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 #20-0040
Inpatient Hospital Services

Dear Mr. Cooley:

The State requests approval of the enclosed amendment #20-0040 to the Title XIX (Medicaid) State Plan for inpatient hospital services to be effective April 2, 2020 (Appendix I). This amendment is being submitted based upon enacted legislation. A summary of the proposed amendment is contained in Appendix II.

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

Notice of the changes in the methods and standards for setting payment rates for general hospital inpatient services were given in the New York State Register on April 1, 2020 and clarified on June 3, 2020.

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

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

Sincerely,

[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 — 0040

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(r)(5) of the Social Security Act, and 42 CFR 447

7. FEDERAL BUDGET IMPACT
a. FFY 04/02/20-09/30/20 $ (27,600,000)
b. FFY 10/01/20-09/30/21 $ (55,200,000)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment: 4.19-A Page(s): 161(d), 161(g), 161(h), 161(i), 161(j)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment: 4.19-A Page(s): 161(d), 161(g), 161(h), 161(i), 161(j)

10. SUBJECT OF AMENDMENT
INDIGENT CARE POOL - Extends through 3/31/2023 and implements the recommendations of MRT 2.0. (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
161(d)

Indigent Care Pool Reform – effective January 1, 2013

The provisions of this section will be effective for the period January 1, 2013 through December 31, [2020] 2022.

(a) Indigent Care Pool Reform Methodology. Each hospital's uncompensated care nominal need will be calculated in accordance with the following:

1. **Inpatient Uncompensated Care.** Inpatient units of service for uninsured (self-pay and charity) patients, as reported in Exhibit 32 of the Institutional Cost Report (ICR) for the calendar year two years prior to the distribution year for each inpatient service area which has a distinct reimbursement rate, excluding hospital-based residential health care facility (RHCF) and hospice units of service, will be multiplied by the applicable Medicaid inpatient rates in effect for January 1 of the distribution year.

   Medicaid inpatient rates for acute and psychiatric services will be the statewide base price adjusted for hospital-specific factors including an average case mix adjustment plus all rate add-ons except the public goods surcharge. Medicaid inpatient rates for all other inpatient services will be the per diem rate, excluding the public goods surcharge add-on. Units of service for acute care services will be uninsured patient discharges; units of service for all other inpatient services will be uninsured patient days, not including alternate level of care (ALC) days.

2. **Outpatient Uncompensated Care.** Outpatient units of service for those uninsured (self-pay and charity) patients reported in Exhibit 33 of the ICR for the calendar year two years prior to the distribution year, excluding referred ambulatory services and home health units of service, will be multiplied by the average paid Medicaid outpatient rates that reflect the exclusive utilization of the ambulatory patient groups (APG) rate-setting methodology; however, for those services for which APG rates are not available the applicable Medicaid rate in effect for January 1 of the distribution year will be utilized. The outpatient rates used are exclusive of the public goods surcharge.

   Units of service for ambulatory surgery services will be uninsured procedures, not including those which result in inpatient admissions; units of service for all other outpatient services will be uninsured visits, not including those which result in inpatient admissions.

New York
161(g)

(b) Indigent Care Pool. Indigent care pool distributions will be made to eligible hospitals in the following amounts, which will be paid in twelve, approximately equal lump sum, monthly installments:

1. **Major Government General Hospital Pool Distributions.** $139.4 million, less the amount allocated pursuant to the Financial Assistance Compliance Pool section in subparagraph (7) below, will be distributed as Medicaid disproportionate share hospital (DSH) payments to major government general hospitals, including the hospitals operated by public benefit corporations, on the basis of each hospital's relative share of uncompensated care nominal need to the aggregate uncompensated care nominal need for all major government general hospitals determined in accordance with the Indigent Care Pool Reform methodology described in [sub]paragraph [3] (a) of this section.

   Major government general hospitals are defined as all State-operated general hospitals, all general hospitals operated by the New York City Health and Hospital Corporation, and all other government general hospitals having annual inpatient operating costs in excess of $25 million. Hospitals eligible for distributions from this pool will be all such major government general hospitals which are open for all or part of the distribution year. Hospitals open for a partial year will receive a pro-rated share based on the number of months open.

2. **Voluntary General Hospital Pool Distributions.** $994.9 million, less the amount allocated pursuant to the Financial Assistance Compliance Pool section in subparagraph (7) below and the Voluntary ICP Reduction in subparagraph (3) below, plus the Enhanced Safety Net Transition Collar Pool in subparagraph (4) below will be distributed as Medicaid disproportionate share hospital (DHS) payments to eligible voluntary general hospitals, other than major public general hospitals, on the basis of each hospitals relative share of uncompensated care nominal need to the aggregate uncompensated care nominal need for all eligible voluntary general hospitals as determined in accordance with the Indigent Care Pool Reform methodology described in paragraph (a) of this section. Distributions to voluntary general hospitals, other than major public general hospitals, relative to calendar year 2020 and calendar years thereafter made pursuant to this subparagraph shall not include transition pool distributions, subject to exceptions in subparagraph (4). Such reduced distributions shall not affect any hospital's relative share as determined in accordance with the Indigent Care Pool Reform methodology described in paragraph (a) of this section and shall reflect a reduction in the amount of the pool to $969.9 million.

   Voluntary general hospitals are defined as all voluntary non-profit, private proprietary, and government general hospitals other than major government general hospitals. Hospitals eligible for distributions from this pool will be all such voluntary hospitals which are open for all or part of the distribution year. Hospitals open for a partial year will receive a pro-rated share based on the number of months open.

New York
161(h)

3. **Transition Pool.** An eight-year transition pool utilizing a floor/ceiling model has been established to help hospitals avoid large funding swings. The transition pool funding will be generated through a redistribution of dollars from those hospitals which experience an increase in distributions using the new Indigent Care Reform Methodology to those that experience a decrease. Transition amounts will be determined based on a comparison of the distributions for the applicable calendar year 2013 through 2020 to an average of the annual distributions for the three year period January 1, 2010 through December 31, 2012.

   A separate transition pool will be established for major government general hospitals and voluntary general hospitals. Individual hospital gains and losses in each pool will be capped by means of the following transition adjustments. Any adjustments provided pursuant to this subparagraph shall not apply to distributions relative to calendar years beyond 2019.

   a. Distribution Amount. A hospital's distribution will be determined by means of a comparison between their allocation as calculated in accordance with the Indigent Care Reform Methodology described in section (a)(1) through (a)(7), the Floor Amount in 3(c) below, and the Ceiling Amount in 3(d) below. If the Indigent Care Reform Methodology allocation is:
      i. less than or equal to the Floor Amount, the hospital will receive the Floor Amount.
      ii. greater than or equal to the Ceiling Amount, the hospital will receive the Ceiling Amount.
      iii. greater than the Floor Amount but less than the Ceiling Amount, the hospital will receive the Indigent Care Reform Methodology allocation payment.

   b. Separate uniform Floor percentages and uniform Ceiling percentages are calculated for each of the major governmental and voluntary pools.

   c. The Floor Amount for each hospital is equal to the average payment received in the three year period between 1/1/10 and 12/31/12 multiplied by the Floor Percentage for its respective pool. The Floor percentage is:
      i. 97.5% for 2013
      ii. 95.0% for 2014
      iii. 92.5% for 2015
      iv. 90.0% for 2016
      v. 87.5% for 2017
      vi. 85.0% for 2018
      vii. 82.5% for 2019
      [viii. 80.0% for 2020**]**

   d. The Ceiling Amount for each hospital is equal to the average payment received in the three year period between 1/1/10 and 12/31/12 multiplied by the Ceiling Percentage for its respective pool. The ceiling percentage is calculated using an iterative process to obtain the unique percentage value such that:
      i. The total payments to all providers in each pool equals the amount of the respective pool in subdivision (b)(1) or (b)(2) and
      ii. The individual hospital payments will comply with the requirements described in paragraphs 3(a) through (c) above

   e. For 2014 through [2020]2019, these amounts will be further adjusted to carve out amounts used to fund the Financial Assistance Compliance Pool payments in paragraph 6

New York
161(i)

RESERVED

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	A	B	C	D	E	F	G	H	I	J	K	L	M
1	**Sample Transition Period DSH Pool Payment Calculations**												
2				**Floor Pct.**	**Ceiling Pct.**								
3	**CY 2014**			95 0%	109 9%								
4				**(i)**	**(ii)**								
5	**Hospital Name**	**Indigent Care Pool Payment Before Transition Period Adjustment**	**Three Year Historical Average of Pool Payments (2010-2012)**	**Floor Amount**	**Ceiling Amount**	**Tentative Transition Period Payment**	**Financial Assistance Compliance Pool Carve-out (2014-2015)**	**Actual Transition Period Payment**			**Allocation Before Adjustment as Pct. of Three Year Avg**	**Tentative Transition Period Payment as Pct of Three Year Avg**	
6	**(a)**	**(b)**	**(c)**	**(d)**	**(e)**	**(f)**							
7													
8	Hospital A	$25 000 000	$18 000 000	$17 100 000	$19 782 000	$19 782 000	$454 106	$19 327 894			138.9%	109.9%	
9	Hospital B	$14 000 000	$12 000 000	$11 400 000	$13 188 000	$13 188 000	$302 737	$12 885 263			116.7%	109.9%	
10	Hospital C	$20 000 000	$19 600 000	$18 620 000	$21 540 400	$20 000 000	$459 110	$19 540 890			102.0%	102.0%	
11	Hospital D	$30 000 000	$30 400 000	$28 880 000	$33 409 600	$30 000 000	$688 666	$29 311 334			98.7%	98.7%	
12	Hospital E	$27 000 000	$31 000 000	$29 450 000	$34 069 000	$29 450 000	$676 040	$28 773 960			87.1%	95.0%	
13	Hospital F	$19 000 000	$23 000 000	$21 850 000	$25 277 000	$21 850 000	$501 578	$21 348 422			82.6%	95.0%	
14	Hospital G	$4 400 000	$5 400 000	$5 130 000	$5 934 600	$5 130 000	$117 762	$5 012 238			81.5%	95.0%	
15													
16	Statew ide Totals	$139 400 000	$139 400 000	$132 430 000	$153 200 600	$139 400 000	$3 200 000	$136 200 000					
17													
18	(1)	Tentative Transition Period Payment:											
19		(a) Hospital name											
20		(b) The unadjusted amount that w ould otherw ise be paid to each hospital under the new DSH pool allocation methodology beginning 1/1/2013											
21		(c) The actual average amount paid to each hospital under the prior DSH pool allocation methodology in CYs 2010 - 2012											
22		(d) The amount for each hospital in (c) multiplied by the Floor Percentage in (i)											
23		(e) The amount for each hospital in (c) multiplied by the Ceiling Percentage in (ii)											
24		(f) For each individual hospital if the Indigent Care Pool Actual Transition Period Payment is:											
25			(1) < the Floor Amount the Transition Period Payment is the Floor Amount										
26			(2) > the Ceiling Amount the Transition Period Payment is the Ceiling Amount										
27			(3) Otherw ise it is the amount in (b) calculated using the new DSH pool allocation methodology effective 1/1/2013.										
28		Using the formula = F(Bn<Dn,Dn, F(Bn>En,En,Bn))											
29													
30	(2)	Percentages:											
31		(i) The Floor Percentage equals 97 5% in 2013 95 0% in 2014 and 92.5% in 2015											
32		(ii) A unique Ceiling Percentage is calculated using an iterative set of calculations w here both:											
33			(1) the total transition payments equal the respective pool amounts and										
34			(2) all the constraints in (f) are respected										
35		For instance using the Excel Goal Seek data tool:											
36			Set Cell F15										
37			Equal to $139 400 000										
38			By Changing Cell E2										
39													
40	(3)	Financial Assistance Compliance Pool Carve-out for 2014 & 2015:											
41		The carve out w ill be calculated by using each hospital's share of the $139.4M allocation and											
42		applying that percentage to the $3.2M in compliance pool funds.											
43													
44	(4)	This same process w ould apply to the Voluntary Allocations of $994.9M											

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New York
161(j)

4.Voluntary ICP Pool Reduction. Total distributions relative to calendar years 2020 through 2022, made to eligible voluntary general hospitals shall reflect a reduction of one hundred fifty million dollars annually. Hospitals that qualify as Enhanced Safety Net hospitals in State Fiscal Year 2019-2020 are exempt from such reductions. The methodology to allocate the reduction may take into account the payor mix of each voluntary hospital, including the percentage of inpatient days paid by Medicaid.

5. Enhanced Safety Net Transition Collar Pool. For distributions relative to calendar years 2020 through 2022, sixty-four million six hundred thousand dollars will be distributed to hospitals qualifying as Enhanced Safety Net Hospitals in State Fiscal Year 2019-2020 that experience a reduction in their distribution year Indigent Care Pool payments when compared to their 2019 ICP payments. The methodology to allocate this funding will be proportional to the reduction received by the facility.

[4.]6. Voluntary UPL Payment Reductions. The distributions in this section will be reduced by the final payment amounts paid to the eligible voluntary general hospitals, excluding government general hospitals, made in accordance with the Voluntary Supplemental Inpatient and Outpatient Payments section.

[5.]7. DSH Payment Limits. The distributions in this section are subject to the provisions of the Disproportionate share limitations section.

[6]8. Financial Assistance Compliance Pool. For calendar year 2014 through [2020] 2022, an amount equivalent to one percent of total DSH funds will be segregated into the Financial Assistance Compliance Pool (FACP) and allocated to all hospitals which prior to December 31, 2015 demonstrate substantial compliance with §2807-k(5-d)(b)(iv) of the Public Health Law (New York State Financial Aid Law) as in effect on January 1, 2013. There will be separate pool amounts for major governmental and voluntary hospitals. The DSH funds in the FACP will be proportionately allocated to all compliant hospitals using the Indigent Care Methodology described in paragraph (a) of this section. Compliance will be on a pass/fail basis. When a hospital is deemed compliant, one hundred percent of its share of the FACP funds will be released; there will be no partial payment for partial compliance. Any unallocated funds resulting from hospitals being non-compliant will be proportionally reallocated to compliant hospitals in each respective group based on their relative share of the distributions calculated in paragraph (a).

Appendix II
2020 Title XIX State Plan
Second Quarter Amendment
Summary

SUMMARY
SPA #20-0040

This State Plan Amendment proposes extending the Indigent Care Pool (ICP) Methodology through March 31, 2023 and implement the following changes included in the FY 2021 Enacted Budget:

- Eliminate the 'Transition Collar' and corresponding $25 million (gross) in funding;
- Implement a $150 million (gross) reduction in ICP Payments to Voluntary hospitals; and,
- Implement a $64.6 million (gross) Safety Net transition collar for Enhanced Safety Net hospitals who have a year over year reduction in ICP payments as a result of the elimination of the transition collar.

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

SPA 20-0040

§3 of Part KK of Chapter 56 of the Laws of 2020.

§ 3. Subdivision 5-d of section 2807-k of the public health law, as amended by section 6 of part H of chapter 57 of the laws of 2019, is amended to read as follows:

5-d. (a) Notwithstanding any inconsistent provision of this section, section twenty-eight hundred seven-w of this article or any other contrary provision of law, and subject to the availability of federal financial participation, for periods on and after January first, two thousand twenty, through March thirty-first, two thousand twenty-three, all funds available for distribution pursuant to this section, except for funds distributed pursuant to subparagraph (v) of paragraph (b) of subdivision five-b of this section, and all funds available for distribution pursuant to section twenty-eight hundred seven-w of this article, shall be reserved and set aside and distributed in accordance with the provisions of this subdivision.

(b) The commissioner shall promulgate regulations, and may promulgate emergency regulations, establishing methodologies for the distribution of funds as described in paragraph (a) of this subdivision and such regulations shall include, but not be limited to, the following:

(i) Such regulations shall establish methodologies for determining each facility's relative uncompensated care need amount based on uninsured inpatient and outpatient units of service from the cost reporting year two years prior to the distribution year, multiplied by the applicable medicaid rates in effect January first of the distribution year, as summed and adjusted by a statewide cost adjustment factor and reduced by the sum of all payment amounts collected from such uninsured patients, and as further adjusted by application of a nominal need computation that shall take into account each facility's medicaid inpatient share.

(ii) Annual distributions pursuant to such regulations for the two thousand twenty through two thousand twenty-two calendar years shall be in accord with the following:

(A) one hundred thirty-nine million four hundred thousand dollars shall be distributed as Medicaid Disproportionate Share Hospital ("DSH") payments to major public general hospitals; and

(B) nine hundred sixty-nine million nine hundred thousand dollars as Medicaid DSH payments to eligible general hospitals, other than major public general hospitals.

For the calendar years two thousand twenty through two thousand twenty-two, the total distributions to eligible general hospitals, other than major public general hospitals, shall be subject to an aggregate reduction of one hundred fifty million dollars annually, provided that eligible general hospitals, other than major public general hospitals, that qualify as enhanced safety net hospitals under section two thousand eight hundred seven-c of this article shall not be subject to such reduction.

Such reduction shall be determined by a methodology to be established by the commissioner. Such methodology may take into account the payor mix of each non-public general hospital, including the percentage of inpatient days paid by Medicaid.

(iii) For calendar years two thousand twenty through two thousand twenty-two, sixty-four million six hundred thousand dollars shall be distributed to eligible general hospitals,

other than major public general hospitals, that experience a reduction in indigent care pool payments pursuant to this subdivision, and that qualify as enhanced safety net hospitals under section two thousand eight hundred seven-c of this article as of April first, two thousand twenty. Such distribution shall be established pursuant to regulations promulgated by the commissioner and shall be proportional to the reduction experienced by the facility.

(iv) Such regulations shall reserve one percent of the funds available for distribution in the two thousand fourteen and two thousand fifteen calendar years, and for calendar years thereafter, pursuant to this subdivision, subdivision fourteen-f of section twenty-eight hundred seven-c of this article, and sections two hundred eleven and two hundred twelve of chapter four hundred seventy-four of the laws of nineteen hundred ninety-six, in a "financial assistance compliance pool" and shall establish methodologies for the distribution of such pool funds to facilities based on their level of compliance, as determined by the commissioner, with the provisions of subdivision nine-a of this section.

(c) The commissioner shall annually report to the governor and the legislature on the distribution of funds under this subdivision including, but not limited to:

(i) the impact on safety net providers, including community providers, rural general hospitals and major public general hospitals;

(ii) the provision of indigent care by units of services and funds distributed by general hospitals; and

(iii) the extent to which access to care has been enhanced.

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

MISCELLANEOUS
NOTICES/HEARINGS

Notice of Abandoned Property Received by the State Comptroller

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

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

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

PUBLIC NOTICE
Department of Health

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

All Services

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

1. Payments whereby federal law precludes such reduction, including:
- Federally Qualified Health Center services;
- Indian Health Services and services provided to Native Americans;
- Supplemental Medical Insurance – Part A and Part B;
- State Contribution for Prescription Drug Benefit (aka Medicare Part D payments);
- Any local share cap payment required by the Federal Medical Assistance Percentage (FMAP) increase legislation;
- Services provided to American citizen repatriates; and
- Hospice Services.

2. Payments funded exclusively with federal and/or local funds include, but are not limited to, the following:
- Upper payment limit payments to non-state owned or operated governmental providers certified under Article 28 of the NYS Public Health Law;
- Certified public expenditure payments to the NYC Health and Hospital Corporation;
- Certain disproportionate share payments to non-state operated or owned governmental hospitals;
- Certain managed care payments pursuant to section 3-d of Part B of the Chapter 58 of the Laws of 2010; and
- Services provided to inmates of local correctional facilities.

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

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

PUBLIC NOTICE
Department of Health

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

The Department of Health proposes to amend the Title XIX (Medicaid) State Plan for institutional, non-institutional or long term care services to comply with proposed Medicaid Redesign Team II (MRT) initiatives. The following changes are proposed:

All Services

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

- Payments whereby federal law precludes such reduction, including:
  - Federally Qualified Health Center services;
  - Indian Health Services and services provided to Native Americans;
  - Supplemental Medical Insurance – Part A and Part B;
  - State Contribution for Prescription Drug Benefit (aka Medicare Part D payments);
  - Any local share cap payment required by the Federal Medical Assistance Percentage (FMAP) increase legislation;
  - Services provided to American citizen repatriates; and
  - Hospice Services.
- Payments funded exclusively with federal and/or local funds include, but are not limited to, the following:
  - Upper payment limit payments to non-state owned or operated governmental providers certified under Article 28 of the NYS Public Health Law;
  - Certified public expenditure payments to the NYC Health and Hospitals Corporation;
  - Certain disproportionate share payments to non-state oper-

ated or owned governmental hospitals;
- Certain managed care payments pursuant to section 3-d of Part B of the Chapter 58 of the Laws of 2010; and
- Services provided to inmates of local correctional facilities.

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

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

Non-Institutional Services

Care Management

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

- Implement Health Home Improvement, Efficiency, Consolidation and Standardization: These efficiencies include eliminating outreach payments, reducing unnecessary documentation, revising the criteria for admission, and re-evaluating the benchmarks for stepping patients down to lower levels of care management or graduation from a Health Home. Finally, placing the most seriously mentally ill clients in care management arrangements with appropriate caseload sizes – overseen by the Office of Mental Health – while moving lower acuity members into less intensive care management arrangements will both improve program quality and achieve efficiencies.

- Promote Further Adoption of Patient-Centered Medical Homes (PCMH): Continues incentive payments at current levels for lower cost, higher value PCMH programs while incorporating a tiered quality component into the incentive payments to align with other State initiatives such as the Prevention Agenda.

- Comprehensive Prevention and Management of Chronic Disease: Advances the use of evidence-based prevention strategies to manage highly prevalent chronic diseases, including diabetes, hypertension, asthma, smoking, osteoarthritis, chronic kidney disease, HIV/AIDS, and sickle cell disease. Specifically, the proposal will: (1) promote the use of evidence-based, self-care education, and prevention strategies; (2) implement an awareness campaign to educate Medicaid Managed Care (MMC) Plans, providers, and Medicaid members on the various resources and programs that are available; (3) educate the provider community relative to adherence to established evidence-based practice guidelines; (4) optimize services that are already covered by Medicaid, including expanding who can provide services; (5) optimize pharmacist services and leverage the frequency of patient visits to the pharmacy by expanding Collaborative Drug Therapy Management (CDTM) to the community setting, enable pharmacists to administer point-of-care testing for designated CLIA-waived tests and to initiate prescriptions for certain medications; (6) focus on chronic condition management within Patient-Centered Medical Homes (PCMHs) and Health Homes; initially, focus treatment and care management resources on adults with diabetes and hypertension, and children with asthma.

- Children's Preventive Care and Care Transitions: Promotes behavioral health integration in pediatrics by continuing ongoing pilot work focused on pregnancy and early childhood (e.g., preschool screening and universal, light-touch home visits) and leverages participation in CMMI's Integrated Care for Kids (InCK) model of integration of medical and behavioral health care, using resources already available in the community. In addition, this proposal improves care transitions for children with chronic medical and behavioral conditions, with a special focus on children with sickle cell disease (SCD) moving from pediatric to adult care settings.

- Children and Family Treatment and Support Services (CFTSS) - Restores specialized transition rates for CFTSS.

- Invest in Medically Fragile Children: Invests Medicaid resources to improve access to private duty nursing (PDN) for medically fragile children in order to prevent hospitalization and emergency visits, by leveraging additional utilization of telehealth, commercial insurance coverage for PDN, further PDN network development and enhanced rates. Specifically, the proposal would increase fee-for-service PDN rates over a three year period to benchmark to the current Medicaid Managed Care rates; create a PDN Network whereby PDN providers would receive a negotiated enhanced rate of payment for PDN services.

- Preventive Dentistry: Promotes evidence-based preventative dentistry using fluoride varnish and silver diamine fluoride. Specifically, the proposal increases the application of fluoride varnish by primary care providers, including Registered Nurses, which will decrease early childhood decay and associated restorative costs. In addition, the proposal expands Medicaid dental coverage to include silver diamine fluoride which stops tooth decay and prevents additional oral complications.

- Emergency Room Avoidance and Cost Reductions: this proposal reduces unnecessary Emergency Department (ED) utilization and/or cost by redesigning care pathways for high ED utilizing patients and transitions navigation to community services by: allowing sharing of individualized patient treatment plans for chronic conditions (through Qualified Entity (QEs)); expanding access to Urgent Care Centers by increasing co-location with Emergency Rooms; requiring Urgent Care Centers to accept Medicaid; and exploring a lower ED triage fee for non-emergency conditions.

- Addressing Barriers to Opioid Care: Implements a series of Opioid related interventions to address certain barriers to care for Medicaid members, including but not limited to, better bundled payments that support opiate treatment through the adjustment of Ambulatory Patient Groups (APG) payments to eliminate unnecessary volume incentive and to promote more appropriate access including take home medication, when clinically appropriate; reduced Medicaid Coverage Limits for Rehabilitation Services as pathway to nonpharmacologic treatment alternative for pain management, and increased utilization of the Opioid Medical Maintenance (OMM) Model.

- Promote Maternal Health to Reduce Maternal Mortality: Focuses on optimizing the health of individuals of reproductive age, including discussions on comprehensive family planning and patient centered primary and preventive care. The proposal aims to improve access to quality prenatal care, free from implicit bias, and ensuring postpartum home visits are available to all individuals who agree have a home visit after giving birth, by working with Medicaid Managed Care plans to identify and address the barriers to achieving these goals. The proposal also includes ensuring all pregnant individuals have access to childbirth education and supports the participation of birthing centers in the Perinatal Quality Collaborative.

The estimated annual net aggregate decrease in gross Medicaid expenditures attributable to these initiatives contained in the budget for SFY 2020-2021 is $86 million and for SFY 2021-2022 is $140 million.

Pharmacy

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

- Reduce Drug Cap Growth by Enhancing Purchasing Power to Lower Drug Costs by providing the ability to negotiate supplemental rebates for new blockbuster drugs and gene therapies that do not yet have utilization; and the authority to negotiate value-based agreements with manufacturers.

- Reducing coverage of certain OTC products and increasing copayments (with exceptions for the most vulnerable populations).

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

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

Transportation

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

• Transition the State to a single Medicaid Transportation Broker to ensure that consumers receive reliable, high quality transportation services using the mode that is appropriate for the consumer.

• Discontinue the Supplemental Ambulance Rebate Payments to emergency medical transportation (EMT) providers since updating and rationalized the ambulance fee schedule consistent with the Department of Health's Ambulance Rate Adequacy Study.

• Carve transportation out of the MLTC Benefit (excluding PACE) and into fee-for-service to create efficiencies and consistency in purchasing, arranging and managing transportation services across the Medicaid program.

• Maximize Public Transit in New York City and other urban areas to encourage the use of public transportation as an alternative to livery when appropriate for the consumer.

• Reduce Taxi/Livery Rates and promoting other modes of transportation to reflect market rates for transportation services.

• Implement an ambulance diversion - Triage, Treat and Transport (ET3) - support program to reduce avoidable hospitalizations, subject to any necessary federal approvals.

• Pursue a Certified Public Expenditure program to maximize federal reimbursement for NEMT services incurred by municipalities.

• Create a Community Paramedicine Program to expand the roles of Emergency Medical Technicians (EMTs) and Paramedics by providing medical care to patients at home to avoid unnecessary trips to the Emergency Department (ED). EMTs and Paramedics would provide additional patient health and safety services (e.g., food, medications, fall precautions) and clinical assessment and diagnostic testing in consultation with online medical control/telemedicine physicians/advanced practitioners to avoid unnecessary trips to the hospital.

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

Telehealth

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

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

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

Institutional Services

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

• Reduce the size of the voluntary hospital Indigent Care Pool by $75 million (State share);

• Eliminate the Indigent Care Pool "Transition Collar", which generates an additional $12.5 million in State share savings; and

• Eliminate the Public Hospitals Indigent Care Pool, which generates $70 million in State savings;

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

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

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

Long Term Care Services

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

• Modify the current eligibility criteria for individuals to receive Personal Care Services and Consumer Directed Personal Assistance Services (CDPAS) as a Medicaid benefit, regardless of whether such services are received through fee-for-service, Mainstream Managed Care plans, or Managed Long Term Care (MLTC) plans. In order to be eligible to receive such services, an individual must be assessed to need assistance with more than two activities of daily living (ADLs) (ranging from limited assistance to total dependence).

• Institute a Home and Community Based Services lookback period of 60 months for asset transfers in determining eligibility for Medicaid for those seeking home and community based long term care services and supports as currently applies to those seeking Medicaid eligibility for nursing home care.

• Eliminate the ability of spouses living together in the community, and parents living with their child, to refuse to make their income and resources available during the determination of an applicant's eligibility for Medicaid.

• Utilize an independent clinician panel, similar to the State's Conflict Free Evaluation and Enrollment Center, to assess patients and order PCS and CDPAS under a clear set of standards and protocols.

• Implement an enhanced utilization review process by an independent assessor for any individuals who are assessed to need more than 12 hours per day on average in a given month (i.e., 360 hours per month for a 30-day month) to ensure that it remains safe for that individual to remain in the community.

• Change the frequency in which the Community Health Assessment is conducted from every six months to once annually, subject to requiring reassessments based on changes in health condition or status.

• Implement a uniform tasking tool for use by plans and Local Departments of Social Services (LDSS) to help determine service utilization, including the hours of Personal Care Services and CDPAS required each day.

• Employ the provider "choice" model to proceed with the implementation and electronic visit verification (EVV) system, as required by the Federal 21st Century Cures Act.

• Eliminate requirements that plans and LDSS educate consumers about the availability of the CDPAP program semi-annually Develop standards and protocols to determine whether consumers are self-directing and, if applicable, their designated representative is able to fulfill their obligations appropriately.

• Delay the implementation date of certain permissible Consumer First Choice Option Services (CFCO) services from January 1, 2020 to April 1, 2022.

• Incorporate additional transparency, compliance, and accountability standards to ensure that entities receiving wage parity payments are appropriately using those funds for the benefit home care aides.

• Reduce Workforce Recruitment and Retention funding for home health care workers.

• Migrate the completion of all Community Health Assessments (CHA) and reassessments to a single, statewide Independent Assessor (IA).

• Modify the minimum community spouse resource amount, which is used to determine the Medicaid eligibility of an applicant under spousal impoverishment budgeting.

• Reduce funding associated with nursing home capital reim-

MISCELLANEOUS NOTICES/HEARINGS

Notice of Abandoned Property Received by the State Comptroller

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

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

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

PUBLIC NOTICE

Department of Civil Service

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

Please take notice that the regular monthly meeting of the State Civil Service Commission for 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
HOSPITAL SERVICES
State Plan Amendment #20-0040

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 an appropriation received by the State agency that oversees medical assistance (Medicaid), which is the Department of Health.

The source of the appropriation is the Indigent Care Program within the HCRA Special Revenue Account, which is part of the Global Cap. This portion of the Global Cap is funded with HCRA resources.

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

Tribal Assurance:

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

IHCIA Section 2107(e)(I) of the Act was also amended to apply these requirements to the Children's Health Insurance Program CHIP. Consultation is required concerning Medicaid and CHIP matters having a direct impact on Indian health programs and Urban Indian organizations.
a) Please describe the process the State uses to seek advice on a regular ongoing basis from federally recognized tribes Indian Health Programs and Urban Indian Organizations on matters related to Medicaid and CHIP programs and for consultation on State Plan Amendments waiver proposals waiver extensions waiver amendments waiver renewals and proposals for demonstration projects prior to submission to CMS.
b) Please include information about the frequency inclusiveness and process for seeking such advice.
c) Please describe the consultation process that occurred specifically for the development and submission of this State Plan Amendment when it occurred and who was involved.

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

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

APPENDIX VI
INPATIENT SERVICES
State Plan Amendment 20-0040

CMS Standard Access Questions

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

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

   Response: This amendment seeks to make changes to the Indigent Care Pool including elimination of the 'Transition Collar' ($25 million gross); reduction in funding to the voluntary hospitals ($150 million gross); and implementation of a Safety Net transition collar for Enhanced Safety Net hospitals who have a year over year reduction in ICP payments as a result of the elimination of the transition collar ($64.6 million gross). While this is a reduction in reimbursement, it reflects a minor change for providers, and will not result in major impacts to the payments made for provision of services.

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

   Response:
   The State has various ways to ensure that access levels in the Medicaid program are retained and is currently not aware of any access issues. 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. In addition, NY published notice in the state register of the proposed policy and did not receive any comments.

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

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

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

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