



Department of Health

ANDREW M. CUOMO
Governor

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

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

JUN 25 2018

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

Re: SPA #18-0016
Inpatient Hospital Services

Dear Mr. Cooley:

The State requests approval of the enclosed amendment #18-0016 to the Title XIX (Medicaid) State Plan for inpatient hospital services to be effective April 1, 2018 (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 March 28, 2018.


Copies of pertinent sections of enacted legislation are 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

cc: Mr. Michael Melendez
Mr. Tom Brady

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: HEALTH CARE FINANCING ADMINISTRATION		1. TRANSMITTAL NUMBER: 18-0016	2. STATE New York
		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE April 1, 2018	
5. TYPE OF PLAN MATERIAL (<i>Check One</i>): <input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (<i>Separate Transmittal for each amendment</i>)			
6. FEDERAL STATUTE/REGULATION CITATION: § 1902(a) of the Social Security Act, and 42 CFR 447		7. FEDERAL BUDGET IMPACT: (<i>in thousands</i>) a. FFY 04/01/18-09/30/18 \$ 1,040.81 b. FFY 10/01/18-09/30/19 \$ 2,189.50	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-A: Page 136(c)		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (<i>If Applicable</i>): Attachment 4.19-A: Page 136(c)	
10. SUBJECT OF AMENDMENT: Safety Net/VAP-Strong Memorial Hospital (IP) (FMAP = 50%)			
11. GOVERNOR'S REVIEW (<i>Check One</i>): <input checked="" type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input type="checkbox"/> OTHER, AS SPECIFIED: <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL			
12. SIGNATURE OF STATE AGENCY OFFICIAL: 		16. RETURN TO: New York State Department of Health Division of Finance and Rate Setting 99 Washington Ave – One Commerce Plaza Suite 1460 Albany, NY 12210	
13. TYPED NAME: Donna Frescatore			
14. TITLE: Medicaid Director Department of Health			
15. DATE SUBMITTED: JUN 25 2018			
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
2018 Title XIX State Plan
Second Quarter Amendment
Amended SPA Pages

**New York
136(c)**

Hospitals (Continued):

Provider Name	Gross Medicaid Rate Adjustment	Rate Period Effective
Maimonides Medical Center	\$2,500,000	11/01/2014 – 03/31/2015
Montefiore Medical Center	\$6,000,000	11/01/2013 – 03/31/2014
	\$ 750,000	10/01/2016 – 03/31/2017
	\$ 454,545	04/01/2017 – 03/31/2018
	\$ 454,546	04/01/2018 – 03/31/2019
	\$ 340,909	04/01/2019 – 09/30/2019
New York Methodist Hospital	\$3,005,000	01/01/2014 – 03/31/2014
	\$3,201,500	04/01/2014 – 03/31/2015
	\$3,118,500	04/01/2015 – 03/31/2016
Niagara Falls Memorial Medical Center	\$228,318	04/01/2012 – 03/31/2013
	\$171,238	04/01/2013 – 12/31/2013
	\$318,755	01/01/2014 – 03/31/2014
	\$501,862	04/01/2014 – 03/31/2015
	\$260,345	04/01/2015 – 03/31/2016
Nassau University Medical Center	\$4,000,000	04/01/2012 – 03/31/2013
	\$6,500,000	04/01/2013 – 03/31/2014
	\$7,000,000	04/01/2014 – 03/31/2015
Richmond University Medical Center	\$8,897,955	01/01/2013 – 03/31/2013
	\$2,355,167	04/01/2013 – 03/31/2014
	\$1,634,311	04/01/2014 – 03/31/2015
St. Barnabas Hospital	\$2,588,278	01/01/2013 – 03/31/2013
	\$1,876,759	04/01/2013 – 03/31/2014
	\$1,322,597	04/01/2014 – 03/31/2015
	\$ 2,500,000	01/01/2017 – 03/31/2017
	\$10,000,000	04/01/2017 – 03/31/2018
	\$10,000,000	04/01/2018 – 03/31/2019
	\$ 7,500,000	04/01/2019 – 12/31/2019
Soldiers & Sailors Memorial Hospital	\$ 19,625	02/01/2014 – 03/31/2014
	\$117,252	04/01/2014 – 03/31/2015
	\$134,923	04/01/2015 – 03/31/2016
South Nassau Communities Hospital	\$3,000,000	11/01/2014 – 03/31/2015
	\$1,000,000	04/01/2015 – 03/31/2016
Strong Memorial Hospital	\$4,163,227	04/01/2018 – 03/31/2019
	\$4,594,780	04/01/2019 – 03/31/2020
	\$4,370,030	04/01/2020 – 03/31/2021
Wyckoff Heights Medical Center	\$1,321,800	01/01/2014 – 03/31/2014
	\$1,314,158	04/01/2014 – 03/31/2015
	\$1,344,505	04/01/2015 – 03/31/2016

TN #18-0016
Supersedes TN #17-0016

Approval Date _____
Effective Date _____

Appendix II
2018 Title XIX State Plan
Second Quarter Amendment
Summary

SUMMARY
SPA #18-0016

This State Plan Amendment proposes to revise the State Plan to modify the temporary rate adjustment for additional hospitals which are subject to or impacted by the closure, merger, acquisition, consolidation or restructuring of a health care provider. The additional provider for which approval is being requested is Strong Memorial Hospital.

Appendix III
2018 Title XIX State Plan
Second Quarter Amendment
Authorizing Provisions

Public Health Law

§ 2826. Temporary adjustment to reimbursement rates. (a) Notwithstanding any provision of law to the contrary, within funds appropriated and subject to the availability of federal financial participation, the commissioner may grant approval of a temporary adjustment to the non-capital components of rates, or make temporary lump-sum Medicaid payments, to eligible general hospitals, skilled nursing facilities, clinics and home care providers, provided however, that should federal financial participation not be available for any eligible provider, then payments pursuant to this subdivision may be made as grants and shall not be deemed to be medical assistance payments.

(b) Eligible providers shall include:

- (i) providers undergoing closure;
- (ii) providers impacted by the closure of other health care providers;
- (iii) providers subject to mergers, acquisitions, consolidations or restructuring; or
- (iv) providers impacted by the merger, acquisition, consolidation or restructuring of other health care providers.

(c) Providers seeking temporary rate adjustments under this section shall demonstrate through submission of a written proposal to the commissioner that the additional resources provided by a temporary rate adjustment will achieve one or more of the following:

- (i) protect or enhance access to care;
- (ii) protect or enhance quality of care;
- (iii) improve the cost effectiveness of the delivery of health care services; or
- (iv) otherwise protect or enhance the health care delivery system, as determined by the commissioner.

(c-1) The commissioner, under applications submitted to the department pursuant to subdivision (d) of this section, shall consider criteria that includes, but is not limited to:

- (i) Such applicant's financial condition as evidenced by operating margins, negative fund balance or negative equity position;
- (ii) The extent to which such applicant fulfills or will fulfill an unmet health care need for acute inpatient, outpatient, primary or residential health care services in a community;
- (iii) The extent to which such application will involve savings to the Medicaid program;
- (iv) The quality of the application as evidenced by such application's long term solutions for such applicant to achieve sustainable health care services, improving the quality of patient care, and/or transforming the delivery of health care services to meet community needs;
- (v) The extent to which such applicant is geographically isolated in relation to other providers; or
- (vi) The extent to which such applicant provides services to an underserved area in relation to other providers.

(d) (i) Such written proposal shall be submitted to the commissioner at least sixty days prior to the requested effective date of the temporary rate adjustment, and shall include a proposed budget to achieve the goals of the proposal. Any Medicaid payment issued pursuant to this section shall be in effect for a specified period of time as determined by the commissioner, of up to three years. At the end of the

specified timeframe such payments or adjustments to the non-capital component of rates shall cease, and the provider shall be reimbursed in accordance with the otherwise applicable rate-setting methodology as set forth in applicable statutes and regulations. The commissioner may establish, as a condition of receiving such temporary rate adjustments or grants, benchmarks and goals to be achieved in conformity with the provider's written proposal as approved by the commissioner and may also require that the facility submit such periodic reports concerning the achievement of such benchmarks and goals as the commissioner deems necessary. Failure to achieve satisfactory progress, as determined by the commissioner, in accomplishing such benchmarks and goals shall be a basis for ending the facility's temporary rate adjustment or grant prior to the end of the specified timeframe. (ii) The commissioner may require that applications submitted pursuant to this section be submitted in response to and in accordance with a Request For Applications or a Request For Proposals issued by the commissioner.

(e) Notwithstanding any law to the contrary, general hospitals defined as critical access hospitals pursuant to title XVIII of the federal social security act shall be allocated no less than seven million five hundred thousand dollars annually pursuant to this section. The department of health shall provide a report to the governor and legislature no later than June first, two thousand fifteen providing recommendations on how to ensure the financial stability of, and preserve patient access to, critical access hospitals, including an examination of permanent Medicaid rate methodology changes.

(e-1) Thirty days prior to executing an allocation or modification to an allocation made pursuant to this section, the commissioner shall provide written notice to the chair of the senate finance committee and the chair of the assembly ways and means committee with regards to the intent to distribute such funds. Such notice shall include, but not be limited to, information on the methodology used to distribute the funds, the facility specific allocations of the funds, any facility specific project descriptions or requirements for receiving such funds, the multi-year impacts of these allocations, and the availability of federal matching funds. The commissioner shall provide quarterly reports to the chair of the senate finance committee and the chair of the assembly ways and means committee on the distribution and disbursement of such funds. Within sixty days of the effectiveness of this subdivision, the commissioner shall provide a written report to the chair of the senate finance committee and the chair of the assembly ways and means committee on all awards made pursuant to this section prior to the effectiveness of this subdivision, including all information that is required to be included in the notice requirements of this subdivision.

(f) Notwithstanding any provision of law to the contrary, and subject to federal financial participation, no less than ten million dollars shall be allocated to providers described in this subdivision; provided, however that if federal financial participation is unavailable for any eligible provider, or for any potential investment under this subdivision then the non-federal share of payments pursuant to this subdivision may be made as state grants.

(i) Providers serving rural areas as such term is defined in section two thousand nine hundred fifty-one of this chapter, including but not limited to hospitals, residential health care facilities, diagnostic and treatment centers, ambulatory surgery centers and clinics shall be eligible for enhanced payments or reimbursement under a supplemental rate methodology for the purpose of promoting access and improving the quality of care.

(ii) Notwithstanding any provision of law to the contrary, and subject to federal financial participation, essential community providers, which, for the purposes of this section, shall mean a provider that offers health services within a defined and isolated geographic region where such services would otherwise be unavailable to the population of such region, shall be eligible for enhanced payments or reimbursement under a supplemental rate methodology for the purpose of promoting access and improving quality of care. Eligible providers under this paragraph may include, but are not limited to, hospitals, residential health care facilities, diagnostic and treatment centers, ambulatory surgery centers and clinics.

(iii) In making such payments the commissioner may contemplate the extent to which any such provider receives assistance under subdivision (a) of this section and may require such provider to submit a written proposal demonstrating that the need for monies under this subdivision exceeds monies otherwise distributed pursuant to this section.

(iv) Payments under this subdivision may include, but not be limited to, temporary rate adjustments, lump sum Medicaid payments, supplemental rate methodologies and any other payments as determined by the commissioner.

(v) Payments under this subdivision shall be subject to approval by the director of the budget.

(vi) The commissioner may promulgate regulations to effectuate the provisions of this subdivision.

(vii) Thirty days prior to adopting or applying a methodology or procedure for making an allocation or modification to an allocation made pursuant to this subdivision, the commissioner shall provide written notice to the chairs of the senate finance committee, the assembly ways and means committee, and the senate and assembly health committees with regard to the intent to adopt or apply the methodology or procedure, including a detailed explanation of the methodology or procedure.

(viii) Thirty days prior to executing an allocation or modification to an allocation made pursuant to this subdivision, the commissioner shall provide written notice to the chairs of the senate finance committee, the assembly ways and means committee, and the senate and assembly health committees with regard to the intent to distribute such funds. Such notice shall include, but not be limited to, information on the methodology used to distribute the funds, the facility specific allocations of the funds, any facility specific project descriptions or requirements for receiving such funds, the multi-year impacts of these allocations, and the availability of federal matching funds. The commissioner shall provide quarterly reports to the chair of the senate finance committee and the chair of the assembly ways and means committee on the distribution and disbursement of such funds.

(g) Notwithstanding subdivision (a) of this section, and within amounts appropriated for such purposes as described herein, for the period of April first, two thousand fifteen through March thirty-first, two thousand sixteen, the commissioner may award a temporary adjustment to the non-capital components of rates, or make temporary lump-sum Medicaid payments to eligible general hospitals in severe financial distress to enable such facilities to maintain operations and vital services while such facilities establish long term solutions to achieve sustainable health services.

(i) Eligible general hospitals shall include:

(A) a public hospital, which for purposes of this subdivision, shall mean a general hospital operated by a county or municipality, but shall exclude any such hospital operated by a public benefit corporation;

(B) a federally designated critical access hospital;
(C) a federally designated sole community hospital; or
(D) a general hospital that is a safety net hospital, which for purposes of this subdivision shall mean:

(1) such hospital has at least thirty percent of its inpatient discharges made up of Medicaid eligible individuals, uninsured individuals or Medicaid dually eligible individuals and with at least thirty-five percent of its outpatient visits made up of Medicaid eligible individuals, uninsured individuals or Medicaid dually-eligible individuals; or

(2) such hospital serves at least thirty percent of the residents of a county or a multi-county area who are Medicaid eligible individuals, uninsured individuals or Medicaid dually-eligible individuals.

(ii) Eligible applicants must demonstrate that without such award, they will be in severe financial distress through March thirty-first, two thousand sixteen, as evidenced by:

(A) certification that such applicant has less than fifteen days cash and equivalents;

(B) such applicant has no assets that can be monetized other than those vital to operations; and

(C) such applicant has exhausted all efforts to obtain resources from corporate parents and affiliated entities to sustain operations.

(iii) Awards under this subdivision shall be made upon application to the department.

(A) Applications under this subdivision shall include a multi-year transformation plan that is aligned with the delivery system reform incentive payment ("DSRIP") program goals and objectives. Such plan shall be approved by the department and shall demonstrate a path towards long term sustainability and improved patient care.

(B) The department may authorize initial award payments to eligible applicants based solely on the criteria pursuant to paragraphs (i) and (ii) of this subdivision.

(C) Notwithstanding subparagraph (B) of this paragraph, the department may suspend or repeal an award if an eligible applicant fails to submit a multi-year transformation plan pursuant to subparagraph (A) of this paragraph that is acceptable to the department by no later than the thirtieth day of September two thousand fifteen.

(D) Applicants under this subdivision shall detail the extent to which the affected community has been engaged and consulted on potential projects of such application, as well as any outreach to stakeholders and health plans.

(E) The department shall review all applications under this subdivision, and determine:

(1) applicant eligibility;

(2) each applicant's projected financial status;

(3) each applicant's proposed use of funds to maintain critical services needed by its community; and

(4) the anticipated impact of the loss of such services.

(F) After review of all applications under this subdivision, and a determination of the aggregate amount of requested funds, the department shall make awards to eligible applicants; provided, however, that such awards may be in an amount lower than such requested funding, on a per applicant or aggregate basis.

(iv) Awards under this subdivision may not be used for:

(A) capital expenditures, including, but not limited to: construction, renovation and acquisition of capital equipment, including major medical equipment;

- (B) consultant fees;
- (C) retirement of long term debt; or
- (D) bankruptcy-related costs.

(v) Payments made to awardees pursuant to this subdivision shall be made on a monthly basis. Such payments will be based on the applicant's actual monthly financial performance during such period and the reasonable cash amount necessary to sustain operations for the following month. The applicant's monthly financial performance shall be measured by such applicant's monthly financial and activity reports, which shall include, but not be limited to, actual revenue and expenses for the prior month, projected cash need for the current month, and projected cash need for the following month.

(vi) The department shall provide a report on a quarterly basis to the chairs of the senate finance, assembly ways and means, senate health and assembly health committees. Such reports shall be submitted no later than sixty days after the close of the quarter, and shall include for each award, the name of the applicant, the amount of the award, payments to date, and a description of the status of the multi-year transformation plan pursuant to paragraph (iii) of this subdivision.

**Appendix IV
2018 Title XIX State Plan
Second Quarter Amendment
Public Notice**

patients it provides services to are attributed to the care of uninsured patients; provides care to uninsured patients in its emergency room, hospital based clinics and community based clinics, including the provision of important community services, such as dental care and prenatal care.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative is \$20 million.

Effective on or after April 1, 2018, payments to Critical Access Hospitals, Safety Net Hospitals, and Sole Community Hospitals will be based on criteria as determined by the Commissioner of Health.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2018/2019 is \$40 million.

Long Term Care Services

Effective on or after April 1, 2018, continues additional payments to non-state government operated public residential health care facilities, including public residential health care facilities located in Nassau, Westchester, and Erie counties, but excluding public residential health care facilities operated by a town or city within a county, in aggregate amounts of up to \$500 million. The amount allocated to each eligible public RHCF will be in accordance with the previously approved methodology, provided, however that patient days shall be utilized for such computation reflecting actual reported data for 2016 and each representative succeeding year as applicable. Payments to eligible RHCF's may be added to rates of payment or made as aggregate payments.

The overall combined estimated annual net aggregate increase in gross Medicaid expenditures attributable to the extension of all upper payment limit (UPL) payments for state fiscal year 2018/2019 in \$2.5 billion.

Effective on or after April 1, 2018, the Commissioner shall convene with New York State Nursing Home Associations and other industry experts alongside representatives from the New York State Health Department, to revise the current Case Mix collection process in an effort to promote a higher degree of accuracy in the case mix data which would result in a reduction of audit findings. Pending the development and implementation of the revised process, the commissioner shall be authorized to reduce the overall amount of case mix reimbursement as is necessary to achieve savings.

The estimated annual net aggregate decrease in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2018/2019 is \$15 million.

Effective on or after April 1, 2018 this proposes legislation to authorize the department to conduct a study of Home and Community Based Services in rural areas of the state. This study will include a review and analysis of factors including but not limited to transportation costs, costs of direct care personnel including home health aides, personal care attendants and other direct service personnel, and opportunities for telehealth and/ or technological advances to improve efficiencies.

The Legislation would also authorize the department to provide a targeted, Medicaid rate enhancement if supported by the study, for fee for service personal care.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2018/2019 is \$3 million.

The following is a clarification for the partial restoration of the two percent annual uniform reduction of Medicaid payments which was originally noticed on March 26, 2014. Effective on or after April 1, 2018, supplemental payments will be made to all RHCF Nursing Homes for the value of SFY 2014/15, 2015/16, 2016/17 and 2017/18 beginning SFY 2018/19 and will be paid out at \$70 million each year over four years. Additional supplemental payments will be made each year beginning in SFY 2018/19 in the amount of \$70 million.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2018/2019 is \$140,000,000.

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, or e-mail: 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 institutional care related to temporary rate adjustments to providers that are undergoing closure, merger, consolidation, acquisition or restructuring themselves or other health care providers. These payments are authorized by § 2826 of the New York Public Health Law. The following changes are proposed:

Additional temporary rate adjustments have been reviewed and approved for the following hospital:

- Strong Memorial Hospital

The aggregate payment amounts total up to \$4,163,227 for the period April 1, 2018 through March 31, 2019.

The aggregate payment amounts total up to \$4,594,780 for the period April 1, 2019 through March 31, 2020.

The aggregate payment amounts total up to \$4,370,030 for the period April 1, 2020 through March 31, 2021.

The public is invited to review and comment on this proposed State Plan Amendment. Copies of which will be available for public review on the Department's website at http://www.health.ny.gov/regulations/state_plans/status.

Copies of the proposed State Plan Amendments will be on file in each local (county) social services district and available for public review.

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

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

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

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

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

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

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 1460, Albany, NY
12210, or e-mail: spa_inquiries@health.ny.gov

PUBLIC NOTICE

Department of State
F-2017-1198

Date of Issuance – March 28, 2018

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. 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-2017-1198, the Fishers Island Marina, LLC (Fishers Island Yacht Club), Central Avenue, Fishers Island, Town of Southold, Suffolk County: The applicant is proposing to perform maintenance dredging of approximately 14,443 cy of material with subsequent unconfined open-water disposal of the dredged material at the Central Long Island Sound Disposal Site (CLDS).

The applicant's consistency certification and supporting information are also available at: http://www.dos.ny.gov/opd/programs/pdfs/Consistency/F-2017-1198_ConsistencyCertification.pdf

Any interested parties and/or agencies desiring to express their views concerning the above proposed activities may do so by filing their comments, in writing, no later than 4:30 p.m., 15 days from the date of publication of this notice, or, by April 12, 2018.

Comments should be addressed to the Department of State, ATTN: Consistency Review Unit, One Commerce Plaza, Suite 1010, 99 Washington Ave., Albany, NY 12231, (518) 474-6000; Fax (518) 473-2464. Comments can also be submitted electronically via e-mail 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
F-2018-0004

Date of Issuance – March 28, 2018

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. 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-2018-0004, the Brewer Deep River Marina, Connecticut River, Town of Deep River, CT: The applicant is proposing to perform maintenance dredging of approximately 11,000 cy of material with subsequent unconfined open-water disposal of the dredged material at the Western Long Island Sound Disposal Site (WLDS).

The applicant's consistency certification and supporting information are also available at: http://www.dos.ny.gov/opd/programs/pdfs/Consistency/F-2018-0004_ConsistencyCertification.pdf

Any interested parties and/or agencies desiring to express their views concerning the above proposed activities may do so by filing their comments, in writing, no later than 4:30 p.m., 15 days from the date of publication of this notice, or, by April 12, 2018.

Comments should be addressed to the Department of State, ATTN: Consistency Review Unit, One Commerce Plaza, Suite 1010, 99 Washington Ave., Albany, NY 12231, (518) 474-6000; Fax (518) 473-2464. Comments can also be submitted electronically via e-mail 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
F-2018-0041

Date of Issuance – March 28, 2018

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. 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-2018-0041, the Indian Neck Yacht Club, Branford River, Branford, CT: The applicant is proposing to perform maintenance dredging of approximately 5,488 cy of material with subsequent unconfined open-water disposal of the dredged material at the Western Long Island Sound Disposal Site (WLDS).

The applicant's consistency certification and supporting information are also available at: http://www.dos.ny.gov/opd/programs/pdfs/Consistency/F-2018-0041_ConsistencyCertification.pdf

Any interested parties and/or agencies desiring to express their views concerning the above proposed activities may do so by filing their comments, in writing, no later than 4:30 p.m., 15 days from the date of publication of this notice, or, by April 12, 2018.

Comments should be addressed to the Department of State, ATTN: Consistency Review Unit, One Commerce Plaza, Suite 1010, 99 Washington Ave., Albany, NY 12231, (518) 474-6000; Fax (518) 473-2464. Comments can also be submitted electronically via e-mail 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
F-2018-0120

Date of Issuance – March 28, 2018

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 activities comply with

Appendix V
2018 Title XIX State Plan
Second Quarter Amendment
Responses to Standard Funding Questions

**APPENDIX V
HOSPITAL SERVICES
State Plan Amendment #18-0016**

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 established or 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 add-on services payments made to those providers listed who will receive temporary rate adjustments to be paid quarterly.

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 is currently working with CMS to finalize the 2018 Inpatient 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 FMAPs for expenditures made on or after January 1, 2014 for individuals determined eligible under section 1902(a)(10)(A)(i)(VIII) of the Act. Under section 1905(cc) of the Act, the increased FMAP under sections 1905(y) and (z) would not be available for States that require local political subdivisions to contribute amounts toward the non-Federal share of the State's expenditures at a greater percentage than would have been required on December 31, 2009.

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

percentages prior to the January 1, 2014 date in order to anticipate potential violations and/or appropriate corrective actions by the States and the Federal government.

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

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

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

Tribal Assurance:

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

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

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

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

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

Response: Tribal consultation was performed in accordance with the State's tribal consultation policy as approved in SPA 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
2018 Title XIX State Plan
Second Quarter Amendment
Responses to Standard Access Questions**

**APPENDIX VI
INPATIENT SERVICES
State Plan Amendment 18-0016**

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: First, hospitals are required to meet licensure and certification requirements to ensure providers are qualified to deliver services to Medicaid patients. These requirements as well as other methods and procedures the state has in place to ensure efficiency, economy and quality of care are not impacted in any way by this amendment. Second, all licensed hospitals currently participate in New York State's Medicaid program and are located across the state so Medicaid recipients in any geographic area have access to services that are available to the general population in those communities. Continuing the policy to maintain a trend factor no greater than zero is intended to hold rates constant, not reduce them. While this one element in the state's methods and procedures for setting payment rates will control costs, any savings attributed to it will be reinvested in Medicaid hospital payments under other provisions of the state's methodology resulting in overall hospital payments being set at the maximum permitted by the Federal Medicaid Upper Payment limit requirements.

- 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, particularly since there is excess bed capacity for both hospitals and nursing homes. Additionally, hospital and nursing home providers must notify and receive approval from the Department's Office of Health Systems Management (OHSM) 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 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: Funding was enacted by the State Legislature as part of the negotiation of the final Budget. 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: Over the course of the past three years, the State has undertaken a massive reform initiative to better align reimbursement with care. When fully implemented, the initiative will invest over \$600 million in the State's ambulatory care system (outpatient, ambulatory surgery, emergency department, clinic and physicians) to incentivize care in the most appropriate setting. The State has also increased its physician reimbursement schedule to resemble Medicare payments for similar services, thus ensuring continued access for Medicaid beneficiaries. In addition, the State is implementing initiatives that will award \$600 million annually, over the next few years, to providers who promote efficiency and quality care through the Federal-State Health Reform Partnership(F-SHRP)/ NYS Healthcare Efficiency and

Affordability Law (HEAL). Further, the New York State Budget provides for a Quality Pool for hospital inpatient services for up to \$57.8M for SFY 2017/2018 which will be paid through the Medicaid Managed Care Health Plan rates. The State Budget also provides for a \$20M investment in Critical Access Hospitals, as well as a \$20M investment in Enhanced Safety Net facilities. DOH is also in the process of implementing the Delivery System Reform Incentive Payment (DSRIP) program whereby up to \$6.42 billion is being reinvested in the Medicaid program over a five-year period. The State also offers a number of 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.