



Department of Health

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

JUN 26 2015

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

RE: SPA #15-0028
Non-Institutional Services

Dear Mr. Melendez:

The State requests approval of the enclosed amendment #15-0028 to the Title XIX (Medicaid) State Plan for non-institutional services to be effective April 1, 2015 (Appendix I). This amendment is being submitted based on enacted legislation. A summary of the plan amendment is provided in Appendix II.

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

Copies of pertinent sections of proposed State statute are enclosed for your information (Appendix III). A copy of the public notice of this plan amendment, which was given in the New York State Register on March 25, 2015 and clarified on April 22, 2015, 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,

Jason A. Helgerson
Medicaid Director
Office of Health Insurance Programs

Enclosures

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: HEALTH CARE FINANCING ADMINISTRATION		1. TRANSMITTAL NUMBER: 15-0028	2. STATE New York
		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE April 1, 2015	
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: § 1902(a) of the Social Security Act, and 42 CFR 447		7. FEDERAL BUDGET IMPACT: (in thousands) a. FFY 04/01/15-09/30/15 \$ (27,453.80) b. FFY 10/01/15-09/30/16 \$ (54,907.60)	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-B: Pages 1(b), 1(c)(ii), 4(2), 4(a)(iii), 4(a)(iii)(A), 4(a)(iv), 4(a)(iv)(1), 4(a)(iv)(2), 4(a)(v)		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (<i>If Applicable</i>): Attachment 4.19-B: Pages 1(b), 1(c)(ii), 4(2), 4(a)(iii), 4(a)(iii)(A), 4(a)(iv), 4(a)(iv)(1), 4(a)(iv)(2), 4(a)(v)	
10. SUBJECT OF AMENDMENT: 2015 Non-Institutional Cost Containment Extenders (FMAP = 50%)			
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 Division of Finance & Rate Setting 99 Washington Ave – One Commerce Plaza Suite 1460 Albany, NY 12210	
13. TYPED NAME: Jason A. Helgeson			
14. TITLE: Medicaid Director Department of Health			
15. DATE SUBMITTED: JUN 26 2015			
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
2015 Title XIX State Plan
Second Quarter Amendment
Amended SPA Pages**

**New York
1(b)**

(two year trend movement) on a per visit basis, except that commencing April 1, 1995 through March 31, 1999 and on and after July 1, 1999 through March 31, 2000 and on and after April 1, 2000 through March 31, 2003, and on and after April 1, 2003 through March 31, 2009, and on and after April 1, 2009 through March 31, 2011, and on and after April 1, 2011 through March 31, 2013, and on and after April 1, 2013 through March 31, 2015, and on and after April 1, 2015 through March 31, 2017, for rates of payment for patients eligible for payments made by state governmental agencies, the capital cost per visit components shall be adjusted by the Commissioner to exclude such expenses related to 1) forty-four percent of the costs of major moveable equipment and 2) staff housing. A return on equity is recognized in those instances where the hospital is organized under the auspices of proprietary sponsorship. MMTP services may be reimbursed on a uniform fixed weekly fee per enrolled patient basis. Renal dialysis services are reimbursed on the lower of a facility's actual cost or statewide ceiling of \$150.00 per procedure. Payment rates for renal dialysis services are adjusted to reflect utilization patterns for CAPD, CCPD, hemodialysis and extended peritoneal dialysis services. Effective October 1, 1995, the rate for primary care clinic services provided in primary care hospitals, shall be a per visit rate based on allowable reportable operating costs subject to a cap on operating costs of \$67.50 per visit. For dates of service beginning on December 1, 2008 through March 31, 2010, primary care clinic and renal dialysis services shall be reimbursed using the Ambulatory Patient Group classification and reimbursement system. Allowable reportable capital costs will be reimbursed on a per visit basis not subject to a ceiling on reimbursement, provided however that for the period October 1, 1995 through March 31, 1999 and on and after July 1, 1999 through March 31, 2000 and on and after April 1, 2000 through March 31, 2003, and on and after April 1, 2003 through March 31, 2009, and on and after April 1, 2009 through March 31, 2011, and on and after April 1, 2011 through March 31, 2013, and on and after April 1, 2013 through March 31, 2015, and on and after April 1, 2015 through March 31, 2017, the capital cost per visit components shall be adjusted by the Commissioner to exclude such expenses related to 1) forty-four percent of the cost of major movable equipment and 2) staff housing. A return on equity is recognized in those instances where the hospital is organized under the auspices of proprietary sponsorship.

Effective October 1, 1995, the rate for emergency services provided in primary care hospitals, shall be a per visit rate based upon allowable reportable operating costs and limited to a cap on operating costs of \$95 per visit provided however, that for the period January 1, 2007 through December 31, 2007 the maximum payment for the operating component shall be \$125 per visit; and during the period January 1, 2008 through December 31, 2008, the maximum payment for the operating cost component shall be \$140 per visit; and during the period January 1, 2009 through March 31, 2010 emergency department services shall be reimbursed through the Ambulatory Patient Group (APG) classification and reimbursement system. Allowable reportable capital costs will be reimbursed on a per visit basis not subject to a ceiling on reimbursement, provided however, that for the period of October 1, 1995 through March 31, 1999 and on and after July 1, 1999 through March 31, 2000, and on and after April 1, 2000 through March 31, 2003, and on and after April 1, 2003 through March 31, 2009, and on and after April 1, 2009 through March 31, 2011, and on and after April 1, 2011 through March 31, 2013, and on and after April 1, 2013 through March 31, 2015, and on and after April 1, 2015 through March 31, 2017, the capital costs per visit components shall be adjusted by the Commissioner to exclude such expenses related to 1) forty-four percent of the cost of major movable equipment and 2) staff housing. A return on equity is recognized in those instances where the hospital is organized under the auspices of proprietary sponsorship.

TN #15-0028

Approval Date _____

Supersedes TN #13-0025

Effective Date _____

New York
1(c)(ii)

Freestanding Clinic Services (diagnostic and treatment facilities) Facilities Certified Under Article 28 of the State Public Health Law

Prospective, all inclusive rates calculated by Department of Health, based on the lower of the allowable average cost per visit or the group ceiling trended to the current year. For purposes of establishing rates of payment for diagnostic and treatment centers for services provided on or after April 1, 1995 through March 31, 1999, and on or after July 1, 1999 through March 31, 2000, and on and after April 1, 2000 through March 31 2003, on and after April 1, 2003 through March 31, 2011, [and] on and after April 1, 2011 through March 31, 2013, and on and after April 1, 2013 through March 31, 2015, the reimbursable base year administrative and general costs of a provider, excluding a provider reimbursed on an initial budget basis, shall not exceed the statewide average of total reimbursable base year administrative and general costs of diagnostic and treatment centers. For the purposes of this provision, reimbursable base year administrative and general costs shall mean those base year administrative and general costs remaining after application of all other efficiency standards, including, but not limited to, peer group cost ceilings or guidelines. The limitation on reimbursement for provider administrative and general expenses shall be expressed as a percentage reduction of the operating cost component of the rate promulgated for each diagnostic and treatment center with base year administrative and general costs exceeding the average. Facilities offering similar types of services and having similar regional economic factors are grouped and ceilings are calculated on the cost experience of facilities within the group taking into account regional economic factors such as geographic location. Costs at or below these ceilings have been determined to be reasonable. The facility-specific impact of eliminating the statewide cap on administrative and general costs, for the period April 1, 1999 through June 30, 1999 shall be included in rates of payment for facilities affected by such elimination for the period October 1, 1999 through December 31, 1999.

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New York
4(2)

Providers are grouped geographically into upstate/downstate and by sponsorship, public/voluntary. Ceilings are calculated using the group cost experience. For purposes of establishing rates of payment by governmental agencies for certified home health agencies for the period April 1, 1995 through December 31, 1995, and for rate periods beginning on or after January 1, 1996 through March 31, 1999, and on July 1, 1999 through March 31, 2000, and on and after April 1, 2000 through March 31, 2003, and on and after April 1, 2003 through March 31, 2009, and on and after April 1, 2009 through March 31, 2011, and on and after April 1, 2011 through March 31, 2013, and on and after April 1, 2013 through March 31, 2015, and on and after April 1, 2015 through March 31, 2017, the reimbursable base year administrative and general costs of a provider of services, excluding a provider of services reimbursed on an initial budget basis, and a new provider, excluding changes in ownership or changes in name, who begins operations in the year prior to the year which is used as base year in determining rates of payment, shall not exceed the statewide average of total reimbursable base year administrative and general costs of such providers of services. In the 1996, 1997, 1998, 1999, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, and 2009, rate periods respectively the amount of such reduction in certified home health agency rates of payments made during the twelve month period running from April 1, of the year prior to the respective rate period through March 31, of such respective rate period shall be adjusted in the respective rate period on a pro-rate basis, if it is determined upon post-audit review by June 15, of the respective rate period and reconciliation, that the savings for the state share, excluding the federal and local government shares, of medical assistance payments is in excess of one million five hundred thousand dollars or is less than one million five hundred thousand dollars for payments made on or before March 31, of the applicable twelve month period to reflect the amount by which such savings are in excess of or lower than one million five hundred thousand dollars. The amount of such reduction in certified home health agency rates of payment made during the period July 1, 1999 through March 31, 2000, shall be adjusted in the 2000 rate period on a pro-rate basis, if it is determined upon post-audit review by June 15, 2000 and reconciliation, that the savings for the state share, excluding the federal and local government shares, of medical assistance payments is in excess of one million one hundred twenty-five thousand dollars or is less than one million one hundred twenty-five thousand dollars for payments made on or before March 31, 2000, to reflect the amount by which such savings are in excess of or lower than one million one hundred twenty-five thousand dollars.

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**New York
4(a)(iii)**

Effective for the period August 1, 1996 through November 30, 2009, certified home health agencies (CHHAs) [shall] will be required to increase their Medicare revenues relative to their Medicaid revenues measured from a base period (calendar year 1995) to a target period (the 1996 target period is August 1, 1996 through March 31, 1997, the 1997 target period is January 1, 1997 through November 30, 1997, the 1998 target period [shall] will mean January 1, 1998 through November 30, 1998, the 1999 target period [shall] will mean January 1, 1999 through November 30, 1999, the 2000 target period [shall] will mean January 1, 2000 through November 30, 2000, the 2001 target period [shall] will mean January 1, 2001 through November 30, 2001, the 2002 target period [shall] will mean January 1, 2002 through November 30, 2002, the 2003 target period [shall] will mean January 1, 2003 through November 30, 2003, the 2004 target period [shall] will mean January 1, 2004 through November 30, 2004, the 2005 target period [shall] will mean January 1, 2005 through November 30, 2005, the 2006 target period [shall] will mean January 1, 2006 through November 30, 2006, the 2007 target period [shall] will mean January 1, 2007 through November 30, 2007, the 2008 target period [shall] will mean January 1, 2008 through November 30, 2008, and the 2009 target period [shall] will mean January 1, 2009 through November 30, 2009, and the 2010 target period [shall] will mean January 1, 2010 through November 30, 2010, and the 2011 target period [shall] will mean January 1, 2011 through November 30, 2011, and the 2012 target period [shall] will mean January 1, 2012 through November 30, 2012 and the 2013 target period [shall] will mean January 1, 2013 through November 30, 2013, and the 2014 target period will mean January 1, 2014 through November 30, 2014, and the 2015 target period will mean January 1, 2015 through November 30, 2015, and the 2016 target will mean January 1, 2016 through November 30, 2016, and the 2017 target period will mean January 1, 2017 through November 30, 2017, or receive a reduction in their Medicaid payments. For this purpose, regions [shall] will consist of a downstate region comprised of Kings, New York, Richmond, Queens, Bronx, Nassau and Suffolk counties and an upstate region comprised of all other New York State counties. A certified home health agency [shall] will be located in the same county utilized by the Commissioner of Health for the establishment of rates pursuant to Article 36 of the Public Health Law. Regional group [shall] will mean all those CHHAs located within a region. Medicaid revenue percentage [shall] will mean CHHA revenues attributable to services provided to persons eligible for payments pursuant to Title 11 of Article 5 of the Social Services law divided by such revenues plus CHHA revenues attributable to services provided to beneficiaries of Title XVIII of the Federal Social Security Act (Medicare).

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**New York
4(a)(iii)(A)**

Prior to February 1, 1997, for each regional group, 1996 Medicaid revenue percentage for the period commencing August 1, 1996, to the last date for which such data is available and reasonably accurate [shall] will be calculated. Prior to February 1, 1998, prior to February 1, 1999, prior to February 1, 2000, prior to February 1, 2001, prior to February 1, 2002, prior to February 1, 2003, prior to February 1, 2004, prior to February 1, 2005, prior to February 1, 2006, prior to February 1, 2007, prior to February 1, 2008, prior to February 1, 2009, prior to February 1, 2010, prior to February 1, 2011, prior to February 1, 2012 and prior to February 1, 2013, prior to February 1, [2014], and prior to February 1, 2015, prior to February 1, 2016, and prior to February 1, 2017, for each regional group, the Commissioner of Health [shall] will calculate the prior years Medicaid revenue percentages for the period beginning January 1 through November 30 of such prior year. By September 15, 1996, for each regional group, the base period Medicaid revenue percentage [shall] will be calculated.

For each regional group, the 1996 target Medicaid revenue percentage [shall] will be calculated by subtracting the 1996 Medicaid revenue reduction percentages from the base period Medicaid revenue percentages. The 1996 Medicaid revenue reduction percentage, taking into account regional and program differences in utilization of Medicaid and Medicare services, for the following regional groups [shall] will be equal to:

- one and one-tenth percentage points for CHHAs located within the downstate region;
- and,
- six-tenths of one percentage point for CHHAs located within the upstate region.

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New York
4(a)(iv)

For 1997, 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, [and] 2015, 2016, and 2017, for each regional group, the target Medicaid revenue percentage for the respective year [shall] will be calculated by subtracting the respective year's Medicaid revenue reduction percentage from the base period Medicaid revenue percentage. The Medicaid revenue reduction percentages for 1997, 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, [and] 2015, 2016, and 2017 taking into account regional and program differences in utilization of Medicaid and Medicare services, for the following regional groups [shall] will be equal to:

one and one-tenth percentage points for CHHAs located within the downstate region;
and,

six-tenths of one percentage point for CHHAs located within the upstage region.

For each regional group, the 1999 target Medicaid revenue percentage [shall] will be calculated by subtracting the 1999 Medicaid revenue reduction percentage from the base period Medicaid revenue percentage. The 1999 Medicaid revenue reduction percentages, taking into account regional and program differences in utilization of Medicaid and Medicare services, for the following regional groups [shall] will be equal to:

eight hundred twenty-five thousandths (.825) of one percentage point for CHHAs located within the downstate region;

forty-five hundredths (.45) of one percentage point for CHHAs located within the upstate region;

For each regional group, if the 1996 Medicaid revenue percentage is not equal to or less than the 1996 target Medicaid revenue percentage, a 1996 reduction factor [shall] will be calculated by comparing the 1996 Medicaid revenue percentage to the 1996 target Medicaid revenue percentage to determine the amount of the shortfall and dividing such shortfall by the 1996 Medicaid revenue reduction percentage. These amounts, expressed as a percentage, [shall] will not exceed one hundred percent. If the 1996 Medicaid revenue percentage is equal to or less than 1996 target Medicaid revenue percentage, the 1996 reduction factor [shall] will be zero. For each regional group, the 1996 reduction factor [shall] will be multiplied by the following amounts to determine each regional group's applicable 1996 state share reduction amount.

two million three hundred ninety thousand dollars (\$2,390,000) for CHHAs located within the downstate region;

seven hundred fifty thousand dollars (\$750,000) for CHHAs located within the upstate region.

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**New York
4(a)(iv)(1)**

For each regional group reduction, if the 1996 reduction factor shall be zero, there shall be no 1996 state share reduction amount.

For 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010 2011, 2012, 2013, 2014, [and] 2015, 2016, and 2017, for each regional group, if the Medicaid revenue percentage for the respective year is not equal to or less than the target Medicaid revenue percentage for such respective year, the Commissioner of Health [shall] will compare such respective year's Medicaid revenue percentage to such respective year's target Medicaid revenue percentage to determine the amount of the shortfall which, when divided by the respective year's Medicaid revenue reduction percentage, [shall] will be called the reduction factor for such respective year. These amounts, expressed as a percentage, [shall] will not exceed one hundred percent. If the Medicaid revenue percentage for a particular year is equal to or less than the target Medicaid revenue percentage for that year, the reduction factor for that year shall be zero.

For 1997, 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, [and] 2015, 2016, and 2017, for each regional group, the reduction factor for the respective year [shall] will be multiplied by the following amounts to determine each regional group's applicable state share reduction amount for such respective year.

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New York
4(a)(iv)(2)

two million three hundred ninety thousand dollars (\$2,390,000) for CHHAs located within the downstate region;

seven hundred fifty thousand dollars (\$750,000) for CHHAs located within the upstate region;

For each regional group reduction, if the reduction factor for a particular year is zero, there [shall] will be no state share reduction amount for such year.

For each regional group, the 1999 reduction factor [shall] will be multiplied by the following amounts to determine each regional group's applicable 1999 state share reduction amount:

one million seven hundred ninety-two thousand five hundred dollars (\$1,792,500) for CHHAs located within the downstate region;

five hundred sixty-two thousand five hundred dollars (\$562,500) for CHHAs located within the upstate region;

For each regional group reduction, if the 1999 reduction factor is zero, there [shall] will be no 1999 state share reduction amount.

For each regional group, the 1996 state share reduction amount [shall] will be allocated among CHHAs on the basis of the extent of each CHHA's failure to achieve the 1996 target Medicaid revenue percentage, calculated on a provider specific basis utilizing revenues for this purpose, expressed as a proportion of the total of each CHHA's failure to achieve the 1996 target Medicaid revenue percentage within the applicable regional group. This proportion [shall] will be multiplied by the applicable 1996 state share reduction amount. This amount [shall] will be called the 1996 provider specific state share reduction amount.

The 1996 provider specific state share reduction amount [shall] will be due to the state from each CHHA and may be recouped by the State by March 31, 1997, in a lump sum amount or amounts from payments due to the CHHA pursuant to Title 11 of Article 5 of the Social Services Law.

For 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, [and] 2015, 2016, and 2017, for each regional group, the state share reduction amount for the respective year [shall] will be allocated among CHHAs on the basis of the extent of each CHHA's failure to achieve the target Medicaid revenue percentage for the applicable year, calculated on a provider specific basis utilizing revenues for this purpose, expressed as a proportion of the total of each CHHA's failure to achieve the target Medicaid revenue percentage for the applicable year within the applicable regional group. This proportion [shall] will be multiplied by the applicable year's state share reduction amount for the applicable regional group. This amount [shall] will be called the provider specific state share reduction amount for the applicable year.

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**New York
4(a)(v)**

The provider specific state share reduction amount for 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, [and] 2015, 2016, and 2017, respectively, [shall] will be due to the state from each CHHA and the amount due for each respective year may be recouped by the state by March 31 of the following year in a lump sum amount or amounts from payments due to the CHHA pursuant to Title 11 of Article 5 of the Social Services Law.

CHHAs [shall] will submit such data and information at such times as the Commissioner of Health may require. The Commissioner of Health may use data available from third party payors.

On or about June 1, 1997, for each regional group, the Commissioner of Health [shall] will calculate for the period of August 1, 1996 through March 31, 1997, a Medicaid revenue percentage, a reduction factor, a state share reduction amount, and a provider specific state share reduction amount in accordance with the methodology provided herein for calculating such amounts for the 1996 target period. The provider specific state share reduction amount calculated [shall] will be compared to the 1996 provider specific state share reduction amount. Any amount in excess of the 1996 provider specific state share reduction amount [shall] will be due to the state from each CHHA and may be recouped. If the amount is less than the 1996 provider specific state share reduction amount, the difference [shall] will be refunded to the CHHA by the state no later than July 15, 1997. CHHAs [shall] will submit data for the period August 1, 1996 through March 31, 1997, to the Commissioner of Health by April 15, 1997.

If a CHHA fails to submit data and information as required, such CHHA [shall] will be presumed to have no decrease in Medicaid revenue percentage between the base period and the applicable target period for purposes of the calculations described herein and the Commissioner of Health [shall] will reduce the current rate paid to such CHHA by state governmental agencies pursuant to Article 36 of the Public Health Law by one percent for the period beginning on the first day of the calendar month following the applicable due date as established by the Commissioner of Health and continuing until the last day of the calendar month in which the required data and information are submitted.

Notwithstanding any inconsistent provision set forth herein, the annual percentage reductions as set forth above, [shall] will be prorated by the Commissioner of Health for the period April 1, 2007 through March 31, 2009.

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Appendix II
2015 Title XIX State Plan
Second Quarter Amendment
Summary

SUMMARY
SPA #15-0028

This State Plan Amendment proposes to continue for periods April 1, 2015 through March 31, 2017, the following previously enacted cost containment measures:

- the cap on administrative and general component of rates for certified home health agencies and freestanding diagnostic and treatment centers;
- continues to appropriately allocate capital costs for outpatient and emergency department rates, and
- continues home health care maximization initiatives.

**Appendix III
2015 Title XIX State Plan
Second Quarter Amendment
Authorizing Provisions**

Chapter 57 of the Laws of 2015 - Part D

§ 6. Subdivision 1 of section 89-a of part C of chapter 58 of the laws of 2007, amending the social services law and other laws relating to enacting the major components of legislation necessary to implement the health and mental hygiene budget for the 2007-2008 state fiscal year, as amended by section 10 of part B of chapter 56 of the laws of 2013, is amended to read as follows:

1. Notwithstanding paragraph (c) of subdivision 10 of section 2807-c of the public health law and section 21 of chapter 1 of the laws of 1999, as amended, and any other inconsistent provision of law or regulation to the contrary, in determining rates of payments by state governmental agencies effective for services provided beginning April 1, 2006, through March 31, 2009, and on and after April 1, 2009 through March 31, 2011, and on and after April 1, 2011 through March 31, 2013, and on and after April 1, 2013 through March 31, 2015, and on and after April 1, 2015 through March 31, 2017 for inpatient and outpatient services provided by general hospitals and for inpatient services and outpatient adult day health care services provided by residential health care facilities pursuant to article 28 of the public health law, the commissioner of health shall apply a trend factor projection of two and twenty-five hundredths percent attributable to the period January 1, 2006 through December 31, 2006, and on and after January 1, 2007, provided, however, that on reconciliation of such trend factor for the period January 1, 2006 through December 31, 2006 pursuant to paragraph (c) of subdivision 10 of section 2807-c of the public health law, such trend factor shall be the final US Consumer Price Index (CPI) for all urban consumers, as published by the US Department of Labor, Bureau of Labor Statistics less twenty-five hundredths of a percentage point.

§ 10. Section 228 of chapter 474 of the laws of 1996, amending the education law and other laws relating to rates for residential health care facilities, as amended by section 14-a of part B of chapter 56 of the laws of 2013, is amended to read as follows:

§ 228. 1. Definitions. (a) Regions, for purposes of this section, shall mean a downstate region to consist of Kings, New York, Richmond, Queens, Bronx, Nassau and Suffolk counties and an upstate region to consist of all other New York state counties. A certified home health agency or long term home health care program shall be located in the same county utilized by the commissioner of health for the establishment of rates pursuant to article 36 of the public health law.

(b) Certified home health agency (CHHA) shall mean such term as defined in section 3602 of the public health law.

(c) Long term home health care program (LTHHCP) shall mean such term as defined in subdivision 8 of section 3602 of the public health law.

(d) Regional group shall mean all those CHHAs and LTHHCPs, respectively, located within a region.

(e) Medicaid revenue percentage, for purposes of this section, shall mean CHHA and LTHHCP revenues attributable to services provided to persons eligible for payments pursuant to title 11 of article 5 of the social services law divided by such revenues plus CHHA and LTHHCP revenues attributable to services provided to beneficiaries of Title XVIII of the federal social security act (medicare).

(f) Base period, for purposes of this section, shall mean calendar

year 1995.

(g) Target period. For purposes of this section, the 1996 target period shall mean August 1, 1996 through March 31, 1997, the 1997 target period shall mean January 1, 1997 through November 30, 1997, the 1998 target period shall mean January 1, 1998 through November 30, 1998, the 1999 target period shall mean January 1, 1999 through November 30, 1999, the 2000 target period shall mean January 1, 2000 through November 30, 2000, the 2001 target period shall mean January 1, 2001 through November 30, 2001, the 2002 target period shall mean January 1, 2002 through November 30, 2002, the 2003 target period shall mean January 1, 2003 through November 30, 2003, the 2004 target period shall mean January 1, 2004 through November 30, 2004, and the 2005 target period shall mean January 1, 2005 through November 30, 2005, the 2006 target period shall mean January 1, 2006 through November 30, 2006, and the 2007 target period shall mean January 1, 2007 through November 30, 2007 and the 2008 target period shall mean January 1, 2008 through November 30, 2008, and the 2009 target period shall mean January 1, 2009 through November 30, 2009 and the 2010 target period shall mean January 1, 2010 through November 30, 2010 and the 2011 target period shall mean January 1, 2011 through November 30, 2011 and the 2012 target period shall mean January 1, 2012 through November 30, 2012 and the 2013 target period shall mean January 1, 2013 through November 30, 2013, and the 2014 target period shall mean January 1, 2014 through November 30, 2014 and the 2015 target period shall mean January 1, 2015 through November 30, 2015 and the 2016 target period shall mean January 1, 2016 through November 30, 2016 and the 2017 target period shall mean January 1, 2017 through November 30, 2017.

2. (a) Prior to February 1, 1997, for each regional group the commissioner of health shall calculate the 1996 medicaid revenue percentages for the period commencing August 1, 1996 to the last date for which such data is available and reasonably accurate.

(b) Prior to February 1, 1998, prior to February 1, 1999, prior to February 1, 2000, prior to February 1, 2001, prior to February 1, 2002, prior to February 1, 2003, prior to February 1, 2004, prior to February 1, 2005, prior to February 1, 2006, prior to February 1, 2007, prior to February 1, 2008, prior to February 1, 2009, prior to February 1, 2010, prior to February 1, 2011, prior to February 1, 2012, prior to February 1, 2013, prior to February 1, 2014 [and], prior to February 1, 2015, and prior to February 1, 2016 and prior to February 1, 2017 for each regional group the commissioner of health shall calculate the prior year's medicaid revenue percentages for the period commencing January 1 through November 30 of such prior year.

3. By September 15, 1996, for each regional group the commissioner of health shall calculate the base period medicaid revenue percentage.

4. (a) For each regional group, the 1996 target medicaid revenue percentage shall be calculated by subtracting the 1996 medicaid revenue reduction percentages from the base period medicaid revenue percentages. The 1996 medicaid revenue reduction percentage, taking into account regional and program differences in utilization of medicaid and medicare services, for the following regional groups shall be equal to:

(i) one and one-tenth percentage points for CHHAs located within the downstate region;

(ii) six-tenths of one percentage point for CHHAs located within the upstate region;

(iii) one and eight-tenths percentage points for LTHHCPS located within the downstate region; and

(iv) one and seven-tenths percentage points for LTHHCPS located within

the upstate region.

(b) For 1997, 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014 [and], 2015, 2016 and 2017 for each regional group, the target medicaid revenue percentage for the respective year shall be calculated by subtracting the respective year's medicaid revenue reduction percentage from the base period medicaid revenue percentage. The medicaid revenue reduction percentages for 1997, 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014 [and], 2015, 2016 and 2017, taking into account regional and program differences in utilization of medicaid and medicare services, for the following regional groups shall be equal to for each such year:

(i) one and one-tenth percentage points for CHHAs located within the downstate region;

(ii) six-tenths of one percentage point for CHHAs located within the upstate region;

(iii) one and eight-tenths percentage points for LTHHCPS located within the downstate region; and

(iv) one and seven-tenths percentage points for LTHHCPS located within the upstate region.

(c) For each regional group, the 1999 target medicaid revenue percentage shall be calculated by subtracting the 1999 medicaid revenue reduction percentage from the base period medicaid revenue percentage. The 1999 medicaid revenue reduction percentages, taking into account regional and program differences in utilization of medicaid and medicare services, for the following regional groups shall be equal to:

(i) eight hundred twenty-five thousandths (.825) of one percentage point for CHHAs located within the downstate region;

(ii) forty-five hundredths (.45) of one percentage point for CHHAs located within the upstate region;

(iii) one and thirty-five hundredths percentage points (1.35) for LTHHCPS located within the downstate region; and

(iv) one and two hundred seventy-five thousandths percentage points (1.275) for LTHHCPS located within the upstate region.

5. (a) For each regional group, if the 1996 medicaid revenue percentage is not equal to or less than the 1996 target medicaid revenue percentage, the commissioner of health shall compare the 1996 medicaid revenue percentage to the 1996 target medicaid revenue percentage to determine the amount of the shortfall which, when divided by the 1996 medicaid revenue reduction percentage, shall be called the 1996 reduction factor. These amounts, expressed as a percentage, shall not exceed one hundred percent. If the 1996 medicaid revenue percentage is equal to or less than the 1996 target medicaid revenue percentage, the 1996 reduction factor shall be zero.

(b) For 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014 [and], 2015, 2016, and 2017, for each regional group, if the medicaid revenue percentage for the respective year is not equal to or less than the target medicaid revenue percentage for such respective year, the commissioner of health shall compare such respective year's medicaid revenue percentage to such respective year's target medicaid revenue percentage to determine the amount of the shortfall which, when divided by the respective year's medicaid revenue reduction percentage, shall be called the reduction factor for such respective year. These amounts, expressed as a percentage, shall not exceed one hundred percent. If the medicaid revenue percentage for a particular year is equal to or less than the target medicaid revenue percentage for that year, the reduction factor for that

year shall be zero.

6. (a) For each regional group, the 1996 reduction factor shall be multiplied by the following amounts to determine each regional group's applicable 1996 state share reduction amount:

(i) two million three hundred ninety thousand dollars (\$2,390,000) for CHHAs located within the downstate region;

(ii) seven hundred fifty thousand dollars (\$750,000) for CHHAs located within the upstate region;

(iii) one million two hundred seventy thousand dollars (\$1,270,000) for LTHHCPS located within the downstate region; and

(iv) five hundred ninety thousand dollars (\$590,000) for LTHHCPS located within the upstate region.

For each regional group reduction, if the 1996 reduction factor shall be zero, there shall be no 1996 state share reduction amount.

(b) For 1997, 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014 [and], 2015, 2016 and 2017, for each regional group, the reduction factor for the respective year shall be multiplied by the following amounts to determine each regional group's applicable state share reduction amount for such respective year:

(i) two million three hundred ninety thousand dollars (\$2,390,000) for CHHAs located within the downstate region;

(ii) seven hundred fifty thousand dollars (\$750,000) for CHHAs located within the upstate region;

(iii) one million two hundred seventy thousand dollars (\$1,270,000) for LTHHCPS located within the downstate region; and

(iv) five hundred ninety thousand dollars (\$590,000) for LTHHCPS located within the upstate region.

For each regional group reduction, if the reduction factor for a particular year shall be zero, there shall be no state share reduction amount for such year.

(c) For each regional group, the 1999 reduction factor shall be multiplied by the following amounts to determine each regional group's applicable 1999 state share reduction amount:

(i) one million seven hundred ninety-two thousand five hundred dollars (\$1,792,500) for CHHAs located within the downstate region;

(ii) five hundred sixty-two thousand five hundred dollars (\$562,500) for CHHAs located within the upstate region;

(iii) nine hundred fifty-two thousand five hundred dollars (\$952,500) for LTHHCPS located within the downstate region; and

(iv) four hundred forty-two thousand five hundred dollars (\$442,500) for LTHHCPS located within the upstate region.

For each regional group reduction, if the 1999 reduction factor shall be zero, there shall be no 1999 state share reduction amount.

7. (a) For each regional group, the 1996 state share reduction amount shall be allocated by the commissioner of health among CHHAs and LTHHCPS on the basis of the extent of each CHHA's and LTHHCPS's failure to achieve the 1996 target medicaid revenue percentage, calculated on a provider specific basis utilizing revenues for this purpose, expressed as a proportion of the total of each CHHA's and LTHHCPS's failure to achieve the 1996 target medicaid revenue percentage within the applicable regional group. This proportion shall be multiplied by the applicable 1996 state share reduction amount calculation pursuant to paragraph

(a) of subdivision 6 of this section. This amount shall be called the 1996 provider specific state share reduction amount.

(b) For 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014 [and], 2015, 2016 and

2017 for each regional group, the state share reduction amount for the respective year shall be allocated by the commissioner of health among CHHAs and LTHHCPs on the basis of the extent of each CHHA's and LTHHCP's failure to achieve the target medicaid revenue percentage for the applicable year, calculated on a provider specific basis utilizing revenues for this purpose, expressed as a proportion of the total of each CHHA's and LTHHCP's failure to achieve the target medicaid revenue percentage for the applicable year within the applicable regional group. This proportion shall be multiplied by the applicable year's state share reduction amount calculation pursuant to paragraph (b) or (c) of subdivision 6 of this section. This amount shall be called the provider specific state share reduction amount for the applicable year.

8. (a) The 1996 provider specific state share reduction amount shall be due to the state from each CHHA and LTHHCP and may be recouped by the state by March 31, 1997 in a lump sum amount or amounts from payments due to the CHHA and LTHHCP pursuant to title 11 of article 5 of the social services law.

(b) The provider specific state share reduction amount for 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014 [and], 2015, 2016 and 2017 respectively, shall be due to the state from each CHHA and LTHHCP and each year the amount due for such year may be recouped by the state by March 31 of the following year in a lump sum amount or amounts from payments due to the CHHA and LTHHCP pursuant to title 11 of article 5 of the social services law.

9. CHHAs and LTHHCPs shall submit such data and information at such times as the commissioner of health may require for purposes of this section. The commissioner of health may use data available from third-party payors.

10. On or about June 1, 1997, for each regional group the commissioner of health shall calculate for the period August 1, 1996 through March 31, 1997 a medicaid revenue percentage, a reduction factor, a state share reduction amount, and a provider specific state share reduction amount in accordance with the methodology provided in paragraph (a) of subdivision 2, paragraph (a) of subdivision 5, paragraph (a) of subdivision 6 and paragraph (a) of subdivision 7 of this section. The provider specific state share reduction amount calculated in accordance with this subdivision shall be compared to the 1996 provider specific state share reduction amount calculated in accordance with paragraph (a) of subdivision 7 of this section. Any amount in excess of the amount determined in accordance with paragraph (a) of subdivision 7 of this section shall be due to the state from each CHHA and LTHHCP and may be recouped in accordance with paragraph (a) of subdivision 8 of this section. If the amount is less than the amount determined in accordance with paragraph

(a) of subdivision 7 of this section, the difference shall be refunded to the CHHA and LTHHCP by the state no later than July 15, 1997. CHHAs and LTHHCPs shall submit data for the period August 1, 1996 through March 31, 1997 to the commissioner of health by April 15, 1997.

11. If a CHHA or LTHHCP fails to submit data and information as required for purposes of this section:

(a) such CHHA or LTHHCP shall be presumed to have no decrease in medicaid revenue percentage between the applicable base period and the applicable target period for purposes of the calculations pursuant to this section; and

(b) the commissioner of health shall reduce the current rate paid to such CHHA and such LTHHCP by state governmental agencies pursuant to article 36 of the public health law by one percent for a period beginning on the first day of the calendar month following the applicable due

date as established by the commissioner of health and continuing until the last day of the calendar month in which the required data and information are submitted.

12. The commissioner of health shall inform in writing the director of the budget and the chair of the senate finance committee and the chair of the assembly ways and means committee of the results of the calculations pursuant to this section.

§ 11. Subdivision 5-a of section 246 of chapter 81 of the laws of 1995, amending the public health law and other laws relating to medical reimbursement and welfare reform, as amended by section 15 of part B of chapter 56 of the laws of 2013, is amended to read as follows:
5-a. Section sixty-four-a of this act shall be deemed to have been in full force and effect on and after April 1, 1995 through March 31, 1999 and on and after July 1, 1999 through March 31, 2000 and on and after April 1, 2000 through March 31, 2003 and on and after April 1, 2003 through March 31, 2007, and on and after April 1, 2007 through March 31, 2009, and on and after April 1, 2009 through March 31, 2011, and on and after April 1, 2011 through March 31, 2013, and on and after April 1, 2013 through March 31, 2015, and on and after April 1, 2015 through March 31, 2017;

**Appendix IV
2015 Title XIX State Plan
Second Quarter Amendment
Public Notice**

MISCELLANEOUS NOTICES/HEARINGS

Notice of Abandoned Property Received by the State Comptroller

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

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

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

PUBLIC NOTICE Department of Health

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

The Department of Health proposes to amend the Title XIX (Medicaid) State Plan for inpatient, long term care, and non-institutional services and prescription drugs to comply with recently proposed statutory provisions. The following provides clarification to provisions previously noticed on March 25, 2015, unless otherwise indicated, and notification of new significant changes.

All Services

Permanently Eliminate Trend Factors Clarification (Part D/29-a)

- As previously noticed March 27, 2013, clarifies, effective on and after January 1, 2015, no greater than zero trend factors attributable to the 2015 and 2016 calendar year pursuant to the provisions of Public Health Law § 2807-c(10)(c) to rates of payment for hospital inpatient and outpatient services, inpatient and adult day health care outpatient services provided by residential health care facilities pursuant to Article 28 of the Public Health Law, except for residential health care facilities or units of such facilities providing services primarily to children under 21 year of age, certified home health agencies, AIDS home care programs, and for personal care services pursuant to section 365-a of the Social Services Law, including 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, and assisted living program services.

The annual decrease in gross Medicaid expenditures for state fiscal year 2015/16 is (\$436.4) million.

VAP Award Criteria Considerations (Part B/51)

- Effective on or after April 1, 2015, the Commissioner of Health shall consider criteria for vital access provider (VAP) applications submitted to the Department that includes, but is not limited to:

- The applicant's financial condition as evidenced by operating margins, negative fund balance or negative equity position;

- The extent to which the applicant fulfills or will fulfill an unmet health care need for acute inpatient, outpatient primary or residential health care services in a community;

- The extent to which the application will involve savings to the Medicaid program;

- The quality of the application as evidenced by such application's long term solutions for such applicant to achieve sustainable health care services, improving the quality of patient care, and/or transforming the delivery of health care services to meet community needs;

- The extent to which such applicant is geographically isolated in relation to other providers; or

- The extent to which such applicant provides services to an underserved area in relation to other providers.

Institutional Services

IP Cost Containment - Appropriately Allocate Capital Costs Clarification (Part D/2)

- Clarifies, 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, will continue effective April 1, 2015 through March 31, 2017.

IP Cost Containment - Continuation of .25 Trend Reduction Clarification (Part D/6)

- Clarifies, 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% and extends current provisions for services on and after April 1, 2015 through March 31, 2017.

The estimated annual net decrease in gross Medicaid expenditures attributable to these cost containment initiatives contained in the budget for state fiscal year 2015/2016 is \$114.5 million.

Hospital VAP Applications for Financially Distressed (Additional Article VII)

- Effective for the periods of April 1, 2015 through March 31, 2016, the Commissioner of Health may award a temporary adjustment to the non-capital component of rates, or make temporary lump-sum medical assistance payments to eligible general hospitals in severe financial distress to enable such facilities to maintain operations and vital services while such facilities establish long term solutions to achieve sustainable health services. Eligible general hospitals shall include: a public general hospital operated by a county or municipality, but shall exclude any such hospital operated by a public benefit corporation; a federally designated critical access hospital; a federally designated sole community hospital; or a general hospital that is a safety net hospital.

- A safety net hospital shall be defined as having at least 30% of its inpatient discharges made up of Medicaid eligible individuals, uninsured individuals or Medicaid dually-eligible individuals; or

- Such hospital must serve at least 30% of the residents of a county or a multi-county area who are Medicaid eligible individuals, uninsured individuals or Medicaid dually-eligible individuals.

- Eligible applicants must demonstrate that without such award, they will be in severe financial distress through March 31, 2016. Evidence of such distress will be by:

- Certification that such applicant has less than 15 days cash and equivalents;

- Such applicant has no assets that can be monetized other than those vital to operations; and

- Such applicant has exhausted all efforts to obtain resources from corporate parents and affiliated entities to sustain operations.

- For those applicants meeting such criteria, awards shall be made upon application to the Department of Health. Such awards shall include a multi-year transformation plan that is aligned with the Delivery System Reform Incentive Program (DSRIP) program goals and objectives which must be approved by the Department and demonstrate a path towards long term sustainability and improved patient care.

- Initial award payments to eligible applicant may be based solely on the aforementioned criteria; however, the Department may suspend or repeal an award if the eligible applicant fails to submit a multi-year transformation plan that is acceptable to the Department by no later than September 30, 2015.

- Applicants also must detail the extent to which the affected community has been engaged or consulted on potential projects within the application, as well as any outreach to stakeholder and health plans.

- Applications shall be reviewed by the Department to determine an applicant's eligibility; each applicant's projected financial status; each applicant's proposed use of funds to maintain critical services needed by the community; and the anticipated impact of the loss of such services.

- The Department, after review of all applications and determination of the aggregate amount of requested funds, shall make awards to eligible applicants; provided, however, that such awards may be in an amount lower than such requested funding, on a per applicant or aggregate basis.

- Awards issued may not be used for: capital expenditures, including, but not limited to construction, renovation and acquisition of capital equipment, including major medical equipment; consultant fees; retirement of long term debt; or bankruptcy-related costs.

- Payments made to awardees shall be made on a monthly basis. Such payments will be based on the applicant's actual monthly financial performance during such period and the reasonable cash amount necessary to sustain operations for the following month. The applicant's monthly financial and activity reports, which shall include, but not be limited to: actual revenue and expenses for the prior month, projected cash need for current month, and projected need for the following month.

Long Term Care Services

LTC Cost Containment – Eliminate 96/97 Trend Factor Clarification (Part D/5)

- Clarifies, rates of payment for RHCs shall not reflect trend factor projections or adjustments for the period April 1, 1996 through March 31, 1997 and continues the provision effective on and after April 1, 2015 through March 31, 2017.

LTC Cost Containment – Continuation of .25 Trend Reduction Clarification (Part D/6)

- Clarifies, the reimbursable operating cost component for RHCs 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% and extends current provisions to services on and after April 1, 2015 through March 31, 2017.

LTC Cost Containment – NH Medicare Maximization Clarification (Part D/7-9)

- Clarifies, long-term care Medicare maximization initiatives will continue effective April 1, 2015 through March 31, 2017.

The estimated annual net decrease in gross Medicaid expenditures attributable to these cost containment initiatives contained in the budget for state fiscal year 2015/2016 is \$117 million.

NH Cash Assessment Extension Clarification (Part D/3)

- Clarifies, 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 will be effective for periods April 1, 2015 through March 31, 2017. The extent to which a facility is reimbursed for the additional cost of the assessment is dependent upon Medicaid volume of services.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2015/2016 is \$420 million.

Spousal Support Clarification (Part B/33)

- The initiative previously noticed regarding medical assistance being furnished to applicants in cases where, although such applicant has a responsible relative with sufficient income and resources to provide medical assistance, the income and resources of the responsible relative are not available to such applicant because of the absence of such relative and the refusal or failure of such absent relative to provide the necessary care and assistance was eliminated from the budget for state fiscal year 2015/2016.

Young Adult (Part B/47)

- Effective on or after April 1, 2015, the Commissioner of Health shall establish up to three young adult special populations demonstration programs to provide cost effective, necessary services and enhanced quality of care for targeted populations. Eligible individuals included in the programs shall have severe and chronic medical or health problems or multiple disabling conditions which may be combined with developmental disabilities. Such programs shall provide more appropriate settings and services for these individuals, help prevent out of state placements and allow repatriation back to their home communities. Eligible operators of such programs must have demonstrated expertise in caring for the targeted population and have a record of providing quality care.

- Funds for such programs may include, but not be limited to start up funds, capital investments and enhanced rates.

- Of the demonstrations at least one program shall be designed to serve persons ages 21-35 who are aging out of pediatric acute care hospitals or nursing homes; and at least one program shall be designed to serve persons 21-35 who have a developmental disability in addition to their severe and chronic medical or health problems and who are aging out of pediatric acute care hospitals, pediatric nursing homes or children's residential homes operated under the New York State Office for Persons With Developmental Disabilities.

- The Department of Health shall be responsible for monitoring the quality, appropriateness, and effectiveness of such programs.

The estimated annual net increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal years 2015/2016 and 2016/2017 is \$2M for each state fiscal year.

Refinancing/Shared Savings (Part B/52)

- Effective on or after April 1, 2015, for facilities with operating certificates granted on or after March 10, 1975, real property costs shall be based on historical costs to the owner of the facility, provided payment for real property costs shall not be in excess of the actual debt service, including principal and interest, and payment with respect to owners' equity.

- Owners' equity shall be calculated without regard to any surplus created by revaluation of assets and shall not include amounts resulting from mortgage amortization where the payment has been provided by real property cost reimbursement.

- Further provided, the Commissioner of Health may modify such payments for real property cases for purposes of effectuating a shared savings program where facilities share a minimum of 50% of savings, for those facilities that elect to refinance their mortgage loans.

There is no additional estimated annual change to gross Medicaid expenditures attributable to this initiative for state fiscal year 2015/2016.

ATB 1% Give Back

- Clarifies, while alternative methods of cost containment continue, as partial restoration of the two per cent annual uniform reduction of Medicaid payments which was noticed on March 26, 2014, across the

board rate increases of one half the value of monies collected under such cost containment measures will be made.

Non-institutional Services

Non-institutional Cost Containment – Continuation of 25 Trend Reduction Clarification (Part D/6)

- Clarifies, 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% and extends current provisions to services on and after April 1, 2015 through March 31, 2017.

Non-institutional Cost Containment – CHHA A&G Cap Clarification (Part D/11-12)

- Clarifies, for certified home health agency administrative and general cost reimbursement limits, current provisions will be extended for the periods on and after April 1, 2015 through March 31, 2017.

Non-institutional Cost Containment – Home Care Medicare Max Clarification (Part D/10)

- Clarifies, home health care Medicare maximization initiatives will continue effective April 1, 2015 through March 31, 2017.

The estimated annual net decrease in gross Medicaid expenditures attributable to these cost containment initiatives contained in the budget for state fiscal year 2015/2016 is \$17.8 million.

Apply Cost-Sharing Limits for Medicare Part C Cross-Over Services Clarification (Part B/32)

- The initiative previously noticed to apply cost sharing limits for Medicare Part C cross over services was eliminated from the budget for state fiscal year 2015/2016.

CHHA Episodic Payment Extender (Part D/22)

- Continues, effective on and after April 1, 2015 through March 31, 2019, payments by government agencies for services provided by certified home health agencies, except for such services provided to children under 18 and other discreet groups, shall be based on episodic payments. A statewide base price, for such payments, shall be established for each 60-day episode of patient 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.

There is no additional estimated annual change to gross Medicaid expenditures attributable to this initiative for state fiscal year 2015/2016.

Annual Supplemental Assistance Payment for Emergency Medicaid Transportation (Part B/53)

Effective on and after April 1, 2015, provides a supplemental medical assistance payment to providers of emergency medical transportation not to exceed \$6 million in state fiscal year 2015/2016.

Apply Cost-Sharing Limits for Medicare Part B Cross-Over Services Clarification (Part B/31)

- Clarifies the initiative related to cost-sharing limits will be applied to Medicare Part B cross-over services will now be effective July 1, 2015.

The estimated annual net aggregate decrease in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2015/2016 is \$49.7 million.

Prescription Drugs

AWP Discount for Brand Name Drugs & Dispensing Fee Adjustment Clarification (Part B/2-3)

- The initiative for the Average Wholesale Price (AWP) for sole or multiple source brand name drugs and the dispensing fee for such was eliminated from the budget for state fiscal year 2015/2016.

340B Drugs Clarification (Part B/7)

- The initiative previously noticed related to claims for payment of outpatient prescription drugs submitted to a managed care provider by a covered entity pursuant to section 340B of the federal public health service act (42 USCA § 256b) was eliminated from the budget for state fiscal year 2015/2016.

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

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

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

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

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

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

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

For further information and to review and comment, please contact: Department of Health, Bureau of Federal Relations & Provider Assessments, 99 Washington Ave. – One Commerce Plaza, Suite 1460, Albany, NY 12210, or e-mail: spa_inquiries@health.state.ny.us

PUBLIC NOTICE

**New York State and Local Retirement Systems
Unclaimed Amounts Payable to Beneficiaries**

Pursuant to the Retirement and Social Security Law, the New York State and Local Retirement Systems hereby gives public notice of the amounts payable to beneficiaries.

The State Comptroller, pursuant to Sections 109(a) and 409(a) of the Retirement and Social Security Law has received, from the New York State and Local Retirement Systems, a listing of beneficiaries or estates having unclaimed amounts in the Retirement System. A list of the names contained in this notice is on file and open to public inspection at the office of the New York State and Local Retirement Systems located at 110 State St., in the City of Albany, New York.

Set forth below are the names and addresses (last known) of beneficiaries and estates appearing from the records of the New York State and Local Retirement Systems, entitled to the unclaimed benefits.

At the expiration of six months from the date of publication of this list of beneficiaries and estates, unless previously paid to the claimant, the amounts shall be deemed abandoned and placed in the pension accumulation fund to be used for the purpose of said fund.

Any amounts so deemed abandoned and transferred to the pension accumulation fund, may be claimed by the executor or administrator of the estates or beneficiaries so designated to receive such amounts, by filing a claim with the State Comptroller. In the event such claim is properly made, the State Comptroller shall pay over to the estates or to the person or persons making such claim, the amount without interest.

- ABRAMTSEV, CHRISTINA T ESTATE OF MOUNT KISCO NY
- ACKERMAN, CARL W ESTATE OF LAKE HAVASU CITY AZ
- ADAMS, ROBYN L SPARTANBURG SC
- ADCOCK, BEULAH M ESTATE OF PHOENIX NY
- ADLER, GORDON ELIZABETH CO
- AIELLO, VERA UTICA NY
- ALIX, EVELYN NEW ROCHELLE NY
- ALLEN, LEO M ESTATE OF PLATTSBURGH NY

expenditures attributable to this initiative contained in the budget for state fiscal year 2015/2016 is \$21.4 million.

- Continues, effective April 1, 2015, and thereafter, the provision that rates of payment for RHCFS shall not reflect trend factor projections or adjustments for the period April 1, 1996 through March 31, 1997.

- Extends current provisions to services on and after April 1, 2015, 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, 2015, and thereafter, long-term care Medicare maximization initiatives.

The estimated annual net decrease in gross Medicaid expenditures attributable to these cost containment initiatives contained in the budget for state fiscal year 2015/2016 is \$117 million.

- Continues, effective for periods on and after April 1, 2015, 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.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2015/2016 is \$420 million.

- For state fiscal years beginning April 1, 2015, 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 \$500 million. The amount allocated to each eligible public RHCFS will be in accordance with the previously approved methodology, provided, however that patient days shall be utilized for such computation reflecting actual reported data for 2013 and each representative succeeding year as applicable. Payments to eligible RHCFS's may be added to rates of payment or made as aggregate payments.

- Effective with the 2013 rate year, the Department of Health provided a new incentive to improve quality for non-specialty nursing homes by linking incentive payments to quality. Under the program, nursing homes are scored and compared on a define set of quality measures. This amendment will maintain the quality incentive program into the 2015 rate year and will continue to recognize improvement in performance as an element in the program and provide for other minor modifications.

Non-Institutional Services

- For state fiscal year beginning April 1, 2015 through March 31, 2016, continues hospital outpatient payment adjustments that increase the operating cost components of rates of payment for hospital outpatient and emergency departments on and after April 1, 2011, 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 amount to be paid will be up to \$287 million annually based on criteria and methodology set by the Commissioner of Health, which the Commissioner may periodically set through a memorandum of understanding with the New York City Health and Hospitals Corporation. Such adjustments shall be paid by means of one or more estimated payments, which shall be reconciled to the final adjustment determinations after the disproportionate share hospital payment adjustment caps have been calculated for such period under sections 1923(f) and (g) of the federal Social Security Act. Payments may be added to rates of payment or made as aggregate payments.

- Extends current provisions to services on and after April 1, 2013, 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%.

- Extends current provisions for certified home health agency administrative and general cost reimbursement limits for the periods April 1, 2015 through March 31, 2018.

- Continues, effective April 1, 2015, and thereafter, home health care Medicare maximization initiatives.

The estimated annual net decrease in gross Medicaid expenditures attributable to these cost containment initiatives contained in the budget for state fiscal year 2015/2016 is \$17.8 million.

- Effective April 1, 2015, in accordance with 42 CFR 447.56, "Limitations on Premiums and Cost Sharing", which requires that State Medicaid fee-for-service (FFS) co-payment policies have to be applied consistently across all Medicaid payers including managed care. The State Plan is being amended to expand Medicaid co-payment requirements to eligible Medicaid managed care (MMC) beneficiaries for eligible procedures, services and supplies. Specifically, the non-pharmacy services in which Medicaid managed care co-payments will apply include: clinic and non-urgent Emergency Department visits (\$3.00), lab tests (\$0.50), radiology (\$1.00), medical supplies (\$1.00), and inpatient hospitalizations (\$25.00). Consistent with the current co-payment policy, children under age 21; pregnant women; American Indians; and recipients with incomes at or below 100% of the Federal Poverty Level (FPL) will not be subject to co-payments. Additionally, the \$200 Medicaid cap that limits the total co-payment amount a recipient can be charged on annual basis will apply to both FFS and managed care. Pharmacy co-payments currently apply to managed care recipients for new prescriptions, fiscal orders and refills.

The estimated annual net aggregate decrease in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2015/2016 is \$1.9 million.

- Effective April 1, 2015, in accordance with an amendment to Section 367-a(1)(d)(iii) of the Social Services Law, cost-sharing limits will be applied to Medicare Part B cross-over services. Such limits are being applied to prevent the Medicaid program from paying any cost-sharing amount more than the maximum amount that Medicaid would pay for the same service.

Currently, Medicare Part B, which provides medical insurance for professional practitioners' services, reimburses the provider 80% of the Medicare approved amount. The remaining 20% is the Medicare Part B coinsurance or patient responsibility amount. The Medicaid program then reimburses the provider 20% of the coinsurance amount even if the Medicare payment exceeds what the Medicaid program would have paid for the same service. Under the new limitations, the Medicaid program would not pay any cost sharing if the provider received payment greater than the Medicaid fee. Under the new limitations, the Medicaid program would not pay any cost sharing if the provider received payment greater than the Medicaid fee. The provider would be required to accept the Medicare payment as full payment for the service and the recipient could not billed for any co-insurance amount that is not reimbursed by Medicaid.

The estimated annual net aggregate decrease in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2015/2016 is \$49.7 million.

- Effective April 1, 2015, in accordance with an amendment to Section 367-a(1)(d)(iv) of the Social Services Law, cost-sharing limits will be applied to Medicare Part C (Medicare Advantage or Medicare managed care) claims. Such limits are being applied to prevent the Medicaid program from paying any cost-sharing amount more than the maximum amount that Medicaid would pay for the same service.

Currently, the Medicaid program pays the full co-payment or co-insurance amounts for Medicare Part C claims, even when the provider has received more than the amount the Medicaid program would have paid for that service. Under the new limitations, the Medicaid program would not pay any co-payment/co-insurance amount if the provider received payment greater than the Medicaid amount. The provider would be required to accept the Medicare Part C health plan payment as full payment for the service and the recipient could not be billed for any co-payment/co-insurance amount that was not reimbursed by Medicaid.

In FFS Medicaid, the state reduces the payment it makes to a provider by the amount of a beneficiary's cost sharing obligation.

Appendix V
2015 Title XIX State Plan
Second Quarter Amendment
Responses to Standard Funding Questions

NON-INSTITUTIONAL SERVICES
State Plan Amendment #15-0028

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: The State and CMS are having ongoing discussions related to prior years UPLs of which the 2015 is contingent upon.

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

Response: The rate methodology included in the State Plan for freestanding diagnostic and treatment and ambulatory surgery center services or hospital outpatient services is based upon the Ambulatory Patient Group (APG) system with the exception of Federally Qualified Health Centers who have the option to opt into the APG system or remain on the Prospective Payment Methodology (PPS) as approved by CMS in SPA 01-0003. We are unaware of any requirement under current federal law or regulation that limits individual providers' payments to their actual costs.

ACA Assurances:

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

MOE Period.

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

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

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

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

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

Response: This SPA would [] / would not [✓] violate these provisions, if they remained in effect on or after January 1, 2014.

3. **Please indicate whether the State is currently in conformance with the requirements of section 1902(a)(37) of the Act regarding prompt payment of claims.**

Response: This State does comply with the requirements of section 1902(a)(37) of the Act regarding prompt payment of claims.

Tribal Assurance:

Section 1902(a)(73) of the Social Security Act the Act requires a State in which one or more Indian Health Programs or Urban Indian Organizations furnish health care services to establish a process for the State Medicaid agency to seek advice on a regular ongoing basis from designees of Indian health programs whether operated by the Indian Health Service HIS Tribes or Tribal organizations under the Indian Self Determination and Education Assistance Act ISDEAA or Urban Indian Organizations under the Indian Health Care Improvement Act.

IHCIA Section 2107(e)(I) of the Act was also amended to apply these requirements to the Children's Health Insurance Program CHIP. Consultation is required concerning Medicaid and CHIP matters having a direct impact on Indian health programs and Urban Indian organizations.

- a) Please describe the process the State uses to seek advice on a regular ongoing basis from federally recognized tribes Indian Health Programs and Urban Indian Organizations on matters related to Medicaid and CHIP programs and for consultation on State Plan Amendments waiver proposals waiver extensions waiver amendments waiver renewals and proposals for demonstration projects prior to submission to CMS.
- b) Please include information about the frequency inclusiveness and process for seeking such advice.
- c) Please describe the consultation process that occurred specifically for the development and submission of this State Plan Amendment when it occurred and who was involved.

Response: Tribal consultation was performed in accordance with the State's tribal consultation policy as approved in SPA 11-06, and documentation of such is included with this submission. To date, no feedback has been received from any tribal representative in response to the proposed change in this SPA.

**Appendix VI
2015 Title XIX State Plan
Second Quarter Amendment
Responses to Standard Access Questions**

**APPENDIX VI
NON-INSTITUTIONAL SERVICES
State Plan Amendment #15-0028**

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 continue cost saving measures previously enacted. This is an overall effort to control Medicaid spending. The change should not significantly impact providers since overall rates are being held constant, not being reduced.

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

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

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

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

the State would be alerted and would take appropriate action to ensure retention of access to such services.

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

Response: This change was enacted by the State Legislature as part of the negotiation of the 2015-2016 Budget. The impact of this change was weighed in the context of the overall Budget in the State. The legislative process provides opportunities for all stakeholders to lobby their concerns, objections, or support for various legislative initiatives.

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

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

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

Response: Over the course of the past three years, the State has undertaken a massive reform initiative to better align reimbursement with care. When fully implemented, the initiative will invest over \$600 million in the State's ambulatory care system (outpatient, ambulatory surgery, emergency department, clinic and physicians) to incentivize care in the most appropriate setting. The State has also increased its physician reimbursement schedule to resemble Medicare payments for similar services, thus ensuring continued access for Medicaid beneficiaries. While some of these initiatives are outside the scope of the State Plan, they represent some of the measures the State is taking to ensure quality care for the State's most vulnerable population.

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Freestanding Clinic Services (diagnostic and treatment facilities) Facilities Certified Under Article 28 of the State Public Health Law

Prospective, all inclusive rates calculated by Department of Health, based on the lower of the allowable average cost per visit or the group ceiling trended to the current year. For purposes of establishing rates of payment for diagnostic and treatment centers for services provided on or after April 1, 1995 through March 31, 1999, and on or after July 1, 1999 through March 31, 2000, and on and after April 1, 2000 through March 31 2003, on and after April 1, 2003 through March 31, 2011, on and after April 1, 2011 through March 31, 2013, and on and after April 1, 2013 through March 31, 2015, and on and after April 1, 2015 through March 31, 2017, the reimbursable base year administrative and general costs of a provider, excluding a provider reimbursed on an initial budget basis, shall not exceed the statewide average of total reimbursable base year administrative and general costs of diagnostic and treatment centers. For the purposes of this provision, reimbursable base year administrative and general costs shall mean those base year administrative and general costs remaining after application of all other efficiency standards, including, but not limited to, peer group cost ceilings or guidelines. The limitation on reimbursement for provider administrative and general expenses shall be expressed as a percentage reduction of the operating cost component of the rate promulgated for each diagnostic and treatment center with base year administrative and general costs exceeding the average. Facilities offering similar types of services and having similar regional economic factors are grouped and ceilings are calculated on the cost experience of facilities within the group taking into account regional economic factors such as geographic location. Costs at or below these ceilings have been determined to be reasonable. The facility-specific impact of eliminating the statewide cap on administrative and general costs, for the period April 1, 1999 through June 30, 1999 shall be included in rates of payment for facilities affected by such elimination for the period October 1, 1999 through December 31, 1999.

TN #15-0028

Approval Date _____

Supersedes TN #13-0047

Effective Date _____