and will be recouped [by the Department in a lump sum amount or] through reductions in the Medicaid payments due to the agency. In those instances where an interim payment adjustment was applied to an agency, and such agency's actual per-patient Medicaid claims are determined to be less than the agency's adjusted ceiling, the amount by which such Medicaid claims are less than the agency's adjusted ceiling will be remitted to each such agency by the Department in a lump sum amount [or through an increase in the Medicaid payments due to the agency].

- (f) Interim payment adjustments pursuant to this section will be based on Medicaid paid claims for services provided by agencies in the base year 2009. Amounts due from reconciling payment adjustments will be based on Medicaid paid claims for services provided by agencies in the base year 2009 and Medicaid paid claims for services provided by agencies in the reconciliation period April 1, 2011 through March 31, 2012.
- (g) The payment adjustments will not result in an aggregate annual decrease in Medicaid payments to providers in excess of \$200 million. If upon reconciliation it is determined that application of the calculated ceilings would result in an aggregate annual decrease of more than \$200 million, all providers' ceilings would be adjusted proportionately to reduce the decrease to \$200 million. Such reconciliation will not be subject to subsequent adjustment.
- (h) The Commissioner may require agencies to collect and submit any data required to implement the provisions of this subdivision.
- (i) Effective April 1, 2012, Medicaid payments for services provided by certified home health agencies, except for such services provided to children under 18 years of age, shall be based on payment amounts calculated for 60-day episodes of care. The Commissioner will establish a base price for 60-day episodes of care, and this price will be adjusted for the case mix index, which applies to each patient, and for regional wage differences.

The initial statewide episodic base price to be effective April 1, 2012, will be calculated based on paid Medicaid claims, as determined by the Department, for services provided by all certified home health agencies during the base year period of January 1, 2009 through December 31, 2009. The base price will be calculated by grouping all paid claims in the base period into 60-day episodes of care. All such 2009 episodes, which include episodes beginning in November or December of 2008 or ending in January or

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February of 2010, will be included in the base price calculation. Low utilization episodes of care, as defined below, shall be excluded from the base price calculation. For high utilization episodes of care, costs in excess of outlier thresholds shall be excluded from the base price calculation. The remaining costs will be divided by the number of episodes to determine the unadjusted base price. The resulting base price shall be subject to further adjustment as is required to comply with the aggregate savings mandated by paragraph (b) of subdivision 13 of section 3614 of the Public Health Law (PHL). The applicable base year for determining the episodic base price will be updated not less frequently than every three years.

The case mix index applicable to each episodic claim, excluding low utilization claims, shall be based on patient information contained in the federal Outcome Assessment Information Set (OASIS). The patient shall be assigned to a resource group based on data which includes, but is not limited to, clinical and functional information, age group, and the reason for the assessment. A case mix index shall be calculated for each resource group based on the relative cost of paid claims during the base period.

A regional wage index will be calculated for each of the ten labor market regions in New York as defined by the New York State Department of Labor. Average wages will be determined for the health care service occupations applicable to certified home health agencies. The average wages in each region shall be assigned relative weights in proportion to the Medicaid utilization for each of the agency service categories reported in the most recently available agency Medicaid cost report submissions. Weighted average wages for each region will be compared to the statewide average wages to determine an index for each region. The wage index will be applied to the portion of each payment which is attributable to labor costs. If necessary, the Department will adjust the regional index values proportionately to assure that the application of the index values is revenue-neutral on a statewide basis.

Payments for low utilization cases shall be based on the statewide weighted average of fee-for-service rates for services provided by certified home health agencies, as adjusted by the applicable regional wage index factor. Low utilization cases will be defined as 60-day episodes of care with a total cost of \$500 or less, based on statewide weighted average fee-for-service rates paid on a per-visit, per-hour, or other appropriate basis, calculated prior to the application of the regional wage index factor.

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Payments for 60-day episodes of care shall be adjusted for high-utilization cases in which total costs, based on statewide weighted average fee-for-service rates paid on a per-visit, per-hour, or other appropriate basis, exceed outlier cost thresholds determined by the Department for each case mix group. In such cases the provider will receive the adjusted episodic base payment, plus a percentage, to be determined by the Department, of the costs which exceed the outlier threshold. Both the base payment and the excess outlier payment will be adjusted by the regional wage index factor. The percentage of excess costs to be reimbursed shall be subject to such further adjustment as deemed necessary to comply with the aggregate savings mandated by PHL section 3614(13)(b).

The outlier threshold for each resource group shall be equal to a specified percentile of all episodic claims totals for the resource group during the base period, excluding low utilization episodes. Such percentiles shall range from the seventieth percentile for groups with the lowest case mix index to the ninetieth percentile for groups with the highest case mix index.

Services provided to maternity patients, defined as patients who are currently or were recently pregnant and are receiving treatment as a direct result of such pregnancy, may be reimbursed pursuant to this section without the submission of an OASIS form, provided that providers billing for such services must bill in accordance with such special billing instructions as may be established by the Commissioner, and such patients shall receive a case mix designation based on the lowest acuity resource group.

Payments for episodes of care shall be proportionately reduced to reflect episodes of care totaling less than 60 days provided, however, that CHHAs will receive reimbursement for a full episode of care if the episode totaled less than 60 days and the patient was discharged to the home, to a hospital, or to a hospice, or if the episode ended due to the death of the patient.

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Approval Date _____

Supersedes TN NEW

Effective Date _____

Appendix II
2012 Title XIX State Plan
First Quarter Amendment
Non-Institutional Services
Summary

SUMMARY
SPA #11-51

This state plan amendment proposes to implement an episodic pricing system for certified home health agencies (CHHA), utilizing a statewide base price for 60-day episodes of care with adjustments for patient acuity and regional wage differences, effective April 1, 2012.

Appendix III
2012 Title XIX State Plan
First Quarter Amendment
Non-Institutional Services
Authorizing Provisions

SPA 11-51

S. 2809-D / A. 4009-D - Part H

§ 4. Section 3614 of the public health law is amended by adding a new subdivision 13 to read as follows:

13. (a) Notwithstanding any inconsistent provision of law or regulation and subject to the availability of federal financial participation, effective April first, two thousand twelve through March thirty-first, two thousand fifteen, payments by government agencies for services provided by certified home health agencies, except for such services provided to children under eighteen years of age and other discreet groups as may be determined by the commissioner pursuant to regulations, shall be based on episodic payments. In establishing such payments, a statewide base price shall be established for each sixty day episode of care and adjusted by a regional wage index factor and an individual patient case mix index. Such episodic payments may be further adjusted for low utilization cases and to reflect a percentage limitation of the cost for high-utilization cases that exceed outlier thresholds of such payments.

(b) Initial base year episodic payments shall be based on Medicaid paid claims, as determined and adjusted by the commissioner to achieve savings comparable to the prior state fiscal year, for services provided by all certified home health agencies in the base year two thousand nine. Subsequent base year episodic payments may be based on Medicaid paid claims for services provided by all certified home health agencies in a base year subsequent to two thousand nine, as determined by the commissioner, provided, however, that such base year adjustment shall be made not less frequently than every three years. In determining case mix, each patient shall be classified using a system based on measures which may include, but not limited to, clinical and functional measures, as reported on the federal Outcome and Assessment Information Set (OASIS), as may be amended.

(c) The commissioner may require agencies to collect and submit any data required to implement this subdivision. The commissioner may promulgate regulations to implement the provisions of this subdivision.

Pursuant to the authority vested in the Commissioner of Health by section 3614(13) of the Public Health Law, Subpart 86-1 of Title 10 of the Official Compilation of Codes, Rules and Regulations of the State of New York, is amended, to be effective upon publication of a Notice of Adoption in the New York State Register, to read as follows:

Subpart 86-1 of title 10 of NYCRR is amended and a new section 86-1.44 is added, to read as follows:

86-1.44. Episodic Payments for Certified Home Health Agency Services

(a) Effective for services provided on and after April 1, 2012, Medicaid payments for certified home health care agencies (“CHHA”), except for such services provided to children under eighteen years of age, 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, 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.

(1) Such base price shall be calculated by grouping all Medicaid paid CHHA claims for dates of services in 2009 into 60 day episodes of care. All such 2009 episodes which include dates of service beginning in November or December of 2008 or ending in January or February of 2010 shall be included in such base price calculation. Low utilization episodes of care, as defined in subdivision (d) of this section, shall be excluded

from such calculation. With regard to high utilization episodes of care, costs in excess of outlier thresholds, as determined in accordance with subdivision (e) of this section, shall be excluded from such calculation. The resulting base price shall be subject to such further adjustment as is required to comply with the aggregate savings mandated by paragraph (b) of subdivision 13 of section 3614 of the Public Health Law (“PHL”).

(2) The episodic base price for periods beginning on or after April 1, 2013, may be based on paid Medicaid claims for services provided by all certified home health agencies during a base year period subsequent to 2009, as determined by the Department.

(3) The applicable base year for determining the base price shall be updated not less frequently than every three years.

(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 (g) of this section; and also by a regional wage index factor as determined pursuant to subdivision (h) of this section.

(d) Notwithstanding any inconsistent provision of this section, payments for low utilization cases shall be based on the statewide weighted average of fee-for-service rates for such services, as determined by the Department and as adjusted by the applicable regional wage index factor as described in subdivision (h) of this section. For purposes of this section, low utilization cases will be defined as 60 day episodes of care with a total cost of \$500 or less, based on statewide

weighted average fee-for-service rates paid on a per-visit, per-hour, or other appropriate historical basis.

(e) (1) Payments for 60-day episodes of care shall be adjusted for high-utilization cases in which total costs, based on statewide weighted average fee-for-service rates as determined by the Department and as paid on a per-visit, per-hour, or other appropriate historical basis, exceed outlier cost thresholds determined by the Department for each case mix group. In such cases the provider will receive the adjusted episodic base payment pursuant to subdivisions (b) and (c) of this section, plus a percentage, to be determined by the Department, of the cost which exceeds the outlier threshold, as adjusted by the regional wage index factor, provided, however, that such adjustment percentage is subject to such further adjustment as may be necessary to comply with the aggregate savings mandated by PHL section 3614(13)(b).

(2) The outlier threshold for each resource group, as described in subdivision (g) of this section, shall be equal to a specified percentile of all episodic claims totals for the resource group during the base period, excluding low utilization episodes. Such percentiles shall range from the seventieth percentile for groups with the lowest case mix index to the ninetieth percentile for groups with the highest case mix index.

(f) The case mix index to be applied to each episodic claim, excluding low utilization claims, shall be based on patient information contained in the federal Outcome Assessment Information Set (OASIS) for the episode. The patient shall be assigned to a resource group based on data that includes, but is not limited to, clinical and functional information, age group, and the reason for

the assessment. A case mix index shall be calculated for each resource group based on the relative cost of paid claims during the base period.

(g) Reimbursement for maternity patients, defined as patients who are currently or were recently pregnant and are receiving treatment as a direct result of such pregnancy, may be made pursuant to this section without the submission of an OASIS form, provided that providers billing for such patients must bill in accordance with such special billing instructions as may be established by the commissioner and such patients shall be grouped in a case mix designation based on the lowest acuity resource group.

(h) The regional wage index factor (WIF) shall be computed in accordance with the following and applied to the portion of the episodic base price attributable to labor costs:

(1) Average wages shall be determined for agency health care service occupations for each of the 10 labor market regions in New York, as defined by the New York State Department of Labor.

(2) The average wages in each region shall be assigned relative weights in proportion to the Medicaid utilization for each of the agency service categories as reported in the most recently available agency cost report submissions.

(3) Based on the average wages as determined pursuant to paragraph (1) of this subdivision, as weighted pursuant to paragraph (2) of this subdivision, an index shall be

determined for each region, based on a comparison of the weighted average regional wages to the statewide average wages.

(4) The Department may adjust the regional WIFs proportionately, if necessary, to assure that the application of the WIFs is revenue-neutral on a statewide basis.

(i) Payments for episodes of care shall be proportionally reduced to reflect episodes of care totaling less than 60 days, provided, however, that CHHAs providing episodes of care totaling less than 60 days as a result of the following circumstances shall be reimbursed for a full 60 day episode:

(1) discharges from the CHHA resulting from a determination that the patient no longer requires CHHA care and may remain at home;

(2) transfer to a general hospital to receive acute care services;

(3) transfer to a hospice for end-of-life care; or

(4) the patient's death.

The commissioner shall monitor cases for which full payments are made for episodes of care of less than 60 days pursuant to the provisions of this subdivision and may require the CHHA to provide such information and documentation as the commissioner deems necessary to ensure quality of care.

(j) The Department may require agencies to collect and submit any data deemed by the Department to be required to implement the provisions of this section.

DRAFT

**Appendix IV
2012 Title XIX State Plan
First Quarter Amendment
Non-Institutional Services
Public Notice**

MISCELLANEOUS NOTICES/HEARINGS

Notice of Abandoned Property Received by the State Comptroller

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

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

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

PUBLIC NOTICE

Department of Civil Service

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

Please take notice that the regular monthly meeting of the State Civil Service Commission for April 2011 will be conducted on April 14 commencing at 10:00 a.m. This meeting will be conducted at New York Network, Suite 146, South Concourse, Empire State Plaza, Albany, NY. Directions and parking information available at (www.nyn.suny.edu).

For further information, contact: Office of Commission Operations, Department of Civil Service, Alfred E. Smith State Office Bldg., Albany, NY 12239, (518) 473-6598.

PUBLIC NOTICE

Department of Health

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

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

All Services

- Effective on and after April 1, 2011, no annual trend factor will be applied pursuant to the provisions of Public Health Law § 2807-c(10)(c) to rates of payment for hospital inpatient, residential health care facilities, certified home health agencies, personal care services, and adult day health care services provided to patients diagnosed with AIDS. This includes the elimination of the 2011 trend factor effective for rates of payment April 1, 2011, and thereafter. In addition, the Department is authorized to promulgate regulations, to be effective April 1, 2011, such that no annual trend factor may be applied to rates of payment by the Department of Health for assisted living program

services, adult day health care services or personal care services provided in those local social services districts, including New York City, whose rates of payment for services is established by such social services districts pursuant to a rate-setting exemption granted by the Department. This includes the elimination of the 2011 trend factor effective for rates of payment April 1, 2011, and thereafter.

- Effective for dates of service April 1, 2011, through March 31, 2012, and each state fiscal year thereafter, all non-exempt Medicaid payments as referenced below will be uniformly reduced by two percent. Such reductions will be applied only if an alternative method that achieves at least \$345 million in Medicaid state share savings annually is not implemented.

- Medicaid administration costs paid to local governments, contractors and other such entities will also be reduced in the same manner as described above.

- Payments exempt from the uniform reduction based on federal law prohibitions include, but are not limited to, the following:

- Federally Qualified Health Center services;
- Indian Health Services and services provided to Native Americans;
- Supplemental Medical Insurance - Part A and Part B;
- State Contribution for Prescription Drug Benefit (aka Medicare Part D payments);
- Any local share cap payment required by the Federal Medical Assistance Percentage (FMAP) increase legislation;
- Required payments related to the School Supportive Health Services Program and Preschool Supportive Health Services Program settlement agreement;
- Services provided to American citizen repatriates; and
- Hospice Services.

- Payments exempt from the uniform reduction based on being funded exclusively with federal and/or local funds include, but are not limited to, the following:

- Upper payment limit payments to non-state owned or operated governmental providers certified under Article 28 of the NYS Public Health Law;
- Certified public expenditure payments to the NYC Health and Hospital Corporation;
- Certain disproportionate share payments to non-state operated or owned governmental hospitals;
- Certain managed care payments pursuant to section 3-d of Part B of the Chapter 58 of the Laws of 2010; and
- Services provided to inmates of local correctional facilities.
- Payments pursuant to the mental hygiene law will be exempt from the reduction;
- Court orders and judgments; and
- Payments where applying the reduction would result in a lower FMAP as determined by the Commissioner of Health and the Director of the Budget will be exempt.

- Medicaid expenditures will be held to a year to year rate of growth spending cap which does not exceed the rolling average of the preceding 10 years of the medical component of the Consumer Price Index (CPI) as published by the United States Department of Labor, Bureau of Labor Statistics.

- The Director of the Budget and the Commissioner of Health will periodically assess known and projected Medicaid expenditures to determine whether the Medicaid growth spending cap appears to be pierced. The cap may be adjusted to account for any revision in State Financial Plan projections due to a change in the FMAP amount, provider based revenues, and beginning April 1, 2012, the operational costs of the medical indemnity fund. In the event it is determined that Medicaid expenditures exceed the Medicaid spending cap, after any adjustment to the cap if needed, the Director of the Division of the Budget and the Commissioner of Health will develop a Medicaid savings allocation plan to limit the Medicaid expenditures by the amount of the projected overspending. The savings allocation plan will be in compliance with the following guidelines:

- The plan must be in compliance with the federal law;
- It must comply with the State's current Medicaid plan, amendment, or new plan that may be submitted;
- Reductions must be made uniformly among category of service, to the extent practicable, except where it is determined by the Commissioner of Health that there are grounds for non-uniformity; and
- The exceptions to uniformity include but are not limited to: sustaining safety net services in underserved communities, to ensuring that the quality and access to care is maintained, and to avoiding administrative burden to Medicaid applicants and recipients or providers.

Medicaid expenditures will be reduced through the Medicaid savings allocation plan by the amount of projected overspending through actions including, but not limited to: modifying or suspending reimbursement methods such as fees, premium levels, and rates of payment; modifying or discontinuing Medicaid program benefits; seeking new waivers or waiver amendments.

Institutional Services

- For the state fiscal year beginning April 1, 2011 through March 31, 2012, continues specialty hospital adjustments for hospital inpatient services provided on and after April 1, 2011, 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 for periods on and after January 1, 2011, for purposes of calculating maximum disproportionate share (DSH) payment distributions for a rate year or part thereof, costs incurred of furnishing hospital services net of medical assistance payments, other than DSH payments, and payments by uninsured patients shall for the 2011 calendar year, be determined initially based on each hospital's submission of a fully completed 2008 DSH hospital data collection tool, which is required to be submitted to the Department, and shall be subsequently revised to reflect each hospital's submission of a fully completed 2009 DSH hospital data collection tool, which is required to be submitted to the Department.

- For calendar years on and after 2012, such initial determinations shall reflect submission of data as required by the Commissioner on a specific date. All such initial determinations shall subsequently be revised to reflect actual rate period data and statistics. Indigent care payments will be withheld in instances when a hospital has not submitted required information by the due dates, provided, however, that such payments shall be made upon submission of such required data.

- For purposes of eligibility to receive DSH payments for a rate year or part thereof, the hospital inpatient utilization rate shall be determined based on the base year statistics and costs incurred of furnishing hospital services determined in accordance with the established methodology that is consistent with all federal requirements.

- Extends through December 31, 2014, the authorization to distribute Indigent Care and High Need Indigent Care disproportionate share payments in accordance with the previously approved methodology.

- For state fiscal years beginning April 1, 2011, and for each state fiscal year thereafter, additional medical assistance payments for inpatient hospital services may be made to public general hospitals

operated by the State of New York or the State University of New York, or by a county which shall not include a city with a population over one million, and those public general hospitals located in the counties of Westchester, Erie, or Nassau, up to one hundred percent (100%) of each such public hospital's medical assistance and uninsured patient losses after all other medical assistance, including disproportionate share payments to such general hospitals. Payments may be added to rates of payment or made as aggregate payments. Payments will be based initially on reported reconciled data from the base year two years prior to the payment year adjusted for authorized Medicaid rate changes and further reconciled to actual reported data from such payment year.

- Public general hospitals, other than those operated by the State of New York or the State University of New York, that are located in a city with a population of over one million may receive additional medical assistance DSH payments for inpatient hospital services for the state fiscal year beginning April 1, 2011 through March 31, 2012, and annually thereafter, in the amount of up to \$120 million, as further increased by up to the maximum payment amounts permitted under sections 1923(f) and (g) of the federal Social Security Act, as determined by the Commissioner of Health after application of all other disproportionate share hospital payments. Payments may be added to rates of payment or made as aggregate payments. Payments will be based initially on reported reconciled data from the base year two years prior to the payment year adjusted for authorized Medicaid rate changes and further reconciled to actual reported data from such payment year.

- Extends current provisions to services on and after April 1, 2011, the reimbursable operating cost component for general hospital inpatient rates will be established with the 2006 final trend factor equal to the final Consumer Price Index (CPI) for all urban consumers less 0.25%.

- The State proposes to extend, effective April 1, 2011, and thereafter, certain cost containment initiatives that were enacted in Chapter 81 of the Laws of 1995 and extended by subsequent legislation. The extended provisions are as follows: (1) hospital capital costs shall exclude 44% of major moveable equipment costs; (2) elimination of reimbursement of staff housing operating and capital costs; and (3) budgeted capital inpatient costs of a general hospital applicable to the rate year shall be decreased to reflect the percentage amount by which the budgeted costs for capital related inpatient costs of the hospital for the base year two years prior to the rate year exceeded actual costs.

- Per federal requirements, the Commissioner of Health shall promulgate regulations effective July 1, 2011 that will deny Medicaid payment for costs incurred for hospital acquired conditions (HACs). The regulations promulgated by the Commissioner shall incorporate the listing of Medicaid HACs in the yet to be issued final federal rule.

- The Commissioner of Health shall promulgate regulations to incorporate quality related measures pertaining to potentially preventable conditions and complications, including, but not limited to, diseases or complications of care acquired in the hospital and injuries sustained in the hospital.

- Effective April 1, 2011, hospital inpatient rates of payment for cesarean deliveries will be limited to the average Medicaid payment for vaginal deliveries. All cesarean claims will be subject to an appeal process to determine if the services were medically necessary thus warranting the higher Medicaid payment.

- Effective April 1, 2011, the Department is proposing to expand the current Patient Centered Medical Home (PCMH) to more payers and incorporate several provisions to improve medical care. Two provisions result in a change in the methods by which Medicaid fee-for-service (FFS) reimburses Medicaid providers who are designated by the National Committee for Quality Assurance as patient centered medical homes: 1) testing new models of payment to high-volume Medicaid primary care medical home practices which incorporate risk-adjusted global payments with care management and pay-for-performance, and 2) improving the relationship of FFS Medicaid members to medical homes by creating medical home payments only for FFS members who have evidence of ongoing continuity relationship with provider/practice and providing more reliable care manage-

ment payments to those providers which are independent of specific visit types. These provisions require the following changes to Medicaid:

- New models of reimbursement to high-volume Medicaid providers will be tested which may incorporate risk-adjusted global payments and pay-for-performance. Risk-adjusted payment models will differentially reimburse providers based on their historical case mix. Pay-for-performance will provide enhanced reimbursement to providers who provide high-quality care (such as improved preventative screenings) and/or reduce unnecessary utilization (such as a reduction in admissions for ambulatory sensitive conditions) as defined by standardized measures of performance; and

- Eligible Medicaid fee-for-service recipients, who are currently receiving care from a certified PCMH provider, as determined by an attribution methodology developed by the Commissioner of Health, will be assigned to this PCMH provider. Medicaid FFS will reimburse PCMH providers a per member per month (PMPM) capitation payment for FFS recipients attributed to their practices to provide the necessary care coordination and disease management services.

- Effective April 1, 2011, for inpatient hospital services the commissioner may grant approval of temporary adjustments to Medicaid rates to provide assistance to accommodate additional patient services requirements resulting from the closure, merger or reconfiguration of other hospitals in the area. Such rate increases would enable the surviving hospital to cover costs, including but not limited to additional staff, service reconfiguration, transfer of medical residents to other programs, increased patient volume, and enhancing information technology (IT) systems.

- The institutional cost report shall no longer be required to be certified by an independent licensed public accountant effective with cost reports filed with the Department of Health for cost reporting years ending on or after December 31, 2010. Effective for the same time periods, the Department will have authority to audit such cost reports.

Long Term Care Services

- Effective for periods on and after July 1, 2011, Medicaid rates of payments for inpatient services provided by residential health care facilities (RHCF), which as of April 1, 2011, operate discrete units for treatment of residents with Huntington's disease, and shall be increased by a rate add-on. The aggregate amount of such rate add-ons for the periods July 1, 2011 through December 31, 2011 shall be \$850,000 and for calendar year 2012 and each year thereafter, shall be \$1.7 million. Such amounts shall be allocated to each eligible RHCF proportionally, based on the number of beds in each facility's discrete unit for treatment of Huntington's disease relative to the total number of such beds in all such units. Such rate add-ons shall be computed utilizing reported Medicaid days from certified cost reports as submitted to the Department for the calendar year period two years prior to the applicable rate year and, further, such rate add-ons shall not be subject to subsequent adjustment or reconciliation.

- For state fiscal years beginning April 1, 2011, and thereafter, continues additional payments to non-state government operated public residential health care facilities, including public residential health care facilities located in Nassau, Westchester, and Erie counties, but excluding public residential health care facilities operated by a town or city within a county, in aggregate amounts of up to \$300 million. The amount allocated to each eligible public RHCF will be in accordance with the previously approved methodology. Payments to eligible RHCF's may be added to rates of payment or made as aggregate payments.

- Continues, effective for periods on or after April 1, 2011, the total reimbursable state assessment on each residential health care facility's gross receipts received from all patient care services and other operating income on a cash basis for inpatient or health-related services, including adult day service, but excluding gross receipts attributable to payments received pursuant to Title XVIII of the federal Social Security Act (Medicare), at six percent. The extent to which a facility is reimbursed for the additional cost of the assessment is dependent upon Medicaid volume of services.

- Continues, effective April 1, 2011, and thereafter, the provision that rates of payment for RHCFs shall not reflect trend factor projec-

tions or adjustments for the period April 1, 1996 through March 31, 1997.

- Extends current provisions to services on and after April 1, 2011, the reimbursable operating cost component for RHCFs rates will be established with the final 2006 trend factor equal to the final Consumer Price Index (CPI) for all urban consumers less 0.25%.

- Continues, effective April 1, 2011, and thereafter, long-term care Medicare maximization initiatives.

- Effective April 1, 2011, for inpatient services provided by residential health care facilities (RHCFs), the commissioner may grant approval of temporary adjustments to Medicaid rates to provide assistance to accommodate additional patient services requirements resulting from the closure, merger or reconfiguration of other providers in the area. Such rate increases would enable the surviving RHCF to cover costs, including but not limited to additional staff, service reconfiguration, transfer of medical residents to other programs, increased patient volume, and enhancing information technology (IT) systems.

- The regional pricing methodology previously approved to be effective July 1, 2011 for inpatient services provided by residential health care facilities is repealed and replaced with a Statewide pricing methodology to be effective July 1, 2011.

- The Statewide pricing methodology for the non-capital component of the rates of payment for inpatient services provided by residential health care facilities shall utilize allowable operating costs for a base year, as determined by the Commissioner of Health by regulation, and shall reflect:

- A direct statewide price component adjusted by a wage equalization factor and subject to a Medicaid-only case mix adjustment.

- An indirect statewide price component adjusted by a wage equalization factor; and

- A facility specific non-comparable component.

- The non-capital component of the rates for AIDS facilities or discrete AIDS units within facilities; discrete units for residents receiving care in a long-term inpatient rehabilitation program for traumatic brain injured persons; discrete units providing specialized programs for residents requiring behavioral interventions; discrete units for long-term ventilator dependent residents; and facilities or discrete units within facilities that provide extensive nursing, medical, psychological and counseling support services solely to children shall be established pursuant to regulations.

The Commissioner of Health may promulgate regulations to implement the provisions of the methodology and such regulations may also include, but not be limited to, provisions for rate adjustments or payment enhancements to facilitate the transition of facilities to the rate-setting methodology and for facilitating quality improvements in residential health care facilities.

- Effective April 1, 2011, the capital cost component of Medicaid rates of payment for services provided by residential health care facilities shall not include any payment factor for return on or return of equity or for residual reimbursement.

- Effective January 1, 2012, payments for reserved bed days for temporary hospitalizations, for Medicaid eligible residents aged 21 and older, 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. Payments for these reserved bed days will be consistent with current methodology.

Non-Institutional Services

- For State fiscal years beginning April 1, 2011 through March 31, 2012, continues hospital outpatient payment adjustments that increase the operating cost components of rates of payment for hospital outpatient and emergency departments for public general hospitals other than those operated by the State of New York or the State University of New York, which are located in a city with a population of over one million. The eligibility criteria remain unchanged. The amount to be paid will be up to \$287 million annually. Payments to eligible public general hospitals may be added to rates of payment or made as aggregate payments.

- Effective April 1, 2011, the Office of Mental Health, the Office of

Alcoholism and Substance Abuse Services, and the Office for People with Developmental Disabilities will each establish utilization standards or thresholds for their voluntary-operated clinics. These standards or thresholds will target excessive utilization and will be either patient-specific or provider-specific, at the option of the controlling State agency. The standards or thresholds will be established based on normative provider visit volume for the clinic type, as determined by the controlling State agency. The Commissioner of Health may promulgate regulations, including emergency regulations, to implement these standards.

- Effective April 1, 2011, claims submitted by clinics licensed under Article 28 of New York State Public Health Law will receive an enhanced Medicaid payment for federally designated family planning services.

- Effective for the period April 1, 2011 through March 31, 2012 and each state fiscal year thereafter, the Department of Health is authorized to make supplemental payments for services provided by physicians, nurse practitioners and physician assistants who participate in a plan for the management of clinical practice at the State University of New York. Fees for these professional services shall be increased by an amount equal to the average commercial or Medicare rate that would otherwise be received for such services rendered by physicians, nurse practitioners and physician assistants. Such included payments may be added to such professional fees or made as aggregate lump sum payments made to eligible clinical practice plans.

- Effective for the period April 1, 2011 through March 31, 2012 and each state fiscal year thereafter, the Department of Health is authorized to make supplemental payments for services provided by physicians, nurse practitioners and physician assistants who are employed by non-state operated public general hospitals operated by a public benefit corporation located in a city of more than one million persons or at a facility of such public benefit corporation as a member of a practice plan under contract to provide services to patients of such a public benefit corporation. Fees for these professional services shall be increased by an amount equal to the average commercial or Medicare rate that would otherwise be received for such services rendered by physicians, nurse practitioners and physician assistants, provided, however, that such supplemental fee payments shall not be available with regard to services provided at facilities participating in the Medicare Teaching Election Amendment. Such included payments may be added to such professional fees or made as aggregate lump sum payments.

- Effective April 1, 2011, hospitals that voluntarily reduce excess staffed bed capacity in favor of expanding the State's outpatient, clinic, and ambulatory surgery services capacity may request and receive a temporary rate enhancement under the ambulatory patient groups (APG) methodology.

- Extends current provisions to services on and after April 1, 2011, the reimbursable operating cost component for general hospital outpatient rates and adult day health care services provided by RHCFs rates will be established with the final 2006 trend factor equal to the final consumer price index (CPI) for all urban consumers less 0.25%.

- Continues, effective April 1, 2011, and thereafter, certain cost containment initiatives currently in effect for Medicaid rates of payments. These are as follows: diagnostic and treatment center and certified home health agency administrative and general cost reimbursement limits; home health care Medicare maximization initiatives; hospital outpatient and emergency department reimbursement reductions attributable to exclusion of 44% of major moveable equipment capital costs; and elimination of staff housing costs.

- 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, 2011 through March 31, 2014. Payments for the periods April 1, 2011 through March 31, 2012; 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, 2011 through March 31, 2014. Payments for the period April 1, 2011 through March 31, 2012; April 1, 2012 through March 31, 2013; and April 1, 2013 through March 31, 2014, shall not exceed, in the aggregate, \$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, 2011 through March 31, 2014. Payments shall not exceed in the aggregate, \$100 million for each of the following periods: April 1, 2011 through March 31, 2012; 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.

- Effective April 1, 2011, for the period April 1, 2011 through June 30, 2011, medical assistance rates of payment to residential health care facilities and diagnostic treatment centers licensed under Article 28 of the Public Health Law for adult day health care services provided to registrants with acquired immunodeficiency syndrome (AIDS) or other human immunodeficiency virus (HIV) related illnesses, shall be increased by an aggregated amount of \$1,867,000. Such amount shall be allocated proportionally among such providers based on the medical assistance visits reported by each provider in the most recently available cost reports, submitted to the Department by January 1, 2011. Such adjustments shall be included as adjustments to each provider's daily rate of payment for such services and shall not be subject to subsequent adjustment or reconciliation.

- Effective April 1, 2011, for the period April 1, 2011 through June 30, 2011, rates of payment to residential health care facilities and diagnostic treatment centers licensed under Article 28 of the Public Health Law for adult day health care services provided to registrants with acquired immunodeficiency syndrome (AIDS) or other human immunodeficiency virus (HIV) related illnesses, shall reflect an adjustment to such rates of payment in an aggregate amount of \$236,000. Such adjustments shall be distributed proportionally as rate add-ons, based on each eligible provider's Medicaid visits as reported in such provider's most recently available cost report as submitted to the Department prior to January 1, 2011, and provided further, such adjustments shall not be subject to subsequent adjustment or reconciliation.

- Effective April 1, 2011 through March 31, 2012, Medicaid rates of payment for services provided by certified home health agencies (except for such services provided to children under eighteen years of age and other discrete groups as may be determined by the Commissioner of Health) shall reflect agency ceiling limitations. In the alternative, and at the discretion of the Commissioner, such ceilings may be applied to payments for such services.

- The agency ceilings shall be applied to payments or rates of payment for certified home health agency services as established by applicable regulations and shall be based on a blend of:

- an agency's 2009 average per patient Medicaid claims, weighted at a percentage as determined by the Commissioner; and

- the 2009 statewide average per patient Medicaid claims adjusted by a regional wage index factor and an agency patient case mix index, weighted at a percentage as determined by the Commissioner.

- An interim payment or rate of payment adjustment effective April 1, 2011 shall be applied to agencies with projected average per patient Medicaid claims, as determined by the Commissioner, to be over their

ceilings. Such agencies shall have their payments or rates of payment reduced to reflect the amount by which such claims exceed their ceilings.

- The ceiling limitations shall be subject to retroactive reconciliation and shall be based on a blend of:

- agency's 2009 average per patient Medicaid claims adjusted by the percentage of increase or decrease in such agency's patient case mix from the 2009 calendar year to the annual period April 1, 2011 through March 31, 2012, weighted at a percentage as determined by the Commissioner, and

- the 2009 statewide average per patient Medicaid claims adjusted by a regional wage index factor and the agency's patient case mix index for the annual period April 1, 2011 through March 31, 2012, weighted at a percentage as determined by the Commissioner.

- Such adjusted agency ceiling shall be compared to actual Medicaid paid claims for the period April 1, 2011 through March 31, 2012. In those instances when:

- An agency's actual per patient Medicaid claims are determined to exceed the agency's adjusted ceiling, the amount of such excess shall be due from each such agency to the State and may be recouped by the Department in a lump sum amount or through reductions in the Medicaid payments due to the agency.

- An interim payment or rate of payment adjustment was applied to an agency as described above, and such agency's actual per patient Medicaid claims are determined to be less than the agency's adjusted ceiling, the amount by which such Medicaid claims are less than the agency's adjusted ceiling shall be remitted to each such agency by the Department in a lump sum amount or through an increase in the Medicaid payments due to the agency.

- In determining case mix, each patient shall be classified using a system based on measures which may include, but not be limited to, clinical and functional measures, as reported on the federal Outcome and Assessment Information Set (OASIS), as may be amended.

- The Commissioner may require agencies to collect and submit any data, and may promulgate regulations to implement the agency ceilings.

- The payments or rate of payment adjustments described above shall not, as determined by the Commissioner, result in an aggregate annual decrease in Medicaid payments to providers in excess of \$200 million.

- Effective April 1, 2012, Medicaid payments for services provided by Certified Home Health Agencies (CHHAs), except for such services provided to children under 18 years of age and other discrete groups, as may be determined by the Commissioner of Health, will be based on episodic payments.

- To determine such episodic payments, a statewide base price will be established for each 60-day episode of care and shall be adjusted by a regional wage index factor and an individual patient case mix index. Such episodic payments may be further adjusted for low utilization cases and to reflect a percentage limitation of the cost for high-utilization cases that exceed outlier thresholds of such payments.

- To achieve savings comparable to the prior state fiscal year, the initial 2012 base year episodic payments will be based on 2009 Medicaid paid claims, as determined by the Commissioner. Such base year adjustments shall be made not less frequently than every three years. However, base year episodic payments subsequent to 2012 will be based on a year determined by the Commissioner that will be subsequent to 2009. Such base year adjustments shall be made not less frequently than every three years.

- In determining case mix, each patient shall be classified using a system based on measures which may include, but not be limited to, clinical and functional measures as reported on the federal Outcome and Assessment Information Set (OASIS).

- The Commissioner may require agencies to collect and submit any data determined to be necessary.

- Effective April 1, 2011, Medicaid rates for services provided by certified home health agencies, or by an AIDS home care program shall not reflect a separate payment for home care nursing services

provided to patients diagnosed with Acquired Immune Deficiency Syndrome (AIDS).

- Effective for the period October 1, 2011 through September 30, 2013, pursuant to Section 2703 of the Patient Protection and Affordable Care Act, payments will be made to Managed Long Term Care Plans that have been designated as Health Home providers serving individuals with chronic conditions to cover comprehensive care management, care coordination and health promotion, comprehensive transitional care, patient and family support, referral to community and social support services and the use of health information technology to link services.

- Effective April 1, 2011, the Department is proposing to expand the current Patient Centered Medical Home (PCMH) to more payers and incorporate several provisions to improve medical care. Two provisions result in a change in the methods by which Medicaid fee-for-service (FFS) reimburses Medicaid providers who are designated by the National Committee for Quality Assurance as patient centered medical homes: 1) testing new models of payment to high-volume Medicaid primary care medical home practices which incorporate risk-adjusted global payments with care management and pay-for-performance, and 2) improving the relationship of FFS Medicaid members to medical homes by creating medical home payments only for FFS members who have evidence of ongoing continuity relationship with provider/practice and providing more reliable care management payments to those providers which are independent of specific visit types. These provisions require the following changes to Medicaid.

- New models of reimbursement to high-volume Medicaid providers will be tested which may incorporate risk-adjusted global payments and pay-for-performance. Risk-adjusted payment models will differentially reimburse providers based on their historical case mix. Pay-for-performance will provide enhanced reimbursement to providers who provide high-quality care (such as improved preventative screenings) and/or reduce unnecessary utilization (such as a reduction in admissions for ambulatory sensitive conditions) as defined by standardized measures of performance; and

- Eligible Medicaid fee-for-service recipients, who are currently receiving care from a certified PCMH provider, as determined by an attribution methodology developed by the Commissioner of Health, will be assigned to this PCMH provider. Medicaid FFS will reimburse PCMH providers a per member per month (PMPM) capitation payment for FFS recipients attributed to their practices to provide the necessary care coordination and disease management services.

- Effective October 1, 2011, the Department of Health will update rates paid for Medicaid coverage for preschool and school supportive health services (SSHS). SSHS are provided to Medicaid-eligible students with disabilities in school districts, counties, and State supported § 4201 schools. Payment will be based on a certified public expenditure reimbursement methodology, based on a statistically valid cost study for all school supportive health services and transportation. SSHS are authorized under § 1903(c) of the Social Security Act and include: physical therapy, occupational therapy, speech therapy, psychological evaluations, psychological counseling, skilled nursing services, medical evaluations, medical specialist evaluations, audio-logical evaluations, and special transportation services.

- Effective April 1, 2011, the Medicaid program is authorized to establish Behavioral Health Organizations (BHOs) to manage behavioral health services. BHOs will be authorized to manage mental health and substance abuse services not currently included in the managed care benefit for Medicaid enrollees in managed care and to facilitate the integration of such services with other health services. The BHOs will also be authorized to manage all mental health and substance abuse services for Medicaid enrollees not in managed care. Behavioral health management will be provided through a streamlined procurement process resulting in contracts with regional behavioral health organizations that will have responsibility for authorizing appropriate care and services based on criteria established by the Offices of Mental Health (OMH) and Alcohol and Substance Abuse Services (OASAS). OMH and OASAS will also be authorized, by April 1, 2013 to jointly designate on a regional basis, a limited number of special needs plans and/or

integrated physical and behavioral health provider systems capable of managing the physical and behavioral health needs of Medicaid enrollees with significant behavioral health needs.

- Effective October 1, 2011, Medicaid will expand coverage of smoking cessation counseling services so that it is available to all Medicaid enrollees. Reimbursement for these services will be available to office based providers, hospital outpatient departments and free-standing diagnostic and treatment centers.

- Effective October 1, 2011 the Department of Health is proposing a change in co-payment policy for Medicaid recipients as permitted in the federal regulations on cost sharing, 42 CFR 447.50 through 447.62. Under this proposal the current copayments will be increased and some services previously exempt from co-payments will be subject to co-payments. The chart below summarizes the current and proposed co-payment structure.

MEDICAID CO-PAYMENTS CURRENT AND PROPOSED

SERVICE OR ITEM	CURRENT AMOUNT	PROPOSED AMOUNT
Clinic Visits	\$3.00	\$3.40
Brand Name Prescription	\$3.00	\$3.40
Generic Drug Prescription, and Preferred Brand Name Prescription Drugs	\$1.00	\$1.15
Over-the-counter Medications	\$0.50	\$0.60
Lab Tests	\$0.50	\$0.60
X-Rays	\$1.00	\$1.15
Medical Supplies	\$1.00	\$1.15
Overnight Hospital Stays	\$25.00 on the last day	\$30.00
Emergency Room (for non-emergency room services)	\$3.00	\$6.40
Additional Services Proposed for Copay		
Eye Glasses	\$0.00	\$1.15
Eye Exams	\$0.00	\$1.15
Dental Services	\$0.00	\$3.40
Audiologist	\$0.00	\$2.30
Physician Services	\$0.00	\$3.40
Nurse Practitioner	\$0.00	\$2.30
Occupational Therapist	\$0.00	\$2.30
Physical Therapist	\$0.00	\$3.40
Speech Pathologist	\$0.00	\$3.40
Annual (SFY) Maximum Limit	\$200.00	\$300.00

- Other provisions on co-payments as stated in the § 360-7.12 of New York State Social Services Law remain unchanged. The providers of such services may charge recipients the co-payments. However, providers may not deny services to recipients because of their inability to pay the co-payments.

- The following recipients are exempt from co-payments:
 - Recipients younger than 21 years of age;
 - Recipients who are pregnant;
 - Residents of an adult care facility licensed by the New York State Department of Health (for pharmacy services only);
 - Residents of a nursing home;
 - Residents of an Intermediate Care Facility for the Developmentally Disabled (ICF/DD);
 - Residents of an Office of Mental Health (OMH) or Office of People with Developmental Disabilities (OPWDD) certified Community Residence;
 - Enrollees in a Comprehensive Medicaid Case Management (CMCM) or Service Coordination Program;

- Enrollees in an OMH or OMRDD Home and Community Based Services (HCBS) Waiver Program; and
- Enrollees in a Department of Health HCBS Waiver Program for Persons with Traumatic Brain Injury (TBI).

- The following services are exempt from co-payments:

- Emergency services;
- Family Planning;
- Drugs to treat mental illness; and
- Services provided through managed care plans.

- Physical therapy, occupational therapy, and speech-language pathology are federal optional Medicaid services. New York State Medicaid presently covers these rehabilitation services with no limits. In order to eliminate delivery of excessive and/or unnecessary services, effective October 1, 2011, the New York State Medicaid Program is establishing utilization limits for the provision of these rehabilitation services. Enrollees will be permitted to receive up to a maximum of 20 visits in a 12 month period each for physical therapy, occupational therapy, and speech-language pathology. The utilization limits will apply to services provided by practitioners in private practice settings as well as for services provided in Article 28 certified hospital outpatient departments and diagnostic and treatment centers (free-standing clinics). The service limits will not apply to services provided in hospital inpatient settings, skilled nursing facilities, or in facilities operated by the Office of Mental Health or the Office of Persons with Developmental Disabilities. Additionally, the utilization limits will not apply for services provided to Medicaid enrollees less than 21 years of age enrollees who are developmentally disabled or to enrollees with specified chronic medical/physical conditions.

- Federal rules allow states the option of reducing coinsurance amounts at their discretion. Effective October 1, 2011, the Department of Health will change the cost-sharing basis for Medicare Part B payments. Currently, New York State Medicaid reimburses practitioners the full or partial Medicare Part B coinsurance amount for enrollees who have both Medicare and Medicaid coverage (the dually-eligible). Medicaid reimburses the Medicare Part B coinsurance, regardless of whether or not the service is covered by Medicaid. Upon federal approval of the proposed state plan change, Medicaid will no longer reimburse practitioners for the Medicare Part B coinsurance for those services that are not covered for a Medicaid-only enrollee. Medicaid presently reimburses Article 28 certified clinics (hospital outpatient departments and diagnostic and treatment centers) the full Medicare Part B coinsurance amount. The full coinsurance is paid by Medicaid, even if the total Medicare and Medicaid payment to the provider exceeds the amount that Medicaid would have paid if the enrollee did not have both Medicare and Medicaid coverage. Under the new reimbursement policy, Medicaid will provide payment for the Medicare Part B coinsurance amount, but the total Medicare/Medicaid payment to the provider will not exceed the amount that the provider would have received if the patient had Medicaid-only coverage. Therefore, if the Medicare payment exceeds what Medicaid would have paid for the service, no coinsurance will be paid by Medicaid. Practitioners and clinics will be required to accept the total Medicare and Medicaid payment (if any) as full payment for services. They will be prohibited from billing the Medicaid recipient.

- Effective October 1, 2011, the Department of Health, in collaboration with the Office of Mental Health, the Office of Alcohol and Substance Abuse Services, and the Office for People with Developmental Disabilities, will be authorized to begin Medicaid coverage for health home services to high cost, high need enrollees. Health home services include comprehensive care coordination for medical and behavioral health services, health promotion, transitional care, including appropriate follow-up from inpatient to other settings, patient and family support, referral to community and social support services, and use of health information technology to link services.

- High risk patients will be assigned to provider networks meeting state and federal health home standards (on a mandatory or opt out basis) for the provision of health home services.

- These services will range from lower intensity patient tracking to higher intensity care/service management depending on patient needs.

The provision of coordinated, integrated physical and behavioral health services will be critical components of the health home program. Strong linkages to community resources will be a health home requirement. Use of peer supports will be explored to help enrollees in the community cope with their medical and behavioral health conditions. The Managed Addiction Treatment Program (MATS), which manages access to treatment for high cost, chemically dependent Medicaid enrollees, will be expanded. Health home payment will be based on a variety of reimbursement methodologies including care coordination fees, partial and shared risk. The focus of the program will be reducing avoidable hospitalizations, institutionalizations, ER visits, and improving health outcomes.

- Payment methodologies for health home services shall be based on factors including, but not limited to, complexity of conditions providers will be managing, the anticipated amount of patient contact needed to manage such conditions, and the health care cost savings realized by provision of health home services.

- The Commissioner of Health is authorized to pay additional amounts to providers of health home services that meet process or outcomes standards specified by the Commissioner.

- Through a collaborative effort, the Department of Health, with the Office of Mental Health, Office of Alcohol and Substance Abuse Services, and the Office for People with Developmental Disabilities, will streamline existing program requirements that create barriers to colocating medical and behavioral health services in licensed facilities to support improved coordination and integration of care.

- Effective for dates of service on and after April 1, 2011, coverage for prescription footwear and footwear inserts and components for adults age 21 and over will be limited to diabetic footwear or when the footwear is attached to a lower limb orthotic brace. This will reduce overutilization of footwear. Effective for dates of service on and after May 1, 2011, the DOH will establish maximum fees for prescription footwear, inserts and components. The fees will be based on an average of industry costs of generically equivalent products.

- Effective for dates of service on and after April 1, 2011, coverage of enteral formula for adults age 21 and over will be limited to formula administered by feeding tube or formula for treatment of an inborn metabolic disease. This will preserve coverage for medical need and eliminate coverage of orally consumed formulas for adults who can obtain nutrients through other means.

- Effective for dates of service on and after April 1, 2011, coverage of compression and support stockings will be limited to treatment of open wounds or for use as a pregnancy support. Coverage of stockings will not be available for comfort or convenience.

- Effective on and after July 1, 2011, the Department will choose selected transportation providers to deliver all necessary transportation of Medicaid enrollees to and from dialysis, at a per trip fee arrived through a competitive bid process. The Department will choose one or more transportation providers in a defined community to deliver necessary transportation of Medicaid enrollees to and from dialysis treatment. The enrollee's freedom to choose a transportation provider will be restricted to the selected provider(s) in the community. Medicaid enrollee access to necessary transportation to dialysis treatment will not be impacted by this change.

Prescription Drugs

- Effective April 1, 2011, the following is proposed:

- For sole or multi-source brand name drugs the Estimated Acquisition Cost (EAC) is defined as Average Wholesale Price (AWP) minus seventeen (17) percent and the Average Acquisition Cost (AAC) will be incorporated into the prescription drug reimbursement methodology;

- The dispensing fees paid for generic drugs will be \$3.50; and

- Specialized HIV pharmacy reimbursement rates will be discontinued and a pharmacy previously designated as a specialized HIV pharmacy will receive the same reimbursement as all other pharmacies.

The estimated annual net aggregate decrease in gross Medicaid expenditures attributable to reform and other initiatives contained in the budget for state fiscal year 2011/2012 is \$223 million; and the

estimated annual net aggregate increase in gross Medicaid expenditures attributable to an extension of pertinent disproportionate share (DSH) and upper payment limit (UPL) payments for state fiscal year 2011/2012 is \$1.9 billion.

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

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 HCRA Operations & Financial Analysis, Corning Tower Bldg., Rm. 984, Empire State Plaza, Albany, NY 12237, (518) 474-1673, (518) 473-8825 (FAX), e-mail: spa_inquires@health.state.ny.us

SALE OF FOREST PRODUCTS

Chenango Reforestation Area No. 1
Contract No. X008135

Pursuant to Section 9-0505 of the Environmental Conservation Law, the Department of Environmental Conservation hereby gives Public Notice for the following:

Sealed bids for 21 tons more or less red pine, 32.6 MBF more or less white ash, 23.6 MBF more or less black cherry, 15.2 MBF more or less red maple, 10.0 MBF more or less sugar maple, 0.3 MBF more or less yellow birch, 0.5 MBF more or less basswood, 0.1 MBF more or less aspen, 233 cords more or less firewood, located on Chenango Reforestation Area No. 1, Stands C-27, D-25 and D-28, will be accepted at the Department of Environmental Conservation, Contract Unit, 625 Broadway, 10th Fl., Albany, NY 12233-5027 until 11:00 a.m. on Thursday, April 7, 2011.

For further information, contact: Robert Slavicek, Supervising Forester, Department of Environmental Conservation, Division of Lands and Forests, Region 7, 2715 State Hwy. 80, Sherburne, NY 13460-4507, (607) 674-4036

SALE OF FOREST PRODUCTS

Lewis Reforestation Area No. 20
Contract No. X008125

Pursuant to Section 9-0505 of the Environmental Conservation Law, the Department of Environmental Conservation hereby gives Public Notice of the following:

MISCELLANEOUS NOTICES/HEARINGS

Notice of Abandoned Property Received by the State Comptroller

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

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

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

PUBLIC NOTICE

Department of Civil Service

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

Please take notice that the regular monthly meeting of the State Civil Service Commission for January 2012 will be conducted on January 10 and January 12 commencing at 10:00 a.m. This meeting will be conducted at New York Network, Suite 146, South Concourse, Empire State Plaza, Albany, NY. Directions and parking information available at (www.nyn.suny.edu).

For further information, contact: Office of Commission Operations, Department of Civil Service, Alfred E. Smith State Office Bldg., Albany, NY 12239, (518) 473-6598

PUBLIC NOTICE

Department of Health

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

The Department of Health proposes to amend the Title XIX (Medicaid) State Plan for non-institutional services to comply with enacted State statute. The following provides clarification to a provision previously noticed on March 30, 2011:

Non-Institutional Services

To clarify and expand upon the previously noticed provision, effective April 1, 2012, Medicaid payments for services provided by Certified Home Health Agencies (CHHAs), except for such services provided to children under 18 years of age and other discrete groups as may be determined by the Commissioner of Health, will be based on episodic payments.

- To determine such episodic payments, a statewide base price will be established for each 60-day episode of care, with adjustments for regional wage differences, patient case mix, and high and low utilization cases.

- Low utilization cases will be defined as episodes in which the total cost of care, based on weighted average statewide rates, is \$500 or less for a 60-day period. Outlier cases are those in which the total cost of care, based on weighted average statewide rates, exceeds the unique outlier threshold which has been established for each patient case mix group.

- A regional wage index factor will be calculated for each of the 10 labor market regions defined by the NYS Department of Labor, utilizing wage data compiled by the Federal Bureau of Labor Statistics.

- In determining case mix, each patient shall be classified using a system based on measures which may include, but are not limited to, clinical and functional measures as reported on the federal Outcome and Assessment Information Set (OASIS).

- Episodic payments for the period of April 1, 2012 through March 31, 2013, will be based on Base Year 2009 Medicaid paid claims, as determined and adjusted by the Commissioner to achieve fiscal savings comparable to those achieved by CHHA cost containment measures in the prior state fiscal year. Episodic payments for periods beginning April 1, 2013 and subsequent may be based on a Base Year subsequent to 2009, and the Base Year must be changed not less frequently than every three years.

- The Commissioner may require agencies to collect and submit any data necessary to implement this provision.

The estimated annual net aggregate savings in gross Medicaid expenditures for state fiscal year 2012/2013 as a result of this proposed initiative is \$140 million.

Copies of the proposed state plan amendments will be available for public review on the Department's website at: http://www.health.ny.gov/regulations/state_plans/status

In addition, copies will be on file in each local (county) social services district. 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

The public is invited to review and comment on this proposed state plan amendment. For further information or to submit a comment, please contact: Department of Health, Bureau of HCRA Operations & Financial Analysis, Corning Tower Building, Rm. 984, Empire State Plaza, Albany, NY, 12237, (518) 474-1673, (518) 473-8825 (fax), spa_inquiries@health.state.ny.us

PUBLIC NOTICE

Department of Health

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

The Department of Health proposes to amend the Title XIX (Medicaid) State Plan with respect to the provision of targeted case management services in accordance with the Deficit Reduction Act of 2005 and regulations promulgated by the Centers for Medicare and Medicaid Services (CMS). The following changes are proposed:

Non-Institutional Services

- Case management services include assessment, development of a care plan, referral to needed services and monitoring. The proposed amendment will ensure that targeted case management services are provided in accordance with the statutory definition of case management adopted in the Deficit Reduction Act of 2005.
- The proposed amendment adds the county of Onondaga to the First-time Mothers/Newborns targeted case management program.
- The proposed amendment clarifies the requirement that all RNs are required to possess a Bachelor of Science in Nursing (BSN) degree for employment in the First-time Mothers/Newborns program, but adds that in limited circumstances, an RN who does not have a BSN but has a specific language competency may be hired to provide care to an under-served population with specific language needs. Specific criteria for this exception are described in this amendment.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this proposed initiative for State fiscal year 2011/2012 is \$6 million.

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.

Copies of the proposed state plan amendment 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

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 HCRA Operations & Financial Analysis, Corning Tower Building, Rm. 984, Empire State Plaza, Albany, NY 12237, (518) 474-1673, (518) 473-8825 (fax), 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 for long-term care services to comply with enacted statutory provisions. The following provides clarification to provisions previously noticed on April 27, 2011, and notification of new significant changes:

Long-Term Care Services

- The statewide pricing methodology for inpatient services provided by non-specialty residential health care facilities will be effective on January 1, 2012.
- The statewide pricing methodology for the non-capital component of the rates of payment for inpatient services provided by non-specialty residential health care facilities shall reflect a direct statewide price, an indirect statewide price and a facility-specific non-comparable component, determined as follows:
 - A direct statewide price component, which shall consist of a blended price, to be determined as follows:
 - o 50% of the direct price component that is based upon 2007 allowable costs for all non-specialty facilities; and
 - o either 50% of a direct price component that is based upon 2007 allowable costs for hospital-based facilities and facilities with 300 or more beds, or 50% of a direct price component that is based upon 2007 allowable costs for all non-specialty facilities, excluding hospital-based facilities and facilities with 300 or more beds, as applicable.
 - o The direct statewide price shall be adjusted by a wage equalization factor which shall be a blend of 50% of a facility-specific wage equalization factor and 50% of regional wage equalization factor as determined by the Commissioner by regulation. As defined by regulation, there shall be 16 regions used to determine the regional wage equalization factor, and the facility-specific and regional wage equalization factor adjustments shall use data reported for 2009.
 - o The direct statewide price shall also be adjusted by a Medicaid-only case mix. The prices effective January 1, 2012 shall utilize case mix data for January 1, 2011. Thereafter, the direct statewide price shall be updated for a Medicaid-only case mix in July and January of each year, using the case mix data applicable to the previous period (e.g., July 2012 case mix adjustment shall use the January 1, 2012 case mix data, the January 1, 2013 case mix shall use the July 2012 case mix data, etc.).
 - An indirect statewide price component, which shall consist of a blended price, to be determined as follows:
 - o 50% of the indirect price component that is based upon 2007 allowable costs for all non-specialty facilities; and
 - o either 50% of an indirect price component that is based upon 2007 allowable costs for hospital-based facilities and facilities with 300 or more beds or 50% of an indirect price component that is based upon 2007 allowable costs for non-specialty facilities, excluding hospital-based facilities and facilities with 300 or more beds, as applicable.
 - o The indirect statewide price shall be adjusted by a wage equalization factor which shall be a blend of 50% of a facility-specific wage equalization factor and 50% of regional wage equalization factor as determined by the Commissioner by regulation. As defined by regulation, there shall be 16 regions used to determine the regional wage equalization factor, and the facility-specific and regional wage equalization factor adjustments shall use data reported for 2009.
- The rate shall be adjusted to reflect per diem add-ons for dementia, bariatric, and traumatic brain injury patients, as defined by regulation, of \$8 per day, \$17 per day, and \$36 per day, respectively. Such adjustments will be made using case mix data and will be made at the same time that the direct component of the rate is adjusted for case mix as described above.
- The non-comparable component of the rate shall be based upon facility-specific 2007 allowable costs as determined by regulation.

- The statewide pricing methodology described above will reflect a six-year transition period.
- As determined by regulation, the Commissioner shall also establish an annual quality pool. In 2012, the rate shall include an adjustment for the reporting by facilities of data related to established quality indicators and benchmarks. Beginning in 2013, the Commissioner will develop regulations to annually distribute quality pool funds to facilities that improve or maintain quality against the indicators and benchmarks.
- The non-capital component of the "specialty" rates for AIDS facilities or discrete AIDS units within facilities; discrete units for residents receiving care in a long-term inpatient rehabilitation program for traumatic brain injured persons; discrete units providing specialized programs for residents requiring behavioral interventions; discrete units for long-term ventilator dependent residents; and facilities or discrete units within facilities that provide extensive nursing, medical, psychological and counseling support services solely to children shall be the rates in effect on January 1, 2009 and adjusted for applicable rate appeals. Such rates shall not be subject to case mix adjustments. The AIDS rates in effect January 1, 2009 shall be adjusted to reflect the elimination of the AIDS occupancy factor enacted in 2009.
- The Commissioner may promulgate regulations, including emergency regulations, to implement the provisions of the methodology.

The non-capital component of the rates described for non-specialty facilities under the statewide pricing methodology and for specialty facilities shall be subject to the residential health care facility cap, thus there is no increase or decrease in gross Medicaid expenditures for state fiscal year 2011-12.

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

Copies of the proposed state plan amendments will also be on file in each local (county) social services district and available for public review.

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

- New York County
250 Church Street
New York, New York 10018
- Queens County, Queens Center
3220 Northern Boulevard
Long Island City, New York 11101
- Kings County, Fulton Center
114 Willoughby Street
Brooklyn, New York 11201
- Bronx County, Tremont Center
1916 Monterey Avenue
Bronx, New York 10457
- Richmond County, Richmond Center
95 Central Avenue, St. George
Staten Island, New York 10301

For further information and to review and comment, please contact: Department of Health, Bureau of HCRA Operations & Financial Analysis, Corning Tower Building, Rm. 984, Empire State Plaza, Albany, NY 12237, (518) 474-1673, (518) 473-8825 (fax), spa_inquiries@health.state.ny.us

PUBLIC NOTICE
Monroe County

Notice of Draft Request for Proposals (RFP)

NOTICE IS HEREBY GIVEN, that sealed proposals are sought and requested by the County of Monroe for the performance of the following contract, according to terms of the RFP:

PROPOSAL FOR THE OPERATION AND MAINTENANCE OF

THE MONROE COUNTY RECYCLING CENTER AND PROGRAM

Monroe County is soliciting proposals for the Operation and Maintenance of the County Recycling Center and Program for a Contract with a minimum term of approximately six (6) years, unless Respondents can justify a longer-term Contract, such as by capital investment, up to a maximum of twenty-five (25) years. These operations include the receiving, processing, marketing and residual disposal associated with residential-generated recyclables collected by private and public haulers. Prospective Respondents must offer a proposal that will meet the scope of services, qualifications and general description of work activities identified in the Request for Proposals (RFP).

Prior to release of the final version of the RFP, the RFP will be available in draft form on December 30, 2011. This draft RFP is issued pursuant to the provisions of New York General Municipal Law (NY GML) § 120-w.

The draft RFP will be available for download from the Monroe County website, at <http://www.monroecounty.gov/bid/rfps>. Individuals must register through the Monroe County website to obtain the PDF version of the draft RFP. In addition, the draft RFP will be on file at the Monroe County Clerk's Office, 39 West Main Street, Room 101, Rochester, NY, 14614.

Monroe County is soliciting comments and questions on the draft by February 28, 2012. All comments and questions regarding the draft RFP from prospective Respondents and the public are due to the RFP Coordinator in accordance with the requirements listed in the draft RFP, and will be incorporated as appropriate into the final RFP, or filed with the final RFP, as set forth in the draft RFP. Any verbal or other communication sent or made to anyone other than to the RFP Coordinator will not be considered and may be cause for rejection of the Respondent's proposal.

A pre-proposal meeting and site tour will be conducted on January 24, 2011 at 1:00 PM. Individuals who would like to attend the tour must RSVP by January 20, 2011. Details regarding RSVPs and the pre-proposal meeting and site tour will be available in the draft RFP.

The final Request for Proposals (RFP) will be released in accordance with the timeline and regulations set forth in New York General Municipal Law (NY GML) § 120-w. Final RFP submissions from Respondents must be received in accordance with the specifications contained within the final RFP.

PUBLIC NOTICE
Village of Old Westbury

The Village of Old Westbury is soliciting proposals from qualified administrative services agencies, and/or financial organizations relating to administration, trustee services and/or funding of a Deferred Compensation Plan for employees of the Village of Old Westbury meeting the requirements of Section 457 of the Internal Revenue Code and Section 5 of the New York State Finance Law, including all rules and regulations issued pursuant thereto.

A copy of the proposal questionnaire may be obtained from: Kenneth Callahan, Village Administrator, Village of Old Westbury, One Store Hill Road, Old Westbury, NY 11568

All proposals must be submitted not later than thirty (30) days from the date of publication in the New York State Register by 4:30 p.m.

PUBLIC NOTICE
Department of State

F-2011-0833a - Rescinding Public Notice F-2011-0833
Date of Issuance - December 28, 2011

The New York State Department of State (DOS) is rescinding the public notice issued December 14, 2011, for the activities described below, which are subject to the consistency provisions of the Federal Coastal Zone Management Act of 1972, as amended.

The applicant has certified that the proposed activity complies with and will be conducted in a manner consistent with the approved New

York State Coastal Management Program. The applicant's consistency certification and accompanying public information and data are available for inspection at the New York State Department of State offices located at One Commerce Plaza, 99 Washington Avenue, in Albany, New York.

In F-2011-0833, John D. and Eunice P. Benfield are proposing to: Remove an upper retaining wall, stairs & remains of wood deck. Remove remains of 135' of bh & stairs to beach. Remove & relocate lower portion of drain line & install new catch basin. Construct 147' of new bh (ip) of existing. Backfill w/190 cyds of clean fill. Construct 8'x11' wood deck & new stairway to beach. The project is located at 50 Blue Marlin Drive Southold, Suffolk County.

Effective immediately, no further comments will be accepted or reviewed in connection with the F-2011-0833 notice published December 14, 2011.

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

PUBLIC NOTICE

Uniform Code Regional Boards of Review

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

2011-0408 Matter of: Dave and Melissa Acton, 26 Woodward Ave, Buffalo, NY 14214 for an appeal/variance concerning requirements for determination of the number of stories in the building and requirements for a sprinkler system.

Involved is the additions and alterations to an existing three story building of non-protected wood frame construction for permanent multiple dwelling occupancy with approximate gross floor area of 4300 square feet, located at 26 Woodward avenue, City of Buffalo, County of Erie, State of New York.

2011-0409 Matter of Mark Schweickert, 13499 Grove Street, Chaffe, NY 14030 for a variance concerning the NYS Residential Code 2007 edition, section P2602.1 disconnect from existing public distribution system.

Involves is the requirement of having the water distribution system of the residential home connected to the public water system (private owner disconnected from public water source and is using a private well). The subject property consists of a 2 Story Residential Home, of Type VB (wood frame) construction classification, having a cumulative gross floor area of 2700 square feet. The building is known as the Residence of Mark Schweickert, located at 13499 Grove Street, Chaffe, Erie County, State of New York.

2011-0410 Matter of Presbyterian Church of Wellsville, 83 Chamberlain Street, Wellsville, New York, 14895, for a variance Concerning NYS Existing Building Code 2010 edition, code Section EB 903.2.1 an automatic sprinkler system shall be provided throughout buildings and portions thereof used as Group A occupancies.

Involved is the requirement of Automatic Sprinkler System in the existing basement (1st floor is designed to have sprinklers) of the structure. The subject property consists of a 1 Story Building Occupancy Group A-3, Type III-B Construction, having a cumulative gross floor area of 30,462 square feet, The building is known as the Presbyterian Church of Wellsville, located at 83 Chamberlain Street, Wellsville, Allegany County, State of New York.

2011-0413 Matter of David Cramoy, Director, Brant Lake Camp, 7586 State Rte. 8, Brant Lake, NY 12915 for a variance concerning access for the physically handicapped.

Involved is the construction of a summer camp bunk house and the code requirement for accessibility for the physically handicapped. The

proposed building contains an R-1 (residential) occupancy, of Type VB (combustible) construction, 1 story in height having a gross floor area of 1,600 square feet. The building is located at 7586 State Route 8, Town of Horicon, Warren County, State of New York.

2011-0414 Matter of Neil Pelone, Principal Architect, NPARCH, 153 Madison St., Troy, NY 12180 for a variance concerning public safety issues including the requirement for 2 exits in a multi-story building.

Involved is the alteration of an existing building containing a R-2/A-2 (residential/assembly) occupancy, 5 stories in height of Type IB (fire resistive) construction having a cumulative gross floor area of 38,400 square feet. The building is located at 60 State Street, City of Albany, Albany County, State of New York.

2011-0415 Matter of Adam D. Richter for T. Y. Lin International, 255 East Avenue, Rochester, New York, 14604, for a variance concerning fire safety requirements including relief from requirements to maintain free egress. The building is classified as an S2 (Storage occupancy) parking garage, 2 stories in height, of Type Ia (Fire resistive) construction, approximately 530,724 square feet in gross area, and is located at 51 South Fizhugh Street, in the City of Rochester, Monroe County, State of New York.

2011-0419 Matter of Jeff Parkman, 35 Buffalo Street, Churchville, New York, 14428, for a variance concerning fire safety requirements including relief from requirements to maintain an exterior egress stairway. The building is classified as a mixed-use building containing two B (business occupancies) retail stores on the first story and four R2 (permanent occupancy) apartments on the second story, and is 2 stories in height, of Type V b (unprotected wood frame) construction, approximately 6,000 square feet in gross area, and is located at 17 North Lake Road, in the Village of Bergen, Genesee County, State of New York.

2011-00420 Matter of Christopher Costanza for R.A 9X 3 Design, Architecture, LLP, 62 Westland Avenue, Rochester, New York, 14618, for a variance concerning fire safety requirements including relief from requirements to provide code compliant egress stairs. The building is classified as a mixed-use building containing an A2 (assembly occupancy), U (Utility occupancy), and R 2 (permanent occupancy) apartments, and is 5 stories in height, of Type III b (unprotected ordinary) construction, approximately 39,850 square feet in gross area, and is located at 1 Capron Street/228 South Avenue, #5D, in the City of Rochester, Monroe County, State of New York.

SALE OF FOREST PRODUCTS

Chautauqua Reforestation Area No. 3
Contract No. X008488

Pursuant to Section 9-0505 of the Environmental Conservation Law, the Department of Environmental Conservation hereby gives Public Notice for the following:

Sealed bids for 344.5 MBF more or less of Norway spruce and 18 cords more or less of Norway spruce pulp, located on Chautauqua Reforestation Area No. 3, Stands 14.1 and 14.2, will be accepted at the Department of Environmental Conservation, Contract Unit, 625 Broadway, 10th Fl., Albany, NY 12233-5027 until 11:00 a.m., Thursday, Jan. 5, 2011.

For further information, contact: Keith Carrow, Senior Forester, Department of Environmental Conservation, Division of Lands and Forests, Region 9, 178 Point Dr. N, Dunkirk, NY 14048, (716) 363-2052

SALE OF FOREST PRODUCTS

Chautauqua Reforestation Area No. 10
Contract No. X008487

Pursuant to Section 9-0505 of the Environmental Conservation Law, the Department of Environmental Conservation hereby gives Public Notice for the following:

. Sealed bids for 605.4 MBF, more or less, of Norway spruce, located on Chautauqua Reforestation Area No. 10, Stands 7 & 11, will be accepted at the Department of Environmental Conservation, Contract Unit, 625 Broadway, 10th Fl., Albany, NY 12233-5027 until 11:00 a.m., Thursday, Jan. 5, 2012.

For further information, contact: Keith Carrow, Senior Forester, Department of Environmental Conservation, Division of Lands and Forests, Region 9, 178 Point Dr. N, Dunkirk, NY 14048, (716) 363-2052

Appendix V
2012 Title XIX State Plan
First Quarter Amendment
Non-Institutional Services
Responses to Standard Funding Questions

NON-INSTITUTIONAL SERVICES
State Plan Amendment #11-51

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 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.

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.**

The State must assure that the SPA complies with the conditions of the MOE provision of section 1902(gg) of the Act for continued funding under the Medicaid program.

Response: There are no eligibility provisions applicable for this SPA.

- 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.

The State must assure that this SPA would [] / would not [] violate these provisions, if they remained in effect on or after January 1, 2014.

Response: The State assures that this SPA would not violate the above provisions if they remained in effect on or after January 1, 2014.

3. The State must assure that this SPA complies with the requirements of section 1902(a)(37) of the Act regarding prompt payment of claims.

Response: The State assures that this SPA complies with the requirements of section 1902(a)(37) of the Act regarding prompt payment of claims.

4. The State needs to verify it is in compliance with the provisions of Section 5006 of the Recovery Act concerning tribal consultations for the SPA, or an explanation why the provisions did not apply in this instance.

Response: On March 29, 2011, Phil Mossman, from the NYS Department of Health, personally presented information regarding the New York State Medicaid Plan, the Medicaid Redesign Team recommendations and the proposed changes to the Plan at the 2011 Annual Tribal Consultation Session in Verona, New York. The change proposed in this SPA was one such recommendation, and public notice of such was included in the handouts at that meeting. In addition, a follow-up package containing the information from the presentation was mailed to all tribal leaders and health clinic administrators who were not in attendance (sample attached sample with information related to this SPA). In all cases, tribal representatives were invited to comment on the proposals and/or to request a personal meeting with State staff to discuss the proposals. Additionally, contact information was provided both at the meeting, in the follow-up package, and in the public notice. Further, on December 28, 2011, a clarifying notice was published in the State Register, again inviting comment and providing contact information. To date, no feedback has been received from any tribal representative in response to these efforts.

NEW YORK
state department of
HEALTH

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

Sue Kelly
Executive Deputy Commissioner

April 29, 2011

Shinnecock Indian Nation
Randy King, Trustee-Chairman
P.O. Box 59
Church Street
Southampton, NY 11969

Dear Mr. King:

On March 29th, I had the pleasure of attending the 2011 Annual Tribal Consultation Session in Verona and presenting information about New York State's Medicaid State Plan, the draft policy for tribal consultation related to the Plan, and proposed changes to the Plan. Following the presentation, attendees had the opportunity to ask questions and comment on the information that was presented, all of which will be taken into consideration as we move forward with drafting and finalizing the proposed changes.

For your information, I am enclosing a copy of the PowerPoint that was used for that presentation, along with a copy of the *Federal Public Notice* (FPN) dated March 30, 2011, which provides brief descriptions of the proposed changes, and the FPN dated April 27, 2011, which provides clarification to the March 30th FPN, along with information about new initiatives that were not previously noticed but were contained in New York's enacted budget.

For many of the proposed changes, a formal State Plan Amendment (SPA) must be written and submitted to the federal Centers for Medicare and Medicaid Services for approval. Once the SPAs associated with these proposed changes are drafted, copies will be forwarded to you for your review and comment. It is important that, as part of the tribal consultation process, the draft SPAs be reviewed and all comments or questions raised be addressed by the State. If you have any comments regarding the enclosed information or would like to request a personal meeting to discuss it, please contact me within two weeks from the date of this letter at the number below.

Also for your information, the next meeting of the New York State Medicaid Redesign Team (MRT) will take place on Thursday, May 12, beginning at 10:30 a.m. and running until approximately 1:30 p.m. The meeting will be held in Manhattan at:

The William and Anita Newman Conference Center
Baruch College
151 East 25th Street - Room 750
(Closest Intersection - Lexington & 25th)

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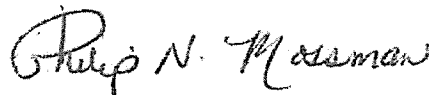
Mr. King
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This will be a team work session, so there will be no public comment period. However, limited audience seating will be available, and the meeting will be webcast. Although no agenda is available at this point, the team will be discussing the enacted budget and the proposed next steps of the MRT.

As further information about MRT activities becomes available, it will be posted to the Department of Health's website at health.ny.gov/health_care/medicaid/redesign/. Information and a link for the webcast will be available on the website approximately one week before the meeting. To sign up for automatic e-mail updates regarding the MRT, please also visit health.ny.gov/health_care/medicaid/redesign/listserv.htm.

Again, if you have any questions or comments concerning the information in this letter, please feel free to contact me at (518) 474-1673.

Sincerely,



Philip N. Mossman, Director
Bureau of HCRA Operations
and Financial Analysis

Enclosures

cc: Michael Melendez
Associate Regional Administrator
Centers for Medicare and Medicaid Services

Wendy Stoddart
New York State Department of Health
American Indian Health Program

ceilings. Such agencies shall have their payments or rates of payment reduced to reflect the amount by which such claims exceed their ceilings.

- The ceiling limitations shall be subject to retroactive reconciliation and shall be based on a blend of:

- agency's 2009 average per patient Medicaid claims adjusted by the percentage of increase or decrease in such agency's patient case mix from the 2009 calendar year to the annual period April 1, 2011 through March 31, 2012, weighted at a percentage as determined by the Commissioner, and

- the 2009 statewide average per patient Medicaid claims adjusted by a regional wage index factor and the agency's patient case mix index for the annual period April 1, 2011 through March 31, 2012, weighted at a percentage as determined by the Commissioner.

- Such adjusted agency ceiling shall be compared to actual Medicaid paid claims for the period April 1, 2011 through March 31, 2012. In those instances when:

- An agency's actual per patient Medicaid claims are determined to exceed the agency's adjusted ceiling, the amount of such excess shall be due from each such agency to the State and may be recouped by the Department in a lump sum amount or through reductions in the Medicaid payments due to the agency.

- An interim payment or rate of payment adjustment was applied to an agency as described above, and such agency's actual per patient Medicaid claims are determined to be less than the agency's adjusted ceiling, the amount by which such Medicaid claims are less than the agency's adjusted ceiling shall be remitted to each such agency by the Department in a lump sum amount or through an increase in the Medicaid payments due to the agency.

- In determining case mix, each patient shall be classified using a system based on measures which may include, but not be limited to, clinical and functional measures, as reported on the federal Outcome and Assessment Information Set (OASIS), as may be amended.

- The Commissioner may require agencies to collect and submit any data, and may promulgate regulations to implement the agency ceilings.

- The payments or rate of payment adjustments described above shall not, as determined by the Commissioner, result in an aggregate annual decrease in Medicaid payments to providers in excess of \$200 million.

- Effective April 1, 2012, Medicaid payments for services provided by Certified Home Health Agencies (CHHAs), except for such services provided to children under 18 years of age and other discrete groups, as may be determined by the Commissioner of Health, will be based on episodic payments.

- To determine such episodic payments, a statewide base price will be established for each 60-day episode of care and shall be adjusted by a regional wage index factor and an individual patient case mix index. Such episodic payments may be further adjusted for low utilization cases and to reflect a percentage limitation of the cost for high-utilization cases that exceed outlier thresholds of such payments.

- To achieve savings comparable to the prior state fiscal year, the initial 2012 base year episodic payments will be based on 2009 Medicaid paid claims, as determined by the Commissioner. Such base year adjustments shall be made not less frequently than every three years. However, base year episodic payments subsequent to 2012 will be based on a year determined by the Commissioner that will be subsequent to 2009. Such base year adjustments shall be made not less frequently than every three years.

- In determining case mix, each patient shall be classified using a system based on measures which may include, but not be limited to, clinical and functional measures as reported on the federal Outcome and Assessment Information Set (OASIS).

- The Commissioner may require agencies to collect and submit any data determined to be necessary.

- Effective April 1, 2011, Medicaid rates for services provided by certified home health agencies, or by an AIDS home care program shall not reflect a separate payment for home care nursing services

provided to patients diagnosed with Acquired Immune Deficiency Syndrome (AIDS).

- Effective for the period October 1, 2011 through September 30, 2013, pursuant to Section 2703 of the Patient Protection and Affordable Care Act, payments will be made to Managed Long Term Care Plans that have been designated as Health Home providers serving individuals with chronic conditions to cover comprehensive care management, care coordination and health promotion, comprehensive transitional care, patient and family support, referral to community and social support services and the use of health information technology to link services.

- Effective April 1, 2011, the Department is proposing to expand the current Patient Centered Medical Home (PCMH) to more payers and incorporate several provisions to improve medical care. Two provisions result in a change in the methods by which Medicaid fee-for-service (FFS) reimburses Medicaid providers who are designated by the National Committee for Quality Assurance as patient centered medical homes: 1) testing new models of payment to high-volume Medicaid primary care medical home practices which incorporate risk-adjusted global payments with care management and pay-for-performance, and 2) improving the relationship of FFS Medicaid members to medical homes by creating medical home payments only for FFS members who have evidence of ongoing continuity relationship with provider/practice and providing more reliable care management payments to those providers which are independent of specific visit types. These provisions require the following changes to Medicaid.

- New models of reimbursement to high-volume Medicaid providers will be tested which may incorporate risk-adjusted global payments and pay-for-performance. Risk-adjusted payment models will differentially reimburse providers based on their historical case mix. Pay-for-performance will provide enhanced reimbursement to providers who provide high-quality care (such as improved preventative screenings) and/or reduce unnecessary utilization (such as a reduction in admissions for ambulatory sensitive conditions) as defined by standardized measures of performance; and

- Eligible Medicaid fee-for-service recipients, who are currently receiving care from a certified PCMH provider, as determined by an attribution methodology developed by the Commissioner of Health, will be assigned to this PCMH provider. Medicaid FFS will reimburse PCMH providers a per member per month (PMPM) capitation payment for FFS recipients attributed to their practices to provide the necessary care coordination and disease management services.

- Effective October 1, 2011, the Department of Health will update rates paid for Medicaid coverage for preschool and school supportive health services (SSHS). SSHS are provided to Medicaid-eligible students with disabilities in school districts, counties, and State supported § 4201 schools. Payment will be based on a certified public expenditure reimbursement methodology, based on a statistically valid cost study for all school supportive health services and transportation. SSHS are authorized under § 1903(c) of the Social Security Act and include: physical therapy, occupational therapy, speech therapy, psychological evaluations, psychological counseling, skilled nursing services, medical evaluations, medical specialist evaluations, audio-logical evaluations, and special transportation services.

- Effective April 1, 2011, the Medicaid program is authorized to establish Behavioral Health Organizations (BHOs) to manage behavioral health services. BHOs will be authorized to manage mental health and substance abuse services not currently included in the managed care benefit for Medicaid enrollees in managed care and to facilitate the integration of such services with other health services. The BHOs will also be authorized to manage all mental health and substance abuse services for Medicaid enrollees not in managed care. Behavioral health management will be provided through a streamlined procurement process resulting in contracts with regional behavioral health organizations that will have responsibility for authorizing appropriate care and services based on criteria established by the Offices of Mental Health (OMH) and Alcohol and Substance Abuse Services (OASAS). OMH and OASAS will also be authorized, by April 1, 2013 to jointly designate on a regional basis, a limited number of special needs plans and/or

**NON-INSTITUTIONAL SERVICES
State Plan Amendment #11-51**

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 rationalize reimbursement for Certified Home Health Agency (CHHA) services by replacing the current fee-for-service system with an episodic pricing model for most patients. The episodic system will introduce patient acuity into the reimbursement formula, thereby better matching Medicaid payments to resource needs. The use of an adjusted base price for 60-day episodes of care also will provide CHHAs with an incentive to eliminate excessive utilization. For high-utilization cases, risk-sharing will be introduced by the provision of outlier payments, which will reimburse agencies for a percentage of the costs which exceed the outlier threshold for the applicable patient resource group.

- 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. Certain classes of providers must notify and receive approval from the Department's Office of Health Systems Management or the Office of Long Term Care, as applicable, in order to discontinue services. These offices monitor and consider 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.

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 recommended by the Medicaid Redesign Team. The Medicaid Redesign Team had discussions with industry associations, held multiple regional hearings and solicited ideas through a public process. The change was then enacted by the State Legislature as part of the 2011-12 Budget. The legislative process also provides opportunities for all stakeholders to lobby their concerns, objections, or support for various legislative initiatives. In addition, providers and other interested parties were given an opportunity to suggest and evaluate proposed reforms through the Home Care Reimbursement Work Group.

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. The State has issued additional guidance that clearly articulates provider responsibility should they decide to stop accepting patients, decrease available services to existing patients, or to close. CHHAs have a period of one year following the statutory approval of the episodic system to prepare for implementation on April 1, 2012, and to make any necessary adjustments to their operations.

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: This amendment is part of a wide-reaching Medicaid Reform project which includes initiatives to shift many current home care patients into Managed Long Term Care programs or other care management program models.