NEW YORK STATE OF OPPORTUNITY. 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 #20-0053
Long Term Care Facility Services

Dear Mr. Cooley:

The State requests approval of the enclosed amendment #20-0053 to the Title XIX (Medicaid) State Plan for long term care facility services to be effective April 2, 2020 (Appendix I). This amendment is being submitted based on enacted legislation. A summary of the proposed amendment is provided 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, Part 447, Subpart C, (42 CFR §447).

A copy of the pertinent section of enacted legislation is enclosed for your information (Appendix III). Copies of the public notice of this proposed amendment, which were given in the New York State Register on April 1, 2020, and clarified on June 3, 2020, are also enclosed for your information (Appendix IV). In addition, responses to the five standard funding questions and 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,

[redacted]

Donna Frescatore
Medicaid Director
Office of Health Insurance Programs

Enclosures
cc: Todd McMillion

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 20 — 0053

2. STATE: New York

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)
TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

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

4. PROPOSED EFFECTIVE DATE
April 2, 2020

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(a) of the Social Security Act and 42 CFR 447

7. FEDERAL BUDGET IMPACT
a. FFY 04/02/20-09/30/20 $ ($ 6,019,238.00)
b. FFY 10/01/20-09/30/21 $ ($12,038,476.00)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.19-D Part I: Page A(1)(i)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 4.19-D Part I: Page A(1)(i)

10. SUBJECT OF AMENDMENT
ATB Reduction(.5%)-Long Term Care
(FMAP=50%)

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
[redacted]

13. TYPED NAME
Donna Frescatore

14. TITLE
Medicaid Director, Department of Health

15. DATE SUBMITTED
June 30, 2020

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

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

Instructions on Back

Appendix I
2020 Title XIX State Plan
Second Quarter Amendment
Amended SPA Pages

New York
A(1)(i)

1% Across-the-Board Reductions to Payments – Effective January 1, 2020 through March 31, 2020; additional 0.5% Across-the-Board Payment Reduction – effective on or after 4/2/2020 and Thereafter

(1) For dates of service on and after January 1, 2020, the rates of reimbursement for Article 28 nursing homes will be adjusted to reflect an across the board reduction of one percent (1%).

(2) For dates of service on or after April 2, 2020, the rates of reimbursement for Article 28 nursing homes will be adjusted by an additional one-half percent (0.5%) to reflect an across the board reduction of one and one half percent (1.5%).

a. Sections subjected to the one percent (1%) and one and one half percent (1.5%) reduction are as follows:

i. Nursing Home Reimbursement

ii. Specialty Care Facilities

Appendix II
2020 Title XIX State Plan
Second Quarter Amendment
Summary

SUMMARY
SPA #20-0053

This State Plan Amendment proposes to apply a 0.5% reduction uniformly across most long term care payments made under the State's Long Term Care State Plan section 4.19-D effective April 2, 2020 and each state fiscal year thereafter.

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

SPA 20-0053

Chapter 50 of the laws of 2020

2020/21 Appropriation Bill

Notwithstanding any provision of law to the contrary, the director of the budget, in consultation with the commissioner of health, may use a payment reduction plan to make across-the-board reductions to the department of health state funds medicaid spending by $373,000,000 for state fiscal year 2020-2021 and $175,000,000 in state fiscal year 2021-2022 to limit such spending to the aggregate limit specified herein, or reduce the aggregate limit specified herein to provide a reduction to the state's financial plan. Reductions shall be made in a manner that complies with the state medicaid plan approved by the federal centers for medicare and medicaid services, provided, however, that the commissioner of health is authorized to submit any state plan amendment or seek other federal approval to implement the provisions of the medicaid payment

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).

MISCELLANEOUS
NOTICES/HEARINGS

Notice of Abandoned Property Received by the State Comptroller

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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 June 2020 will be conducted on June 10 and June 11 commencing at 10:00 a.m. This meeting will be conducted at NYS Media Services Center, Suite 146, South Concourse, Empire State Plaza, Albany, NY with live coverage available at https://www.cs.ny.gov/commission/.

For further information, contact: Office of Commission Operations, Department of Civil Service, Empire State Plaza, Agency Bldg. One, 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 non-institutional services to comply with Section 1927 of the Social Security Act. The following changes are proposed:

Non-Institutional Services

Effective on or after July 1, 2020, to allow supplemental rebates on MCO and FFS utilization, the State will implement a single statewide formulary for opioid dependence agents and opioid antagonists, the purpose of which is to standardize preferred products across Medicaid Fee-for-Service and Managed Care. The National Medicaid Pooling Initiative (NMPI) Supplemental Drug Rebate Agreement will be used for both FFS and MCO utilization.

There is no additional estimated annual change to gross Medicaid expenditures as a result of the proposed amendment.

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
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 all services to comply with enacted statutory provisions. The following changes are proposed:

All Services

The following is a clarification to the April 1, 2020 noticed provision for the 1.875 percent uniformed reduction of state Medicaid funds. With clarification, effective for dates of service on or after April 2, 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 an additional 0.5 percent to the December 31, 2019 noticed provision for the 1.0 percent uniform reduction. Also with clarification, Medicaid payments that will be exempted from the uniform reduction will also include Health Homes serving children.

The following is a clarification to the December 31, 2019 noticed provision for the estimated annual net aggregate decrease in gross Medicaid expenditures attributable to the 1.0 uniform reduction. With clarification, the estimated annual net aggregate decrease in gross

Medicaid expenditures is ($35,750,000) for State Fiscal Year 2019-20 and ($143,000,000) for each State Fiscal Year thereafter. The estimated annual net aggregate decrease in gross Medicaid expenditures attributable to the additional 0.5 percent additional initiative contained in the budget for State Fiscal Year 2020-21 is ($71,600,000) and each State Fiscal Year thereafter.

Non-Institutional Services

The following is a clarification to the April 1, 2020 noticed provision for converting 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. With clarification, this provision was published under Institutional Services only, but should've been published under Non-Institutional services, as well.

The following is a clarification to the April 1, 2020 noticed provision to delay the implementation date of certain permissible Consumer First Choice Options Services (CFCO) from January 1, 2020 to April 1, 2022. With clarification, this was incorrectly published under Long Term Care services. This should have been published under Non-Institutional services.

The following is a clarification to the April 1, 2020 noticed provision to reduce funding associated with nursing home capital reimbursement by 5 percent and eliminate funding associated with residual equity payments to all nursing homes. With clarification, there is an Adult Day Health Care piece to this provision, to that, this should have been published under Non-institutional services as well as Long Term Care.

Institutional Services

The following is a clarification to the April 1, 2020 noticed provision to 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. With clarification, the provision is to reduce the size of the voluntary hospital Indigent Care Pool by $150 million (gross); eliminate the Indigent Care Pool "Transition Collar", which generates an additional $25 million in gross savings; and create an Enhanced Safety Net Transition Collar Pool for $64.6 million (gross).

Long Term Care Services

The following is a clarification to the April 1, 2020 noticed provision for instituting a Home and Community Based services lookback period. With clarification, the lookback period is 30 months.

The following is a clarification to the April 1, 2020 noticed provision for modifying current eligibility criteria to receive Personal Care Services and Consumer Directed Personal Assistance as a Medicaid Benefit. With clarification, 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) or, for individuals with a diagnosis of Alzheimer's or dementia, that need at least supervision with more than one ADL.

The following is a clarification to the April 1, 2020 noticed provision to reduce funding associated with nursing home capital reimbursement by 5 percent. With clarification, the proper wording is to reduce funding associated with nursing home capital reimbursement by 5 percent and eliminate funding associated with residual equity payments to all nursing homes.

The following is a clarification to the December 31, 2019 noticed provision to provide funding to support a two percent increase in annual salary and salary-related fringe benefits to direct case staff and direct support professions for all qualifying Mental Hygiene Services. With clarification, the estimated annual net aggregate increase to gross Medicaid expenditures attributable to this initiative for SFY 2019/2020 is $21 million. The impact published December 31, 2019, erroneously included $119 million for waivered services.

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

Department of State
F-2020-0195
Date of Issuance – June 3, 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 (CZMA) of 1972, as amended.

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

In F-2020-0195, Diana Griffith is proposing to removal existing float piers and install a 3' x 30' aluminum ramp, 5' x 140' and 8' x 20' wood floating docks with 16 new timber piers. The project on Lloyd Harbor at 9 Oak Hill Road, Lloyd Harbor, NY 11743 in Suffolk County.

The applicant's consistency certification and supporting information are available for review at: http://www.dos.ny.gov/opd/programs/pdfs/Consistency/F-2020-0195Griffith.pdf

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 July 3, 2020.

Comments should be addressed to: Department of State, Office of Planning and Development and Community Infrastructure, Consistency Review Unit, One Commerce Plaza, Suite 1010, 99 Washington Ave., Albany, NY 12231, (518) 474-6000. 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.

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

APPENDIX V
LONG TERM CARE SERVICES
State Plan Amendment #20-0053

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-D 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 completing 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: Effective January 1, 2012, the rate methodology included in the approved State Plan for non-specialty nursing facility services for the operating component of the rate is a blended statewide/peer group price adjusted for case mix and wage equalization factor (WEF). Specialty nursing facility and units are paid the operating rate in effect on January 1, 2009. The capital component of the rate for all specialty and non-specialty facilities is based upon a cost based methodology. 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 FMAPs for expenditures made on or after January 1, 2014 for individuals determined eligible under section 1902(a)(10)(A)(i)(VIII) of the Act. Under section 1905(cc) of the Act, the increased FMAP under sections 1905(y) and (z) would not be available for States that require local political subdivisions to contribute amounts toward the non-Federal share of the State's expenditures at a greater percentage than would have been required on December 31, 2009.**

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

   Response: This SPA would [ ] / would not [✓] violate these provisions, if they remained in effect on or after January 1, 2015.

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 the original 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
LONG TERM CARE SERVICES
State Plan Amendment 20-0053

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-D 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 a one half percent (0.5%) reduction uniformly across most long-term care payments made under the State's Long Term Care State Plan section 4.19-D, effective April 2, 2020 and thereafter. While this is a reduction in reimbursement, it reflects a minimal change for providers, and is being uniformly applied so there will be no 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. The State monitors and considers requests in the context of access as they approve/deny changes in services. Finally, providers cannot discriminate based on source of payment.

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

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

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

Response: This change was enacted by the State Legislature as part of the negotiation of the 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.

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 State updates nursing home rates twice a year to support changes in patient acuity, which ensures appropriate payment for the needs of individuals in care. The recently approved 1.5% nursing home rate increase will help assist facilities whose rates are negatively impacted by this change. The State is also continuing the 1% supplemental increase that goes to all nursing homes. Finally, the State offers other programs to nursing homes, such as the Vital Access Provider (VAP) program and the Nursing Home Quality Pool (NHQI), 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.