

ANDREW M. CUOMO Governor **HOWARD A. ZUCKER, M.D., J.D.**Commissioner

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

December 31, 2020

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

> RE: SPA #20-0055 Long Term Care Facility Services

Dear Mr. Cooley:

The State requests approval of the enclosed amendment #20-0055 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 Social Services Law, Public Health Law and Mental Hygiene Law. 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 laws is enclosed for your information (Appendix III). A copy of the public notice of this proposed amendment, which was given in the <u>New York State Register</u> on May 27, 2020, is 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,

Donna Frescatore Medicaid Director Office of Health Insurance Programs

Enclosures

cc: Todd McMillion

CENTERS FOR MEDICARE & MEDICARD SERVICES		
TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL	1. TRANSMITTAL NUMBER	2. STATE
FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES	3. PROGRAM IDENTIFICATION: 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	
5. TYPE OF PLAN MATERIAL (Check One)	•	
☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDE		AMENDMENT
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMEND		nendment)
6. FEDERAL STATUTE/REGULATION CITATION	7. FEDERAL BUDGET IMPACT a. FFY\$\$	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT	9. PAGE NUMBER OF THE SUPERSE OR ATTACHMENT (If Applicable)	DED PLAN SECTION
10. SUBJECT OF AMENDMENT		
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 16	. RETURN TO	
13. TYPED NAME		
14. TITLE		
15. DATE SUBMITTED December 31, 2020		
FOR REGIONAL OFFI		
17. DATE RECEIVED 18	. DATE APPROVED	
PLAN APPROVED - ONE	COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL 20	. SIGNATURE OF REGIONAL OFFICIAL	_
21. TYPED NAME 22	. TITLE	
23. REMARKS		

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

Rates for ICF/IID services delivered by Non-Government and Voluntary ICFs/IID on and after July 1, 2014 will be determined in accordance with this section.

(1) Definitions (applicable to this section):

Active Treatment (AT) – Habilitation services provided for residents of an ICF/IID who are under the age of 21, in all areas of life and at any location. The ICF/IID can arrange for and reimburse other providers (schools or otherwise) to carry out some of the AT called for in the facility's plan of care for an individual. The purpose of AT provided during normal school hours must be habilitation, not educational.

Allowable Agency Administration – For Non-State Government and Voluntary Providers, from the CFR for the base year, divide the Agency Administration Allocation (from CFR1 Line 65) by the Total Operating Costs (from CFR1 Line 64) to determine the agency administration percentage. Effective on or after October 1, 2020, a screen on allowable agency administration costs of 15 percent will be applied to the product of the agency administration percentage multiplied by Total Operating Costs, and the result is the amount permitted for Agency Administration and used within the methodology.

Allowable Operating Costs – All necessary and proper costs which are appropriate and helpful in developing and maintaining the operation of ICFs/IID. Necessary and proper costs are costs which are common and accepted occurrences in the field of ICFs/IID. These costs will be determined in accordance with the cost principles described in the Medicare Provider Reimbursement Manual (HIM-15). This will include allowable program administration, direct care, support, clinical, fringe benefits, and indirect personal service/non-personal service.

Allowable Capital Costs – Are all necessary and proper capital costs that are appropriate and helpful in developing and maintaining the provision of ICF/IID services to beneficiaries determined in accordance with the cost principles described in the Medicare Provider Reimbursement Manual (HIM-15) except as further defined below. This will include, where appropriate, allowable lease/rental and ancillary costs; amortization of leasehold improvements and depreciation of real property; financing expenditures associated with the purchase of real property and related expenditures, and leasehold improvements.

Capital costs of depreciation, and lease/rental of equipment and vehicles (annual lease, depreciation and interest) will be included in the operating components of the provider's rate.

Base Year Consolidated Fiscal Report (CFR) – For Non-Government and Voluntary Providers, the CFR from which the initial target rate will be calculated. Such period will be January 1, 2011 through December 31, 2011 for providers reporting on a calendar year basis and July 1, 2010 through June 30, 2011 for providers reporting on a fiscal year basis. For subsequent periods, the base year CFR will mean the CFR used to update the methodology.

Base Operating Rate – Reimbursement amount calculated by dividing annual reimbursement by applicable annual units of service, both in effect on June 30, 2014.

Budget Neutrality Adjustment – Factor applied to adjust the proposed amount so that it is equivalent to the base amount of dollars.

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(c) Region 3: Broome, Capital District, Central, Finger Lakes, Sunmount, Western, Hudson Valley (Sullivan, Orange Counties), Taconic (Greene, Columbia, Ulster and Dutchess Counties)

Reimbursable Cost – The final allowable costs of the rate period after all audit and/or adjustments are made.

Medical Leave Day – are days of Medical leave or an associated day where any other institutional or in-patient Medicaid payment is made for providing services to the beneficiary. A provider is limited to billing 14 Medical Leave days per rate year, per individual, without prior authorization. Effective on or after October 1, 2020, Medical Leave days will be reimbursed at a rate of 50 percent of the provider's established rate.

Specialized Populations Funding – An all-inclusive fee payment for ICF/IID paid to voluntary ICF/IID providers that serve individuals who left an institutional setting or who have aged out of a New York State residential school setting between November 1, 2011 and March 31, 2013. Special Populations Funding is time limited. Reimbursement for this Special Population will be from the Special Population Fee Table below for ICFs/IID.

Standard Academic Curricula -The subjects comprising a course of study in an educational institution.

Subsequent Rate Period — The corresponding 12-month rate periods that follow the Initial Period.

Target Rate – The final rate in effect at the end of the transition period for each provider.

Therapy Day – A therapy day is a day when the individual is away from the ICF/IID and is not receiving services from paid Residential Habilitation staff and the absence is for the purpose of a visiting with family or friends, or a vacation. The therapy day must be described in the person's plan of care to be eligible for payment and the person may not receive another Medicaid-funded residential, in-patient service or day service on that day. Effective October 1, 2020 or after, a provider is limited to being paid 96 Therapy days per rate year per person. All Therapy days will be reimbursed at a rate of 50 percent of the provider's established rate.

Transition Period – The three-year period which the reimbursement methodology will be phased-in, with a year for purposes of the transition period meaning a twelve-month period from July 1st to the following June 30th, and with full implementation in the beginning of the fourth year.

Wage Equalization Factor (WEF) – The sum of the provider average direct care hourly wage multiplied by .75 and the applicable regional average direct care hourly wage, multiplied by .25.

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- 26. **Statewide budget neutrality adjustment factor for operating dollars** The quotient of the operating portion of all provider rates in accordance with the State Plan in effect on June 30, 2014, divided by the provider operating revenue for all providers.
- 27. **Total provider operating revenue adjusted -** The product of the provider operating revenue and the statewide budget neutrality adjustment factor for operating dollars.
- 28. **Final daily operating rate** This rate is determined by dividing the total provider operating revenue adjusted by the applicable provider rate sheet capacity for the initial period and such quotient to be further divided by 365.
- 29. **Occupancy Adjustment**.
 - (i) For the initial rate period of July 1, 2014 through June 30, 2015; Providers will be paid 75% of the operating component for up to an annual total of 90 days per bed for days when there is a vacancy.
 - (ii) For the rate period[s] beginning July 1, 2015, [and thereafter;] Providers will receive an occupancy adjustment to the operating component of their rate for vacancy days. The occupancy adjustment percentage is calculated by dividing the sum of the agency's rate period medical leave days, service days and the therapy days by 100% of the agency's certified capacity. The certified capacity is calculated taking into account capacity changes throughout the year, multiplied by 100% of the year's days. This adjustment will begin on July 1, 2015 and be recalculated on an annual basis based on the most recent 12 months' experience.
 - (iii) For the period beginning October 1, 2020 or after, the occupancy will no longer be calculated and applied to the provider's rate. The occupancy adjustment will be zero percent.
- (3) Alternative Operating Component. For providers that did not submit a cost report or submitted a cost report that was incomplete for the base year, the final daily operating rate will be a regional daily operating rate. This rate will be the sum of:
 - i. The result of the appropriate regional average direct care hourly rate and the applicable regional average direct care hours, which is the quotient of base year salaried and contracted direct care hours for each provider of a DOH region, totaled for all providers in such region, divided by the rate sheet capacities, pro-rated for partial year sites for the base year for each provider of a DOH region, totaled for all providers in such region; and
 - ii. The result of the applicable regional average clinical hourly wage and the applicable regional average clinical hours, which is the quotient of base year salaried and contracted clinical hours for each provider of a DOH region, totaled for all providers in

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such region, divided by the rate sheet capacities, pro-rated for partial year sites for the base year for each provider of a DOH region, totaled for all providers in such region; and

- iii. The applicable regional average facility revenue, which is the quotient of the sum of food; repairs and maintenance; utilities; expensed equipment; household supplies; telephone; lease/rental equipment; depreciation; insurance property and casualty; housekeeping and maintenance staff; and program administration property for the base year divided by the rate sheet capacities, pro-rated for partial year sites for the base year for each provider of a DOH region, totaled for all providers in such region.
- iv. This sum is then multiplied by the statewide budget neutrality adjustment factor for operating dollars and divided by 365.
 - (a) This rate will be in effect until such time that the provider has submitted a cost report for a base year which will be used in the calculation of a subsequent rate period.
 - (b) For cost reporting periods beginning July 1, 2015 and thereafter, providers are required to file an annual Consolidated Fiscal Report (CFR) to the State by June 1st for providers reporting on the January 1st through December 31st period or December 1st for providers reporting on the July 1st through June 30th period. If the completed CFR is not submitted by either June 1st for providers reporting on the January 1st through December 31st period or December 1st for providers reporting on the July 1st through June 30th period, a 2 percent penalty on the provider's OPWDD Medicaid reimbursement will be imposed effective on the due date of the CFR. However, OPWDD will not impose such a penalty if it determines that there were unforeseeable circumstances beyond the provider's control (such as a natural disaster, or other circumstance as determined by the OPWDD commissioner) that prevented the provider from filing the cost report by the due date.

If a provider fails to file a complete and compliant CFR by the first day of the second month following the imposition of the 2 percent penalty, the State must provide timely notice to the delinquent provider that Federal Financial Participation (FFP) will end on the first day of the eighth month following the imposition of the 2 percent penalty; and the State will not claim FFP for any Waiver service provided by the provider with a date of service after the first day of the eighth month.

[If a provider fails to file a cost report by the due date (including one 30 day extension, if granted by

OPWDD), OPWDD will impose a penalty of 2% on the provider's Medicaid reimbursement. For cost reporting periods ending December 31, 2014 and later, if a provider fails to file a cost report by the due date (including one 30 day extension, if granted by OPWDD, OPWDD will impose a penalty of 2% on the provider's Medicaid reimbursement, effective the first day of the sixth month following the end of the cost reporting period. However, OPWDD will not impose such a penalty if it determines that there were unforeseeable circumstances beyond the provider's control (such as a natural disaster) that prevented the provider from filing the cost report by the due date. If a provider has not filed a complete and compliant annual CFR for any CFR reporting period ending between January 1, 2013 and January 1, 2015, the provider will be considered delinquent. The State will give notice to delinquent providers that to avoid the loss of FFP effective April 1, 2016, a complete and compliant CFR must be submitted by October 1, 2015. The State will not claim FFP for any ICF/IID Service provided by the delinquent provider after April 1, 2016.

For CFR cost reporting periods beginning July 1, 2014 and thereafter, providers are required to file an annual CFR to the State within 120 days (150 with a requested extension) following the end of the provider's fiscal reporting period. If a provider fails to file a complete and compliant CFR within 60 days following the imposition of the 2% penalty, the State must provide timely notice to the delinquent provider that FFP will end 240 days following the imposition of the]

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[2% penalty; and the State will not claim FFP for any ICF/IID service provided by the provider with a date of service after the 240 day period.]

- **(4) Day Program Services Component.** There is a day program services component for individuals who participate in either in-house day programming or day services, or active treatment.
 - i. **In-house day programming** are equal to the sum of the provider in-house day programming amount in accordance with the State Plan in effect on June 30, 2014, plus the product of the units of service for the day services providers as was used in the calculation of the rate in effect on June 30, 2014 and the day service provider's rate in effect on July 1, 2014. A fee schedule follows:

IN-HOUSE DAY PROGRAMMING		
OPWDD DDRO Region Daily Fee		
1	\$111.02	
2	\$124.89	
3	\$103.39	

- ii. **Day Services -** Effective January 1, 2015 the new day services calculation will be equal to the reimbursement of the applicable day habilitation and/or prevocational service, less capital, as delineated in the supplemental language of the 1915c Wavier.
- iii. **Active Treatment (AT) Add-on** is equal to the AT fees, as shown below, multiplied by school days attended, less time spent by children in actual standard educational curricula.

ACTIVE TREATMENT Effective 7/1/14		
OPWDD DDRO Region Daily Fee		
Downstate	\$192.98	
Upstate	\$179.00	

DOH will require a signed attestation annually from Children's Residential Program (CRP) providers documenting the percentage of time spent by an individual in AT versus standard educational curricula.

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iii. For cost reporting periods beginning July 1, 2015 and thereafter, providers are required to file an annual Consolidated Fiscal Report (CFR) to the State by June 1st for providers reporting on the January 1st through December 31st period or December 1st for providers reporting on the July 1st through June 30th period. If the completed CFR is not submitted by either June 1st for providers reporting on the January 1st through December 31st period or December 1st for providers reporting on the July 1st through June 30th period, a 2 percent penalty on the provider's OPWDD Medicaid reimbursement will be imposed effective on the due date of the CFR. However, OPWDD will not impose such a penalty if it determines that there were unforeseeable circumstances beyond the provider's control (such as a natural disaster, or other circumstance as determined by the OPWDD commissioner) that prevented the provider from filing the cost report by the due date.

If a provider fails to file a complete and compliant CFR by the first day of the second month following the imposition of the 2 percent penalty, the State must provide timely notice to the delinquent provider that Federal Financial Participation (FFP) will end on the first day of the eighth month following the imposition of the 2 percent penalty; and the State will not claim FFP for any Waiver service provided by the provider with a date of service after the first day of the eighth month.

[If a provider fails to file a cost report (including the capital reimbursement reconciliation schedule) by the due date (including one 30-day extension, if granted by OPWDD), OPWDD will impose a penalty of 2% on the provider's Medicaid reimbursement. For cost reporting periods ending December 31, 2014 and later, if a provider fails to file a cost report (including the capital schedule) by the due date (including one 30 day extension, if granted by OPWDD), OPWDD will impose a penalty of 2% on the provider's Medicaid reimbursement, effective the first day of the sixth month following the end of the cost reporting period. However, OPWDD will not impose such a penalty if it determines that there were unforeseeable circumstances beyond the provider's control (such as a natural disaster) that prevented the provider from filing the cost report by the due date.

If a provider has not filed a complete and compliant annual Consolidated Fiscal Report (CFR) for any CFR reporting period ending between January 1, 2013 and January 1, 2015, the provider will be considered delinquent. The State will give notice to delinquent providers that to avoid the loss of Federal Financial Participation (FFP) effective April 1, 2016, a complete and compliant CFR must be submitted by October 1, 2015. The State will not claim FFP for any ICF/IID Service provided by the delinquent provider after April 1, 2016.

For CFR cost reporting periods beginning July 1, 2014 and thereafter, providers are required to file an annual CFR to the State within 120 days (150 with a requested extension) following the end of the provider's fiscal reporting period.

If a provider fails to file a complete and compliant CFR within 60 days following the imposition of the 2% penalty, the State must provide timely notice to the delinquent provider that FFP will end 240 days following the imposition of the 2% penalty; and the State will not claim FFP for any ICF/IID service provided by the provider with a date of service after the 240 day period.]

(11) Trend Factors and Increases to Compensation

i. Trend Factors

- a. The trend factor used will be the applicable years from the Medical Care Services Index for the period April to April of each year from www.BLS.gov/cpi; Table 1 Consumer Price Index for All Urban Consumers (CPI-U); U.S. city average, by expenditure category and commodity and service group.
- b. Generally, actual index values will be used for all intervening years between the base period and the rate period. However, because the index value for the last year immediately preceding the current rate period will not be available when the current rate is calculated, an average of the previous five years actual known indexes will be calculated and used as a proxy for that one year.

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New York 1(a)

Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) - General

Absences from all ICF/IIDs, other than for hospitalization, must be provided for in an individual's plan of care.

State Government Owned and Operated ICF/IID Facilities

All recipients eligible after 30 days in the facility. There is no limitation on the number of days a resident may be absent.

(i) payments for reserved bed days for ICF/IIDs are paid at the same rate as occupied days.

All Other ICF/IIDs

All recipients eligible after 30 days in the facility. <u>Effective October 1, 2020, [T]there is [no] a limitation [on the number] of 96 days a patient/resident may be absent, for days defined as Therapy Days, and for which a provider may receive a retainer day reimbursement.</u>

- (i) payments for reserved bed days for ICF/IIDs are paid at the same rate as occupied days.
- (ii) effective October 1, 2020, payments for reserved bed days for ICF/IIDs will be reimbursed at a rate of 50 percent of the provider's established rate.

Psychiatric or Rehabilitation Facility Patients (Other than RTFs)

As provided for recipients receiving similar treatment in general hospitals, as described in the General Hospital Patients section of this Attachment.

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Residential Treatment Facilities for Children and Youth (RTFs)

All recipients eligible who have been institutionalized for 15 days during a current spell of illness, in the facility. There is no limitation on the number of therapy days a recipient may be absent. A therapy day is a day when the individual is away from the RTF and is not receiving services from the RTF and the absence is for the purpose of visiting with family or friends, or a vacation. Absences from all RTFs, other than for hospitalization, including therapy days, must be provided for in an individual's plan of care to be eligible for payment and the person may not receive another Medicaid-funded residential or inpatient service on that day.

(i) payments for reserved bed days for RTFs are paid at the same rate as occupied days.

The 15 day requirement may be waived with prior approval by a designee of the Commissioner of the Office of Mental Health.

B. RESERVED BEDS DURING PERIODS OF HOSPITALIZATION

All recipients eligible after 30 days in:

- 1) an NF;
- 2) an ICF/[MR]IID;
- 3) a specialty hospital;
- 4) a rehabilitation facility or rehabilitation units of general hospitals;
- 5) a hospice

All recipients eligible who have been institutionalized for at least 15 consecutive days in:

- 1) a psychiatric facility or psychiatric units of general hospitals;
- 2) an RTF

The 15 day requirement may be waived with prior approval by a designee of the Commissioner of the Office of Mental Health.

For other than Residential Treatment Facilities:

Without prior approval, not to exceed 15 days during period of hospitalization for acute conditions, for any single hospital stay, when patient returns immediately following a period during which their bed was reserved to his/her originating facility in 15 days or less. Effective October 1, 2020, a Non-state Government Owned & Operated ICF/IID provider is limited to billing 14 Medical Leave days per rate year, per individual, without prior authorization. Effective on or after October 1, 2020, Medical Leave days will be reimbursed at a rate of 50 percent of the provider's established rate.

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Supe	ersedes TN _	#18-0024	Effective Date	October 1, 2020

Appendix II 2020 Title XIX State Plan Fourth Quarter Amendment Summary

SUMMARY SPA #20-0055

This State Plan Amendment proposes to revise the rate setting methodology for calculating the occupancy adjustment for ICFs/IID by limiting or eliminating the adjustment based on a system-wide assessment of vacancy utilization, impose a limit on the amount of administration that is recognized in the rate methodology, as well as consider other actions to limit reimbursement where individuals are not in residence.

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

SPA 20-0055

- a. The Department of Health (DOH) is the single state agency to supervise the administration of the medical assistance plan, known as Medicaid, under title XIX of the federal Social Security Act, known as Medicaid in this state, and is authorized to take actions to implement the Medicaid program, as stated in Social Services Law (SSL) Sections 363-a and 365-n(7); and Public Health Law (PHL) Sections 201(1) (v) and 206.
- b. The Office for People With Developmental Disabilities (OPWDD) has the statutory responsibility to provide and encourage the provision of appropriate programs, supports, and services in the areas of care, treatment, habilitation, rehabilitation, and other education and training of persons with intellectual and developmental disabilities, as stated in Mental Hygiene Law (MHL) Section 13.07.
- c. OPWDD and DOH have the statutory authority to develop rate setting methodologies and to promulgate rules and regulations regarding rate setting methodologies applying to facilities under the jurisdiction of OPWDD, pursuant to Mental Hygiene Law Section 43.02.
- d. Intermediate Care Facilities for Individuals with Intellectual Disabilities are part of New York Medicaid's standard coverage as stated in SSL 365-a(2)(b)

Appendix IV 2020 Title XIX State Plan Fourth 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

Division of Criminal Justice Services Commission on Forensic Science

Pursuant to Public Officers Law section 104, the Division of Criminal Justice Services gives notice of a meeting of the New York State Commission on Forensic Science to be held on:

Date: June 5, 2020 Time: 9:00 a.m. - 1:00 p.m.

Video Conference Only: The webcast information for this meeting will be posted on the Division of Criminal Justice website under the Newsroom, Open Meeting/ Webcasts.

https://www.criminaljustice.ny.gov/pio/openmeetings.htm

PUBLIC NOTICE

Division of Criminal Justice Services Law Enforcement Agency Accreditation Council

Pursuant to Public Officers Law § 104, the NYS Division of Criminal Justice Services gives notice of a virtual meeting of the Law Enforcement Agency Accreditation Council to be held on:

Date: Thursday, June 4, 2020

Гіте: 10:00 а.т.

For further information, please contact: Division of Criminal Justice Services, Office of Public Safety, Alfred E. Smith Office Bldg., 80 S. Swan St., Albany, NY 12210, 518-457-2667

Live Webcast will be available as soon as the meeting commences at: http://www.criminaljustice.ny.gov/pio/openmeetings.htm

PUBLIC NOTICE

Division of Criminal Justice Services Municipal Police Training Council

Pursuant to Public Officers Law § 104, the NYS Division of Criminal Justice Services gives notice of a virtual meeting of the Municipal Police Training Council to be held on:

Date: Wednesday, June 3, 2020

Time: 10:00 a.m.

For further information, please contact: Division of Criminal Justice Services, Office of Public Safety, Alfred E. Smith Office Bldg., 80 S. Swan St., Albany, NY 12210, 518-457-2667

Live Webcast will be available as soon as the meeting commences at: http://www.criminaljustice.ny.gov/pio/openmeetings.htm

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 and long term care services. Proposed changes are being made to effect certain rate setting provisions in the approved 2020-2021 New York State Budget, to reflect historical utilization and efficiencies, and to make other operational, technical and streamlining changes. The following changes are proposed:

Non-Institutional Services:

Effective on or after July 1, 2020 the Commissioner of Health in consultation with the Commissioner of the Office for People With Developmental Disabilities (OPWDD), will amend the State Plan for Health Home services to adjust reimbursement to reflect historical utilization and other efficiencies related to the transition to CCOs.

Long Term Care Services:

Effective on or after October 1, 2020, DOH and OPWDD propose to amend the State Plan, to revise the rate setting methodology for calculating the occupancy adjustment for Intermediate Care Facilities for Individuals with Intellectual Disabilities by limiting or eliminating the adjustment based on a system-wide assessment of vacancy utilization, impose a limit on the amount of administration that is recognized in the rate methodology, as well as consider other actions to limit reimbursement where individuals are not in residence.

The estimated annual net aggregate decrease in gross Medicaid expenditures attributable to these initiatives contained in the budget for state fiscal year 2020-2021 is approximately (\$ 75.2 million).

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, NY 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 (DOH) proposes to amend the Office for People With Developmental Disabilities (OPWDD) 1915(c) Home and Community-Based Services Comprehensive Waiver (NY.0238). Proposed changes are being made to effect certain rate setting provisions in the approved 2020-2021 New York State Budget and to make other operational changes and streamlining changes.

The Amendment will revise the rate setting methodology for calculating the occupancy adjustment for Supervised Residential Habilitation services by limiting or eliminating the adjustment based on a system-wide assessment of vacancy utilization, as well as consider other actions to limit reimbursement where individuals are not in residence. The rate setting regions for Community Prevocational Services will be realigned with the rate settings regions already in use for Community Habilitation services.

The description of Community Habilitation will be updated to reflect that OPWDD will implement clinical review tools to formalize a three-step review process for consistency and efficiency of decision making and fairness and equity of service authorizations for Community Habilitation. This amendment will also implement technical changes to streamline the completion of the Documentation of Choices form by eliminating the need for Regional Office staff to sign the form.

The estimated annual net aggregate decrease in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2020-2021 is approximately \$103.8 million.

The public is invited to review and comment on this proposed HCBS Waiver Amendment, a copy of which will be available for public review on the OPWDD's website at: https://opwdd.ny.gov/providers/home-and-community-based-services-waiver as of June 1, 2020. Individuals without Internet access may view the proposed Amendment at any local (county) social services district.

Copies will be also be available at local Developmental Disabilities Regional Offices (DDRO) at the following addresses:

Finger Lakes DDRO 620 Westfall Rd./326 Sun St. Rochester, NY 14620

Western NY DDRO 1200 East and West Rd., Building 16 West Seneca, NY 14224

Broome DDRO 249 Glenwood Rd. Binghamton, NY 13905 Central NY DDRO 187 Northern Concourse North Syracuse, NY 13212

Sunmount DDRO 2445 State Route 30 Tupper Lake, NY 12986

Capital District DDRO 500 Balltown Rd. Schenectady, NY 12304

Hudson Valley DDRO 9 Wilbur Rd. Thiells, NY 10984

Taconic DDRO 38 Firemens Way Poughkeepsie, NY 12603

Bernard Fineson DDRO 80-45 Winchester Blvd, Building 80, 2nd Floor Administrative Suite Queens Village, NY 11427

Metro NY DDRO/Bronx 2400 Halsey St. Bronx, NY 10461

Brooklyn DDRO 888 Fountain Ave. Bldg. 1, 2nd Floor Brooklyn, NY 11239

Metro NY DDRO/Manhattan 25 Beaver St., 7th Floor New York, NY 10004

Staten Island DDRO 930 Willowbrook Rd. Staten Island, NY 10314

Long Island DDRO 415-A Oser Ave. Hauppauge, NY 11788

Written comments will be accepted by email at peoplefirstwaiver@opwdd.ny.gov or by mail at Office for People With Developmental Disabilities, Division of Policy and Program Development, 44 Holland Avenue, Albany, NY 12229. All comments must be postmarked or emailed by July 1, 2020. Please indicate "OPWDD 1915(c) October 2020 Waiver Amendment Comments" in the subject line.

PUBLIC NOTICE

Department of State F-2020-0084

Date of Issuance – May 27, 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).

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

APPENDIX V LONG TERM CARE SERVICES State Plan Amendment #20-0055

CMS Standard Funding Questions

The following questions are being asked and should be answered in relation to all payments made to all providers reimbursed pursuant to a methodology described in Attachment 4.19-D of this SPA. For SPAs that provide for changes to payments for <u>clinic or outpatient hospital services</u> or for <u>enhanced or supplemental payments to physician or other practitioners</u>, the questions must be answered for all payments made under the state plan for such service.

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 payments, a complete listing of providers that return a portion of their payments, 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: OPWDD's ICF/IID rate setting methodology includes a 5.5 percent reimbursable provider assessment on the gross receipts of the ICF/IID facility. This assessment is authorized by Public Law 102-234, Section 43.04 of the New York State Mental Hygiene Law, Federal Medicaid regulations at 42 CFR 433.68, and Attachment 4.19-D, Part II page 29. All voluntary and State-operated ICF/IIDs are subject to this provider assessment.

Using "Authorization to Withhold" forms submitted by voluntary providers, OPWDD recoups the assessment from the ICF/IID Medicaid payment before the payment is sent to the voluntary provider. This assessment is deposited into a fund called "Assessments for Business Organizations."

For State operated ICF/IIDs, the Legislature appropriates an amount for payment of the assessment. Periodically, funds from this appropriation are used to pay the assessment. These amounts are deposited into the general fund of the State Treasury.

Aside from the assessments, providers receive and retain all the Medicaid payments for ICF/IID services.

- 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 through 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 governmental 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: For services delivered by non-State operated ICF/IIDs, which are the subject of the proposed changes, the source of funds for the State share is tax revenues appropriated to OPWDD. When these ICF/IIDs bill eMedNY for payment, the Department of Health covers the non-federal share expenditures in the first instance. Throughout the state fiscal year, such expenditures are applied against OPWDD appropriations through an accounting transaction in the Statewide Financial System, known as a Journal Voucher, that effectively reimburses DOH for the actual State share value of claims made by OPWDD provider agencies. The total non-federal share liability for non-State operated ICF/IIDs for the current fiscal year is projected at approximately \$400 million.

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: No supplemental or enhanced payments are made in the ICF/IID program.

4. For clinic or outpatient hospital services 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.

Response: This plan amendment does not concern clinic or outpatient hospital services.

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: As this SPA relates to payments to NFP providers, and not governmental providers, this question is not applicable.

ACA Assurances:

 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.

<u>Prior to January 1, 2014</u> States may potentially require contributions by local political subdivisions toward the non-Federal share of the States' expenditures at percentages <u>greater than</u> were required on December 31, 2009. <u>However</u>, 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 <u>anticipate potential violations and/or appropriate corrective actions</u> by the States and the Federal government.

Response: This SPA would [] / would \underline{not} [\checkmark] 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 11-06, 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 Fourth Quarter Amendment Responses to Standard Access Questions

APPENDIX VI LONG TERM CARE SERVICES State Plan Amendment 20-0055

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 State Plan Amendment seeks revise the rate setting methodology for calculating the occupancy adjustment for ICFs/IID by limiting or eliminating the adjustment based on a system-wide assessment of vacancy utilization, impose a limit on the amount of administration that is recognized in the rate methodology, as well as consider other actions to limit reimbursement where individuals are not in residence.

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

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

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

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

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

Response: This change was enacted by the State Legislature as part of the negotiation of the 2020-2021 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: Over the course of the past three years, the State has undertaken a massive reform initiative to better align reimbursement with care. When fully implemented, the initiative will invest over \$600 million in the State's ambulatory care system (outpatient, ambulatory surgery, emergency department, clinic and physicians) to incentivize care in the most appropriate setting. The State has also increased its physician reimbursement schedule to resemble Medicare payments for similar services, thus ensuring continued access for Medicaid beneficiaries. While some of these initiatives are outside the scope of the State Plan, they represent some of the measures the State is taking to ensure quality care for the State's most vulnerable population.