ANDREW M. CUOMO
Governor

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

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

DEC 3 1 2018

Mr. Michael Melendez
Associate Regional Administrator
Department of Health & Human Services
Centers for Medicare & Medicaid Services
New York Regional Office
Division of Medicaid and Children's Health Operations
26 Federal Plaza - Room 37-100 North
New York, New York 10278

RE: SPA #18-0067
Non-Institutional Services

Dear Mr. Melendez:

The State requests approval of the enclosed amendment #18-0067 to the Title XIX (Medicaid) State Plan for non-institutional services to be effective December 1, 2018 (Appendix I). This amendment is being submitted based on State Regulations. A summary of the plan amendment is provided in Appendix II.

The State of New York reimburses these services through the use of rates that are consistent with and promote efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area as required by §1902(a)(30) of the Social Security Act and 42 CFR §447.204.

Copies of pertinent sections of State Regulations are enclosed for your information (Appendix III). A copy of the public notice of this plan amendment, which was given in the New York State Register on November 28, 2018, is also enclosed for your information (Appendix IV). In addition, responses to the five standard funding questions are also enclosed (Appendix V).

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

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: 1 8 — 0 0 6 7

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: December 1, 2018

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 12/01/18-9/30/19 $ 13,012.50
b. FFY 10/01/19-9/30/20 $ 8,675.00

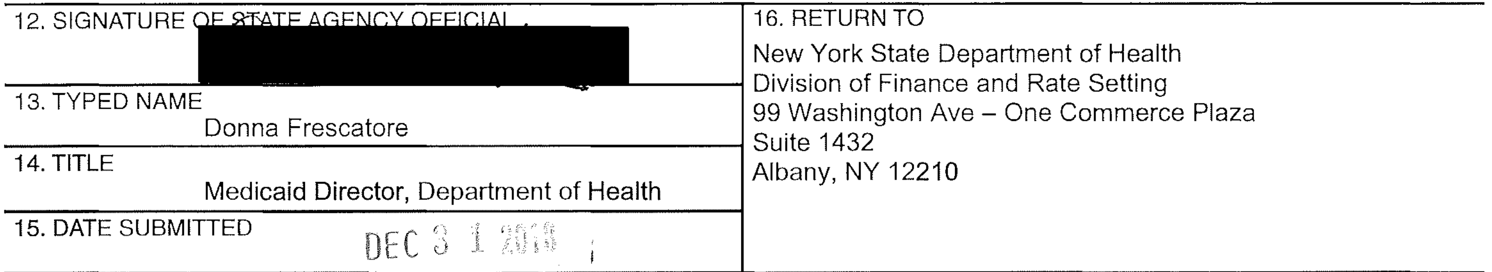
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.19-B: 2(an), 2(an)(1), 2(an)(1.1)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*

10. SUBJECT OF AMENDMENT
Clinic Safety Net Payment for Non-FQHC's
(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

13. TYPED NAME
Donna Frescatore

14. TITLE
Medicaid Director, Department of Health

15. DATE SUBMITTED
DEC 3 1 2018

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

Appendix I
2018 Title XIX State Plan
Fourth Quarter Amendment
Amended SPA Pages

Diagnostic and Treatment Centers (D&TCs) Safety Net Payment

1. For the period December 1, 2018, through March 31, 2019, and for annual state fiscal years thereafter, up to $17,350,000 of additional payments will be made to eligible Medicaid safety net diagnostic and treatment centers (D&TCs), except for Federally Qualified Health Centers (FQHCs), to sustain access to services. The amount of $17,350,000 is subject to modification by the transfers described in paragraphs (2) and (3) of this section.

   a. "Eligible Medicaid safety net diagnostic and treatment centers", for purposes of this section, will mean voluntary non-profit and publicly sponsored diagnostic and treatment centers licensed under Article 28 or Article 31, and must meet the following criteria: deliver comprehensive range of health care or mental health services; provide at least 5% of their annual visits to uninsured individuals; and have a process in place to collect payment from third party payers.

   b. The base year data used for the period commencing on December 1, 2018 through March 31, 2019 will be the 2016 certified cost report and will be advanced one year thereafter for each subsequent period. In order to be included in the distribution calculation, a provider must timely submit a certified cost report for the base year used in the distribution calculation.

   c. New providers which do not have a full year cost or visit experience in the base year used for the distribution may qualify to be included in the distribution as follows:

      i. The provider meets the criteria in paragraph (1)(a).

      ii. The provider must be eligible to receive a Medicaid rate.

      iii. The provider must submit a request to the Department of Health to participate in the distribution. This request must include annualized patient visits, by payer source, which are certified by the Chief Executive Officer, or a similar executive position.

      iv. The effective date to be included in the distribution will be the first state fiscal year distribution calculation after the provider qualifies to be included based on the requirements in paragraphs (1)(c)(i) through (1)(c)(iii) (herein after referred to as paragraph (1)(c)) or the first state fiscal year distribution calculation after the date a request is made to the Department of Health to be included in the distribution, whichever is later.

      v. The distribution method applied to a new provider that qualifies to be included in the distribution based on paragraph (1)(c) of this section will be in accordance with the distribution method for other providers in this section. However, the annual distribution for a provider that qualifies based on paragraph (1)(c) of this section will not exceed $100,000.

      vi. The distribution for a provider that qualifies based on paragraph (1)(c) of this section will be included in the total safety net distribution amount as described in paragraph (1) of this section.

Diagnostic and Treatment Centers (D&TCs) Safety Net Payment (continued):

d. Each eligible D&TC will qualify for a rate add-on based on its percentage of uninsured visits to total visits according to the following tiers:

% of eligible uninsured visits to total visits							
Upstate				Downstate			
Low (at Least)	High (Less Than)	Amount	Tier	Low (at Least)	High (Less Than)	Amount	Tier
0%	5%	$0	0	0%	5%	$0	0
5%	10%	$30	1	5%	15%	$47	1
10%	15%	$40	2	15%	20%	$57	2
15%	20%	$51	3	20%	25%	$68	3
20%	25%	$63	4	25%	35%	$80	4
25% or more		$76	5	35% or more		$93	5

e. Safety net payments will be calculated by multiplying each facility's rate add-on, based on the tiers in paragraph (1)(d), by the number of Medicaid fee-for-service visits reported on the base year certified cost report.

f. The safety net rate adjustment for each eligible D&TC that is determined based on the tier system will be scaled based on the ratio of the total funds allocated for distribution, using the tier system, to the total statewide safety net payment that is available for all eligible D&TCs.

g. Adjustments to rates of payment made pursuant to this section will be made quarterly as aggregate payments to eligible diagnostic and treatment centers and will not be subject to subsequent adjustment or reconciliation.

2. In the event that a provider that is included in this D&TCs Safety Net Payment section receives FQHC designation during a state fiscal year, the newly designated FQHC provider will be removed from this D&TCs Safety Net Payment section and included in section for the FQHCs Safety Net Payment as follows:

a. The effective date of the transfer will be the later of the following:

i. The first state fiscal year distribution calculation after the FQHC designated approval date; or

ii. The first state fiscal year distribution calculation after the date the Department of Health is notified of the FQHC designation.

b. The funds that were allocated to the new FQHC provider in this D&TCs Safety Net Payment section will be transferred to the FQHC Safety Net Payment section based on the prior state fiscal year calculation.

Diagnostic and Treatment Centers (D&TCs) Safety Net Payment (continued):

i. The transfer of funds will be at the same time the new FQHC provider is included in the FQHC Safety Net Payment section distribution.

ii. Due to the transfer of the newly designated FQHC's funds to the FQHCs Safety Net Payment section, the total value of the additional payment, as described in paragraph (1) of this section for the additional annual payment, will decrease.

c. In no event will the sum of the total safety net distribution amount of the FQHCs Safety Net Payment in this section and the D&TCs Safety Net Payment section exceed $151,500,000 for the period July 28, 2016, through March 31, 2017, and $110,000,000 for the annual state fiscal periods thereafter.

3. In the event that a provider that is included in the FQHCs Safety Net Payment section loses its FQHC designation, the FQHCs Safety Net Payment distribution to the provider calculated for the state fiscal year during which the provider lost its FQHC designation will be transferred to this section as follows:

a. The provider will be removed from the distribution calculated in the FQHC Safety Net Payment section and included in this section for the D&TC Safety Net Payment.

b. The effective date of the transfer will be the first state fiscal year distribution calculation after the date the provider lost their FQHC designation.

c. The funds allocated to the provider in the FQHC Safety Net Payment section will be transferred to this D&TC Safety Net Payment section based on the portion of the distribution pertaining to the Medicaid fee-for-service visits applied to the tier add-on payment. The transfer of funds will be at the same time the provider is included in this D&TC Safety Net Payment section distribution, as stated in paragraph (3)(b) of this section, increasing the total value of the additional payment as described on paragraph (1) of this section.

Appendix II
2018 Title XIX State Plan
Fourth Quarter Amendment
Summary

SUMMARY
SPA #18-0067

This State Plan Amendment proposes to revise the State Plan to provide additional payments to Medicaid safety net diagnostic and treatment centers (DTCs), excluding Federally Qualified Health Centers (FQHCs), to sustain access to services.

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

Express Terms

Pursuant to the authority vested in the Commissioner of Health by Section 2807 of the Public Health Law, Part 86-4.33 of Title 10 (Health) of the Official Compilation of Codes, Rules and Regulations of the State of New York is hereby added to be effective upon publications of a Notice of Adoption in the New York State Register, to read as follows:

Subpart 86-4 of NYCSS is amended by adding a new Section 86-4.33 to read as follows:

(a) Additional payments will be made annually on a state fiscal year basis to eligible Medicaid safety net Federally Qualified Health Centers (FQHC) and eligible Medicaid safety net diagnostic and treatment centers excluding FQHCs (non-FQHC), to sustain access to services.

(1) Two separate distributions will be developed and clinics will be eligible for each distinct distribution based on the following:

(i) The Medicaid Safety Net distribution for Federally Qualified Health Centers (hereafter referred to as FQHC clinics), for purposes of this section, will mean voluntary non-profit and publicly sponsored diagnostic and treatment centers licensed under Article 28 or Article 31, and must meet the following criteria: deliver comprehensive range of health care services to the general population where comprehensive services is their principal mission; provide at least 5% of their annual visits to uninsured individuals; have a process in place to collect payment from third party payers; received Federally Qualified Health Center or Rural Health Center status from the Health Resources & Services Administration (HRSA).

(ii) The Medicaid Safety Net distribution for Diagnostic and Treatment Centers (hereafter referred to as non-FQHC clinics), for purposes of this section, will mean voluntary non-profit and publicly sponsored diagnostic and treatment centers licensed under Article 28 or Article 31, and must meet the following criteria: deliver comprehensive range of health care services to the general population where comprehensive services is their principal mission; provide at least 5% of their annual visits to uninsured individuals; and have a process in place to collect payment from third party payers.

(2) The base year data used for both distributions for the uninsured eligibility criteria will be the cost report from 2-years prior to the beginning effective date of the distribution. For the initial distribution period the 2014 calendar year certified cost report or 2013/2014 fiscal year cost report will be used and will be advanced one year thereafter for each subsequent distribution period. In order to be included in the safety net distribution calculation, a clinic must timely submit a certified cost report for the base year used in the distribution calculation.

(i) The Ambulatory Health Care Facility (AHCF) cost report will be utilized for Article 28 providers, using the Article 28 reported comprehensive data only, and the Consolidated Fiscal Report (CFR) will be utilized for Article 31 providers. Where providers have both an Article 28 and an Article 31 clinic, the data will be kept separate within the distribution and the provisions for qualification and distribution as stated in this section will be applied to the data separately.

(3) The total additional payments for the initial safety net distributions will be as follows:

(i) FQHC clinics meeting the criteria in paragraph (1) subparagraph (i) will receive additional safety net payments in the initial distribution year totaling $127,600,000.

(ii) Non-FQHC clinics meeting the criteria in paragraph (1) subparagraph (ii) will receive additional safety net payments in the initial distribution year totaling $23,900,000.

(iii) In no event shall the total combined safety net payments for the initial distribution period exceed $151,500,000.

(iv) During the initial distribution period, a mitigation pool may be implemented utilizing State funds allocated for the 2015 distribution period under a prior method.

(4) The total additional payments combining the two safety net distributions subsequent to the initial distributions will be $110,000,000. These funds will be allocated between the FQHC and non-FQHC Safety Net distributions in subdivision (a), paragraphs (1)(i) and (1)(ii) maintaining the same proportion of the distributions at the time of the reduction in the total combined amount.

(i) The distribution proportions for each subsequent year is subject to modification by the transfers described in subdivision (b) paragraphs (4) and (5).

(iii) In no event shall the total combined safety net payments exceed $110,000,000 for the subsequent distributions.

(5) Adjustments to payments made pursuant to this section will be made as aggregate payments to eligible FQHC and non-FQHC clinics and will not be subject to adjustment or reconciliation.

(6) State only payments will be made to eligible FQHC and non-FQHC clinics for distributions not

receiving Federal Financial Participation.

(b) FQHC clinics meeting the criteria in paragraph (1) subparagraph (i) will receive additional safety net payments based on the following distribution method:

(1) Each eligible FQHC clinic will qualify for a rate add-on based on its percentage of uninsured visits as defined in subdivision (a) paragraphs (1) and (2) according to the following tiers:

% of eligible uninsured visits to total visits							
Upstate				**Downstate**			
Low	**High (up to)**	**Add-on Amt**	**Tier**	**Low**	**High (up to)**	**Add-on Amt**	**Tier**
5%	10%	$15	1	5%	15%	$32	1
10%	15%	$25	2	15%	20%	$42	2
15%	20%	$36	3	20%	25%	$53	3
20%	25%	$48	4	25%	35%	$65	4
25%	100%	$61	5	35%	100%	$78	5

(2) Safety net payments will be calculated by multiplying each facility's rate add-on by the number of Medicaid fee-for-service and Medicaid Managed Care visits reported in the certified base year cost report as defined in subdivision (a) paragraph (2) of this section. Dual claims where Medicaid is not the only payer will not be included in the Medicaid claims count.

(3) The safety net rate adjustment for each eligible FQHC clinic that is determined based on the tier system will be scaled based on the ratio of the total funds allocated for distribution, using the tier system, to the total statewide safety net payment that is available for all eligible FQHC clinics as defined in subdivision (a) paragraphs (3) and (4).

(4) Clinics included in subdivision (c) of this section for the non-FQHC Safety Net distribution that receive the FQHC designation prior to a subsequent state fiscal year distribution calculation will be removed from the subdivision (c) non-FQHC clinic distribution and included in the FQHC clinic distribution in subdivision (b) of this section.

(i) The funds allocated to the provider in the subdivision (c) non-FQHC clinic distribution will be transferred based on the prior state fiscal year calculation and will be transferred at the time the clinic is transferred.

(ii) The effective date of the transfer of the clinic to the subdivision (b) FQHC clinic distribution will be the first state fiscal year distribution calculation after receiving the FQHC designation approval or the first state fiscal year distribution calculation after the date the Department of Health is notified of the FQHC designation, whichever is later.

(iii) Due to the transfer of the newly designated FQHC clinic to the FQHC Safety Net distribution as described in this subdivision, paragraph (4), the total value of the additional payment for the FQHC Safety Net distribution will increase decreasing the non-FQHC Safety Net distribution additional payment total value.

(5) Clinics included in subdivision (b) that lose its FQHC designation, the FQHC Safety Net payment distribution to the clinic, that was calculated for the state fiscal year in which the date falls of when the provider lost its FQHC designation, will be reduced as follows:

(i) The portion of the distribution pertaining to the Medicaid managed care visits applied to the tier add-on payment will no longer be paid to the clinic as of the date the FQHC clinic loses its

designation. The clinic will continue to receive their distribution pertaining to the Medicaid fee-for-service visits applied to the tier add-on payment.

(ii) The amount of the reduction of the distribution will be calculated based on the number of days remaining in the distribution period from the date the FQHC clinic loses its designation.

(iii) The funds from this subdivision, paragraph (5) subparagraphs (i) and (ii), will be preserved until the fourth quarterly aggregate payment as the provider may regain their FQHC designation during the same state fiscal year and would then be entitled to the Medicaid managed care portion of their distribution from the date they regained the FQHC designation.

(iv) In the event the clinic does not regain their FQHC status, any remaining funds from paragraph (5) subparagraphs (i) and (ii) will be redistributed to the other eligible FQHC clinics based on the proportion of their distribution to the total distribution and included in the fourth quarterly aggregate payment.

(v) The clinic will be removed from the FQHC clinic distribution calculated in this subdivision and included in subdivision (c) for the non-FQHC clinics Safety Net distribution in the first state fiscal year distribution calculation subsequent to the date they lost their FQHC designation.

(vi) The funds allocated to the clinic in subdivision (b) will be transferred to subdivision (c) non-FQHC Safety Net distribution based on the portion of the distribution pertaining to the Medicaid fee-for-service visits applied to the tier add-on payment. The transfer of funds will be at the same time the clinic is included in subdivision (c) for the non-FQHC Safety Net distribution.

(vii) Due to the transfer of the funds from subdivision (b) to subdivision (c) for the non-FQHC Safety Net distribution, the total value of the additional payment for the FQHC Safety Net distribution in subdivision (b) will decrease increasing the non-FQHC additional payment total value in subdivision (c).

(c) Non-FQHC clinics meeting the criteria in paragraph (1) subparagraph (ii) will receive additional safety net payments based on the following distribution method:

(1) Each eligible D&TC will qualify for a rate add-on based on its percentage of uninsured visits as defined in subdivision (a) paragraphs (1) and (2) according to the following tiers:

% of eligible uninsured visits to total visits							
Upstate				**Downstate**			
Low	**High (up to)**	**Add-on Amt**	**Tier**	**Low**	**High (up to)**	**Add-on Amt**	**Tier**
5%	10%	$30	1	5%	15%	$47	1
10%	15%	$40	2	15%	20%	$57	2
15%	20%	$51	3	20%	25%	$68	3
20%	25%	$63	4	25%	35%	$80	4
25%	100%	$76	5	35%	100%	$93	5

(2) Safety net payments will be calculated by multiplying each facility's rate add-on by the number of Medicaid fee-for-service visits reported in the certified base year cost report as defined in subdivision (a) paragraph (2) of this section. Dual claims where Medicaid is not the only payer will not be included in the Medicaid claims count.

(3) The safety net rate adjustment for each eligible non-FQHC clinic that is determined based on the tier system will be scaled based on the ratio of the total funds allocated for distribution, using the tier system, to the total statewide safety net payment that is available for all eligible non-

FQHC clinics.

(d) New providers (defined as new provider, not new extension site) that do not have a full year cost experience in the base year used for the distributions in subdivisions (b) and (c) may qualify to be included in the distributions as follows:

(1) The provider meets the criteria in subdivision (a) paragraphs (1)(i) and (1)(ii) of this section.

(2) The provider must be eligible to receive a Medicaid rate in New York State.

(3) The provider must submit a request to the Department of Health to participate in the distribution. This request must include annualized patient visits, by payer source, which are certified by the Chief Executive Officer, or a similar executive position.

(4) The effective date to be included in the distribution will be the first state fiscal year distribution calculation after the provider qualifies to be included based on the requirements in subdivision (d) of this section or the first state fiscal year distribution calculation after the date a request is made to the Department of Health to be included in the distribution, whichever is later.

(5) The distribution method applied to a new provider that qualifies to be included in the distribution calculation will be in accordance with the distribution method in which they qualify to participate in accordance with subdivision (a) paragraphs (1)(i) or (1)(ii) of this section. However, the annual distribution for a provider that qualifies based on subdivision (d) will not exceed $100,000.

(6) The distribution for a provider that qualifies based on subdivision (d) of this section will be included in the total safety net distribution amount as described in subdivision (a) paragraphs (3) and (4) of this section and will not be additional funds increasing the distributions total value.

Appendix IV
2018 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
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 December 2018 will be conducted on December 11 and December 12 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
Division of Criminal Justice Services
Law Enforcement Agency Accreditation Council

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

Date: Thursday, December 13, 2018
Time: 10:00 a.m.
Place: Division of Criminal Justice Services
Alfred E. Smith Office Bldg.
80 S. Swan St.
CrimeStat Rm. (Rm. 118)
Albany, NY 12210

Identification and sign-in are required at this location. *For further information, or if you need a reasonable accommodation to attend this meeting, 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 Division of Criminal Justice Services gives notice of a meeting of the Municipal Police Training Council to be held on:

Date: Wednesday, December 12, 2018
Time: 10:00 a.m.
Place: Division of Criminal Justice Services
Alfred E. Smith Office Bldg.
80 S. Swan St.
CrimeStat Rm. (Rm. 118)
Albany, NY 12210

Identification and sign-in are required at this location. *For further information, or if you need a reasonable accommodation to attend this meeting, 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 services to revise provisions of Comprehensive diagnostic and treatment centers Indigent Care program. The following changes are proposed:

Non-Institutional Services

Effective on or after December 1, 2018, and for each State Fiscal Year thereafter, the State proposes to provide additional payments of up to $17,350,000 annually to Medicaid safety net non-FQHC clinics to sustain access to services. Eligible facilities must meet the following criteria: deliver comprehensive range of health care or mental health services; provide at least 5% of their annual visits/services to uninsured individuals; and have a process in place to collect payment from third party payers. The proposed distribution methodology will qualify facilities into tiers on their percentage of uninsured visits. An Add-on amount will be established for each tier and each facility's proportion of Medicaid services will then be used to arrive at a final safety net payment. Payment made to each facility may be added to rates of payment or made as lump sum.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2018/2019 is $17,350,000.

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

For the New York City district, access 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

Village of Rockville Centre

Pursuant to Section 120-w of the New York State General Municipal Law, the Village of Rockville Centre (Nassau County) hereby gives notice that on November 16, 2018 it is issuing a Draft Request for Proposals for Solid Waste Disposal Services. Interested companies may access the Draft RFP at www.rvcny.us. A pre-proposal conference and site visit will be conducted at 3 p.m. on December 19, 2018. Comments on this Draft RFP must be submitted in writing to the contact person identified below, no later than 3:00 p.m. on February 1, 2019. Subsequent to review of all comments, a Final RFP is expected to be issued on or about February 15, 2019. Written proposals submitted in response to that Final RFP are expected to be required to be received from interested contractors no later than March 4, 2019. These dates may be changed in the Final RFP. A separate public notice will be disseminated with respect to the Final RFP prior to its issuance.

Contact person: Gwynne Feiner, Director of Public Works Administration, 10 Sunrise Hwy., Rockville Centre, NY 11570, (516) 678-9267, Fax: (516) 766-0879, e-mail: gfeiner@rvcny.us

PUBLIC NOTICE

Department of State
F-2018-0735
Date of Issuance - November 28, 2018

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

The applicant has certified that the proposed activity complies with and will be conducted in a manner consistent with the approved New York State Coastal Management Program. The applicant's consistency certification and accompanying public information and data are available for inspection at the New York State Department of State offices located at One Commerce Plaza, 99 Washington Avenue, in Albany, New York, and are available for review at: http://www.dos.ny.gov/opd/programs/pdfs/Consistency/F-2018-0735_Application.pdf

In F-2018-0735, Maspeth Recycling, Inc., is proposing to construct a barge mooring facility along Newtown Creek at 58 08 48th Street, in the Borough of Queens, Queens County. The facility would include a new 402-linear foot steel sheetpile bulkhead installed waterward of the existing shoreline and backfilled with approximately 3,500 cubic yards of acceptable fill below the spring high water elevation. This would result in a loss of approximately 34,272 square feet (0.79 acres) of tidal wetlands. An area of approximately 26,225 square feet (0.60 acres) would be dredged on the waterward side of the proposed bulkhead to establish a depth of -10 feet. The initial dredging volume is estimated at approximately 3,900 cubic yards, and maintenance dredging of approximately 300 cubic yards is proposed every two years. The stated purpose of the project is to allow for the transport of demolition and recycled materials via the waterway in lieu of overland transport via truck.

The proposed activities would be undertaken within the New York City Waterfront Revitalization Program (WRP) area and is subject to consistency with the WRP policies. The WRP can be reviewed at: https://waterfrontnavigator.nyc/agency-contacts-information/nyc-dcp/

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, December 28, 2018.

Comments should be addressed to the 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
F-2018-0841
Date of Issuance – November 28, 2018

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

The applicant has certified that the proposed activity complies with and will be conducted in a manner consistent with the approved New York State Coastal Management Program. The applicant's consistency certification and accompanying public information and data are available for inspection on the New York State Department of State's website at http://www.dos.ny.gov/opd/programs/pdfs/Consistency/F-2018-0841MadlinDock&Deck.pdf

In F-2018-0841, or the "Madlin Seasonal Dock & Permanent Deck", the applicant – Patrick Madlin – proposes to build a 10 foot long by 10 foot wide deck on top of the existing 8 foot long by 8 foot wide crib on the eastern dock. In addition, the applicant proposes to install a 36 long foot by 4 foot wide aluminum rollout dock with two 28 foot long by 4 foot wide extensions perpendicular to the rollout dock. Between the fingers, the applicant proposes to install a 12 foot by 8 foot boat hoist. The rollout dock, fingers and boat lift will be seasonal. The application states purpose of the project is to reach a sufficient water depth for the applicant's boat.

Any interested parties and/or agencies desiring to express their views concerning the above proposed activities may do so by filing their comments, in writing, no later than 4:30 p.m., 30 days from the date of publication of this notice, or, December 28, 2018.

Comments should be addressed to the Consistency Review Unit, Department of State, Planning, Development and 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

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

NON-INSTITUTIONAL SERVICES
State Plan Amendment #18-0067

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-B of the state plan. For SPAs that provide for changes to payments for clinic or outpatient hospital services or for enhanced or supplemental payments to physician or other practitioners, 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: 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 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: Payments made to service providers under the provisions of this SPA are funded through a general appropriation received by the State agency that oversees medical assistance (Medicaid), which is the Department of Health.

    The source of the appropriation is the Medicaid General Fund Local Assistance Account, which is part of the Global Cap. The Global Cap is funded by General Fund and HCRA resources.

    There have been no new provider taxes and no existing taxes have been modified.

3. **Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan. If supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to each provider type.**

Response: The payments authorized for this provision are not supplemental or enhanced payments.

4. **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: The State is currently working with CMS to finalize the 2018 Clinic UPL.

5. **Does any governmental provider receive payments that in the aggregate (normal per diem, supplemental, enhanced, other) exceed their reasonable costs of providing services? If payments exceed the cost of services, do you recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report?**

   Response: The rate methodology included in the State Plan for freestanding diagnostic and treatment and ambulatory surgery center services is based upon the Ambulatory Patient Group (APG) system. We are unaware of any requirement under current federal law or regulation that limits individual providers' payments to their actual costs.

ACA Assurances:

1. **Maintenance of Effort (MOE). Under section 1902(gg) of the Social Security Act (the Act), as amended by the Affordable Care Act, as a condition of receiving any Federal payments under the Medicaid program during the MOE period indicated below, the State shall not have in effect any eligibility standards, methodologies, or procedures in its Medicaid program which are more restrictive than such eligibility provisions as in effect in its Medicaid program on March 10, 2010.**

   MOE Period.
   - **Begins on: March 10, 2010, and**
   - **Ends on: The date the Secretary of the Federal Department of Health and Human Services determines an Exchange established by a State under the provisions of section 1311 of the Affordable Care Act is fully operational.**

   Response: This SPA complies with the conditions of the MOE provision of section 1902(gg) of the Act for continued funding under the Medicaid program.

2. **Section 1905(y) and (z) of the Act provides for increased FMAPs for expenditures made on or after January 1, 2014 for individuals determined eligible under section 1902(a)(10)(A)(i)(VIII) of the Act. Under section 1905(cc) of the Act, the increased FMAP under sections 1905(y) and (z) would not be available for States that require local political subdivisions to**

contribute amounts toward the non-Federal share of the State's expenditures at a greater percentage than would have been required on December 31, 2009.

<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.

<u>Response:</u> This SPA would [ ] / would <u>not</u> [✓] 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.**

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

<u>Tribal Assurance:</u>

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.**

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