NEW YORK
state department of
HEALTH

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

Sue Kelly
Executive Deputy Commissioner

May 31, 2011

Mr. Michael Melendez
Associate Regional Administrator
Department of Health & Human Services
Centers for Medicare & Medicaid Services
New York Regional Office
Division of Medicaid & Children's Health
26 Federal Plaza, Room 3800
New York, NY 10278

RE: SPA #11-06
Non-Institutional Services

Dear Mr. Melendez:

The State requests approval of the enclosed amendment #11-06 to the Title XIX (Medicaid) State Plan for non-institutional services related to New York State's procedure for tribal consultations to be effective April 1, 2011 (Appendix I). This amendment is being submitted based on federal legislation and CMS directive. A summary of the plan amendment is provided in Appendix II.

The State of New York reimburses 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.

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

Sincerely,

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

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL **FOR: HEALTH CARE FINANCING ADMINISTRATION**	1. TRANSMITTAL NUMBER: **11-06**	2. STATE **New York**
	3. PROGRAM IDENTIFICATION: **TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)**	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE **April 1, 2011**	

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: **ARRA of 2009, Public Law 111-5, Section 5006**	7. FEDERAL BUDGET IMPACT: a. FFY **$0** b. FFY **$0**
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: **Pages 9 and 9-1**	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: **Page 9**

10. SUBJECT OF AMENDMENT:
Tribal Consultation Procedure

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:	16. RETURN TO: **New York State Department of Health** **Corning Tower** **Empire State Plaza** **Albany, New York 12237**
13. TYPED NAME: **Jason A. Helgerson**	
14. TITLE: **Medicaid Director & Deputy Commissioner Department of Health**	
15. DATE SUBMITTED: May 31, 2011	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:	18. DATE APPROVED:
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL:	20. SIGNATURE OF REGIONAL OFFICIAL:
21. TYPED NAME:	22. TITLE:

23. REMARKS:

Appendix I
2011 Title XIX State Plan
First Quarter Amendment
Amended SPA Pages

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: **New York**

1.4 State Medical Care Advisory Committee **(42 CFR 431.12(b))**
There is an advisory committee to the Medicaid agency director on health and medical care services established in accordance with and meeting all the requirements of 42 CFR 431.12.

Tribal Consultation Requirements
Section 1902(a)(73) of the Social Security Act (the Act) requires a State in which one or more Indian Health Programs or Urban Indian Organizations furnish health care services to establish a process for the State Medicaid agency to seek advice on a regular, ongoing basis from designees of Indian health programs, whether operated by the Indian Health Service (IHS), Tribes or Tribal organizations under the Indian Self-Determination and Education Assistance Act (ISDEAA), or Urban Indian Organizations under the Indian Health Care Improvement Act (IHCIA). Section 2107(e)(I) of the Act was also amended to apply these requirements to the Children's Health Insurance Program (CHIP). Consultation is required concerning Medicaid and CHIP matters having a direct impact on Indian health programs and Urban Indian organizations.

Please describe the process the State uses to seek advice on a regular, ongoing basis from federally-recognized tribes, Indian Health Programs and Urban Indian Organizations on matters related to Medicaid and CHIP programs and for consultation on State Plan Amendments, waiver proposals, waiver extensions, waiver amendments, waiver renewals and proposals for demonstration projects prior to submission to CMS. Please include information about the frequency, inclusiveness and process for seeking such advice.

Please describe the consultation process that occurred specifically for the development and submission of this State Plan Amendment, when it occurred and who was involved.

Tribal Consultation Process
For changes to the State's Medicaid Plan (Plan) that require a State Plan Amendment (SPA), Indian nation leaders and health clinic administrators and Urban Indian Organization leaders and health department administrators will be sent a copy of the Federal Public Notice related to a particular SPA, along with a cover letter offering the availability of State staff to meet with respective Indian leaders in person upon requests made within two weeks of the date of notification. At least two weeks' prior to submitting a SPA to CMS for approval, a draft copy of the proposed amendment will be forwarded to the above Indian representatives, allowing for a two-week comment period. Indian health clinic administrators will be notified via e-mail, and all other Indian representatives will be notified via U.S. Postal Service.

For Medicaid policy changes that do not require a SPA, a draft copy of the Administrative Directive related to the change will be forwarded to Indian representatives, as outlined above, for a two-week comment period. A State contact person will be identified for each draft directive.

Written notification of the State's intent to submit proposals for demonstration projects or new applications, amendments, extension requests or renewals for waivers that have an impact on Indians, Indian health providers or Urban Indian Organizations will be made to Indian representatives, as identified above, at least 60 days prior to the publication and submission of such. Indian health clinic administrators will be notified via e-mail, and all other Indian representatives will be notified via U.S. Postal Service.

Tribal Consultation Process Development

State representatives attended the 2011 Department of Health and Human Services (HHS) Annual Regional Tribal Consultation Session held on March 29, 2011. At that meeting, State staff distributed and discussed the draft Federal Public Notice which contained a summary description of the proposed tribal consultation policy. State staff also distributed a draft SPA and conducted a PowerPoint presentation, both of which elaborated on the proposed tribal consultation policy. Tribal representatives received contact information for various State staff who could answer any questions that may arise. Copies of all handouts were left with HHS HIS representatives to share with those Indian nations who did not have representatives in attendance. As of May 1, 2011, no questions or comments were received by the State subsequent to the above meeting.

Appendix II
2011 Title XIX State Plan
First Quarter Amendment
Summary

SUMMARY
SPA #11-06

This State Plan Amendment establishes a procedure for soliciting advice from designees of the State's Indian health programs concerning Medicaid and CHIP matters that may have an impact on Indians or Indian health programs.

Appendix III
2011 Title XIX State Plan
First Quarter Amendment
Authorizing Provisions

`DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Center for Medicaid and State Operations

SMDL#: 10-001
ARRA #: 6

January 22, 2010

Re: ARRA Protections for Indians in Medicaid and CHIP

Dear State Medicaid Director:

This letter is one of a series that provides guidance on the implementation of the American Recovery and Reinvestment Act of 2009 (Recovery Act), Public Law 111-5. Section 5006 of the Recovery Act provides protections for Indians in Medicaid and the Children's Health Insurance Program (CHIP). The amendments made by this section were effective on July 1, 2009. This letter provides a brief overview to assist States with implementation of these new provisions for Indians in your programs.

Section 5006 of the Recovery Act provides certain premium and cost-sharing protections under Medicaid and exemption for certain Indian-specific property from consideration in determining Medicaid eligibility and from Medicaid estate recovery. It also provides certain Medicaid managed care protections for Indian health programs and Indian beneficiaries and establishes new requirements for consultation on Medicaid and CHIP with Indian health programs. The new provisions are described in greater detail below.

Premium and Cost-Sharing Protections Under Medicaid

The Social Security Act (the Act) allows States to impose enrollment fees, premiums, cost-sharing and similar charges under certain conditions on Medicaid participants under title XIX and CHIP participants under title XXI of the Act. The Medicaid provisions are at section 1916 of the Act for nominal premiums and cost-sharing and at section 1916A of the Act for alternative premiums and cost-sharing, as authorized by the Deficit Reduction Act of 2005 (DRA), Public Law 109-171. CHIP provisions can be found at section 2103(e) of the Act.

Section 5006(a) of the Recovery Act amends sections 1916 and 1916A of the Act, to preclude States from imposing Medicaid premiums or any other Medicaid cost sharing on Indian applicants and participants served by Indian health providers and to assure that Indian health providers, and providers of contract health services (CHS) under a referral from an Indian health provider, will receive full payment. These provisions apply to the Medicaid program. Premiums and cost-sharing exemptions for Indians under CHIP are not affected. These provisions became effective **July 1, 2009**. Specifically, section 5006(a):

- Exempts Indians from payment of enrollment fees, premiums, or similar charges if they are furnished an item or service by an Indian health care provider; Indian Health Service (IHS); an Indian Tribe, Tribal Organization, or Urban Indian Organization (I/T/U)) or through referral under CHS. We consider this condition to be met if the individual meets the definition of Indian below.
- Exempts Indians from payment of a deductible, coinsurance, copayment, or similar charge for any item or service covered by Medicaid if the Indian is furnished the item or service directly by an Indian health care provider, I/T/U or through CHS.
- Prohibits any reduction in payment that is due under Medicaid to the I/T/U or to a health care provider through referral under CHS for furnishing an item or service to an Indian. The State must pay these providers the full Medicaid payment rate for furnishing the item or service. Their payments may not be reduced by the amount of any enrollment fee, premium, deduction, copayment, or similar charge that otherwise would be due from the Indian.

Definitions

For purposes of ensuring compliance with the cost-sharing provisions under the Recovery Act, CMS will use the following definitions in reviewing State plans:

- Indian Health Care Provider means a health care program, including CHS, operated by the IHS or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).
- Indian means an individual, defined at title 25 of the U.S.C. sections 1603(c), 1603(f). 1679(b) or who has been determined eligible, as an Indian, pursuant to 42 C.F.R. 136.12 or Title V of the Indian Health Care Improvement Act, to receive health care services from Indian health care providers (IHS, an Indian Tribe, Tribal Organization, or Urban Indian Organization–I/T/U) or through referral under Contract Health Services.

State Medicaid programs are encouraged to work closely with I/T/Us and Contract Health Services programs within the State to implement the exemption of Indians from Medicaid enrollment fees, premiums, or other similar charges and for exemption from deductibles, coinsurance payments, copayments, or similar charges. In addition, States are encouraged to inform non-I/T/U providers who participate in CHS about the absence of cost-sharing.

Exemption of Certain Property from Resources for Medicaid and CHIP Eligibility

Section 5006(b) of the Recovery Act amends the Medicaid statute by adding section 1902(ff) of the Act and the CHIP statute by adding section 2107(e)(1)(C) of the Act to require States to exclude certain types of Indian-specific property from being considered as "resources" when determining Medicaid or CHIP eligibility for an individual who is an Indian. These resource exclusions became effective **July 1, 2009.**

In general, the Recovery Act requires States to exclude resources in two categories:

- Property connected to the political relationship between Indian Tribes and the Federal government; and
- Property with unique Indian significance.

The following resources must be excluded:

1. Property, including real property and improvements, that is held in trust, subject to Federal restrictions, or otherwise under the supervision of the Secretary of the Interior; located on a reservation, including any federally-recognized Indian Tribe's reservation, pueblo, or colony, including former reservations in Oklahoma, Alaska Native regions established by the Alaska Native Claims Settlement Act and Indian allotments on or near a reservation as designated and approved by the Bureau of Indian Affairs of the Department of the Interior.
2. For any federally-recognized Tribe not described in paragraph (1), property located within the most recent boundaries of a prior Federal reservation.
3. Ownership interests in rents, leases, royalties, or usage rights related to natural resources (including extraction of natural resources or harvesting of timber, other plants and plant products, animals, fish, and shellfish) resulting from the exercise of federally-protected rights.
4. Ownership interests in or usage rights to items not covered by paragraphs (1) through (3) that have unique religious, spiritual, traditional, or cultural significance or rights that support subsistence or a traditional lifestyle according to applicable Tribal law or custom.

Enclosed is additional guidance on consideration of income and conversion of resources for Medicaid eligibility of Indians. It is important to note that section 5006(b) did not change the treatment of income for Medicaid or CHIP eligibility purposes. Income that was protected under previous laws or rules will be protected still and income that was counted under previous laws or rules will be counted still.

Continuation of Current Protections for Certain Indian Property from Medicaid Estate Recovery

Section 5006(c) of the Recovery Act amends section 1917(b)(3) of the Act to specify in the Act that certain Indian income, resources, and property are exempt from Medicaid estate recovery. These provisions have been in the State Medicaid Manual since April 1, 2003 and can be found at section 3810.A.7.

The specific income, resources, and property exempted from Medicaid estate recovery for Indians include:

1. Certain income and resources (such as interests in and income derived from Tribal land and other resources currently held in trust status and judgment funds from the Indian Claims Commission and the U.S. Claims Court) that are exempt from Medicaid estate recovery by other laws and regulations.
2. Ownership interest in trust or non-trust property, including real property and improvements:

a. Located on a reservation (any federally-recognized Indian Tribe's reservation, pueblo, or colony, including former reservations in Oklahoma, Alaska Native regions established by Alaska Native Claims Settlement Act and Indian allotments) or near a reservation as designated and approved by the Bureau of Indian Affairs of the U.S. Department of the Interior; or
b. For any federally-recognized Tribe not described in (a), located within the most recent boundaries of a prior federal reservation.
c. Protection of non-trust property described in (a) and (b) is limited to circumstances when the property passes from an Indian (as defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. section 1603)) to one or more relatives (by blood, adoption, or marriage), including Indians not enrolled as members of a Tribe and non-Indians, such as spouses and step-children, that their culture would nevertheless protect as family members; to a Tribe or Tribal Organization; and/or to one or more Indians;

3. Income left as a remainder in an estate derived from property protected in section 2 above, that was either collected by an Indian, or by a Tribe or Tribal Organization and distributed to Indian(s), as long as the individual can clearly trace it as coming from the protected property.
4. Ownership interests left as a remainder in an estate in rents, leases, royalties, or usage rights related to natural resources (including extraction of natural resources or harvesting of timber, other plants and plant products, animals, fish, and shellfish) resulting from the exercise of federally-protected rights, and income either collected by an Indian, or by a Tribe or Tribal Organization and distributed to Indians(s) derived from these sources as long as the individual can clearly trace it as coming from protected sources; and.
5. Ownership interests in, or usage rights to, items not covered by 1-4 above that have unique religious, spiritual, traditional, and/or cultural significance or rights that support subsistence or a traditional life style according to applicable Tribal law or custom.

<u>New Statutory Requirements Regarding Indians, Indian Health Care Providers, Indian Managed Care Entities in Medicaid, and CHIP Managed Care Programs</u>

Section 5006(d) of the Recovery Act adds a new section 1932(h) to the Medicaid statute and section 2107(e)(1)(J) to the CHIP statute, which will apply consistent rules governing the treatment of Indians, Indian health care providers–I/T/Us, and Indian Managed Care Entities (IMCEs) in a State Medicaid or CHIP managed care program. The term Indian Managed Care Entity (IMCE) means a managed care entity that is controlled by the IHS, a Tribe, Tribal Organization, or Urban Indian Organization, or a consortium, which may be composed of one or more Tribes, Tribal Organizations, or Urban Indian Organizations, and which may also include the IHS. The new statutory provision expressly recognizes that an IMCE may restrict its enrollment to Indians in the same manner as Indian health programs may restrict the delivery of services to Indians.

Indians who are eligible for Medicaid or CHIP may elect to enroll in managed care entities for this purpose, including primary care case management (PCCM) programs on a voluntary basis. They may be enrolled on a mandatory basis under a Medicaid or CHIP waiver or in an I/T/U managed care entity.

Under section 5006(d), all contracts with Medicaid and CHIP managed care entities, which include Medicaid and CHIP managed care organizations (MCOs) and PCCMs, must:

- Permit any Indian who is enrolled in a non-Indian MCE and eligible to receive services from a participating I/T/U provider, to choose to receive covered services from that I/T/U provider, and if that I/T/U provider participates in the network as a primary care provider, to choose that I/T/U as his or her primary care provider, as long as that provider has capacity to provide the services;
- Require each managed care entity to demonstrate that there are sufficient I/T/U providers in the network to ensure timely access to services available under the contract for Indian enrollees who are eligible to receive services from such providers;
- Require that I/T/U providers, whether participating in the network or not, be paid for covered Medicaid or CHIP managed care services provided to Indian enrollees who are eligible to receive services from such providers either (1) at a rate negotiated between the managed care entity and the I/T/U provider, or (2) if there is no negotiated rate, at a rate not less than the level and amount of payment that would be made if the provider were not an I/T/U provider; and
- Provide that the managed care entity must make prompt payment to all I/T/U providers in its network as required for payments to practitioners in individual or group practices under federal regulations at 42 CFR sections 447.45 and 447.46.

The Centers for Medicare & Medicaid Services intends to issue forthcoming regulations to address the application of the requirement for sufficient I/T/Us in States where there are few or none available.

Under prior provisions of law, I/T/U providers that receive reimbursement as federally qualified health centers (FQHCs) pursuant to a contract from a managed care entity also receive a supplemental payment from the State to make up the difference between the amount the managed care entity pays and what the I/T/U FQHC would have received under the State Plan.

The new provision provides a supplemental payment from the State to all I/T/U providers for services furnished to managed care enrollees, whether the provider is an FQHC or not, and without regard to whether the provider has a contract with the managed care entity. The supplemental payment must make up the difference between the amount paid by the managed care entity and the applicable rate under the State plan.

Consultation on Medicaid, CHIP, and Other Health Care Programs Funded under the Act Involving Indian Health Programs and Urban Indian Organizations

Section 5006(e) of the Recovery Act codifies in statute, at section 1902(a)(73) and section 2107(e)(1)(C) of the Act, the requirement for the Secretary of Health and Human Services (HHS) to maintain a Tribal Technical Advisory Group (TTAG) within CMS. The TTAG, initially established in accordance with a charter dated September 30, 2003, is now required to include a representative of IHS and a representative of a national Urban Indian Organization.

Additionally, effective July 1, 2009, certain States are required to utilize a process for the State to seek advice on a regular, ongoing basis from designees of the Indian health programs and Urban Indian Organizations concerning Medicaid and CHIP matters having a direct effect on Indians, Indian health programs or Urban Indian Organizations. The consultation process must be followed by any State in which one or more Indian health programs or Urban Indian Organizations furnish health care services, even if no federally-recognized Indian Tribes are located within the State. These States are required to specifically solicit such advice prior to the State's submission of any Medicaid or CHIP State plan amendment, waiver request, or proposal for a demonstration project likely to have a direct effect on Indians, Indian health programs, or Urban Indian Organizations. The consultation may include the appointment of an advisory committee or a designee of these IHS (including those programs operated by federally-recognized Tribes under P.L. 93-638 authority) and Urban Organizations to the State medical care advisory committee required by Federal regulations at 42 CFR 431.12, both, or another method. Also, enclosed is the Medicaid State plan template that a State must use for a State plan amendment in order to document its process for such consultation. CMS is sharing, in draft, the SPA template under the guidelines of the Paperwork Reduction Act (PRA) currently under OMB review. Until the PRA process is completed, States are not obligated to use the recommended template. After CMS obtains the necessary PRA clearance number from OMB, States will be required to complete the SPA template.

Previously, CMS has provided guidance on the consultation process with federally-recognized Indian Tribes, which may be found in the July 17, 2001, State Medicaid Director Letter, requiring State consultation with federally-recognized Indian Tribes for waivers. The letter will be revised to address additional requirements in Section 5006(e) of the Recovery Act. The above-referenced letter can be found on the CMS Web site at: http://www.cms.hhs.gov/smdl/downloads/smd071701.pdf .

Examples of changes that would have a direct effect on Indians, Indian health programs, or Urban Indian Organizations include Medicaid or CHIP changes (submitted through State plan amendments, proposed waivers, waiver extensions, waiver amendments or waiver renewals) that are more restrictive for eligibility determinations, changes that reduce payment rates or changes in payment methodologies to I/T/U providers or for services reimbursed to I/T/U providers, reductions in covered services, changes in consultation policies, and proposals for demonstrations or waivers that may impact Indians or I/T/U providers.

Implementation

This guidance is offered in order to assist States in planning for application of these provisions. Additional guidance will be forthcoming on this issue, and CMS will work with States to help them implement these provisions in a manner that is consistent with the statute.

In keeping with the HHS Tribal consultation policy and the new provisions in the Recovery Act, CMS collaborated and consulted with the TTAG and IHS to solicit advice on implementing these provisions. The Tribal Affairs Group and the Center for Medicaid and State Operations, within CMS, jointly hosted two All Tribes Calls on June 5 and 12, 2009, to consult on implementation of section 5006 of the Recovery Act. Two face-to-face consultation meetings were held in

Denver on July 8 and 10, 2009, to solicit advice and input on these provisions from federally-recognized Tribes, Indian health providers, and Urban Indian Organizations. An All States Call was held on June 10, 2009, with the State Medicaid and CHIP programs to describe the CMS Tribal consultation process on the Recovery Act provisions and to solicit feedback and questions from States.

Contact Information

We hope you find this information helpful in your efforts to implement the provisions of the Recovery Act. If you have questions regarding this guidance, please send an email to CMSOCHIPRAQuestions@cms.hhs.gov or contact Ms. Victoria Wachino, Director, Family and Children's Health Programs Group, who may be reached at (410) 786-5647.

Sincerely,

/s/

Cindy Mann
Director
Center for Medicaid and State Operations

Enclosures

cc:

CMS Regional Administrators

CMS Associate Regional Administrators
Division of Medicaid and Children's Health

Ann C. Kohler
NASMD Executive Director
American Public Human Services Association

Joy Wilson
Director, Health Committee
National Conference of State Legislatures

Matt Salo
Director of Health Legislation
National Governors Association

Debra Miller
Director for Health Policy
Council of State Governments

Christine Evans, M.H.P.
Director, Government Relations
Association of State and Territorial Health Officials

Alan R. Weil, J.D., M.P.P.
Executive Director
National Academy for State Health Policy

Dr. Yvette Roubideaux
Director
Indian Health Service

Valerie Davidson
Chairman
Tribal Technical Advisory Group

Stacy Bohlen
Executive Director
National Indian Health Board

Additional Guidance for Consideration of Income and Resources for Medicaid Eligibility of Indians

In order to be eligible for Medicaid or the Children's Health Insurance Program (CHIP), an individual must have countable income and resources at or below the maximum amounts established by the State plan. The following rules, in accordance with Federal regulations at 42 CFR 435.601(b), generally apply to eligibility for Medicaid and CHIP:

- Income is defined for Medicaid and CHIP purposes as anything that an individual receives (e.g., wages, self-employment income, interest, dividends, Social Security payments) that the individual can use to pay for the family's basic necessities.
- Resources are defined as cash or anything an individual owns (e.g., checking or savings accounts, real estate, personal property, stocks, bonds) that the individual can convert to cash to pay for the family's basic necessities.
- Any income not spent during the month of receipt is considered as resources in the following months. It is counted or excluded as a resource depending on the form that it takes (e.g., cash, checking account, stocks, property).
- Certain types of income and resources are not counted for Medicaid and/or CHIP eligibility, such as the home property in which the family lives.

If an individual does not have the legal right, authority, or power to liquidate resources or to use income or resources that the individual owns, that income or resource is not counted for Medicaid or CHIP eligibility because the individual is not free to access and spend it.

- For example, if an Indian has a restricted Individual Indian Money (IIM) Account with money held in trust for the individual's use, but that individual must be authorized by someone else to access the money, and that access may be denied, the money in the IIM is considered to be inaccessible and so is excluded from consideration as a resource for Medicaid or CHIP eligibility.

Resources include an individual's right to harvest or extract natural resources from land that the individual owns or for which the individual has an ownership interest (e.g., mineral rights, fishing rights, timber rights). If the individual cannot sell those rights or that ownership interest, or those rights or that ownership is specifically excluded by statute, those resources are not accessible and are not counted for Medicaid or CHIP eligibility.

- For example, if a Tribe holds rights to extract natural resources from a geographical area, those rights are not owned by any individual and cannot be sold by any Tribal member, even if an individual exercises those rights to extract and sell natural resources from the property (e.g., oil, gas, gravel, timber). Therefore, the mineral/timber rights are not counted as a resource for any Tribal member's Medicaid or CHIP eligibility.

If a resource is sold or exchanged, the proceeds are still considered resources, not income. Therefore, if natural resources (e.g., gravel, timber, fish, oil) are sold by the owner of the property or by the owner of rights for use of that geographical area, the money received from that sale is also considered as a resource in the determination of Medicaid or CHIP eligibility.

However, if the rights for use of the natural resources are excluded as a resource (such as because the individual cannot sell the ownership interest), the money received for the sale of natural resources extracted or harvested from that area is also excluded as a resource during the month of receipt. If the individual retains money from the sale of the natural resources and does not spend it, the money is considered for Medicaid or CHIP resource eligibility in the months following the month of receipt depending on the form the money takes (e.g., countable in a checking account or cash, excludable in certain property such as a home). If the individual sells the resource and then spends the money or uses it to purchase another resource that is also considered exempt under Medicaid and CHIP rules, eligibility may not be affected.

- For example, if a Tribal member or Tribe exercises federally-protected mineral rights and sells minerals extracted in that designated area, money received from the sale of the minerals is not income but is considered to be an excluded resource in the month that the money is received.
- If the money from the sale of the minerals is not spent by the end of the month it is received (e.g., to pay for the family's food or other personal or business expenses), the money is either counted or excluded as a resource based on the type of resource in which the money is retained after the month of receipt.
    - For example, if the money is deposited and retained in the individual's checking account, it is counted as a resource along with all other money in the checking account after the month the money is received. If the money is spent to purchase a car and the State's Medicaid program excludes motor vehicles as a resource, it is excluded from consideration as a resource for Medicaid or CHIP eligibility.

Certain types of Tribal per capita payments and other types of Tribal income are excluded from consideration as income per Public Law 98-64 (the Per Capita Act) and 45 CFR section 233.20(a)(4)(ii)(e). This law and implementing regulations specify that per capita distribution of all funds held in trust by the Secretary of Interior for members of an Indian Tribe are excluded from consideration as income and resources for federal means-tested public benefits programs (e.g., Medicaid and CHIP).

However, also according to Public Law 98-64, local Tribal funds that a Tribe distributes to individuals on a per capita basis, but which have not been held in trust by the Secretary of Interior (e.g., Tribally managed gaming revenues), are not excluded from income and resources. Therefore, those funds are considered as countable income in the month of receipt. Any per capita payments from gaming revenues that are retained after the month of receipt are counted or excluded based on the type of resource in which the money is retained.

- For example, if a Tribal member receives a quarterly check from the Tribe as the individual's per capita payment from the casino owned by Tribe, the money is considered as the individual's countable income in the month that the check is received.
- Any money from a per capita casino payment that the individual still has after the month of receipt is counted or excluded based where the money is. If it is retained in a countable resource (e.g., cash, checking or savings account), it is counted for Medicaid and CHIP eligibility. If it is converted to an excludable resource (e.g., personal property like a refrigerator), it is excluded for Medicaid and CHIP eligibility.

DRAFT DRAFT

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State:

1.4 State Medical Care Advisory Committee **(42 CFR 431.12(b))**
There is an advisory committee to the Medicaid agency director on health and medical care services established in accordance with and meeting all the requirements of 42 CFR 431.12.

Tribal Consultation Requirements
Section 1902(a)(73) of the Social Security Act requires a State in which one or more Indian Health Programs or Urban Indian Organizations furnish health care services to establish a process for the State Medicaid agency to seek advice on a regular, ongoing basis from designees of Indian health programs, whether operated by the Indian Health Service (IHS), Tribes or Tribal organizations under the Indian Self-Determination and Education Assistance Act (ISDEAA), or Urban Indian Organizations under the Indian Health Care Improvement Act (IHCIA) Consultation is required concerning Medicaid matters having a direct impact on these Indian health programs . Please indicate below whether the State, as part of its consultation process, appoints an advisory committee or appoints a designee of the Indian health programs and Urban Indian Organizations to the State medical care advisory committee, both of these, or something else.

__/ State appoints a tribal advisory committee.
__/ State appoints a designee of the IHS, Tribes or Tribal organizations operating health programs under the ISDEAA, and/or Urban Indian organizations operating health programs under the IHCIA to the State medical care advisory committee.
__/ Other. Specify:
__/ Not applicable because the State does not have at least one Indian Health Program or Urban Indian Organization furnishing health care services.

TN No: Approval Date Effective Date _____

Supersedes TN No.

ARRA of 2009
Public Law 111-5

to Congress annual reports concerning enrollment and participation rates described in such paragraph.".

(e) EFFECTIVE DATE.—The amendments made by subsections (b) through (d) shall take effect on July 1, 2009.

SEC. 5005. EXTENSION OF THE QUALIFYING INDIVIDUAL (QI) PROGRAM.

(a) EXTENSION.—Section 1902(a)(10)(E)(iv) of the Social Security Act (42 U.S.C. 1396a(a)(10)(E)(iv)) is amended by striking "December 2009" and inserting "December 2010".

(b) EXTENDING TOTAL AMOUNT AVAILABLE FOR ALLOCATION.—Section 1933(g) of such Act (42 U.S.C. 1396u–3(g)) is amended—

(1) in paragraph (2)—

(A) by striking "and" at the end of subparagraph (K);

(B) in subparagraph (L), by striking the period at the end and inserting a semicolon; and

(C) by adding at the end the following new subparagraphs:

"(M) for the period that begins on January 1, 2010, and ends on September 30, 2010, the total allocation amount is $412,500,000; and

"(N) for the period that begins on October 1, 2010, and ends on December 31, 2010, the total allocation amount is $150,000,000."; and

(2) in paragraph (3), in the matter preceding subparagraph (A), by striking "or (L)" and inserting "(L), or (N)".

SEC. 5006. PROTECTIONS FOR INDIANS UNDER MEDICAID AND CHIP.

(a) PREMIUMS AND COST SHARING PROTECTION UNDER MEDICAID.—

(1) IN GENERAL.—Section 1916 of the Social Security Act (42 U.S.C. 1396o) is amended—

(A) in subsection (a), in the matter preceding paragraph (1), by striking "and (i)" and inserting ", (i), and (j)"; and

(B) by adding at the end the following new subsection:

"(j) NO PREMIUMS OR COST SHARING FOR INDIANS FURNISHED ITEMS OR SERVICES DIRECTLY BY INDIAN HEALTH PROGRAMS OR THROUGH REFERRAL UNDER CONTRACT HEALTH SERVICES.—

"(1) NO COST SHARING FOR ITEMS OR SERVICES FURNISHED TO INDIANS THROUGH INDIAN HEALTH PROGRAMS.—

"(A) IN GENERAL.—No enrollment fee, premium, or similar charge, and no deduction, copayment, cost sharing, or similar charge shall be imposed against an Indian who is furnished an item or service directly by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization or through referral under contract health services for which payment may be made under this title.

"(B) NO REDUCTION IN AMOUNT OF PAYMENT TO INDIAN HEALTH PROVIDERS.—Payment due under this title to the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization, or a health care provider through referral under contract health services for the furnishing of an item or service to an Indian who is eligible for assistance under such title, may not be reduced by the amount of any enrollment fee, premium, or similar charge, or any deduction, copayment, cost

sharing, or similar charge that would be due from the Indian but for the operation of subparagraph (A).

"(2) RULE OF CONSTRUCTION.—Nothing in this subsection shall be construed as restricting the application of any other limitations on the imposition of premiums or cost sharing that may apply to an individual receiving medical assistance under this title who is an Indian.".

(2) CONFORMING AMENDMENT.—Section 1916A(b)(3) of such Act (42 U.S.C. 1396o–1(b)(3)) is amended—

(A) in subparagraph (A), by adding at the end the following new clause:

"(vii) An Indian who is furnished an item or service directly by the Indian Health Service, an Indian Tribe, Tribal Organization or Urban Indian Organization or through referral under contract health services."; and

(B) in subparagraph (B), by adding at the end the following new clause:

"(x) Items and services furnished to an Indian directly by the Indian Health Service, an Indian Tribe, Tribal Organization or Urban Indian Organization or through referral under contract health services.".

(b) TREATMENT OF CERTAIN PROPERTY FROM RESOURCES FOR MEDICAID AND CHIP ELIGIBILITY.—

(1) MEDICAID.—Section 1902 of the Social Security Act (42 U.S.C. 1396a), as amended by sections 203(c) and 211(a)(1)(A)(ii) of the Children's Health Insurance Program Reauthorization Act of 2009 (Public Law 111–3), is amended by adding at the end the following new subsection:

"(ff) Notwithstanding any other requirement of this title or any other provision of Federal or State law, a State shall disregard the following property from resources for purposes of determining the eligibility of an individual who is an Indian for medical assistance under this title:

"(1) Property, including real property and improvements, that is held in trust, subject to Federal restrictions, or otherwise under the supervision of the Secretary of the Interior, located on a reservation, including any federally recognized Indian Tribe's reservation, pueblo, or colony, including former reservations in Oklahoma, Alaska Native regions established by the Alaska Native Claims Settlement Act, and Indian allotments on or near a reservation as designated and approved by the Bureau of Indian Affairs of the Department of the Interior.

"(2) For any federally recognized Tribe not described in paragraph (1), property located within the most recent boundaries of a prior Federal reservation.

"(3) Ownership interests in rents, leases, royalties, or usage rights related to natural resources (including extraction of natural resources or harvesting of timber, other plants and plant products, animals, fish, and shellfish) resulting from the exercise of federally protected rights.

"(4) Ownership interests in or usage rights to items not covered by paragraphs (1) through (3) that have unique religious, spiritual, traditional, or cultural significance or rights that support subsistence or a traditional lifestyle according to applicable tribal law or custom.".

(2) APPLICATION TO CHIP.—Section 2107(e)(1) of such Act (42 U.S.C. 1397gg(e)(1)), as amended by sections 203(a)(2),

203(d)(2), 214(b), 501(d)(2), and 503(a)(1) of the Children's Health Insurance Program Reauthorization Act of 2009 (Public Law 111–3), is amended—

(A) by redesignating subparagraphs (C) through (I), as subparagraphs (D) through (J), respectively; and

(B) by inserting after subparagraph (B), the following new subparagraph:

"(C) Section 1902(ff) (relating to disregard of certain property for purposes of making eligibility determinations).".

(c) CONTINUATION OF CURRENT LAW PROTECTIONS OF CERTAIN INDIAN PROPERTY FROM MEDICAID ESTATE RECOVERY.—Section 1917(b)(3) of the Social Security Act (42 U.S.C. 1396p(b)(3)) is amended—

(1) by inserting "(A)" after "(3)"; and

(2) by adding at the end the following new subparagraph:

"(B) The standards specified by the Secretary under subparagraph (A) shall require that the procedures established by the State agency under subparagraph (A) exempt income, resources, and property that are exempt from the application of this subsection as of April 1, 2003, under manual instructions issued to carry out this subsection (as in effect on such date) because of the Federal responsibility for Indian Tribes and Alaska Native Villages. Nothing in this subparagraph shall be construed as preventing the Secretary from providing additional estate recovery exemptions under this title for Indians.".

(d) RULES APPLICABLE UNDER MEDICAID AND CHIP TO MANAGED CARE ENTITIES WITH RESPECT TO INDIAN ENROLLEES AND INDIAN HEALTH CARE PROVIDERS AND INDIAN MANAGED CARE ENTITIES.—

(1) IN GENERAL.—Section 1932 of the Social Security Act (42 U.S.C. 1396u–2) is amended by adding at the end the following new subsection:

"(h) SPECIAL RULES WITH RESPECT TO INDIAN ENROLLEES, INDIAN HEALTH CARE PROVIDERS, AND INDIAN MANAGED CARE ENTITIES.—

"(1) ENROLLEE OPTION TO SELECT AN INDIAN HEALTH CARE PROVIDER AS PRIMARY CARE PROVIDER.—In the case of a non-Indian Medicaid managed care entity that—

"(A) has an Indian enrolled with the entity; and

"(B) has an Indian health care provider that is participating as a primary care provider within the network of the entity,

insofar as the Indian is otherwise eligible to receive services from such Indian health care provider and the Indian health care provider has the capacity to provide primary care services to such Indian, the contract with the entity under section 1903(m) or under section 1905(t)(3) shall require, as a condition of receiving payment under such contract, that the Indian shall be allowed to choose such Indian health care provider as the Indian's primary care provider under the entity.

"(2) ASSURANCE OF PAYMENT TO INDIAN HEALTH CARE PROVIDERS FOR PROVISION OF COVERED SERVICES.—Each contract with a managed care entity under section 1903(m) or under section 1905(t)(3) shall require any such entity, as a condition of receiving payment under such contract, to satisfy the following requirements:

"(A) DEMONSTRATION OF ACCESS TO INDIAN HEALTH CARE PROVIDERS AND APPLICATION OF ALTERNATIVE PAYMENT ARRANGEMENTS.—Subject to subparagraph (C), to—

"(i) demonstrate that the number of Indian health care providers that are participating providers with respect to such entity are sufficient to ensure timely access to covered Medicaid managed care services for those Indian enrollees who are eligible to receive services from such providers; and

"(ii) agree to pay Indian health care providers, whether such providers are participating or nonparticipating providers with respect to the entity, for covered Medicaid managed care services provided to those Indian enrollees who are eligible to receive services from such providers at a rate equal to the rate negotiated between such entity and the provider involved or, if such a rate has not been negotiated, at a rate that is not less than the level and amount of payment which the entity would make for the services if the services were furnished by a participating provider which is not an Indian health care provider.

The Secretary shall establish procedures for applying the requirements of clause (i) in States where there are no or few Indian health providers.

"(B) PROMPT PAYMENT.—To agree to make prompt payment (consistent with rule for prompt payment of providers under section 1932(f)) to Indian health care providers that are participating providers with respect to such entity or, in the case of an entity to which subparagraph (A)(ii) or (C) applies, that the entity is required to pay in accordance with that subparagraph.

"(C) APPLICATION OF SPECIAL PAYMENT REQUIREMENTS FOR FEDERALLY-QUALIFIED HEALTH CENTERS AND FOR SERVICES PROVIDED BY CERTAIN INDIAN HEALTH CARE PROVIDERS.—

"(i) FEDERALLY-QUALIFIED HEALTH CENTERS.—

"(I) MANAGED CARE ENTITY PAYMENT REQUIREMENT.—To agree to pay any Indian health care provider that is a federally-qualified health center under this title but not a participating provider with respect to the entity, for the provision of covered Medicaid managed care services by such provider to an Indian enrollee of the entity at a rate equal to the amount of payment that the entity would pay a federally-qualified health center that is a participating provider with respect to the entity but is not an Indian health care provider for such services.

"(II) CONTINUED APPLICATION OF STATE REQUIREMENT TO MAKE SUPPLEMENTAL PAYMENT.—Nothing in subclause (I) or subparagraph (A) or (B) shall be construed as waiving the application of section 1902(bb)(5) regarding the State plan requirement to make any supplemental payment due under such section to a federally-qualified health center for services furnished by such center to an enrollee of a managed care entity (regardless

of whether the federally-qualified health center is or is not a participating provider with the entity).

"(ii) PAYMENT RATE FOR SERVICES PROVIDED BY CERTAIN INDIAN HEALTH CARE PROVIDERS.—If the amount paid by a managed care entity to an Indian health care provider that is not a federally-qualified health center for services provided by the provider to an Indian enrollee with the managed care entity is less than the rate that applies to the provision of such services by the provider under the State plan, the plan shall provide for payment to the Indian health care provider, whether the provider is a participating or nonparticipating provider with respect to the entity, of the difference between such applicable rate and the amount paid by the managed care entity to the provider for such services.

"(D) CONSTRUCTION.—Nothing in this paragraph shall be construed as waiving the application of section 1902(a)(30)(A) (relating to application of standards to assure that payments are consistent with efficiency, economy, and quality of care).

"(3) SPECIAL RULE FOR ENROLLMENT FOR INDIAN MANAGED CARE ENTITIES.—Regarding the application of a Medicaid managed care program to Indian Medicaid managed care entities, an Indian Medicaid managed care entity may restrict enrollment under such program to Indians in the same manner as Indian Health Programs may restrict the delivery of services to Indians.

"(4) DEFINITIONS.—For purposes of this subsection:

"(A) INDIAN HEALTH CARE PROVIDER.—The term 'Indian health care provider' means an Indian Health Program or an Urban Indian Organization.

"(B) INDIAN MEDICAID MANAGED CARE ENTITY.—The term 'Indian Medicaid managed care entity' means a managed care entity that is controlled (within the meaning of the last sentence of section 1903(m)(1)(C)) by the Indian Health Service, a Tribe, Tribal Organization, or Urban Indian Organization, or a consortium, which may be composed of 1 or more Tribes, Tribal Organizations, or Urban Indian Organizations, and which also may include the Service.

"(C) NON-INDIAN MEDICAID MANAGED CARE ENTITY.—The term 'non-Indian Medicaid managed care entity' means a managed care entity that is not an Indian Medicaid managed care entity.

"(D) COVERED MEDICAID MANAGED CARE SERVICES.—The term 'covered Medicaid managed care services' means, with respect to an individual enrolled with a managed care entity, items and services for which benefits are available with respect to the individual under the contract between the entity and the State involved.

"(E) MEDICAID MANAGED CARE PROGRAM.—The term 'Medicaid managed care program' means a program under sections 1903(m), 1905(t), and 1932 and includes a managed care program operating under a waiver under section 1915(b) or 1115 or otherwise.".

(2) APPLICATION TO CHIP.—Section 2107(e)(1) of such Act (42 U.S.C. 1397gg(1)), as amended by subsection (b)(2), is amended—

(A) by redesignating subparagraph (J) as subparagraph (K); and

(B) by inserting after subparagraph (I) the following new subparagraph:

"(J) Subsections (a)(2)(C) and (h) of section 1932.".

(e) CONSULTATION ON MEDICAID, CHIP, AND OTHER HEALTH CARE PROGRAMS FUNDED UNDER THE SOCIAL SECURITY ACT INVOLVING INDIAN HEALTH PROGRAMS AND URBAN INDIAN ORGANIZATIONS.—

(1) CONSULTATION WITH TRIBAL TECHNICAL ADVISORY GROUP (TTAG).—The Secretary of Health and Human Services shall maintain within the Centers for Medicaid & Medicare Services (CMS) a Tribal Technical Advisory Group (TTAG), which was first established in accordance with requirements of the charter dated September 30, 2003, and the Secretary of Health and Human Services shall include in such Group a representative of a national urban Indian health organization and a representative of the Indian Health Service. The inclusion of a representative of a national urban Indian health organization in such Group shall not affect the nonapplication of the Federal Advisory Committee Act (5 U.S.C. App.) to such Group.

(2) SOLICITATION OF ADVICE UNDER MEDICAID AND CHIP.—

(A) MEDICAID STATE PLAN AMENDMENT.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)), as amended by section 501(d)(1) of the Children's Health Insurance Program Reauthorization Act of 2009 (Public Law 111–3), (42 U.S.C. 1396a(a)) is amended—

(i) in paragraph (71), by striking "and" at the end;

(ii) in paragraph (72), by striking the period at the end and inserting "; and"; and

(iii) by inserting after paragraph (72), the following new paragraph:

"(73) in the case of any State in which 1 or more Indian Health Programs or Urban Indian Organizations furnishes health care services, provide for a process under which the State seeks advice on a regular, ongoing basis from designees of such Indian Health Programs and Urban Indian Organizations on matters relating to the application of this title that are likely to have a direct effect on such Indian Health Programs and Urban Indian Organizations and that—

"(A) shall include solicitation of advice prior to submission of any plan amendments, waiver requests, and proposals for demonstration projects likely to have a direct effect on Indians, Indian Health Programs, or Urban Indian Organizations; and

"(B) may include appointment of an advisory committee and of a designee of such Indian Health Programs and Urban Indian Organizations to the medical care advisory committee advising the State on its State plan under this title.".

(B) APPLICATION TO CHIP.—Section 2107(e)(1) of such Act (42 U.S.C. 1397gg(1)), as amended by subsections (b)(2) and (d) (2), is amended—

(i) by redesignating subparagraphs (B), (C), (D), (E), (F), (G), (H), (I), (J), and (K) as subparagraphs (D), (F), (B), (E), (G), (I), (H), (J), (K), and (L), respectively;

(ii) by moving such subparagraphs so as to appear in alphabetical order; and

(iii) by inserting after subparagraph (B) (as so redesiganted and moved) the following new subparagraph:

"(C) Section 1902(a)(73) (relating to requiring certain States to seek advice from designees of Indian Health Programs and Urban Indian Organizations).".

(3) RULE OF CONSTRUCTION.—Nothing in the amendments made by this subsection shall be construed as superseding existing advisory committees, working groups, guidance, or other advisory procedures established by the Secretary of Health and Human Services or by any State with respect to the provision of health care to Indians.

(f) EFFECTIVE DATE.—The amendments made by this section shall take effect on July 1, 2009.

SEC. 5007. FUNDING FOR OVERSIGHT AND IMPLEMENTATION.

(a) OVERSIGHT.—For purposes of ensuring the proper expenditure of Federal funds under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.), there is appropriated to the Office of the Inspector General of the Department of Health and Human Services, out of any money in the Treasury not otherwise appropriated and without further appropriation, $31,250,000 for fiscal year 2009, which shall remain available for expenditure until September 30, 2011, and shall be in addition to any other amounts appropriated or made available to such Office for such purposes.

(b) IMPLEMENTATION OF INCREASED FMAP.—For purposes of carrying out section 5001, there is appropriated to the Secretary of Health and Human Services, out of any money in the Treasury not otherwise appropriated and without further appropriation, $5,000,000 for fiscal year 2009, which shall remain available for expenditure until September 30, 2011, and shall be in addition to any other amounts appropriated or made available to such Secretary for such purposes.

SEC. 5008. GAO STUDY AND REPORT REGARDING STATE NEEDS DURING PERIODS OF NATIONAL ECONOMIC DOWNTURN.

(a) IN GENERAL.—The Comptroller General of the United States shall study the period of national economic downturn in effect on the date of enactment of this Act, as well as previous periods of national economic downturn since 1974, for the purpose of developing recommendations for addressing the needs of States during such periods. As part of such analysis, the Comptroller General shall study the past and projected effects of temporary increases in the Federal medical assistance percentage under the Medicaid program with respect to such periods.

(b) REPORT.—Not later than April 1, 2011, the Comptroller General of the United States shall submit a report to the appropriate committees of Congress on the results of the study conducted under paragraph (1). Such report shall include the following:

(1) Such recommendations as the Comptroller General determines appropriate for modifying the national economic downturn assistance formula for temporary adjustment of the

BACKGROUND INFORMATION

Handouts from

2011 Department of Health and Human Services Annual Regional Tribal Consultation Session

on March 29th in Verona

HHS Region II Tribal Consultation

Tuesday, March 29, 2011

Oneida Indian Nation

In collaboration with United South & Eastern Tribes (USET)

TRIBAL CONSULTATION AGENDA

8:00 – 8:05 — **Tribal Opening Blessing**

- Mary Blau, Oneida Indian Nation

8:05 – 8:10 — **HHS Welcome**

- Lauren Kidwell, Deputy Director – Office of the Secretary/IGA
- Jaime R. Torres – Regional Director - HHS Region II

8:10 – 8:15 — **Tribal Welcome**

- Kim Jacobs, Commissioner of Nation Administration - Oneida Indian Nation
- Dee Sabattus, USET Representative

8:15 – 8:30 — **Self Introductions of all Attendees**

8:30 – 9:00 — **Updates from HHS**

Potential Issues of Discussion:

- 2010 Region Tribal Consultation Overview
- National HHS Update

Presenters:

- Lauren Kidwell, Deputy Director - Office of the Secretary/IGA
- Jaime Torres, Regional Director, HHS Region II

Open Discussion of HHS Updates

9:00 – 10:00 — **Open Tribal Leader Discussion / Testimony**

- Tribal Leader comments, issues, or testimony.

10:00 – 11:00 — **Cross-cutting Issue Area #1: Affordable Care Act**

Potential Issues of Discussion:

- Improving Quality & Lowering Costs
- Increasing Access to Affordable Care
- New Consumer Protections

Panel Members:

- CMS
- HRSA
- IHS
- OCIIO (Office of Consumer Information and Insurance Oversight)

Open Discussion of Issue and Q&A - Area #1

** Please take individual breaks as you need throughout the day**

11:00 – 12:00 **Indian Health Service Budget and Priorities Update**

Potential Issues of Discussion:

- Video: Gathering Health Data for Next 7 Generations (St. Regis Mohawk)
- Tribal Health Priorities
- IHS Reform Efforts
- EHR Meaningful Use
- Health Insurance for Tribal Employees
- Facilities Construction

Presenter: CAPT Timothy L. Ricks, DMD, MPH
Deputy Area Director (acting), Nashville Area

Open Discussion of IHS Budget & Update

Noon – 1:00 **Lunch (on your own)**

1:00 – 2:00 **Cross–cutting Issue Area #2: Human Services Issues / Initiatives**

Panel Members:

- ACF
- AoA
- SAMHSA

Open Discussion of Issue Area #2

2:00 – 3:00 **Cross–cutting Issue Area #3: HHS Initiatives**

Panel Members:

- ASPR
- CMS
- HRSA
- OASH

Open Discussion of Issue Area #3

3:00 – 4:00 **Cross–cutting Issue Area #4: Tribal - State Relations**

- Introduction to new administration
- Medicaid

Panel Members:

- Gov. Cuomo's Office
- NYS Medicaid Office

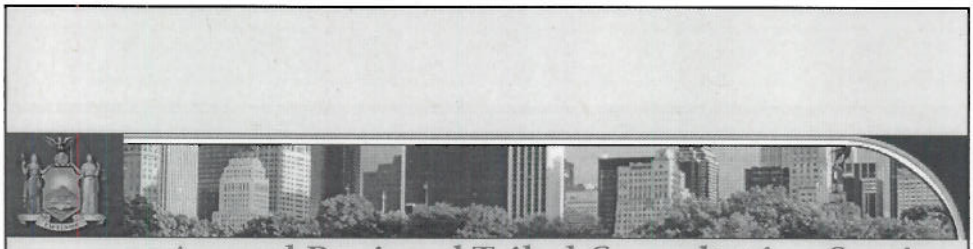
Open Discussion of Issue Area #4

4:00 – 4:30 **Wrap-up/Next Steps**

- Jaime Torres
  Regional Director, HHS Region II

4:30 – 4:45 **Tribal Closing**

**** Please take individual breaks as you need throughout the day****



2011 Annual Regional Tribal Consultation Session
Verona, New York
March 29,2011

New York State Department of Health
Philip N. Mossman, Director
Bureau of HCRA Operations & Financial Analysis

Today's Agenda

- *Tribal Consultation Process*
- *Medicaid Redesign Team (MRT) Overview*
- *MRT Recommendations*
- *Final Budget Update*

TRIBAL CONSULTATION PROCESS

Tribal Consultation Requirements

Section 1902(a)(73) of the Social Security Act requires a State in which one or more Indian Health Programs or Urban Indian Organizations furnish health care services to establish a process for the State Medicaid agency to seek advice on a regular, ongoing basis from designees of Indian health programs, whether operated by the Indian Health Service (IHS), Tribes or Tribal organizations under the Indian Self-Determination and Education Assistance Act (ISDEAA), or Urban Indian Organizations under the Indian Health Care Improvement Act (IHCIA) Consultation is required concerning Medicaid matters having a direct impact on these Indian health programs

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Proposed Process

- *Federal Public Notice (FPN):* For policy changes requiring a State Plan Amendment (SPA), the State will provide a copy of the FPN to designated Indian nation representatives in advance and allow for a 15-day comment period.
- *Administrative Directives:* For policy changes that do not require a SPA or for eligibility related SPAs, a draft copy of the Administrative Directive will be sent to designated Indian nation representatives, allowing for a two-week comment period
- *Waivers / Demonstrations:* written notification of the State's intent to submit new applications, amendments, extension requests and renewals for federal waivers to the State's Medicaid plan or demonstrations will be made at least 60 days prior to the publication and submission of such applications.

Upon request, State staff will be available to meet with nation leaders face-to-face to discuss content of FPNs, SPAs and/or waivers

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Contact Information

- **Reimbursement / Financing**
  Division of Health Care Financing
  Philip N. Mossman
  (518) 474-1673
  pnm01@health.state.ny.us
- **Long Term Care**
  Division of Health Facility Planning
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- **Provider Relations**
  Division of Provider Relations & Utilization Management
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- **Eligibility, Child Health Plus & Family Health Plus**
  Division of Coverage and Enrollment
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- **Managed Care**
  Division of Managed Care
  Vida L. Wehren
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  vlw02@health.state.ny.us
- **American Indian Health Program (AIHP)**
  Division of Family Health / Office of the Medical Director
  Wendy B. Stoddart
  (518) 473-3511
  wbs01@health.state.ny.us

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MEDICAID REDESIGN TEAM (MRT) OVERVIEW

MRT Charge

Redesigning THE MEDICAID PROGRAM

- The Team shall engage Medicaid program stakeholders for the purpose of conducting a comprehensive review of and making recommendations regarding the Medicaid program. *(Executive Order #5)*
- The Recommendations shall include specific cost saving and quality improvement measures for redesigning the Medicaid program to meet specific budget reductions for Medicaid spending.
  (Executive Order #5)

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MRT Charge (continued)

Redesigning THE MEDICAID PROGRAM

- The Recommendation should include closing actions totaling $2.85 billion for 2011-12 (Governor Cuomo's Budget Address).
- On or before March 1, 2011, the Team shall submit its first report to the Governor of its findings and recommendations for consideration in the budget process for New York State Fiscal Year 2011-12.

REVIEW TIMELINE

Timeline Review

January 7:

- First organizational meeting with Governor Cuomo. Team members announced in press release.

January 10:

- Unveil Website: http://www.health.ny.gov/health_care/medicaid/redesign/
- Request ideas from Stakeholders (public) on redesigning Medicaid.

January 13:

- First Team meeting – Albany

January 16 – February 7:

- Hold regional Stakeholder meetings – Western, Central, Northern, Hudson Valley, Long Island, and New York City.

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Timeline Review

February 9:

- Second MRT meeting

February 24:

- Third MRT meeting
  - Brief on draft package of proposals
  - Open discussion
  - Voted to forward MRT package to Governor Cuomo

Additional MRT Meetings

- May 3, July 1, September 1, November 1
- Focus will be on comprehensive reform and implementation updates

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Public Feedback Overview

- We have received over 4,000 ideas from New Yorkers on how to reform the Medicaid program.
  - **829 ideas** from hearings
  - **2,341 ideas** from website
  - **72 ideas** from MRT members
  - **660 ideas** from public (other ways)
  - **148 ideas** from state staff

- All ideas have been posted on the website.

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MRT RECOMMENDATIONS

Recommendations: *Basic Facts*

- **Total Number of Recommendations – 79**
  (all short-term, implemented during 2011-12).
- The package attempts to advance both meaningful reform while simultaneously reaching the budget target.
- Reform-related 2011-12 Total State Savings = $1.138 billion.
- Year 2 total savings (2012-13) exceeds Year 1 savings by $378M (state share). The proposal does in fact bend the Medicaid cost curve.
- MRT's work is not yet finalized. The package identifies a series of issues which need further work and the hope is that sub-teams will tackle those long-term issues.

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Key Features of Package

- The package relies on a mix of mechanisms for lower costs in the program to achieve the Governor's target.
  1. ***Payment/Program Reform - $1.138 billion.***
  2. ***Elimination of statutory cost drivers - $186 million.***
  3. ***Rate reductions - $345 million.***

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Savings By Sector (State Share)

		SFY 11/12 State Share Savings			
Sector Proposals	Number of Proposals	MRT Reform Savings	1.7% Trend Reductions	Across the Board Cuts	Total Reductions
All Sector Crossover	7	$ -	NA	NA	$ -
Eligibility	8	$ (29.20)	NA	NA	$ (29.20)
Fraud and Abuse	1	$ (80.30)	NA	NA	$ (80.30)
FS Clinic & Practitioner	20	$ (187.97)	NA	$ (22.09)	$ (210.06)
Hospital	12	$ (238.22)	$ (28.00)	$ (62.56)	$ (328.78)
Managed Care	9	$ (173.13)	$ (84.00)	$ (86.01)	$ (343.14)
Non-Inst. LTC	10	$ (157.16)	$ (26.50)	$ (57.81)	$ (241.47)
Nursing Homes	9	$ (102.15)	$ (47.50)	$ (70.41)	$ (220.06)
Pharmacy	2	$ (139.40)	NA	$ (42.29)	$ (181.69)
Transportation	1	$ (30.50)	NA	$ (3.84)	$ (34.34)
Sector Sub-Total	79	$ (1,138.03)	$ (186.00)	$ (345.00)	$ (1,669.03)

1. PAYMENT / PROGRAM REFORM

MISCELLANEOUS NOTICES/HEARINGS

Notice of Abandoned Property Received by the State Comptroller

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

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

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

PUBLIC NOTICE
Department of Civil Service

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

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

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

PUBLIC NOTICE
Department of Health

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

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

All Services

• Effective on and after April 1, 2011, no annual trend factor will be applied pursuant to the provisions of Public Health Law § 2807-c(10)(c) to rates of payment for hospital inpatient, residential health care facilities, certified home health agencies, personal care services, and adult day health care services provided to patients diagnosed with AIDS. This includes the elimination of the 2011 trend factor effective for rates of payment April 1, 2011, and thereafter. In addition, the Department is authorized to promulgate regulations, to be effective April 1, 2011, such that no annual trend factor may be applied to rates of payment by the Department of Health for assisted living program services, adult day health care services or personal care services provided in those local social services districts, including New York City, whose rates of payment for services is established by such social services districts pursuant to a rate-setting exemption granted by the Department. This includes the elimination of the 2011 trend factor effective for rates of payment April 1, 2011, and thereafter.

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

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

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

• Federally Qualified Health Center services;

• Indian Health Services and services provided to Native Americans;

• Supplemental Medical Insurance - Part A and Part B;

• State Contribution for Prescription Drug Benefit (aka Medicare Part D payments);

• Any local share cap payment required by the Federal Medical Assistance Percentage (FMAP) increase legislation;

• Required payments related to the School Supportive Health Services Program and Preschool Supportive Health Services Program settlement agreement;

• Services provided to American citizen repatriates; and

• Hospice Services.

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

• Upper payment limit payments to non-state owned or operated governmental providers certified under Article 28 of the NYS Public Health Law;

• Certified public expenditure payments to the NYC Health and Hospital Corporation;

• Certain disproportionate share payments to non-state operated or owned governmental hospitals;

• Certain managed care payments pursuant to section 3-d of Part B of the Chapter 58 of the Laws of 2010; and

• Services provided to inmates of local correctional facilities.

- Payments pursuant to the mental hygiene law will be exempt from the reduction;

- Court orders and judgments; and

- Payments where applying the reduction would result in a lower FMAP as determined by the Commissioner of Health and the Director of the Budget will be exempt.

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

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

• The plan must be in compliance with the federal law;

• It must comply with the State's current Medicaid plan, amendment, or new plan that may be submitted;

• Reductions must be made uniformly among category of service, to the extent practicable, except where it is determined by the Commissioner of Health that there are grounds for non-uniformity; and

• The exceptions to uniformity include but are not limited to: sustaining safety net services in underserved communities, to ensuring that the quality and access to care is maintained, and to avoiding administrative burden to Medicaid applicants and recipients or providers.

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

Institutional Services

• For the state fiscal year beginning April 1, 2011 through March 31, 2012, continues specialty hospital adjustments for hospital inpatient services provided on and after April 1, 2011, to public general hospitals, other than those operated by the State of New York or the State University of New York, located in a city with a population of over one million and receiving reimbursement of up to $1.08 billion annually. Payments to eligible public general hospitals may be added to rates of payment or made as aggregate payments.

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

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

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

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

• For state fiscal years beginning April 1, 2011, and for each state fiscal year thereafter, additional medical assistance payments for inpatient hospital services may be made to public general hospitals operated by the State of New York or the State University of New York, or by a county which shall not include a city with a population over one million, and those public general hospitals located in the counties of Westchester, Erie, or Nassau, up to one hundred percent (100%) of each such public hospital's medical assistance and uninsured patient losses after all other medical assistance, including disproportionate share payments to such general hospitals. Payments may be added to rates of payment or made as aggregate payments. Payments will be based initially on reported reconciled data from the base year two years prior to the payment year adjusted for authorized Medicaid rate changes and further reconciled to actual reported data from such payment year.

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

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

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

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

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

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

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

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

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

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

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

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

Long Term Care Services

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

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

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

• Continues, effective April 1, 2011, and thereafter, the provision that rates of payment for RHCFs shall not reflect trend factor projections or adjustments for the period April 1, 1996 through March 31, 1997.

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

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

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

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

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

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

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

• A facility specific non-comparable component.

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

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

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

• Effective January 1, 2012, payments for reserved bed days for temporary hospitalizations, for Medicaid eligible residents aged 21 and older, shall only be made to a residential health care facility if at least fifty percent of the facility's residents eligible to participate in a Medicare managed care plan are enrolled in such a plan. Payments for these reserved bed days will be consistent with current methodology.

Non-Institutional Services

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

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

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

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

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

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

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

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

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

• The current authority to adjust Medicaid rates of payment for personal care services, provided in local social services districts which include a city with a population of over one million persons and distributed in accordance with memorandums of understanding entered into between the State and such local districts for purpose of supporting recruitment and retention of personal care service workers has been extended for the period April 1, 2011 through March 31, 2014. Payments for the periods April 1, 2011 through March 31, 2012; April 1, 2012 through March 31, 2013; and April 1, 2013 through March 31, 2014, shall not exceed, in the aggregate, $340 million for each applicable period.

• The current authority to adjust Medicaid rates of payment for personal care services, provided in local social services districts which shall not include a city with a population of over one million persons, for purpose of supporting recruitment and retention of personal care service workers has been extended for the period April 1, 2011 through March 31, 2014. Payments for the period April 1, 2011 through March 31, 2012; April 1, 2012 through March 31, 2013; and April 1, 2013 through March 31, 2014, shall not exceed, in the aggregate, $28.5 million for each applicable period.

• The current authority to adjust Medicaid rates of payment for certified home health agencies, AIDS home care programs, and hospice programs for purposes of supporting recruitment and retention of non-supervisory health care workers or any worker with direct patient care responsibility has been extended for the period April 1, 2011 through March 31, 2014. Payments shall not exceed in the aggregate, $100 million for each of the following periods: April 1, 2011 through March 31, 2012; April 1, 2012 through March 31, 2013; and April 1, 2013 through March 31, 2014, and shall be calculated in accordance with the previously approved methodology. Such adjustments to rates of payment shall be allocated proportionally based on each certified home health agency's, AIDS home care and hospice programs' home health aide or other direct care services total annual hours of service provided to Medicaid patients, as reported in each such agency's most recently available cost report as submitted to the Department. Payments made shall not be subject to subsequent adjustment or reconciliation.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

• Effective April 1, 2011, Medicaid rates for services provided by certified home health agencies, or by an AIDS home care program shall not reflect a separate payment for home care nursing services provided to patients diagnosed with Acquired Immune Deficiency Syndrome (AIDS).

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

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

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

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

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

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

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

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

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

MEDICAID CO-PAYMENTS CURRENT AND PROPOSED

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

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

- The following recipients are exempt from co-payments:

• Recipients younger than 21 years of age;

• Recipients who are pregnant;

• Residents of an adult care facility licensed by the New York State Department of Health (for pharmacy services only);

• Residents of a nursing home;

• Residents of an Intermediate Care Facility for the Developmentally Disabled (ICF/DD);

• Residents of an Office of Mental Health (OMH) or Office of People with Developmental Disabilities (OPWDD) certified Community Residence;

• Enrollees in a Comprehensive Medicaid Case Management (CMCM) or Service Coordination Program;

• Enrollees in an OMH or OMRDD Home and Community Based Services (HCBS) Waiver Program; and

• Enrollees in a Department of Health HCBS Waiver Program for Persons with Traumatic Brain Injury (TBI).

- The following services are exempt from co-payments:

• Emergency services;

• Family Planning;

• Drugs to treat mental illness; and

• Services provided through managed care plans.

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

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

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

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

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

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

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

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

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

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

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

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

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

Prescription Drugs

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

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

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

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

The estimated annual net aggregate decrease in gross Medicaid expenditures attributable to reform and other initiatives contained in the budget for state fiscal year 2011/2012 is $223 million; and the estimated annual net aggregate increase in gross Medicaid expenditures attributable to an extension of pertinent disproportionate share (DSH) and upper payment limit (UPL) payments for state fiscal year 2011/2012 is $1.9 billion.

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

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

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

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

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

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

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

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

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

SALE OF FOREST PRODUCTS

Chenango Reforestation Area No. 1
Contract No. X008135

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

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

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

SALE OF FOREST PRODUCTS

Lewis Reforestation Area No. 20
Contract No. X008125

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

Sealed bids for hard maple ST - 134.6 MBF more or less, black cherry ST - 29.5 MBF more or less, white ash ST - 30.9 MBF more or less, red maple ST - 7.7 MBF more or less, yellow birch ST - 5.8 MBF more or less, basswood ST - 6.9 MBF more or less, red oak ST - 2.5 MBF more or less, hemlock - 0.8 MBF more or less, pine pulp - 13 cords more or less, firewood - 626.6 cords more or less, located on Lewis Reforestation Area No. 20, Stands A-7, 8, 15, 17 & 21, 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, April 7, 2011.

For further information, contact: Andrea Mercurio, Senior Forester, Department of Environmental Conservation, Division of Lands and Forests, Region 6, 7327 State Rte. 812, Lowville, NY 13367, (315) 376-3521