



Department of Health

ANDREW M. CUOMO
Governor

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

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

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

June 30, 2020

RE: SPA #20-0043
Non-Institutional Services

Dear Ms. McKnight:

The State requests approval of the enclosed amendment #20-0043 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 enacted legislation. 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 pertinent sections of enacted legislation 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 clarified on June 3, 2020, are 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

**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

OTHER, AS SPECIFIED

COMMENTS OF GOVERNOR'S OFFICE ENCLOSED

NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

12. SIGNATURE OF STATE AGENCY OFFICIAL

16. RETURN TO

13. TYPED NAME

14. TITLE

15. DATE SUBMITTED

June 30, 2020

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
2020 Title XIX State Plan
Second Quarter Amendment
Amended SPA Pages

**New York
1(I)(iii)**

Upper Payment Limit (UPL) Rate Add-ons

- IX. Effective April 2, 2020 through December 31, 2020, and each calendar year thereafter, rates of payment computed pursuant to this Attachment will be adjusted in accordance with the following:
1. A UPL payment per visit will be added to emergency department rates. The add-on will be calculated for each hospital by dividing the facility's latest approved UPL demonstration payment, as calculated in accordance with the Hospital Outpatient Supplemental Payment Adjustment – Public General Hospitals (HOSPA-PGH) section of this Attachment, by its Medicaid fee-for-service emergency department visits, as reported in its most recently submitted Institutional Cost Report.
 - a. These add-ons are only applicable for eligible general government hospitals in a city with a population over one million and not operated by the State of New York or the State University of New York and are in lieu of aggregate UPL payments made outside the rates.
 - b. The total amount paid will be included in the applicable annual UPL demonstration. In the event the UPL demonstration does not provide satisfactory assurances as required in the HOSPA-PGH section of the Attachment, the add-ons will be adjusted, as necessary.

TN #20-0043 _____

Approval Date: _____

Supersedes TN #New _____

Effective Date: April 2, 2020 _____

Appendix II
2020 Title XIX State Plan
Second Quarter Amendment
Summary

SUMMARY
SPA #20-0043

This State Plan Amendment proposes to convert the value of Upper Payment Limit (UPL) payments received by eligible government hospitals in a city with a population over one million and not operated by the State of New York or State University of New York into Medicaid reimbursement outpatient rates.

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

SPA 20-0043

Upper Payment Limit Conversion Payments

Article VII Language Bill

Chapter 56 of the Laws of 2020, S7506-B/A9506-B, Part KK, § 7

§ 7. Notwithstanding any inconsistent provision of law, rule or regulation to the contrary, and subject to the availability of federal financial participation pursuant to title XIX of the federal social security act, effective for the period April 1, 2020 through March 31, 2021, and state fiscal years thereafter, the department of health is authorized to increase the operating cost component of rates of payment for general hospital outpatient services and general hospital emergency room services issued pursuant to paragraph (g) of subdivision 2 of

defined in subdivision 10 of section 2801 of the public health law, other than those operated by the state of New York or the state university of New York, and located in a city with a population over one million, as a rate adjustment either directly as fee for service medical assistance payments or to managed care organizations authorized under article 44 of the public health law or article 43 of the insurance law that have in their network such hospitals, as medical assistance payments for outpatient services pursuant to title 11 of article 5 of the social services law for patients eligible for federal financial participation under title XIX of the federal social security act, contingent upon the execution of a memorandum of understanding between

conditions, criteria and methodologies for such rate adjustments and shall, at a minimum, set forth: (a) the estimated amounts to be paid pursuant to this rate adjustment; (b) the timing and methodology by

consistent with section 1905(cc) of the federal social security act, or any successor provision, toward the aggregate amount to be paid as part of the rate adjustment; and (c) the methodology by which the anticipated total amount to be paid through such rate adjustment will be funded in advance through an estimated local share contribution and then reconciled with actual utilization of services and application of the annual upper payment limit demonstration to the extent required by the secretary of the United States Department of Health and Human Services pursuant to 42 CFR 431.16, or any successor provision. If the annual upper payment limit demonstration yields an amount that is less than the

health law, then the rate adjustment shall be reduced to reflect the demonstration amount and other actions as authorized by the memorandum of understanding. If the annual upper payment limit demonstration yields an amount that is more than the aggregate amount paid in the rate adjustment provided by the public health law, the rate adjustment shall be adjusted to reflect the demonstration amount.

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

ated or owned governmental hospitals;

- Certain managed care payments pursuant to section 3-d of Part B of the Chapter 58 of the Laws of 2010; and
- Services provided to inmates of local correctional facilities.
- Other Payments that are not subject to the reduction include:
 - Payments pursuant to Article 32, Article 31 and Article 16 of the Mental Hygiene Law;
 - Required payments related to the School Supportive Health Services Program and Preschool Supportive Health Services Program;
 - Early Intervention;
 - Payments for services provided by Other State Agencies including Office of Children and Family Services, State Education Department, and the Department of Corrections and Community Supervision;
 - Vital Access Providers and Vital Access Provider Assurance Program;
 - Physician Administered Drugs;
 - Children and Family Treatment and Support Services (CFTSS);
 - Court orders and judgments; and
 - Family Planning services.

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

Non-Institutional Services

Care Management

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

- Implement Health Home Improvement, Efficiency, Consolidation and Standardization: These efficiencies include eliminating outreach payments, reducing unnecessary documentation, revising the criteria for admission, and re-evaluating the benchmarks for stepping patients down to lower levels of care management or graduation from a Health Home. Finally, placing the most seriously mentally ill clients in care management arrangements with appropriate caseload sizes – overseen by the Office of Mental Health – while moving lower acuity members into less intensive care management arrangements will both improve program quality and achieve efficiencies.
- Promote Further Adoption of Patient-Centered Medical Homes (PCMH): Continues incentive payments at current levels for lower cost, higher value PCMH programs while incorporating a tiered quality component into the incentive payments to align with other State initiatives such as the Prevention Agenda.
- Comprehensive Prevention and Management of Chronic Disease: Advances the use of evidence-based prevention strategies to manage highly prevalent chronic diseases, including diabetes, hypertension, asthma, smoking, osteoarthritis, chronic kidney disease, HIV/AIDS, and sickle cell disease. Specifically, the proposal will: (1) promote the use of evidence-based, self-care education, and prevention strategies; (2) implement an awareness campaign to educate Medicaid Managed Care (MMC) Plans, providers, and Medicaid members on the various resources and programs that are available; (3) educate the provider community relative to adherence to established evidence-based practice guidelines; (4) optimize services that are already covered by Medicaid, including expanding who can provide services; (5) optimize pharmacist services and leverage the frequency of patient visits to the pharmacy by expanding Collaborative Drug Therapy Management (CDTM) to the community setting, enable pharmacists to administer point-of-care testing for designated CLIA-waived tests and to initiate prescriptions for certain medications; (6) focus on chronic condition management within Patient-Centered Medical Homes (PCMHs) and Health Homes; initially, focus treatment and care management resources on adults with diabetes and hypertension, and children with asthma.
- Children's Preventive Care and Care Transitions: Promotes behavioral health integration in pediatrics by continuing ongoing pilot work focused on pregnancy and early childhood (e.g., preschool screening and universal, light-touch home visits) and leverages participation in CMMI's Integrated Care for Kids (InCK) model of

integration of medical and behavioral health care, using resources already available in the community. In addition, this proposal improves care transitions for children with chronic medical and behavioral conditions, with a special focus on children with sickle cell disease (SCD) moving from pediatric to adult care settings.

- Children and Family Treatment and Support Services (CFTSS) - Restores specialized transition rates for CFTSS.
 - Invest in Medically Fragile Children: Invests Medicaid resources to improve access to private duty nursing (PDN) for medically fragile children in order to prevent hospitalization and emergency visits, by leveraging additional utilization of telehealth, commercial insurance coverage for PDN, further PDN network development and enhanced rates. Specifically, the proposal would increase fee-for-service PDN rates over a three year period to benchmark to the current Medicaid Managed Care rates; create a PDN Network whereby PDN providers would receive a negotiated enhanced rate of payment for PDN services.
 - Preventive Dentistry: Promotes evidence-based preventative dentistry using fluoride varnish and silver diamine fluoride. Specifically, the proposal increases the application of fluoride varnish by primary care providers, including Registered Nurses, which will decrease early childhood decay and associated restorative costs. In addition, the proposal expands Medicaid dental coverage to include silver diamine fluoride which stops tooth decay and prevents additional oral complications.
 - Emergency Room Avoidance and Cost Reductions: this proposal reduces unnecessary Emergency Department (ED) utilization and/or cost by redesigning care pathways for high ED utilizing patients and transitions navigation to community services by: allowing sharing of individualized patient treatment plans for chronic conditions (through Qualified Entity (QEs)); expanding access to Urgent Care Centers by increasing co-location with Emergency Rooms; requiring Urgent Care Centers to accept Medicaid; and exploring a lower ED triage fee for non-emergency conditions.
 - Addressing Barriers to Opioid Care: Implements a series of Opioid related interventions to address certain barriers to care for Medicaid members, including but not limited to, better bundled payments that support opiate treatment through the adjustment of Ambulatory Patient Groups (APG) payments to eliminate unnecessary volume incentive and to promote more appropriate access including take home medication, when clinically appropriate; reduced Medicaid Coverage Limits for Rehabilitation Services as pathway to nonpharmacologic treatment alternative for pain management, and increased utilization of the Opioid Medical Maintenance (OMM) Model.
 - Promote Maternal Health to Reduce Maternal Mortality: Focuses on optimizing the health of individuals of reproductive age, including discussions on comprehensive family planning and patient centered primary and preventive care. The proposal aims to improve access to quality prenatal care, free from implicit bias, and ensuring postpartum home visits are available to all individuals who agree have a home visit after giving birth, by working with Medicaid Managed Care plans to identify and address the barriers to achieving these goals. The proposal also includes ensuring all pregnant individuals have access to childbirth education and supports the participation of birthing centers in the Perinatal Quality Collaborative.
- The estimated annual net aggregate decrease in gross Medicaid expenditures attributable to these initiatives contained in the budget for SFY 2020-2021 is \$86 million and for SFY 2021-2022 is \$140 million.

Pharmacy

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

- Reduce Drug Cap Growth by Enhancing Purchasing Power to Lower Drug Costs by providing the ability to negotiate supplemental rebates for new blockbuster drugs and gene therapies that do not yet have utilization; and the authority to negotiate value-based agreements with manufacturers.
- Reducing coverage of certain OTC products and increasing copayments (with exceptions for the most vulnerable populations).

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

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

Transportation

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

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

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

Telehealth

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

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

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

Institutional Services

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

- Reduce the size of the voluntary hospital Indigent Care Pool by \$75 million (State share);
- Eliminate the Indigent Care Pool "Transition Collar", which generates an additional \$12.5 million in State share savings; and
- Eliminate the Public Hospitals Indigent Care Pool, which generates \$70 million in State savings;

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

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

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

Long Term Care Services

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

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

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 Stratford 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 uniform 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 waived 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 #20-0043**

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 Health and Hospitals Corporation (NYC Health + Hospitals) 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.

However, it should be noted that an Intergovernmental Transfer (IGT) payment for the non-federal share will be processed in accordance with a Memorandum of Understanding (MOU) between the Department of Health and NYC Health + Hospitals.

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 and CMS are working toward completing and approval of current year UPL.

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

Response: The rate methodologies included in the State Plan for outpatient hospital services are either cost-based subject to ceilings or based upon the Ambulatory Patient Group (APG) system. We are unaware of any requirement under current federal law or regulation that limits individual provider's payments to their actual costs.

ACA Assurances:

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

MOE Period.

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

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

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

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

Response: This SPA would [] / would not [✓] violate these provisions, if they remained in effect on or after January 1, 2014.

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

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

Tribal Assurance:

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

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

- a) Please describe the process the State uses to seek advice on a regular ongoing basis from federally recognized tribes Indian Health Programs and Urban Indian Organizations on matters related to Medicaid and CHIP programs and for consultation on State Plan Amendments waiver proposals waiver extensions waiver amendments

- waiver renewals and proposals for demonstration projects prior to submission to CMS.**
- b) Please include information about the frequency inclusiveness and process for seeking such advice.**
 - c) Please describe the consultation process that occurred specifically for the development and submission of this State Plan Amendment when it occurred and who was involved.**

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