NEW YORK STATE | Department of Health

KATHY HOCHUL
Governor

JAMES V. McDONALD, MD, MPH
Commissioner

JOHANNE E. MORNE, MS
Executive Deputy Commissioner

December 31, 2024

James G. Scott, Director
Division of Program Operations
Centers for Medicare & Medicaid Services
601 E. 12th St., Room 355
Kansas City, Missouri 64106

RE: SPA #24-0072
Non-Institutional Services

Dear Director Scott:

The State requests approval of the enclosed amendment #24-0072 to the Title XIX (Medicaid) State Plan for non-institutional services to be effective November 1, 2024 (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 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). A copy of the public notice of this plan amendment, which was given in the *New York State Register* on October 16, 2024, is also enclosed for your information (Appendix IV). In addition, responses to the five standard funding questions are also enclosed (Appendix V).

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

Sincerely,

[redacted]

Michael Ogborn
Deputy 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: 24 — 0072

2. STATE: NY

3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT: (●) XIX ( ) XXI

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
November 1, 2024

5. FEDERAL STATUTE/REGULATION CITATION
§ 1905(a)(18) Hospice care

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 11/01/24-09/30/25 $ 0
b. FFY 10/01/25-09/30/26 $ 0

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 3.1-A Supp Page: 3(c)
Attachment 3.1-B Supp Page: 3(c)

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 3.1-A Supp Page: 3(c)
Attachment 3.1-B Supp Page: 3(c)

9. SUBJECT OF AMENDMENT
Hospice in Assisted Living Programs

10. 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:

11. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

12. TYPED NAME
Michael Ogborn

13. TITLE
Deputy Medicaid Director

14. DATE SUBMITTED December 31, 2024

15. RETURN TO
New York State Department of Health
Division of Finance and Rate Setting
99 Washington Ave – One Commerce Plaza
Suite 1432
Albany, NY 12210

FOR CMS USE ONLY

16. DATE RECEIVED

17. DATE APPROVED

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL

19. SIGNATURE OF APPROVING OFFICIAL

20. TYPED NAME OF APPROVING OFFICIAL

21. TITLE OF APPROVING OFFICIAL

22. REMARKS

FORM CMS-179 (09/24)

Instructions on Back

Appendix I
2024 Title XIX State Plan
Fourth Quarter Amendment
Amended SPA Pages

New York
3(c)

1905(a)(18) Hospice care

18. Limitations on Hospice Services:

Hospice services are provided to individuals who are certified by a physician as being terminally ill, with a life expectancy of approximately twelve months or less.

Recipients must sign an informed consent electing hospice over conventional care, subject to periodic review.

Services provided are palliative in nature as opposed to curative: Services include supportive medical, social, emotional, and spiritual services to terminally ill individuals as well as emotional support for family members. Hospice services may be delivered at home, in a nursing home, in a hospital, in an assisted living program, or in a hospice residence.

Recipients who elect hospice care waive all rights to Medicaid reimbursement made on their behalf for the duration of the election of any services covered under the Medicaid State Plan that are related to the treatment of the terminal condition for which hospice care was elected, or a related condition. For services delivered to a hospice patient residing at an assisted living program, the rate associated with the assisted living program will cover services, durable medical equipment and medications associated with that rate. Services, durable medical equipment, and medications approved and provided in connection with hospice care will be covered by the hospice rate. The assisted living program may not bill Medicaid for services, medications or durable medical equipment provided by the hospice provider. A Medicaid or Children's Health Insurance Program (CHIP) eligible child, under age 21, electing hospice is not required to forego curative treatment for the treatment of the terminal illness.

Hospice services provider qualifications are provided for registered professional nurse, home health aide, physical therapist, occupational therapist, speech pathologist, personal care aide, housekeeper/homemaker, pastoral care coordinator, social worker, nutritionist, audiologist, and respiratory therapist.

Registered professional nurse ~~shall~~ will mean a person who is licensed and currently registered as a registered professional nurse pursuant to Article 139 of the New York State Education Law.

New York
3(c)

1905(a)(18) Hospice care

18. Limitations on Hospice Services:

Hospice services are provided to individuals who are certified by a physician as being terminally ill, with a life expectancy of approximately twelve months or less.

Recipients must sign an informed consent electing hospice over conventional care, subject to periodic review.

Services provided are palliative in nature as opposed to curative: Services include supportive medical, social, emotional, and spiritual services to terminally ill individuals as well as emotional support for family members. Hospice services may be delivered at home, in a nursing home, in a hospital, in an assisted living program, or in a hospice residence.

Recipients who elect hospice care waive all rights to Medicaid reimbursement made on their behalf for the duration of the election of any services covered under the Medicaid State Plan that are related to the treatment of the terminal condition for which hospice care was elected, or a related condition. For services delivered to a hospice patient residing at an assisted living program, the rate associated with the assisted living program will cover services, durable medical equipment and medications associated with that rate. Services, durable medical equipment, and medications approved and provided in connection with hospice care will be covered by the hospice rate. The assisted living program may not bill Medicaid for services, medications or durable medical equipment provided by the hospice provider. A Medicaid or Children's Health Insurance Program (CHIP) eligible child, under age 21, electing hospice is not required to forego curative treatment for the treatment of the terminal illness.

Hospice services provider qualifications are provided for registered professional nurse, home health aide, physical therapist, occupational therapist, speech pathologist, personal care aide, housekeeper/homemaker, pastoral care coordinator, social worker, nutritionist, audiologist, and respiratory therapist.

Registered professional nurse ~~shall~~ will mean a person who is licensed and currently registered as a registered professional nurse pursuant to Article 139 of the New York State Education Law.

Appendix II
2024 Title XIX State Plan
Fourth Quarter Amendment
Summary

SUMMARY
SPA #24-0072

This State Plan Amendment proposes to make a technical change to align with New York statute which allows residents of Adult Care Facilities to receive both Hospice and Assisted Living Program services without having to disenroll from either. The Department convened a stakeholder workgroup which studied how the two programs will coordinate services, responsibilities, and reimbursement to help ensure no duplicative services or payments. It was determined that a Medicaid State Plan Amendment was necessary to align with statute and ensure the State Plan explicitly allows Hospice services for those enrolled in the Assisted Living Program. Prior to this statutory change, those enrolled in the Assisted Living Program who elected Hospice were required to disenroll from the Assisted Living Program, and with this change that will no longer be necessary.

Appendix III
2024 Title XIX State Plan
Fourth Quarter Amendment
Authorizing Provisions

SPA 24-0072

The Authorizing Provisions for Hospice Care in an Assisted Living Program, as provided below, can be found in:

- **New York State Public Health Law § 4012(4) and**
- **New York State Social Services Law § 461-l(2)(d)(iv)**

Public Health

§ 4012. Payment for hospice. 1. No government agency shall purchase, pay for or make reimbursement or grants-in-aid for services provided by a hospice unless, at the time the services were provided, the hospice possessed a valid certificate of approval.

2. Payments for hospice care made by government agencies shall be at rates approved by the state director of the budget.

3. Prior to the approval of hospice rates, the commissioner shall determine and certify to the state director of the budget that the proposed rate schedules for payments for hospice services are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated programs. In making such certification, the commissioner shall take into consideration the elements of cost, geographical differentials in the elements of cost considered, economic factors in the area in which the hospice is located, costs of hospice programs of comparable size, the need for incentives to improve services and institute economies, and applicable medicare reimbursement regulations.

4. Eligible individuals shall be permitted to receive hospice services from a provider under this article while continuing to reside in an adult care facility under title two of article seven of the social services law and enrolled in the assisted living program, subject to the availability of federal financial participation. The commissioner shall make regulations and take other actions reasonably necessary and appropriate to implement this subdivision.

5. The commissioner shall establish a methodology as of July first, two thousand eighteen subject to federal financial participation that shall ensure a prospective ten-percent increase in the medicaid reimbursement rates for hospice providers, relative to the reimbursement rate, as of March thirty-first, two thousand eighteen, for services provided by such providers on and after April first, two thousand eighteen.

Social Services

§ 461-l. Assisted living program. 1. Definitions. As used in this section, the following words shall have the following meanings:

(a) "Assisted living program" means an entity or entities with identical ownership, which are approved to operate pursuant to subdivision three of this section and possesses a valid operating certificate as an adult care facility, other than a shelter for adults, a residence for adults or a family type home for adults, issued pursuant to this article and which possesses either: (i) a valid license as a home care services agency issued pursuant to section thirty-six hundred

five of the public health law; or (ii) a valid certificate of approval as a certified home health agency issued pursuant to section thirty-six hundred six of the public health law; or (iii) valid authorization as a long term home health care program issued pursuant to section thirty-six hundred ten of the public health law.

(b) "Capitated rate of payment" means the rate established pursuant to subdivision six of section thirty-six hundred fourteen of the public health law.

(c) "Eligible applicant" means:

(i) A single entity that is:

(A) only a natural person or partnership composed only of natural persons, a not-for-profit corporation, a public corporation, a business corporation other than a corporation whose shares are traded on a national securities exchange or are regularly quoted on a national over-the-counter market or a subsidiary of such a corporation or a corporation any of the stock of which is owned by another corporation, a limited liability company provided that if a limited liability company has a member that is a corporation, a limited liability company or a partnership, the shareholders of the member corporation, the members of the member limited liability company, or the partners of the member partnership must be natural persons, a social services district or other governmental agency which possesses or is eligible pursuant to this article to apply for an adult care facility operating certificate; and

(B) either: (1) an entity which possesses or is eligible pursuant to article thirty-six of the public health law to apply for licensure as a home care services agency; (2) an entity which possesses valid authorization as a long term home health care program; or (3) an entity which possesses a valid certificate of approval as a certified home health agency pursuant to article thirty-six of the public health law; or

(ii) One or more entities listed in subparagraph (i) of this paragraph with identical owners that, in combination, meet each of the criteria set forth by subparagraph (i) of this paragraph.

(d) "Eligible person" means a person who:

(i) requires more care and services to meet his or her daily health or functional needs than can be directly provided by an adult care facility and although medically eligible for placement in a residential health care facility, can be appropriately cared for in an assisted living program and who would otherwise require placement in a residential health care facility due to factors which may include but need not be limited to the lack of a home or a home environment in which to live and receive services safely; and

(ii) is categorized by the long-term care patient classification system as defined in regulations of the department of health as a person who has a stable medical condition and who is able, with direction, to take action sufficient to assure self-preservation in an emergency. In no event shall an eligible person include anyone in need of continual nursing or medical care, a person who is chronically bedfast, or anyone who is cognitively, physically or medically impaired to such a degree that his or her safety would be endangered.

(e) "Services" shall mean all services for which full payment to an assisted living program is included in the capitated rate of payment, which shall include personal care services, home care services and such other services as the commissioner in conjunction with the commissioner of health determine by regulation must be included in the capitated rate of payment, and which the assisted living program shall provide, or arrange for the provision of, through contracts with a social services

district, long term home health care programs, certified home health agencies, and other qualified providers.

2. General requirements. (a) Applicability. Unless expressly provided otherwise in this article or article thirty-six of the public health law, an assisted living program shall be subject to any other law, rule or regulation governing adult care facilities, long term home health care programs, certified home health agencies, licensed home care agencies or personal care services.

(b) If an assisted living program itself is not a certified home health agency or long term home health care program, the assisted living program shall contract with one or more certified home health agencies and/or long term home health care programs for the provision of services pursuant to article thirty-six of the public health law.

(c) Participation by eligible persons. Participation in an assisted living program by an eligible person shall be voluntary and eligible persons shall be provided with sufficient information regarding the program to make an informed choice concerning participation.

(d) Patient services and care. (i) An assisted living program shall, either directly or through contract with a long term home health care program or certified home health agency, conduct an initial assessment to determine whether a person would otherwise require placement in a residential health care facility if not for the availability of the assisted living program and is appropriate for admission to an assisted living program.

(ii) No person shall be determined eligible for and admitted to an assisted living program unless the assisted living program finds that the person meets the criteria provided in paragraph (d) of subdivision one of this section.

(iii) Appropriate services shall be provided to an eligible person only in accordance with a plan of care which is based upon an initial assessment and periodic reassessments conducted by an assisted living program, either directly or through contract with a long term home health care program or certified home health agency. A reassessment shall be conducted as frequently as is required to respond to changes in the resident's condition and ensure immediate access to necessary and appropriate services by the resident, but in no event less frequently than once every six months. No person shall be admitted to or retained in an assisted living program unless the person can be safely and adequately cared for with the provision of services determined by such assessment or reassessment.

(iv) Eligible individuals shall be permitted to receive hospice services from a provider under article forty of the public health law while continuing to reside in an adult care facility under this title and enrolled in the assisted living program, subject to the availability of federal financial participation. The commissioner shall make regulations and take other actions reasonably necessary and appropriate to implement this subparagraph.

3. Assisted living program approval. (a) An eligible applicant proposing to operate an assisted living program shall submit an application to the department. Upon receipt, the department shall transmit a copy of the application and accompanying documents to the department of health. Such application shall be in a format and a quantity determined by the department and shall include, but not be limited to:

(i) a copy of or an application for an adult care facility operating certificate;

(ii) a copy of or an application for a home care services agency

license or a copy of a certificate for a certified home health agency or authorization as a long term home health care program;

(iii) a copy of a proposed contract with a social services district or in a social services district with a population of one million or more, a copy of a proposed contract with the social services district or the department;

(iv) if the applicant is not a long term home health care program or certified home health agency, a copy of a proposed contract with a long term home health care program or certified home health agency for the provisions of services in accordance with article thirty-six of the public health law; and

(v) a detailed description of the proposed program including budget, staffing and services.

(b) If the application for the proposed program includes an application for licensure as a home care service agency, the department of health shall forward the application for the proposed program and accompanying documents to the public health and health planning council for its written approval in accordance with the provisions of section thirty-six hundred five of the public health law.

(c) An application for an assisted living program shall not be approved unless the commissioner is satisfied as to:

(i) the character, competence and standing in the community of the operator of the adult care facility;

(ii) the financial responsibility of the operator of the adult care facility;

(iii) that the buildings, equipment, staff, standards of care and records of the adult care facility to be employed in the operation comply with applicable law, rule and regulation;

(iv) the commissioner of health is satisfied that the licensed home care agency has received the written approval of the public health and health planning council as required by paragraph (b) of this subdivision and the equipment, personnel, rules, standards of care, and home care services provided by the licensed home care agency and certified home health agency or long term home health care program are fit and adequate and will be provided in the manner required by article thirty-six of the public health law and the rules and regulations thereunder; and

(v) the commissioner and the commissioner of health are satisfied as to the public need for the assisted living program.

(d) The department shall not approve an application for an assisted living program for any eligible applicant who does not meet the requirements of this article, including but not limited to, an eligible applicant who is already or within the past ten years has been an incorporator, director, sponsor, principal stockholder, member or owner of any adult care facility which has been issued an operating certificate by the board or the department, or of a halfway house, hostel or other residential facility or institution for the care, custody or treatment of the mentally disabled which is subject to approval by an office of the department of mental hygiene, or of any residential health care facility or home care agency as defined in the public health law, unless the department, in conjunction with the department of health, finds by substantial evidence as to each such applicant that a substantially consistent high level of care has been rendered in each such facility or institution under which such person is or was affiliated. For the purposes of this paragraph, there may be a finding that a substantially consistent high level of care has been rendered despite a record of violations of applicable rules and regulations, if such violations (i) did not threaten to directly affect

the health, safety or welfare of any patient or resident, and (ii) were promptly corrected and not recurrent.

(e) The commissioner of health shall provide written notice of approval or disapproval of portions of the proposed application concerning a licensed home care agency, certified home health agency or long term home health care program, and, where applicable, of the approval or disapproval of the public health and health planning council to the commissioner. If an application receives all the necessary approvals, the commissioner shall notify the applicant in writing. The commissioner's written approval shall constitute authorization to operate an assisted living program.

(f) No assisted living program may be operated without the written approval of the department, the department of health and, where applicable, the public health and health planning council.

(g) Notwithstanding any other provision of law to the contrary, any assisted living program having less than seventy-five authorized bed slots, located in a county with a population of more than one hundred ten thousand and less than one hundred fifty thousand persons based upon the decennial federal census for the year two thousand, and which at any point in time is unable to accommodate individuals awaiting placement into the assisted living program, shall be authorized to increase the number of assisted living beds available for a specified period of time as part of a demonstration program by up to thirty percent of its approved bed level; provided, however, that such program shall otherwise satisfy all other assisted living program requirements as set forth in this section. In addition, any program which receives such authorization and which at any point on or after July first, two thousand five is unable to accommodate individuals awaiting placement into the assisted program, shall be authorized to further increase the number of assisted living beds available as part of this demonstration program by up to twenty-five percent of its bed level as of July first, two thousand five; provided, however, that such program shall otherwise satisfy all other assisted living program requirements as set forth in this section.

(h) The commissioner is authorized to add one thousand five hundred assisted living program beds to the gross number of assisted living program beds having been determined to be available as of April first, two thousand seven.

(i) (a) The commissioner of health is authorized to add up to six thousand assisted living program beds to the gross number of assisted living program beds having been determined to be available as of April first, two thousand nine. Nothing herein shall be interpreted as prohibiting any eligible applicant from submitting an application for any assisted living program bed so added. The commissioner of health shall not be required to review on a comparative basis applications submitted for assisted living program beds made available under this paragraph. The commissioner of health shall only authorize the addition of six thousand beds pursuant to a seven year plan ending prior to January first, two thousand seventeen.

(b) The commissioner of health shall provide an annual written report to the chair of the senate standing committee on health and the chair of the assembly health committee no later than January first of each year. Such report shall include, but not be limited to, the number of assisted living program beds made available pursuant to this section by county, the total number of assisted living program beds by county, the number of vacant assisted living program beds by county, and any other information deemed necessary and appropriate.

(j) The commissioner of health is authorized to add up to four

thousand five hundred assisted living program beds to the gross number of assisted living program beds having been determined to be available as of April first, two thousand twelve. Applicants eligible to submit an application under this paragraph shall be limited to adult homes established pursuant to section four hundred sixty-one-b of this article with, as of September first, two thousand twelve, a certified capacity of eighty beds or more in which twenty-five percent or more of the resident population are persons with serious mental illness as defined in regulations promulgated by the commissioner of health. The commissioner of health shall not be required to review on a comparative basis applications submitted for assisted living program beds made available under this paragraph.

(k) (i) Existing assisted living program providers may apply to the department of health for approval to add up to nine additional assisted living program beds that do not require major renovation or construction. Eligible applicants are those that agree to dedicate such beds to serve only individuals receiving medical assistance, are in good standing with the department of health, and are in compliance with appropriate state and local requirements as determined by the department of health.

(ii) Existing assisted living program providers licensed on or before April first, two thousand eighteen may submit applications under this paragraph beginning no later than June thirtieth, two thousand eighteen and until a deadline to be determined by the department of health. Existing assisted living program providers licensed on or before April first, two thousand twenty may submit such applications beginning no later than June thirtieth, two thousand twenty and until a deadline to be determined by the department of health.

(iii) The number of additional assisted living program beds approved under this paragraph shall be based on the total number of previously awarded beds either withdrawn by applicants or denied by the department of health. The commissioner of health shall utilize an expedited review process allowing certification of the additional beds within ninety days of such department's receipt of a satisfactory application.

(l) (i) The commissioner of health is authorized to solicit and award applications for up to a total of five hundred new assisted living program beds in those counties where there is one or no assisted living program providers, pursuant to criteria to be determined by the commissioner.

(ii) The commissioner of health is authorized to solicit and award applications for up to five hundred new assisted living program beds in counties where utilization of existing assisted living program beds exceeds eighty-five percent. All applicants shall comply with federal home and community-based settings requirements, as set forth in 42 CFR Part 441 Subpart G. To be eligible for an award, an applicant must agree to:

(A) Dedicate such beds to serve only individuals receiving medical assistance;

(B) Develop and execute collaborative agreements within twenty-four months of an application being made to the department of health, in accordance with guidance to be published by such department, between at least one of each of the following entities: an adult care facility; a residential health care facility; and a general hospital; and

(C) Enter into an agreement with an existing managed care entity.

(iii) The commissioner of health is authorized to award any assisted living program beds for which a solicitation is made under subparagraph (i) of this paragraph, but which are not awarded, to applicants that

meet all applicable criteria pursuant to a solicitation made under subparagraph (ii) of this paragraph.

(m) Beginning April first, two thousand twenty-five, additional assisted living program beds shall be approved on a case by case basis whenever the commissioner of health is satisfied that public need exists at the time and place and under circumstances proposed by the applicant.

(i) The consideration of public need may take into account factors such as, but not limited to, regional occupancy rates for adult care facilities and assisted living program occupancy rates and the extent to which the project will serve individuals receiving medical assistance.

(ii) Existing assisted living program providers may apply for approval to add up to nine additional assisted living program beds that do not require major renovation or construction under an expedited review process. The expedited review process is available to applicants that are in good standing with the department of health, and are in compliance with appropriate state and local requirements as determined by the department of health. The expedited review process shall allow certification of the additional beds for which the commissioner of health is satisfied that public need exists within ninety days of such department's receipt of a satisfactory application.

(n) The commissioner of health is authorized to create a program to subsidize the cost of assisted living for those individuals living with Alzheimer's disease and dementia who are not eligible for medical assistance pursuant to title eleven of article five of this chapter and reside in a special needs assisted living residence certified under section forty-six hundred fifty-five of the public health law. Subject to appropriations, the program shall authorize vouchers to individuals through an application process and pay for up to seventy-five percent of the average private pay rate in the respective region. The commissioner of health may propose rules and regulations to effectuate this provision.

4. Revocation, suspension, limitation or annulment. Authorization to operate an assisted living program may be revoked, suspended, limited or annulled by the commissioner in accordance with the provisions of this article if the adult care facility fails to comply with applicable provisions of this chapter or rules or regulations promulgated hereunder or by the commissioner of health in accordance with the provisions of article thirty-six of the public health law if the licensed home care service agency, certified home health agency or long term home health care program fails to comply with the provisions of article thirty-six of the public health law or rules or regulations promulgated thereunder.

5. Rules and regulations. The commissioner and the commissioner of health shall jointly promulgate any rules and regulations necessary to effectuate the provisions and purposes of this section and section thirty-six hundred fourteen of the public health law. Such regulations shall provide that the department and the department of health shall coordinate their surveillance and enforcement efforts, including but not limited to, on-site surveys of assisted living programs.

6. Report. The commissioner and the commissioner of health shall submit a joint report to the governor, the temporary president of the senate, the speaker of the assembly, the state hospital review and planning council and health systems agencies on or before March first, nineteen hundred ninety-three which shall include a description of the programs, including the number of programs established and authorized by geographic area, the cost of the program, including the savings to state and local governments, the number of persons served by the program by geographic area, a description of the demographic and clinical

characteristics of patients served by the program and an evaluation of the quality of care provided to persons served by the program. Such report shall be utilized by the department of health in estimating statewide need for long term care beds for the planning target year next succeeding nineteen hundred ninety-three. In addition, the state hospital review and planning council shall consider the results of such report in approving the methodology for determining statewide need for long term care beds for the planning target year next succeeding nineteen hundred ninety-three.

Appendix IV
2024 Title XIX State Plan
Fourth Quarter Amendment
Public Notice

averages) of up to 0.720 mgd from Well 1 (renewal of Docket No. 19940701) and up to 0.311 mgd from Well 3.

12. Project Sponsor and Facility: Schuylkill County Municipal Authority, Butler Township, Schuylkill County, Pa. Application for renewal of groundwater withdrawal of up to 0.362 mgd (30-day average) from the Gordon Well (Docket No. 20090624). Service area is located in an Environmental Justice area.

13. Project Sponsor and Facility: Strasburg Lancaster County Borough Authority, Strasburg Township, Lancaster County, Pa. Application for renewal of groundwater withdrawal of up to 0.275 mgd (30-day average) from the Fisher Well (Docket No. 19890107). Service area is located in an Environmental Justice area.

14. Project Sponsor and Facility: SWN Production Company, LLC (Susquehanna River), Great Bend Township, Susquehanna County, Pa. Application for renewal of surface water withdrawal of up to 2.000 mgd (peak day) (Docket No. 20191209).

15. Project Sponsor and Facility: Tallman Family Farms, L.L.C. (Wiconisco Creek), Washington Township, Dauphin County, Pa. Application for surface water withdrawal of up to 0.720 mgd (peak day).

16. Project Sponsor: Valley CC LLC. Project Facility: Valley Country Club, Sugarloaf Township, Luzerne County, Pa. Applications for renewal of groundwater withdrawals (30-day averages) of up to 0.090 mgd from the Shop Well and up to 0.090 mgd from the Pumphouse Well (Docket No. 20090632).

Opportunity to Appear and Comment:

Interested parties may appear or call into the hearing to offer comments to the Commission on any business listed above required to be the subject of a public hearing. Given the nature of the meeting, the Commission strongly encourages those members of the public wishing to provide oral comments to pre-register with the Commission by e-mailing Jason Oyler at joyler@srbc.gov before the hearing date. The presiding officer reserves the right to limit oral statements in the interest of time and to control the course of the hearing otherwise. Access to the hearing via telephone will begin at 6:15 p.m. Guidelines for the public hearing are posted on the Commission's website, www.srbc.gov, before the hearing for review. The presiding officer reserves the right to modify or supplement such guidelines at the hearing. Written comments on any business listed above required to be the subject of a public hearing may also be mailed to Mr. Jason Oyler, Secretary to the Commission, Susquehanna River Basin Commission, 4423 North Front Street, Harrisburg, Pa. 17110-1788, or submitted electronically through https://www.srbc.gov/meetingcomment/default.aspx?type=2&cat=7. Comments mailed or electronically submitted must be received by the Commission on or before Tuesday, November 12, 2024, to be considered.

Authority: Pub. L. 91-575, 84 Stat. 1509 et seq., 18 CFR Parts 806, 807, and 808.

Dated: September 25, 2024.

Jason E. Oyler,

General Counsel and Secretary to the Commission

PUBLIC NOTICE

Office of General Services
New York State GreenNY Council

Pursuant to Executive Order No. 22, Leading By Example: Directing State Agencies to Adopt a Sustainability and Decarbonization Program, September 20, 2022 ("EO 22"), the GreenNY Council hereby gives public notice of the following:

Seven (7) sustainable procurement specifications were tentatively approved by the GreenNY Council and have been posted for public comment.

This includes a new or amended specifications on the following topics:

- Metal Cleaners and Polishes
- Odor Control Products
- Oven, Grill and Barbecue Cleaners
- Surface Cleaning Wipes
- Dishwashing Detergents
- Disposable Gloves
- Lower Carbon Concrete

The above specification is available for viewing at: https://ogs.ny.gov/greenny/executive-order-4-tentatively-approved-specifications

Information regarding the green specification approval process is also available at the above link.

Comments may be submitted electronically to GreenNY@dec.ny.gov

Comments from the public regarding the tentatively approved specifications will be accepted until Monday, November 18, 2024.

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 4012 of New York State Public Health Law. The following changes are proposed:

Non-Institutional Services

Effective on or after November 1, 2024, the rate paid for durable medical equipment, medications, and hospice-approved services provided to a hospice patient who resides at an assisted living program will be covered by the hospice rate. The assisted living program may not bill Medicaid for services or equipment provided by the hospice provider. This will require coordinated case management between the assisted living program and hospice provider through the duration of the hospice patient's assisted living program residency.

There is no estimated change to gross Medicaid expenditures as a result of this 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

Appendix V
2024 Title XIX State Plan
Fourth Quarter Amendment
Responses to Standard Funding Questions

NON-INSTITUTIONAL SERVICES
State Plan Amendment #24-0072

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.

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

   Response: Providers receive and retain 100 percent of total Medicaid expenditures claimed by the State and the State does not require any provider to return any portion of such payments to the State, local government entities, or any other intermediary organization.

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

(iii) the total amounts transferred or certified by each entity;
(iv) clarify whether the certifying or transferring entity has general taxing authority: and,
(v) whether the certifying or transferring entity received appropriations (identify level of appropriations).

Response: The Non-Federal share Medicaid provider payment is funded by a combination of the following funds/funding sources through enacted appropriations authority to the Department of Health (DOH) for the New York State Medicaid program.

		4/1/24 – 3/31/25	
Payment Type	**Non-Federal Share Funding**	**Non-Federal**	**Gross**
Supplemental	General Fund	$43M	$83M

A. **General Fund:** Revenue resources for the State's General Fund includes taxes (e.g., income, sales, etc.), and miscellaneous fees (including audit recoveries). Medicaid expenditures from the State's General Fund are authorized from Department of Health Medicaid.

1) New York State Audit Recoveries: The Department of Health collaborates with the Office of the Medical Inspector General (OMIG) and the Office of the Attorney General (AG) in recovering improperly expended Medicaid funds. OMIG conducts and coordinates the investigation, detection, audit, and review of Medicaid providers and recipients to ensure they are complying with all applicable laws and regulation. OMIG recovers any improper payments through cash collections and voided claim recoveries. Cash collections are deposited into the State's General Fund to offset Medicaid costs.

In addition to cash collections, OMIG finds inappropriately billed claims within provider claims. To correct an error, OMIG and DOH process the current accurate claim, and reduce this claim by the inappropriate claim value to recoup the previous overclaim and decrease state spending.

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: Not applicable, this State Plan Amendment is not for 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. Under regulations at 42 CFR 447.272, States are prohibited from setting payment rates for Medicaid inpatient services that exceed a reasonable estimate of the amount that would be paid under Medicare payment principals.

Response: The Medicaid payments authorized under this State Plan Amendment do not impact the UPL demonstrations.

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: Providers do not receive payments that in the aggregate exceed their reasonable costs of providing services. If any providers received payments that in the aggregate exceeded their reasonable costs of providing services, the State would recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report.

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 complies 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.