NEW YORK STATE OF OPPORTUNITY. Department of Health

ANDREW M. CUOMO
Governor

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

LISA J. PINO, M.A., J.D.
Executive Deputy Commissioner

September 29, 2020

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

RE: SPA #20-0041
Long Term Care Facility Services

Dear Mr. Cooley:

The State requests approval of the enclosed amendment #20-0041 to the Title XIX (Medicaid) State Plan for long term care facility services to be effective October 1, 2020 (Appendix I). This amendment is being submitted based on enacted legislation. A summary of the proposed amendment is provided in Appendix II.

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

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

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

Sincerely,

[redacted]

Donna Frescatore
Medicaid Director
Office of Health Insurance Programs

Enclosures
cc: Todd McMillion

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

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 20 — 0041

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
October 1, 2020

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

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

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

6. FEDERAL STATUTE/REGULATION CITATION
§ 1902(a) of the Social Security Act and 42 CFR 447

7. FEDERAL BUDGET IMPACT
a. FFY 10/01/20-09/30/21 $ (315,800.000)
b. FFY 10/01/21-09/30/22 $ (315,800,000)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 3.1-A Supp. Pages: 3(d), 3(d)(A), 3(d)(i)
Attachment 3.1-B Supp. Pages: 3(d), 3(d)(A), 3(d)(i)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 3.1-A Supp. Pages: 3(d), 3(d)(A), 3(d)(i)
Attachment 3.1-B Supp. Pages: 3(d), 3(d)(A), 3(d)(i)

10. SUBJECT OF AMENDMENT
PCS- CDPAP Eligibility
(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
September 29, 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
Third Quarter Amendment
Amended SPA Pages

New York
3(d)

24a. Prior approval is required for non-emergent transportation, including the services and subsistence of the attendant. Requests can be made by recipients or their family members; or medical practitioners acting on behalf of a recipient.

Transportation providers are assigned to requests for non-emergency transportation services based upon first, a recipient's choice of available participating vendors at the medically appropriate level of transportation; then, if the recipient indicates no preference, the ordering practitioner's choice among available participating vendors at the medically appropriate level of transportation; and finally, if no choice is made by the ordering practitioner, the request is given via rotation among the medically available and appropriate mode of transportation providers.

1. To assure comparability and statewideness, each county's local department of social services manages transportation services on behalf of recipient's assigned to the county.

2. The Commissioner of Health is authorized to assume the responsibility of managing transportation services from any local social services district. If the Commissioner elects to assume this responsibility, the Commissioner may choose to contract with a transportation manager or managers to manage transportation services in any local social services district.

3. Recipient, family member, or volunteer reimbursement is made as an administrative expense of the Medicaid Program. This applies to any personal vehicle mileage reimbursement, lodging, airfare, or other expense borne on behalf of the Medicaid recipient by a non-direct vendor.

24d. Prior approval is required for skilled nursing facility services except when admitted directly from a hospital, another skilled nursing facility or from a health related facility.

Medicaid payments [shall] <u>will</u> not be authorized for skilled nursing facilities which are not certified or have not applied for certification to participate in Medicare.

26. Personal Care Services means some or total assistance with personal hygiene, dressing and feeding and nutritional and environmental support functions. Prior approval is required for all personal care services. The authorization period and amount of personal care services authorized depends upon patient need, as indicated in the patient's assessment. <u>Cases in which the need for such services is expected to exceed a specified level, to be determined by the Commissioner of Health, will be forwarded for additional independent medical review by an independent panel of medical professionals, or other clinicians, selected or approved by the Department of Health to review the appropriateness or sufficiency of such services.</u>

[Personal care services, shared aide and individual aide, furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease, as determined to meet the recipient's needs for assistance, and when prescribed by a physician, in accordance with the recipient's plan of treatment and provided by individuals who are qualified to provide such services, who are supervised by a registered nurse and who are not members of the recipient's family, and furnished in the recipient's home or other location.]

New York
3(d)(A)

Personal care services, shared aide and individual aide, furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease, as determined to meet the recipient's needs for assistance, and when prescribed by a qualified independent physician or clinician selected or approved by the Department of Health, in accordance with the recipient's plan of treatment and provided by individuals who are qualified to provide such services, who are supervised by a registered nurse and who are not members of the recipient's family, and furnished in the recipient's home or other location.

Providers of personal care services (personal care aides) must have:

- maturity, emotional and mental stability, and experience in personal care or homemaking;
- the ability to read and write, understand and carry out directions and instructions, record messages, and keep simple records;
- a sympathetic attitude toward providing services for patients at home who have medical problems;
- good physical health, as indicated by the documentation in the personnel file of all persons providing personal care services. This documentation must include the same assurances and proof of good physical health that the Department of health requires for employees of certified home agencies;
- a criminal history record check performed to the extent required under section 124 of the PHL; and
- successfully completed a training program approved by the Department.

Personal care aides must be supervised by a registered professional nurse who is licensed and currently certified to practice in New York State and who has at least two years satisfactory recent home health care experience. Nursing supervision includes orienting the personal care aide to his/her job assignment(s); providing needed on-the-job training; making nursing supervisory visits to the patient's home PRN, but at least every 90 days; and, annually conducting an overall job performance evaluation of the aide.

New York State's Personal Care Services are provided in accordance with 42 CFR 440.167.

New York
3(d)(i)

26 (cont.). Consumer Directed Personal Assistance Program

The Consumer Directed Personal Assistance Program (CDPAP) is a consumer directed home care services delivery model. The program serves Medicaid recipients who have a [Medicaid] medical need for home care services and who choose to participate in this model. It has operated under the State's Personal Care Services benefit since 1990. As such, the eligibility, assessment and prior authorization of services processes mirror that of the Personal Care Services Program (PCSP). In the traditional PCSP, the local department of social services [district] ([LSSD]LDSS) contracts with home care agencies for the provision of services. The home care agency is responsible for hiring, training, supervising and providing the home care worker with salary and benefits. In the CDPAP, [the LDSS contracts with a CDPAP agency (fiscal intermediary) and] there is a co-employer relationship between the CDPAP agency (also known as a fiscal intermediary) and the consumer that encompasses these functions.

The CDPAP consumer is responsible for hiring/training/supervising/and firing his/her aides. The CDPAP agency acts as the co-employer of each aide hired by the consumer for the purpose of setting wage levels and fringe benefits, including health insurance coverage and other benefits, e.g. unemployment and workers compensation. It is the CDPAP agency that actually pays each aide and administers related fringe benefits. The CDPAP agency also submits claims for payment to the Department's agent that processes and pays claims for services provided to Medicaid recipients.

26 (cont.). Initial Authorizations On and After October 1, 2020

For initial authorizations beginning on and after October 1, 2020, personal care services including services delivered through CDPAP will be available only to individuals assessed as needing at least limited assistance with physical maneuvering with more than two Activities of Daily Living (ADLs), or for individuals with a dementia or Alzheimer's diagnosis, assessed as needing at least supervision with more than one ADL, as defined and determined by using an evidence based, validated assessment instrument approved by the Commissioner of Health and in accordance with regulations of the Department of Health and any applicable state and federal laws.

New York
3(d)

24a. Prior approval is required for non-emergent transportation, including the services and subsistence of the attendant. Requests can be made by recipients or their family members; or medical practitioners acting on behalf of a recipient.

Transportation providers are assigned to requests for non-emergency transportation services based upon first, a recipient's choice of available participating vendors at the medically appropriate level of transportation; then, if the recipient indicates no preference, the ordering practitioner's choice among available participating vendors at the medically appropriate level of transportation; and finally, if no choice is made by the ordering practitioner, the request is given via rotation among the medically available and appropriate mode of transportation providers.

1. To assure comparability and statewideness, each county's local department of social services manages transportation services on behalf of recipient's assigned to the county.

2. The Commissioner of Health is authorized to assume the responsibility of managing transportation services from any local social services district. If the Commissioner elects to assume this responsibility, the Commissioner may choose to contract with a transportation manager or managers to manage transportation services in any local social services district.

3. Recipient, family member, or volunteer reimbursement is made as an administrative expense of the Medicaid Program. This applies to any personal vehicle mileage reimbursement, lodging, airfare, or other expense borne on behalf of the Medicaid recipient by a non-direct vendor.

24d. Prior approval is required for skilled nursing facility services except when admitted directly from a hospital, another skilled nursing facility or from a health related facility.

Medicaid payments [shall] <u>will</u> not be authorized for skilled nursing facilities which are not certified or have not applied for certification to participate in Medicare.

26. Personal Care Services means some or total assistance with personal hygiene, dressing and feeding and nutritional and environmental support functions. Prior approval is required for all personal care services. The authorization period and amount of personal care services authorized depends upon patient need, as indicated in the patient's assessment. <u>Cases in which the need for such services is expected to exceed a specified level, to be determined by the Commissioner of Health, will be forwarded for additional independent medical review by an independent panel of medical professionals, or other clinicians, selected or approved by the Department of Health to review the appropriateness or sufficiency of such services.</u>

[Personal care services, shared aide and individual aide, furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease, as determined to meet the recipient's needs for assistance, and when prescribed by a physician, in accordance with the recipient's plan of treatment and provided by individuals who are qualified to provide such services, who are supervised by a registered nurse and who are not members of the recipient's family, and furnished in the recipient's home or other location.]

New York
3(d)(A)

Personal care services, shared aide and individual aide, furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease, as determined to meet the recipient's needs for assistance, and when prescribed by a qualified independent physician or clinician selected or approved by the Department of Health, in accordance with the recipient's plan of treatment and provided by individuals who are qualified to provide such services, who are supervised by a registered nurse and who are not members of the recipient's family, and furnished in the recipient's home or other location.

Providers of personal care services (personal care aides) must have:

- maturity, emotional and mental stability, and experience in personal care or homemaking;
- the ability to read and write, understand and carry out directions and instructions, record messages, and keep simple records;
- a sympathetic attitude toward providing services for patients at home who have medical problems;
- good physical health, as indicated by the documentation in the personnel file of all persons providing personal care services. This documentation must include the same assurances and proof of good physical health that the Department of health requires for employees of certified home agencies;
- a criminal history record check performed to the extent required under section 124 of the PHL; and
- successfully completed a training program approved by the Department.

Personal care aides must be supervised by a registered professional nurse who is licensed and currently certified to practice in New York State and who has at least two years satisfactory recent home health care experience. Nursing supervision includes orienting the personal care aide to his/her job assignment(s); providing needed on-the-job training; making nursing supervisory visits to the patient's home PRN, but at least every 90 days; and, annually conducting an overall job performance evaluation of the aide.

New York State's Personal Care Services are provided in accordance with 42 CFR 440.167.

New York
3(d)(i)

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The Consumer Directed Personal Assistance Program (CDPAP) is a consumer directed home care services delivery model. The program serves Medicaid recipients who have a [Medicaid] medical need for home care services and who choose to participate in this model. It has operated under the State's Personal Care Services benefit since 1990. As such, the eligibility, assessment and prior authorization of services processes mirror that of the Personal Care Services Program (PCSP). In the traditional PCSP, the local department of social services [district] ([LSSD]LDSS) contracts with home care agencies for the provision of services. The home care agency is responsible for hiring, training, supervising and providing the home care worker with salary and benefits. In the CDPAP, [the LDSS contracts with a CDPAP agency (fiscal intermediary) and] there is a co-employer relationship between the CDPAP agency (also known as a fiscal intermediary) and the consumer that encompasses these functions.

The CDPAP consumer is responsible for hiring/training/supervising/and firing his/her aides. The CDPAP agency acts as the co-employer of each aide hired by the consumer for the purpose of setting wage levels and fringe benefits, including health insurance coverage and other benefits, e.g. unemployment and workers compensation. It is the CDPAP agency that actually pays each aide and administers related fringe benefits. The CDPAP agency also submits claims for payment to the Department's agent that processes and pays claims for services provided to Medicaid recipients.

26 (cont.). Initial Authorizations On and After October 1, 2020

For initial authorizations beginning on and after October 1, 2020, personal care services including services delivered through CDPAP will be available only to individuals assessed as needing at least limited assistance with physical maneuvering with more than two Activities of Daily Living (ADLs), or for individuals with a dementia or Alzheimer's diagnosis, assessed as needing at least supervision with more than one ADL, as defined and determined by using an evidence based, validated assessment instrument approved by the Commissioner of Health and in accordance with regulations of the Department of Health and any applicable state and federal laws.

Appendix II
2020 Title XIX State Plan
Third Quarter Amendment
Summary

SUMMARY
SPA #20-0041

This State Plan Amendment proposes to:

- Require an independent physician or clinical professional to provide orders for personal care services (PCS), including Consumer Directed Personal Assistance (CDPAP) services.
- Change the eligibility criteria for PCS and CDPAP to the currently required physician's order and to individuals that need assistance with more than two activities of daily living (ADLs) (from limited to total assistance) or, for individuals with Alzheimer's or dementia, that need at least supervision with more than one ADL.
- Require that service authorizations for PCS or CDPAP that exceed a specified level be forwarded for an additional independent medical review by an independent panel of medical professionals to review the appropriateness or sufficiency of such services.

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

SPA 20-0041

Chapter 56 of the Laws of 2020

PART MM (Excerpts)

Section 1. Intentionally omitted.

§ 2. Subparagraphs (i) and (ii) of paragraph (e) of subdivision 2 of section 365-a of the social services law, as amended by section 36-a of part B of chapter 57 of the laws of 2015, are amended to read as follows:

(i) personal care services, including personal emergency response services, shared aide and an individual aide, subject to the provisions of subparagraphs (ii), (iii), [and] (iv), (V) AND (VI) of this para-

graph, furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for [the mentally retarded] INDIVIDUALS WITH INTELLECTUAL DISABILITIES, or institution for mental disease, as determined to meet the recipient's needs for assistance when cost effective and appropriate, and when prescribed by a QUALIFIED INDEPENDENT physician SELECTED OR APPROVED BY THE DEPARTMENT OF HEALTH, in accordance with the recipient's plan of treatment and provided by individuals who are qualified to provide such services, who are supervised by a registered nurse and who are not members of the recipient's family, and furnished in the recipient's home or other location;

(ii) the commissioner is authorized to adopt standards, pursuant to emergency regulation, for the provision [and], management AND ASSESSMENT of services available under this paragraph for individuals whose need for such services exceeds a specified level to be determined by the commissioner, AND WHO WITH THE PROVISION OF SUCH SERVICES IS CAPABLE OF SAFELY REMAINING IN THE COMMUNITY IN ACCORDANCE WITH THE STANDARDS SET FORTH IN OLMSTEAD V. LC BY ZIMRING, 527 US 581 (1999) AND CONSIDER WHETHER AN INDIVIDUAL IS CAPABLE OF SAFELY REMAINING IN THE COMMUNITY;

§ 2-a. Paragraph (e) of subdivision 2 of section 365-a of the social services law is amended by adding two new subparagraphs (v) and (vi) to read as follows:

(V) SUBJECT TO THE AVAILABILITY OF FEDERAL FINANCIAL PARTICIPATION, PERSONAL CARE SERVICES OTHER THAN PERSONAL EMERGENCY RESPONSE SERVICES AVAILABLE PURSUANT TO THIS PARAGRAPH SHALL BE AVAILABLE ONLY TO INDIVIDUALS ASSESSED AS NEEDING AT LEAST LIMITED ASSISTANCE WITH PHYSICAL MANEUVERING WITH MORE THAN TWO ACTIVITIES OF DAILY LIVING, OR FOR INDIVIDUALS WITH A DEMENTIA OR ALZHEIMER'S DIAGNOSIS, ASSESSED AS NEEDING AT LEAST SUPERVISION WITH MORE THAN ONE ACTIVITY OF DAILY LIVING, AS DEFINED AND DETERMINED BY USING AN EVIDENCED BASED VALIDATED ASSESSMENT INSTRUMENT APPROVED BY THE COMMISSIONER AND IN ACCORDANCE WITH REGULATIONS OF THE DEPARTMENT AND ANY APPLICABLE STATE AND FEDERAL LAWS BY AN INDEPENDENT ASSESSOR. THE PROVISIONS OF THIS SUBPARAGRAPH SHALL ONLY APPLY TO INDIVIDUALS WHO RECEIVE AN INITIAL AUTHORIZATION FOR SUCH SERVICES ON OR AFTER OCTOBER FIRST, TWO THOUSAND TWENTY;

(VI) IN ESTABLISHING ANY STANDARDS FOR THE PROVISION, MANAGEMENT OR ASSESSMENT OF PERSONAL CARE SERVICES THE STATE SHALL MEET THE STANDARDS SET FORTH IN OLMSTEAD V. LC BY ZIMRING, 527 US 581 (1999) AND CONSIDER WHETHER AN INDIVIDUAL IS CAPABLE OF SAFELY REMAINING IN THE COMMUNITY;

§ 2-b. Paragraph (a) of subdivision 2 of section 365-f of the social services law, as added by chapter 81 of the laws of 1995, is amended to read as follows:

(a) is eligible for long term care and services provided by a certified home health agency, long term home health care program or AIDS home care program authorized pursuant to article thirty-six of the public health law, or is eligible for personal care services provided pursuant

to this article, AND WHO WITH THE PROVISION OF SUCH SERVICES IS CAPABLE OF SAFELY REMAINING IN THE COMMUNITY IN ACCORDANCE WITH THE STANDARDS SET FORTH IN OLMSTEAD V. LC BY ZIMRING, 527 US 581 (1999) AND CONSIDER WHETHER AN INDIVIDUAL IS CAPABLE OF SAFELY REMAINING IN THE COMMUNITY;

§ 3. Paragraph (c) of subdivision 2 of section 365-f of the social services law, as amended by chapter 511 of the laws of 2015, is amended to read as follows:

(c) has been determined by the social services district, pursuant to an assessment of the person's appropriateness for the program, conducted with an appropriate long term home health care program, a certified home

health agency, or an AIDS home care program or pursuant to the personal care program, as being in need of home care services or private duty nursing and AS NEEDING AT LEAST LIMITED ASSISTANCE WITH PHYSICAL MANEUVERING WITH MORE THAN TWO ACTIVITIES OF DAILY LIVING, OR FOR PERSONS WITH A DEMENTIA OR ALZHEIMER'S DIAGNOSIS, AS NEEDING AT LEAST SUPERVISION WITH MORE THAN ONE ACTIVITY OF DAILY LIVING, PROVIDED THAT THE PROVISIONS RELATED TO ACTIVITIES OF DAILY LIVING IN THIS PARAGRAPH SHALL ONLY APPLY TO PERSONS WHO INITIALLY SEEK ELIGIBILITY FOR THE PROGRAM ON OR AFTER OCTOBER FIRST, TWO THOUSAND TWENTY, AND WHO is able and willing or has a designated representative, including a legal guardian able and willing to make informed choices, or a designated relative or other adult who is able and willing to assist in making informed choices, as to the type and quality of services, including but not limited to such services as nursing care, personal care, transportation and respite services; and

. . .

. . .

§ 18. Clauses 12 and 13 of subparagraph (v) of paragraph (b) of subdivision 7 of section 4403-f of the public health law, as amended by section 5 of part B of chapter 57 of the laws of 2018, are amended and a new clause 14 is added to read as follows:

(12) Native Americans; [and]

(13) a person who is permanently placed in a nursing home for a consecutive period of three months or more. In implementing this provision, the department shall continue to support service delivery and outcomes that result in community living for enrollees[.]; AND

(14) A PERSON WHO HAS NOT BEEN ASSESSED AS NEEDING AT LEAST LIMITED ASSISTANCE WITH PHYSICAL MANEUVERING WITH MORE THAN TWO ACTIVITIES OF DAILY LIVING, OR FOR INDIVIDUALS WITH A DEMENTIA OR ALZHEIMER'S DIAGNOSIS, ASSESSED AS NEEDING AT LEAST SUPERVISION WITH MORE THAN ONE ACTIVITY OF DAILY LIVING, AS DEFINED AND DETERMINED USING AN EVIDENCED BASED VALIDATED ASSESSMENT INSTRUMENT APPROVED BY THE COMMISSIONER AND IN ACCORDANCE WITH APPLICABLE STATE AND FEDERAL LAW AND REGULATIONS OF THE DEPARTMENT, PROVIDED THAT THE PROVISIONS OF THIS CLAUSE SHALL NOT APPLY TO A PERSON WHO HAS BEEN CONTINUOUSLY ENROLLED IN A MANAGED LONG TERM CARE PROGRAM BEGINNING PRIOR TO OCTOBER FIRST, TWO THOUSAND TWENTY.

. . .

§ 20. The department of health shall establish or procure services of an independent panel or panels of clinical professionals no later than October 1, 2022, in a manner and schedule as determined by the commissioner of health, to provide as appropriate independent physician or other applicable clinician orders for personal care services, including as provided through the consumer directed personal assistance program,

available pursuant to the state's medical assistance program and to determine eligibility for the consumer directed personal assistance program. Notwithstanding the provisions of section 163 of the state finance law, or sections 142 and 143 of the economic development law, or any contrary provision of law, contracts may be entered or the commissioner may amend and extend the terms of a contract awarded prior to the effective date and entered into pursuant to subdivision twenty-four of section two hundred six of the public health law, as added by section thirty-nine of part C of chapter fifty-eight of the laws of two thousand eight, and a contract awarded prior to the effective date and entered into to conduct enrollment broker and conflict-free evaluation services for the Medicaid program, if such contract or contract amendment is for the purpose of establishing an independent panel or panels of clinical professionals as described in this section; provided, however, in the case of a contract entered into after the effective date of this section, that:

(a) The department of health shall post on its website, for a period of no less than 30 days:

(i) A description of the proposed services to be provided pursuant to the contract or contracts;

(ii) The criteria for selection of a contractor or contractors;

(iii) The period of time during which a prospective contractor may seek to be selected by the department of health, which shall be no less than 30 days after such information is first posted on the website; and

(iv) The manner by which a prospective contractor may submit a proposal for selection, which may include submission by electronic means;

(b) All reasonable and responsive submissions that are received from prospective contractors in timely fashion shall be reviewed by the commissioner of health; and

(c) The commissioner of health shall select such contractor or contractors that, in such commissioner's discretion, are best suited to serve the purposes of this section and the needs of recipients; and

(d) all decisions made and approaches taken pursuant to this section shall be documented in a procurement record as defined in section one hundred sixty-three of the state finance law.

Appendix IV
2020 Title XIX State Plan
Third 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-

• 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-

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

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

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

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

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

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

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

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

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

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

PUBLIC NOTICE

New York City Deferred Compensation Plan & NYCE IRA

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

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

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

PUBLIC NOTICE

Department of State
F-2019-1176
Date of Issuance – April 1, 2020

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

The applicant has certified that the proposed activity complies with and will be conducted in a manner consistent with the approved New York State Coastal Management Program.

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

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

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

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

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

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

PUBLIC NOTICE

Department of State
Uniform Code Variance / Appeal Petitions

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

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

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

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

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

PUBLIC NOTICE

Department of State
Uniform Code Variance / Appeal Petitions

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

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
Third Quarter Amendment
Responses to Standard Funding Questions

APPENDIX V
LONG TERM CARE SERVICES
State Plan Amendment #20-0041

CMS Standard Funding Questions (NIRT Standard Funding Questions)

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

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

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

2. **Section 1902(a)(2) provides that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan. Please describe how the state share of each type of Medicaid payment (normal per diem, supplemental, enhanced, other) is funded. Please describe whether the state share is from appropriations from the legislature to the Medicaid agency, through intergovernmental transfer agreements (IGTs), certified public expenditures (CPEs), provider taxes, or any other mechanism used by the state to provide state share. Note that, if the appropriation is not to the Medicaid agency, the source of the state share would necessarily be derived through either an IGT or CPE. In this case, please identify the agency to which the funds are appropriated. Please provide an estimate of total expenditure and State share amounts for each type of Medicaid payment. If any of the non-federal share is being provided using IGTs or CPEs, please fully describe the matching arrangement including when the state agency receives the transferred amounts from the local government entity transferring the funds. If CPEs are used, please describe the methodology used by the state to verify that the total expenditures being certified are eligible for Federal matching funds in accordance with 42 CFR 433.51(b). For any payment funded by CPEs or IGTs, please provide the following:**
    - **(i) a complete list of the names of entities transferring or certifying funds;**
    - **(ii) the operational nature of the entity (state, county, city, other);**
    - **(iii) the total amounts transferred or certified by each entity;**
    - **(iv) clarify whether the certifying or transferring entity has general taxing authority; and,**
    - **(v) whether the certifying or transferring entity received appropriations (identify level of appropriations).**

Response: Payments made to service providers under the provisions of this SPA are funded through a budget 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 not been changes to provider taxes relative to this SPA.

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: This SPA is not applicable to a 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: This amendment does not make any changes to Medicaid payments for personal care services or the Consumer Directed Personal Assistance Program. The payment methodology for these services has been established to reimburse providers for their reasonable costs. However, 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 complied with the conditions of the MOE provision of section 1902(gg) of the Act for continued funding under the Medicaid program.

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

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

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

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

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

Tribal Assurance:

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

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

a) **Please describe the process the State uses to seek advice on a regular ongoing basis from federally recognized tribes Indian Health Programs and Urban Indian Organizations on matters related to Medicaid and CHIP programs and for consultation on State Plan Amendments waiver proposals waiver extensions waiver amendments waiver renewals and proposals for demonstration projects prior to submission to CMS.**
b) **Please include information about the frequency inclusiveness and process for seeking such advice.**
c) **Please describe the consultation process that occurred specifically for the development and submission of this State Plan Amendment when it occurred and who was involved.**

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

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

APPENDIX VI
LONG TERM CARE SERVICES
State Plan Amendment 20-0041

CMS Standard Access Questions

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

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

   Response: This amendment does not make any changes to Medicaid payments for personal care services or the Consumer Directed Personal Assistance Program.

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: This amendment does not make any changes to Medicaid payments for personal care services or the Consumer Directed Personal Assistance Program.

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

   Response: This change was enacted by the State Legislature as part of the negotiation of the 2020-21 Budget. The impact of this change was weighed in the context of the overall Budget in the State. The legislative process provides opportunities for all stakeholders to lobby their concerns, objections, or support for various legislative initiatives.

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

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

5. **Is the State modifying anything else in the State Plan which will counterbalance any impact on access that may be caused by the decrease**

in rates (e.g. increasing scope of services that other provider types may provide or providing care in other settings)?

Response: There is no anticipated change in rates associated with this SPA.