



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare &
Medicaid Services

Refer to DMCH: SJ

Region II
Federal Building
26 Federal Plaza
New York, N.Y. 10278

Jason A. Helgerson
Deputy Commissioner
New York State Department of Health
Corning Tower
Empire State Plaza
Albany, New York 12237

Dear Commissioner Helgerson:

This is to notify you that New York State Plan Amendment (SPA) #09-19 has been approved for adoption into the State Medicaid Plan with an effective date of January 1, 2009. The SPA concerns rates of payment for outpatient general hospitals, home health services including services provided to home care patients diagnosed with AIDS, personal care services and adult day health care services. The SPA revises the statutorily mandated adjustments to 2009 rates reflecting the application of final calendar year CPI related trend adjustments by a reduction of 1.3%, and in computing rates for services provided on and after January 1, 2009, no final adjustments to the 2008 calendar year trend will be applied with regard to the period April 1 to December 31, 2008.

This SPA approval consists of 6 Pages. As New York has requested, we are approving the following 14 Attachment 4.19-B Pages which was submitted by the State on October 26, 2011: Attachment 4.19-B-Page 1(b)(i), 2(b)(ii), 2(c), 4(1), 6(a), and 7(a)(ii). These 6 Pages replace all previously Pages that were submitted at various times by the State for SPA #09-19. In addition, we are processing the SPA using the HCFA-179 which was provided by the State to CMS on October 26, 2011.

This amendment satisfies all of the statutory requirements at sections 1902(a)(13) and (a)(30) of the Social Security Act, and the implementing regulations at 42 CFR 447.250 and 447.272. Enclosed are copies of #09-19 and the HCFA-179 form, as approved.

If you have any questions or wish to discuss this SPA further, please contact Ricardo Holligan or Shing Jew of this office. Mr. Holligan may be reached at (212) 616-2424, and Mr. Jew's telephone number is (212) 616-2426.

Sincerely,

Michael Melendez
Associate Regional Administrator
Division of Medicaid and Children's Health

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL		1. TRANSMITTAL NUMBER: 09-19	2. STATE New York
FOR: HEALTH CARE FINANCING ADMINISTRATION		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
		4. PROPOSED EFFECTIVE DATE: January 1, 2009	
5. TYPE OF PLAN MATERIAL (<i>Check One</i>): ☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT			
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (<i>Separate Transmittal for each amendment</i>)			
6. FEDERAL STATUTE/REGULATION CITATION: Section 1902(a)(30) of the Social Security Act 42 CFR Part 447.204		7. FEDERAL BUDGET IMPACT: a. FFY 01/01/09 - 09/30/09 (\$16,069,840) b. FFY 10/01/09 - 09/30/10 (\$21,926,040)	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-B: Pages 1(b)(i), 2(b)(ii), 2(c), 4(1), 6(a), 7(a)(ii)		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (<i>If Applicable</i>): Attachment 4.19-B: Pages 1(b)(i), 2(b)(ii), 2(c), 4(1), 6(a), 7(a)(ii)	
10. SUBJECT OF AMENDMENT: Non-Institutional Trend Factor Adjustment (FMAP = 58.78% (1/1/09-3/31/09); 60.19% (4/1/09-6/30/09); 61.59% (7/1/09-9/30/10))			
11. GOVERNOR'S REVIEW (<i>Check One</i>): ☒ GOVERNOR'S OFFICE REPORTED NO COMMENT ☐ OTHER, AS SPECIFIED: ☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED ☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL			
12. [REDACTED] STATE AGENCY OFFICIAL:		16. RETURN TO: New York State Department of Health Corning Tower Empire State Plaza Albany, New York 12237	
13. TYPED NAME: Jason A. Helgeson			
14. TITLE: Medicaid Director & Deputy Commissioner Department of Health			
15. DATE SUBMITTED: October 26, 2011			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED		18. DATE APPROVED December 22, 2011	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL January 1, 2009		20. SIGNATURE OF REGIONAL OFFICIAL: [REDACTED]	
21. TYPED NAME Michael Melendez		22. TITLE Associate Regional Administrator Division of Medicaid and Children Health Operations	
22. REMARKS Non-Institutional Trend Factor Adjustment For 2008-2009			

OFFICIAL

**New York
1(b)(i)**

**Attachment 4.19-B
(01/09)**

For outpatient services provided by general hospitals as noted in the proceeding paragraphs of this Section, beginning on and after April 1, 2006, the Commissioner of Health shall apply a trend factor projection of 2.25% attributable to the period January 1, 2006 through December 31, 2006. Upon reconciliation of this trend factor, in accordance with the previously approved state methodology, the final 2006 trend factor shall be the U.S. Consumer Price Index (CPI) for all Urban Consumers, as published by the U.S. Department of Labor, Bureau of Labor Statistics, minus 0.25%.

For reimbursement of outpatient hospital services provided on and after April 1, 2007, the Commissioner of Health shall apply a trend factor projection equal to 75% of the otherwise applicable trend factor for calendar year 2007.

For reimbursement of outpatient hospital services provided on and after April 1, 2008, the Commissioner of Health shall apply a trend factor projection equal to 65% of the otherwise applicable trend factor for calendar year 2008, as calculated in accordance with the general Trend Factor section of this Attachment.

For rates of payment effective for outpatient hospital services provided on and after [September 11, 2008] January 1, 2009, the otherwise applicable final trend factor attributable to the 2008 calendar year period shall be adjusted such that any increase to the average trend factor for the period April 1, 2008 through December 31, 2008 shall be reduced, on an annualized basis, by 1.3%. However, no retroactive adjustment to such trend factor will be made for the period April 1, 2008 through December 31, 2008.

For rates of payment effective for outpatient hospital services provided on and after January 1, 2009, a trend factor equal to the otherwise applicable trend factor attributable to the period January 1, 2009 through December 31, 2009, less 1% shall be applied.

All rates are subject to approval by the Division of the Budget. For emergency room services only, a retrospective adjustment may be made if it is determined that patients requiring general clinical services are provided such services in the emergency room for the sole purpose of maximizing reimbursement.

TN	<u> #09-19 </u>	Approval Date	<u> DEC 22 2011 </u>
Supersedes TN	<u> #08-32 </u>	Effective Date	<u> JAN 01 2009 </u>

OFFICIAL

New York
2(b)(ii)

**Attachment 4.19-B
(01/09)**

For rates of payment effective for outpatient hospital services provided on and after [September 11, 2008] January 1, 2009, the otherwise applicable final trend factor attributable to the 2008 calendar year period shall be adjusted such that any increase to the average trend factor for the period April 1, 2008 through December 31, 2008 shall be reduced, on an annualized basis, by 1.3%. However, no retroactive adjustment to such trend factor will be made for the period April 1, 2008 through December 31, 2008.

For rates of payment effective for outpatient hospital services provided on and after January 1, 2009, a trend factor equal to the otherwise applicable trend factor attributable to the period January 1, 2009 through December 31, 2009, less 1% shall be applied.

TN #09-19 _____

Approval Date DEC 22 2011

Supersedes TN #08-32 _____

Effective Date JAN 01 2009

OFFICIAL

New York
2(c)

Attachment 4.19-B
(04/08)

Hospital Based Outpatient Department

Facilities Certified Under Article 28 of the Public Health Law as Hospital-Based Outpatient Departments

Services for Pregnant Women

Visit based rates of payment have been calculated for three discrete clinic services provided to pregnant women, for each service a discrete price has been established. The prices have been regionally adjusted to reflect regional differences in labor and facility overhead costs and an economic trend factor has been applied to make the prices prospective.

For outpatient services provided by general hospitals, beginning on and after April 1, 2006, the Commissioner of Health shall apply a trend factor projection of 2.25% attributable to the period January 1, 2006 through December 31, 2006. Upon reconciliation of this trend factor, in accordance with the previously approved state methodology, the final 2006 trend factor shall be the U.S. Consumer Price Index (CPI) for all Urban Consumers, as published by the U.S. Department of Labor, Bureau of Labor Statistics, minus 0.25%.

Effective for services provided on and after January 1, 2007 and April 1 of each state fiscal year thereafter, the Commissioner of Health shall adjust prenatal care assistance program rates to effect a cost of living adjustment (COLA). This COLA will be calculated in accordance with the general Trend Factor section of this Attachment.

For reimbursement of outpatient services provided by general hospitals, provided on and after April 1, 2007, the Commissioner of Health shall apply a trend factor projection equal to 75% of the otherwise applicable trend factor for calendar year 2007, as calculated in accordance with the general Trend Factor section of this Attachment.

For reimbursement of outpatient services provided by general hospitals, provided on and after April 1, 2008, the Commissioner of Health shall apply a trend factor projection equal to 65% of the otherwise applicable trend factor for calendar year 2008, as calculated in accordance with the general Trend Factor section of this Attachment.

For rates of payment effective for outpatient hospital services provided on and after [September 11, 2008] January 1, 2009, the otherwise applicable final trend factor attributable to the 2008 calendar year period shall be adjusted such that any increase to the average trend factor for the period April 1, 2008 through December 31, 2008 shall be reduced, on an annualized basis, by 1.3%. However, no retroactive adjustment to such trend factor will be made for the period April 1, 2008 through December 31, 2008.

For dates of service beginning on December 1, 2008 through March 31, 2010, for hospital outpatient clinic services, the operating component of rates shall be reimbursed through the Ambulatory Patient Group (APG) classification and reimbursement system.

TN #09-19

Approval Date

DEC 22 2011

Supersedes TN #08-32

Effective Date

JAN 01 2009

OFFICIAL

New York
4(1)

Attachment 4.19-B
(01/09)

Home Health Services/Certified Home Health Agencies

Prospective, cost based hourly and per visit rates for five services shall be calculated by the Department of Health and approved by Division of the Budget. Rates are based on the lower of cost or ceiling, trended or, if lower, the charge provided, however, for services on and after April 1, 2008, the Commissioner of Health shall apply a trend factor projection equal to 65% of the otherwise applicable trend factor for calendar year 2008, as calculated in accordance with the general Trend Factor section of this Attachment.

For rates of payment effective for services provided on and after [September 11, 2008] January 1, 2009, the otherwise applicable final trend factor attributable to the 2008 calendar year period shall be adjusted such that any increase to the average trend factor for the period April 1, 2008 through December 31, 2008 shall be reduced, on an annualized basis, by 1.3%. However, no retroactive adjustment to such trend factor will be made for the period April 1, 2008 through December 31, 2008.

For rates of payment effective for services provided on and after January 1, 2009, a trend factor equal to the otherwise applicable trend factor attributable to the period January 1, 2009 through December 31, 2009, less 1% shall be applied.

TN #09-19 _____

Approval Date DEC 22 2007

Supersedes TN #08-32 _____

Effective Date JAN 01 2009

OFFICIAL

New York
6(a)

Attachment 4.19-B
(01/09)

Out-of-State Services

Fee-based providers:

Those providers who meet their state's licensure/certification requirements are reimbursed charges up to the appropriate New York State fee, for services rendered.

HMO's and Prepaid Health Plans

Monthly capitation rates established through negotiation with the Department of Health and approved by the Division of the Budget are in compliance with 42 CFR Part 434, Part 442.302 and Part 447.361 including all federal requirements for the reimbursement methodology.

Personal Care Services

For personal care services provided pursuant to a contract between a social services district and a voluntary, proprietary or public personal care services provider, payment is made at the lower of the provider's charge to the general public for personal care services or a rate the Department establishes for the provider, subject to the approval of the Director of the Budget, in accordance with a cost-based methodology. Under the cost-based methodology, the Department determines a provider's rate based upon the provider's reported allowable costs, as adjusted by annual trend factors provided, however, for services on and after April 1, 2008, the Commissioner of Health shall apply a trend factor projection equal to 65% of the otherwise applicable trend factor for calendar year 2008, as calculated in accordance with the general Trend Factor section of this Attachment.

For rates of payment effective for personal care services provided on and after [September 11, 2008] January 1, 2009, the otherwise applicable final trend factor attributable to the 2008 calendar year period shall be adjusted such that any increase to the average trend factor for the period April 1, 2008 through December 31, 2008 shall be reduced, on an annualized basis, by 1.3%. However, no retroactive adjustment to such trend factor will be made for the period April 1, 2008 through December 31, 2008.

For rates of payment effective for personal care services provided on and after January 1, 2009, a trend factor equal to the otherwise applicable trend factor attributable to the period January 1, 2009 through December 31, 2009, less 1% shall be applied.

The provider's rate includes payment for the provider's reported allowable trended costs only in an amount that does not exceed the ceilings for allowable costs that the Department has established for all providers in the applicable geographic group to which the provider belongs. The rate includes an adjustment for profit, for proprietary providers, or surplus, for voluntary providers.

TN #09-19 _____

Approval Date DEC 22 2011

Supersedes TN #08-32 _____

Effective Date JAN 01 2009

OFFICIAL

**New York
7(a)(ii)**

**Attachment 4.19-B
(01/09)**

For rates of payment effective for adult day health care services provided on and after [September 11, 2008] January 1, 2009, the otherwise applicable final trend factor attributable to the 2008 calendar year period shall be adjusted such that any increase to the average trend factor for the period April 1, 2008 through December 31, 2008 shall be reduced, on an annualized basis, by 1.3%. However, no retroactive adjustment to such trend factor will be made for the period April 1, 2008 through December 31, 2008.

For rates of payment effective for adult day health care services provided on and after January 1, 2009, a trend factor equal to the otherwise applicable trend factor attributable to the period January 1, 2009 through December 31, 2009, less 1% shall be applied.

TN #09-19 _____

Approval Date DEC 22 2011

Supersedes TN #08-32 _____

Effective Date JAN 01 2009



Department of Health & Human Services
Centers for Medicare & Medicaid Services
26 Federal Plaza Room 37-100
New York, N.Y. 10278



Memorandum

To: NYRO

From: NYRO

Date: 03/31/09, 10/26/11

Subject: NY ☒ NJ ☐ PR ☐ VI ☐ SPA # 09-19 (fill in)

Date Received in ROII: 03/31/09, 10/26/11 FAXED ☐ FED EX ☐ OTHER ☒

Subject of Amendment: Non-INSTITUTIONAL TREND FACTOR ADJUSTMENT FOR 2008-2009

The attached State Plan Amendment (SPA) request requires your analysis and recommendation for approval, disapproval, withdrawal or modification. Please route a copy of correspondence to CO/the State to me for Status of Plan updating and filing.

COPY TO CO _____ (YES IF CHECKED – only in the case of 4.19A and 4.19D Institutional).

Copy of this form to :
Branch Chief, Geographic Area
FILE

STATE PLAN ANALYSIS

APPROVED ✓
(check if yes)

Effective date only if different from date on HCFA-179 _____

PLEASE LIST APPROVED PAGES BELOW AND ATTACH PAGES TO THIS FORM:

ATTACHMENT 4.19-B- PAGE 1(b)(i)

2(b)(ii)

2(c)

4(i)

6(a)

7(a)(ii)

TOTAL = 6 PAGES

RECOMMENDATION:

APPROVABLE AS SUBMITTED _____

APPROVABLE WITH REVISIONS ✓

NOT APPROVABLE _____

Shing Lee 11/14/11
Analyst Signature of Approval

Holligan, Ricardo E. (CMS/NC)

From: Payne, Candice J. (CMS/CMCS)
Sent: Thursday, December 22, 2011 4:22 PM
To: CMS OSN
Cc: Pratt, Theresa A. (CMS/CMCS); Hentz, Cynthia J. (CMS/CMCS); CMS R5DMCHOP2; Allen, Richard C. (CMS/CMCHO); Battaglia, Laurie H. (CMS/CPI); Bosstick, Suzanne R. (CMS/CMCS); Brown, Carolyn D. (CMS/MC); Couch, Thomas R. (CMS/SC); CMS SPA_Waivers_DEHPG_DIHS_CO; Crystal, Frances C. (CMS/CMCS); Easley, Marguerite (CMS/CMCHO); Egan, Roseanne (CMS/CMHPO); Fan, Kristin A. (CMS/CMCS); Farrell, Billy B. (CMS/SC); Farris, James R. (CMS/CQISCO); Fico, Joseph A. (CMS/WC); Franklin, Shantell L. (CMS/MC); Freund, Alan F. (CMS/CMCHO); Garner, Angela D. (CMS/CMCS); Garner, Jackie S. (CMS/CMCHO); Gaskins, Sheri P. (CMS/CMCS); Glaze, Jackie L. (CMS/CMCHO); Hain, Ginni M. (CMS/CMCS); Hardwick, Claire M. (CMS/CMCS); Hatcher, Karen S. (CMS/MC); Hughes, Ruth A. (CMS/CMCHO); John, Abraham (CMS/CMCS); Johnson, Verlon (CMS/OA); Kahn, Mary M. (CMS/OPE); Lee, Hye Sun (CMS/CMCHO); Lloyd, Beth E. (CMS/CMCS); Mackay, Charles K. (CMS/CMCS); Marks, Marsha L. (CMS/SC); McCloy, Tamara M. (CMS/CMHPO); McGreal, Richard R. (CMS/NC); McKesson, Ruth M. (CMS/CMCS); Meacham, David L. (CMS/WC); Melendez, Michael (CMS/CMCHO); Mertel, Jan E. (CMS/WC); Meyers, Anna C. (CMS/CMCS); Mirach, Harry A. (CMS/CMCHO); Nagle, Gloria (CMS/CMCHO); Noonan, Darlene F. (CMS/CMCHO); OConnor, Nancy B. (CMS/CMHPO); Poisal, Kathryn J. (CMS/CMCS); Pratt, Theresa A. (CMS/CMCS); Reed, Larry L. (CMS/CMCS); Reed, Maria R. (CMS/CMCS); Reese, Yolanda (CMS/CMCS); Scott, James G. (CMS/CMCHO); Smith, Carrie A. (CMS/CMCS); Strauss, Richard (CMS/CMCS); Tarantino, Jan V. (CMS/OCSQ); Tavener, Linda A. (CMS/CMCS); Trudel, Roy R. (CMS/CMCS); Truman, Joel S. (CMS/CPI); Wilson, Derrick A. (CMS/OEA); Alberino, Julie R. (CMS/CMCHO); Holligan, Ricardo E. (CMS/NC); Khan, Farooq A. (CMS/OSORA); Turner, Trudy J. (CMS/WC); Boston, Beverly A. (CMS/CMCS); Nose, Stephen (CMS/WC); Allen, Richard C. (CMS/CMCHO); Holly, Mary V. (CMS/CMCHO); Grano, Nancy E. (CMS/NC); Garner, Angela D. (CMS/CMCS); Harris, Monica F. (CMS/CPI); Keller, Betty S. (CMS/CMCS); Hoang, Dzung A. (CMS/CMCHO); Holmes, William J. (CMS/WC); Corddry, Mary C. (CMS/CMCS); Riddle, Cynthia A. (CMS/CMCHO); Peverly, Carol J. (CMS/CMCHO); McCarthy, Daniel P. (CMS/CMCS); Marchioni, Mary A. (CMS/WC); Gerhardt, Christine R. (CMS/CMCS); Rich, Irvin J. (CMS/NC); Heffron, Dianne E. (CMS/CMCS); Klimon, Nancy L. (CMS/CMCS); Billy, Indy A. (CMS/CMCS); Gerrits, Diane T. (CMS/CMCS); Randle, Ronetta D. (CMS/CMCS); Boben, Paul J. (CMS/CMCS); Harris, Melissa L. (CMS/CMCS); Chen, Jenny C. (CMS/CMCHO); Jones, Mary B. (CMS/WC); Hicks, Daphne D. (CMS/CMCHO); Taube, Angela B. (CMS/CMCS); Mills, Stephen C. (CMS/NC); Williams, Barbara A. (CMS/CMCS); Williamson, Barbara (CMS/CMCHO); Weidler, Timothy A. (CMS/MC); Hughes, Ruth A. (CMS/CMCHO); Watchorn, Marge L. (CMS/CMCS); Dobson, Camille (CMS/CMCS); Buress, Sharonda L. (CMS/CMCS); Holt, Kathryn (CMS/CMCHO); McCarthy, Julie (CMS/CMCHO); Gilbert, Rosario G. (CMS/SC); Moore, Tonya A. (CMS/CMCS); Corbin, Angela T. (CMS/CMCS); CMS SPA_Waivers_Seattle_R10; Gillette, Nicole (CMS/CMCS); Anthony, Jodie M. (CMS/CMCS); Proper, Cindy M. (CMS/CMCS); Taube, Angela B. (CMS/CMCS); Tankersley, Michael (CMS/CMCS); Ker, Kara (CMS/CMCS); Jarosinski, Donna Y. (CMS/CMCS); Mikow, Asher S. (CMS/CMCS); McCarthy, Robert D. (CMS/CMCHO); Feild, Rosemary A. (CMS/NC); Fine, Joseph L. (CMS/CMCS); Chickering, Maria (CMS/CDMCHO); Kaufman, Nicole L. (CMS/CMCS); Straley, Kyle (CMS/MC); Garza, Maria I. (CMS/WC); Joyce, Tannisse L. (CMS/MC); McGreal, Richard R. (CMS/NC); Glaze, Jackie L. (CMS/CMCHO); Johnson, Verlon (CMS/OA); Brooks, Bill D. (CMS/CMCHO); Scott, James G. (CMS/CMCHO); Allen, Richard C. (CMS/CMCHO); Nagle, Gloria (CMS/CMCHO); Jensen, Richard (CMS/CMCS); Nablo, Linda (CMS/CMCS); Lillie-Blanton, Marsha D. (CMS/CMCS); Hain, Ginni M. (CMS/CMCS); Lollar, Ralph F. (CMS/CMCS); Reed, Larry L. (CMS/CMCS); Hall, Mike. (CMS/CMCS); Pratt, Theresa A. (CMS/CMCS); Olin, Elaine M. (CMS/CMCS); Freeze, Janet G. (CMS/CMCS); Heffron, Dianne E. (CMS/CMCS); Wachino, Victoria A. (CMS/CMCS); Reed, Maria R. (CMS/CMCS); Ryan, Jennifer (CMS/CMCS); Jensen, Richard (CMS/CMCS); Lillie-Blanton, Marsha D. (CMS/CMCS); Edwards, Barbara C. (CMS/CMCS); Burnett, Jennifer (CMS/CMCS); Williams, John H. (CMS/CMCS); Raschke, Karen S. (CMS/CMCS); Gorman, James L. (CMS/CMCS); Hulbert, Melissa S. (CMS/CMCS); Perkins, Ronald W. (CMS/CMCS); DaSilva, Gilson F. (CMS/CMCHO); Novo, Don (CMS/CMCHO); Guhl, John R. (CMS/CMCHO); McCullough, Francis T. (CMS/CMCHO);

Due Date	CO Date Received	SPA/waiver number	OSN description
01/08/12	12/14/11	MS 0355.R02.01	Approval of HCBS waiver amendment to remove the limitation on the number of clients individual case managers may serve and the requirement for monthly calls and quarterly face-to-face meetings between clients and case managers.
01/09/12	12/15/11	MA 40207.R01.01	Approval of HCBS autism waiver amendment to increase the number of participants from 170 to 205 for years 2-5 of the waiver, to update utilization and expenditure estimates to reflect cost, and to update the SMD contact information.
01/17/12	11/28/11	WA 0049.R06.03	Approval of HCBS waiver amendment for COPES waiver, which adds adult day health services no longer offered under 1915(i), and increases unduplicated participants from 35,965 to 36,782
01/24/12	11/14/11	NY SPA 09-19	Approval of SPA to revise rates for several non-institutional services effective 1/1/2009. The SPA revises the statutorily mandated adjustments to 2009 rates reflecting the application of final calendar year CPI related trend adjustments by a reduction of 1.3%.
01/24/12	11/14/11	NY SPA 09-23-A	Approval of SPA to continue previously enacted cost saving measures which were to sunset, for hospital outpatient clinic, ER, home health, adult day health and freestanding clinic services. Must be approved after or concurrently with NY SPA 09-19.
01/25/12	12/01/11	CA SPA 11-032	Approval of SPA to delay RAC implementation. The State has initiated procurement and developed and RFP and scope of work.
01/26/12	12/07/11	WV 0876.R00.00	Approval of a new HCBS traumatic brain injury waiver to serve 94 people
01/31/12	11/30/11	WY SPA 10-010	Approval of SPA to ask for an exception to the RAC implementation date of 01/01/12 and anticipates that the implementation date will be 06/01/12. Implementation timeline included with SPA.

Jew, Shing (CMS/NC)

From: Jew, Shing (CMS/NC)
Sent: Monday, November 14, 2011 7:33 AM
To: Holligan, Ricardo E. (CMS/NC); Guhl, John R. (CMS/CMCHO); Melendez, Michael (CMS/CMCHO)
Cc: Weaver, Robert K. (CMS/CMCS)
Subject: osn's for ny spa 09-19 (to be processed first) and 09-23-A (process after 09-19)
Attachments: osny0919.doc; osny0923A.doc

NY spas 09-19 and 09-23-A have been reviewed by cms co and ro staff and the 2 spas are recommended for approval. Please review and forward the attached osn's to co for their consideration and action. Please advise co that the osn for 09-19 should be processed first, since we must complete action on 09-19 before we can do anything with spa 09-23-A. Both spas are on ny's latest priority list and they would like to get them processed as soon as possible. Day 90 for both spas is 1/24/12. If you should have any questions or wish to discuss either or both spas further, please let me know. Thank you.

11/14

Ricardo,

Please ~~to~~ hold until the osn for 09-19
has cleared before giving to Maribel
for approval processing.
Day 90 is 1/24/12.

Thanks,

SLJ

OS Notification

Title/Plan Number: New York State Plan Amendment (SPA) #09-19

Type of Action: The SPA concerns non-institutional services related to rates of payment for outpatient general hospitals and adult day health care center services

Required Date for State Notification: Day 90 for the SPA will be January 24, 2012. However, New York State would like to have the SPA processed and be notified as quickly as possible.

Fiscal Impact: \$ 16,069,840 savings in Federal Financial Participation (FFP) for Federal Fiscal Year (FFY) 2008-2009 (October 1, 2008-September 30, 2009). For FFY 2009-2010 (October 1, 2009-September 30, 2010), the FFP impact also will be a savings, in the amount of \$ 21,926,040.

Number of People Affected by Enhanced Coverage, Benefits or Retained Eligibility:
Not Applicable

Number of People Affected by Eligibility Change: Not Applicable

Eligibility Simplification: Yes/No

Provider Payment Increase: Yes/No or **Decrease:** Yes/No

Delivery Systems Innovation: Yes/No

Number of People Losing Medicaid Eligibility: Not Applicable

Reduces Benefits: Yes/No

Detail: SPA #09-19, with a proposed effective date of January 1, 2009, concerns rates of payment for outpatient general hospitals, home health services including services provided to home care patients diagnosed with AIDS, personal care services and adult day health care services. The SPA revises the statutorily mandated adjustments to 2009 rates reflecting the application of final calendar year CPI related trend adjustments by a reduction of 1.3%, and in computing rates for services provided on and after January 1, 2009, no final adjustments to the 2008 calendar year trend will be applied with regard to the period April 1 to December 31, 2008.

The SPA has been pending until this time due to the Outpatient UPL and other programmatic issues associated with the SPA, which have now been resolved.

The State has satisfactorily responded to the standard funding questions.

Although the State has indicated savings on the 179, there is no reduction in rates and there are no access issues. The SPA provides that in 2009, rate computations will not make any adjustments to the 2008 calendar year trend factor which would have normally been made.

The SPA does not require tribal consultation.

New York has assured that it is in compliance with the terms of the Recovery Act concerning (1) Maintenance of Effort (MOE); (2) State or local match; (3) Prompt payment; (4) Rainy day funds; and (5) Eligible expenditures (e.g. no DSH or other enhanced match payments).

Other Considerations: None

CMS Contact: Michael Melendez
Associate Regional Administrator, Region 2
Division of Medicaid and Children's Health
212-616-2430



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare &
Medicaid Services

Refer to DMCH: SJ

Region II
Federal Building
26 Federal Plaza
New York, N.Y. 10278

Jason A. Helgeson
Deputy Commissioner
New York State Department of Health
Corning Tower
Empire State Plaza
Albany, New York 12237

Dear Commissioner Helgeson:

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This SPA approval consists of 6 Pages. As New York has requested, we are approving the following 14 Attachment 4.19-B Pages which was submitted by the State on October 26, 2011: Attachment 4.19-B-Page 1(b)(i), 2(b)(ii), 2(c), 4(1), 6(a), and 7(a)(ii). These 6 Pages replace all previously Pages that were submitted at various times by the State for SPA #09-19. In addition, we are processing the SPA using the HCFA-179 which was provided by the State to CMS on October 26, 2011.

This amendment satisfies all of the statutory requirements at sections 1902(a)(13) and (a)(30) of the Social Security Act, and the implementing regulations at 42 CFR 447.250 and 447.272. Enclosed are copies of #09-19 and the HCFA-179 form, as approved.

If you have any questions or wish to discuss this SPA further, please contact Ricardo Holligan or Shing Jew of this office. Mr. Holligan may be reached at (212) 616-2424, and Mr. Jew's telephone number is (212) 616-2426.

Sincerely,

Michael Melendez
Associate Regional Administrator
Division of Medicaid and Children's Health

DMCH: SL 11/14/11

AM 12/22/11

[Handwritten signature]

Enclosure: SPA #09-19
HCFA-179 Form

CC: JUlberg
PMossman
KKnuth
RWeaver
LTavener
MRoss
AHiggs
MSchervish
GCritelli
PMarra
SJew

Lopez, Maribel (CMS/CMCHO)

From: Karla Knuth [khk02@health.state.ny.us]
Sent: Wednesday, October 26, 2011 11:45 AM
To: CMS SPA_Waivers_NewYork_R02
Cc: sjao3@health.state.ny.us; Philip N. Mossman; Stephanie Fagnoli
Subject: Resubmission of 09-19
Attachments: Resubmission of 09-19 (CMS 10-26-11).pdf

Attached for your review and approval is the re-submission of NY SPA 09-19. If you need anything further, please let me know.
Thanks.

(See attached file: Resubmission of 09-19 (CMS 10-26-11).pdf)

Alone we can do so little; together we can do so much - Helen Keller

Karla Knuth :o)
Medicaid State Plan Coordinator &
Assoc Health Care Mgmt Systems Analyst
NYS Department of Health
Bureau of HCRA Operations & Financial Analysis
☎: (518) 473-8822
📠: (518) 486-5796
✉: khk02@health.state.ny.us

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

NEW YORK
state department of
HEALTH

Sue Kelly
Executive Deputy Commissioner

October 26, 2011

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

RE: SPA #09-19
Non-Institutional Services

Dear Mr. Melendez:

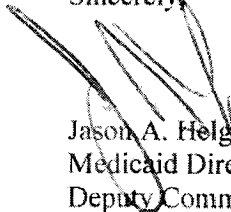
The State is resubmitting and requests approval of the enclosed amendment #09-19 to the Title XIX (Medicaid) State Plan for rates of payment for certain non-institutional services to be effective January 1, 2009, based on enacted New York State statute.

This amendment is being resubmitted, as requested by CMS. The appropriate plan pages associated with this SPA along with a revised CMS-179 are enclosed.

The changes achieve a savings by implementing mandated adjustments to 2009 rates, reflecting the application of final 2008 calendar year CPI related trend adjustments, on Medicaid trend factors for certain non-institutional services. As CMS is aware, approval of this SPA is critical in order to avoid serious impact to the financing of New York's health care delivery system. We look forward to working together to accomplish such approval.

If you have any questions regarding this resubmission, please do not hesitate to contact Mr. John E. Ulberg, Jr., Director, Division of Health Care Financing at (518) 474-6350.

Sincerely,



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

Enclosures

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

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER:

09-19

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
January 1, 2009

5. TYPE OF PLAN MATERIAL (Check One):

☐ NEW STATE PLAN

☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN

☒ AMENDMENT

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

6. FEDERAL STATUTE/REGULATION CITATION:

**Section 1902(a)(30) of the Social Security Act
42 CFR Part 447.204**

7. FEDERAL BUDGET IMPACT:

a. FFY **01/01/09 - 09/30/09** (\$16,069,840)

b. FFY **10/01/09 - 09/30/10** (\$21,926,040)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

**Attachment 4.19-B: Pages 1(b)(i), 2(b)(ii), 2(c), 4(1), 6(a),
7(a)(ii)**

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

**Attachment 4.19-B: Pages 1(b)(i), 2(b)(ii), 2(c), 4(1),
6(a), 7(a)(ii)**

10. SUBJECT OF AMENDMENT:

Non-Institutional Trend Factor Adjustment

(FMAP = 58.78% (1/1/09-3/31/09); 60.19% (4/1/09-6/30/09); 61.59% (7/1/09-9/30/10))

11. GOVERNOR'S REVIEW (Check One):

☒ GOVERNOR'S OFFICE REPORTED NO COMMENT

☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED

☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME: **Mason A. Helgerson**

14. TITLE: **Medicaid Director & Deputy Commissioner
Department of Health**

15. DATE SUBMITTED:

October 26, 2011

16. RETURN TO:

**New York State Department of Health
Corning Tower
Empire State Plaza
Albany, New York 12237**

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:

Attachment 4.19-B
(01/09)

All rates are subject to approval by the Division of the Budget. For emergency room services only, a retrospective adjustment may be made if it is determined that patients requiring general clinical services are provided such services in the emergency room for the sole purpose of maximizing reimbursement.

TN #09-19 Approval Date _____
Supersedes TN #08-32 Effective Date _____

New York
2(b)(ii)

Attachment 4.19-B
(01/09)

For rates of payment effective for outpatient hospital services provided on and after [September 11, 2008] January 1, 2009, the otherwise applicable final trend factor attributable to the 2008 calendar year period shall be adjusted such that any increase to the average trend factor for the period April 1, 2008 through December 31, 2008 shall be reduced, on an annualized basis, by 1.3%. However, no retroactive adjustment to such trend factor will be made for the period April 1, 2008 through December 31, 2008.

For rates of payment effective for outpatient hospital services provided on and after January 1, 2009, a trend factor equal to the otherwise applicable trend factor attributable to the period January 1, 2009 through December 31, 2009, less 1% shall be applied.

TN #09-19 _____

Approval Date _____

Supersedes TN #08-32 _____

Effective Date _____

Hospital Based Outpatient Department

Facilities Certified Under Article 28 of the Public Health Law as Hospital-Based Outpatient Departments

Services for Pregnant Women

Visit based rates of payment have been calculated for three discrete clinic services provided to pregnant women, for each service a discrete price has been established. The prices have been regionally adjusted to reflect regional differences in labor and facility overhead costs and an economic trend factor has been applied to make the prices prospective.

For outpatient services provided by general hospitals, beginning on and after April 1, 2006, the Commissioner of Health shall apply a trend factor projection of 2.25% attributable to the period January 1, 2006 through December 31, 2006. Upon reconciliation of this trend factor, in accordance with the previously approved state methodology, the final 2006 trend factor shall be the U.S. Consumer Price Index (CPI) for all Urban Consumers, as published by the U.S. Department of Labor, Bureau of Labor Statistics, minus 0.25%.

Effective for services provided on and after January 1, 2007 and April 1 of each state fiscal year thereafter, the Commissioner of Health shall adjust prenatal care assistance program rates to effect a cost of living adjustment (COLA). This COLA will be calculated in accordance with the general Trend Factor section of this Attachment.

For reimbursement of outpatient services provided by general hospitals, provided on and after April 1, 2007, the Commissioner of Health shall apply a trend factor projection equal to 75% of the otherwise applicable trend factor for calendar year 2007, as calculated in accordance with the general Trend Factor section of this Attachment.

For reimbursement of outpatient services provided by general hospitals, provided on and after April 1, 2008, the Commissioner of Health shall apply a trend factor projection equal to 65% of the otherwise applicable trend factor for calendar year 2008, as calculated in accordance with the general Trend Factor section of this Attachment.

For rates of payment effective for outpatient hospital services provided on and after [September 11, 2008] January 1, 2009, the otherwise applicable final trend factor attributable to the 2008 calendar year period shall be adjusted such that any increase to the average trend factor for the period April 1, 2008 through December 31, 2008 shall be reduced, on an annualized basis, by 1.3%. However, no retroactive adjustment to such trend factor will be made for the period April 1, 2008 through December 31, 2008.

For dates of service beginning on December 1, 2008 through March 31, 2010, for hospital outpatient clinic services, the operating component of rates shall be reimbursed through the Ambulatory Patient Group (APG) classification and reimbursement system.

TN #09-19 _____

Approval Date _____

Supersedes TN #08-32 _____

Effective Date _____

Home Health Services/Certified Home Health Agencies

Prospective, cost based hourly and per visit rates for five services shall be calculated by the Department of Health and approved by Division of the Budget. Rates are based on the lower of cost or ceiling, trended or, if lower, the charge provided, however, for services on and after April 1, 2008, the Commissioner of Health shall apply a trend factor projection equal to 65% of the otherwise applicable trend factor for calendar year 2008, as calculated in accordance with the general Trend Factor section of this Attachment.

For rates of payment effective for services provided on and after [September 11, 2008] January 1, 2009, the otherwise applicable final trend factor attributable to the 2008 calendar year period shall be adjusted such that any increase to the average trend factor for the period April 1, 2008 through December 31, 2008 shall be reduced, on an annualized basis, by 1.3%. However, no retroactive adjustment to such trend factor will be made for the period April 1, 2008 through December 31, 2008.

For rates of payment effective for services provided on and after January 1, 2009, a trend factor equal to the otherwise applicable trend factor attributable to the period January 1, 2009 through December 31, 2009, less 1% shall be applied.

TN #09-19 _____

Approval Date _____

Supersedes TN #08-32 _____

Effective Date _____

**New York
6(a)**

**Attachment 4.19-B
(01/09)**

Out-of-State Services

Fee-based providers:

Those providers who meet their state's licensure/certification requirements are reimbursed charges up to the appropriate New York State fee, for services rendered.

HMO's and Prepaid Health Plans

Monthly capitation rates established through negotiation with the Department of Health and approved by the Division of the Budget are in compliance with 42 CFR Part 434, Part 442.302 and Part 447.361 including all federal requirements for the reimbursement methodology.

Personal Care Services

For personal care services provided pursuant to a contract between a social services district and a voluntary, proprietary or public personal care services provider, payment is made at the lower of the provider's charge to the general public for personal care services or a rate the Department establishes for the provider, subject to the approval of the Director of the Budget, in accordance with a cost-based methodology. Under the cost-based methodology, the Department determines a provider's rate based upon the provider's reported allowable costs, as adjusted by annual trend factors provided, however, for services on and after April 1, 2008, the Commissioner of Health shall apply a trend factor projection equal to 65% of the otherwise applicable trend factor for calendar year 2008, as calculated in accordance with the general Trend Factor section of this Attachment.

For rates of payment effective for personal care services provided on and after [September 11, 2008] January 1, 2009, the otherwise applicable final trend factor attributable to the 2008 calendar year period shall be adjusted such that any increase to the average trend factor for the period April 1, 2008 through December 31, 2008 shall be reduced, on an annualized basis, by 1.3%. However, no retroactive adjustment to such trend factor will be made for the period April 1, 2008 through December 31, 2008.

For rates of payment effective for personal care services provided on and after January 1, 2009, a trend factor equal to the otherwise applicable trend factor attributable to the period January 1, 2009 through December 31, 2009, less 1% shall be applied.

The provider's rate includes payment for the provider's reported allowable trended costs only in an amount that does not exceed the ceilings for allowable costs that the Department has established for all providers in the applicable geographic group to which the provider belongs. The rate includes an adjustment for profit, for proprietary providers, or surplus, for voluntary providers.

TN #09-19 _____

Approval Date _____

Supersedes TN #08-32 _____

Effective Date _____

New York
7(a)(ii)

Attachment 4.19-B
(01/09)

For rates of payment effective for adult day health care services provided on and after [September 11, 2008] January 1, 2009, the otherwise applicable final trend factor attributable to the 2008 calendar year period shall be adjusted such that any increase to the average trend factor for the period April 1, 2008 through December 31, 2008 shall be reduced, on an annualized basis, by 1.3%. However, no retroactive adjustment to such trend factor will be made for the period April 1, 2008 through December 31, 2008.

For rates of payment effective for adult day health care services provided on and after January 1, 2009, a trend factor equal to the otherwise applicable trend factor attributable to the period January 1, 2009 through December 31, 2009, less 1% shall be applied.

TN #09-19 _____

Approval Date _____

Supersedes TN #08-32 _____

Effective Date _____

Lopez, Maribel (CMS/CMCHO)

From: CMS SPA
Sent: Thursday, October 27, 2011 3:27 PM
To: CMS SPA_Waivers_NewYork_R02; Guhl, John R. (CMS/CMCHO)
Cc: Hentz, Cynthia J. (CMS/CMCS)
Subject: RE: Resubmission of 09-19

Rob Weaver is the CO NIPT Lead and Marguerite Schervish and Annese Higgs will be the CO Program Leads for this SPA. Please include them on all future communication and review of this SPA. SPW has been updated. Thanks, Cin

From: CMS SPA_Waivers_NewYork_R02 [mailto:SPA_Waivers_NewYork_R02@cms.hhs.gov]
Sent: Wednesday, October 26, 2011 11:45 AM
To: CMS SPA; Guhl, John R. (CMS/CMCHO)
Subject: FW: Resubmission of 09-19

From: Karla Knuth [SMTP:KHK02@HEALTH.STATE.NY.US]
Sent: Wednesday, October 26, 2011 11:44:39 AM
To: CMS SPA_Waivers_NewYork_R02
Cc: sja03@health.state.ny.us; Philip N. Mossman; Stephanie Fargnoli
Subject: Resubmission of 09-19
Auto forwarded by a Rule

Attached for your review and approval is the re-submission of NY SPA 09-19. If you need anything further, please let me know. Thanks.

(See attached file: Resubmission of 09-19 (CMS 10-26-11).pdf)

Alone we can do so little; together we can do so much - Helen Keller

Karla Knuth :o)
Medicaid State Plan Coordinator &
Assoc Health Care Mgmt Systems Analyst
NYS Department of Health
Bureau of HCRA Operations & Financial Analysis
☎: (518) 473-8822
📠: (518) 486-5796
✉: khk02@health.state.ny.us

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DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare &
Medicaid Services

Refer to DMCH: SJ

Region II
Federal Building
26 Federal Plaza
New York, N.Y. 10278

JUN 19 2009

Deborah Bachrach
Deputy Commissioner
Office of Health Insurance Programs
New York State Department of Health
Corning Tower
Empire State Plaza
Albany, New York 12237

Dear Ms. Bachrach:

New York submitted State Plan Amendment (SPA) #09-19 which was received by CMS on March 31, 2009. The SPA, with a proposed effective date of January 1, 2009, revises the statutorily mandated adjustments to 2009 rates reflecting the application of final 2008 calendar year CPI related trend adjustments by a reduction of 1.3%, on an annualized basis, for outpatient services provided by general hospitals, home health services including services provided to home care patients diagnosed with AIDS, personal care services and adult day health care services provided on and after January 1, 2009. In computing rates for services provided on and after January 1, 2009, no such final adjustments to the 2008 calendar year trend will be applied with regard to the period April 1-December 31, 2008.

Based on our review of SPA #09-19, we offer the following for the State's consideration:

Reimbursement-Related

1. This SPA cannot be processed until we have completed processing action on SPAs 06-64, 07-06, 07-12 and 08-32, including processing action on the Outpatient and Clinic UPLs. Both UPL demonstrations are currently under discussion and review. Therefore, the State should not respond for 09-19 until we have completed processing actions on the preceding SPAs.
2. There appear to be differences between the SPA provisions and the public notice. The SPA proposes that, for specific services rates effective 01/01/09, the 2008 trend factor would reflect the 2008 CPI less a reduction of 1.3%, and the 2008 trend would not be subject to final adjustment. However, the December 31, 2008 public notice that was provided indicated that for 01/01/09 forward, rates would "reflect a zero factor projection attributed to calendar year 2008." The notice does indicate there would be no final reconciliation of the 2008 trend. Also, the notice indicates that "the trend factor applicable for the 2009 calendar year will be reduced to zero"; this is not in the SPA. Currently, in pending SPA 08-32, for 2009, it would be the other applicable trend factor attributable to the period January 1-December 31, 2009, less 1%. The State should clarify what provisions

concerning the 2008 trend factor are proposed in the SPA, what the 2009 trend factor will be and where/when the public notice announcing these provisions can be found. As appropriate and necessary, the State should submit revised SPA Pages to reflect the final decisions regarding the 2008 and/or the 2009 trend factors.

3. New York should provide an example to show exactly what is the 2009 trend factor that will be effective January 1, 2009 (including accounting for the adjustments for the 2008 trend factor), how it is calculated and what the end result is. An example will make it easier to understand the calculation methodology used to come up with the 2009 trend factor.
4. Part of the American Reinvestment and Recovery Act of 2009 (the Recovery Act) increases the federal share of Medicaid payments from 50% as of October 1, 2008. The current FMAP rate is 58.78%, which may be revised in future quarters based on the unemployment rate. Therefore, the Federal impact on the HCFA-179 should be calculated based on the higher FMAP rates and a 'pen and ink' change is necessary to reflect the increased FMAP rates. New York should indicate what is the new FFP amount for this SPA under the higher FMAP. In addition, the State needs to remember that for future SPA submissions, the fiscal impact amounts to be shown on the HCFA-179 should be based on the increased rate.
5. The proposed new SPA language indicates that "no retroactive adjustment to such trend factor will be made for the period April 1, 2008 through December 31, 2008." The State should provide clarification to CMS on 1) how this rate change will result in the savings identified in on the HCFA-179, and 2) the basis for the estimated savings amounts shown.
6. Standard Funding Question #1-this is not an acceptable response. CMS has already raised the question of identifying exactly what are "appropriate expenses incurred by the local government on behalf of the public provider", in other SPAs, such as in the response to the RAI for SPA 08-27 (Recruitment and Retention of Personal Care Workers). Please review and provide an appropriate response for this question.

Coverage Issues

1. In earlier SPAs, we had asked the State to confirm that it does not limit home health services to Assisted Living Programs, but rather that such services are available to all persons in their homes if they are determined to meet the medical necessity criteria for the service. So that this question is not asked repeatedly for future SPA submissions, the State should consider adding language to the State Plan (in Attachment 3.1-A-Supplement and Attachment 3.1-B-Supplement Pages, as appropriate) that would clarify that home health services are available to all persons in their homes, if they are determined to meet the medical necessity criteria for the service.
2. In reviewing the related coverage sections and pages (Attachment 3.1A-Supplement, and Attachment 3.1B-Supplement) for the services in 09-19, there were references to "LDSS". Please insert in the State Plan what this acronym means.

Samuel, Maurina C. (CMS/NC)

From: Susan C. Irwin [sci01@health.state.ny.us]
Sent: Tuesday, March 31, 2009 11:23 AM
To: CMS SPA_Waivers_NewYork_R02
Subject: NYS SPA 09-10 Hospital Based Outpatient UPL, SPA 09-19 Non Institutional Trend Factor Adjustment

Attachments: 09-10cmsc.pdf, 09-10CMS.pdf, 09-19cmsc.pdf, 09-19CMS.pdf



09-10cmsc.pdf
(316 KB)



09-10CMS.pdf
(1 MB)



09-19cmsc.pdf
(324 KB)



09-19CMS.pdf
(1 MB)

Attached are SPAs 09-10 and 09-19 for your review and approval. Thank you

(See attached file: 09-10cmsc.pdf) (See attached file: 09-10CMS.pdf)

(See attached file: 09-19cmsc.pdf) (See attached file: 09-19CMS.pdf) Sue Irwin NYS Department of Health Office of Health Insurance Programs
Division of Financial Planning & Policy sci01@health.state.ny.us
518-473-5881

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STATE OF NEW YORK DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Richard F. Daines, M.D.
Commissioner

Wendy E. Saunders
Executive Deputy Commissioner

March 31, 2009

Ms. Sue Kelly
Associate Regional Administrator
Department of Health & Human Services
Centers For Medicare & Medicaid Services
New York Regional Office
Division of Medicaid and Children's Health
26 Federal Plaza - Room 3800
New York, New York 10278

RE: SPA #09-19
Non-Institutional Services

Dear Ms. Kelly:

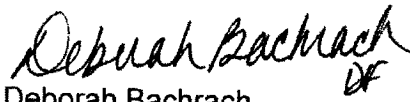
The State requests approval of the enclosed amendment #09-19 to the Title XIX (Medicaid) State Plan for non-institutional services related to outpatient general hospitals, adult day health care services, home health services/certified home health agencies, and personal care services to be effective January 1, 2009 (Appendix I). This amendment is being submitted based upon provisions contained in legislation recently enacted by the New York State Legislature. A summary of the proposed 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 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 December 31, 2008, is also enclosed for your information (Appendix IV). In addition, responses to the five standard funding questions are also enclosed (Appendix V).

If you have any questions regarding this State Plan submission, please do not hesitate to contact John E. Ulberg Jr., Director, Division of Health Care Financing at (518) 474-6350.

Sincerely,

A handwritten signature in black ink that reads "Deborah Bachrach" with a stylized initial "DB" at the end.

Deborah Bachrach
Medicaid Director
Deputy Commissioner
Office of Health Insurance Programs

Enclosures

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL		1. TRANSMITTAL NUMBER: 09-19	2. STATE New York
FOR: HEALTH CARE FINANCING ADMINISTRATION		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE January 1, 2009	
5. TYPE OF PLAN MATERIAL (Check One): ☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT			
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)			
6. FEDERAL STATUTE/REGULATION CITATION: Section 1902(a) of the Social Security Act, and 42 CFR 447.204		7. FEDERAL BUDGET IMPACT: a. FFY 01/01/09-9/30/09 (\$13,350,000) b. FFY 10/01/09-9/30/10 (\$17,800,000)	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-B, pages 1(b)(ii), 2(b)(ii), 2(c)(A), 4(1), 6(a)(1), 7(a)(ii)		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Attachment 4.19-B, pages 1(b)(ii), 2(b)(ii), 2(c)(A), 4(1), 6(a)(1), 7(a)(ii)	
10. SUBJECT OF AMENDMENT: Non Institutional Trend Factor Adjustment			
11. GOVERNOR'S REVIEW (Check One): ☒ GOVERNOR'S OFFICE REPORTED NO COMMENT ☐ OTHER, AS SPECIFIED: ☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED ☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL			
12. SIGNATURE OF STATE AGENCY OFFICIAL: 		16. RETURN TO: New York State Department of Health Corning Tower Empire State Plaza Albany, New York 12237	
13. TYPED NAME: Deborah Bachrach			
14. TITLE: Deputy Commissioner Department of Health			
15. DATE SUBMITTED: March 31, 2009			
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:			

**New York
2(b)(ii)**

**Attachment 4.19-B
(01/09)**

For rates of payment effective for outpatient hospital services provided on and after [September 11, 2008] January 1, 2009, the otherwise applicable final trend factor attributable to the 2008 calendar year period shall be adjusted such that any increase to the average trend factor for the period April 1, 2008 through December 31, 2008 shall be reduced, on an annualized basis, by 1.3%. However, no retroactive adjustment to such trend factor will be made for the period April 1, 2008 through December 31, 2008.

For rates of payment effective for outpatient hospital services provided on and after January 1, 2009, a trend factor equal to the otherwise applicable trend factor attributable to the period January 1, 2009 through December 31, 2009, less 1% shall be applied.

TN #09-19 _____

Approval Date _____

Supersedes TN #08-32 _____

Effective Date _____

**New York
2(c)(A)**

**Attachment 4.19-B
(01/09)**

For rates of payment effective for outpatient hospital services provided on and after [September 11, 2008] January 1, 2009, the otherwise applicable final trend factor attributable to the 2008 calendar year period shall be adjusted such that any increase to the average trend factor for the period April 1, 2008 through December 31, 2008 shall be reduced, on an annualized basis, by 1.3%. However, no retroactive adjustment to such trend factor will be made for the period April 1, 2008 through December 31, 2008.

For rates of payment effective for outpatient hospital services provided on and after January 1, 2009, a trend factor equal to the otherwise applicable trend factor attributable to the period January 1, 2009 through December 31, 2009, less 1% shall be applied.

**Freestanding Diagnostic and Treatment
Centers**

**Facilities Certified Under Article 28 of the Public Health Law as Freestanding
Diagnostic and Treatment Centers**

Services for Pregnant Women

Visit based rates of payment have been calculated for three discrete clinic services provided to pregnant women. For each service a discrete price has been established. The prices have been regionally adjusted to reflect regional differences in labor and facility overhead costs and an economic trend factor has been applied to make the prices prospective, except that rates of payment for the period ending September 30, 1995 shall continue in effect through September 30, 2009, provided however that, effective May 1, 2005, such rates may be adjusted to include additional capital costs not previously included in the corresponding rate.

Effective for services provided on and after October 1, 2006 and April 1 of each state fiscal year thereafter, the Commissioner of Health shall adjust prenatal care assistance program rates to effect a cost of living adjustment (COLA). This COLA will be calculated in accordance with the previously approved trend factor methodology contained on page 1(c)(i) in this Attachment.

TN #09-19

Approval Date _____

Supersedes TN #08-32

Effective Date _____

**New York
4(1)**

**Attachment 4.19-B
(01/09)**

For rates of payment effective for services provided on and after [September 11, 2008] January 1, 2009, the otherwise applicable final trend factor attributable to the 2008 calendar year period shall be adjusted such that any increase to the average trend factor for the period April 1, 2008 through December 31, 2008 shall be reduced, on an annualized basis, by 1.3%. However, no retroactive adjustment to such trend factor will be made for the period April 1, 2008 through December 31, 2008.

For rates of payment effective for services provided on and after January 1, 2009, a trend factor equal to the otherwise applicable trend factor attributable to the period January 1, 2009 through December 31, 2009, less 1% shall be applied.

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, 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.

TN #09-19 _____

Approval Date _____

Supersedes TN #08-32 _____

Effective Date _____

**New York
6(a)(1)**

**Attachment 4.19B
(01/09)**

For rates of payment effective for personal care services provided on and after [September 11, 2008] January 1, 2009, the otherwise applicable final trend factor attributable to the 2008 calendar year period shall be adjusted such that any increase to the average trend factor for the period April 1, 2008 through December 31, 2008 shall be reduced, on an annualized basis, by 1.3%. However, no retroactive adjustment to such trend factor will be made for the period April 1, 2008 through December 31, 2008.

For rates of payment effective for personal care services provided on and after January 1, 2009, a trend factor equal to the otherwise applicable trend factor attributable to the period January 1, 2009 through December 31, 2009, less 1% shall be applied.

The provider's rate includes payment for the provider's reported allowable trended costs only in an amount that does not exceed the ceilings for allowable costs that the Department has established for all providers in the applicable geographic group to which the provider belongs. The rate includes an adjustment for profit, for proprietary providers, or surplus, for voluntary providers.

Such rates of payment shall be further adjusted to reflect costs associated with the recruitment and retention of non-supervisory workers. For programs providing services in local social service districts which include a city with a population of over one million persons, rates shall be adjusted in accordance with a memorandum of understanding between the State of New York and the local social service districts. For programs providing services in local social services districts which do not include a city with a population of over one million persons, adjustments to Medicaid rates of payment will be calculated by allocating the total dollars available for the applicable rate period to each individual provider proportionally based on each personal care service provider's total annual hours of personal care service provided to recipients of medical assistance to the total annual hours for all providers in this category. The allocated dollars will be included as a reimbursable cost add-on to the Medicaid rates of payment based on the Medicaid utilization data reported in each provider's annual cost report for the period two years prior to the rate year.

TN #09-19 _____

Approval Date _____

Supersedes TN #08-32 _____

Effective Date _____

**New York
7(a)(ii)**

**Attachment 4.19-B
(01/09)**

For rates of payment effective for adult day health care services provided on and after [September 11, 2008] January 1, 2009, the otherwise applicable final trend factor attributable to the 2008 calendar year period shall be adjusted such that any increase to the average trend factor for the period April 1, 2008 through December 31, 2008 shall be reduced, on an annualized basis, by 1.3%. However, no retroactive adjustment to such trend factor will be made for the period April 1, 2008 through December 31, 2008.

For rates of payment effective for adult day health care services provided on and after January 1, 2009, a trend factor equal to the otherwise applicable trend factor attributable to the period January 1, 2009 through December 31, 2009, less 1% shall be applied.

TN #09-19 _____

Approval Date _____

Supersedes TN #08-32 _____

Effective Date _____

SUMMARY
SPA #09-19

This state plan amendment proposes to revise the statutorily mandated adjustments to 2009 rates reflecting the application of final 2008 calendar year CPI related trend adjustments by a reduction of 1.3%, on an annualized basis, for outpatient services provided by general hospitals, home health services including services provided to home care patients diagnosed with AIDS, personal care services and adult day health care services provided on and after January 1, 2009. In computing rates for services provided on and after January 1, 2009, no such final adjustment to the 2008 calendar year trend will be applied with regard to the period April 1, through December 31, 2008.

Section 1. Section 11 of part C of chapter 58 of the laws of 2008 amending the social services law and the public health law relating to adjustments of rates, as amended by section 4 of part F of chapter 497 of the laws of 2008, is amended to read as follows:

11. 1. Notwithstanding paragraph (c) of subdivision 10 of section 2807-c of the public health law, subdivision 2-b of section 2808 of the public health law, section 21 of chapter 1 of the laws of 1999, and any other contrary provision of law, but subject to subparagraph (iii) of paragraph (b) of subdivision 33 of section 2807-c of the public health law, in determining rates of payments by state governmental agencies effective for services provided on and after April 1, 2008, for inpatient and outpatient services provided by general hospitals, for inpatient services 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 that provide extensive nursing, medical, psychological and counseling support services to children, for home health care services provided pursuant to article 36 of the public health law by certified home health agencies and long term home health care programs, other than for services provided to home care patients diagnosed with AIDS as determined by applicable regulations, and personal care services provided pursuant to paragraph (e) of subdivision two of section 365-a of the social services law, the commissioner of health shall apply a trend factor projection equal to sixty-five percent of the otherwise applicable trend factor projection attributable to the period January 1, 2008 through December 31, 2008 in accordance with paragraph (c) of subdivision 10 of section 2807-c of the public health law, provided, however, that for rates of payment effective for services provided on and after ~~[September 10, 2008]~~ January 1, 2009, the final trend factor projections attributable to the 2008 calendar year period shall be further adjusted such that any increase to the average trend factor projections for the period April 1, 2008 through December 31, 2008 shall be reduced, on an annualized basis, by one and three tenths percentage points and provided further, however, no retroactive adjustment to such 2008 trend factor projection shall be made for the period April 1, 2008 through December 31, 2008 pursuant to subparagraph 3 of paragraph (c) of subdivision 10 of section 2807-c of the public health law.

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 7:00 a.m. to 5:00 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

NOTICE OF PUBLIC HEARING Department of Labor

In the November 26, 2008 issue of the New York Register, the Department of Labor announced that it would hold public hearings to receive testimony regarding proposed regulations relating to preventing workplace violence against public employees at the following place and time:

January 20, 2009:

10:00 a.m. - 2:00 p.m.

State office Campus

Building 12

Training Rooms D and E - 1st Floor

Albany, New York

Please note that due to public requests, an additional hearing date has been added. The date, time, and place are as follows:

February 3, 2009:

10:00 a.m. - 2:00 p.m.

State Office Campus

Building 12

Training Rooms D and E - 1st Floor

Persons wishing to speak at either hearing must notify the Department by January 16, 2009. Speakers must also prepare their testimony in writing and bring 1 copy to the hearing. In addition, it is requested that speakers submit one electronic version of their comments either by e-mail (e-mail address listed below) or CD-ROM. Verbal statements are limited to 10 minutes each. Written testimony will be accepted until February 9, 2009.

The hearing facilities meet the accessibility needs of individuals with disabilities. Attendees in need of reasonable accommodations should inform the Department at least two weeks prior to the hearing date. Call (518) 457-1519 for assistance or information.

For further information and to request an opportunity to speak at the hearing, contact: David Ruppert, Assistant Director, Division of Safety and Health, State Office Campus, Bldg. 12, Rm. 522, Albany, NY 12240, (518) 457-2574, (518) 457-1519 (fax), david.ruppert@labor.state.ny.us

PUBLIC NOTICE Department of Civil Service

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

Please take notice that the regular monthly meeting of the State Civil Service Commission for January 2009 will be conducted on January 13 commencing at 9:30 a.m. and January 14 at 9:30 a.m. This meeting will be conducted at New York Network, Suite 146, South Concourse, Empire State Plaza, Albany, NY. Directions and parking information available at (www.nyn.suny.edu).

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

PUBLIC NOTICE Department of Health

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

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

Inpatient Hospital Services

- Effective for services rendered on January 1, 2009 and thereafter, rates of payment for general hospitals shall reflect a zero trend factor projection attributed to calendar year 2008. In addition, no adjustment to the 2008 trend factor for the period April 1, 2008 through December 31, 2008 shall be made on a prospective basis to reflect the reconciliation of such trend factor to the final Consumer Price Index for Urban Consumers for 2008. Furthermore, for services on and after January 1, 2009, the trend factor applicable for the 2009 calendar year will be reduced to zero.

- Effective for discharges and days occurring on and after January 1, 2009 through March 31, 2009, the operating component of per diem and per discharge rates of payment will be adjusted to reflect a uniform percentage reduction of 8%. Effective for discharges and days occurring on and after April 1, 2009 through March 31, 2010, the operating component of per diem and per discharge rates of payment will be adjusted to reflect a uniform percentage reduction of 2%. These uniform percentage reductions will be applied after applicable adjustments to the trend factors affecting such rates.

- For the periods January 1, 2009 through December 31, 2010, the 10% of the aggregate annual distributions to general hospitals for indigent care and high need indigent care that was to be distributed by multiplying reported inpatient and outpatient uninsured units of service from the calendar year two years prior to the distribution year by the Medicaid rate applicable for this two year prior period will now be determined as follows:

-For inpatient services, multiply the inpatient units of service for all uninsured patients from the calendar year two years prior to distribution year, excluding referred ambulatory, by the applicable Medicaid inpatient rates in effect for such prior year, excluding prospective rate adjustments and add-ons, provided that on and after January 1, 2010, the uncompensated care need amount for inpatient services will utilize the inpatient rates in effect as of July 1st of the prior year.

-For outpatient services, multiply the outpatient unit of service for all uninsured patients from the calendar year two years prior to the distribution year, including emergency department and ambulatory surgery, but excluding referred ambulatory, by Medicaid outpatient rates based on the ambulatory patient groups (APG) methodology in effect for the distribution year and for those services for which APG rates are not available, the applicable Medicaid outpatient rate will be the rate in effect for the calendar year two years prior to the distribution year.

- Effective for periods on and after January 1, 2009, the \$27M available in the existing Supplemental Indigent Care Hospital Pool will be increased by an additional \$283M and will be distributed on an annual basis for teaching hospitals using the same methodology applicable to the 10% aggregate distribution pool referenced above.

- For periods on and after January 1, 2009, uncompensated care need for each facility will be reduced by the sum of all payment amounts collected from such patients, further adjusted by application of a nominal need scale.

Long Term Care Services

- Effective for services rendered on January 1, 2009 and thereafter, rates of payment for nursing home inpatient services except for nursing home services provided to children, shall reflect a zero trend factor projection attributed to calendar year 2008. In addition, no adjustment to the 2008 trend factor for the period April 1, 2008 through December 31, 2008 shall be made on a prospective basis to reflect the reconciliation of such trend factor to the final Consumer Price Index for Urban Consumers for 2008. Furthermore, for services on and after January 1, 2009 except for services provided to children, the trend factor applicable for the 2009 calendar year will be reduced to zero.

- Effective for services rendered on January 1, 2009 through March 31, 2009, the operating cost component of nursing home rates shall be the operating cost component effective as of December 31, 2006 adjusted for the applicable inflation adjustments.

- Effective for services rendered on April 1, 2009 and thereafter, the operating cost component of nursing home rates shall be based on the operating costs for each facility as reported in the 2002 annual cost report and in accordance with the rebasing provisions previously noticed on April 5, 2006 and September 27, 2006.

- Effective for services rendered on and after January 1, 2009 through March 31, 2009, the operating cost component of nursing home rates of payment will be adjusted to reflect a uniform percentage reduction of 8%. Effective for services rendered on and after April 1, 2009 through March 31, 2010, the operating cost component of such rates of payment will be adjusted to reflect a uniform percentage reduction of 2%. These uniform percentage reductions will be applied after applicable adjustments to the trend factors affecting such rates.

- The current authority to adjust Medicaid rates of payment for non-public residential health care facilities (RHCs) to include an adjustment for recruitment and retention of non-supervisory health care workers or any worker with direct patient care responsibility has been extended through March 31, 2010, and each state fiscal year thereafter. Aggregate payments for the period January 1, 2009 through March 31, 2009, have been reduced to \$51.7 million; and for the period April 1, 2009 through March 31, 2010, and each state fiscal year thereafter, have been reduced to \$13.1 million.

Non-Institutional Services

- Effective for services rendered on January 1, 2009 and thereafter, rates of payment for hospital outpatient services, home health services including services provided to home care patients diagnosed with AIDS, personal care services, adult day health care services, and assisted living services, rates shall reflect a zero trend factor projection attributed to calendar year 2008. In addition, no adjustment to the

2008 trend factor for the period April 1, 2008 through December 31, 2008 shall be made on a prospective basis to reflect the reconciliation of such trend factor to the final Consumer Price Index for Urban Consumers for 2008. Furthermore, for such services provided on and after January 1, 2009, the trend factor applicable for the 2009 calendar year will be reduced to zero. These trend factor reductions also apply to rates of payment for personal care services provided in social services districts, including New York City, whose rates of payments for such services are issued by such social services districts pursuant to a rate-setting exemption issued by the Commissioner of Health.

- Effective for services rendered on and after January 1, 2009, rates of payment for home health services including AIDS home care services, and personal care services, including those personal care services provided in social services districts, including New York City, whose rates of payments for such services are issued by such social services districts pursuant to a rate-setting exemption issued by the Commissioner of Health shall be adjusted to reflect a uniform percentage reduction of 1%. These uniform percentage reductions will be applied after applicable adjustments to the trend factors affecting such rates.

- Effective for services rendered by Certified Home Health Care Agencies on and after January 1, 2009, the reimbursable base year administrative and general costs for those agencies with annual expenses in excess of \$20 million, as determined using the reported base year cost data used to establish the statewide average administrative and general cost ceiling for the applicable rate year, shall not exceed the lower of such statewide average or twenty percent of such agency's total reimbursable base year costs.

- Effective for services rendered by Certified Home Health Care Agencies on and after January 1, 2009, no amount shall be included in the rate for any community-based agency or program that is in excess of 100% of the weighted average cost of all community-based agencies or programs in each such agency's or program's group. In the case of hospital-based agencies or programs, no amount shall be included that is in excess of 100% of the weighted average cost of community-based agencies or programs in the area in which such hospital-based agencies or programs are located.

- Additional payments of \$4,912,000 for the period December 1, 2008 through December 31, 2008, will be made to qualifying diagnostic and treatment centers to reflect additional costs associated with the operation of electronic health records systems that meet such standards as established by the Commissioner of Health. Such additional payments shall not be subject to subsequent adjustment or reconciliation and can be made as aggregate payments to eligible providers.

- The previously enacted statutory provisions providing for additional payments of up to \$16 million in the aggregate to enhance the provision, accessibility, quality, and/or efficiency of home care services by home care providers located in social services districts that do not include a city with a population of over one million persons, effective for the period January 1, 2009 through March 31, 2009, will be reduced by 50% (\$8,000,000) and will be paid as additional payments for services rendered for the period January 1, 2009 through March 31, 2009.

Prescription Drugs

- Effective March 1, 2009, for sole or multi-source brand name drugs, the Estimated Acquisition Cost (EAC) is defined as Average Wholesale Price (AWP) minus 17.25%. For multi-source generic drugs, the EAC remains as currently defined without change. For approved HIV pharmacies, the EAC remains as currently defined without change.

The estimated annual net aggregate decrease in gross Medicaid expenditures attributable to these proposed initiatives for state fiscal year 2009/2010 is \$1.2 billion.

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

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

New York County

250 Church Street
New York, New York 10018

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

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

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

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

The public is invited to review and comment on this proposed state plan amendment.

For further information and to review and comment, please contact:
Philip N. Mossman, Department of Health, Bureau of HCRA Operations & Financial Analysis, Corning Tower Building, Rm. 984, Empire State Plaza, Albany, NY 12237, (518) 474-1673, (518) 473-8825 (FAX), PNM01@health.state.ny.us

PUBLIC NOTICE

Department of State
F-2008-0885

Date of Issuance - December 31, 2008

The New York State Department of State (DOS) is required by Federal regulations to provide timely public notice for the activities described below, which are subject to the consistency provisions of the Federal Coastal Zone Management Act of 1972, as amended.

The applicants have certified that the proposed activity complies with and will be conducted in a manner consistent with the approved New York State Coastal Management Program. The applicant's consistency certification and accompanying public information and data are available for inspection at the New York State Department of State offices located at One Commerce Plaza, 99 Washington Avenue in Albany, New York.

In F-2008-0885, Highland Estates, LLC, Thornwood, NY, has applied to the U.S. Army Corps of Engineers, New York District, for a permit to fill federal wetlands at the intersection of Mack Lane and US Rt. 9W, in the Town of Lloyd, Ulster County in conjunction with a commercial development to include restaurant and retail space.

Specifically, the proposal includes filling 0.27 acres of wetlands under federal jurisdiction and mitigating this with the establishment of 0.31 acres of constructed wetlands adjacent to the site of the proposed development. The proposed activity includes the discharge of stormwater runoff into adjacent wetlands after treatment in an onsite stormwater retention pond. The activity is proposed to be conducted in two phases; phase I proposes to construct a 7,200 sqft restaurant facility and a 14, 608 sqft retail facility with the associated parking, road, stormwater and utility infrastructure, whereas phase II proposes two additional retail facilities of 15,000 sqft and 3,000 sqft with the associated facilities described above. Phase II will require the construction of an additional stormwater detention pond.

Any interested parties and/or agencies desiring to express their views concerning the above proposed activities may do so by filing their comments, in writing, no later than 4:30 p.m., 30 days from the date of publication of this notice, or, January 30, 2009.

Comments should be addressed to the Office of Coastal, Local Government and Community Sustainability, New York State Department of State, One Commerce Plaza, 99 Washington Avenue, Suite

1010, Albany, New York 12231. Telephone (518) 474-6000; Fax (518) 473-2464.

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

PUBLIC NOTICE

Department of State
Proclamation

Revoking Limited Liability Partnerships

WHEREAS, Article 8-B of the Partnership Law, requires registered limited liability partnerships and New York registered foreign limited liability partnerships to furnish the Department of State with a statement every five years updating specified information, and

WHEREAS, the following registered limited liability partnerships and New York registered foreign limited liability partnerships have not furnished the department with the required statement, and

WHEREAS, such registered limited liability partnerships and New York registered foreign limited liability partnerships have been provided with 60 days notice of this action;

NOW, THEREFORE, I, Lorraine A. Cortés-Vázquez, Secretary of State of the State of New York, do declare and proclaim that the registrations of the following registered limited liability partnerships are hereby revoked and the status of the following New York foreign limited liability partnerships are hereby revoked pursuant to the provisions of Article 8-B of the Partnership Law, as amended:

DOMESTIC REGISTERED LIMITED LIABILITY PARTNERSHIPS

A

ADAMS & DISTEFANO, LLP (03)
AMORUSO & AMORUSO, LLP (03)

B

BEGOS & HORGAN, LLP (98)
BONINA & BONINA, LLP (03)
BROOKS & ASSOCIATES, ATTORNEYS & COUNSELORS AT LAW, LLP. (03)

C

CALVEY & AMON, LLP (03)
CHENG & FASANYA, LLP (03)
CHILDRESS COOPER & HUNTE, LLP (98)
COHEN & LOUIS LLP (03)
COOK & FOX ARCHITECTS, LLP (03)
CTE TAX AND ADVISORY SERVICES, LLP (03)

D

D'ERRICO DREBEN, LLP (03)
DAMBRO & CARBONE, LLP (03)
DAVIS, GRABER & NASBERG, LLP (98)
DEAN ROSEN AND ASSOCIATES, LLP (03)
DYNAMIC HEALTH CHIROPRACTIC LLP (03)

E

EDWARDS & SHEEHAN, C.P.A.'S, LLP (03)

F

F. CHAU & ASSOCIATES, LLP (98)
FOREST HILLS PULMONARY MEDICAL ASSOCIATES, LLP (03)

G

GREENWALD & WEINSTOCK LLP (03)

H

HAMPTON CARE ASSOCIATES, LLP (98)
HAYT, HAYT & LANDAU LLP (03)

J

JEAN CHEN MEDICAL LLP (03)
JONES, FERGUSON & CAMPBELL, LLP (03)

K

K H & H, LLP (03)

KEARNEY & KEARNEY, LLP (98)

L

LANDRIGAN & MURTAGH LLP (03)

LILA J. WOLFE, LLP (03)

M

MAGAVERN, RICH & MORGAN, LLP (98)

N

NASSY HILL LANGSAM & MOIN LLP (98)

NISTA & PERIMENIS, LLP (03)

O

ORAN URGENT CARE PHYSICIANS LLP (03)

P

PENINO & MOYNIHAN, LLP (98)

PONCE DE LEON FOUNTAIN OF YOUTH LLP (03)

R

RAO & LEE DERMATOLOGY LLP (03)

RAYMOND J. KEEGAN & ASSOC., LLP (98)

RENZULLI & RUTHERFORD, LLP (98)

ROSNER & NOCERA LLP (98)

ROSNER, NOCERA & RAGONE, LLP (98)

RUDGAYZER & GRATT LLP (03)

S

S & C LLP (03)

SHIERMAN DUNN, M.D. AND GILDA F. NAFARRETTE, M.D., LLP (98)

SMILE BY DESIGN DENTAL LLP (03)

SMITH & OZALIS, LLP (98)

T

TANNER MCCOLGAN, LLP (03)

TANNER PROPP, LLP (98)

TOMPKINS & DAVIDSON, LLP (98)

TRI-COUNTY ORTHOPEDICS, LLP (98)

W

WEST SIDE CHIROPRACTIC & REHABILITATION L.L.P. (03)

WESTERN RAMAPO DESIGN AND PROCUREMENT TEAM, LLP (03)

WESTLAKE, LOCKWOOD, CHANGLAI, MCMAHON & SHAWL, L.L.P. (98)

FOREIGN REGISTERED LIMITED

LIABILITY PARTNERSHIPS

NY REGISTERED FOREIGN LIMITED LIABILITY PARTNERSHIP REVOCATION OF REGISTRATION H I

H

HARKINS CUNNINGHAM LLP (03) (DC)

HENNIGAN, BENNETT & DORMAN LLP (03) (CA)

M

MAYER BROWN LLP (03) (IL)

P

PETER LENCHUR MD, LLP (03) (NJ)

T

THE VIDERE GROUP, L.L.P. (03) (NJ)

[SEAL]

WITNESS my hand and the official seal of the Department of State at its office in the City of Albany this thirty-first day of December in the year two thousand eight.

LORRAINE A. CORTÉS-VÁZQUEZ

Secretary of State

PUBLIC NOTICE

Uniform Code Regional Boards of Review

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

2002-0988 Matter of Barry and Rona Smith, 325 Maple Lane, Box 404, Orient, NY 11957, for a variance concerning fire-safety requirements with alterations and additions to an existing one-family dwelling.

Involved is an alteration and additions of third story without the installation of an automatic sprinkler system and required headroom above stairs for an existing one-family dwelling, Type VA construction, 3 stories in height, approximately 5,547 square feet in area, located at, 325 Maple Lane, Orient, Town of Southold, Suffolk County, State of New York.

2008-0634 Matter of Jerome Meckler, Meckler Associates, 144 Rte 59, Suffern, NY 10901 concerning handicap accessibility requirements including maneuverability space within six dwelling units in a multiple dwelling containing 57 dwelling units.

Involved is the construction of a new building known as Ellenville Senior Housing, located at the corner of Rte 209 and Healthy Way, Ellenville, Town of Warwarsing, County of Ulster, State of New York.

2008-0635 Matter of Sal LaDuca of Environmental Assay, Inc., 792 Green Street, Phillipsburg, NJ 08865 for a variance concerning fire safety requirements, including the installation of a Balance Voltage electrical system in an existing residence.

Involved are proposed alterations to an existing one family dwelling owned by Ms. Esta Schultz, located at 230 Yerry Hill Road, Town of Woodstock, County of Ulster, State of New York.

2008-0666 Matter of Michelle and William Kern, 127 Seaquams Lane West, West Islip, NY 11795, for a variance concerning fire-safety requirements with an addition and alterations to an existing one-family dwelling.

Involved is the required freeboard elevation in addition to the FEMA design flood elevation for an existing one-family dwelling, two stories in height, approximately 2,510 square feet in area, located at 127 Seaquams lane., Town of Islip, Suffolk County, State of New York.

2008-0615 Matter of Jerry Wolkoff, Boys Enterprises, LP, 1 Executive Drive, Egewood, NY 11717, for a variance concerning fire-safety requirements for alterations to an existing gymnasium.

Involved is the construction of a second story for use as an exercise room, employee break room and bathroom with a sub-minimum construction fire rating, exit enclosure and sub-minimum number of exits for a gymnasium of an A-3 occupancy, Type VB construction, 2 stories in height, approximately 20,402 square feet in area, located at, 41 Mercedes Way, Egewood, Town of Islip, Suffolk County, State of New York.

SALE OF

FOREST PRODUCTS

Chenango Reforestation Area No. 16

Contract No. X007315

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

Sealed bids for 1,447 tons more or less of European larch sawtimber, 71 tons more or less of Jack pine, 22.9 MBF more or less of white ash, 8.8 MBF more or less of black cherry, 4.3 MBF more or less of hard maple, 2.6 MBF more or less of red maple, 0.1 MBF more or less of

yellow birch, 5.0 MBF more or less of white pine, 0.3 MBF more or less of Eastern hemlock, 74 cords more or less of hardwood firewood and 31 cords more or less of softwood pulp located on Chenango RA 16; Stands B-13, 17.1, 17.2, and 45, will be accepted at the Department of Environmental Conservation, Contract Unit, 625 Broadway, 10th Fl., Albany, NY 12233-5027 until 11:00 a.m. on Thursday, Jan. 15, 2009.

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

SALE OF FOREST PRODUCTS

Madison Reforestation Area No. 19
Contract No. X007314

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

Sealed bids for 490.4 MBF more or less of Norway spruce, 187 Cords more or less of Norway spruce, 17 Cords more or less of white spruce, 256 Tons more or less of red pine, 14 Tons more or less of jack pine, 5.1 MBF more or less of white ash, 1.5 MBF more or less of black cherry, 0.2 MBF more or less of hard maple, 0.1 MBF more or less of red maple, 30 Cords more or less of hardwood firewood, located on Madison Reforestation Area No. 9; Stand(s) A-26, 27, 28, 29 and 65. Sealed Bids will be accepted at the Department of Environmental Conservation, Contract Unit, 625 Broadway, 10th Fl., Albany, NY, 12233-5027 until 11:00 a.m., Thursday, Jan. 15, 2009.

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

SALE OF FOREST PRODUCTS

Tioga Reforestation Area No. 1
Contract No. X007316

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

Sealed bids for 156.22 MBF more or less of sawtimber and 712 cords more or less of pulpwood located on Tioga Reforestation Area No. 1; Stands A-1, 2, 3, 8, 15, 19, 21 and 22, will be accepted at the Department of Environmental Conservation, Contract Unit, 625 Broadway, 10th Fl., Albany, NY 12233-5027 until 11:00 a.m., Thursday, Jan. 15, 2009.

For further information, contact: Henry C. Dedrick, Jr., Department of Environmental Conservation, Division of Lands and Forests, Region 7, 1285 Fisher Ave., Cortland, NY 13045-1090, (607) 753-3095

NON-INSTITUTIONAL SERVICES
State Plan Amendment #09-19

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 from reimbursing the sponsoring local government for appropriate expenses incurred by the local government on behalf of the public provider. Please refer to the enclosed October 23, 2006 letter from Nicholas Meister, which has previously been provided to CMS.

- 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: Regarding the use of IGTs, it is important to note that since its inception New York's Medicaid state plan has included local government cost sharing. IGTs from counties and the City of New York to the state are integral to a majority of New York's Medicaid financing statutes. Payments made to service providers under the provisions of this SPA will be funded with 50 percent federal and 50 percent state funding. Statutory language has been included that authorizes the Comptroller of the State of New York, upon the certification of the Director of the Budget and with written consent of the chief elected officer of the City of New York or an individual county, to deposit to the state's General Fund, amounts from any tax revenue or payment from a state appropriation payable to the City of New York or a county. In addition, the state has statutory authority to intercept local aid funds for certain purposes (e.g. school debt service payments, unified court system expenses, City of New York rent control administration). These statutory provisions are not legally conditioned upon any IGT transactions. Instead, they are among many provisions or arrangements that allow the Director of the Budget to manage the financial relationships that exist between the state and its local governments. There are currently no agreements with either the City of New York or any county under these provisions to deposit any monies in the state's General Fund.

Regarding CMS' inquiry into the use of CPEs, the state does not utilize CPEs to assist in financing any of the payments under this SPA.

Regarding CMS' inquiry into the use of provider taxes, the state does utilize health provider tax programs to assist in financing its overall health care delivery system. There are instances in which the Medicaid portion of certain assessments is a reimbursable expense under the approved state plan. Further, there are instances in which the revenue from provider assessments is used to support the state's share of Medicaid payments. This is appropriate under federal law and regulations. Finally, it is important to note that Congress

deemed New York's provider taxes to be permissible when it enacted §4722(c) of the Balanced Budget Act of 1997. Provided below is a description of the state's health provider taxes, but it is important to note that state statutes do not target any of the proceeds of these taxes specifically to the payments under this SPA.

Many of the state's provider taxes relate to a health care financing system that was originally implemented in 1983, with Medicare participation through a federal waiver under the name "New York Prospective Hospital Reimbursement Methodology" (NYPHRM). While the federal waiver and Medicare participation ceased as of 1986, NYPHRM existed through 1996 and was succeeded by the "Health Care Reform Act" (HCRA) in 1997. NYPHRM and HCRA provide the methodologies that govern Medicaid and various other payors' reimbursement of inpatient hospital services and include provisions for pooling of revenue from various sources to fund health care initiatives that are crucial to the well being of all New Yorkers. Both NYPHRM and HCRA are reflected in various forms in the Medicaid state plan.

Under NYPHRM and HCRA, there are three revenue sources that are considered provider taxes under the Voluntary Contribution and Provider Specific Tax Amendments of 1991: (1) assessments on net patient services; (2) an assessment on general hospitals' gross inpatient hospital revenue (currently set at one percent), which is not required to be reimbursed; and (3) a now expired assessment on certain general hospitals' gross receipts for patient care services and other operating income, which also was not required to be reimbursed.

Health care programs, both Medicaid and non-Medicaid, are funded from the combination of the provider taxes described above and other monies dedicated to HCRA from sources that are not provider taxes under federal law, such as cigarette tax revenue. Programs receiving funding from these revenue sources include Medicaid disproportionate share hospital (DSH) payments, and non-Medicaid rural hospital grants. Among the HCRA purposes is \$82 million that supports in an untargeted manner the state share of overall Medicaid expenses.

Separate from NYPHRM and HCRA are assessments on general hospitals' and nursing homes' gross receipts for patient care services and other operating income. Pursuant to state statute, the proceeds from these assessments support in an untargeted manner the state share of overall Medicaid expenses.

Regarding the state's practices for verifying that expenditures being certified under this SPA are eligible for federal matching funds in accordance with 42 CFR 433.51(b), the State Department of Health (Department) and the New York State Comptroller's Office subject Medicaid claims to both prepayment and post-payment audits to ensure that providers comply with all applicable state and federal laws and regulations. The state contracts with a fiscal agent, Computer Sciences Corporation (CSC), to process Medicaid claims and make payments to providers. The fiscal agent processes claims and pays providers for services rendered to eligible Medicaid recipients through the electronic Medicaid system of New York State (eMedNY), a computerized payment and information reporting

system. All claims are subjected to numerous system edits to help ensure only legitimate services are reimbursed to properly enrolled providers.

In New York State, Medicaid payments are issued to providers every Wednesday. The Department of Health arranges for the required funds to be placed in an escrow account until they are needed to pay for the checks presented by providers. All federal Medicaid matching funds are drawn down by the state in accordance with an agreement between the United States Department of the Treasury and the state as required by the Cash Management Improvement Act of 1990, as amended.

On a quarterly basis, Computer Sciences Corporation, the state's vendor for adjudicating Medicaid claims, provides a report of paid claims to the Department of Health. The Department combines that expenditure information with data concerning other Medicaid expenditures made directly by the Department or other state agencies. The Department then submits the CMS-64 report to the Department of Health and Human Services, which enable the state to earn the appropriate federal reimbursement for its Medicaid costs. All Medicaid reimbursement claimed on the CMS-64 is based on certified claims submitted either by providers of service or by state agency representatives. These activities are used by the state to ensure federal Medicaid funds are only used to pay for legitimate Medicaid services.

- 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 continues to work with CMS on the completion of an acceptable UPL calculation. On January 27, 2009, the State submitted a proposed UPL methodology to CMS for their review. Upon agreement of the basic methodology, the State will complete the UPL demonstration.

- 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 outpatient hospital, home health services including services provided to home care patients diagnosed with AIDS, personal care services and adult day health care services is a cost-based methodology subject to ceilings. We are unaware of any current requirement under federal law or regulation that limits individual providers' payments to their actual costs.

Samuel, Maurina C. (CMS/NC)

From: Susan C. Irwin [sci01@health.state.ny.us]
Sent: Thursday, October 15, 2009 11:39 AM
To: CMS SPA_Waivers_NewYork_R02
Subject: NYS SPA 09-13 ADHC Trend(AIDS Funding) & Rates NYS SPA 09-19 Non Institutional Trend Factor Adjustment NYS SPA 09-62 APG Ancillary Services
Attachments: 09-13RAIresponse.pdf; 09-19RAIresponse.pdf; 09-62RAIresponse.pdf

Attached are RAI responses to 09-13, 09-19, and 09-62 for your review. Thank you.

(See attached file: 09-13RAIresponse.pdf) (See attached file: 09-19RAIresponse.pdf) (See attached file: 09-62RAIresponse.pdf)

Sue Irwin
NYS Department of Health
Office of Health Insurance Programs
Division of Financial Planning & Policy
sci01@health.state.ny.us
518-473-5881

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STATE OF NEW YORK
DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Richard F. Daines, M.D.
Commissioner

James W. Clyne, Jr.
Executive Deputy Commissioner

October 15, 2009

Ms. Sue Kelly
Associate Regional Administrator
Division of Medicaid and Children's Health
Centers for Medicaid & Medicare Services
26 Federal Plaza - Room 37-100
New York, New York 10278

RE: SPA #09-19
Non-Institutional Services

Dear Ms. Kelly:

This letter responds to your June 19, 2009 correspondence requesting additional information regarding state plan amendment (SPA) #09-19. This amendment, effective January 1, 2009, would revise the statutorily mandated adjustments to 2009 rates reflecting the application of final 2008 calendar year CPI related trend adjustments by a reduction of 1.3%, on an annualized basis, for outpatient services provided by general hospitals, home health services including services provided to home care patients diagnosed with AIDS, personal care services and adult day health care services provided on and after January 1, 2009. In computing rates for services provided on and after January 1, 2009, no such final adjustments to the 2008 calendar year trend will be applied with regard to the period April 1 - December 31, 2008.

For your convenience each issue and/or question is repeated below, followed by our response.

Reimbursement-Related

1. **This SPA cannot be processed until we have completed processing action on SPAs 06-64, 07-06, 07-12 and 08-32, including processing action on the Outpatient and Clinic UPLs. Both UPL demonstrations are currently under discussion and review. Therefore, the State should not respond for 09-19 until we have completed processing actions on the preceding SPAs.**

Response: The State continues to work with CMS on the completion of an acceptable UPL demonstration. We acknowledge that this SPA cannot be approved until CMS approves the outpatient and clinic UPLs. However, the State believes it is critical to the approval process to satisfactorily respond to all non-UPL questions in order for this SPA to move forward once acceptable UPL demonstrations are submitted.

2. **There appear to be differences between the SPA provisions and the public notice. The SPA proposes that, for specific services rates effective 01/01/09, the 2008 trend factor would reflect the 2008 CPI less a reduction of 1.3%, and the 2008 trend would not be subject to final adjustment. However, the December 31, 2008 public notice that was provided indicated that for 01/01/09 forward, rates would "reflect a zero factor projection attributed to calendar year 2008." The notice does indicate there would be no final reconciliation of the 2008 trend. Also, the notice indicates that "the trend factor applicable for the 2009 calendar year will be reduced to zero"; this is not in the SPA. Currently, in pending SPA 08-32, for 2009, it would be the other applicable trend factor attributable to the period January 1-December 31, 2009, less 1%. The State should clarify what provisions concerning the 2008 trend factor are proposed in the SPA, what the 2009 trend factor will be and where/when the public notice announcing these provisions can be found. As appropriate and necessary, the State should submit revised SPA Pages to reflect the final decisions regarding the 2008 and/or the 2009 trend factors.**

Response: The confusion is being created by the backlog of non-institutional SPA's awaiting CMS approval and the overlapping of pages and language within these SPA's. There are three outstanding non-institutional SPA's containing trend factor reduction language. The following will provide clarification.

SPA 08-32

The final trend factor for the 2008 calendar year is to be adjusted such that any increase to the average trend factor for the period 4/1/08 - 12/31/08 is reduced, on an annualized basis by 1.3%. This reduction is effective for rates of payment for services on or after 9/11/08. In addition, the applicable trend factor (initial or final) attributable for calendar year 2009 is reduced by 1%. This reduction is for rates of payment for services provided on or after 1/1/09. These proposed adjustments were noticed in the New York State Register on September 10, 2009.

SPA 09-19

Clarifying statutory language changed the effective date for the 1.3% reduction to the final trend factor for the 2008 calendar year to be for services on or after January 1, 2009, instead of September 11, 2008. In addition, the language

eliminated the retroactive reconciliation of the 2008 trend factor for the period 4/1/08 - 12/31/08. These adjustments were noticed in the New York State Register on December 31, 2008. The provisions included in the same notice that would eliminate the 2009 trend factor for services on or after January 1, 2009, did not receive corresponding legislative approval.

SPA 09-46

Effective for rates of payment for services rendered on and after April 1, 2009, the trend factors (initial and final) attributed to calendar years 2008 and 2009 are eliminated. The initial notice of the elimination of these trend factors effective January 1, 2009, was given in the New York State Register on December 31, 2008, and the effective date clarification was given in the New York State Register on June 10, 2009 (copy enclosed).

As evidenced by the clarifying explanation above, the State Legislature has authorized adjustments to 2008 and 2009 trend factors ranging from reductions to elimination. This was necessitated by the deteriorating fiscal condition of the State's budget. These various measures required wording changes to the same pages in three different SPA's. The State has submitted all applicable pages with language changes that build off the language in the previously submitted SPAs. Assuming that these SPA's will be approved sequentially, no further revisions are required.

3. **New York should provide an example to show exactly what is the 2009 trend factor that will be effective January 1, 2009 (including accounting for the adjustments for the 2008 trend factor), how it is calculated and what the end result is. An example will make it easier to understand the calculation methodology used to come up with the 2009 trend factor.**

Response: Enclosed is an example of how the 2008 and 2009 trend factors are calculated for the 2008 and 2009 rate periods.

4. **Part of the American Reinvestment and Recovery Act of 2009 (the Recovery Act) increases the federal share of Medicaid payments from 50% as of October 1, 2008. The current FMAP rate is 58.78%, which may be revised in future quarters based on the unemployment rate. Therefore, the Federal impact on the HCFA-179 should be calculated based on the higher FMAP rates and a 'pen and ink' change is necessary to reflect the increased FMAP rates. New York should indicate what the new FFP amount is for this SPA under the higher FMAP. In addition, the State needs to remember that for future SPA submissions, the fiscal impact amounts to be shown on the HCFA-179 should be based on the increased rate.**

Response: The HCFA-179 has been revised to reflect the higher FMAP rates and is enclosed.

5. **The proposed new SPA language indicates that "no retroactive adjustment to such trend factor will be made for the period April 1, 2008 through December 31, 2008." The State should provide clarification to CMS on 1) how this rate change will result in the savings identified in on the HCFA-179, and 2) the basis for the estimated savings amounts shown.**

Response: Reconciliations to final trend factors in payment rates are made on a prospective basis after the release of the final CPI by the Bureau of Labor Statistics in the month of January following the applicable rate year. In accordance with the proposed SPA language, no adjustment will be made to reflect the reconciliation to the final 2008 CPI, which normally would have been made as an adjustment to the 2009 payment rates. Since the final CPI for 2008 was higher than the initial adjusted CPI, the Medicaid program will realize a cost avoidance or savings. This has been reflected on the HCFA 179 form. Please see responses to Questions 2 and 3 for further clarification.

6. **Standard Funding Question # 1-this is not an acceptable response. CMS has already raised the question of identifying exactly what are "appropriate expenses incurred by the local government on behalf of the public provider", in other SPAs, such as in the response to the RAI for SPA 08-27 (Recruitment and Retention of Personal Care Workers). Please review and provide an appropriate response for this question.**

Response: The State has revised its response to SFQ #1, and a copy is enclosed. In addition, lengthy discussions between CMS and Department staff regarding this issue were held in a recent conference call.

Coverage Issues

1. **In earlier SPAs, we had asked the State to confirm that it does not limit home health services to Assisted Living Programs, but rather that such services are available to all persons in their homes if they are determined to meet the medical necessity criteria for the service. So that this question is not asked repeatedly for future SPA submissions, the State should consider adding language to the State Plan (in Attachment 3.1-A-Supplement and Attachment 3.1-B-Supplement Pages, as appropriate) that would clarify that home health services are available to all persons in their homes, if they are determined to meet the medical necessity criteria for the service.**

Response: Home health services are available to all categorically and medically eligible recipients who demonstrate medical necessity for the service and whose health and safety can be assured with the provision of needed services. Language clarifying that home health services are available to all persons in their homes, was added as part of our response to CMS' follow-up issues for SPA 09-23. Copies of plan pages 2(a), 2(a)(i), and 2(a)(i)(A) of Attachments

3.1-A and 3.1-B Supplements are enclosed for information.

2. **In reviewing the related coverage sections and pages (Attachment 3.1A-Supplement, and Attachment 3.1B-Supplement) for the services in 09-19, there were references to "LDSS". Please insert in the State Plan what this acronym means.**

Response: The acronym "LDSS" should actually be LSSD, which means Local Social Services District and has been defined on state plan page 2(a)(i). Plan page 2(a)(ii) of Attachment 3.1-A and Attachment 3.1-B Supplements, was corrected. Please refer to our RAI response to question #4 under coverage issues for SPA 09-23. A copy of the corrected pages is enclosed for informational purposes.

If you have any questions regarding this matter, please do not hesitate to contact John E. Ulberg Jr., Director, Division of Health Care Financing at (518) 474-6350.

Sincerely,


Deborah Bachrach
Medicaid Director
Deputy Commissioner
Office of Health Insurance Programs

Enclosures

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL		1. TRANSMITTAL NUMBER: 09-19	2. STATE New York
FOR: HEALTH CARE FINANCING ADMINISTRATION		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
		4. PROPOSED EFFECTIVE DATE January 1, 2009	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES			
5. TYPE OF PLAN MATERIAL (Check One): ☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT			
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)			
6. FEDERAL STATUTE/REGULATION CITATION: Section 1902(a)(30) of the Social Security Act 42 CFR Part 447.204		7. FEDERAL BUDGET IMPACT: a. FFY 01/01/09 - 09/30/09 (\$15,694,260) b. FFY 10/01/09 - 09/30/10 (\$20,925,680)	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-B, Pages 1(b)(ii), 2(b)(ii), 2(c)(A), 4(1), 6(a)(1) and 7(a)(ii)		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Attachment 4.19-B, Pages 1(b)(ii), 2(b)(ii), 2(c)(A), 4(1), 6(a)(1) and 7(a)(ii)	
10. SUBJECT OF AMENDMENT: Non-Institutional Trend Factor Adjustment FMAP = 58.98% Impact Based on Effective Date of 1/1/09.			
11. GOVERNOR'S REVIEW (Check One): ☒ GOVERNOR'S OFFICE REPORTED NO COMMENT ☐ OTHER, AS SPECIFIED: ☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED ☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL			
12. SIGNATURE OF STATE AGENCY OFFICIAL: 		16. RETURN TO: New York State Department of Health Corning Tower Empire State Plaza Albany, New York 12237	
13. TYPED NAME: Deborah Bachrach			
14. TITLE: Deputy Commissioner Department of Health			
15. DATE SUBMITTED: September 24, 2009			
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:			

New York
2(a)

**Attachment 3.1-A
Supplement**

- 7a. Home care services are medically necessary services (physician order required) provided by a Certified Home Health Agency (CHHA) to individuals, regardless of residence, in the home and community. Such services include both part time and intermittent skilled health care and long-term nursing and home health aide services. Home (health) care services include nursing, home health aide, physical therapy, occupational therapy, and speech therapy. Patients must be assessed as being appropriate for intermittent or part-time nursing service ordered by a physician pursuant to a written plan of care provided by a home health agency upon admission to an Assisted Living Program (ALP), [no later than 45 days from the date of admission, and] at least once during each subsequent six month period. The social services district must review the assessment and prior authorize the service.

Prior to an applicant's admission, the ALP obtains a physician's order, a social assessment, and a nursing assessment completed by a CHHA. Following a review of such documents, the ALP will determine whether the individual's health care needs can be met. The ALP will submit the assessment documents and a plan of care to the local social services district (LSSD) for those individuals whose needs can be met. Upon agreement by the LSSD with the ALP's determinations, the required information is entered into the Welfare Management System (WMS) and eMedNY (New York State's Medicaid claims processing agent); and the ALP and the recipient are notified of the start date of the ALP submission. Payment to the ALP and receipt of assessed and approved services for the recipient/ALP participant will begin on such state date.

All CHHA services provided to an ALP resident, including nursing and home health aide services, must be provided in accordance with all state and federal home health services requirements, and a CHHA must obtain physician approval of the ALP resident's home health service care plan every 60 days.

Fee-for-service home health services provided to individuals outside of the ALP are not assessed or prior authorized by the LSSD. The role of the LSSD is to determine whether an applicant is appropriate for the ALP, and whether the ALP assessments and the resource utilization group (RUG) category determination are accurate. Based on the accuracy of such determination, the LSSD will prior authorize payment of a daily Medicaid rate to the ALP for the recipient, which is payment in full for nine home care services: personal care services, home health aide services, personal emergency response services, nursing services, physical therapy, occupational therapy, medical supplies and equipment not requiring prior approval, and adult day health care.

Providers of home (health) care services must possess a valid certificate of approval issued pursuant to the provisions of Article 36 of the Public Health Law, be certified in accordance with certified home health agency, long term home health care program and AIDS home care program certification and authorization and provide services in accordance with minimum standards.

TN#: #09-23

Approval Date: _____

Supersedes TN#: #07-13

Effective Date: _____

**New York
2(a)(i)**

**Attachment 3.1-A
Supplement**

Home (health) care services provider qualifications are provided for registered professional nurse, home health aide, physical therapist, occupational therapist and speech pathologist.

Registered professional nurse shall mean a person who is licensed and currently registered as a registered professional nurse pursuant to Article 139 of the New York State Education Law.

The State assures the provision of Home Health services will be provided in accordance with 42 CFR 440.70.

- 7b. Patients must be assessed as being appropriate for home health aide services ordered by a physician pursuant to a written plan of care provided by a home health agency upon admission to an Assisted Living Program (ALP), [no later than 45 days from the date of admission, and] at least once during each subsequent six month period. The social services district must review the assessment and prior authorize the service.

Prior to an applicant's admission, the ALP obtains a physician's order, a social assessment, and a nursing assessment completed by a CHHA. Following a review of such documents, the ALP will determine whether the individual's health care needs can be met. The ALP will submit the assessment documents and a plan of care to the local social services district (LSSD) for those individuals whose needs can be met. Upon agreement by the LSSD with the ALP's determinations, the required information is entered into the Welfare Management System (WMS) and eMedNY (New York State's Medicaid claims processing agent); and the ALP and the recipient are notified of the start date of the ALP submission. Payment to the ALP and receipt of assessed and approved services for the recipient/ALP participant will begin on such state date.

All CHHA services provided to an ALP resident, including nursing and home health aide services, must be provided in accordance with all state and federal home health services requirements, and a CHHA must obtain physician approval of the ALP resident's home health service care plan every 60 days.

Fee-for-service home health services provided to individuals outside of the ALP are not assessed or prior authorized by the LSSD. The role of the LSSD is to determine whether an applicant is appropriate for the ALP, and whether the ALP assessments and the resource utilization group (RUG) category determination are accurate. Based on the accuracy of such determination, the LSSD will prior authorize payment of a daily Medicaid rate to the ALP for the recipient, which is payment in full for nine home care services: personal care services, home health aide services, personal emergency response services, nursing services, physical therapy, occupational therapy, medical supplies and equipment not requiring prior approval, and adult day health care.

TN #09-23 _____

Approval Date _____

Supersedes TN #07-13 _____

Effective Date _____

**New York
2(a)(i)(A)**

**Attachment 3.1-A
Supplement**

Home Health aide shall mean a person who carries out health care tasks under the supervision of a registered nurse or licensed therapist and who may also provide assistance with personal hygiene, housekeeping and other related supportive tasks to a patient with health care needs in his/her home. Home health aides shall have successfully completed a basic training program in home health aide services or an equivalent exam approved by the Department and possess written evidence of such completion.

Certified home health agencies may provide home health services to individual's diagnosed by a physician as having AIDS and are not required to hold a specific designation for providing home health services to AIDS patients.

Providers of AIDS home care services must possess a valid certificate of approval issued pursuant to the provisions of Article 36 of the Public Health Law (PHL), or a residential health care facility or hospital possessing a valid operating certificate issued under Article 28 of the PHL which is authorized under Article 36 of the PHL to provide an AIDS home care program; or an AIDS Center, specifically authorized pursuant to Article 36 of the PHL to provide an AIDS home care program, be certified in accordance with certified home health agency, long term home health care program and AIDS home care program certification and authorization pursuant to sections 3606, 3611 and 3612 of PHL and provide services in accordance with minimum standards pursuant to section 3612 of PHL. Such an agency or program must participate as a home health agency under the provisions of Titles XVIII and XIX of the Federal Social Security Act.

TN #09-23 _____

Approval Date _____

Supersedes TN New _____

Effective Date _____

**Attachment 3.1-B
Supplement**

- Prior to an applicant's admission, the ALP obtains a physician's order, a social assessment, and a nursing assessment completed by a CHHA. Following a review of such documents, the ALP will determine whether the individual's health care needs can be met. The ALP will submit the assessment documents and a plan of care to the local social services district (LSSD) for those individuals whose needs can be met. Upon agreement by the LSSD with the ALP's determinations, the required information is entered into the Welfare Management System (WMS) and eMedNY (New York State's Medicaid claims processing agent); and the ALP and the recipient are notified of the start date of the ALP submission. Payment to the ALP and receipt of assessed and approved services for the recipient/ALP participant will begin on such state date.

Fee-for-service home health services provided to individuals outside of the ALP are not assessed or prior authorized by the LSSD. The role of the LSSD is to determine whether an applicant is appropriate for the ALP, and whether the ALP assessments and the resource utilization group (RUG) category determination are accurate. Based on the accuracy of such determination, the LSSD will prior authorize payment of a daily Medicaid rate to the ALP for the recipient, which is payment in full for nine home care services: personal care services, home health aide services, personal emergency response services, nursing services, physical therapy, occupational therapy, medical supplies and equipment not requiring prior approval, and adult day health care.

Providers of home (health) care services must possess a valid certificate of approval issued pursuant to the provisions of Article 36 of the Public Health Law, be certified in accordance with certified home health agency, long term home health care program and AIDS home care program certification and authorization and provide services in accordance with minimum standards.

Approval Date: _____

Effective Date: _____

**New York
2(a)(i)**

**Attachment 3.1-B
Supplement**

Home (health) care services provider qualifications are provided for registered professional nurse, home health aide, physical therapist, occupational therapist and speech pathologist.

Registered professional nurse shall mean a person who is licensed and currently registered as a registered professional nurse pursuant to Article 139 of the New York State Education Law.

The State assures the provision of Home Health services will be provided in accordance with 42 CFR 440.70.

- 7b. Patients must be assessed as being appropriate for home health aide services ordered by a physician pursuant to a written plan of care provided by a home health agency upon admission to an Assisted Living Program (ALP), [no later than 45 days from the date of admission, and] at least once during each subsequent six month period. The social services district must review the assessment and prior authorize the service.

Prior to an applicant's admission, the ALP obtains a physician's order, a social assessment, and a nursing assessment completed by a CHHA. Following a review of such documents, the ALP will determine whether the individual's health care needs can be met. The ALP will submit the assessment documents and a plan of care to the local social services district (LSSD) for those individuals whose needs can be met. Upon agreement by the LSSD with the ALP's determinations, the required information is entered into the Welfare Management System (WMS) and eMedNY (New York State's Medicaid claims processing agent); and the ALP and the recipient are notified of the start date of the ALP submission. Payment to the ALP and receipt of assessed and approved services for the recipient/ALP participant will begin on such state date.

All CHHA services provided to an ALP resident, including nursing and home health aide services, must be provided in accordance with all state and federal home health services requirements, and a CHHA must obtain physician approval of the ALP resident's home health service care plan every 60 days.

Fee-for-service home health services provided to individuals outside of the ALP are not assessed or prior authorized by the LSSD. The role of the LSSD is to determine whether an applicant is appropriate for the ALP, and whether the ALP assessments and the resource utilization group (RUG) category determination are accurate. Based on the accuracy of such determination, the LSSD will prior authorize payment of a daily Medicaid rate to the ALP for the recipient, which is payment in full for nine home care services: personal care services, home health aide services, personal emergency response services, nursing services, physical therapy, occupational therapy, medical supplies and equipment not requiring prior approval, and adult day health care.

TN #09-23 _____

Approval Date _____

Supersedes TN #07-13 _____

Effective Date _____

**New York
2(a)(i)(A)**

**Attachment 3.1-B
Supplement**

Home Health aide shall mean a person who carries out health care tasks under the supervision of a registered nurse or licensed therapist and who may also provide assistance with personal hygiene, housekeeping and other related supportive tasks to a patient with health care needs in his/her home. Home health aides shall have successfully completed a basic training program in home health aide services or an equivalent exam approved by the Department and possess written evidence of such completion.

Certified home health agencies may provide home health services to individual's diagnosed by a physician as having AIDS and are not required to hold a specific designation for providing home health services to AIDS patients.

Providers of AIDS home care services must possess a valid certificate of approval issued pursuant to the provisions of Article 36 of the Public Health Law (PHL), or a residential health care facility or hospital possessing a valid operating certificate issued under Article 28 of the PHL which is authorized under Article 36 of the PHL to provide an AIDS home care program; or an AIDS Center, specifically authorized pursuant to Article 36 of the PHL to provide an AIDS home care program, be certified in accordance with certified home health agency, long term home health care program and AIDS home care program certification and authorization pursuant to sections 3606, 3611 and 3612 of PHL and provide services in accordance with minimum standards pursuant to section 3612 of PHL. Such an agency or program must participate as a home health agency under the provisions of Titles XVIII and XIX of the Federal Social Security Act.

TN #09-23 _____

Approval Date _____

Supersedes TN New _____

Effective Date _____

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.

NOTICE OF PUBLIC HEARING

Village of Oyster Bay Cove Planning Board

A public hearing and meeting will be held by and before the Planning Board of the Incorporated Village of Oyster Bay Cove, Nassau County, New York, at the East Woods School on Yellow Cote Road in the Village on Wednesday, June 3, 2009 at 8:00 P.M.

The hearing will be on the application of Scott Klansky, owner of a 2.0 acre parcel of land located at 6 Redmond Lane in the Village, designated as Section 27, Block G, Lot 1553 on the Land and Tax Map of Nassau County.

The Applicant seeks site plan approval to permit construction of a driveway courtyard, swimming pool, cabana and patios, as shown on the site plan entitled "Site Plan..." prepared by Bladykas & Panetta, L.S. & P.E. and last dated April 21, 2009.

The above application and plan are on file at the Village Hall, #25B Route 25A, Oyster Bay, New York where it may be seen during regular business hours Monday, Wednesday or Friday until the time of the hearing.

If any individual requires special assistance to attend, please notify the Village Clerk at least 48 hours in advance of the hearing.

PUBLIC NOTICE

Division of Criminal Justice Services

Law Enforcement Agency Accreditation Council

Pursuant to Public Officers Law Section 104, the Division of Criminal Justice Services gives notice of a meeting of the Law Enforcement Agency Accreditation Council.

Date: Thursday, June 11, 2009
Time: 10:00 a.m.
Place: Four Tower Place
Albany, New York

For further information or if you need a reasonable accommodation to attend this meeting, contact: Henry Boland, Office of Public Safety, Division of Criminal Justice Services, Four Tower Place, Albany, NY 12203, (518) 485-7641

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 hospital, long term care and non-institutional services to comply with recently enacted statutory provisions. The following provides clarification to previously noticed provisions and notification of new significant changes:

Inpatient Hospital Services

- For state fiscal years beginning April 1, 2009 through March 31, 2011, additional medical assistance payments for inpatient hospital services may be made to public general hospitals operated by the State of New York or the State University of New York, or by a county which shall not include a city with a population over one million, and those public general hospitals located in the counties of Westchester, Erie, or Nassau, up to one hundred percent (100%) of each such public hospital's medical assistance and uninsured patient losses after all other medical assistance, including disproportionate share payments to such general hospitals. For state fiscal years beginning on and after April 1, 2007 through March 31, 2009, initial payments will be based on reported 2000 reconciled data and be further reconciled to actual reported data for 2007; for state fiscal years beginning on and after April 1, 2009, initial payments will be based on reported 2007 reconciled data, adjusted for authorized Medicaid rate changes applicable to the state fiscal year, and further reconciled to actual reported data for 2009, and to actual reported data for each respective succeeding year. Payments to eligible public general hospitals may be added to rates of payment or made as aggregate payments.
- For state fiscal years beginning April 1, 2009 through March 31, 2011, additional medical assistance payments for inpatient hospital services may be made to public general hospitals, other than those operated by the State of New York or the State University of New York, that are located in a city with a population over one million. Additional medical assistance payments for medical inpatient hospital services of up to \$420 million annually may be made for state fiscal years beginning April 1, 2009 through March 31, 2011, and up to \$120 million for state fiscal years beginning April 1, 2011 and annually thereafter based on the relative share of each such non-state operated public general hospital's medical assistance and uninsured losses after all other medical assistance payments including disproportionate share payments. For the state fiscal years on and after April 1, 2009, initial payments will be based on reported 2007 reconciled data, adjusted for authorized Medicaid rate changes applicable to the state fiscal year, and further reconciled to actual reported data for 2009 and to actual reported data for each respective succeeding year. Payments to eligible public general hospitals may be added to rates of payments or made as aggregate payments.

- Continues, effective April 1, 2009 through March 31, 2011, holding the operating component of rates of payment for patients assigned to one of the twenty most common non-Medicare diagnosis-related groups (DRGs) to the lower of the facility specific blended operating cost component or the group average operating cost price for all hospitals assigned to the same peer group.
- Continues, effective April 1, 2009 through March 31, 2011, certain cost containment initiatives that were enacted in Chapter 81 of the Laws of 1995 and extended by subsequent legislation. The extended provisions are as follows: (1) hospital short stay adjustment factor remains at 100%; (2) hospital long stay adjustment factor remains at 50%; (3) hospital capital costs shall exclude 44% of major moveable equipment costs; (4) elimination of reimbursement of staff housing operating and capital costs; (5) capital costs will be allocated between Medicare and non-Medicare payers based on the proportion of total days for these payers; (6) 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; (7) reimbursement of based year inpatient administrative and general costs; and (8) elimination of NYPHRM rate enhancements for new technology and universal precautions.
- Continues, effective for periods April 1, 2009 through March 31, 2011, the 3.33% reduction to the average reimbursable operating costs per discharge of a general hospital, excluding the costs of graduate medical education, to encourage improved productivity and efficiency.
- Continues, effective April 1, 2009 through March 31, 2011, an \$89 million reduction per year in inpatient rates of payment for general hospital services to encourage improved productivity and efficiency.
- Continues, effective April 1, 2009 through March 31, 2011, to allow an annual increase in the statewide average case mix of one percent per year in inpatient rates of payment. The increase in the statewide average case mix in the period January 1, 2000 through December 31, 2000, from the statewide average case mix for the period January 1, 1996 through December 31, 1996, shall not exceed 4% plus an additional 1% per year thereafter. This increase continues to be based on a comparison of data only for patients that are eligible for medical assistance including those patients enrolled in health maintenance organizations.
- Effective April 1, 2009 through March 31, 2011, continues the provision that rates of payment for inpatient hospital services shall not reflect trend factor projections or adjustments for the period April 1, 1996 through March 31, 1997.
- Continues for services on and after April 1, 2009 through March 31, 2011, the reimbursable operating cost component for general hospital inpatient rates will be based on 2006 final trend factor equal to the final CPI less 0.25%.
- Effective for services rendered on and after April 1, 2009, rates of payment for general hospitals shall reflect a zero trend factor projection attributed to calendar year 2008. Furthermore, for services on and after April 1, 2009, the trend factor applicable for the 2009 calendar year will be reduced to zero.
- For the period April 1, 2009 through March 31, 2010, per diem and per discharge rates of payment for general hospital inpatient services will be subject to a uniform reduction to achieve an annual aggregate reduction of no less than \$154 million. The methodology used to achieve such reduction was previously noticed on March 26, 2008.
- For discharges, effective December 1, 2009, and thereafter, case based rates of payment for general hospitals will reflect certain 2005 operating costs as reported by each facility to the Department prior to July 1, 2009. The rates will be computed based on the case mix neutral statewide base price applicable to each rate period, excluding adjustments for graduate medical education costs, high cost outlier costs, and costs related to patient transfers, and other non-comparable costs. Such statewide base prices will be periodically adjusted to reflect changes in provider coding patterns, case-mix, and such other factors determined by the Commissioner. Rates of payment and case mix factors will reflect 2005 costs relating to services provided to Medicaid inpatients as determined by the applicable ratio of costs to charge methodology. Rates will reflect the application of hospital specific wage equalization factors reflecting differences in wage rates, and will be based on the All Patient Refined (APR) case mix methodology, utilizing diagnostic related groups with assigned weights that incorporate differing levels of severity of patient condition and associated risk of mortality, periodically updated by the Commissioner.
- Regulations will be proposed by the Commissioner of Health, establishing the methodology for the computation of general hospital case based inpatient rates. Such regulations may incorporate quality related measures pertaining to potentially preventable complications and re-admissions and will address adjustments based on the costs of high cost outlier patients.
- Case based rates of payment shall continue to reflect trend factor adjustments based on the consumer price index adjustment factor as provided in and otherwise modified by any applicable statute.
- Regulations will provide for administrative rate appeals, only with regard to the correction of computational errors or omissions of data, including hospital specific computations relating to graduate medical education, wage equalization factor adjustments and power equalization factor adjustments, and capital cost reimbursement.
- Case based rates of payment for teaching general hospitals will include reimbursement for direct and indirect graduate medical education as defined and calculated in accordance with regulations. Such regulations will specify the reports and information required by the Commissioner to assess the cost, quality and health system needs for medical education provided.
- The base period reported costs and statistics used for case based rate-setting operating cost components, including the weights assigned to diagnostic related groups, will be updated no less frequently than every four years and the new base period will be no more than four years prior to the first applicable rate period that utilizes such new base period.
- There is no change to the capital cost reimbursement methodology used to determine such case based rates.
- These provisions will not apply to general hospitals or distinct units whose inpatient reimbursement does not, as of November 30, 2009, reflect case based payment per diagnosis-related group (DRG) or whose reimbursement is, for periods on and after July 1, 2009, determined in the provisions noted above.
- For rate periods on and after December 1, 2009, additional adjustments to the inpatient rates of payment to eligible general hospitals may be made to facilitate improvements in hospital operations and finances, in accordance with the following:
 - General hospitals eligible for distributions will be non-public hospitals with Medicaid discharges equal to or greater than 17.5 percent for 2007.
 - Funds distributed will be allocated to eligible hospitals pursuant to a formula such that, no hospital's reduction in Medicaid inpatient revenue as a result of the application of these provisions exceeds a percentage reduction as determined by the Commissioner. Funding will be available in aggregate payments of up to \$75 million for the period December 1, 2009 through March 31, 2010; up to \$33 million for the period April 1, 2010 through March 31, 2011; up to \$50 million for the period April 1, 2011 through March 31, 2012; and up to \$25 million for the period April 1, 2012 through March 31, 2013.
 - Payments made will not be subject to retroactive adjustment or reconciliation and will be added to rates of payments.
 - Each hospital receiving funds will, as a condition for eligibility, adopt a resolution setting forth its current financial condition and a plan for reforming and improving such financial

condition, including ongoing board oversight, and will, after two years, issue a report setting forth progress achieved regarding such improvement, provided, however, if such report is not issued and adopted, or if such report fails to set forth adequate progress, such facility may be deemed ineligible for further distributions, which may be redistributed to other eligible facilities. Copies of all resolutions and reports will be provided to the Commissioner.

- The revised inpatient per discharge methodology will result in a statewide decrease in aggregate Medicaid payments of no less than \$75 million for the period December 1, 2009 through March 31, 2010 and \$225 million for the period April 1, 2010 through March 31, 2011. The reductions are in addition to the prior year rate reduction.
- The current authority to adjust Medicaid rates of payment for non-public general hospitals to include an adjustment for recruitment and retention of non-supervisory health care workers or any worker with direct patient care responsibility will be extended through November 30, 2009. Aggregate payments for the period April 1, 2009 through November 30, 2009, will be \$163.145 million.
- In accordance with previously noticed provisions, payments for patients discharged on and after December 1, 2008, who are determined to be in the diagnostic category of alcohol and substance abuse (MDC 20, DRGs 743 through 751) will be made on a per diem basis. This includes inpatient detoxification, withdrawal, and observation services. The per diem rates of payment will be computed using 2006 costs and statistics as reported to the Department by general hospitals prior to 2008. Average cost per diem for the region in which the hospital is located will be calculated with regard to cost incurred for patients requiring medically managed detoxification services and medically supervised withdrawal services as defined by regulations adopted by the Office of Alcoholism and Substance Abuse. The per diem rates will be transitioned to 2006 costs and will be determined as follows:
 - For the period December 1, 2008 through March 31, 2009, 75% of the operating cost component will reflect the operating cost component of rates of payment effective for December 31, 2007, as adjusted for inflation and otherwise modified by any applicable statutes, and 25% of such rates will reflect the use of the 2006 operating costs.
 - For the period April 1, 2009 through March 31, 2010, 37.5% of the operating cost component will reflect the operating cost component of rates of payment effective December 31, 2007, as adjusted for inflation and otherwise modified by any applicable statutes, and 62.5% of such rates will reflect the use of the 2006 operating costs.
 - For periods on and after April 1, 2010, 100% of the operating cost component of the rates will be based on the 2006 operating costs.
- Effective December 1, 2009, and thereafter, per diem rates for inpatient psychiatric services at a general hospital, or a distinct unit of a general hospital, shall be computed as follows:
 - For rate periods on and after December 1, 2009, the Commissioner will promulgate regulations that establish a reimbursement methodology that utilizes the 2005 operating costs in a case mix adjusted per diem payment, provide for post-discharge referral to outpatient services, and establish outpatient rates for evaluation and pre-admission referrals.
 - Per diem rates of payment for reimbursement of psychiatric services will reflect an aggregate net statewide increase of up to \$25 million on an annual basis.
 - There is no change to the capital cost reimbursement methodology.
- Effective December 1, 2009, and thereafter, per diem rates for inpatient medical rehabilitation services and inpatient chemical dependency rehabilitation services will reflect the 2005 operating costs (not including direct medical education) as reported to the Department prior to July 1, 2009, adjusted for inflation in accordance with existing statutory provisions and held to a ceiling of 110% of the regional average cost for all such services within the region the hospital is located.
- Effective December 1, 2009, and thereafter, per diem inpatient rates for Critical Access Hospitals (CAH's) will reflect the 2005 operating costs as reported to the Department prior to July 1, 2009, adjusted for inflation in accordance with existing statutory provisions and held to a ceiling of 110% of the average cost for CAH's statewide.
- Effective December 1, 2009, and thereafter, for inpatient services provided by specialty long term acute care hospitals, and cancer hospitals designated as of December 31, 2008, the operating cost component will reflect the 2005 operating costs of each such hospital as reported to the Department prior to July 1, 2009 and adjusted by inflation in accordance with existing statutory provisions. There is no ceiling on such costs.
- Effective December 1, 2009, and thereafter, for exempt acute care children's hospitals designated as such by the federal DHHS as of December 31, 2008, for which a discrete institutional cost report was filed for the 2007 calendar year, and which has reported Medicaid discharges greater than 50% of total discharges in such cost report, the following methodologies shall be in effect:
 - the operating cost component will reflect the use of 2007 operating costs as reported to the Department prior to July 1, 2009 and adjusted by inflation in accordance with existing statutory provisions, and further adjusted as the Commissioner deems appropriate, including transition adjustments. The operating component may be on a per case or per diem basis as set forth in regulations promulgated by the Commissioner.
 - The base period reported operating costs used to establish inpatient rates for children's hospitals will be updated no less frequently than every two years.
- Effective December 1, 2009, and thereafter, such per diem rates for general hospitals or a distinct unit of a general hospital will exclude physician's costs. Claims for Medicaid fee-for-service payments for such physician's services may be submitted separately.
- There is no change to the capital cost reimbursement methodology used to determine such per diem rates of payment.
- Regulations will be proposed by the Commissioner to implement these provisions.
- For general hospitals or distinct units of a general hospital without adequate cost experience, the operating cost component of the applicable per diem rate will be based on the lower of the facility's or unit's inpatient budgeted operating costs per day, adjusted to actual, or the applicable regional ceiling, if any.
- For payment of alternate level of care (ALC) days of care, the operating cost component for physical medical rehab services, chemical dependency rehab services, services provided by CAHs, and services provided by specialty long-term acute care hospitals, with regard to ALC, will be computed based on the 1987 regional average operating cost component of rates of payment for hospital-based residential health care facilities and trended to the rate period, in accordance with existing methodology.
- Continues through November 30, 2009, an increase to rates of payment for hospital inpatient services by an amount not to exceed \$60 million annually in the aggregate. This amount will be allocated among those voluntary non-profit general hospitals, which continue to provide inpatient services as of April 1, 2007, and that have Medicaid discharge percentages equal to or greater than 35%. This percentage shall be computed based on inpatient discharge data reported in each hospital's 2004 cost report submitted on or before January 1, 2007. The rate adjustments shall be calculated by allocating the available funding proportionately based on each eligible hospital's total 2004 Medicaid discharges to the total 2004 Medicaid discharges of all eligible hospitals. The rate adjustments calculated in accordance with this provision will be subject to reconciliation to ensure that each

hospital receives in the aggregate its proportionate share of the full allocation. The adjustments may be added to rates of payment or made in aggregate payments to eligible hospitals.

Long Term Care Services

- Continues, effective April 1, 2009 through March 31, 2011, the provision that rates of payment for RHCs 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, 2009 through March 31, 2011, the reimbursable operating cost component for RHCs rates will be established with the final 2006 trend factor equal to the final CPI less 0.25%.
- Continues, effective April 1, 2009 through March 31, 2011, long-term care Medicare maximization initiatives.
- Effective for services rendered on and after April 1, 2009, rates of payment for nursing home inpatient services except for nursing home services provided to children shall reflect a zero trend factor projection attributed to calendar year 2008. Furthermore, for services on and after April 1, 2009, the trend factor applicable for the 2009 calendar year will be reduced to zero.
- Effective for periods on and after April 1, 2009 through March 31, 2010, the operating cost component of payment rates will reflect allowable operating costs as reported in each facility's 2002 cost reports, adjusted for inflation on an annual basis in accordance with current statutory provisions. For those facilities which do not receive a per diem add-on adjustment in 2008, rates will be further adjusted as determined by paragraph (a) of subdivision 16 and of paragraph (a) of subdivision 14 of section 3 of Part D of the Laws of 2009, and will not be less than the operating component such facilities received in the 2008 rate period, adjusted for inflation on an annual basis. Rates for facilities whose operating cost component reflects base year costs subsequent to January 1, 2002 will have rates computed utilizing allowable operating costs as reported in such subsequent base year period, trended forward to the rate year in accordance with applicable inflation factors.
- Effective for the period April 1, 2010 through March 31, 2011, the operating cost component of payment rates for inpatient services provided by residential health care facilities the direct and indirect components of the operating cost component of such rates will be computed on a regional basis, and will reflect allowable operating costs as reported in each facility's 2007 cost reports, filed with the Department as of January 1, 2009, adjusted for inflation calculated in accordance with current statutory provisions.

The non-comparable component of the operating cost component of such rates will be computed on a facility specific basis and will reflect allowable operating costs, as reported in each facility's 2007 cost reports filed with the Department as of January 1, 2009, as adjusted for inflation in accordance with applicable statutes.

Effective for periods on and after January 1, 2009, the capital component of payment rates will fully reflect the cost of local property taxes, and payments made in lieu of local property taxes, as reported in each facility's cost report submitted for the year two years prior to the rate year.

The direct component of the operating component of payment rates will be subject to a case mix adjustment through application of the Minimum Data Set (MDS) classification used by the federal government for Medicare payments to skilled nursing facilities to reflect patient services intensity and as may be further adjusted by the Commissioner. Such adjustments will be made semi-annually in each calendar year, and both the adjustments and patient classifications in each facility will be subject to audit review in accordance with regulations promulgated by the Commissioner of Health.

Effective on and after April 1, 2010, rates of payment will, except for the establishment of regional prices, be calculated utilizing only the number of patients reported in each patient classification group and eligible for Medicaid.

Effective April 1, 2010, the operating component of payment rates,

for the following categories of facilities will reflect the rates in effect for such facilities on March 31, 2010, as adjusted for inflation in accordance with current statutory provisions:

- AIDS facilities or discrete AIDS units;
- discrete units for residents receiving care in a long-term inpatient rehabilitation program for traumatic brain injury;
- discrete units providing specialized programs for residents requiring behavioral interventions;
- discrete units for long term ventilator dependent residents; and
- facilities or discrete units that provide extensive nursing, medical, psychological and counseling support services for children.

Such rates will remain in effect until the Department, in consultation with representatives of the nursing home industry, develops a regional pricing or alternative methodology for determining such rates.

Effective no later than the 2013 rate period, the operating component of the rates will be based on allowable costs from an annual cost report period which is not earlier than three years prior to the initial rate year. Thereafter, the operating component base year will be updated to be current no less frequently than every six years, provided, however, that current shall mean that the operating components of the initial rate year shall utilize updated base year costs for periods no earlier than three years prior to the initial rate year, adjusted for inflation.

The operating component of the rates will be adjusted to reflect a per diem add-on for the following patient categories:

- each patient whose body mass index is greater than 35;
- each patient who qualifies under the RUG-III impaired cognition and behavioral problems categories, or has been diagnosed with Alzheimer's disease or dementia, and is classified in the reduced physical functions A, B, or C, or in behavioral problems A or B categories, and has an activities of daily living index score of less than ten; and
- each patient who qualifies for extended care as a result of traumatic brain injury as defined by applicable regulations.
- For the period on and after April 1, 2010, a quality of care incentive pool may be established for eligible residential health care facilities (RHCs) in order to increase Medicaid rates of payment for such eligible facilities. Aggregate payments will be determined by the Commissioner by applying criteria, including, but not limited to, the quality components of the minimum data set required under federal law, staffing and survey information, and other facility data. Facilities that fall within one or more of the following categories during a review period will be excluded from award eligibility:
 - any RHC that is currently designated by the federal Centers for Medicare and Medicaid Services as a "special focus facility";
 - any RHC for which the Department has issued a finding of immediate jeopardy during the most recently completed federal fiscal year;
 - any RHC that has received a citation for substandard quality of care in the areas of quality of life, quality of care, resident behavior, and/or facility practices during the most recently completed federal fiscal year;
 - any RHC that is part of a continuing care retirement community;
 - any RHC that operates as a transitional care unit; and
 - any other exclusion deemed appropriate by the Commissioner.

In the event the total amount of funding allocated for a particular fiscal year is not distributed, funds shall be reserved and accumulated from year to year so that remaining funds at the end of a particular fiscal year will be available for distribution during the following fiscal year.

- For periods beginning April 1, 2010, additional transition adjustments may be made to payment rates for residential health care facilities to facilitate improvements in residential health care facilities (RHCs) operations and finances in accordance with the following:

- RHCFS eligible for distributions will be those non-public facilities and state operated public residential health care facilities, which have an average annual Medicaid utilization percentage of 50% or greater, for the period two years prior to the rate year, and which experience a reduction in their Medicaid revenue of a percentage as a result of the application of regional pricing.
- Transition funds distributed will be allocated based on each eligible facility's relative need. Payments made will not be subject to retroactive adjustment or reconciliation and may be added to payment rates or made as lump sum payments.
- As a condition for eligibility for receiving such funds, each RHCF will adopt a resolution of the Board of Directors or submit a report by the owner acceptable to the Commissioner setting forth its current financial condition and a plan for reforming and improving such financial condition, including ongoing board or owner oversight, and will after two years, issue a report, adopted by such board or issue a further acceptable report by the owner setting forth progress achieved regarding such improvement, provided, however, if such further report is not submitted or fails to set forth adequate progress, such facility may be deemed ineligible for further distributions which may be redistributed to other eligible facilities. Copies of all such resolutions and reports will be provided to the Commissioner.
- Such rates will be adjusted to reflect appropriate cost differentials related to direct care staffing and adjustments made to the direct component of the operating cost component of such rate, through a quality of care incentive pool or using such other mechanism deemed appropriate by the Commissioner, after consideration of any recommendation and discussions of the established workgroup.
- Effective April 1, 2009, the Department will only review administrative rate appeals for the correction of computational errors or omissions of data by the Department in determining the operating rate based upon the information provided to the Department prior to the computation of the rate, capital cost reimbursement, or such reasons as the Commissioner determines are appropriate. Any revisions made to a facility's annual cost report for operating rate adjustment purposes later than the due date established by the Commissioner will not be considered.
- Effective for rate periods on and after April 1, 2009, rate of payment for eligible RHCFS, excluding public facilities, will reflect an adjustment for financially disadvantaged assistance. Eligibility for such adjustment will continue to be determined based on RHCFS operating margin over the most recent three-year period for which data is available. Disqualification from such adjustment continues to include any facility with a positive operating margin, a negative operating margin that is within the quartile of the smallest margins, a positive margin in the most recent year of the three year period, or an average Medicaid utilization percentage of 50% or less during the most recent year of the three-year period. However, disqualification will not be applied solely on the basis of a positive margin in the most recent year of such three-year period. Additionally, disqualification will include any facility with a negative operating margin within the quartile with the second smallest margins; and any facility with an average Medicaid utilization percentage of less than 70% during the most recent year of the three-year period.

Determination of the operating loss for eligibility continues to be based on the average of the three-year period and will be calculated by subtracting total operating expenses for the three-year period from total operating revenues for the that period, provided, however, on and after April 1, 2009, such average loss will be reduced by an amount equal to the amount of financially distressed funds received by each facility.

For hospital-based RHCFS, for which the average loss cannot be calculated on the basis of submitted costs reports, the sponsoring hospital's overall average loss for the three-year period will be apportioned to the RHCF based on the proportion of the RHCF's total

revenues for the period to the total revenues reported by the sponsoring hospital, and such apportioned average annual operating loss will be further reduced by an amount equal to the amount received by such facility.

- For periods on and after April 1, 2009, the financially distressed assistance distributions will not be reduced by a facility's estimated benefit of the 2001 update to the regional input price adjustment factors. In addition, the amount of each facility's distribution will be limited to no more than \$1 million for the period April 1, 2009 through December 31, 2009 and for each annual rate period thereafter.

The total amount of funds to be allocated and distributed as medical assistance for financially disadvantaged RHCF rate adjustments to eligible facilities will be \$30 million on an annualized basis on and after January 1, 2009.

For periods on and after April 1, 2009, RHCFS which are eligible for financially disadvantaged rate adjustments will, as a condition for receipt of such rate adjustments, submit to the Commissioner a written restructuring plan that is in accordance with the following:

- The plan will be submitted to the Commissioner within 60 days of the facility's receipt of the rate adjustments for a rate period subsequent to March 31, 2008, provided, however, facilities which are allocated \$400,000 or less on an annualized basis shall be required to submit such plans within 120 days, and further provided that these periods may be extended by the Commissioner by no more than 30 days, for good cause shown;
- The plan will provide a detailed description of the steps the facility will take to improve operational efficiency and align its expenditures with its revenues, and will include a projected schedule of quantifiable benchmarks to be achieved in the implementation of the plan;
- The plan will require periodic reports to the Commissioner, in accordance with a schedule acceptable to the Commissioner, setting forth the progress the facility has made in implementing its plan; and
- The plan will include the facility's retention of a qualified chief restructuring officer to assist in the implementation of the plan, provided, however, that this requirement be waived by the Commissioner, for good cause shown, upon written application by the facility.

If a RHCF fails to submit an acceptable restructuring plan in accordance with these provisions, the facility will, from that time forward, be precluded from receipt of all further financially disadvantaged rate adjustments and will be deemed ineligible from any future re-application for such adjustments. Further, if the Commissioner determines that a facility has failed to make substantial progress in implementing its plan or in achieving the benchmarks set forth in such plan, then the Commissioner may, upon 30 days notice to that facility, disqualify the facility from further participation in the rate adjustments, and the Commissioner may require the facility to replay some or all of the previous rate adjustments.

- Effective April 1, 2009, rates of payment for inpatient services provided by RHCFS, in determining the operating component of a facility's rate for care provided for an AIDS patient in a RHCF designated as an AIDS facility or discrete AIDS unit, the operating component will not reflect an occupancy factor increase.

Non-Institutional Services

- Continues, effective April 1, 2009, and thereafter, the provision that payments for hospital-based and freestanding ambulatory surgery center services will be at the rates in effect as of March 31, 2003.
- Continues, effective April 1, 2009 through March 31, 2011, certain cost containment initiatives currently in effect for Medicaid rates of payment. These are as follows: diagnostic and treatment center rate freeze, including products of ambulatory care; diagnostic and treatment center and certified home health agency administrative and general cost reimbursement limits; home health care Medicare maximization initiatives; hospital outpatient and emergency department reimbursement reductions

attributable to exclusion of 44% of major moveable equipment capital costs and elimination of staff housing costs; and adult day health care reimbursement caps.

- Extends current provisions to services on and after April 1, 2009 through March 31, 2011, the reimbursable operating cost component for general hospital outpatient rates and adult day health care services provided by RHCs will be established with the 2006 final trend factor equal to the final CPI less 0.25%.
- Effective for services rendered on and after April 1, 2009, rates of payment for hospital outpatient services; home health services, including services provided to home care patients diagnosed with AIDS; personal care services, in those social services districts, including New York City, whose rates of payment for such services are issued by such social services districts pursuant to a rate-setting exemption; adult day health care services; and assisted living services shall reflect a zero trend factor projection attributed to calendar year 2008. Furthermore, for services on and after April 1, 2009, the trend factor applicable for the 2009 calendar year will be reduced to zero.
- For facilities designated by the federal department of health and human services as exempt acute care children's hospitals as of December 31, 2008, for which a discrete institutional cost report was filed for the 2007 calendar year, and which has reported Medicaid discharges greater than 50% of total discharges in such cost report, the following shall be required:
 - Effective December 1, 2009, the operating component of outpatient specialty rates of hospitals will reflect the use of 2007 operating costs as reported to the Department prior to December 1, 2008, and shall include such adjustments as the Commissioner deems appropriate.
 - The base period reported operating costs used to establish outpatient rates will be updated no less frequently than every two years and each such hospital will submit such additional data as the Commissioner may require to assist in the development of ambulatory patient groups (APGs) rates for such hospitals' outpatient specialty services.
- Medicaid payments under the Ambulatory Patient Group (APG) methodology for general hospital outpatient services, including ambulatory surgery services, and freestanding clinic services, including freestanding ambulatory surgery centers, shall be in accordance with the following:
 - General Hospital Outpatient Services: for the period December 1, 2008 through November 30, 2009, 75% of the operating component of such payment rates will reflect the 2007 average Medicaid payment per claim, for each hospital, for services provided by that hospital in the 2007 calendar year excluding payments for services covered by the facility's licensure, if any, under the Mental Hygiene Law, and 25% of the operating component will reflect the utilization of the Ambulatory Patient Group (APG) reimbursement methodology.
 - For the period December 1, 2009 through December 31, 2010, 50% of the operating component of such payment rates will reflect the 2007 average Medicaid payment per claim and 50% of the operating component will reflect the utilization of the APG reimbursement methodology.
 - For the period January 1, 2011 through December 31, 2011, 25% of the operating component of such payment rates will reflect the 2007 average Medicaid payment per claim and 75% of the operating component will reflect the utilization of the APG reimbursement methodology.
 - For periods on and after January 1, 2012, 100% of such payment will reflect the utilization of the APG reimbursement methodology.
 - Freestanding clinics including freestanding ambulatory surgery centers: for the period March 1, 2009 through December 1, 2009, 75% of the operating cost component of payment rates will reflect the average 2007 calendar year Medicaid payment per claim, for services provided by that facility excluding any payments for services covered by the facility's licensure, if

any, under the Mental Health Law, and 25% of the operating component will reflect the utilization of the APG reimbursement methodology.

- For the period January 1, 2010 through December 31, 2010, 50% of the operating cost component of payment rates will reflect the average 2007 Medicaid payment per claim and 50% of will reflect the utilization of the APG reimbursement methodology.
- For the period January 1, 2011 through December 31, 2011, 25% of the operating cost component of payment rates will reflect the average 2007 Medicaid payment per claim, and 75% of such rates of payments will, for the operating cost component, will reflect the utilization of the APG reimbursement methodology.
- For periods on and after January 1, 2012, 100% of such payment rates will reflect the utilization of the APG reimbursement methodology.
- If the Commissioner determines that the use of the APG methodology is not, or is not yet, appropriate or practical for specified services, the Commissioner may use existing payment methodologies for such services, or may establish alternative payment methodologies for such services or may promulgate regulations, and may promulgate emergency regulations, establishing alternative payment methodologies for such services.
- The APG payment methodology may incorporate payment for services provided by facilities pursuant to licensure under the Mental Hygiene Law, provided such APG payment methodology may be phased into effect in accordance with a schedule or schedules as jointly determined by the Commissioner of Mental Health, the Commissioner of Alcoholism and Substance Abuse Services, and the Commissioner of Mental Retardation and Developmental Disabilities.
- Rates of payment for general hospital outpatient services, general hospital emergency services and ambulatory surgical services provided by a general hospital will result in an aggregate increase from \$178 million on an annualized basis for the period April 1, 2009 through November 30, 2009 and \$270 million on an annualized basis, for periods thereafter. Such amounts may be adjusted to reflect projected decreases in fee-for-service Medicaid utilization and changes in case-mix with regard to such services from the 2007 calendar year to the applicable rate year. Funds made available as a result of any decreases may be used by the Commissioner to increase capitation rates paid to Medicaid managed care plans and Family Health Plus plans to cover increased payments to health care providers for ambulatory care services and to increase such other ambulatory care payment rates necessary to facilitate access to quality ambulatory care services.
- Rates of payment for diagnostic and treatment center services will result in an aggregate increase of \$12.5 million on an annualized basis for the period March 1, 2009 through November 30, 2009, and \$50 million on an annualized basis for periods thereafter.
- The following additional services provided by general hospital outpatient departments and freestanding clinics will be reimbursed with rates of payment based entirely on the APG methodology:
 - Effective for dates of service on and after March 1, 2009, smoking cessation counseling services provided to pregnant women on any day of her pregnancy, during a medical visit provided by a general hospital outpatient department or a freestanding clinic.
 - On and after January 1, 2010, smoking cessation counseling services for post-partum women will be available through the end of the month in which the one hundred eightieth day following the end of the pregnancy occurs, during a medical visit.
 - On and after January 1, 2010, cardiac rehabilitation services when ordered by the attending physician and provided in a hospital-based or free-standing clinic in an area set aside for cardiac rehabilitation.

- On and after January 1, 2010, smoking cessation counseling services will also be available to children and adolescents ten to nineteen years of age, during a medical visit.
- Effective June 1, 2009, immunizations provided by hospital outpatient departments and diagnostic and treatment clinics.
- For periods on or after October 1, 2009, the Commissioners of Mental Health and Health, subject to the approval of the Director of the Budget, are jointly authorized to implement and enhance funding of the APG reimbursement methodology, for determining rates of payment for outpatient clinic services rendered by providers pursuant to their licensure under Article 31 of the Mental Hygiene Law. Regulations will be proposed by the Commissioner of Mental Health, subject to the approval of the Commissioner of Health, and the Director of the Budget, to reflect utilization of the APG reimbursement methodology.
- For periods on or after October 1, 2009, the Commissioners of Health and Mental Retardation and Developmental Disabilities, subject to the approval of the Director of the Budget, are jointly authorized to implement the APG reimbursement methodology for clinic services rendered by providers pursuant to their licensure under Article 16 of the Mental Hygiene Law. Regulations will be proposed by the Commissioner of Mental Retardation and Developmental Disabilities, subject to the approval of the Commissioner of Health and Director of the Budget, to reflect utilization of the APG reimbursement methodology.
- For periods on or after October 1, 2009, the Commissioners of Health and Alcoholism and Substance Abuse Services, subject to the approval of the Director of the Budget, are jointly authorized to implement and enhance funding for determining rates of payment for outpatient clinic services rendered pursuant to providers' operating certificates under Article 32 of the Mental Hygiene Law. Regulations will be proposed by the Commissioner of Alcoholism and Substance Abuse Services, subject to the approval of the Commissioner of Health and the Director of the Budget, to reflect the utilization of the APG reimbursement methodology.
- Effective for dates of service on and after July 1, 2009, APG base-rates for hospital outpatient, emergency department and ambulatory surgery services will be updated to reflect more current data relative to utilization and case-mix in order to align reimbursement to statutorily required investment amounts. The initial update will be based on Medicaid APG claims data from the December 1, 2008, through April 30, 2009 period.
- Effective for dates of service on and after December 1, 2009, for hospital outpatient, emergency department and ambulatory surgery services, APG base rates and related aspects of the APG payment system will be updated to reflect Medicaid APG claims data from the most recent twelve month period.
- Effective for dates of service on and after January 1, 2010, for hospital outpatient, emergency department and ambulatory surgery services, APG base rates, APG relative weights and related aspects of the APG payment system will be updated to reflect Medicaid APG claims data from the most recent twelve month period.
- Effective December 1, 2009, to improve health outcomes and efficiency through patient care continuity and coordination of health services, the Commissioner is authorized to certify certain clinicians and clinics as health care homes. Providers will be eligible for enhanced payments for services provided to: recipients eligible for Medicaid fee-for-service, persons enrolled in Medicaid HMOs or Family Health Plus; and enrollees eligible for Child Health Plus and in approved organizations.
- On or before December 1, 2009, under the Statewide Patient Centered Medical Home Program, standards of certification for patient centered medical homes for Medicaid fee-for-service and Medicaid managed care, Family Health Plus and Child Health Plus programs will be developed and implemented considering existing standards developed by national accrediting and professional organizations; and consulting with national and local organizations working on medical home models, physicians, hospitals, clinics, health plans and consumers and their representatives.
- For this program, clinics will mean any general hospital providing outpatient care or a diagnostic and treatment center licensed under Article 28 of the PHL.
- To maintain certification, patient centered medical homes must: renew their certification at a frequency determined by the Commissioner; and provide data to the Department and to health plans to permit the Commissioner, or his contractor or designee, to evaluate the impact of health care homes on quality, outcomes, and cost.
- Enhanced rates of payment may be made to clinics and clinicians that are certified as patient centered medical homes. Such enhancements may be tiered based on the level of standard achieved by the clinician or clinic and will be made to patient centered medical homes that meet specific process or outcome standards.
- On or before December 31, 2012, the Commissioner will report to the Governor and the Legislature on the impact of the Statewide Patient Centered Medical Home Program on quality, cost, and outcomes for enrollees in Medicaid fee-for-service, Medicaid managed care, Family Health Plus and Child Health Plus.
- Effective December 1, 2009, to promote improved quality of, and access to health care services, and improved clinical outcomes to residents in the upper northeastern region of New York, through patient care continuity and coordination of services, under the Adirondack Medical Home Multipayor Program, the Commissioner is authorized to certify certain clinicians and clinics in the upper northeastern region of New York as medical homes. Providers will be eligible for enhanced payments for services provided to: recipients eligible for Medicaid fee-for-service; persons enrolled in Medicaid HMOs or Family Health Plus; enrollees eligible for Child Health Plus and in approved organizations; enrollees and subscribers of commercial managed care plans organized and operating in accordance with Article 43 of the Insurance Law or other commercial insurers; and employees of employer-sponsored self-insured plans.
- Under the active supervision of the Commissioner, the policy will be to encourage cooperative, collaborative and integrative arrangements between health care services payors and providers who might otherwise be competitors. To the extent such arrangements might be anti-competitive under federal anti-trust laws, the intent is to supplant competition to the extent necessary and to provide state action immunity under the state and federal antitrust laws with respect to planning, implementation and operation of the Adirondack Medical Home Multipayor Program; and health care services payors and providers.
- The Commissioner or his designee may engage in appropriate state supervision necessary to promote state action immunity under the state and federal antitrust laws, and may inspect or request additional documentation to verify the program is implemented in accordance with its intent and purpose.
- The Commissioner is authorized to participate in, actively supervise, facilitate, and approve a primary care health care home collaborative with health care services providers, which may include hospitals, freestanding clinics, private practices, and health care services payors including employers, health plans, and insurers, to establish: the boundaries of the program and the providers eligible to participate; practice standards for medical home professional organizations including the joint principles of the American College of Physicians (ACP), the American Academy of Family Physicians (AAFP), the American Academy of Pediatrics (AAP), the American Osteopathic Association (AOA), and as further defined by Patient-Centered Medical Home, as represented in certification programs developed by the National Committee for Quality Assurance (NCQA); methodologies by which payors will provide enhanced rates of payment to certified medical homes; and methodologies to pay additional amounts for medical homes

that meet specific process or outcome standards established by the Adirondack Medical Home Collaborative.

- Patient and health care services provider participation in the program will be on a voluntary basis. Clinics and clinicians participating in the program are not eligible for additional enhancements or bonuses under the Statewide Medical Home program for services provided to participants in Medicaid fee-for-service, Medicaid managed care, Family Health Plus or Child Health Plus.

Enhanced rates of payment may be made to clinics and clinicians that are certified as medical homes under this program. Additional payment amounts will be made to medical homes that meet specific process or outcome standards specified by the Commissioner, in consultation with the Adirondack Medical Home Collaborative.

- Effective April 1, 2009, distributions will be made to public general hospitals located in a city with a population over one million persons, other than those hospitals operated by the State or the State University system, for those hospitals which experienced free patient visits in excess of 20% of the total free and self pay visits, and uninsured losses in excess of 75% of the total inpatient and outpatient losses as reported in the 1999 ICR. Such distributions will be based on each eligible hospital's proportionate share of Medicaid outpatient visits to the total of all Medicaid outpatient visits for all eligible hospitals. The proportionate distributions may be added to the rates or made in aggregate payments.
- Additional payments of \$7.388 million in aggregate, for the period October 1, 2009 through December 31, 2009, will be made to qualifying diagnostic and treatment centers to reflect additional costs associated with the operation of electronic health records systems that meet such standards as established by the Commissioner.
- Additional payments of \$224,000 in aggregate, for the period October 1, 2009 through December 31, 2009, will be made to freestanding facilities, sponsored by a university or dental school, which have been granted an operating certificate under Article 28 of the Public Health Law and which provide dental services as their principal mission.
- Effective for periods on and after April 1, 2009, rates of payment for diagnostic and treatment centers, certified home health agencies and personal care providers providing adult day health care services to patients diagnosed with AIDS as defined by applicable regulations, the Commissioner will apply trend factors using existing methodology, except that such trend factors will not be applied to services for which rates of payment are established by the Commissioner of Mental Hygiene.
- Effective on and after April 1, 2009, the operating component of payment rates, for adult day health care services provided by RHCs, that have not achieved an occupancy rate of 90% or greater for a calendar year prior to January 1, 2009, or for programs that achieved an occupancy percentage of 90% or greater prior to the 2004 calendar year but in such year had an approved capacity that was not the same as in the 2004 calendar year, will be calculated using 2009 reported allowable costs divided by visits imputed at actual or 90%, whichever is greater.

The following significant changes are proposed:

- Medicaid payments under the Ambulatory Patient Group (APG) methodology for general hospital outpatient services, including ambulatory surgery services, and freestanding clinic services, including freestanding ambulatory surgery centers, shall be in accordance with the following:
 - General Hospital Outpatient Services: for the period December 1, 2008 through November 30, 2009, 75% of the operating component of such payment rates will reflect the 2007 average Medicaid payment per claim, for each hospital, for services provided by that hospital in the 2007 calendar year excluding payments for services covered by the facility's licensure, if any, under the Mental Hygiene Law, and 25% of the operating component will reflect the utilization of the Ambulatory Patient Group (APG) reimbursement methodology.
 - For the period December 1, 2009 through December 31, 2010,

50% of the operating component of such payment rates will reflect the 2007 average Medicaid payment per claim and 50% of the operating component will reflect the utilization of the APG reimbursement methodology.

- For the period January 1, 2011 through December 31, 2011, 25% of the operating component of such payment rates will reflect the 2007 average Medicaid payment per claim and 75% of the operating component will reflect the utilization of the APG reimbursement methodology.
- For periods on and after January 1, 2012, 100% of such payment rates will reflect the utilization of the APG reimbursement methodology.
- Freestanding clinics including freestanding ambulatory surgery centers: for the period March 1, 2009 through November 30, 2009, 75% of the operating cost component of payment rates will reflect the average 2007 calendar year Medicaid payment per claim, for services provided by that facility excluding any payments for services covered by the facility's licensure, if any, under the Mental Health Law, and 25% of the operating component will reflect the utilization of the APG reimbursement methodology.
- For the period December 1, 2009 through December 31, 2010, 50% of the operating cost component of payment rates will reflect the average 2007 Medicaid payment per claim and 50% of will reflect the utilization of the APG reimbursement methodology.
- For the period January 1, 2011 through December 31, 2011, 25% of the operating cost component of payment rates will reflect the average 2007 Medicaid payment per claim, and 75% of such rates of payments will, for the operating cost component, will reflect the utilization of the APG reimbursement methodology.
- For periods on and after January 1, 2012, 100% of such payment rates will reflect the utilization of the APG reimbursement methodology.

Prescription Drugs

- Effective June 1, 2009, based upon the federal Centers for Medicare and Medicaid Services approval of the State's request for a section 1915(b) waiver, the State proposes to include coverage of pilot medication therapy management (MTM) services provided by qualified MTM pharmacists. MTM services consist of one-on-one medication regimen counseling services for eligible Medicaid beneficiaries provided by a qualified MTM pharmacist for purposes of improving overall health outcomes and decreasing overall health care costs. MTM services may be billed by a Medicaid MTM-designated pharmacy. Reimbursement for MTM services will be available at rates established by the State Division of the Budget. A beneficiary shall be eligible for one new patient visit per lifetime, a maximum of six established patient visits per 12-month period, and a maximum of 12 supplemental claims per 12-month period. The rates are as follows:

CPT Codes	Description	Amount
99605	New Enrollee (initial 15 minutes) - max of 1 claim per lifetime	\$ 35.00
99606	Established Enrollee (initial 15 minutes) - max of 6 claims in 12 months	\$ 25.00
99607	Code to be used with either 99605 or 99606 (additional 15 minutes) - max of 12 claims in 12 months (with no more than 3 claims per visit)	\$ 15.00

The estimated annual net aggregate decrease in gross Medicaid expenditures attributable to this proposed initiative for state fiscal year 2009/2010 is \$38.4 million.

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

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

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

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

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

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

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

The public is invited to review and comment on this proposed state plan amendment.

For further information and to review and comment, please contact: Philip N. Mossman, Department of Health, Bureau of HCRA Operations & Financial Analysis, Corning Tower Bldg., Rm. 984, Empire State Plaza, Albany, NY 12237, (518) 474-1673, (518) 473-8825 (FAX), PNM01@health.state.ny.us

PUBLIC NOTICE

Monroe County

The Monroe County Deferred Compensation Plan Committee is soliciting proposals from firms to provide investment advisory services for our Deferred Compensation 457 Plan. The Plan is subject to the Rules and Regulations of the New York State Deferred Compensation Board, Part 9000.

A copy of the proposal questionnaire may be obtained from: Brayton M. Connard, Chairman, Monroe County Deferred Compensation Committee, 39 Main St., W, 210 County Office Bldg., Rochester, NY 14614, (585) 753-1747

Five copies plus one original of the proposal should be received no later than 5:00 p.m. on July 1, 2009 to Brayton Connard at the above address. Late proposals will not be considered.

PUBLIC NOTICE

New York State and Local Retirement System

Pursuant to Retirement and Social Security Law, the New York State and Local Employees' Retirement System hereby gives public notice of the following:

The persons whose names and last known addresses are set forth below appear from records of the above named Retirement System to be entitled to accumulated contributions held by said retirement system whose membership terminated pursuant to Section 517-a of the Retirement and Social Security Law on or before July 31, 2007. This notice is published pursuant to Section 109 of the Retirement and Social Security Law of the State of New York. 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 System located at the 110 State St, in the City of Albany, New York. At the expiration of six months from the date of the publication of this notice. The accumulated contributions of the persons so listed shall be deemed abandoned and shall be placed in the pension accumulation fund to be used for the purpose of said fund. Any accumulated contributions so deemed abandoned and transferred to the pension accumulation fund may be claimed by the persons who made such accumulated contributions or, in the event of his death, by his estate or such person as he shall have nominated to receive such accumulated contributions, by filing a claim with the State Comptroller in such form and in such a manner as may be prescribed by him, seeking the return of such

abandoned contributions. In the event such claim is properly made the State Comptroller shall pay over to the person or persons or estate making the claim such amount of such accumulated contributions without interest.

Baerya, Carl - Bronx, NY
Barnes, Roderick C - Oriskany Falls, NY
Baxter, Jeffrey - New York, NY
Cangemi, Judith A - Rocky Point, NY
Epps, Munford C - Albany, NY
Jaeger, Paul M - Sag Harbor, NY
Kachler, Mary C - Albany, NY
Kelly, Dennis J - Jordan, NY
Laurent, Robert - Brentwood, NY
Matherson, Wilbert S - Pleasantville, NJ
Robinson, Charles E - Plattsburgh, NY
Scott, Tampa D - Chandler, AZ
Spear, Robert W - Buffalo, NY
Tyler, Rosalind R - Poughkeepsie, NY
Virzi, Frank A - Winter Haven, FL
Wells, Tad - Jamaica, NY
Zeller, Scott S - Gouverneur, NY

PUBLIC NOTICE

New York State and Local Retirement System

Pursuant to Retirement and Social Security Law, the New York State and Local Employees' Retirement System hereby gives public notice of the following:

The persons whose names and last known addresses are set forth below appear from records of the above named Retirement System to be entitled to accumulated contributions held by said retirement system whose membership terminated pursuant to Section 613 of the Retirement and Social Security Law on or before July 31, 2007. This notice is published pursuant to Section 109 of the Retirement and Social Security Law of the State of New York. 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 System located at the 110 State St, in the City of Albany, New York. At the expiration of six months from the date of the publication of this notice. The accumulated contributions of the persons so listed shall be deemed abandoned and shall be placed in the pension accumulation fund to be used for the purpose of said fund. Any accumulated contributions so deemed abandoned and transferred to the pension accumulation fund may be claimed by the persons who made such accumulated contributions or, in the event of his death, by his estate or such person as he shall have nominated to receive such accumulated contributions, by filing a claim with the State Comptroller in such form and in such a manner as may be prescribed by him, seeking the return of such abandoned contributions. In the event such claim is properly made the State Comptroller shall pay over to the person or persons or estate making the claim such amount of such accumulated contributions without interest.

Abatemarco, Michelle - Sea Cliff, NY
Abdul-Karim, Nisaa - Windsor Mill, MD
Abe, Chiaki - New York, NY
Abrahamsen, Gary H - Riverhead, NY
Abrahamsen, Steven J - Flanders, NY
Adams, Victor - Highland Falls, NY
Adevoso, Brandon - Manassas, VA
Afanador, Iris D - Raleigh, NC
Agrillo, Richard S - Planview, NY
Albert, D'Andre T - Mount Vernon, NY
Alesse, Katherine R - North Tonawanda, NY
Allen Brown, Orianna E - Villa Rica, GA
Allums, Deborah Baker - Yonkers, NY
Alonzo, Constance M - Saratoga Springs, NY
Altomari, Marla - Hurley, NY

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 7:00 a.m. to 5:00 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

NOTICE OF PUBLIC HEARING

Department of Labor

In the November 26, 2008 issue of the New York Register, the Department of Labor announced that it would hold public hearings to receive testimony regarding proposed regulations relating to preventing workplace violence against public employees at the following place and time:

January 20, 2009:
10:00 a.m. - 2:00 p.m.
State office Campus
Building 12
Training Rooms D and E - 1st Floor
Albany, New York

Please note that due to public requests, an additional hearing date has been added. The date, time, and place are as follows:

February 3, 2009:
10:00 a.m. - 2:00 p.m.
State Office Campus
Building 12
Training Rooms D and E - 1st Floor

Persons wishing to speak at either hearing must notify the Department by January 16, 2009. Speakers must also prepare their testimony in writing and bring 1 copy to the hearing. In addition, it is requested that speakers submit one electronic version of their comments either by e-mail (e-mail address listed below) or CD-ROM. Verbal statements are limited to 10 minutes each. Written testimony will be accepted until February 9, 2009.

The hearing facilities meet the accessibility needs of individuals with disabilities. Attendees in need of reasonable accommodations should inform the Department at least two weeks prior to the hearing date. Call (518) 457-1519 for assistance or information.

For further information and to request an opportunity to speak at the hearing, contact: David Ruppert, Assistant Director, Division of Safety and Health, State Office Campus, Bldg. 12, Rm. 522, Albany, NY 12240, (518) 457-2574, (518) 457-1519 (fax), david.ruppert@labor.state.ny.us

PUBLIC NOTICE

Department of Civil Service

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

Please take notice that the regular monthly meeting of the State Civil Service Commission for January 2009 will be conducted on January 13 commencing at 9:30 a.m. and January 14 at 9:30 a.m. This meeting will be conducted at New York Network, Suite 146, South Concourse, Empire State Plaza, Albany, NY. Directions and parking information available at (www.nyn.suny.edu).

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

PUBLIC NOTICE

Department of Health

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

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

Inpatient Hospital Services

- Effective for services rendered on January 1, 2009 and thereafter, rates of payment for general hospitals shall reflect a zero trend factor projection attributed to calendar year 2008. In addition, no adjustment to the 2008 trend factor for the period April 1, 2008 through December 31, 2008 shall be made on a prospective basis to reflect the reconciliation of such trend factor to the final Consumer Price Index for Urban Consumers for 2008. Furthermore, for services on and after January 1, 2009, the trend factor applicable for the 2009 calendar year will be reduced to zero.

- Effective for discharges and days occurring on and after January 1, 2009 through March 31, 2009, the operating component of per diem and per discharge rates of payment will be adjusted to reflect a uniform percentage reduction of 8%. Effective for discharges and days occurring on and after April 1, 2009 through March 31, 2010, the operating component of per diem and per discharge rates of payment will be adjusted to reflect a uniform percentage reduction of 2%. These uniform percentage reductions will be applied after applicable adjustments to the trend factors affecting such rates.

- For the periods January 1, 2009 through December 31, 2010, the 10% of the aggregate annual distributions to general hospitals for indigent care and high need indigent care that was to be distributed by multiplying reported inpatient and outpatient uninsured units of service from the calendar year two years prior to the distribution year by the Medicaid rate applicable for this two year prior period will now be determined as follows:

Miscellaneous Notices/Hearings

-For inpatient services, multiply the inpatient units of service for all uninsured patients from the calendar year two years prior to distribution year, excluding referred ambulatory, by the applicable Medicaid inpatient rates in effect for such prior year, excluding prospective rate adjustments and add-ons, provided that on and after January 1, 2010, the uncompensated care need amount for inpatient services will utilize the inpatient rates in effect as of July 1st of the prior year.

-For outpatient services, multiply the outpatient unit of service for all uninsured patients from the calendar year two years prior to the distribution year, including emergency department and ambulatory surgery, but excluding referred ambulatory, by Medicaid outpatient rates based on the ambulatory patient groups (APG) methodology in effect for the distribution year and for those services for which APG rates are not available, the applicable Medicaid outpatient rate will be the rate in effect for the calendar year two years prior to the distribution year.

- Effective for periods on and after January 1, 2009, the \$27M available in the existing Supplemental Indigent Care Hospital Pool will be increased by an additional \$283M and will be distributed on an annual basis for teaching hospitals using the same methodology applicable to the 10% aggregate distribution pool referenced above.

- For periods on and after January 1, 2009, uncompensated care need for each facility will be reduced by the sum of all payment amounts collected from such patients, further adjusted by application of a nominal need scale.

Long Term Care Services

- Effective for services rendered on January 1, 2009 and thereafter, rates of payment for nursing home inpatient services except for nursing home services provided to children, shall reflect a zero trend factor projection attributed to calendar year 2008. In addition, no adjustment to the 2008 trend factor for the period April 1, 2008 through December 31, 2008 shall be made on a prospective basis to reflect the reconciliation of such trend factor to the final Consumer Price Index for Urban Consumers for 2008. Furthermore, for services on and after January 1, 2009 except for services provided to children, the trend factor applicable for the 2009 calendar year will be reduced to zero.

- Effective for services rendered on January 1, 2009 through March 31, 2009, the operating cost component of nursing home rates shall be the operating cost component effective as of December 31, 2006 adjusted for the applicable inflation adjustments.

- Effective for services rendered on April 1, 2009 and thereafter, the operating cost component of nursing home rates shall be based on the operating costs for each facility as reported in the 2002 annual cost report and in accordance with the rebasing provisions previously noticed on April 5, 2006 and September 27, 2006.

- Effective for services rendered on and after January 1, 2009 through March 31, 2009, the operating cost component of nursing home rates of payment will be adjusted to reflect a uniform percentage reduction of 8%. Effective for services rendered on and after April 1, 2009 through March 31, 2010, the operating cost component of such rates of payment will be adjusted to reflect a uniform percentage reduction of 2%. These uniform percentage reductions will be applied after applicable adjustments to the trend factors affecting such rates.

- The current authority to adjust Medicaid rates of payment for non-public residential health care facilities (RHCs) to include an adjustment for recruitment and retention of non-supervisory health care workers or any worker with direct patient care responsibility has been extended through March 31, 2010, and each state fiscal year thereafter. Aggregate payments for the period January 1, 2009 through March 31, 2009, have been reduced to \$51.7 million; and for the period April 1, 2009 through March 31, 2010, and each state fiscal year thereafter, have been reduced to \$13.1 million.

Non-Institutional Services

- Effective for services rendered on January 1, 2009 and thereafter, rates of payment for hospital outpatient services, home health services including services provided to home care patients diagnosed with AIDS, personal care services, adult day health care services, and assisted living services, rates shall reflect a zero trend factor projection attributed to calendar year 2008. In addition, no adjustment to the

2008 trend factor for the period April 1, 2008 through December 31, 2008 shall be made on a prospective basis to reflect the reconciliation of such trend factor to the final Consumer Price Index for Urban Consumers for 2008. Furthermore, for such services provided on and after January 1, 2009, the trend factor applicable for the 2009 calendar year will be reduced to zero. These trend factor reductions also apply to rates of payment for personal care services provided in social services districts, including New York City, whose rates of payments for such services are issued by such social services districts pursuant to a rate-setting exemption issued by the Commissioner of Health.

- Effective for services rendered on and after January 1, 2009, rates of payment for home health services including AIDS home care services, and personal care services, including those personal care services provided in social services districts, including New York City, whose rates of payments for such services are issued by such social services districts pursuant to a rate-setting exemption issued by the Commissioner of Health shall be adjusted to reflect a uniform percentage reduction of 1%. These uniform percentage reductions will be applied after applicable adjustments to the trend factors affecting such rates.

- Effective for services rendered by Certified Home Health Care Agencies on and after January 1, 2009, the reimbursable base year administrative and general costs for those agencies with annual expenses in excess of \$20 million, as determined using the reported base year cost data used to establish the statewide average administrative and general cost ceiling for the applicable rate year, shall not exceed the lower of such statewide average or twenty percent of such agency's total reimbursable base year costs.

- Effective for services rendered by Certified Home Health Care Agencies on and after January 1, 2009, no amount shall be included in the rate for any community-based agency or program that is in excess of 100% of the weighted average cost of all community-based agencies or programs in each such agency's or program's group. In the case of hospital-based agencies or programs, no amount shall be included that is in excess of 100% of the weighted average cost of community-based agencies or programs in the area in which such hospital-based agencies or programs are located.

- Additional payments of \$4,912,000 for the period December 1, 2008 through December 31, 2008, will be made to qualifying diagnostic and treatment centers to reflect additional costs associated with the operation of electronic health records systems that meet such standards as established by the Commissioner of Health. Such additional payments shall not be subject to subsequent adjustment or reconciliation and can be made as aggregate payments to eligible providers.

- The previously enacted statutory provisions providing for additional payments of up to \$16 million in the aggregate to enhance the provision, accessibility, quality, and/or efficiency of home care services by home care providers located in social services districts that do not include a city with a population of over one million persons, effective for the period January 1, 2009 through March 31, 2009, will be reduced by 50% (\$8,000,000) and will be paid as additional payments for services rendered for the period January 1, 2009 through March 31, 2009.

Prescription Drugs

- Effective March 1, 2009, for sole or multi-source brand name drugs, the Estimated Acquisition Cost (EAC) is defined as Average Wholesale Price (AWP) minus 17.25%. For multi-source generic drugs, the EAC remains as currently defined without change. For approved HIV pharmacies, the EAC remains as currently defined without change.

The estimated annual net aggregate decrease in gross Medicaid expenditures attributable to these proposed initiatives for state fiscal year 2009/2010 is \$1.2 billion.

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

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

250 Church Street
New York, New York 10018

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

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

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

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

The public is invited to review and comment on this proposed state plan amendment.

For further information and to review and comment, please contact: Philip N. Mossman, Department of Health, Bureau of HCRA Operations & Financial Analysis, Corning Tower Building, Rm. 984, Empire State Plaza, Albany, NY 12237, (518) 474-1673, (518) 473-8825 (FAX), PNM01@health.state.ny.us

PUBLIC NOTICE

Department of State
F-2008-0885

Date of Issuance - December 31, 2008

The New York State Department of State (DOS) is required by Federal regulations to provide timely public notice for the activities described below, which are subject to the consistency provisions of the Federal Coastal Zone Management Act of 1972, as amended.

The applicants have certified that the proposed activity complies with and will be conducted in a manner consistent with the approved New York State Coastal Management Program. The applicant's consistency certification and accompanying public information and data are available for inspection at the New York State Department of State offices located at One Commerce Plaza, 99 Washington Avenue in Albany, New York.

In F-2008-0885, Highland Estates, LLC, Thornwood, NY, has applied to the U.S. Army Corps of Engineers, New York District, for a permit to fill federal wetlands at the intersection of Mack Lane and US Rt. 9W, in the Town of Lloyd, Ulster County in conjunction with a commercial development to include restaurant and retail space.

Specifically, the proposal includes filling 0.27 acres of wetlands under federal jurisdiction and mitigating this with the establishment of 0.31 acres of constructed wetlands adjacent to the site of the proposed development. The proposed activity includes the discharge of stormwater runoff into adjacent wetlands after treatment in an onsite stormwater retention pond. The activity is proposed to be conducted in two phases: phase I proposes to construct a 7,200 sqft restaurant facility and a 14,608 sqft retail facility with the associated parking, road, stormwater and utility infrastructure, whereas phase II proposes two additional retail facilities of 15,000 sqft and 3,000 sqft with the associated facilities described above. Phase II will require the construction of an additional stormwater detention pond.

Any interested parties and/or agencies desiring to express their views concerning the above proposed activities may do so by filing their comments, in writing, no later than 4:30 p.m., 30 days from the date of publication of this notice, or, January 30, 2009.

Comments should be addressed to the Office of Coastal, Local Government and Community Sustainability, New York State Department of State, One Commerce Plaza, 99 Washington Avenue, Suite

1010, Albany, New York 12231. Telephone (518) 474-6000; Fax (518) 473-2464.

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

PUBLIC NOTICE

Department of State

Proclamation

Revoking Limited Liability Partnerships

WHEREAS, Article 8-B of the Partnership Law, requires registered limited liability partnerships and New York registered foreign limited liability partnerships to furnish the Department of State with a statement every five years updating specified information, and

WHEREAS, the following registered limited liability partnerships and New York registered foreign limited liability partnerships have not furnished the department with the required statement, and

WHEREAS, such registered limited liability partnerships and New York registered foreign limited liability partnerships have been provided with 60 days notice of this action;

NOW, THEREFORE, I, Lorraine A. Cortes-Vazquez, Secretary of State of the State of New York, do declare and proclaim that the registrations of the following registered limited liability partnerships are hereby revoked and the status of the following New York foreign limited liability partnerships are hereby revoked pursuant to the provisions of Article 8-B of the Partnership Law, as amended:

DOMESTIC REGISTERED LIMITED LIABILITY PARTNERSHIPS

A

ADAMS & DISTEFANO, LLP (03)
AMORUSO & AMORUSO, LLP (03)

B

BEGOS & HORGAN, LLP (98)
BONINA & BONINA, LLP (03)
BROOKS & ASSOCIATES, ATTORNEYS & COUNSELORS AT LAW, LLP. (03)

C

CALVEY & AMON, LLP (03)
CHENG & FASANYA, LLP (03)
CHILDRESS COOPER & HUNTE, LLP (98)
COHEN & LOUIS LLP (03)
COOK + FOX ARCHITECTS, LLP (03)
CTE TAX AND ADVISORY SERVICES, LLP (03)

D

D'ERRICO DREEBEN, LLP (03)
DAMBRO & CARBONE, LLP (03)
DAVIS, GRABER & NASBERG, LLP (98)
DEAN ROSEN AND ASSOCIATES, LLP (03)
DYNAMIC HEALTH CHIROPRACTIC LLP (03)

E

EDWARDS & SHEEHAN, C.P.A.'S, LLP (03)

F

F. CHAU & ASSOCIATES, LLP (98)
FOREST HILLS PULMONARY MEDICAL ASSOCIATES, LLP (03)

G

GREENWALD & WEINSTOCK LLP (03)

H

HAMPTON CARE ASSOCIATES, LLP (98)
HAYT, HAYT & LANDAU LLP (03)

J

JEAN CHEN MEDICAL LLP (03)
JONES, FERGUSON & CAMPBELL, LLP (03)

K

K H & H, LLP (03)

KEARNEY & KEARNEY, LLP (98)

L

LANDRIGAN & MURTAGH LLP (03)

LILA J. WOLFE, LLP (03)

M

MAGAVERN, RICH & MORGAN, LLP (98)

N

NASSY HILL LANGSAM & MOIN LLP (98)

NISTA & PERIMENIS, LLP (03)

O

ORAN URGENT CARE PHYSICIANS LLP (03)

P

PENINO & MOYNIHAN, LLP (98)

PONCE DE LEON FOUNTAIN OF YOUTH LLP (03)

R

RAO & LEE DERMATOLOGY LLP (03)

RAYMOND J. KEEGAN & ASSOC., LLP (98)

RENZULLI & RUTHERFORD, LLP (98)

ROSNER & NOCERA LLP (98)

ROSNER, NOCERA & RAGONE, LLP (98)

RUDGAYZER & GRATT LLP (03)

S

S & C LLP (03)

SHERMAN DUNN, M.D. AND GILDA F. NAFARRETTE, M.D., LLP (98)

SMILE BY DESIGN DENTAL LLP (03)

SMITH & OZALIS, LLP (98)

T

TANNER MCCOLGAN, LLP (03)

TANNER PROPP, LLP (98)

TOMPKINS & DAVIDSON, LLP (98)

TRI-COUNTY ORTHOPEDICS, LLP (98)

W

WEST SIDE CHIROPRACTIC & REHABILITATION L.L.P. (03)

WESTERN RAMAPO DESIGN AND PROCUREMENT TEAM, LLP (03)

WESTLAKE, LOCKWOOD, CHANGLAI, MCMAHON & SHAWL, L.L.P. (98)

**FOREIGN REGISTERED LIMITED
LIABILITY PARTNERSHIPS**

NY REGISTERED FOREIGN LIMITED LIABILITY PARTNER-
SHIP REVOCATION OF REGISTRATION H I

H

HARKINS CUNNINGHAM LLP (03) (DC)

HENNIGAN, BENNETT & DORMAN LLP (03) (CA)

M

MAYER BROWN LLP (03) (IL)

P

PETER LENCHUR MD, LLP (03) (NJ)

T

THE VIDERE GROUP, L.L.P. (03) (NJ)

[SEAL]

WITNESS my hand and the official seal
of the Department of State at its office in
the City of Albany this thirty-first day of
December in the year two thousand
eight.

LORRAINE A. CORTÉS-VÁZQUEZ
Secretary of State

PUBLIC NOTICE

Uniform Code Regional Boards of Review

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

2002-0988 Matter of Barry and Rona Smith, 325 Maple Lane, Box 404, Orient, NY 11957, for a variance concerning fire-safety requirements with alterations and additions to an existing one-family dwelling.

Involved is an alteration and additions of third story without the installation of an automatic sprinkler system and required headroom above stairs for an existing one-family dwelling, Type VA construction, 3 stories in height, approximately 5,547 square feet in area, located at 325 Maple Lane, Orient, Town of Southold, Suffolk County, State of New York.

2008-0634 Matter of Jerome Meckler, Meckler Associates, 144 Rte 59, Suffern, NY 10901 concerning handicap accessibility requirements including maneuverability space within six dwelling units in a multiple dwelling containing 57 dwelling units.

Involved is the construction of a new building known as Ellenville Senior Housing, located at the corner of Rte 209 and Healthy Way, Ellenville, Town of Warwarsing, County of Ulster, State of New York.

2008-0635 Matter of Sal LaDuca of Environmental Assay, Inc., 792 Green Street, Phillipsburg, NJ 08865 for a variance concerning fire safety requirements, including the installation of a Balance Voltage electrical system in an existing residence.

Involved are proposed alterations to an existing one family dwelling owned by Ms. Esta Schultz, located at 230 Yerry Hill Road, Town of Woodstock, County of Ulster, State of New York.

2008-0666 Matter of Michelle and William Kern, 127 Seaquams Lane West, West Islip, NY 11795, for a variance concerning fire-safety requirements with an addition and alterations to an existing one-family dwelling.

Involved is the required freeboard elevation in addition to the FEMA design flood elevation for an existing one-family dwelling, two stories in height, approximately 2,510 square feet in area, located at 127 Seaquams lane., Town of Islip, Suffolk County, State of New York.

2008-0615 Matter of Jerry Wolkoff, Boys Enterprises, LP, 1 Executive Drive, Egewood, NY 11717, for a variance concerning fire-safety requirements for alterations to an existing gymnasium.

Involved is the construction of a second story for use as an exercise room, employee break room and bathroom with a sub-minimum construction fire rating, exit enclosure and sub-minimum number of exits for a gymnasium of an A-3 occupancy, Type VB construction, 2 stories in height, approximately 20,402 square feet in area, located at 41 Mercedes Way, Edgewood, Town of Islip, Suffolk County, State of New York.

**SALE OF
FOREST PRODUCTS**

Chenango Reforestation Area No. 16
Contract No. X007315

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

Sealed bids for 1,447 tons more or less of European larch sawtimber, 71 tons more or less of Jack pine, 22.9 MBF more or less of white ash, 8.8 MBF more or less of black cherry, 4.3 MBF more or less of hard maple, 2.6 MBF more or less of red maple, 0.1 MBF more or less of

yellow birch, 5.0 MBF more or less of white pine, 0.3 MBF more or less of Eastern hemlock, 74 cords more or less of hardwood firewood and 31 cords more or less of softwood pulp located on Chenango RA 16: Stands B-13, 17.1, 17.2, and 45, will be accepted at the Department of Environmental Conservation, Contract Unit, 625 Broadway, 10th Fl., Albany, NY 12233-5027 until 11:00 a.m. on Thursday, Jan. 15, 2009.

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

SALE OF FOREST PRODUCTS

Madison Reforestation Area No. 19
Contract No. X007314

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

Sealed bids for 490.4 MBF more or less of Norway spruce, 187 Cords more or less of Norway spruce, 17 Cords more or less of white spruce, 256 Tons more or less of red pine, 14 Tons more or less of jack pine, 5.1 MBF more or less of white ash, 1.5 MBF more or less of black cherry, 0.2 MBF more or less of hard maple, 0.1 MBF more or less of red maple, 30 Cords more or less of hardwood firewood, located on Madison Reforestation Area No. 9; Stand(s) A-26, 27, 28, 29 and 65. Sealed Bids will be accepted at the Department of Environmental Conservation, Contract Unit, 625 Broadway, 10th Fl., Albany, NY, 12233-5027 until 11:00 a.m., Thursday, Jan. 15, 2009.

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

SALE OF FOREST PRODUCTS

Tioga Reforestation Area No. 1
Contract No. X007316

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

Sealed bids for 156.22 MBF more or less of sawtimber and 712 cords more or less of pulpwood located on Tioga Reforestation Area No. 1; Stands A-1, 2, 3, 8, 15, 19, 21 and 22, will be accepted at the Department of Environmental Conservation, Contract Unit, 625 Broadway, 10th Fl., Albany, NY 12233-5027 until 11:00 a.m., Thursday, Jan. 15, 2009.

For further information, contact: Henry C. Dedrick, Jr., Department of Environmental Conservation, Division of Lands and Forests, Region 7, 1285 Fisher Ave., Cortland, NY 13045-1090, (607) 753-3095

Actual Trend Factors for Non-Institutional Services:

2008 Trend in 2008 Rate:

1/1/08 - 3/31/08: Full Final Trend of 3.8% (Initial was 2.3%)
4/1/08 - 12/31/08: Initial Trend Reduced by 35% = 1.495% [CMS previously approved 35% reduction]

SPA 09-19

- Calculation for this period's trend is Initial trend of 2.3% reduced by 35% = 1.495%
- The initial 2.3% is not increased to the final trend of 3.8%

Weighted 2008 Trend to be used for 2008 = $2.0713\% = 2.07\%$ using 4 decimals
[Based on 3.8% for 3 months and 1.495% for 9 months]

2008 Trend in 2009 Rate:

SPA 09-19

1/1/09 - 12/31/09: $3.8\% \text{ less } 35\% = 2.47\% - 1.3\% = 1.17\%$

SPA 09-46

4/1/09 - 12/31/09: Eliminate the Remaining Trend Factor = 0%

Weighted 2008 Trend to be used for 2009 = .0029 or 0.29%
[Based on 1.17% for 3 months and 0% for 9 months]

2009 Trend in 2009 Rate:

SPA 08-32

1/1/09 - 12/31/09: $3.1\% \text{ Initial } 2009 \text{ Trend} - 1\% = 2.1\%$

SPA 09-46

4/1/09 - 12/31/09: Eliminate the Remaining Trend Factor = 0%

Weighted 2009 Trend to be used for 2009 = .0053 or 0.53%
[Based on 2.1% for 3 months and 0% for 9 months]

NON-INSTITUTIONAL SERVICES
State Plan Amendment #09-19

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. 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: An outpatient "mini" UPL calculated in accordance with an agreed upon methodology was submitted to CMS on May 29, 2009. The State is required per agreement with CMS to provide a full year's UPL no later than March 31, 2010.

- 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 outpatient hospital, home health services including services provided to home care patients diagnosed with AIDS, personal care services and adult day health care services is a cost-based methodology subject to ceilings. We are unaware of any current requirement under federal law or regulation that limits individual providers' payments to their actual costs.