



Department of Health

ANDREW M. CUOMO
Governor

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

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

June 30, 2020

National Institutional Reimbursement Team
Attention: Mark Cooley
CMS, CMCS
7500 Security Boulevard, M/S S3-14-28
Baltimore, MD 21244-1850

Re: SPA #20-0035
Inpatient Hospital Services

Dear Mr. Cooley:

The State requests approval of the enclosed amendment #20-0035 to the Title XIX (Medicaid) State Plan for inpatient hospital services to be effective April 2, 2020 (Appendix I). This amendment is being submitted based upon enacted legislation. A summary of the proposed amendment is contained in Appendix II.

This amendment is submitted pursuant to §1902(a) of the Social Security Act (42 USC 1396a(a)) and Title 42 of the Code of Federal Regulations (CFR), Part 447, Subpart C.

Notice of the changes in the methods and standards for setting payment rates for general hospital inpatient services were given in the New York State Register on April 1, 2020.

A copy of pertinent sections of enacted legislation is enclosed for your information (Appendix III). In addition, responses to the five standard funding questions and the standard access questions are also enclosed (Appendix V and VI, respectively).

If you have any questions regarding this State Plan Amendment submission, please do not hesitate to contact Regina Deyette, Medicaid State Plan Coordinator, Division of Finance and Rate Setting, Office of Health Insurance Programs at (518) 473-3658.

Sincerely,



Donna Frescatore
Medicaid Director
Office of Health Insurance Programs

Enclosures
cc: Todd McMillion

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL
FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES**

1. TRANSMITTAL NUMBER <u>2 0 — 0 0 3 5</u>	2. STATE New York
3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID) TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
4. PROPOSED EFFECTIVE DATE April 2, 2020	

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

5. TYPE OF PLAN MATERIAL (*Check One*)

- NEW STATE PLAN AMENDMENT TO BE CONSIDERED AS NEW PLAN AMENDMENT

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


6. FEDERAL STATUTE/REGULATION CITATION §1902(r)(5) of the Social Security Act, and 42 CFR 447	7. FEDERAL BUDGET IMPACT a. FFY <u>04/02/20-09/30/20</u> \$ <u>(2,429,134.50)</u> b. FFY <u>10/01/20-09/30/21</u> \$ <u>(4,858,269.00)</u>
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT Attachment: 4.19-A Page(s): 123, 124	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (<i>If Applicable</i>) Attachment: 4.19-A Page(s): 123, 124

10. SUBJECT OF AMENDMENT

Capital Reductions - IP
(FMAP=50%)

11. GOVERNOR'S REVIEW (*Check One*)

- GOVERNOR'S OFFICE REPORTED NO COMMENT OTHER, AS SPECIFIED
 COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
 NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

12. REGIONAL OFFICIAL 	16. RETURN TO New York State Department of Health Division of Finance and Rate Setting 99 Washington Ave – One Commerce Plaza Suite 1432 Albany, NY 12210
13. TYPED NAME Donna Frescatore	
14. TITLE Medicaid Director, Department of Health	
15. DATE SUBMITTED June 30, 2020	

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
2020 Title XIX State Plan
Second Quarter Amendment
Amended SPA Pages

**New York
123**

5. *Payment for budgeted allocated capital costs.*

- a. Capital per diems for exempt units and hospitals [shall] will be calculated by dividing the budgeted capital costs allocated to such rates pursuant to paragraph (4) above by budgeted exempt unit days, reconciled to rate year days and actual rate year exempt unit or hospital-approved capital expense. Effective on or after April 2, 2020, the budgeted and actual capital per diem rates will be reduced by five percent (5%). Additionally, for capital per diem rates reconciled on or after April 2, 2020, if the difference between the budgeted and actual capital per diem rate results in a positive rate adjustment, that rate adjustment will be reduced by ten percent (10%). Conversely, if the difference between the budgeted and actual capital per diem rate results in a negative rate adjustment, that rate adjustment will be increased by ten percent (10%).
- b. Capital payments for APR-DRG case rates [shall] will be determined by dividing the budgeted capital allocated to such rates pursuant to paragraph (4) above by the hospital's budgeted, nonexempt unit discharges, reconciled to rate year discharges and actual rate year nonexempt unit or hospital-approved capital expense. Effective on or after April 2, 2020, the budgeted and actual capital per APR-DRG case rates will be reduced by five percent (5%). Additionally, for capital per APR-DRG case rates reconciled on or after April 2, 2020, if the difference between the budgeted and actual capital per APR-DRG case rate results in a positive rate adjustment, that rate adjustment will be reduced by ten percent (10%). Conversely, if the difference between the budgeted and actual capital per APR-DRG case rate results in a negative rate adjustment, that rate adjustment will be increased by ten percent (10%).
- c. Capital payments for transferred patients [shall] will be the determined by dividing the budgeted capital allocated to the APR-DRG case rate by the hospital's budgeted non-exempt unit days, reconciled to rate year days and actual rate year non-exempt unit or hospital approved capital expense.

6. *Depreciation.*

- a. Reported depreciation based on historical cost is recognized as a proper element of cost. Useful lives [shall] will be the higher of the reported useful life or those useful lives from the Estimated Useful Lives of Depreciable Hospital Assets, American Hospital Association, consistent with title XVIII provisions. Copies of this publication are available from the American Hospital Association, 840 North Lake Shore Drive, Chicago, IL 60611, and a copy is available for inspection and copying at the offices of the Records Access Officer of the Department of Health, Corning Tower, Empire State Plaza, Albany, NY 12237.
- b. In the computation of rates for voluntary facilities, depreciation [shall] will be included on a straight line method on plant and non-movable equipment.

TN #20-0035 _____

Approval Date _____

Supersedes TN #09-0034 _____

Effective Date April 2, 2020

Appendix II
2020 Title XIX State Plan
Second Quarter Amendment
Summary

SUMMARY
SPA #20-0035

This State Plan Amendment proposes to:

- 1) Apply a 5% reduction to the both the budgeted and actual inpatient capital add-ons for rates beginning on or after April 2, 2020; and
- 2) For all inpatient rate add-ons reconciled on or after April 2, 2020, if the difference between the budgeted and actual capital add-on results in a positive add-on, the positive add-on will be reduced by 10%. Conversely, if the difference results in a negative add-on, the negative add-on will be increased by 10%.

Appendix III
2020 Title XIX State Plan
Second Quarter Amendment
Authorizing Provisions

Capital Reductions

Public Health Law, Section 2807-c(8)(c)

8. Capital related inpatient expenses. (a) Capital related inpatient expenses including but not limited to straight line depreciation on buildings and non-movable equipment, accelerated depreciation on major movable equipment if requested by the hospital, rentals and interest on capital debt (or for hospitals financed pursuant to article twenty-eight-B of this chapter, such expenses, including amortization in lieu of depreciation, as determined pursuant to the reimbursement regulations promulgated pursuant to such article and article twenty-eight of this chapter), shall be included in rates of payment determined pursuant to this section based on a budget for capital related inpatient expenses and subsequently reconciled to actual expenses and statistics through appropriate audit procedures. General hospitals shall submit to the commissioner, at least one hundred twenty days prior to the commencement of each year, a schedule of capital related inpatient expenses for the forthcoming year. Any capital

must have received such approval for any capital related expense generated by such capital expenditure to be included in rates of payment. The basis for determining capital related inpatient expenses shall be the lesser of actual cost or the final amount specifically approved for the construction of the capital asset. The submitted budget may include the capital related inpatient expenses for all existing capital assets as well as estimates of capital related inpatient expenses for capital assets to be acquired or placed in use prior to the commencement of the rate year or during the rate year provided all required approvals have been obtained.

The council shall adopt, with the approval of the commissioner, regulations to:

- (i) identify by type the eligible capital related inpatient expenses;
- (ii) safeguard the future financial viability of voluntary, non-profit general hospitals by requiring funding of inpatient depreciation on building and fixed and movable equipment;
- (iii) provide authorization to adjust inpatient rates by advancing payment of depreciation as needed, in instances of capital debt related financial distress of voluntary, non-profit general hospitals; and
- (iv) provide a methodology for the reimbursement treatment of sales.

(b) Capital related inpatient expenses shall be included in case based payments based on the hospital's average capital related inpatient expenses per discharge. Adjustments shall be made to capital related costs and statistics to reflect capital related inpatient expenses reimbursed on a per diem basis in accordance with paragraphs (a), (d), (e), (g) and (i) of subdivision four of this section.

(c) In order to reconcile capital related inpatient expenses included in rates of payment based on a budget to actual expenses and statistics for the rate period for a general hospital, rates of payment for a general hospital shall be adjusted to reflect the dollar value of the difference between capital related inpatient expenses included in the computation of rates of payment for a prior rate period based on a budget and actual capital related inpatient expenses for such prior rate

subdivision, adjusted to reflect increases or decreases in volume of service in such prior rate period compared to statistics applied in

determining the capital related inpatient expenses component of rates of payment based on a budget for such prior rate period. For rates

capital-related expenses add-on as described in paragraph (a) of this subdivision, based on a budget submitted in accordance to paragraph (a) of this subdivision, shall be reduced by five percent relative to the rate in effect on such date; and the actual capital expenses add-on as described in paragraph (a) of this subdivision, based on actual expenses and statistics through appropriate audit procedures in accordance with paragraph (a) of this subdivision shall be reduced by five percent relative to the rate in effect on such date. For any rate year, all

thousand twenty shall be reduced by ten percent, and all reconciliation

twenty shall increase by ten percent.

Appendix IV
2020 Title XIX State Plan
Second Quarter Amendment
Public Notice

MISCELLANEOUS NOTICES/HEARINGS

Notice of Abandoned Property Received by the State Comptroller

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

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

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

PUBLIC NOTICE Department of Health

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 for dates of service April 1, 2020 through March 31, 2021, and each state fiscal year thereafter, all non-exempt Department of Health state funds Medicaid payments will be uniformly reduced by \$2.5 billion. Such reductions will be applied only to the extent that alternative methods that achieve Medicaid state share savings annually are not implemented. Medicaid payments that will be exempted from the uniform reduction include:

1. Payments whereby federal law precludes such reduction, including:
 - 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;
 - Services provided to American citizen repatriates; and
 - Hospice Services.
2. Payments 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.
3. Other Payments that are not subject to the reduction include:
 - Payments pursuant to Article 32, Article 31 and Article 16 of the Mental Hygiene Law;
 - Required payments related to the School Supportive Health Services Program and Preschool Supportive Health Services Program;
 - Early Intervention;
 - Payments for services provided by Other State Agencies including Office of Children and Family Services, State Education Department, and the Department of Corrections and Community Supervision.
 - Vital Access Providers and Vital Access Provider Assurance Program;
 - Physician Administered Drugs;
 - Court orders and judgments; and
 - Family Planning services.

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

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 institutional, non-institutional or long term care services to comply with proposed Medicaid Redesign Team II (MRT) initiatives. The following changes are proposed:

All Services

Effective for dates of service April 1, 2020 through March 31, 2021, and each State Fiscal Year (SFY) thereafter, all non-exempt Department of Health state funds Medicaid payments will be uniformly reduced by 1.875 percent. Medicaid payments that will be exempted from the uniform reduction include:

- Payments whereby federal law precludes such reduction, including:
 - 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;
 - Services provided to American citizen repatriates; and
 - Hospice Services.
- Payments 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 Hospitals Corporation;
 - Certain disproportionate share payments to non-state oper-

ated 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.
- Other Payments that are not subject to the reduction include:
 - Payments pursuant to Article 32, Article 31 and Article 16 of the Mental Hygiene Law;
 - Required payments related to the School Supportive Health Services Program and Preschool Supportive Health Services Program;
 - Early Intervention;
 - Payments for services provided by Other State Agencies including Office of Children and Family Services, State Education Department, and the Department of Corrections and Community Supervision;
 - Vital Access Providers and Vital Access Provider Assurance Program;
 - Physician Administered Drugs;
 - Children and Family Treatment and Support Services (CFTSS);
 - Court orders and judgments; and
 - Family Planning services.

The estimated annual net aggregate decrease in gross Medicaid expenditures attributable to this initiative contained in the budget for SFY 2020-21 is (\$438 million).

Non-Institutional Services

Care Management

Effective on or after April 1, 2020 and SFY thereafter, these proposals will:

- Implement Health Home Improvement, Efficiency, Consolidation and Standardization: These efficiencies include eliminating outreach payments, reducing unnecessary documentation, revising the criteria for admission, and re-evaluating the benchmarks for stepping patients down to lower levels of care management or graduation from a Health Home. Finally, placing the most seriously mentally ill clients in care management arrangements with appropriate caseload sizes – overseen by the Office of Mental Health – while moving lower acuity members into less intensive care management arrangements will both improve program quality and achieve efficiencies.
- Promote Further Adoption of Patient-Centered Medical Homes (PCMH): Continues incentive payments at current levels for lower cost, higher value PCMH programs while incorporating a tiered quality component into the incentive payments to align with other State initiatives such as the Prevention Agenda.
- Comprehensive Prevention and Management of Chronic Disease: Advances the use of evidence-based prevention strategies to manage highly prevalent chronic diseases, including diabetes, hypertension, asthma, smoking, osteoarthritis, chronic kidney disease, HIV/AIDS, and sickle cell disease. Specifically, the proposal will: (1) promote the use of evidence-based, self-care education, and prevention strategies; (2) implement an awareness campaign to educate Medicaid Managed Care (MMC) Plans, providers, and Medicaid members on the various resources and programs that are available; (3) educate the provider community relative to adherence to established evidence-based practice guidelines; (4) optimize services that are already covered by Medicaid, including expanding who can provide services; (5) optimize pharmacist services and leverage the frequency of patient visits to the pharmacy by expanding Collaborative Drug Therapy Management (CDTM) to the community setting, enable pharmacists to administer point-of-care testing for designated CLIA-waived tests and to initiate prescriptions for certain medications; (6) focus on chronic condition management within Patient-Centered Medical Homes (PCMHs) and Health Homes; initially, focus treatment and care management resources on adults with diabetes and hypertension, and children with asthma.
- Children's Preventive Care and Care Transitions: Promotes behavioral health integration in pediatrics by continuing ongoing pilot work focused on pregnancy and early childhood (e.g., preschool screening and universal, light-touch home visits) and leverages participation in CMMI's Integrated Care for Kids (InCK) model of

integration of medical and behavioral health care, using resources already available in the community. In addition, this proposal improves care transitions for children with chronic medical and behavioral conditions, with a special focus on children with sickle cell disease (SCD) moving from pediatric to adult care settings.

- Children and Family Treatment and Support Services (CFTSS) - Restores specialized transition rates for CFTSS.
 - Invest in Medically Fragile Children: Invests Medicaid resources to improve access to private duty nursing (PDN) for medically fragile children in order to prevent hospitalization and emergency visits, by leveraging additional utilization of telehealth, commercial insurance coverage for PDN, further PDN network development and enhanced rates. Specifically, the proposal would increase fee-for-service PDN rates over a three year period to benchmark to the current Medicaid Managed Care rates; create a PDN Network whereby PDN providers would receive a negotiated enhanced rate of payment for PDN services.
 - Preventive Dentistry: Promotes evidence-based preventative dentistry using fluoride varnish and silver diamine fluoride. Specifically, the proposal increases the application of fluoride varnish by primary care providers, including Registered Nurses, which will decrease early childhood decay and associated restorative costs. In addition, the proposal expands Medicaid dental coverage to include silver diamine fluoride which stops tooth decay and prevents additional oral complications.
 - Emergency Room Avoidance and Cost Reductions: this proposal reduces unnecessary Emergency Department (ED) utilization and/or cost by redesigning care pathways for high ED utilizing patients and transitions navigation to community services by: allowing sharing of individualized patient treatment plans for chronic conditions (through Qualified Entity (QEs)); expanding access to Urgent Care Centers by increasing co-location with Emergency Rooms; requiring Urgent Care Centers to accept Medicaid; and exploring a lower ED triage fee for non-emergency conditions.
 - Addressing Barriers to Opioid Care: Implements a series of Opioid related interventions to address certain barriers to care for Medicaid members, including but not limited to, better bundled payments that support opiate treatment through the adjustment of Ambulatory Patient Groups (APG) payments to eliminate unnecessary volume incentive and to promote more appropriate access including take home medication, when clinically appropriate; reduced Medicaid Coverage Limits for Rehabilitation Services as pathway to nonpharmacologic treatment alternative for pain management, and increased utilization of the Opioid Medical Maintenance (OMM) Model.
 - Promote Maternal Health to Reduce Maternal Mortality: Focuses on optimizing the health of individuals of reproductive age, including discussions on comprehensive family planning and patient centered primary and preventive care. The proposal aims to improve access to quality prenatal care, free from implicit bias, and ensuring postpartum home visits are available to all individuals who agree have a home visit after giving birth, by working with Medicaid Managed Care plans to identify and address the barriers to achieving these goals. The proposal also includes ensuring all pregnant individuals have access to childbirth education and supports the participation of birthing centers in the Perinatal Quality Collaborative.
- The estimated annual net aggregate decrease in gross Medicaid expenditures attributable to these initiatives contained in the budget for SFY 2020-2021 is \$86 million and for SFY 2021-2022 is \$140 million.

Pharmacy

Effective on or after April 1, 2020 and SFY thereafter, these proposals would:

- Reduce Drug Cap Growth by Enhancing Purchasing Power to Lower Drug Costs by providing the ability to negotiate supplemental rebates for new blockbuster drugs and gene therapies that do not yet have utilization; and the authority to negotiate value-based agreements with manufacturers.
- Reducing coverage of certain OTC products and increasing copayments (with exceptions for the most vulnerable populations).

- Eliminating Prescriber Prevails which applies to the Medicaid fee-for-service pharmacy program and to selected drug classes for managed care plans. Doing so would reduce inappropriate prescribing, remove barriers that limit the State's ability to manage pharmacy programs, and minimize the inappropriate influence of pharmaceutical manufacturers in the prior authorization process.

The estimated annual net aggregate decrease in gross Medicaid expenditures attributable to these initiatives contained in the budget for SFY 2020/2021 is \$142 million and for SFY 2021/2022 is \$428 million.

Transportation

Effective on or after April 1, 2020 and SFY thereafter, these proposals would:

- Transition the State to a single Medicaid Transportation Broker to ensure that consumers receive reliable, high quality transportation services using the mode that is appropriate for the consumer.
- Discontinue the Supplemental Ambulance Rebate Payments to emergency medical transportation (EMT) providers since updating and rationalized the ambulance fee schedule consistent with the Department of Health's Ambulance Rate Adequacy Study.
- Carve transportation out of the MLTC Benefit (excluding PACE) and into fee-for-service to create efficiencies and consistency in purchasing, arranging and managing transportation services across the Medicaid program.
- Maximize Public Transit in New York City and other urban areas to encourage the use of public transportation as an alternative to livery when appropriate for the consumer.
- Reduce Taxi/Livery Rates and promoting other modes of transportation to reflect market rates for transportation services.
- Implement an ambulance diversion - Triage, Treat and Transport (ET3) - support program to reduce avoidable hospitalizations, subject to any necessary federal approvals.
- Pursue a Certified Public Expenditure program to maximize federal reimbursement for NEMT services incurred by municipalities.
- Create a Community Paramedicine Program to expand the roles of Emergency Medical Technicians (EMTs) and Paramedics by providing medical care to patients at home to avoid unnecessary trips to the Emergency Department (ED). EMTs and Paramedics would provide additional patient health and safety services (e.g., food, medications, fall precautions) and clinical assessment and diagnostic testing in consultation with online medical control/telemedicine physicians/advanced practitioners to avoid unnecessary trips to the hospital.

The estimated annual net aggregate decrease in gross Medicaid expenditures attributable to these initiatives contained in the budget for SFY 2020-2021 is \$188 million and for SFY 2021-2022 is \$488 million.

Telehealth

Effective on or after April 1, 2020 and SFY thereafter, these proposals would:

- Expand Utilization of Telehealth services and reimbursement models, specifically to address behavioral health, oral health, maternity care and other high-need populations. The proposal contemplates a state-wide, hosted telehealth platform to help mitigate interoperability barriers, as well as to enhance broadband to ensure telehealth connectivity in rural areas.

The estimated annual net aggregate decrease in gross Medicaid expenditures attributable to these initiatives contained in the budget for SFY 2020-2021 is \$15 million and for SFY 2021-2022 is \$25.4 million.

Institutional Services

Effective on or after April 1, 2020 and SFY thereafter, these proposals would:

- Reduce the size of the voluntary hospital Indigent Care Pool by \$75 million (State share);
- Eliminate the Indigent Care Pool "Transition Collar", which generates an additional \$12.5 million in State share savings; and
- Eliminate the Public Hospitals Indigent Care Pool, which generates \$70 million in State savings;

- Convert the value of Upper Payment Limit (UPL) payments received by public hospitals in a city with a population over a million into Medicaid reimbursement rates;

- Reduce hospital inpatient capital rate add-on by 5 percent and capital reconciliation payments by 10 percent.

The estimated annual net aggregate decrease in gross Medicaid expenditures attributable to these initiatives contained in the budget for SFY 2020-2021 is \$728 million and for SFY 2021-2022 is \$743 million.

Long Term Care Services

Effective on or after April 1, 2020 and SFY thereafter, these proposals would:

- Modify the current eligibility criteria for individuals to receive Personal Care Services and Consumer Directed Personal Assistance Services (CDPAS) as a Medicaid benefit, regardless of whether such services are received through fee-for-service, Mainstream Managed Care plans, or Managed Long Term Care (MLTC) plans. In order to be eligible to receive such services, an individual must be assessed to need assistance with more than two activities of daily living (ADLs) (ranging from limited assistance to total dependence).
- Institute a Home and Community Based Services lookback period of 60 months for asset transfers in determining eligibility for Medicaid for those seeking home and community based long term care services and supports as currently applies to those seeking Medicaid eligibility for nursing home care.
- Eliminate the ability of spouses living together in the community, and parents living with their child, to refuse to make their income and resources available during the determination of an applicant's eligibility for Medicaid.
- Utilize an independent clinician panel, similar to the State's Conflict Free Evaluation and Enrollment Center, to assess patients and order PCS and CDPAS under a clear set of standards and protocols.
- Implement an enhanced utilization review process by an independent assessor for any individuals who are assessed to need more than 12 hours per day on average in a given month (i.e., 360 hours per month for a 30-day month) to ensure that it remains safe for that individual to remain in the community.
- Change the frequency in which the Community Health Assessment is conducted from every six months to once annually, subject to requiring reassessments based on changes in health condition or status.
- Implement a uniform tasking tool for use by plans and Local Departments of Social Services (LDSS) to help determine service utilization, including the hours of Personal Care Services and CDPAS required each day.
- Employ the provider "choice" model to proceed with the implementation and electronic visit verification (EVV) system, as required by the Federal 21st Century Cures Act.
- Eliminate requirements that plans and LDSS educate consumers about the availability of the CDPAP program semi-annually. Develop standards and protocols to determine whether consumers are self-directing and, if applicable, their designated representative is able to fulfill their obligations appropriately.
- Delay the implementation date of certain permissible Consumer First Choice Option Services (CFCO) services from January 1, 2020 to April 1, 2022.
- Incorporate additional transparency, compliance, and accountability standards to ensure that entities receiving wage parity payments are appropriately using those funds for the benefit home care aides.
- Reduce Workforce Recruitment and Retention funding for home health care workers.
- Migrate the completion of all Community Health Assessments (CHA) and reassessments to a single, statewide Independent Assessor (IA).
- Modify the minimum community spouse resource amount, which is used to determine the Medicaid eligibility of an applicant under spousal impoverishment budgeting.
- Reduce funding associated with nursing home capital reim-

bursment by 5 percent and eliminate funding associated with return on equity payments to for-profit nursing homes.

The estimated annual net aggregate decrease in gross Medicaid expenditures attributable to these initiatives contained in the budget for SFY 2020/2021 is \$854 million and for SFY 2021/2022 is \$1.672 billion.

The public is invited to review and comment on this proposed State Plan Amendment, a copy of which will be available for public review on the Department's website at http://www.health.ny.gov/regulations/state_plans/status. Individuals without Internet access may view the State Plan Amendments at any local (county) social services district.

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

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

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

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

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

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

For further information and to review and comment, please contact: Department of Health, Division of Finance and Rate Setting, 99 Washington Ave., One Commerce Plaza, Suite 1432, Albany, NY 12210, spa_inquiries@health.ny.gov

PUBLIC NOTICE

New York City Deferred Compensation Plan & NYCE IRA

The New York City Deferred Compensation Plan & NYCE IRA (the "Plan") is seeking proposals from qualified vendors to provide master custodial services to the City of New York Deferred Compensation Plan. The Request for Proposals ("RFP") will be available beginning on Wednesday, March 18, 2020. Responses are due no later than 4:30 p.m. Eastern Time on Thursday, May 28, 2020. To obtain a copy of the RFP, please visit the Plan's web site at www1.nyc.gov/site/olr/about/about-rfp.page and download and review the applicable documents.

If you have any questions, please submit them by fax to Georgette Gestely, Director, at (212) 306-7376.

Consistent with the policies expressed by the City, proposals from certified minority-owned and/or women-owned businesses or proposals that include partnering arrangements with certified minority-owned and/or women-owned firms are encouraged. Additionally, proposals from small and New York City-based businesses are also encouraged.

PUBLIC NOTICE

Department of State

F-2019-1176

Date of Issuance – April 1, 2020

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

The applicant has certified that the proposed activity complies with

and will be conducted in a manner consistent with the approved New York State Coastal Management Program.

In F-2019-1176 or the "Morgenstern Residence", the applicant Richard Morgenstern, is proposing to maintain as completed 4' x 100.5' pier with 4' x 15' "T" and 3'6" x 10' steps. Maintain as completed 4'8" of additional 4' wide "T", 6' davit, 4'-5' x 31.6" pier and 4' x 32'6" pier, one boat lift, two boat whips and two safety ladders. The authorized work is located at 300 Riviera Drive, Town of Oyster Bay, Nassau County, Great South Bay.

The applicant's consistency certification and supporting information are available for review at: http://www.dos.ny.gov/opd/programs/pdfs/Consistency/F-2019-1176_Morgenstern_App.pdf

Original copies of public information and data submitted by the applicant are available for inspection at the New York State Department of State offices located at One Commerce Plaza, 99 Washington Avenue, in Albany, New York.

Any interested parties and/or agencies desiring to express their views concerning any of the above proposed activities may do so by filing their comments, in writing, no later than 4:30 p.m., 30 days from the date of publication of this notice, or, May 1, 2020.

Comments should be addressed to: Consistency Review Unit, Department of State, Office of Planning, Development & Community Infrastructure, One Commerce Plaza, 99 Washington Ave., Albany, NY 12231, (518) 474-6000, Fax (518) 473-2464. Electronic submissions can be made by email at: CR@dos.ny.gov

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

PUBLIC NOTICE

Department of State

Uniform Code Variance / Appeal Petitions

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

2020-0134 Matter of William Szmala, Nine Cedar Avenue, Medford, NY 11763, for a variance concerning safety requirements, including the height under a girder/soffit. Involved is an existing one family dwelling located at 269 Hampton Avenue, Town of Brookhaven, NY 11772, County of Suffolk, State of New York.

2020-0141 Matter of Nassau Expeditors Inc., Scott Tirone, 75 Albertson Avenue, Albertson, NY 11507, for a variance concerning safety requirements, including the heights under a girder/soffit. Involved is an existing one family dwelling located at 190 Stratford Road, Town of North Hempstead, NY 11040, County of Nassau, State of New York.

2020-0144 Matter of JL Drafting, John Lagoudes, 707 Route 110, Suite A, Farmingdale, NY 11735, for a variance concerning safety requirements, including the height under a girder/soffit. Involved is an existing one family dwelling located at 474 Wolf Hill Road, Town Of Huntington, NY 11746, County of Suffolk, State of New York.

2020-0153 Matter of Todd Oconnell Architect PC, Todd Oconnell, 1200 Veteran Memorial Hwy. S120, Hauppauge, NY 11788, for a variance concerning safety requirements, including the height under a girder/soffit. Involved is an existing one family dwelling located at Six Whitney Court, Town of Huntington, NY 11746, County of Suffolk, State of New York.

PUBLIC NOTICE

Department of State

Uniform Code Variance / Appeal Petitions

Pursuant to 19 NYCRR Part 1205, the variance and appeal petitions below have been received by the Department of State. Unless other-

Appendix V
2020 Title XIX State Plan
Second Quarter Amendment
Responses to Standard Funding Questions

**APPENDIX V
HOSPITAL SERVICES
State Plan Amendment #20-0035**

CMS Standard Funding Questions (NIRT Standard Funding Questions)

The following questions are being asked and should be answered in relation to all payments made to all providers under Attachment 4.19-A of the state plan.

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

Response: Providers do retain the payments made pursuant to this amendment. However, this requirement in no way prohibits the public provider, including county providers, from reimbursing the sponsoring local government for appropriate expenses incurred by the local government on behalf of the public provider. The State does not regulate the financial relationships that exist between public health care providers and their sponsoring governments, which are extremely varied and complex. Local governments may provide direct and/or indirect monetary subsidies to their public providers to cover on-going unreimbursed operational expenses and assure achievement of their mission as primary safety net providers. Examples of appropriate expenses may include payments to the local government which include reimbursement for debt service paid on a provider's behalf, reimbursement for Medicare Part B premiums paid for a provider's retirees, reimbursement for contractually required health benefit fund payments made on a provider's behalf, and payment for overhead expenses as allocated per federal Office of Management and Budget Circular 2 CFR 200 regarding Cost Principles for State, Local, and Indian Tribal Governments. The existence of such transfers should in no way negate the legitimacy of these facilities' Medicaid payments or result in reduced Medicaid federal financial participation for the State. This position was further supported by CMS in review and approval of SPA 07-07C when an on-site audit of these transactions for New York City's Health and Hospitals Corporation was completed with satisfactory results.

2. Section 1902(a)(2) provides that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan. Please describe how the state share of each type of Medicaid payment (normal per diem, supplemental, enhanced, other) is funded. Please describe whether the state share is from appropriations from the legislature to the Medicaid agency, through

intergovernmental transfer agreements (IGTs), certified public expenditures (CPEs), provider taxes, or any other mechanism used by the state to provide state share. Note that, if the appropriation is not to the Medicaid agency, the source of the state share would necessarily be derived through either an IGT or CPE. In this case, please identify the agency to which the funds are appropriated. Please provide an estimate of total expenditure and State share amounts for each type of Medicaid payment. If any of the non-federal share is being provided using IGTs or CPEs, please fully describe the matching arrangement including when the state agency receives the transferred amounts from the local government entity transferring the funds. If CPEs are used, please describe the methodology used by the state to verify that the total expenditures being certified are eligible for Federal matching funds in accordance with 42 CFR 433.51(b). For any payment funded by CPEs or IGTs, please provide the following:

- (i) a complete list of the names of entities transferring or certifying funds;**
- (ii) the operational nature of the entity (state, county, city, other);**
- (iii) the total amounts transferred or certified by each entity;**
- (iv) clarify whether the certifying or transferring entity has general taxing authority; and,**
- (v) whether the certifying or transferring entity received appropriations (identify level of appropriations).**

Response: Payments made to service providers under the provisions of this SPA are funded through a general appropriation received by the State agency that oversees medical assistance (Medicaid), which is the Department of Health.

The source of the appropriation is the Medicaid General Fund Local Assistance Account, which is part of the Global Cap. The Global Cap is funded by General Fund and HCRA resources.

There have been no new provider taxes and no existing taxes have been modified.

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

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

4. Please provide a detailed description of the methodology used by the state to estimate the upper payment limit (UPL) for each class of providers (State owned or operated, non-state government owned or operated, and privately owned or operated). Please provide a current (i.e. applicable to the current rate year) UPL demonstration. Under regulations at 42 CFR 447.272, States are prohibited

from setting payment rates for Medicaid inpatient services that exceed a reasonable estimate of the amount that would be paid under Medicare payment principals.

Response: The state and CMS are working toward completion and approval of current year UPL.

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

Response: The rate methodology included in the approved State Plan for institutional services is prospective payment. We are unaware of any requirement under current federal law or regulation that limits individual provider payments to their actual costs.

ACA Assurances:

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

MOE Period.

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

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

2. Section 1905(y) and (z) of the Act provides for increased FMAs for expenditures made on or after January 1, 2014 for individuals determined eligible under section 1902(a)(10)(A)(i)(VIII) of the Act. Under section 1905(cc) of the Act, the increased FMAP under sections 1905(y) and (z) would not be available for States that require local political subdivisions to contribute amounts toward the non-Federal share of the State's expenditures at a greater percentage than would have been required on December 31, 2009.

Prior to January 1, 2014 States may potentially require contributions by local political subdivisions toward the non-Federal share of the States' expenditures at percentages greater than were required on December 31, 2009. However, because of the provisions of section 1905(cc) of the Act, it is important to

determine and document/flag any SPAs/State plans which have such greater percentages prior to the January 1, 2014 date in order to anticipate potential violations and/or appropriate corrective actions by the States and the Federal government.

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

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

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

Tribal Assurance:

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

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

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

b) Please include information about the frequency inclusiveness and process for seeking such advice.

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

Response: Tribal consultation was performed in accordance with the State's tribal consultation policy as approved in SPA 17-0065, and documentation of such is included with this submission. To date, no feedback has been received from any tribal representative in response to the proposed change in this SPA.

Appendix VI
2020 Title XIX State Plan
Second Quarter Amendment
Responses to Standard Access Questions

**APPENDIX VI
INPATIENT SERVICES
State Plan Amendment 20-0035**

CMS Standard Access Questions

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

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

Response: This amendment seeks to apply reductions to the capital component of the hospital inpatient payments made under the State's Institutional State Plan section 4.19-A, effective for dates of service beginning on or after April 2, 2020. While this is a reduction in reimbursement, it reflects a minor change for providers, and will not result in major impacts to the payments made for provision of services.

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

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

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

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

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

Response: This change was enacted by the State Legislature as part of the negotiation of the 2020-21 Budget. The impact of this change was weighed in the context of the overall Budget in the State. The legislative process provides opportunities for all stakeholders to lobby their concerns, objections, or support for various legislative initiatives. In addition, NY published notice in the state register of the proposed policy and did not receive any comments.

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

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

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

Response: The State continues to implement Medicaid reform initiatives to better align reimbursement and to ensure access to quality of care in the appropriate setting. The pending 2% across the board hospital inpatient investment will help assist those hospitals whose Medicaid payments are negatively impacted by this change. Further, the State offers other programs to hospitals, such as the Vital Access Provider (VAP) program and the Vital Access Provider Assurance Program (VAPAP) to help sustain key health care services. While some of these initiatives are outside the scope of the State Plan, they represent some of the measures the State is taking to ensure quality care for the State's most vulnerable population.