**Department of Health**

**ANDREW M. CUOMO**
Governor

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

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

June 30, 2020

Ms. Nicole McKnight
Acting 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 #20-0002
Non-Institutional Services

Dear Ms. McKnight:

The State requests approval of the enclosed amendment #20-0002 to the Title XIX (Medicaid) State Plan for non-institutional services to be effective April 2, 2020 (Appendix I). This amendment is being submitted based on the New York State 2020-21 Enacted Budget. 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.

A copy of the Medicaid Redesign Team (MRT) II recommendations enacted in the New York State 2020-21 Enacted Budget is enclosed for your information (Appendix III). Copies of the public notice of this plan amendment, which was given in the New York State Register on April 1, 2020 and was clarified on June 3, 2020, are also enclosed for your information (Appendix IV). In addition, responses to the five standard funding questions and the standard access questions are also enclosed (Appendix V and VI, respectively).

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

Sincerely,

Donna Frescatore
Medicaid Director
Office of Health Insurance Programs

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

2. STATE

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 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

7. FEDERAL BUDGET IMPACT
a. FFY__________ $__________
b. FFY__________ $__________

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*

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

13. TYPED NAME

14. TITLE

15. DATE SUBMITTED June 30, 2020

16. RETURN TO

**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED

18. DATE APPROVED

**PLAN APPROVED - ONE COPY ATTACHED**

19. EFFECTIVE DATE OF APPROVED MATERIAL

20. SIGNATURE OF REGIONAL OFFICIAL

21. TYPED NAME

22. TITLE

23. REMARKS



***Instructions on Back***

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

**State Plan under Title XIX of the Social Security Act**
**State/Territory: New York**

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cost of 1915(c) waiver services, to the cost of 1915(k) services. Therefore, excess income is applied to both 1915(c) waiver and 1915(k) services.

The State will ensure that a determination is made initially, and at least annually, that individuals require the Level of Care (LOC) provided in a hospital, a nursing facility, an intermediate care facility for Individuals with Intellectual Disabilities (ICF/IID), an institution providing psychiatric services for individuals under age 21, or an institution for mental diseases for individuals age 65 or over. LOC for individuals between ages 21 and 65 needing psychiatric services is determined using hospital, ICF or nursing facility LOC criteria. [Various]State-approved functional assessment tools that are applicable to the various populations served are in use across [disability populations in New York State (NYS) will] the state. They include a LOC outcome, either as part of the assessment or separately, and will [also] be used to inform development of a person-centered plan of care. [Different tools are utilized in order to accurately assess an individual's specific needs based on the relevant institutional LOC being assessed (i.e., a skilled nursing facility, hospital, intermediate care facility, institute for mental disease, etc.).]

A person-centered plan of care, also known as the Service Plan (SP) will be developed for CFCO-eligible individuals based on a comprehensive functional assessment that, in part, identifies the individual's needs and goals related to living independently in the community. The agent of state government ([i.e.]e.g., local district [for] of social services, [regional developmental disability office] Developmental Disabilities Regional Office (DDRO) care manager or service coordinator or their delegate, etc.) or managed care entity must review the individual's service needs at least annually, upon a significant change in the individual's condition or if requested by the individual. The date of review and signature is required on the SP. The update to the SP will occur no less than annually and as informed by the assessment. Also, annually a review is conducted to assure that the individual continues to meet the LOC criteria.

## ii. Service Delivery Models

Service delivery model options under CFCO are described below. New York State will offer both an Agency Model and an Agency with Choice model. These are described in detail below.

**X** **Agency Model** – The Agency Model is based on the person-centered assessment of need. The Agency Model is a delivery method in which the services and supports are provided by personal care aides, personal attendants, home health aides, or direct service professionals (collectively referred to as direct care workers throughout the SPA pages) employed by a traditional agency or provider. CFCO participants will still exercise as much control over the selection, management and, if necessary, dismissal of their direct care worker as they desire. The Local Department of

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In addition, personal care services and supports will be available related to core IADLs including: managing finances; providing or assisting with transportation (in conjunction with approved service noted in service plan); shopping for food, clothes and other essentials; meal preparation; using the telephone and/or other communication devices; medication management; light housekeeping; and laundry.

Health-related tasks are specific tasks related to the needs of an individual, which can be delegated or assigned by licensed health-care professionals under State law to be performed by a direct care worker. Health-related tasks delegated to direct care workers must meet the applicable exemptions under the Nurse Practice Act. These tasks include, but are not limited to: performing simple measurements and tests; assisting with the preparation of complex modified diets; assisting with a prescribed exercise program; pouring, administering and recording the administration of medications; assisting with the use of prescribed medical equipment, supplies and devices; assisting with special skin care; assisting with a dressing change; and assisting with Ostomy Care.

CFCO participants will have continued access to other health-related services and long term services and supports through the State plan, waivers or demonstrations, for which the enhanced FMAP available under CFCO will not accrue.

**Providers:** Personal Care Aides, Personal Attendants, Personal Assistants, Home Health Aides, and Direct Service Professionals that meet the licensure and certification requirements under NYCCR Title 18 and the guidance of the Department of Health and/or the Office for People With Developmental Disabilities and the Office of Mental Health are qualified providers of personal care services and supports under CFCO.

2. **Skill Acquisition, [m]Maintenance, and [e]Enhancement [of skills] (SAME) necessary for the individual to accomplish ADLs, IADLs and health-related tasks.**

   The State will cover services and supports related to assistance with functional skills training through hands-on assistance, supervision and/or cueing to accomplish the ADL, IADL and health-related tasks, effective 4/1/2022. These services and supports are referred to as the SAME service in non-OPWDD programs and as the Community Habilitation service within OPWDD programs, the differentiating factor being whether the service is provided to an OPWDD program participant or to a non-OPWDD program participant. The terms are used interchangeably within CFCO. The [S]service[s] will be specifically tied to the functional needs assessment and person-centered SP and [are] is a means to maximize independence and integration in the community, preserve functioning and defer or eliminate the likelihood of future institutional placement.

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These services may include: assessment, training, and supervision of, or assistance to, an individual with issues related to self-care, life safety, medication management, communication skills, mobility, community transportation skills, community integration, reduction/elimination of maladaptive behaviors including inappropriate social behaviors, problem solving skills, money management, and skills to maintain a household, as it relates to the provision of ADLs, IADLs, and health related tasks. The SAME service may include community transportation skills when the need for those skills is identified in the PCSP.

A direct care worker whose qualifications are approved by the Department of Health (DOH), the Office for People With Developmental Disabilities (OPWDD) or the Office of Mental Health (OMH) may provide training and maintenance activities under the following conditions:

- The need for skill training or maintenance activities has been determined through the assessment process and has been authorized as part of the person-centered SP;
- The activities are for the sole benefit of the individual and are only provided to the individual receiving CFCO services;
- The activities are designed to preserve or enhance independence or slow/reduce the loss of independence when the person has a progressive medical condition;
- The activities provided are consistent with the stated preferences and outcomes in the person-centered SP;
- The activities provided are concurrent with the performance of ADLs, IADLs and health-related tasks as described in the earlier section;
- Training and skill maintenance activities that involve the management of behavior during the training of skills must use positive reinforcement techniques; and
- The provider is authorized to perform these services for CFCO recipients and has met any required training, certification and/or licensure requirements.

**Providers:** Personal Care Aides, Personal Attendants, Personal Assistants, Home Health Aides, and Direct Service Professionals that meet the licensure and certification requirements under NYCCR Title 18 and the guidance of the Department of Health and/or the Office

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bachelor's degree and two years of related experience or someone with none of the educational requirements with three years of related experience. Service coordinators also include providers who contract with Health Homes to provide Health Home care management services. Individuals who do not meet the requirements may be supervised by those who meet both experience and educational requirements.

Care Managers typically have a background in nursing, social work and/or human services. Case Managers have similar backgrounds and the title is used interchangeably.

**Risk Management Plans**

An in-person risk assessment is conducted for all individuals during the person-centered care planning process. Based on the results of the risk assessment, a risk management plan is developed for each individual and is detailed in the SP.

Safeguards are supports needed to keep the participant safe from risk and harm and actions to be taken when the health or welfare of the participant is at risk.

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Safeguards are significant issues discovered during the planning process that are individualized and specific to the participant. The SP includes a description of the supervision and oversight that may be required in such areas as fire safety, medication management, allergies, community inclusion activities, diet, behavioral concerns, financial transactions, natural disaster preparation, bathing safety and vulnerabilities at home and in the community. Providers monitor and document safeguards as services are provided and through routine checks by direct care workers and their supervisors in accordance with the schedule established by the local district or the (managed or managed long term care) plan. In addition, they must report incidents to state authorities.

**Providers:** The risk assessment is conducted by the [nurse or social worker] individual conducting the functional assessment and/or the individual developing the person-centered service plan.

**v. The State elects to include the following CFCO permissible service(s), effective 4/1/2022:**

✓ 1. Expenditures relating to a need identified in an individual's person-centered plan of services that increases an individual's independence or substitutes for human assistance, to the extent that expenditures would otherwise be made for human assistance. These include:

**Environmental Modifications:** Modifications are provided in accordance with 441.520(b)(2).

**Assistive Devices:** Any category of durable medical equipment, mechanical apparatus, electrical appliance, or instrument of technology used to assist and enhance an individual's independence in performing any activity of daily living. Examples of assistive technology include, but are not limited to: motion and sound sensors, two way communication systems, automatic faucet and soap dispensers, toilet flush sensors, incontinent sensors and fall sensors.

**[Congregate and/or h]Home delivered meal services**: up to two meals per day for individuals who cannot prepare or access nutritionally adequate meals for themselves and the cost of this service is less than it would be to [have someone provide]pay for in-home meal preparation.

✓ 2. Expenditures for transition costs in accordance with 441.520(b)(1) such as rent and utility deposits, first month's rent and utilities, bedding, basic kitchen supplies, and other necessities required for an individual to make the transition from a nursing facility, institution for mental diseases, or intermediate care facility for individuals with developmental/intellectual disabilities, or a provider controlled residence certified by OPWDD to a community-based non-certified home setting where the individual resides. [These expenditures are limited to individuals transitioning from a nursing facility, IMD, or an ICF/IID to a home or community-based setting where the individual resides.]

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Community Transitional [s]Services will be limited to necessary services for individuals transitioning from an institution [in]to a home in the community[-based or in-home program]. Services will be based on an assessed need, determined during the person-centered service planning process and will support the desires and goals of the individual receiving services and supports. [Costs will be limited to a one-time expense of up to $5,000 and service coordinators will fill out and maintain forms detailing the projected and final expenses and what items and/or services were purchased.]

Community Transitional [s]Services for an individual to make the transition from a nursing facility, institution for mental disease, or intermediate care facility for individuals with developmental/intellectual disability, or a provider-controlled residence certified by OPWDD to a community-based non-certified home setting where the individual resides will be limited to[: moving and] move-in costs including; movers, cleaning and security deposits, payment for background/credit check (related to housing), initial deposits for apartments, heating, lighting and phone; and payment of previous utility bills that may prevent the individual from receiving utility services and basic household furnishing (i.e. bed) and other items necessary to re-establish a home. Costs for Community Transitional Services will be limited to a one-time expense of up to $5,000. Service coordinators or providers will fill out and maintain forms detailing the projected and final expenses, as well as the items and/or services that were purchased.

Moving Assistance is the transport of personal belongings from an institution to the individual's home in the community. Costs for Moving Assistance are limited to a one-time expense of up to $5,000.

Contracts for environmental modifications may not exceed $15,000 per year without prior approval of DOH or the managed care plan, as appropriate.

Contracts for vehicle modifications are limited to the primary vehicle of the recipient and may not exceed $15,000 per year without prior approval of DOH or the managed care plan, as appropriate.

Assistive Technology costs cannot exceed $15,000 per year without prior approval of DOH or the managed care plan, as appropriate. Items that cost up to $1,000 a year only require one bid; those over $1,000 a year require three bids. Coverage will be limited to assistive technology devices that are not available through the State Plan Durable Medical Equipment included in the eMedNY Manual at https://www.emedny.org/ProviderManuals/DME/index.aspx, and cannot duplicate a device purchased through a 1915(c) waiver.

In all cases, service limits are soft limits that may be exceeded due to medical necessity.

Individuals will work with their service planners and/or care managers to determine whether or not their needs can be met within the limits established under the Community First Choice Option as they are completing the person-centered service plan. If the individual's needs cannot be met within these limits, the individual may appeal to the Department of Health or their managed care plan, as appropriate, for consideration of the additional costs.

Distinct service elements, procedure codes and claim modifiers will differentiate whether the services are State plan services or other Medicaid Services under 1915(c) or other authorities. This will control and mitigate duplication of services.

**vii. Use of Direct Cash Payments**

__ a) The State elects to disburse cash prospectively to CFCO participants. The State assures that all Internal Revenue Service (IRS) requirements regarding payroll/tax filing functions will be followed, including when participants perform the payroll/tax filing functions themselves.

_✓ b) The State elects not to disburse cash prospectively to CFCO participants.

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L. Non-Emergency Medical Transportation (NEMT) [services] is a discrete service and will only be available to [a]locations [that is] identified in the person-centered service plan pursuant to an assessed functional need [identified in the person's assessment]. The Medicaid payment made for NEMT only accounts for the transportation of the individual; it does not account for the transportation of an aide. Specifically, New York makes the following assurances:

i. The functional needs assessment and the person-centered service plan indicate the need for [a medical escort, the need for ]transportation to medical appointments[ and traveling around and participating in the community];
ii. There is a checks and balances system in place to monitor services to ensure that duplicate billing doesn't take place; and
iii. CFCO SPAs that allow personal care attendants to provide transportation to medical appointments should follow the guidelines that Non-Emergency Medical Transportation (NEMT) uses to ensure the integrity of the transportation services.

**ix. Assessment and the SP**
**Assessment Process**

Eligibility for New York State's Medicaid-supported home and community based long term services and supports is determined by a number of federally-approved assessments. The State will not seek additional FMAP for this administrative function.

These assessment tools will assess individuals across dozens of critical domains such as: function, cognition, behavior, communication, informal supports, clinical, etc. While the UAS-NY determines LOC, not all functional needs assessments in use do, so it will be determined separately. All functional needs assessments will record the individual's needs, strengths, preferences and goals for maximizing their independence and community integration through questions geared to elicit this information, which is essential to the person-centered planning process. [They will be completed face-to-face with each individual by assessor(s) who are specifically trained in the use of the functional needs assessment.] The service recipient will be able to request the participation of any one he or she wants involved in the functional needs assessment and service planning process.

The functional needs assessment must be performed by a health care professional who is qualified to conduct the state-approved assessment in use for the individual's specific population.[Registered nurses or a Qualified Intellectual Disabilities Professional (QIDP) will conduct the functional needs] The assessment will be conducted prior to the person centered planning process; in a face-to-face meeting with the individual; and in his or her home or chosen community or service setting, in an institutional setting from which he or she wishes to transfer to the community, or as part of his or her discharge from clinical or acute care. Depending on whether the individual is enrolled in a Care Management for All environment (managed care, managed long term care, health home, ACO, waiver, etc.) or is receiving or seeking fee-for-service assistance, the nurse or QIDP will be employed by a provider agency, the State, county or local government or designee, or the managed care entity.

Individuals will be reassessed at least annually, or as needed when the individual's support needs or

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## x. HCBS Settings

All CFCO services will be provided in a home or community-based setting, which does not include a nursing facility, hospital providing long-term care services, institution for mental disease, intermediate care facility for individuals with an intellectual disability or related condition, or setting with the characteristics of an institution. All services will be provided in settings that will comply with 42 CFR §441.530. The State has processes and procedures to ensure ongoing compliance with the setting requirements outlined in 42 CFR 441.530. Settings include the individual's own home or a family member's home that meets the settings criteria outlined in 42 CFR 441.530, as well as other settings identified as compliant according to the State's approved Statewide Transition Plan available at:

https://www.health.ny.gov/health_care/medicaid/redesign/hcbs/docs/2018-11-07_hcbs_final_rule.pdf.

This includes provider-owned and -controlled settings that have been assessed and determined to be compliant with the rule. [Settings do not include provider-owned or controlled residential settings. The State will amend this SPA once it determines that other settings meet the settings criteria outlined in 42 CFR 441.530.]

## xi. Qualifications of Providers of CFCO Services

The State CFCO utilizes the agency-provider model for the provision of service delivery. As such, contracted entities must be approved by DOH, OPWDD or OMH. Approved agencies must meet and maintain standards for CFCO and all related state and federal regulations.

Personal Care Aides, also called personal care attendants, are certified by the State Education Department and must complete a minimum 40 hour training course with 6 hours of continuing education annually.

Home health aides are also certified by the State Education Department and must complete a minimum 75 hour training course with 12 hours of continuing education annually.

Aides in each of the above titles must meet the following minimum requirements in addition to the training requirements described above:

(i) maturity, emotional and mental stability, and experience in personal care or homemaking;
(ii) ability to read and write, understand and carry out directions and instructions, record messages, and keep simple records;
(iii) sympathetic attitude toward providing services for individuals at home who have medical problems;
(iv) good physical health, as indicated by the documentation in the personnel file of all persons providing personal care services;
(v) a criminal history record check to the extent required by 10 NYCRR Part 402; and
(vi) compliance with Part 403 of Title 10 NYCRR (Home Care Registry), as required in that Part.

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All of these aides provide personal care under the direction of a registered professional nurse or licensed practical nurse or therapist if the aide is to carry out simple procedures as an extension of physical, occupational, speech or language therapy. Supervising personnel visits are not eligible for the additional FMAP under CFCO.

Personal assistants are individuals that are directly hired by an individual in the agency with choice model. While they may be certified personal care or home health aides, they are not required to have these credentials. They must be adults that are not parent/guardians or spouses of the CFCO recipient. They are not required to undergo a criminal background check under state law unless they are certified aides.

Direct service professionals must be cleared through existing background check systems (ex. DOH, OPWDD and the Justice Center) where required by law and meet the additional qualifications listed below:

18 years or older and ability to:

- Follow both oral and written directions;
- Maintain simple records;
- Communicate effectively;
- Provide appropriate care;
- Safeguard personal information and maintain confidentiality; and
- Understand and follow emergency procedures.

Direct Service Professionals may work under the direction of supervising clinical personnel and these supervisory activities will not accrue the additional FMAP under CFCO.

Registered Nurses licensed by the State Education Department or Qualified Intellectual Disabilities Providers assessing individuals for services. The QIDP title is reserved for individuals with a bachelor's degree in a human services field and one year experience working with people with developmental or intellectual disabilities.

[Medicaid Service Coordinators (who are involved in the person-centered planning process and development and monitoring of an individual's service plan) must complete training in the individual service plan, and in three of the following areas: home and community based waiver, introduction to person centered planning, self advocacy/self determination, quality assurance, and benefits and entitlements. They also must complete professional development hours annually.]

<u>Care Managers supporting individuals with intellectual and developmental disabilities (I/DD) must complete training requirements required by OPWDD and DOH as described in OPWDD regulations and policy guidance including but not limited to: 14 NYCRR regulations, Care Coordination Organization/Health Home (CCO/HH) Policy Manual, Managed Care Qualifications, Fully Integrated Duals Advantage for Individuals with Intellectual and Developmental Disabilities (FIDA-IDD) Three-Way Contract. Health Home care managers must complete any training required of the Health Home program.</u>

New York State will also permit individuals to hire their own aide directly in addition to using agencies and/or the registry and in this case may waive the qualifications above to give the service recipient flexibility to hire a relative or someone in his or her personal network who can meet his or her needs without specific prior training.

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**1. Consumer Satisfaction Survey**

On an annual basis, a statistically significant number representing individuals in all level of care who receive CFCO services and supports will be surveyed. The survey will be a comprehensive tool employed to gain valuable information related to consumer satisfaction and quality of care. In addition, the survey will also include an assessment of the individual's opinion in progress towards goals identified by the individual in their person-centered service plan. The State has chosen to implement the Money Follows the Person (MFP) Quality of Life survey amended with several questions from the Participant Experience Survey (PES). The State may use the services of an independent contractor to perform these surveys with CFC participants to address staff needs and objectivity. Upon completion of each survey, percentages will be calculated and reviewed, and the results analyzed to determine if CFCO recipients are indeed satisfied with their home and community-based service and support needs. Are their support needs being met by the program? Are they able to satisfactorily self-direct their services? A report of survey findings will be disseminated to all CFCO participants, contracted service providers, county departments of social services, relevant state agencies and offices, and lastly, posted on the state's CFCO website.

**2 [UAS-NY utilization]<u>Assessment Tools</u>**

[The State has elected to use the Uniform Assessment System of New York (UAS-NY), a tool customized for the state's aged and physically disabled population based on the InterRAI Suite, to measure the individual outcomes associated with the receipt of community-based attendant services and supports. The UAS-NY provides the State with access to quality data reports that will allow us to monitor and track pertinent information such as the individual's needs, strengths, preferences and goals for maximizing their independence and community integration. We will also be able to generate reports to determine if these personal goals are being met related to living an independent life integrated to the fullest extent in the community. Because the UAS-NY assessment tool is equipped to track data across years and report based on aggregate data by jurisdiction or program, as well as tracking individual participant outcomes and changes throughout time, we will be able to monitor and track long term changes in the clinical/functional status and needs of CFCO participants.]

<u>The assessment tools approved for use by the State provide data on the individual outcomes associated with receipt of community-based attendant services and supports. The State will be able to monitor pertinent information such as the individual's needs, strengths, preferences and goals for maximizing their independence and community integration. Reports can be generated to determine if the goals related to living an independent life, integrated into the community to the fullest extent, are being met. Data, including long term changes in the clinical and functional status and needs of CFCO recipients, can be tracked across years, jurisdiction, or program.</u>

**New York**
**6(a)(vi)**

| Rate Code | State Program | Current Rate | Methodology |
|---|---|---|---|
| 2602, 2622, 2623, 2593, 2594, 2601, 2595, 2596, [2681, 2631,] [2671, 2815,] [2816, 3855,] [3856, 3145,] [9795, 9863] 2626, 2627, 2632, 2633, 2501, 2502, 2507, 2508, 2596, 2597, 2598 | Personal Care | [$20.21/hr*] Provider Specific fees/hour | Provider specific fees are established based on provider reported costs two years prior to the rate year and are posted at: http://www.health.ny.gov/facilities/long_term_care/reimbursement/pcr/ [and http://www.health.ny.gov/facilities/long_term_care/reimbursement/hhc/2015-01-01_lthhc_rates.htm] |
| 2422, 2423, 2402, 2401, [4764, 4769,] [4770, 4771,] [4772, 4777] 2403, 2404, 2405, 2406, 2424, 2425 | CDPAP [(Fiscal Intermediaries)] | [$17.41/hr*] Provider Specific fees/hour | Provider specific fees are established based on provider reported costs two years prior to the rate year and are posted at: http://www.health.ny.gov/facilities/long_term_care/reimbursement/pcr/ [Or statewide fees based on the level of service provided as set forth in Appendix C of the OPWDD Comprehensive HCBS Waiver (NY 0238).] |
| [2611, 2695,] [2810, 2825,] [3850, 3865] 2499, 2610 | [Home Health Care (aide only)] Certified Home Health Aide | [$23.18/hr*] Provider Specific fees/hour | Provider specific fees are established based on provider reported costs two years prior to the rate year and are posted at: https://www.health.ny.gov/facilities/long_term_care/reimbursement/chha/rates [http://www.health.ny.gov/facilities/long_term_care/reimbursement/chha/rates/index.htm] |
| [9997, 9994, 9991] | [Transportation] | [Varies depending on mode, region] | [Fee schedule available at: https://www.emedny.org/ProviderManuals/Transportation/index.aspx] |

[*Weighted average fee provided for informational purposes only. Actual payment rates will be the State established fee for each provider.]

**New York**
**6(a)(vii)**

2. Acquisition, maintenance, and enhancement of skills necessary for the individual to accomplish ADLs, IADLs and health-related tasks. The State will use the current fee or methodology identified in the following programs for the providers listed in Attachment 3.1-K Supplement.

| Rate Code | Service | Current Rate | Methodology |
|---|---|---|---|
| 4722, 4723, 4724, [4725,] 4741, 4742, 4743, [4744,] 4755, 4756, [4757, 4758,] [4765, 4766,] [4767, 4768,] [4796, 4797,] [4798, 4799] 8012, 8013, 8014 | Community Habilitation (SAME) | [N/A]<br>Upstate:<br>1 to 1 $41.61<br>2 to 1 $26.01<br>3+ to 1 $19.67<br><br>Downstate:<br>1 to 1 $41.70<br>2 to 1 $26.04<br>3+ to 1 $20.78 | [Regional Fee for Provider-Delivered Community Habilitation]<br>[Region 1: $ 38.51 (1-to-1); $ 24.07 (Group)]<br>[Region 2: $ 39.91 (1-to-1); $ 24.95 (Group)]<br>[Region 3: $ 39.00 (1-to-1); $ 24.37 (Group)]<br>Community Habilitation rates were adjusted to account for two changes to the rate structure. First, a revision to the regional alignment of New York State counties from Regions 1, 2, and 3 to Upstate and Downstate. Second, a revision to the number of group rate tiers was changed from group sizes of 2, 3 and 4+ to be 2 and 3+ only. To develop the revised rates, a weighted average blending of previously approved Community Habilitation rates based on Calendar Year 2017 utilization experience at the county level and rate level was completed. No additional rate adjustments were applied at this time. |

3. Back-up systems or mechanisms to ensure continuity of services and supports.

| Rate Code | Service | Current Rate | Methodology |
|---|---|---|---|
| [2609, 2616,] [2809, 2818,] [3823, 3831,] [3858, 9981] 2513, 2514 | Personal Emergency Response (PERS) | [$23.11/month*] | [Provider specific fees are established based on provider specific costs reported two years prior to the rate year and are posted at: http://www.health.ny.gov/facilities/long_term_care/reimbursement/hhc/2013-01-01_lthhc_rates.htm]<br><br>https://www.health.ny.gov/health_care/medicaid/redesign/cfco/2019_ffs_rates.htm |

[*Weighted average fee provided for informational purposes only. Actual payment rates will be the State established fee for each provider.]

**New York**
**6(a)(viii)**

4. Permissible services/Substitute for human assistance

| Rate Code | Service | Current Rate | Methodology |
|---|---|---|---|
| 3171 | ADL/IDL Skill Acquisition | $5.50/NYC/Unit $11.00/Rest of State/Unit | ADL/IDL Skill Acquisition is an add-on for Personal Care and CDPAP services to support individuals in attaining non-home based life skills.<br><br>https://www.health.ny.gov/health_care/medicaid/redesign/cfco/2019_ffs_rates.htm |
| [3143,] 4482,4483, 4484,4485, 9752, 3186, 9857, 8037, 8038, 8039, 8040 | Adaptive and Assistive Technology | [100% of claim determined reasonable by the state.]<br><br>100% of contract amount | AT is purchased through vendors who sell the needed medical, communication and adaptive equipment or supplies using a standard bidding process following the rules established by the Office of the State Comptroller. Under the process, items costing up to $1000 a year require only one bid, those over $1000 will require multiple bids. [https://www.health.ny.gov/facilities/long_term_care/waiver/nhtd_manual/section_06/assistive_technology.htm] |
| 9750, 3167, 3168, 3169, 3170, 8041, 8042, 8043, 8044 | Vehicle Adaptation | [100% of billed cost determined reasonable by the state] 100% of contract amount | [NHTD current methodology,] limit $15,000; separate from e-Mods limit<br><br>[https://www.health.ny.gov/facilities/long_term_care/waiver/nhtd_manual/nhtd_program_manual_with_forms.pdf]<br><br>https://www.health.ny.gov/health_care/medicaid/redesign/cfco/2019_ffs_rates.htm |
| [3144,] 4786, 9758, 9867,3187 | Community Transitional Services (establishing a household in the community from an institutional setting) | 100% of claim/approved cost | One-time payment not to exceed $5,000. Specific amount will be based on State review and approval of cost projections. |
| N/A | Durable Medical Equipment | | Fee schedule available at: https://www.emedny.org/ProviderManuals/DME/index.aspx |
| 4476,4477, 4478,4479, [9992,9995,] [9998,] 9762, 9874, 3192, | Environmental Modifications | 100% of claim determined reasonable by the State Annual limit of $15,000 | Qualified contractors are selected through a standard bidding process following the rules established by the Office of the State Comptroller. This process is described at: https://www.health.ny.gov/facilities/long_term_care/waiver/nhtd_manual/section_06/e-mods.htm |

4. Permissible services / Substitute for human assistance (continued):

| Rate Code | Service | Current Rate | Methodology |
|---|---|---|---|
| [2682, 2685,] [2835, 3874,] 9781, 3183, 3185 | Home Delivered Meals | [$5.79/Meal*] 100% of contract amount | [Provider specific fees are established based on reported costs and are posted on State website at: http://www.health.ny.gov/facilities/long_term_care/reimbursement/hhc/2013-01-01_lthhc_rates.htm]<br><br>https://www.health.ny.gov/health_care/medicaid/redesign/cfco/2019_ffs_rates.htm<br><br>Specific amount will be based on State review and approval of contract amount. |
| [2638, 2830, 3872] | [Congregate Meals] | [$5.07/Meal*] | [Provider specific fees are established based on reported costs and are posted on State website at: http://www.health.ny.gov/facilities/long_term_care/reimbursement/hhc/2013-01-01_lthhc_rates.htm] |
| [2636, 2831,] [3870,] 9787, 3188, 7449 | Moving Assistance (transport of personal belongings) | [$58.79/hr*] 100% of contract amount | [Provider specific fees are established based on reported costs and are posted on State website at: http://www.health.ny.gov/facilities/long_term_care/reimbursement/hhc/2013-01-01_lthhc_rates.htm]<br><br>https://www.health.ny.gov/health_care/medicaid/redesign/cfco/2019_ffs_rates.htm<br><br>Specific amount will be based on State review and approval of contract amount. One-time $5,000 max |

[*Weighted average fee provided for informational purposes only. Actual payment rates will be the State established fee for each provider.]

Payments made for State plan services under 1915(k) authority do not duplicate payments made for similar services under 1915(c), 1915(i), 1915(j), or 1115 authorities.

# Appendix II
# 2020 Title XIX State Plan
# Second Quarter Amendment
# Summary

**SUMMARY**
**SPA #20-0002**

This State Plan Amendment proposes to implement initiatives included in the 2020-2021 Enacted State Budget to delay until April 1, 2022 the implementation of the following Community First Choice Option (CFCO) services: Skills Acquisition, Maintenance and Enhancement (SAME), home delivered meals, community transition services, moving services, assistive technology, environmental and vehicle modifications and make other clarifications.

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

**SPA 20-0002**

**Social Services**

§ 363-a. Federal aid; state plan. 1. The department of health shall submit and maintain a plan for medical assistance, as required by title XIX, or any successor title, of the federal social security act, to the federal department of health and human services for approval pursuant to the provisions of such law and shall act as the single state agency to supervise the administration of the plan in this state. The department of health shall act for the state in any negotiations relative to the submission and approval of such plan and any amendments thereto and it may make such arrangements, not inconsistent with law, as may be required by or pursuant to federal law to obtain and retain such approval and to secure for the state the benefits of the provisions of such law.

§ 365-a. Character and adequacy of assistance. The amount, nature and

and in accordance with the local medical plan, this title, and the regulations of the department.

1. "Benchmark coverage" shall mean payment of part or all of the cost of medically necessary medical, dental, and remedial care, services, and supplies described in subdivision two of this section, and to the extent not included therein, any essential benefits as defined in 42 U.S.C. 18022(b), with the exception of institutional long term care services; such care, services and supplies shall be provided consistent with the managed care program described in section three hundred sixty-four-j of this title.

2. "Standard coverage" shall mean payment of part or all of the cost of medically necessary medical, dental and remedial care, services and supplies, as authorized in this title or the regulations of the

conditions in the person that cause acute suffering, endanger life, result in illness or infirmity, interfere with such person's capacity for normal activity, or threaten some significant handicap and which are furnished an eligible person in accordance with this title and the

such medical care, services and supplies provided for in subdivisions three, four and five of this section, and such medical care, services and supplies as are authorized in the regulations of the department:

(a) services of qualified physicians, dentists, nurses, and private

other related professional personnel;

(bb) Subject to the availability of federal financial participation,

Social Services Law Section 365-f(8):

8. Subject to the availability of federal financial participation, the provisions of this section governing consumer directed personal assistance

services shall also apply to such services when offered under the home and community-based attendant services and supports state plan option (Community First Choice) pursuant to 42 U.S.C. § 1396n(k).

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

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

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

Transportation

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

- Transition the State to a single Medicaid Transportation Broker to ensure that consumers receive reliable, high quality transportation services using the mode that is appropriate for the consumer.
- Discontinue the Supplemental Ambulance Rebate Payments to emergency medical transportation (EMT) providers since updating and rationalized the ambulance fee schedule consistent with the Department of Health's Ambulance Rate Adequacy Study.
- Carve transportation out of the MLTC Benefit (excluding PACE) and into fee-for-service to create efficiencies and consistency in purchasing, arranging and managing transportation services across the Medicaid program.
- Maximize Public Transit in New York City and other urban areas to encourage the use of public transportation as an alternative to livery when appropriate for the consumer.
- Reduce Taxi/Livery Rates and promoting other modes of transportation to reflect market rates for transportation services.
- Implement an ambulance diversion - Triage, Treat and Transport (ET3) - support program to reduce avoidable hospitalizations, subject to any necessary federal approvals.
- Pursue a Certified Public Expenditure program to maximize federal reimbursement for NEMT services incurred by municipalities.
- Create a Community Paramedicine Program to expand the roles of Emergency Medical Technicians (EMTs) and Paramedics by providing medical care to patients at home to avoid unnecessary trips to the Emergency Department (ED). EMTs and Paramedics would provide additional patient health and safety services (e.g., food, medications, fall precautions) and clinical assessment and diagnostic testing in consultation with online medical control/telemedicine physicians/advanced practitioners to avoid unnecessary trips to the hospital.

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

Telehealth

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

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

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

**Institutional Services**

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

- Reduce the size of the voluntary hospital Indigent Care Pool by $75 million (State share);
- Eliminate the Indigent Care Pool "Transition Collar", which generates an additional $12.5 million in State share savings; and
- Eliminate the Public Hospitals Indigent Care Pool, which generates $70 million in State savings;
- Convert the value of Upper Payment Limit (UPL) payments received by public hospitals in a city with a population over a million into Medicaid reimbursement rates;
- Reduce hospital inpatient capital rate add-on by 5 percent and capital reconciliation payments by 10 percent.

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

**Long Term Care Services**

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

- Modify the current eligibility criteria for individuals to receive Personal Care Services and Consumer Directed Personal Assistance Services (CDPAS) as a Medicaid benefit, regardless of whether such services are received through fee-for-service, Mainstream Managed Care plans, or Managed Long Term Care (MLTC) plans. In order to be eligible to receive such services, an individual must be assessed to need assistance with more than two activities of daily living (ADLs) (ranging from limited assistance to total dependence).
- Institute a Home and Community Based Services lookback period of 60 months for asset transfers in determining eligibility for Medicaid for those seeking home and community based long term care services and supports as currently applies to those seeking Medicaid eligibility for nursing home care.
- Eliminate the ability of spouses living together in the community, and parents living with their child, to refuse to make their income and resources available during the determination of an applicant's eligibility for Medicaid.
- Utilize an independent clinician panel, similar to the State's Conflict Free Evaluation and Enrollment Center, to assess patients and order PCS and CDPAS under a clear set of standards and protocols.
- Implement an enhanced utilization review process by an independent assessor for any individuals who are assessed to need more than 12 hours per day on average in a given month (i.e., 360 hours per month for a 30-day month) to ensure that it remains safe for that individual to remain in the community.
- Change the frequency in which the Community Health Assessment is conducted from every six months to once annually, subject to requiring reassessments based on changes in health condition or status.
- Implement a uniform tasking tool for use by plans and Local Departments of Social Services (LDSS) to help determine service utilization, including the hours of Personal Care Services and CDPAS required each day.
- Employ the provider "choice" model to proceed with the implementation and electronic visit verification (EVV) system, as required by the Federal 21st Century Cures Act.
- Eliminate requirements that plans and LDSS educate consumers about the availability of the CDPAP program semi-annually Develop standards and protocols to determine whether consumers are self-directing and, if applicable, their designated representative is able to fulfill their obligations appropriately.
- Delay the implementation date of certain permissible Consumer First Choice Option Services (CFCO) services from January 1, 2020 to April 1, 2022.
- Incorporate additional transparency, compliance, and accountability standards to ensure that entities receiving wage parity payments are appropriately using those funds for the benefit home care aides.
- Reduce Workforce Recruitment and Retention funding for home health care workers.
- Migrate the completion of all Community Health Assessments (CHA) and reassessments to a single, statewide Independent Assessor (IA).
- Modify the minimum community spouse resource amount, which is used to determine the Medicaid eligibility of an applicant under spousal impoverishment budgeting.
- Reduce funding associated with nursing home capital reim-

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

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

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

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

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

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

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

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

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

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

## PUBLIC NOTICE

New York City Deferred Compensation Plan & NYCE IRA

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

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

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

## PUBLIC NOTICE

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

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

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

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

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

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

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

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

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

## PUBLIC NOTICE

Department of State
Uniform Code Variance / Appeal Petitions

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

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

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

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

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

## PUBLIC NOTICE

Department of State
Uniform Code Variance / Appeal Petitions

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

# MISCELLANEOUS NOTICES/HEARINGS

## Notice of Abandoned Property Received by the State Comptroller

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

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

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

## PUBLIC NOTICE

Department of Civil Service

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

Please take notice that the regular monthly meeting of the State Civil Service Commission for June 2020 will be conducted on June 10 and June 11 commencing at 10:00 a.m. This meeting will be conducted at NYS Media Services Center, Suite 146, South Concourse, Empire State Plaza, Albany, NY with live coverage available at https://www.cs.ny.gov/commission/.

*For further information, contact*: Office of Commission Operations, Department of Civil Service, Empire State Plaza, Agency Bldg. One, Albany, NY 12239 (518) 473-6598

## PUBLIC NOTICE

Department of Health

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

The Department of Health proposes to amend the Title XIX (Medicaid) State Plan for non-institutional services to comply with Section 1927 of the Social Security Act. The following changes are proposed:

Non-Institutional Services

Effective on or after July 1, 2020, to allow supplemental rebates on MCO and FFS utilization, the State will implement a single statewide formulary for opioid dependence agents and opioid antagonists, the purpose of which is to standardize preferred products across Medicaid Fee-for-Service and Managed Care. The National Medicaid Pooling Initiative (NMPI) Supplemental Drug Rebate Agreement will be used for both FFS and MCO utilization.

There is no additional estimated annual change to gross Medicaid expenditures as a result of the proposed amendment.

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

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

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

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

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

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

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

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

## PUBLIC NOTICE

Department of Health

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

The Department of Health proposes to amend the Title XIX (Medicaid) State Plan for all services to comply with enacted statutory provisions. The following changes are proposed:

All Services

The following is a clarification to the April 1, 2020 noticed provision for the 1.875 percent uniformed reduction of state Medicaid funds. With clarification, effective for dates of service on or after April 2, 2020 through March 31, 2021, and each State Fiscal Year (SFY) thereafter, all non-exempt Department of Health state funds Medicaid payments will be uniformly reduced by an additional 0.5 percent to the December 31, 2019 noticed provision for the 1.0 percent uniform reduction. Also with clarification, Medicaid payments that will be exempted from the uniform reduction will also include Health Homes serving children.

The following is a clarification to the December 31, 2019 noticed provision for the estimated annual net aggregate decrease in gross Medicaid expenditures attributable to the 1.0 uniform reduction. With clarification, the estimated annual net aggregate decrease in gross

Medicaid expenditures is ($35,750,000) for State Fiscal Year 2019-20 and ($143,000,000) for each State Fiscal Year thereafter. The estimated annual net aggregate decrease in gross Medicaid expenditures attributable to the additional 0.5 percent additional initiative contained in the budget for State Fiscal Year 2020-21 is ($71,600,000) and each State Fiscal Year thereafter.

Non-Institutional Services

The following is a clarification to the April 1, 2020 noticed provision for converting the value of Upper Payment Limit (UPL) payments received by public hospitals in a city with a population over a million into Medicaid reimbursement rates. With clarification, this provision was published under Institutional Services only, but should've been published under Non-Institutional services, as well.

The following is a clarification to the April 1, 2020 noticed provision to delay the implementation date of certain permissible Consumer First Choice Options Services (CFCO) from January 1, 2020 to April 1, 2022. With clarification, this was incorrectly published under Long Term Care services. This should have been published under Non-Institutional services.

The following is a clarification to the April 1, 2020 noticed provision to reduce funding associated with nursing home capital reimbursement by 5 percent and eliminate funding associated with residual equity payments to all nursing homes. With clarification, there is an Adult Day Health Care piece to this provision, to that, this should have been published under Non-institutional services as well as Long Term Care.

Institutional Services

The following is a clarification to the April 1, 2020 noticed provision to reduce the size of the voluntary hospital Indigent Care Pool by $75 million (State share); Eliminate the Indigent Care Pool "Transition Collar", which generates an additional $12.5 million in State share savings; and Eliminate the Public Hospitals Indigent Care Pool, which generates $70 million in State savings. With clarification, the provision is to reduce the size of the voluntary hospital Indigent Care Pool by $150 million (gross); eliminate the Indigent Care Pool "Transition Collar", which generates an additional $25 million in gross savings; and create an Enhanced Safety Net Transition Collar Pool for $64.6 million (gross).

Long Term Care Services

The following is a clarification to the April 1, 2020 noticed provision for instituting a Home and Community Based services lookback period. With clarification, the lookback period is 30 months.

The following is a clarification to the April 1, 2020 noticed provision for modifying current eligibility criteria to receive Personal Care Services and Consumer Directed Personal Assistance as a Medicaid Benefit. With clarification, in order to be eligible to receive such services, an individual must be assessed to need assistance with more than two activities of daily living (ADLs) (ranging from limited assistance to total dependence) or, for individuals with a diagnosis of Alzheimer's or dementia, that need at least supervision with more than one ADL.

The following is a clarification to the April 1, 2020 noticed provision to reduce funding associated with nursing home capital reimbursement by 5 percent. With clarification, the proper wording is to reduce funding associated with nursing home capital reimbursement by 5 percent and eliminate funding associated with residual equity payments to all nursing homes.

The following is a clarification to the December 31, 2019 noticed provision to provide funding to support a two percent increase in annual salary and salary-related fringe benefits to direct case staff and direct support professions for all qualifying Mental Hygiene Services. With clarification, the estimated annual net aggregate increase to gross Medicaid expenditures attributable to this initiative for SFY 2019/2020 is $21 million. The impact published December 31, 2019, erroneously included $119 million for waivered services.

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

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

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

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

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

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

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

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

## PUBLIC NOTICE

Department of State
F-2020-0195
Date of Issuance – June 3, 2020

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

The applicant has certified that the proposed activities comply with and will be conducted in a manner consistent with the federally approved New York State Coastal Management Program (NYSCMP). The applicant's consistency certification and accompanying public information and data are available for inspection at the New York State Department of State offices located at One Commerce Plaza, 99 Washington Avenue, in Albany, New York.

In F-2020-0195, Diana Griffith is proposing to removal existing float piers and install a 3' x 30' aluminum ramp, 5' x 140' and 8' x 20' wood floating docks with 16 new timber piers. The project on Lloyd Harbor at 9 Oak Hill Road, Lloyd Harbor, NY 11743 in Suffolk County.

The applicant's consistency certification and supporting information are available for review at: http://www.dos.ny.gov/opd/programs/pdfs/Consistency/F-2020-0195Griffith.pdf

Any interested parties and/or agencies desiring to express their views concerning any of the above proposed activities may do so by filing their comments, in writing, no later than 4:30 p.m., 30 days from the date of publication of this notice or July 3, 2020.

*Comments should be addressed to*: Department of State, Office of Planning and Development and Community Infrastructure, Consistency Review Unit, One Commerce Plaza, Suite 1010, 99 Washington Ave., Albany, NY 12231, (518) 474-6000. Electronic submissions can be made by email at: CR@dos.ny.gov

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

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

**NON-INSTITUTIONAL SERVICES**
**State Plan Amendment #20-0002**

## 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).**

   **<u>Response:</u>** Payments made to service providers under the provisions of this SPA are funded through a budget appropriation received by the State agency that oversees medical assistance (Medicaid), which is the Department of Health.

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

   There have not been changes to provider taxes relative to this SPA.

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

   **<u>Response:</u>** 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.**

   **<u>Response:</u>** These payments are not subject to UPL requirements.

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?**

   **<u>Response:</u>** Payments are to be paid retroactively based on fee-for-service claims or encounter data in the managed care environment. They will not exceed costs.

**<u>ACA Assurances</u>:**

1. **<u>Maintenance of Effort (MOE).</u> Under section 1902(gg) of the Social Security Act (the Act), as amended by the Affordable Care Act, as a condition of receiving <u>any</u> Federal payments under the Medicaid program <u>during the MOE period</u> indicated below, the State shall <u>not</u> 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.**

   **<u>MOE Period.</u>**
   - **<u>Begins on:</u> March 10, 2010, and**
   - **<u>Ends on:</u> 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.**

   **<u>Response:</u>** 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.

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

**APPENDIX VI**
**NON-INSTITUTIONAL SERVICES**
**State Plan Amendment # 20-0002**

**CMS Standard Access Questions - Clinic**

**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-B of the state plan.**

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

   **Response:** This amendment will not have an impact on provider payments as it simply delays implementation of certain Community First Choice Option services. These services are currently available to eligible New Yorkers in many of our 1915(c) waivers and some are even available to enrollees of Medicaid managed long term care plans.

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

   **Response:** The State has various ways to ensure that access levels in the Medicaid program are retained and is currently not aware of any access issues. The State monitors and considers requests in the context of access as they approve/deny changes in services. Finally, providers cannot discriminate based on source of payment.

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

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

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

**Response:** This change was enacted by the State Legislature as part of the negotiation of the 2020-21 Budget. The impact of this change was weighed in the context of the overall Budget in the State. The legislative process provides opportunities for all stakeholders to lobby their concerns, objections, or support for various legislative initiatives. In addition, NY published notice in the state register of the proposed policy and did not receive any comment.

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:** N/A There is no rate change associated with this amendment.

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:** N/A There is no rate change associated with this amendment.