



## Department of Health

ANDREW M. CUOMO  
Governor

HOWARD A. ZUCKER, M.D., J.D.  
Acting 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 #15-0029  
Non-Institutional Services

Dear Mr. Melendez:

The State requests approval of the enclosed amendment #15-0029 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 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,

A handwritten signature in black ink, appearing to read "Jason A. Helgerson", is written over the typed name and title.

Jason A. Helgerson  
Medicaid Director  
Office of Health Insurance Programs

Enclosures

<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</b>  <b>FOR: HEALTH CARE FINANCING ADMINISTRATION</b>		1. TRANSMITTAL NUMBER: <b>15-0029</b>	2. STATE <b>New York</b>
		3. PROGRAM IDENTIFICATION: <b>TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)</b>	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE <b>April 1, 2015</b>	
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: <b>§ 1902(a) of the Social Security Act, and 42 CFR 447</b>		7. FEDERAL BUDGET IMPACT: ( <i>in thousands</i> ) a. FFY 04/01/15-09/30/15 \$ .....0..... b. FFY 10/01/15-09/30/16 \$ .....0.....	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:  <b>Attachment 4.19-B: Pages 4(5), 4(6), 4(7), 4(8)</b>		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT ( <i>If Applicable</i> ):  <b>Attachment 4.19-B: Pages 4(5), 4(6), 4(7), 4(8)</b>	
10. SUBJECT OF AMENDMENT: <b>2015 CHHA Episodic Payment Extension (FMAP = 50%)</b>			
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: <b>New York State Department of Health Division of Finance and Rate Setting 99 Washington Ave – One Commerce Plaza Suite 1460 Albany, NY 12210</b>	
13. TYPED NAME: <b>Jason A. Helgerson</b>			
14. TITLE: <b>Medicaid Director Department of Health</b>			
15. DATE SUBMITTED: <b>JUN 26 2015</b>			
<b>FOR REGIONAL OFFICE USE ONLY</b>			
17. DATE RECEIVED:		18. DATE APPROVED:	
<b>PLAN APPROVED – ONE COPY ATTACHED</b>			
19. EFFECTIVE DATE OF APPROVED MATERIAL:		20. SIGNATURE OF REGIONAL OFFICIAL:	
21. TYPED NAME:		22. TITLE:	
23. REMARKS:			

New York  
4(5)

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

- (f) Interim payment adjustments pursuant to this section will be based on Medicaid paid claims for services provided by agencies in the base year 2009. Amounts due from reconciling payment adjustments will be based on Medicaid paid claims for services provided by agencies in the base year 2009 and Medicaid paid claims for services provided by agencies in the reconciliation period April 1, 2011 through March 31, 2012.
- (g) The payment adjustments will not result in an aggregate annual decrease in Medicaid payments to providers in excess of \$200 million. If upon reconciliation it is determined that application of the calculated ceilings would result in an aggregate annual decrease of more than \$200 million, all providers' ceilings would be adjusted proportionately to reduce the decrease to \$200 million. Such reconciliation will not be subject to subsequent adjustment.
- (h) The Commissioner may require agencies to collect and submit any data required to implement the provisions of this subdivision.
- (i) Effective May 2, 2012[,] through March 31, 2019, Medicaid payments for services provided by certified home health agencies, except for such services provided to children under 18 years of age and [effective May 2, 2012] except for services provided to a special needs population of medically complex and fragile children, adolescents and young disabled adults by a CHHA operating under a pilot program approved by the Department, will be based on payment amounts calculated for 60-day episodes of care. The Commissioner will establish a base price for 60-day episodes of care, and this price will be adjusted for the case mix index, which applies to each patient, and for regional wage differences. Effective May 2, 2012[,] through March 31, 2019, such case mix adjustments will include an adjustment factor for CHHAs providing care to Medicaid-eligible patients, more than 50%, but no fewer than two hundred, of whom are eligible for OPWDD services.

The initial statewide episodic base price to be effective May 2, 2012, will be calculated based on paid Medicaid claims, as determined by the Department, for services provided by all certified home health agencies during the base year period of January 1, 2009 through December 31, 2009. The base price will be calculated by grouping all paid claims in the base period into 60-day episodes of care. All such 2009 episodes, which include episodes beginning in November or December of 2008 or ending in January or

**New York  
4(6)**

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

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

To determine the case mix adjustment factor for agencies providing care to Medicaid-eligible patients of whom more than 50%, and no fewer than 200, are eligible for OPWDD services, total Medicaid claims reimbursement received by each qualified agency during the statutory base year for the Episodic Payment System (calendar year 2009 and subsequently determined base years) will be compared to the projected total reimbursement that would result from applying the episodic methodology to the same services billed in the base year. If the projected episodic reimbursement is less than the actual base year reimbursement, the percentage difference will be applied to the case mix index for all of the agency's episodic claims in order to equalize the traditional fee-for-service and estimated episodic reimbursement totals. All of the provider's episodic rates (which consist of case mix index multiplied by the statewide base price) will be increased by this percentage.

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

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

**TN**   #15-0029   **Approval Date** \_\_\_\_\_  
**Supersedes TN**   #12-0019   **Effective Date** \_\_\_\_\_

**New York  
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Payments for 60-day episodes of care shall be adjusted for high-utilization cases in which total costs, based on statewide weighted average fee-for-service rates paid on a per-visit, per-hour, or other appropriate basis, exceed outlier cost thresholds determined by the Department for each case mix group. In such cases the provider will receive the adjusted episodic base payment, plus 50% of the total costs which exceed the outlier threshold. Both the base payment and the excess outlier payment will be adjusted by the regional wage index factor. The percentage of excess costs to be reimbursed shall be subject to such further adjustment as deemed necessary to comply with the aggregate savings mandated by PHL section 3614(13)(b).

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

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

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

**TN #15-0029** \_\_\_\_\_ **Approval Date** \_\_\_\_\_  
**Supersedes TN #11-0051** \_\_\_\_\_ **Effective Date** \_\_\_\_\_

**New York  
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For services provided on and after May 1, 2012[,] through March 31, 2019, please see the website below for detailed information, which includes information related to the following components of payments for 60-day episodes of care including (as posted on March 14, 2012):

- Definition of 60-day episode of care
- Base price
- Resource groups
- Case mix indices
- Outlier thresholds
- Regional wage index factors
- Weighted average rates used to calculate total costs

[www.health.ny.gov/facilities/long\\_term\\_care/reimbursement/chha/index.htm](http://www.health.ny.gov/facilities/long_term_care/reimbursement/chha/index.htm)

For periods on and after March 1, 2014, the Commissioner of Health will increase Medicaid rates of payment for services provided by certified home health agencies (CHHA) to address cost increases stemming from the wage increases required by implementation of the provisions of section 3614-c of the Public Health Law.

The payment increase for CHHA episodic rates will equal the difference between the minimum per hour rate and the weighted average home health aide rate reflected in the 2009 episodic expenditure base[.] and subsequently determined episodic base periods. This amount will be further adjusted for accurate application to the episodic bundled payment to insure the adjustment is applied to the estimated home health aide portion of the episodic payment and not to the estimated professional nursing and therapy services portions of the payment. An adjustment is also made to reflect the minimum home health aide rate in the low utilization and outlier components of the rate calculation.

For CHHA non-episodic rates (the payment for qualified individuals under 18 years of age), an add-on will be provided which represents the difference between the home health hourly rate in the current rate and the minimum home health aide hourly rate.

TN   #15-0029   Approval Date \_\_\_\_\_  
Supersedes TN   #14-0010   Effective Date \_\_\_\_\_

**Appendix I**  
**2015 Title XIX State Plan**  
**Second Quarter Amendment**  
**Amended SPA Pages**



**Appendix II**  
**2015 Title XIX State Plan**  
**Second Quarter Amendment**  
**Summary**

**SUMMARY**  
**SPA #15-0029**

This State Plan Amendment proposes to extend episodic pricing to certified home health agencies for periods April 1, 2015 through March 31, 2019.

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

SPA #15-0029  
Chapter 60 of the Laws of 2015

Part D

§ 22. Paragraph (a) of subdivision 13 of section 3614 of the public health law, as added by section 4 of part H of chapter 59 of the laws of 2011, is amended to read as follows: (a) Notwithstanding any inconsistent provision of law or regulation and subject to the availability of federal financial participation, effective April first, two thousand twelve through March thirty-first, two thousand ~~fifteen~~ nineteen, payments by government agencies for services provided by certified home health agencies, except for such services provided to children under eighteen years of age and other discreet groups as may be determined by the commissioner pursuant to regulations, shall be based on episodic payments. In establishing such payments, a statewide base price shall be established for each sixty day episode of care and adjusted by a regional wage index factor and an individual patient case mix index. Such episodic payments may be further adjusted for low utilization cases and to reflect a percentage limitation of the cost for high-utilization cases that exceed outlier thresholds of such payments.

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

regardless of whether or not the provider has collected the payment or waived the cost sharing. The State will reduce the MMC premiums by the amount of a beneficiary's cost sharing obligation. As in FFS Medicaid, MMC providers have an obligation not to deny goods and services for beneficiaries who are unable to meet their co-payment requirements.

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 \$41.7 million.

• Continues, effective April 1, 2015 and thereafter, 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.

Prescription Drugs

• Effective May 1, 2015, for sole or multiple source brand name drugs the Estimated Acquisition Cost (EAC) is defined as Average Wholesale Price (AWP) minus twenty four (24) percent, or Wholesale Acquisition Cost (WAC) minus nine (9) percent. For multi-source generic drugs, the EAC remains as currently defined without change. In addition, the dispensing fee for sole or multiple source brand name drugs is \$8.00. For multi-source generic drugs, the dispensing fee remains unchanged.

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 \$18 million.

• Effective April 1, 2015, for 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) or by such covered entity's authorized contract pharmacy, payment shall be at the covered entity's actual acquisition cost for the drug. "Actual acquisition cost" is defined as the invoice price for the drug to the covered entity minus the amount of all discounts and other cost-reductions attributable to the drug.

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 \$21.9 million.

The overall estimated annual net aggregate increase in gross Medicaid expenditures attributable to reform and other initiatives contained in the budget for state fiscal year 2015/2016 is \$114.2 million; and the estimated annual net aggregate increase in gross Medicaid expenditures attributable to an extension of upper payment limit (UPL) payments for state fiscal year 2015/2016 is \$2.2 billion.

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](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, e-mail: [spa\\_inquiries@health.state.ny.us](mailto:spa_inquiries@health.state.ny.us)

PUBLIC NOTICE

Otsego County

Otsego County is soliciting proposals from Administrative Service Agencies, Trustees, and Financial Organizations for services in connection with a Deferred Compensation Plan that will meet the requirements of Section 457 of the Internal Revenue Code and Section 5 of the State Finance Law, including all rules and regulations issued pursuant thereto.

A copy of the proposal questionnaire may be obtained from: Deborah Zvirzdin, Purchasing Agent, 197 Main St., Cooperstown, NY 13326; e-mail address: [zvirzdind@otsegocounty.com](mailto:zvirzdind@otsegocounty.com)

All proposals must be submitted not later than 30 days from the date of publication in the New York State Register.

PUBLIC NOTICE

Department of Taxation and Finance  
Interest Rates

The Commissioner of Taxation and Finance hereby sets the interest rates for the months of April, May, June, 2015 pursuant to sections 697(j) and 1096(e) of the Tax Law, as follows:

For purposes of section 697(j) the overpayment rate of interest is set at 2 percent per annum, and the underpayment rate of interest is set at 7.5 percent per annum. For purposes of section 1096(e), the overpayment rate of interest is set at 2 percent per annum, and the underpayment rate of interest is set at 7.5 percent per annum. (The underpayment rates set pursuant to sections 697(j) and 1096(e) may not be less than 7.5 percent per annum.) Pursuant to section 1145(a)(1) of the Tax Law, the underpayment rate for State and local sales and use taxes administered by the Commissioner of Taxation and Finance is 14.5 percent per annum. The underpayment rate for the special assessments on hazardous waste imposed by section 27-0923 of the Environmental Conservation Law is 15 percent.

For the interest rates applicable to overpayments (refunds) and underpayments (late payments and assessments) of the following taxes administered by the Commissioner of Taxation and Finance for the period April 1, 2015 through June 30, 2015, see the table below:

4/1/15 - 6/30/15  
Interest Rate Per  
Annum  
Compounded Daily

Commonly viewed tax types	Refunds	Late Payments & Assessments
Income **	2%	7.5%
Sales and use	2%	14.5% *
Withholding	2%	7.5%
Corporation **	2%	7.5%
All other tax types	Refunds	Late Payments & Assessments
Alcoholic Beverage	2%	7.5%
Beverage Container Deposits	2%	7.5%

# 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 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.

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](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](mailto: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

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

**NON-INSTITUTIONAL SERVICES  
State Plan Amendment #15-0029**

**CMS Standard Funding Questions**

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

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

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

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

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

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

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

4. **For clinic or outpatient hospital services please provide a detailed description of the methodology used by the state to estimate the upper**

**payment limit (UPL) for each class of providers (State owned or operated, non-state government owned or operated, and privately owned or operated). Please provide a current (i.e., applicable to the current rate year) UPL demonstration.**

**Response:** This question is not applicable for this SPA, as CHHA services are not clinic services.

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

**Response:** The State is unaware of any requirement under current federal law or regulation that limits individual provider payments to their actual costs.

**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 #15-0029**

**CMS Standard Access Questions**

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

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

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

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

**Response:** The State has various ways to ensure that access levels in the Medicaid program are retained and is currently not aware of any access issues. Certain classes of providers must notify and receive approval from the Department's Office of Health Systems Management or the Office of Long Term Care, as applicable, in order to discontinue services. These offices monitor and consider such requests in the context of access as they approve/deny changes in services. Finally, providers cannot discriminate based on source of payment.

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

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

**Response:** This change was recommended by the Medicaid Redesign Team. The Department engaged in discussions with appropriate stakeholders which included providers and industry associations; held multiple regional hearings; and solicited ideas through a public process. 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.

- 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:** This amendment is part of the Medicaid Reform initiatives which includes shifting many current home care patients into managed long term care programs or other care management program models.