



Department of Health

ANDREW M. CUOMO
Governor

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

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

June 15, 2020

Dear Health Clinic Administrator:

Pursuant to our tribal consultation policy, enclosed please find a summary of each proposed amendment to the New York State Plan. We encourage you to review the enclosed information and use the link below to also view the plan pages and Federal Public Notices for each proposal. Please provide any comments or request a personal meeting to discuss the proposed changes within two weeks of the date of this letter.

https://www.health.ny.gov/regulations/state_plans/tribal/

We appreciate the opportunity to share this information with you and if there are any comments or concerns please feel free to contact Regina Deyette, Medicaid State Plan Coordinator, Office of Health Insurance Programs at 518-473-3658.

Sincerely,

/s/

Donna Frescatore
Medicaid Director
Office of Health Insurance Programs

Enclosures

cc: Sean Hightower
US Dept. of Health and Human Services

Nancy Grano
CMS Native American Contact

Michele Hamel
NYSDOH American Indian Health Program

SUMMARY
SPA #20-0002

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

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

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

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

ii. Service Delivery Models

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

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

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

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

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

Providers: Personal Care Aides, Personal Attendants, Personal Assistants, Home Health Aides, and Direct Service Professionals that meet the licensure and certification requirements under NYCCR Title 13 and the guidance of the Department of Health and/or the Office for People With Developmental Disabilities and the Office of Mental Health are qualified providers of personal care services and supports under CFCO.

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

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

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

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

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

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

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

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

Risk Management Plans

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

vii. Use of Direct Cash Payments

- a) The State elects to disburse cash prospectively to CFCO participants. The State assures that all Internal Revenue Service (IRS) requirements regarding payroll/tax filing functions will be followed, including when participants perform the payroll/tax filing functions themselves.
- b) The State elects not to disburse cash prospectively to CFCO participants.

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

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

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

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

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

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

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

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x. HCBS Settings

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

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

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

xi. Qualifications of Providers of CFCO Services

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

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

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

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

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

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

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

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

18 years or older and ability to:

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

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

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

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

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

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

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1. Consumer Satisfaction Survey

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

2 [UAS-NY utilization] Assessment Tools

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

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

New York
6(a)(vi)

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

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

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6(a)(vii)**

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

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

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

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

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

TN #20-0002

Approval Date _____

Supersedes TN #13-0035

Effective Date April 2, 2020

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

4. Permissible services/Substitute for human assistance

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

TN #20-0002

Approval Date _____

Supersedes TN #13-0035Effective Date April 2, 2020

- 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 foat 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.

SUMMARY
SPA #20-0020

This State Plan Amendment proposes to remove course of treatment and annual limitations on partial hospitalization services. All Medicaid recipients receiving partial hospitalization services can receive these services based on medical necessity and without such limitations, effective April 1, 2020.

DRAFT

pursuant to section 6056.4(c)(4) or 6056.4(c)(5) of this Title, may apply to the commissioner for leave to substitute satisfactory completion of a course of basic training completed in such other jurisdiction or may apply to the commissioner for leave to substitute satisfactory completion of the pre-employment police basic training program in satisfaction of all or part of the requirements of an approved basic course for peace officers imposed under section 2.30 of the Criminal Procedure Law. The commissioner shall review and evaluate all such applications and may require the applicant to submit such additional documentation as he or she shall deem necessary. If, upon review and evaluation of such application, the commissioner determines that a program of peace officer basic training completed by the applicant in another jurisdiction or the pre-employment police basic training program completed by the application meets or exceeds all or part of the minimum standards prescribed in section 6025.3 of this Part, the commissioner may authorize such training to be substituted for such requirements of the basic course as he or she shall deem appropriate. The commissioner shall certify, in writing, the extent to which all or part of the curriculum of the basic course may be waived and any noted deficiencies must be satisfactorily completed at a basic course approved by the commissioner, within the period of time prescribed in section 6025.7 of this Part. Applicants for equivalency certificates shall be subject to the same limitations and requirements as prescribed in sections 6025.6 and 6025.7 of this Part and section 2.30 of the Criminal Procedure Law.

PUBLIC NOTICE

Division of Criminal Justice Services

I, Andrew M. Cuomo, Governor of the State of New York, do hereby adopt and promulgate the following regulations that have been recommended by the Municipal Police Training Council pursuant to the provisions of section eight hundred forty of the Executive Law. This action is taken pursuant to the authority vested in me by section eight hundred forty-two of such law and, as such, it is exempted from the rule making provisions of the State Administrative Procedure Act.

NOW, THEREFORE, be it known that the amendments to Part 6024 of Title 9 of the New York State Official Compilation of Codes, Rules and Regulations are hereby adopted and promulgated and shall be effective upon publication in the State Register.

1. Subdivision (d) of Section 6024.1 of Title 9 of NYCRR is renumbered to be subdivision (e). A new subdivision (d) is added to section 6024.1 to read as follows:

(d) The term federal law enforcement officer shall have the same meaning as set forth in section 2.15 of the Criminal Procedure Law.

2. Subdivisions (b) and (c) of Section 6024.2 of Title 9 of NYCRR are amended to read as follows:

(b) Have a minimum of three years of police [or], peace officer or federal law enforcement officer experience. The peace officer and federal law enforcement officer experience requirement can only be satisfied by those persons who have carried a firearm in the course of their official duties and have done so for the prescribed period of time.

(c) Successfully complete a Municipal Police Training Council approved basic course for police officers or basic course for peace officers, as appropriate [.] or a requisite basic training course prescribed by a federal law enforcement officer employer.

3. Section 6024.4 of Title 9 of NYCRR is amended to read as follows:

Firearms instructor certification shall be valid from the date of issuance and shall remain valid during the holder's continuous service as a police officer [or], peace officer, or federal law enforcement officer, or while the holder is employed by a sponsoring police officer or peace officer agency, unless revoked by the commissioner.

PUBLIC NOTICE

Division of Criminal Justice Services

I, Andrew M. Cuomo, Governor of the State of New York, do hereby adopt and promulgate the following regulations that have been recommended by the Law Enforcement Agency Accreditation Council pur-

suant to Executive Law § 846-h(1)(c). This action is taken pursuant to the authority vested in me by such law, and, as such, it is exempted from the rule making provisions of the State Administrative Procedure Act.

NOW, THEREFORE, be it known that the amendment to section 6035.1(a) of Title 9 of the New York State Official Compilation of Codes, Rules and Regulations is hereby adopted and promulgated, and shall be effective upon publication in the State Register.

Subdivision (a) of section 6035.1 of Title 9 NYCRR is amended to read as follows:

(a) The term law enforcement agency shall mean any law enforcement agency or department of any municipality, any police district, or any agency, department, commission, authority or public benefit corporation of the state of New York employing a police officer or police officers as that term is defined in paragraphs (a), (b), (c), (d), (e), (f), (j), (k), (l), (o), (p) [and], (s), and (u) of subdivision thirty-four of section 1.20 of the Criminal Procedure Law. For the purposes of this definition, the term shall not include any entity that employs police officers in a capacity which may require the use of their law enforcement authority but is supplementary to the primary official responsibilities for which they have been hired.

PUBLIC NOTICE

Office of General Services

Pursuant to Section 33 of the Public Lands Law, the Office of General Services hereby gives notice to the following:

Notice is hereby given that the New York State Department of Transportation has determined that:

Address: 3628 NYS Route 281, Town of Cortlandville, Cortland County, N:V 13045 DOT Map 118-D, Parcel 119

a.23 acre+ lot, is surplus and no longer useful or necessary for state program purposes and has abandoned the property to the Commissioner of General Services for sale or other disposition as Unappropriated State land.

For further information, please contact: Thomas Pohl, Esq., Office of General Services, Legal Services, 41st Fl., Coming Tower, Empire State Plaza, Albany, NY 12242, (518) 474-8831, (518) 473-4973 fax

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 institutional, non-institutional and long-term care services to comply with enacted statutory provisions. The following changes are proposed:

Non-Institutional Services

Effective for days of service on or after April 1, 2020, The Department of Health will eliminate the limitations on amount and duration of partial hospitalization services. The State Plan Amendment is necessary to comply with the Mental Health Parity and Addiction Equity Act of 2008.

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

Effective on or after April 1, 2020, continues the supplemental upper payment limit payments made to general hospitals, other than major public general hospitals under non-institutional services of \$339 million annually.

For state fiscal year beginning April 1, 2020 through March 31, 2021, continues hospital outpatient payment adjustments that increase the operating cost components of rates of payment for hospital outpatient and emergency departments on and after April 1, 2011, for public general hospitals other than those operated by the State of New York or the State University of New York, which are located in a city with a population of over one million. The amount to be paid will be up to \$287 million annually based on criteria and methodology set by the Commissioner of Health, which the Commissioner may periodi-

SUMMARY
SPA #20-0022

This State Plan Amendment proposes to extend supplemental payments made for inpatient hospital services in non-state public hospitals in cities with more than one million persons. These payments reflect adjustments to qualifying hospitals.

DRAFT

New York
161

Additional Inpatient Governmental Hospital Payments

For the period beginning state fiscal year April 1, [2019] 2020 and ending March 31, [2020] 2021, the State will provide a supplemental payment for all inpatient services provided by eligible government general hospitals located 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. The amount of the supplemental payment will be \$362,512,355 and paid semi-annually in September and March. It will be distributed to hospitals proportionately using each hospital's proportionate share of total Medicaid days reported for the base year two years prior to the rate year. Such payments, aggregated with other medical assistance payments will not exceed 100% of a reasonable estimate of the amount that would be paid for such services under Medicare payment principles for non-state government owned or operated government general hospitals for the respective period.

DRAFT

TN #20-0022

Approval Date _____

Supersedes TN #19-0024

Effective Date April 1, 2020

cally set through a memorandum of understanding with the New York City Health and Hospitals Corporation. Such adjustments shall be paid by means of one or more estimated payments. Payments may be added to rates of payment or made as aggregate payments.

For state fiscal year beginning April 1, 2020 through March 31, 2021, continues upon the election of the social services district in which an eligible diagnostic and treatment center (DTC) is physically located, up to \$12.6 million in additional annual Medicaid payments may be paid to public DTCs operated by the New York City Health and Hospitals Corporation. Such payments will be based on each DTC's proportionate share of the sum of all clinic visits for all facilities eligible for an adjustment for the base year two years prior to the rate year. The proportionate share payments may be added to rates of payment or made as aggregate payments to eligible DTCs.

For state fiscal year beginning April 1, 2020 through March 31, 2021, continues up to \$5.4 million in additional annual Medicaid payments may be paid to county operated free-standing clinics, not including facilities operated by the New York City Health and Hospitals Corporation, for services provided by such DTC and those provided by a county operated freestanding mental health or substance abuse DTC. Distributions shall be based on each eligible facility's proportionate share of the sum of all DTC and clinic visits for all eligible facilities receiving payments for the base year two years prior to the rate year. The proportionate share payments may be added to rates of payment or made as aggregate payments to eligible facilities.

Institutional Services

Effective on or after April 1, 2020, the temporary rate adjustment has been reviewed and approved for the St. Joseph's Hospital Health Center with aggregate payment amounts totaling up to \$4,000,000 for the period April 1, 2020 through March 31, 2021.

Effective on or after April 1, 2020, continues the supplemental upper payment limit payments made to general hospitals, other than major public general hospitals under institutional services of \$339 million annually.

For state fiscal year beginning April 1, 2020 through March 31, 2021, continues adjustments for hospital inpatient services provided on and after April 1, 2012, to public general hospitals, other than those operated by the State of New York or the State University of New York, located in a city with a population of over one million and receiving reimbursement of up to \$1.08 billion annually based on criteria and methodology set by the Commissioner of Health, which the Commissioner may periodically set through a memorandum of understanding with the New York City Health and Hospitals Corporation. Such adjustments shall be paid by means of one or more estimated payments. Payments to eligible public general hospitals may be added to rates of payment or made as aggregate payments.

For state fiscal year beginning April 1, 2020 through March 31, 2021, supplemental payments will be made to State government owned hospitals. These payments will not exceed the upper payment limit for inpatient services provided by state government-owned hospitals when aggregated with other Medicaid payments.

Effective on or after April 1, 2020, the temporary rate adjustment has been reviewed and approved for Long Island Jewish Medical Center with aggregate payment amounts totaling up to \$1,000,000 for the period April 1, 2020 through March 31, 2021.

Long Term Care Services

Effective on or after April 1, 2020, continues additional payments to non-state government operated public residential health care facilities, including public residential health care facilities located in Nassau, Westchester, and Erie Counties, but excluding public residential health care facilities operated by a town or city within a county, in aggregate amounts of up to \$500 million. The amount allocated to each eligible public RHCF will be in accordance with the previously approved methodology, provided, however that patient days shall be utilized for such computation reflecting actual reported data for 2018 and each representative succeeding year as applicable. Payments to eligible RHCF's may be added to rates of payment or made as aggregate payments.

Effective on or after April 1, 2020, the Department of Health

proposes to amend the Title XIX (Medicaid) State Plan for institutional services related to temporary rate adjustments to long term care providers that are undergoing closure, merger, consolidation, acquisition or restructuring themselves or other health care providers. These payments are authorized by current State statutory and regulatory provisions. The temporary rate adjustments will be reviewed and approved by the CINERGY Collaborative.

The estimated net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2020-2021 is \$30 million.

Effective on or after April 1, 2020, the Department of Health (DOH) will continue the nursing home advanced training program, aimed at teaching staff how to detect early changes in a resident's physical and mental or functional status that could lead to hospitalization. Clinical findings show early detection of patient decline by front line workers, coupled with clinical care models aimed at fostering consistent and continuous care between care givers and patients/families result in better care outcomes. Similarly, nursing homes with higher staff retention rates correlate with better care outcomes and avoided hospital stays. This training program will be developed in cooperation between Nursing Home providers and union representatives offering training opportunities for staff or other qualifying training programs.

These programs and their curricula will be submitted to DOH for review. In addition to offering a training program, eligible facilities must have direct care staff retention rates above the state median. However, hospital-based nursing homes and free standing nursing homes already receiving VAP payments would not be eligible to participate.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2020/2021 is \$46 million.

The public is invited to review and comment on this proposed State Plan Amendment, a copy of which will be available for public review on the Department's website at http://www.health.ny.gov/regulations/state_plans/status. In addition, approved SPA's beginning in 2011 are also available for viewing on this website.

Copies of the proposed State Plan Amendments will be on file in each local (county) social services district and available for public review.

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

SUMMARY
SPA #20-0023

This State Plan Amendment proposes to extend supplemental upper payment limit distributions for inpatient hospital services to voluntary sector hospitals excluding government general hospitals, not to exceed in aggregate \$339M annually in combination with the outpatient voluntary hospital UPL SPA.

DRAFT

**New York
161(1)**

Voluntary Supplemental Inpatient Payments

Effective for the period July 1, 2010 through March 31, 2011, additional inpatient hospital payments are authorized to voluntary sector hospitals, excluding government general hospitals, for inpatient hospital services after all other medical assistance payments, of \$235,500,000 for the period July 1, 2010 through March 31, 2011; \$314,000,000 for the period April 1, 2011 through March 31, 2012; \$281,778,852 for the period April 1, 2012 through March 31, 2013; \$298,860,732 for the period April 1, 2013 through March 31, 2014; and \$226,443,721 for the period April 1, 2014 through March 31, 2015; and \$264,916,150 for the period April 1, 2015 through March 31, 2016; and \$271,204,805 for the period of April 1, 2016 through March 31, 2017; and \$319,459,509 for the period of April 1, 2017 through March 31, 2018; and \$362,865,600 for the period of April 1, 2018 through March 31, 2019; and \$182,541,796 for the period of April 1, 2019 through March 31, 2020; and \$182,541,796 for the period of April 1, 2020 through March 31, 2021 subject to the requirements of 42 CFR 447.272 (upper payment limit) . Such payments are paid monthly to eligible voluntary sector owned or operated general hospitals, excluding government general hospitals.

Eligibility to receive such additional payments, and the allocation amount paid to each hospital, will be based on data from the period two years prior to the rate year, as reported on the Institutional Cost Report (ICR) submitted to the Department as of October 1 of the prior rate year.

- (a) Thirty percent of such payments will be allocated to safety net hospitals based on each eligible hospital's proportionate share of all eligible safety net hospitals' Medicaid discharges for inpatient hospital services, including both Medicaid fee-for-service and managed care discharges for acute and exempt services;
- (i) Safety net hospitals are defined as non-government owned or operated hospitals which provide emergency room services having either: a Medicaid share of total inpatient hospital discharges of at least 35%, including both fee-for-service and managed care discharges for acute and exempt services; or a Medicaid share of total discharges of at least 30%, including both fee-for-service and managed care discharges for acute and exempt services, and also providing obstetrical services.
- (b) Seventy percent of such payments will be allocated to eligible general hospitals, which provide emergency room services, based on each such hospital's proportionate share of all eligible hospitals' Medicaid discharges for inpatient hospital services, including both Medicaid fee-for-service and managed care discharges for acute and exempt services;
- (c) No payment will be made to a hospital described in (i) and (ii). Payment amounts will be reduced as necessary not to exceed the limitations described in (iii).
- (i) did not receive an Indigent Care Pool (ICP) payment;
- (ii) the hospital's facility specific projected disproportionate share hospital payment ceiling is zero; or,
- (iii) the annual payments amount to eligible hospitals exceeds the Medicaid customary charge limit at 42 CFR 447.271.
- (d) Any amounts calculated under paragraphs (a) and (b) but not paid to a hospital because of the requirements in paragraph (c) will be allocated proportionately to those eligible general hospitals that provide emergency room services and which would not be precluded by paragraph (c) from receiving such additional allocations.

TN #20-0023 _____

Supersedes TN #19-0023 _____

Approval Date _____

Effective Date April 1, 2020

cally set through a memorandum of understanding with the New York City Health and Hospitals Corporation. Such adjustments shall be paid by means of one or more estimated payments. Payments may be added to rates of payment or made as aggregate payments.

For state fiscal year beginning April 1, 2020 through March 31, 2021, continues upon the election of the social services district in which an eligible diagnostic and treatment center (DTC) is physically located, up to \$12.6 million in additional annual Medicaid payments may be paid to public DTCs operated by the New York City Health and Hospitals Corporation. Such payments will be based on each DTC's proportionate share of the sum of all clinic visits for all facilities eligible for an adjustment for the base year two years prior to the rate year. The proportionate share payments may be added to rates of payment or made as aggregate payments to eligible DTCs.

For state fiscal year beginning April 1, 2020 through March 31, 2021, continues up to \$5.4 million in additional annual Medicaid payments may be paid to county operated free-standing clinics, not including facilities operated by the New York City Health and Hospitals Corporation, for services provided by such DTC and those provided by a county operated freestanding mental health or substance abuse DTC. Distributions shall be based on each eligible facility's proportionate share of the sum of all DTC and clinic visits for all eligible facilities receiving payments for the base year two years prior to the rate year. The proportionate share payments may be added to rates of payment or made as aggregate payments to eligible facilities.

Institutional Services

Effective on or after April 1, 2020, the temporary rate adjustment has been reviewed and approved for the St. Joseph's Hospital Health Center with aggregate payment amounts totaling up to \$4,000,000 for the period April 1, 2020 through March 31, 2021.

Effective on or after April 1, 2020, continues the supplemental upper payment limit payments made to general hospitals, other than major public general hospitals under institutional services of \$339 million annually.

For state fiscal year beginning April 1, 2020 through March 31, 2021, continues adjustments for hospital inpatient services provided on and after April 1, 2012, to public general hospitals, other than those operated by the State of New York or the State University of New York, located in a city with a population of over one million and receiving reimbursement of up to \$1.08 billion annually based on criteria and methodology set by the Commissioner of Health, which the Commissioner may periodically set through a memorandum of understanding with the New York City Health and Hospitals Corporation. Such adjustments shall be paid by means of one or more estimated payments. Payments to eligible public general hospitals may be added to rates of payment or made as aggregate payments.

For state fiscal year beginning April 1, 2020 through March 31, 2021, supplemental payments will be made to State government owned hospitals. These payments will not exceed the upper payment limit for inpatient services provided by state government-owned hospitals when aggregated with other Medicaid payments.

Effective on or after April 1, 2020, the temporary rate adjustment has been reviewed and approved for Long Island Jewish Medical Center with aggregate payment amounts totaling up to \$1,000,000 for the period April 1, 2020 through March 31, 2021.

Long Term Care Services

Effective on or after April 1, 2020, continues additional payments to non-state government operated public residential health care facilities, including public residential health care facilities located in Nassau, Westchester, and Erie Counties, but excluding public residential health care facilities operated by a town or city within a county, in aggregate amounts of up to \$500 million. The amount allocated to each eligible public RHCF will be in accordance with the previously approved methodology, provided, however that patient days shall be utilized for such computation reflecting actual reported data for 2018 and each representative succeeding year as applicable. Payments to eligible RHCF's may be added to rates of payment or made as aggregate payments.

Effective on or after April 1, 2020, the Department of Health

proposes to amend the Title XIX (Medicaid) State Plan for institutional services related to temporary rate adjustments to long term care providers that are undergoing closure, merger, consolidation, acquisition or restructuring themselves or other health care providers. These payments are authorized by current State statutory and regulatory provisions. The temporary rate adjustments will be reviewed and approved by the CINERGY Collaborative.

The estimated net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2020-2021 is \$30 million.

Effective on or after April 1, 2020, the Department of Health (DOH) will continue the nursing home advanced training program, aimed at teaching staff how to detect early changes in a resident's physical and mental or functional status that could lead to hospitalization. Clinical findings show early detection of patient decline by front line workers, coupled with clinical care models aimed at fostering consistent and continuous care between care givers and patients/families result in better care outcomes. Similarly, nursing homes with higher staff retention rates correlate with better care outcomes and avoided hospital stays. This training program will be developed in cooperation between Nursing Home providers and union representatives offering training opportunities for staff or other qualifying training programs.

These programs and their curricula will be submitted to DOH for review. In addition to offering a training program, eligible facilities must have direct care staff retention rates above the state median. However, hospital-based nursing homes and free standing nursing homes already receiving VAP payments would not be eligible to participate.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2020/2021 is \$46 million.

The public is invited to review and comment on this proposed State Plan Amendment, a copy of which will be available for public review on the Department's website at http://www.health.ny.gov/regulations/state_plans/status. In addition, approved SPA's beginning in 2011 are also available for viewing on this website.

Copies of the proposed State Plan Amendments will be on file in each local (county) social services district and available for public review.

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

SUMMARY
SPA #20-0024

This State Plan Amendment proposes to extend supplemental payments made for outpatient hospital services to non-state public hospitals in cities with more than one million persons. These payments reflect specialty adjustments to qualifying hospitals.

DRAFT

New York
2(c)(v.1)

Hospital Outpatient Supplemental Payment Adjustment – Public General Hospitals

The State will provide a supplemental payment for hospital outpatient and emergency room services provided by eligible public general hospitals. To be eligible, the hospital must (1) be a public general hospital, (2) not be operated by the State of New York or the State University of New York, and (3) be located in a city with a population over one million.

For state fiscal year beginning April 1, 2011 and ending March 31, 2012, the amount of the supplemental payment will be \$98,610,666. For state fiscal year beginning April 1, 2012 and ending March 31, 2013, the amount of the supplemental payment will be \$107,953,672. For state fiscal year beginning April 1, 2013 and ending March 31, 2014, the amount of the supplemental payment will be \$22,101,480. For state fiscal year beginning April 1, 2014 and ending March 31, 2015, the amount of the supplemental payment will be \$26,898,232. For state fiscal year beginning April 1, 2015 and ending March 31, 2016, the amount of the supplemental payment will be \$161,521,405. For state fiscal year beginning April 1, 2016 and ending March 31, 2017, the amount of the supplemental payment will be \$ 112,980,827. For state fiscal year beginning April 1, 2017 and ending March 31, 2018, the amount of the supplemental payment will be \$111,305,328. For state fiscal year beginning April 1, 2018 and ending March 31, 2019, the amount of the supplemental payment will be \$105,303,666. For state fiscal year beginning April 1, 2019 and ending March 31, 2020, the amount of the supplemental payment will be \$106,131,529. For state fiscal year beginning April 1, 2020 and ending March 31, 2021, the amount of the supplemental payment will be \$106,131,529. Medical assistance payments will be made for outpatient services for patients eligible for federal financial participation under Title XIX of the Federal Social Security Act based on each such hospital's proportionate share of the sum of all Medicaid outpatient visits for all facilities eligible for an adjustment for the base year two years prior to the rate year. Such supplemental payments under this section will be made in a single lump-sum payment.

TN #20-0024

Approval Date _____

Supersedes TN #19-0021

Effective Date April 1, 2020

pursuant to section 6056.4(c)(4) or 6056.4(c)(5) of this Title, may apply to the commissioner for leave to substitute satisfactory completion of a course of basic training completed in such other jurisdiction or may apply to the commissioner for leave to substitute satisfactory completion of the pre-employment police basic training program in satisfaction of all or part of the requirements of an approved basic course for peace officers imposed under section 2.30 of the Criminal Procedure Law. The commissioner shall review and evaluate all such applications and may require the applicant to submit such additional documentation as he or she shall deem necessary. If, upon review and evaluation of such application, the commissioner determines that a program of peace officer basic training completed by the applicant in another jurisdiction or the pre-employment police basic training program completed by the application meets or exceeds all or part of the minimum standards prescribed in section 6025.3 of this Part, the commissioner may authorize such training to be substituted for such requirements of the basic course as he or she shall deem appropriate. The commissioner shall certify, in writing, the extent to which all or part of the curriculum of the basic course may be waived and any noted deficiencies must be satisfactorily completed at a basic course approved by the commissioner, within the period of time prescribed in section 6025.7 of this Part. Applicants for equivalency certificates shall be subject to the same limitations and requirements as prescribed in sections 6025.6 and 6025.7 of this Part and section 2.30 of the Criminal Procedure Law.

PUBLIC NOTICE

Division of Criminal Justice Services

I, Andrew M. Cuomo, Governor of the State of New York, do hereby adopt and promulgate the following regulations that have been recommended by the Municipal Police Training Council pursuant to the provisions of section eight hundred forty of the Executive Law. This action is taken pursuant to the authority vested in me by section eight hundred forty-two of such law and, as such, it is exempted from the rule making provisions of the State Administrative Procedure Act.

NOW, THEREFORE, be it known that the amendments to Part 6024 of Title 9 of the New York State Official Compilation of Codes, Rules and Regulations are hereby adopted and promulgated and shall be effective upon publication in the State Register.

1. Subdivision (d) of Section 6024.1 of Title 9 of NYCRR is renumbered to be subdivision (e). A new subdivision (d) is added to section 6024.1 to read as follows:

(d) The term federal law enforcement officer shall have the same meaning as set forth in section 2.15 of the Criminal Procedure Law.

2. Subdivisions (b) and (c) of Section 6024.2 of Title 9 of NYCRR are amended to read as follows:

(b) Have a minimum of three years of police [or], peace officer or federal law enforcement officer experience. The peace officer and federal law enforcement officer experience requirement can only be satisfied by those persons who have carried a firearm in the course of their official duties and have done so for the prescribed period of time.

(c) Successfully complete a Municipal Police Training Council approved basic course for police officers or basic course for peace officers, as appropriate [.] or a requisite basic training course prescribed by a federal law enforcement officer employer.

3. Section 6024.4 of Title 9 of NYCRR is amended to read as follows:

Firearms instructor certification shall be valid from the date of issuance and shall remain valid during the holder's continuous service as a police officer [or], peace officer, or federal law enforcement officer, or while the holder is employed by a sponsoring police officer or peace officer agency, unless revoked by the commissioner.

PUBLIC NOTICE

Division of Criminal Justice Services

I, Andrew M. Cuomo, Governor of the State of New York, do hereby adopt and promulgate the following regulations that have been recommended by the Law Enforcement Agency Accreditation Council pur-

suant to Executive Law § 846-h(1)(c). This action is taken pursuant to the authority vested in me by such law, and, as such, it is exempted from the rule making provisions of the State Administrative Procedure Act.

NOW, THEREFORE, be it known that the amendment to section 6035.1(a) of Title 9 of the New York State Official Compilation of Codes, Rules and Regulations is hereby adopted and promulgated, and shall be effective upon publication in the State Register.

Subdivision (a) of section 6035.1 of Title 9 NYCRR is amended to read as follows:

(a) The term law enforcement agency shall mean any law enforcement agency or department of any municipality, any police district, or any agency, department, commission, authority or public benefit corporation of the state of New York employing a police officer or police officers as that term is defined in paragraphs (a), (b), (c), (d), (e), (f), (j), (k), (l), (o), (p) [and], (s), and (u) of subdivision thirty-four of section 1.20 of the Criminal Procedure Law. For the purposes of this definition, the term shall not include any entity that employs police officers in a capacity which may require the use of their law enforcement authority but is supplementary to the primary official responsibilities for which they have been hired.

PUBLIC NOTICE

Office of General Services

Pursuant to Section 33 of the Public Lands Law, the Office of General Services hereby gives notice to the following:

Notice is hereby given that the New York State Department of Transportation has determined that:

Address: 3628 NYS Route 281, Town of Cortlandville, Cortland County, N:V 13045 DOT Map 118-D, Parcel 119

a.23 acre+ lot, is surplus and no longer useful or necessary for state program purposes and has abandoned the property to the Commissioner of General Services for sale or other disposition as Unappropriated State land.

For further information, please contact: Thomas Pohl, Esq., Office of General Services, Legal Services, 41st Fl., Coming Tower, Empire State Plaza, Albany, NY 12242, (518) 474-8831, (518) 473-4973 fax

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 institutional, non-institutional and long-term care services to comply with enacted statutory provisions. The following changes are proposed:

Non-Institutional Services

Effective for days of service on or after April 1, 2020, The Department of Health will eliminate the limitations on amount and duration of partial hospitalization services. The State Plan Amendment is necessary to comply with the Mental Health Parity and Addiction Equity Act of 2008.

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

Effective on or after April 1, 2020, continues the supplemental upper payment limit payments made to general hospitals, other than major public general hospitals under non-institutional services of \$339 million annually.

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For state fiscal year beginning April 1, 2020 through March 31, 2021, continues up to \$5.4 million in additional annual Medicaid payments may be paid to county operated free-standing clinics, not including facilities operated by the New York City Health and Hospitals Corporation, for services provided by such DTC and those provided by a county operated freestanding mental health or substance abuse DTC. Distributions shall be based on each eligible facility's proportionate share of the sum of all DTC and clinic visits for all eligible facilities receiving payments for the base year two years prior to the rate year. The proportionate share payments may be added to rates of payment or made as aggregate payments to eligible facilities.

Institutional Services

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For state fiscal year beginning April 1, 2020 through March 31, 2021, supplemental payments will be made to State government owned hospitals. These payments will not exceed the upper payment limit for inpatient services provided by state government-owned hospitals when aggregated with other Medicaid payments.

Effective on or after April 1, 2020, the temporary rate adjustment has been reviewed and approved for Long Island Jewish Medical Center with aggregate payment amounts totaling up to \$1,000,000 for the period April 1, 2020 through March 31, 2021.

Long Term Care Services

Effective on or after April 1, 2020, continues additional payments to non-state government operated public residential health care facilities, including public residential health care facilities located in Nassau, Westchester, and Erie Counties, but excluding public residential health care facilities operated by a town or city within a county, in aggregate amounts of up to \$500 million. The amount allocated to each eligible public RHCF will be in accordance with the previously approved methodology, provided, however that patient days shall be utilized for such computation reflecting actual reported data for 2018 and each representative succeeding year as applicable. Payments to eligible RHCF's may be added to rates of payment or made as aggregate payments.

Effective on or after April 1, 2020, the Department of Health

proposes to amend the Title XIX (Medicaid) State Plan for institutional services related to temporary rate adjustments to long term care providers that are undergoing closure, merger, consolidation, acquisition or restructuring themselves or other health care providers. These payments are authorized by current State statutory and regulatory provisions. The temporary rate adjustments will be reviewed and approved by the CINERGY Collaborative.

The estimated net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2020-2021 is \$30 million.

Effective on or after April 1, 2020, the Department of Health (DOH) will continue the nursing home advanced training program, aimed at teaching staff how to detect early changes in a resident's physical and mental or functional status that could lead to hospitalization. Clinical findings show early detection of patient decline by front line workers, coupled with clinical care models aimed at fostering consistent and continuous care between care givers and patients/families result in better care outcomes. Similarly, nursing homes with higher staff retention rates correlate with better care outcomes and avoided hospital stays. This training program will be developed in cooperation between Nursing Home providers and union representatives offering training opportunities for staff or other qualifying training programs.

These programs and their curricula will be submitted to DOH for review. In addition to offering a training program, eligible facilities must have direct care staff retention rates above the state median. However, hospital-based nursing homes and free standing nursing homes already receiving VAP payments would not be eligible to participate.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2020/2021 is \$46 million.

The public is invited to review and comment on this proposed State Plan Amendment, a copy of which will be available for public review on the Department's website at http://www.health.ny.gov/regulations/state_plans/status. In addition, approved SPA's beginning in 2011 are also available for viewing on this website.

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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

SUMMARY
SPA #20-0025

This State Plan Amendment proposes to extend supplemental upper payment limit distributions for outpatient hospital services to voluntary sector hospitals, excluding government general hospitals, not to exceed in aggregate \$339 million annually in combination with the inpatient voluntary hospital Upper Payment Limit SPA.

DRAFT

**New York
2(c)(v.2)**

Hospital Outpatient Supplemental Payments – Non-government Owned or Operated General Hospitals

Effective for the period April 1, [2019] 2020 through March 31, [2020] 2021, supplemental payments are authorized for certain general hospitals for outpatient services furnished in the [2019] 2020 calendar year. Payments under this provision will not exceed \$88,314,963.

To receive payment under this provision, a general hospital, as defined in Attachment 4.19-A of the state plan, must meet all of the following:

- (i) must be non-government owned or operated;
- (ii) must operate an emergency room; and
- (iii) must have received an Indigent Care Pool payment for the [2019] 2020 rate year; and/or must have a facility specific projected disproportionate share hospital payment ceiling for the [2019] 2020 rate year that is greater than zero.

The amount paid to each eligible hospital will be determined based on an allocation methodology utilizing data reported in eligible hospitals' most recent Institutional Cost Report submitted to the New York State Department of Health as of October 1, [2018] 2019:

- (a) Thirty percent of the payments under this provision will be allocated to eligible general hospitals classified as a safety net hospital, based on each hospital's proportionate share of all safety net hospitals' Medicaid discharges for inpatient hospital services, including both Medicaid fee-for-service and managed care discharges for acute and exempt services.

For this purpose, a safety net hospital is defined as an eligible general hospital having either: a Medicaid share of total inpatient hospital discharges of at least 35%, including both fee-for-service and managed care discharges for acute and exempt services; or a Medicaid share of total discharges of at least 30%, including both fee-for-service and managed care discharges for acute and exempt services, and also providing obstetrical services.

- (b) Seventy percent of the payments under this provision will be allocated to eligible general hospitals based on each hospital's proportionate share of all eligible hospitals' Medicaid discharges for inpatient hospital services, including both Medicaid fee-for-service and managed care discharges for acute and exempt services.

[Eligible Hospitals will receive payment under (a) and/or (b), as eligible, with each hospital's payment made in a lump sum distribution that is proportionately allocable across the hospital's share of the \$327,847,406 in in outpatient services reimbursed all eligible hospitals in the 2019 calendar year.]

TN #20-0025

Supersedes TN # 19-0020

Approval Date _____

Effective Date April 1, 2020

pursuant to section 6056.4(c)(4) or 6056.4(c)(5) of this Title, may apply to the commissioner for leave to substitute satisfactory completion of a course of basic training completed in such other jurisdiction or may apply to the commissioner for leave to substitute satisfactory completion of the pre-employment police basic training program in satisfaction of all or part of the requirements of an approved basic course for peace officers imposed under section 2.30 of the Criminal Procedure Law. The commissioner shall review and evaluate all such applications and may require the applicant to submit such additional documentation as he or she shall deem necessary. If, upon review and evaluation of such application, the commissioner determines that a program of peace officer basic training completed by the applicant in another jurisdiction or the pre-employment police basic training program completed by the application meets or exceeds all or part of the minimum standards prescribed in section 6025.3 of this Part, the commissioner may authorize such training to be substituted for such requirements of the basic course as he or she shall deem appropriate. The commissioner shall certify, in writing, the extent to which all or part of the curriculum of the basic course may be waived and any noted deficiencies must be satisfactorily completed at a basic course approved by the commissioner, within the period of time prescribed in section 6025.7 of this Part. Applicants for equivalency certificates shall be subject to the same limitations and requirements as prescribed in sections 6025.6 and 6025.7 of this Part and section 2.30 of the Criminal Procedure Law.

PUBLIC NOTICE

Division of Criminal Justice Services

I, Andrew M. Cuomo, Governor of the State of New York, do hereby adopt and promulgate the following regulations that have been recommended by the Municipal Police Training Council pursuant to the provisions of section eight hundred forty of the Executive Law. This action is taken pursuant to the authority vested in me by section eight hundred forty-two of such law and, as such, it is exempted from the rule making provisions of the State Administrative Procedure Act.

NOW, THEREFORE, be it known that the amendments to Part 6024 of Title 9 of the New York State Official Compilation of Codes, Rules and Regulations are hereby adopted and promulgated and shall be effective upon publication in the State Register.

1. Subdivision (d) of Section 6024.1 of Title 9 of NYCRR is renumbered to be subdivision (e). A new subdivision (d) is added to section 6024.1 to read as follows:

(d) The term federal law enforcement officer shall have the same meaning as set forth in section 2.15 of the Criminal Procedure Law.

2. Subdivisions (b) and (c) of Section 6024.2 of Title 9 of NYCRR are amended to read as follows:

(b) Have a minimum of three years of police [or], peace officer or federal law enforcement officer experience. The peace officer and federal law enforcement officer experience requirement can only be satisfied by those persons who have carried a firearm in the course of their official duties and have done so for the prescribed period of time.

(c) Successfully complete a Municipal Police Training Council approved basic course for police officers or basic course for peace officers, as appropriate [.] or a requisite basic training course prescribed by a federal law enforcement officer employer.

3. Section 6024.4 of Title 9 of NYCRR is amended to read as follows:

Firearms instructor certification shall be valid from the date of issuance and shall remain valid during the holder's continuous service as a police officer [or], peace officer, or federal law enforcement officer, or while the holder is employed by a sponsoring police officer or peace officer agency, unless revoked by the commissioner.

PUBLIC NOTICE

Division of Criminal Justice Services

I, Andrew M. Cuomo, Governor of the State of New York, do hereby adopt and promulgate the following regulations that have been recommended by the Law Enforcement Agency Accreditation Council pur-

suant to Executive Law § 846-h(1)(c). This action is taken pursuant to the authority vested in me by such law, and, as such, it is exempted from the rule making provisions of the State Administrative Procedure Act.

NOW, THEREFORE, be it known that the amendment to section 6035.1(a) of Title 9 of the New York State Official Compilation of Codes, Rules and Regulations is hereby adopted and promulgated, and shall be effective upon publication in the State Register.

Subdivision (a) of section 6035.1 of Title 9 NYCRR is amended to read as follows:

(a) The term law enforcement agency shall mean any law enforcement agency or department of any municipality, any police district, or any agency, department, commission, authority or public benefit corporation of the state of New York employing a police officer or police officers as that term is defined in paragraphs (a), (b), (c), (d), (e), (f), (j), (k), (l), (o), (p) [and], (s), and (u) of subdivision thirty-four of section 1.20 of the Criminal Procedure Law. For the purposes of this definition, the term shall not include any entity that employs police officers in a capacity which may require the use of their law enforcement authority but is supplementary to the primary official responsibilities for which they have been hired.

PUBLIC NOTICE

Office of General Services

Pursuant to Section 33 of the Public Lands Law, the Office of General Services hereby gives notice to the following:

Notice is hereby given that the New York State Department of Transportation has determined that:

Address: 3628 NYS Route 281, Town of Cortlandville, Cortland County, N:V 13045 DOT Map 118-D, Parcel 119

a.23 acre+ lot, is surplus and no longer useful or necessary for state program purposes and has abandoned the property to the Commissioner of General Services for sale or other disposition as Unappropriated State land.

For further information, please contact: Thomas Pohl, Esq., Office of General Services, Legal Services, 41st Fl., Coming Tower, Empire State Plaza, Albany, NY 12242, (518) 474-8831, (518) 473-4973 fax

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 institutional, non-institutional and long-term care services to comply with enacted statutory provisions. The following changes are proposed:

Non-Institutional Services

Effective for days of service on or after April 1, 2020, The Department of Health will eliminate the limitations on amount and duration of partial hospitalization services. The State Plan Amendment is necessary to comply with the Mental Health Parity and Addiction Equity Act of 2008.

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

Effective on or after April 1, 2020, continues the supplemental upper payment limit payments made to general hospitals, other than major public general hospitals under non-institutional services of \$339 million annually.

For state fiscal year beginning April 1, 2020 through March 31, 2021, continues hospital outpatient payment adjustments that increase the operating cost components of rates of payment for hospital outpatient and emergency departments on and after April 1, 2011, for public general hospitals other than those operated by the State of New York or the State University of New York, which are located in a city with a population of over one million. The amount to be paid will be up to \$287 million annually based on criteria and methodology set by the Commissioner of Health, which the Commissioner may periodi-

SUMMARY
SPA #20-0026

This State Plan Amendment proposes to authorize adjustments that increase the operating cost components of rates of payment for the diagnostic and treatment centers (DTC) of the New York City Health and Hospital Corporation and county operated freestanding clinics licensed under Article 31 and 32 of the NYS Mental Hygiene Law, for the period April 1, 2020 through March 31, 2021.

DRAFT

**New York
2(v)**

Upper Payment Limit (UPL) Payments for Diagnostic and Treatment Centers (DTCs)

1. New York City Health and Hospitals Corporation (HHC) operated DTCs

Effective for the period April 1, [2011] 2020 through March 31, [2012] 2021, the Department of Health will increase medical assistance rates of payment for diagnostic and treatment center (DTC) services provided by public DTCs operated by the New York City Health and Hospitals Corporation (HHC), at the annual election of the social services district in which an eligible DTC is physically located. The amount to be paid will be \$12.6 million on an annualized basis.

Medical assistance payments will be made for patients eligible for federal financial participation under Title XIX of the federal Social Security Act based on each diagnostic and treatment center's proportionate share of the sum of all clinic visits for all facilities eligible for an adjustment for the base year two years prior to the rate year. Such proportionate share payments may be added to rates of payment or made as aggregate payments to each eligible HHC diagnostic and treatment center.

2. County Operated DTCs and mental hygiene clinics

Effective for the period April 1, [2019] 2020 through March 31, [2020] 2021, the Department of Health will increase the medical assistance rates of payment for county operated DTCs and mental hygiene clinics, excluding those facilities operated by the New York City HHC. Local social services districts may, on an annual basis, decline such increased payments within thirty days following receipt of notification. The amount to be paid will be \$5.4 million on an annualized basis.

Medical assistance payments will be made for patients eligible for federal financial participation under Title XIX of the federal Social Security Act based on each diagnostic and treatment center's proportionate share of the sum of all clinic visits for all facilities eligible for an adjustment for the base year two years prior to the rate year. Such proportionate share payments may be added to rates of payment or made as aggregate payments to each eligible county operated diagnostic and treatment center and mental hygiene clinic.

TN #20-0026

Approval Date _____

Supersedes TN #19-0022

Effective Date April 1, 2020

cally set through a memorandum of understanding with the New York City Health and Hospitals Corporation. Such adjustments shall be paid by means of one or more estimated payments. Payments may be added to rates of payment or made as aggregate payments.

For state fiscal year beginning April 1, 2020 through March 31, 2021, continues upon the election of the social services district in which an eligible diagnostic and treatment center (DTC) is physically located, up to \$12.6 million in additional annual Medicaid payments may be paid to public DTCs operated by the New York City Health and Hospitals Corporation. Such payments will be based on each DTC's proportionate share of the sum of all clinic visits for all facilities eligible for an adjustment for the base year two years prior to the rate year. The proportionate share payments may be added to rates of payment or made as aggregate payments to eligible DTCs.

For state fiscal year beginning April 1, 2020 through March 31, 2021, continues up to \$5.4 million in additional annual Medicaid payments may be paid to county operated free-standing clinics, not including facilities operated by the New York City Health and Hospitals Corporation, for services provided by such DTC and those provided by a county operated freestanding mental health or substance abuse DTC. Distributions shall be based on each eligible facility's proportionate share of the sum of all DTC and clinic visits for all eligible facilities receiving payments for the base year two years prior to the rate year. The proportionate share payments may be added to rates of payment or made as aggregate payments to eligible facilities.

Institutional Services

Effective on or after April 1, 2020, the temporary rate adjustment has been reviewed and approved for the St. Joseph's Hospital Health Center with aggregate payment amounts totaling up to \$4,000,000 for the period April 1, 2020 through March 31, 2021.

Effective on or after April 1, 2020, continues the supplemental upper payment limit payments made to general hospitals, other than major public general hospitals under institutional services of \$339 million annually.

For state fiscal year beginning April 1, 2020 through March 31, 2021, continues adjustments for hospital inpatient services provided on and after April 1, 2012, to public general hospitals, other than those operated by the State of New York or the State University of New York, located in a city with a population of over one million and receiving reimbursement of up to \$1.08 billion annually based on criteria and methodology set by the Commissioner of Health, which the Commissioner may periodically set through a memorandum of understanding with the New York City Health and Hospitals Corporation. Such adjustments shall be paid by means of one or more estimated payments. Payments to eligible public general hospitals may be added to rates of payment or made as aggregate payments.

For state fiscal year beginning April 1, 2020 through March 31, 2021, supplemental payments will be made to State government owned hospitals. These payments will not exceed the upper payment limit for inpatient services provided by state government-owned hospitals when aggregated with other Medicaid payments.

Effective on or after April 1, 2020, the temporary rate adjustment has been reviewed and approved for Long Island Jewish Medical Center with aggregate payment amounts totaling up to \$1,000,000 for the period April 1, 2020 through March 31, 2021.

Long Term Care Services

Effective on or after April 1, 2020, continues additional payments to non-state government operated public residential health care facilities, including public residential health care facilities located in Nassau, Westchester, and Erie Counties, but excluding public residential health care facilities operated by a town or city within a county, in aggregate amounts of up to \$500 million. The amount allocated to each eligible public RHCF will be in accordance with the previously approved methodology, provided, however that patient days shall be utilized for such computation reflecting actual reported data for 2018 and each representative succeeding year as applicable. Payments to eligible RHCF's may be added to rates of payment or made as aggregate payments.

Effective on or after April 1, 2020, the Department of Health

proposes to amend the Title XIX (Medicaid) State Plan for institutional services related to temporary rate adjustments to long term care providers that are undergoing closure, merger, consolidation, acquisition or restructuring themselves or other health care providers. These payments are authorized by current State statutory and regulatory provisions. The temporary rate adjustments will be reviewed and approved by the CINERGY Collaborative.

The estimated net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2020-2021 is \$30 million.

Effective on or after April 1, 2020, the Department of Health (DOH) will continue the nursing home advanced training program, aimed at teaching staff how to detect early changes in a resident's physical and mental or functional status that could lead to hospitalization. Clinical findings show early detection of patient decline by front line workers, coupled with clinical care models aimed at fostering consistent and continuous care between care givers and patients/families result in better care outcomes. Similarly, nursing homes with higher staff retention rates correlate with better care outcomes and avoided hospital stays. This training program will be developed in cooperation between Nursing Home providers and union representatives offering training opportunities for staff or other qualifying training programs.

These programs and their curricula will be submitted to DOH for review. In addition to offering a training program, eligible facilities must have direct care staff retention rates above the state median. However, hospital-based nursing homes and free standing nursing homes already receiving VAP payments would not be eligible to participate.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2020/2021 is \$46 million.

The public is invited to review and comment on this proposed State Plan Amendment, a copy of which will be available for public review on the Department's website at http://www.health.ny.gov/regulations/state_plans/status. In addition, approved SPA's beginning in 2011 are also available for viewing on this website.

Copies of the proposed State Plan Amendments will be on file in each local (county) social services district and available for public review.

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

SUMMARY
SPA #20-0027

This State Plan Amendment proposes to revise the State Plan to provide additional payments to non-state government public residential health care facilities in aggregate amounts of up to \$500 million.

DRAFT

New York
47(x)(2)(b)

For the period April 1, 1997 through March 31, 1999, proportionate share payments in an annual aggregate amount of \$631.1 million will be made under the medical assistance program to non-state public operated residential health care facilities, excluding public residential health care facilities operated by a town or city within a county. For the period April 1, 1999 through March 31, 2000, proportionate share payments in an annual aggregate amount of \$982 million will be made under the medical assistance program to non-state operated public residential health care facilities, excluding public residential health care facilities operated by a town or city within a county. For annual state fiscal year periods commencing April 1, 2000 and ending March 31, 2005, and April 1, 2005, through March 31, 2009, proportionate share payments in an annual aggregate amount of up to \$991.5 million and \$150.0 million, respectively, for state fiscal year April 1, 2009 through March 31, 2010, \$167 million, and for state fiscal years commencing April 1, 2010 through March 31, 2011, \$189 million in an annual aggregate amount, and for the period April 1, 2011 through March 31, 2012 an aggregate amount of \$172.5 million and for state fiscal years commencing April 1, 2012 through March 31, 2013, an aggregate amount of \$293,147,494, and for the period April 1, 2013 through March 31, 2014, \$246,522,355, and for the period April 1, 2014 through March 31, 2015, \$305,254,832, and for the period April 1, 2015 through March 31, 2016, \$255,208,911, for the period April 1, 2016 through March 31, 2017, \$198,758,133 in an annual aggregate amount, and for the period April 1, 2017 through March 31, 2018, the aggregate amount of \$167,600,071, will be paid semi-annually in September and March, and for the period April 1, 2018 through March 31, 2019, the aggregate amount of \$225,104,113, will be paid semi-annually in September and March, and for the period April 1, 2019 through March 31, 2020, the aggregate amount of \$196,055,358 will be paid semi-annually in September and March, and for the period April 1, 2020 through March 31, 2021, the aggregate amount of \$500,000,000 will be paid semi-annually in September and March, which will be made under the medical assistance program to non-state operated public residential health care facilities, including public residential health care facilities located in the counties of Erie, Nassau and Westchester, but excluding public residential health care facilities operated by a town or city within a county.

The amount allocated to each eligible public residential health care facility for the period April 1, 1997 through March 31, 1998 will be calculated as the result of \$631.1 million multiplied by the ratio of their 1995 Medicaid days relative to the sum of 1995 Medicaid days for all eligible public residential health care facilities. The amount allocated to each eligible public residential health care facility for the period April 1, 1998 through March 31, 1999 will be calculated as the result of \$631.1 million multiplied by the ratio of their 1996 Medicaid days relative to the sum of 1996 Medicaid days for all eligible public residential health care facilities. The amount allocated to each public residential health care facility for the period April 1, 1999 through March 31, 2000 will be calculated as the result of \$982 million multiplied by the ratio of their 1997 Medicaid days relative to the sum of 1997 Medicaid days for all eligible public residential health care facilities. The amount allocated to each public residential health care facility for annual state fiscal year periods commencing April 1, 2000 and ending March 31, 2005, and for annual state fiscal year periods commencing April 1, 2005 through March 31, 2009, and for state fiscal years commencing April 1, 2009 through March 31, 2011; April 1, 2011 through March 31, 2012; April 1, 2012 through March 31, 2013; April 1, 2013 through March 31, 2014; and April 1, 2014 through March 31, 2015; April 1, 2015 through March 31, 2016; April 1, 2016 through March 31, 2017; April 1, 2017 through March 31, 2018; and April 1, 2018 through March 31, 2019; and April 1, 2019 through March 31, 2020; and April 1, 2020 through March 31, 2021 will be calculated as the result of the respective annual aggregate amount multiplied by the ratio of their Medicaid days relative to the sum of Medicaid days for all eligible public residential health care facilities for the calendar year period two years prior provided, however, that an additional amount of \$26,531,995 for the April 1, 2013 through March 2014 period will be distributed to those public residential health care facilities in the list which follows.

TN #20-0027

Approval Date _____

Supersedes TN #19-0025MA

Effective Date April 1, 2020

cally set through a memorandum of understanding with the New York City Health and Hospitals Corporation. Such adjustments shall be paid by means of one or more estimated payments. Payments may be added to rates of payment or made as aggregate payments.

For state fiscal year beginning April 1, 2020 through March 31, 2021, continues upon the election of the social services district in which an eligible diagnostic and treatment center (DTC) is physically located, up to \$12.6 million in additional annual Medicaid payments may be paid to public DTCs operated by the New York City Health and Hospitals Corporation. Such payments will be based on each DTC's proportionate share of the sum of all clinic visits for all facilities eligible for an adjustment for the base year two years prior to the rate year. The proportionate share payments may be added to rates of payment or made as aggregate payments to eligible DTCs.

For state fiscal year beginning April 1, 2020 through March 31, 2021, continues up to \$5.4 million in additional annual Medicaid payments may be paid to county operated free-standing clinics, not including facilities operated by the New York City Health and Hospitals Corporation, for services provided by such DTC and those provided by a county operated freestanding mental health or substance abuse DTC. Distributions shall be based on each eligible facility's proportionate share of the sum of all DTC and clinic visits for all eligible facilities receiving payments for the base year two years prior to the rate year. The proportionate share payments may be added to rates of payment or made as aggregate payments to eligible facilities.

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Effective on or after April 1, 2020, continues the supplemental upper payment limit payments made to general hospitals, other than major public general hospitals under institutional services of \$339 million annually.

For state fiscal year beginning April 1, 2020 through March 31, 2021, continues adjustments for hospital inpatient services provided on and after April 1, 2012, to public general hospitals, other than those operated by the State of New York or the State University of New York, located in a city with a population of over one million and receiving reimbursement of up to \$1.08 billion annually based on criteria and methodology set by the Commissioner of Health, which the Commissioner may periodically set through a memorandum of understanding with the New York City Health and Hospitals Corporation. Such adjustments shall be paid by means of one or more estimated payments. Payments to eligible public general hospitals may be added to rates of payment or made as aggregate payments.

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Effective on or after April 1, 2020, the Department of Health

proposes to amend the Title XIX (Medicaid) State Plan for institutional services related to temporary rate adjustments to long term care providers that are undergoing closure, merger, consolidation, acquisition or restructuring themselves or other health care providers. These payments are authorized by current State statutory and regulatory provisions. The temporary rate adjustments will be reviewed and approved by the CINERGY Collaborative.

The estimated net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2020-2021 is \$30 million.

Effective on or after April 1, 2020, the Department of Health (DOH) will continue the nursing home advanced training program, aimed at teaching staff how to detect early changes in a resident's physical and mental or functional status that could lead to hospitalization. Clinical findings show early detection of patient decline by front line workers, coupled with clinical care models aimed at fostering consistent and continuous care between care givers and patients/families result in better care outcomes. Similarly, nursing homes with higher staff retention rates correlate with better care outcomes and avoided hospital stays. This training program will be developed in cooperation between Nursing Home providers and union representatives offering training opportunities for staff or other qualifying training programs.

These programs and their curricula will be submitted to DOH for review. In addition to offering a training program, eligible facilities must have direct care staff retention rates above the state median. However, hospital-based nursing homes and free standing nursing homes already receiving VAP payments would not be eligible to participate.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2020/2021 is \$46 million.

The public is invited to review and comment on this proposed State Plan Amendment, a copy of which will be available for public review on the Department's website at http://www.health.ny.gov/regulations/state_plans/status. In addition, approved SPA's beginning in 2011 are also available for viewing on this website.

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Bronx, New York 10457

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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

SUMMARY
SPA #20-0028

This State Plan Amendment proposes to revise the State Plan to assist safety net hospitals by providing a temporary rate adjustment under the closure, merger, consolidation, acquisition, or restructuring of a health care provider.

DRAFT

pursuant to section 6056.4(c)(4) or 6056.4(c)(5) of this Title, may apply to the commissioner for leave to substitute satisfactory completion of a course of basic training completed in such other jurisdiction or may apply to the commissioner for leave to substitute satisfactory completion of the pre-employment police basic training program in satisfaction of all or part of the requirements of an approved basic course for peace officers imposed under section 2.30 of the Criminal Procedure Law. The commissioner shall review and evaluate all such applications and may require the applicant to submit such additional documentation as he or she shall deem necessary. If, upon review and evaluation of such application, the commissioner determines that a program of peace officer basic training completed by the applicant in another jurisdiction or the pre-employment police basic training program completed by the application meets or exceeds all or part of the minimum standards prescribed in section 6025.3 of this Part, the commissioner may authorize such training to be substituted for such requirements of the basic course as he or she shall deem appropriate. The commissioner shall certify, in writing, the extent to which all or part of the curriculum of the basic course may be waived and any noted deficiencies must be satisfactorily completed at a basic course approved by the commissioner, within the period of time prescribed in section 6025.7 of this Part. Applicants for equivalency certificates shall be subject to the same limitations and requirements as prescribed in sections 6025.6 and 6025.7 of this Part and section 2.30 of the Criminal Procedure Law.

PUBLIC NOTICE

Division of Criminal Justice Services

I, Andrew M. Cuomo, Governor of the State of New York, do hereby adopt and promulgate the following regulations that have been recommended by the Municipal Police Training Council pursuant to the provisions of section eight hundred forty of the Executive Law. This action is taken pursuant to the authority vested in me by section eight hundred forty-two of such law and, as such, it is exempted from the rule making provisions of the State Administrative Procedure Act.

NOW, THEREFORE, be it known that the amendments to Part 6024 of Title 9 of the New York State Official Compilation of Codes, Rules and Regulations are hereby adopted and promulgated and shall be effective upon publication in the State Register.

1. Subdivision (d) of Section 6024.1 of Title 9 of NYCRR is renumbered to be subdivision (e). A new subdivision (d) is added to section 6024.1 to read as follows:

(d) The term federal law enforcement officer shall have the same meaning as set forth in section 2.15 of the Criminal Procedure Law.

2. Subdivisions (b) and (c) of Section 6024.2 of Title 9 of NYCRR are amended to read as follows:

(b) Have a minimum of three years of police [or], peace officer or federal law enforcement officer experience. The peace officer and federal law enforcement officer experience requirement can only be satisfied by those persons who have carried a firearm in the course of their official duties and have done so for the prescribed period of time.

(c) Successfully complete a Municipal Police Training Council approved basic course for police officers or basic course for peace officers, as appropriate [.] or a requisite basic training course prescribed by a federal law enforcement officer employer.

3. Section 6024.4 of Title 9 of NYCRR is amended to read as follows:

Firearms instructor certification shall be valid from the date of issuance and shall remain valid during the holder's continuous service as a police officer [or], peace officer, or federal law enforcement officer, or while the holder is employed by a sponsoring police officer or peace officer agency, unless revoked by the commissioner.

PUBLIC NOTICE

Division of Criminal Justice Services

I, Andrew M. Cuomo, Governor of the State of New York, do hereby adopt and promulgate the following regulations that have been recommended by the Law Enforcement Agency Accreditation Council pur-

suant to Executive Law § 846-h(1)(c). This action is taken pursuant to the authority vested in me by such law, and, as such, it is exempted from the rule making provisions of the State Administrative Procedure Act.

NOW, THEREFORE, be it known that the amendment to section 6035.1(a) of Title 9 of the New York State Official Compilation of Codes, Rules and Regulations is hereby adopted and promulgated, and shall be effective upon publication in the State Register.

Subdivision (a) of section 6035.1 of Title 9 NYCRR is amended to read as follows:

(a) The term law enforcement agency shall mean any law enforcement agency or department of any municipality, any police district, or any agency, department, commission, authority or public benefit corporation of the state of New York employing a police officer or police officers as that term is defined in paragraphs (a), (b), (c), (d), (e), (f), (j), (k), (l), (o), (p) [and], (s), and (u) of subdivision thirty-four of section 1.20 of the Criminal Procedure Law. For the purposes of this definition, the term shall not include any entity that employs police officers in a capacity which may require the use of their law enforcement authority but is supplementary to the primary official responsibilities for which they have been hired.

PUBLIC NOTICE

Office of General Services

Pursuant to Section 33 of the Public Lands Law, the Office of General Services hereby gives notice to the following:

Notice is hereby given that the New York State Department of Transportation has determined that:

Address: 3628 NYS Route 281, Town of Cortlandville, Cortland County, N:V 13045 DOT Map 118-D, Parcel 119

a.23 acre+ lot, is surplus and no longer useful or necessary for state program purposes and has abandoned the property to the Commissioner of General Services for sale or other disposition as Unappropriated State land.

For further information, please contact: Thomas Pohl, Esq., Office of General Services, Legal Services, 41st Fl., Coming Tower, Empire State Plaza, Albany, NY 12242, (518) 474-8831, (518) 473-4973 fax

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 institutional, non-institutional and long-term care services to comply with enacted statutory provisions. The following changes are proposed:

Non-Institutional Services

Effective for days of service on or after April 1, 2020, The Department of Health will eliminate the limitations on amount and duration of partial hospitalization services. The State Plan Amendment is necessary to comply with the Mental Health Parity and Addiction Equity Act of 2008.

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

Effective on or after April 1, 2020, continues the supplemental upper payment limit payments made to general hospitals, other than major public general hospitals under non-institutional services of \$339 million annually.

For state fiscal year beginning April 1, 2020 through March 31, 2021, continues hospital outpatient payment adjustments that increase the operating cost components of rates of payment for hospital outpatient and emergency departments on and after April 1, 2011, for public general hospitals other than those operated by the State of New York or the State University of New York, which are located in a city with a population of over one million. The amount to be paid will be up to \$287 million annually based on criteria and methodology set by the Commissioner of Health, which the Commissioner may periodi-

cally set through a memorandum of understanding with the New York City Health and Hospitals Corporation. Such adjustments shall be paid by means of one or more estimated payments. Payments may be added to rates of payment or made as aggregate payments.

For state fiscal year beginning April 1, 2020 through March 31, 2021, continues upon the election of the social services district in which an eligible diagnostic and treatment center (DTC) is physically located, up to \$12.6 million in additional annual Medicaid payments may be paid to public DTCs operated by the New York City Health and Hospitals Corporation. Such payments will be based on each DTC's proportionate share of the sum of all clinic visits for all facilities eligible for an adjustment for the base year two years prior to the rate year. The proportionate share payments may be added to rates of payment or made as aggregate payments to eligible DTCs.

For state fiscal year beginning April 1, 2020 through March 31, 2021, continues up to \$5.4 million in additional annual Medicaid payments may be paid to county operated free-standing clinics, not including facilities operated by the New York City Health and Hospitals Corporation, for services provided by such DTC and those provided by a county operated freestanding mental health or substance abuse DTC. Distributions shall be based on each eligible facility's proportionate share of the sum of all DTC and clinic visits for all eligible facilities receiving payments for the base year two years prior to the rate year. The proportionate share payments may be added to rates of payment or made as aggregate payments to eligible facilities.

Institutional Services

Effective on or after April 1, 2020, the temporary rate adjustment has been reviewed and approved for the St. Joseph's Hospital Health Center with aggregate payment amounts totaling up to \$4,000,000 for the period April 1, 2020 through March 31, 2021.

Effective on or after April 1, 2020, continues the supplemental upper payment limit payments made to general hospitals, other than major public general hospitals under institutional services of \$339 million annually.

For state fiscal year beginning April 1, 2020 through March 31, 2021, continues adjustments for hospital inpatient services provided on and after April 1, 2012, to public general hospitals, other than those operated by the State of New York or the State University of New York, located in a city with a population of over one million and receiving reimbursement of up to \$1.08 billion annually based on criteria and methodology set by the Commissioner of Health, which the Commissioner may periodically set through a memorandum of understanding with the New York City Health and Hospitals Corporation. Such adjustments shall be paid by means of one or more estimated payments. Payments to eligible public general hospitals may be added to rates of payment or made as aggregate payments.

For state fiscal year beginning April 1, 2020 through March 31, 2021, supplemental payments will be made to State government owned hospitals. These payments will not exceed the upper payment limit for inpatient services provided by state government-owned hospitals when aggregated with other Medicaid payments.

Effective on or after April 1, 2020, the temporary rate adjustment has been reviewed and approved for Long Island Jewish Medical Center with aggregate payment amounts totaling up to \$1,000,000 for the period April 1, 2020 through March 31, 2021.

Long Term Care Services

Effective on or after April 1, 2020, continues additional payments to non-state government operated public residential health care facilities, including public residential health care facilities located in Nassau, Westchester, and Erie Counties, but excluding public residential health care facilities operated by a town or city within a county, in aggregate amounts of up to \$500 million. The amount allocated to each eligible public RHCF will be in accordance with the previously approved methodology, provided, however that patient days shall be utilized for such computation reflecting actual reported data for 2018 and each representative succeeding year as applicable. Payments to eligible RHCF's may be added to rates of payment or made as aggregate payments.

Effective on or after April 1, 2020, the Department of Health

proposes to amend the Title XIX (Medicaid) State Plan for institutional services related to temporary rate adjustments to long term care providers that are undergoing closure, merger, consolidation, acquisition or restructuring themselves or other health care providers. These payments are authorized by current State statutory and regulatory provisions. The temporary rate adjustments will be reviewed and approved by the CINERGY Collaborative.

The estimated net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2020-2021 is \$30 million.

Effective on or after April 1, 2020, the Department of Health (DOH) will continue the nursing home advanced training program, aimed at teaching staff how to detect early changes in a resident's physical and mental or functional status that could lead to hospitalization. Clinical findings show early detection of patient decline by front line workers, coupled with clinical care models aimed at fostering consistent and continuous care between care givers and patients/families result in better care outcomes. Similarly, nursing homes with higher staff retention rates correlate with better care outcomes and avoided hospital stays. This training program will be developed in cooperation between Nursing Home providers and union representatives offering training opportunities for staff or other qualifying training programs.

These programs and their curricula will be submitted to DOH for review. In addition to offering a training program, eligible facilities must have direct care staff retention rates above the state median. However, hospital-based nursing homes and free standing nursing homes already receiving VAP payments would not be eligible to participate.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2020/2021 is \$46 million.

The public is invited to review and comment on this proposed State Plan Amendment, a copy of which will be available for public review on the Department's website at http://www.health.ny.gov/regulations/state_plans/status. In addition, approved SPA's beginning in 2011 are also available for viewing on this website.

Copies of the proposed State Plan Amendments will be on file in each local (county) social services district and available for public review.

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

SUMMARY
SPA #20-0029

This State Plan Amendment proposes to provide temporary rate adjustments to long term care providers that are undergoing closure, merger, consolidation, acquisition or restructuring themselves or other health care providers. These payments are authorized by current State statutory and regulatory provisions. The temporary rate adjustments will be reviewed and approved by the CINERGY Collaborative.

DRAFT

New York
47(aa)(5)Nursing Homes (Continued):

<u>Provider Name</u>	<u>Gross Medicaid Rate Adjustment</u>	<u>Rate Period Effective</u>
<u>Amsterdam Nursing Home Corp (Amsterdam House)*</u>	<u>\$1,430,938</u>	<u>01/01/2015 – 03/31/2015</u>
	<u>\$1,450,213</u>	<u>04/01/2015 – 03/31/2016</u>
	<u>\$1,447,006</u>	<u>04/01/2016 – 03/31/2017</u>
	<u>\$847,377</u>	<u>04/01/2020 – 03/31/2021</u>
	<u>\$847,377</u>	<u>04/01/2021 – 03/31/2022</u>
<u>Baptist Nursing and Rehabilitation</u>	<u>\$935,000</u>	<u>10/01/2018 - 03/31/2019</u>
	<u>\$910,000</u>	<u>04/01/2019 - 03/31/2020</u>
	<u>\$347,500</u>	<u>04/01/2020 – 03/31/2021</u>
<u>Beth Abraham Health Services*</u>	<u>\$2,460,249</u>	<u>01/01/2015 – 03/31/2015</u>
	<u>\$2,493,389</u>	<u>04/01/2015 – 03/31/2016</u>
	<u>\$2,487,874</u>	<u>04/01/2016 – 03/31/2017</u>
<u>Bronx-Lebanon Special Care Center*</u>	<u>\$788,294</u>	<u>01/01/2015 – 03/31/2015</u>
	<u>\$798,912</u>	<u>04/01/2015 – 03/31/2016</u>
	<u>\$797,146</u>	<u>04/01/2016 – 03/31/2017</u>
	<u>\$521,445</u>	<u>04/01/2020 – 03/31/2021</u>
	<u>\$521,445</u>	<u>04/01/2021 – 03/31/2022</u>

*Denotes provider is part of CINERGY Collaborative.

TN #20-0029

Approval Date _____

Supersedes TN #18-0062Effective Date April 1, 2020

New York
47(aa)(5.1)Nursing Homes (Continued):

<u>Provider Name</u>	<u>Gross Medicaid Rate Adjustment</u>	<u>Rate Period Effective</u>
<u>Brooklyn United Methodist Church Home*</u>	<u>\$702,169</u>	<u>01/01/2015 – 03/31/2015</u>
	<u>\$707,212</u>	<u>04/01/2015 – 03/31/2016</u>
	<u>\$706,273</u>	<u>04/01/2016 – 03/31/2017</u>
	<u>\$384,919</u>	<u>04/01/2020 – 03/31/2021</u>
	<u>\$384,919</u>	<u>04/01/2021 – 03/31/2022</u>
<u>Buena Vida Continuing Care & Rehab Ctr*</u>	<u>\$970,765</u>	<u>01/01/2015 – 03/31/2015</u>
	<u>\$983,841</u>	<u>04/01/2015 – 03/31/2016</u>
	<u>\$981,665</u>	<u>04/01/2016 – 03/31/2017</u>
	<u>\$642,147</u>	<u>04/01/2020 – 03/31/2021</u>
	<u>\$642,147</u>	<u>04/01/2021 – 03/31/2022</u>
<u>Cabrini Center for Nursing*</u>	<u>\$1,130,860</u>	<u>01/01/2015 – 03/31/2015</u>
	<u>\$1,146,093</u>	<u>04/01/2015 – 03/31/2016</u>
	<u>\$1,143,558</u>	<u>04/01/2016 – 03/31/2017</u>
<u>Carmel Richmond Healthcare and Rehabilitation Center*</u>	<u>\$1,084,185</u>	<u>01/01/2015 – 03/31/2015</u>
	<u>\$1,098,790</u>	<u>04/01/2015 – 03/31/2016</u>
	<u>\$1,096,359</u>	<u>04/01/2016 – 03/31/2017</u>
	<u>\$632,161</u>	<u>04/01/2020 – 03/31/2021</u>
	<u>\$632,161</u>	<u>04/01/2021 – 03/31/2022</u>
<u>Center For Nursing & Rehabilitation Inc*</u>	<u>\$1,179,939</u>	<u>01/01/2015 – 03/31/2015</u>
	<u>\$1,195,833</u>	<u>04/01/2015 – 03/31/2016</u>
	<u>\$1,193,189</u>	<u>04/01/2016 – 03/31/2017</u>
	<u>\$746,693</u>	<u>04/01/2020 – 03/31/2021</u>
	<u>\$746,693</u>	<u>04/01/2021 – 03/31/2022</u>
<u>Chapin Home for the Aging*</u>	<u>\$771,403</u>	<u>01/01/2015 – 03/31/2015</u>
	<u>\$781,794</u>	<u>04/01/2015 – 03/31/2016</u>
	<u>\$780,065</u>	<u>04/01/2016 – 03/31/2017</u>
	<u>\$487,868</u>	<u>04/01/2020 – 03/31/2021</u>
	<u>\$487,868</u>	<u>04/01/2021 – 03/31/2022</u>

*Denotes provider is part of CINERGY Collaborative.

TN #20-0029

Approval Date _____

Supersedes TN #NEWEffective Date April 1, 2020

New York
47(aa)(6)**Nursing Homes (Continued):**

<u>Provider Name</u>	<u>Gross Medicaid Rate Adjustment</u>	<u>Rate Period Effective</u>
<u>Charles T. Sitrin Health Care Center Inc.</u>	<u>\$2,000,000</u>	<u>01/01/2015 – 03/31/2015</u>
	<u>\$591,984</u>	<u>06/16/2016 – 03/31/2017</u>
	<u>\$25,817</u>	<u>04/01/2017 – 03/31/2018</u>
<u>Cobble Hill Health Center*</u>	<u>\$400,000</u>	<u>04/01/2020 – 03/31/2021</u>
	<u>\$400,000</u>	<u>04/01/2021 – 03/31/2022</u>
<u>Concord Nursing Home*</u>	<u>\$2,011,962</u>	<u>10/01/2018 – 03/31/2019</u>
	<u>\$2,011,962</u>	<u>04/01/2019 – 03/31/2020</u>
	<u>\$250,000</u>	<u>04/01/2020 – 03/31/2021</u>
	<u>\$250,000</u>	<u>04/01/2021 – 03/31/2022</u>
<u>Crouse Community Center</u>	<u>\$645,000</u>	<u>01/01/2014 – 03/31/2014</u>
	<u>\$710,000</u>	<u>04/01/2014 – 03/31/2015</u>
	<u>\$65,000</u>	<u>04/01/2015 – 03/31/2016</u>
<u>Eger Health Care and Rehabilitation Center*</u>	<u>\$1,463,808</u>	<u>01/01/2015 – 03/31/2015</u>
	<u>\$1,483,526</u>	<u>04/01/2015 – 03/31/2016</u>
	<u>\$1,480,245</u>	<u>04/01/2016 – 03/31/2017</u>
	<u>\$968,289</u>	<u>04/01/2020 – 03/31/2021</u>
	<u>\$968,289</u>	<u>04/01/2021 – 03/31/2022</u>

*Denotes provider is part of CINERGY Collaborative.

New York
47(aa)(6.2)Nursing Homes (Continued):

<u>Provider Name</u>	<u>Gross Medicaid Rate Adjustment</u>	<u>Rate Period Effective</u>
<u>Heritage Commons Residential Health Care</u>	<u>\$976,816</u>	<u>01/01/2014 – 03/31/2014</u>
	<u>\$834,744</u>	<u>04/01/2014 – 03/31/2015</u>
	<u>\$1,055,223</u>	<u>06/16/2016 – 03/31/2017</u>
<u>Isabella Geriatric Center Inc*</u>	<u>\$2,902,269</u>	<u>01/01/2015 – 03/31/2015</u>
	<u>\$2,941,364</u>	<u>04/01/2015 – 03/31/2016</u>
	<u>\$2,934,859</u>	<u>04/01/2016 – 03/31/2017</u>
	<u>\$1,633,648</u>	<u>04/01/2020 – 03/31/2020</u>
	<u>\$1,633,648</u>	<u>04/01/2021 – 03/31/2022</u>
<u>Island Nursing and Rehab Center*</u>	<u>\$903,195</u>	<u>01/01/2015 – 03/31/2015</u>
	<u>\$909,966</u>	<u>04/01/2015 – 03/31/2016</u>
	<u>\$908,716</u>	<u>04/01/2016 – 03/31/2017</u>
	<u>\$495,250</u>	<u>04/01/2020 – 03/31/2021</u>
	<u>\$495,250</u>	<u>04/01/2021 – 03/31/2022</u>

*Denotes provider is part of CINERGY Collaborative.

New York
47(aa)(7)Nursing Homes (Continued):

<u>Provider Name</u>	<u>Gross Medicaid Rate Adjustment</u>	<u>Rate Period Effective</u>
<u>Island Nursing and Rehab</u>	<u>\$3,375,000</u>	<u>12/13/2019 – 03/31/2020</u>
	<u>\$4,200,000</u>	<u>04/01/2020 – 03/31/2021</u>
	<u>\$4,275,000</u>	<u>04/01/2021 – 03/31/2022</u>
<u>Jamaica Hospital Nursing Home Co Inc*</u>	<u>\$764,892</u>	<u>01/01/2015 – 03/31/2015</u>
	<u>\$775,195</u>	<u>04/01/2015 – 03/31/2016</u>
	<u>\$773,481</u>	<u>04/01/2016 – 03/31/2017</u>
	<u>\$505,965</u>	<u>04/01/2020 – 03/31/2021</u>
	<u>\$505,965</u>	<u>04/01/2021 – 03/31/2022</u>
<u>Jefferson's Ferry*</u>	<u>\$324,023</u>	<u>04/01/2020 – 03/31/2021</u>
	<u>\$324,023</u>	<u>04/01/2021 – 03/31/2022</u>
<u>Jewish Home Lifecare Henry and Jeanette Weinberg Campus Bronx*</u>	<u>\$2,939,255</u>	<u>01/01/2015 – 03/31/2015</u>
	<u>\$2,978,848</u>	<u>04/01/2015 – 03/31/2016</u>
	<u>\$2,972,260</u>	<u>04/01/2016 – 03/31/2017</u>
<u>Jewish Home LifeCare Manhattan*</u>	<u>\$1,947,662</u>	<u>01/01/2015 – 03/31/2015</u>
	<u>\$1,973,898</u>	<u>04/01/2015 – 03/31/2016</u>
	<u>\$1,969,532</u>	<u>04/01/2016 – 03/31/2017</u>

*Denotes provider is part of CINERGY Collaborative.

TN #20-0029 Approval Date Supersedes TN #19-0055 Effective Date April 1, 2020

New York
47(aa)(7.1)

Nursing Homes (Continued):

<u>Provider Name</u>	<u>Gross Medicaid Rate Adjustment</u>	<u>Rate Period Effective</u>
<u>Jewish Home LifeCare Sarah Neuman Center*</u>	<u>\$1,169,410</u>	<u>01/01/2015 – 03/31/2015</u>
	<u>\$1,185,162</u>	<u>04/01/2015 – 03/31/2016</u>
	<u>\$1,182,541</u>	<u>04/01/2016 – 03/31/2017</u>
<u>Lutheran Augustana Center for Extended Care & Rehab*</u>	<u>\$1,016,961</u>	<u>01/01/2015 – 03/31/2015</u>
	<u>\$1,030,660</u>	<u>04/01/2015 – 03/31/2016</u>
	<u>\$1,028,381</u>	<u>04/01/2016 – 03/31/2017</u>
<u>Margaret Tietz Center For Nursing Care Inc*</u>	<u>\$700,877</u>	<u>01/01/2015 – 03/31/2015</u>
	<u>\$710,318</u>	<u>04/01/2015 – 03/31/2016</u>
	<u>\$708,747</u>	<u>04/01/2016 – 03/31/2017</u>
	<u>\$463,620</u>	<u>04/01/2020 – 03/31/2021</u>
	<u>\$463,620</u>	<u>04/01/2021 – 03/31/2022</u>
<u>Mary Manning Walsh Nursing Home Co Inc*</u>	<u>\$1,453,160</u>	<u>01/01/2015 – 03/31/2015</u>
	<u>\$1,472,735</u>	<u>04/01/2015 – 03-31-2016</u>
	<u>\$1,469,478</u>	<u>04/01/2016 – 03-31-2017</u>
	<u>\$861,601</u>	<u>04/01/2020 – 03-31-2021</u>
	<u>\$861,601</u>	<u>04/01/2021 – 03-31-2022</u>
<u>Menorah Home And Hospital For Rehabilitation and Nursing*</u>	<u>\$1,210,053</u>	<u>01/01/2015 – 03/31/2015</u>
	<u>\$1,226,353</u>	<u>04/01/2015 – 03/31/2016</u>
	<u>\$1,223,641</u>	<u>04/01/2016 – 03/31/2017</u>
	<u>\$800,433</u>	<u>04/01/2020 – 03/31/2021</u>
	<u>\$800,433</u>	<u>04/01/2021 – 03/31/2022</u>
<u>Methodist Home for Nursing and Rehabilitation*</u>	<u>\$441,177</u>	<u>01/01/2015 – 03/31/2015</u>
	<u>\$447,120</u>	<u>04/01/2015 – 03/31/2016</u>
	<u>\$446,131</u>	<u>04/01/2016 – 03/31/2017</u>
	<u>\$291,832</u>	<u>04/01/2020 – 03/31/2021</u>
	<u>\$291,832</u>	<u>04/01/2021 – 03/31/2022</u>

*Denotes provider is part of CINERGY Collaborative.

TN #20-0029

Approval Date

Supersedes TN #NEW

Effective Date April 1, 2020

**New York
47(aa)(9)**

Nursing Homes (Continued):

<u>Provider Name</u>	<u>Gross Medicaid Rate Adjustment</u>	<u>Rate Period Effective</u>
<u>Samaritan Keep Nursing Home Inc.</u>	<u>\$4,500,000</u>	<u>02/01/2014 – 03/31/2014</u>
	<u>\$4,500,000</u>	<u>04/01/2014 – 03/31/2015</u>
	<u>\$6,754,384</u>	<u>01/01/2017 – 03/31/2017</u>
	<u>\$6,716,384</u>	<u>04/01/2017 – 03/31/2018</u>
<u>Sarah Neuman Center for Healthcare*</u>	<u>\$773,173</u>	<u>04/01/2020 – 03/31/2021</u>
	<u>\$773,173</u>	<u>04/01/2021 – 03/31/2022</u>
<u>Schaffer Extended Care System*</u>	<u>\$441,290</u>	<u>01/01/2015 – 03/31/2015</u>
	<u>\$447,234</u>	<u>04/01/2015 – 03/31/2016</u>
	<u>\$446,245</u>	<u>04/01/2016 – 03/31/2017</u>
	<u>\$291,907</u>	<u>04/01/2020 – 03/31/2021</u>
	<u>\$291,907</u>	<u>04/01/2021 – 03/31/2022</u>
<u>Schervier Nursing Care Center*</u>	<u>\$1,421,550</u>	<u>01/01/2015 – 03/31/2015</u>
	<u>\$1,440,698</u>	<u>04/01/2015 – 03/31/2016</u>
	<u>\$1,437,512</u>	<u>04/01/2016 – 03/31/2017</u>
<u>Schnurmacher Center for Rehabilitation and Nursing*</u>	<u>\$539,168</u>	<u>01/01/2015 – 03/31/2015</u>
	<u>\$546,431</u>	<u>04/01/2015 – 03/31/2016</u>
	<u>\$545,222</u>	<u>04/01/2016 – 03/31/2017</u>

*Denotes provider is part of CINERGY Collaborative.

TN #20-0029

Approval Date _____

Supersedes TN #17-0023

Effective Date April 1, 2020

**New York
47(aa)(9.1)**

Nursing Homes (Continued):

<u>Provider Name</u>	<u>Gross Medicaid Rate Adjustment</u>	<u>Rate Period Effective</u>
<u>Schulman and Schachne Institute for Nursing and Rehabilitation*</u>	<u>\$1,852,978</u>	<u>01/01/2015 – 03/31/2015</u>
	<u>\$1,877,938</u>	<u>04/01/2015 – 03/31/2016</u>
	<u>\$1,873,785</u>	<u>04/01/2016 – 03/31/2017</u>
	<u>\$1,225,719</u>	<u>04/01/2020 – 03/31/2021</u>
	<u>\$1,225,719</u>	<u>04/01/2021 – 03/31/2022</u>
<u>Silvercrest*</u>	<u>\$1,293,304</u>	<u>01/01/2015 – 03/31/2015</u>
	<u>\$1,310,725</u>	<u>04/01/2015 – 03/31/2016</u>
	<u>\$1,307,827</u>	<u>04/01/2016 – 03/31/2017</u>
	<u>\$833,785</u>	<u>04/01/2020 – 03/31/2021</u>
	<u>\$833,785</u>	<u>04/01/2021 – 03/31/2022</u>
<u>St Cabrini Nursing Home*</u>	<u>\$748,048</u>	<u>04/01/2020 – 03/31/2021</u>
	<u>\$748,048</u>	<u>04/01/2021 – 03/31/2022</u>
<u>St Johnland Nursing Center*</u>	<u>\$400,000</u>	<u>04/01/2020 – 03/31/2021</u>
	<u>\$400,000</u>	<u>04/01/2021 – 03/31/2022</u>
<u>St. Mary's Hospital for Children Inc.*</u>	<u>\$1,777,136</u>	<u>01/01/2015 – 03/31/2015</u>
	<u>\$1,795,679</u>	<u>04/01/2015 – 03/31/2016</u>
	<u>\$1,792,470</u>	<u>04/01/2016 – 03/31/2017</u>
	<u>\$1,053,645</u>	<u>04/01/2020 – 03/31/2021</u>
	<u>\$1,053,645</u>	<u>04/01/2021 – 03/31/2022</u>
<u>St Vincent Depaul Residence*</u>	<u>\$417,641</u>	<u>01/01/2015 – 03/31/2015</u>
	<u>\$423,266</u>	<u>04/01/2015 – 03/31/2016</u>
	<u>\$422,330</u>	<u>04/01/2016 – 03/31/2017</u>
	<u>\$276,263</u>	<u>04/01/2020 – 03/31/2021</u>
	<u>\$276,263</u>	<u>04/01/2021 – 03/31/2022</u>

*Denotes provider is part of CINERGY Collaborative.

TN #20-0029

Approval Date _____

Supersedes TN #New

Effective Date April 1, 2020

cally set through a memorandum of understanding with the New York City Health and Hospitals Corporation. Such adjustments shall be paid by means of one or more estimated payments. Payments may be added to rates of payment or made as aggregate payments.

For state fiscal year beginning April 1, 2020 through March 31, 2021, continues upon the election of the social services district in which an eligible diagnostic and treatment center (DTC) is physically located, up to \$12.6 million in additional annual Medicaid payments may be paid to public DTCs operated by the New York City Health and Hospitals Corporation. Such payments will be based on each DTC's proportionate share of the sum of all clinic visits for all facilities eligible for an adjustment for the base year two years prior to the rate year. The proportionate share payments may be added to rates of payment or made as aggregate payments to eligible DTCs.

For state fiscal year beginning April 1, 2020 through March 31, 2021, continues up to \$5.4 million in additional annual Medicaid payments may be paid to county operated free-standing clinics, not including facilities operated by the New York City Health and Hospitals Corporation, for services provided by such DTC and those provided by a county operated freestanding mental health or substance abuse DTC. Distributions shall be based on each eligible facility's proportionate share of the sum of all DTC and clinic visits for all eligible facilities receiving payments for the base year two years prior to the rate year. The proportionate share payments may be added to rates of payment or made as aggregate payments to eligible facilities.

Institutional Services

Effective on or after April 1, 2020, the temporary rate adjustment has been reviewed and approved for the St. Joseph's Hospital Health Center with aggregate payment amounts totaling up to \$4,000,000 for the period April 1, 2020 through March 31, 2021.

Effective on or after April 1, 2020, continues the supplemental upper payment limit payments made to general hospitals, other than major public general hospitals under institutional services of \$339 million annually.

For state fiscal year beginning April 1, 2020 through March 31, 2021, continues adjustments for hospital inpatient services provided on and after April 1, 2012, to public general hospitals, other than those operated by the State of New York or the State University of New York, located in a city with a population of over one million and receiving reimbursement of up to \$1.08 billion annually based on criteria and methodology set by the Commissioner of Health, which the Commissioner may periodically set through a memorandum of understanding with the New York City Health and Hospitals Corporation. Such adjustments shall be paid by means of one or more estimated payments. Payments to eligible public general hospitals may be added to rates of payment or made as aggregate payments.

For state fiscal year beginning April 1, 2020 through March 31, 2021, supplemental payments will be made to State government owned hospitals. These payments will not exceed the upper payment limit for inpatient services provided by state government-owned hospitals when aggregated with other Medicaid payments.

Effective on or after April 1, 2020, the temporary rate adjustment has been reviewed and approved for Long Island Jewish Medical Center with aggregate payment amounts totaling up to \$1,000,000 for the period April 1, 2020 through March 31, 2021.

Long Term Care Services

Effective on or after April 1, 2020, continues additional payments to non-state government operated public residential health care facilities, including public residential health care facilities located in Nassau, Westchester, and Erie Counties, but excluding public residential health care facilities operated by a town or city within a county, in aggregate amounts of up to \$500 million. The amount allocated to each eligible public RHCF will be in accordance with the previously approved methodology, provided, however that patient days shall be utilized for such computation reflecting actual reported data for 2018 and each representative succeeding year as applicable. Payments to eligible RHCF's may be added to rates of payment or made as aggregate payments.

Effective on or after April 1, 2020, the Department of Health

proposes to amend the Title XIX (Medicaid) State Plan for institutional services related to temporary rate adjustments to long term care providers that are undergoing closure, merger, consolidation, acquisition or restructuring themselves or other health care providers. These payments are authorized by current State statutory and regulatory provisions. The temporary rate adjustments will be reviewed and approved by the CINERGY Collaborative.

The estimated net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2020-2021 is \$30 million.

Effective on or after April 1, 2020, the Department of Health (DOH) will continue the nursing home advanced training program, aimed at teaching staff how to detect early changes in a resident's physical and mental or functional status that could lead to hospitalization. Clinical findings show early detection of patient decline by front line workers, coupled with clinical care models aimed at fostering consistent and continuous care between care givers and patients/families result in better care outcomes. Similarly, nursing homes with higher staff retention rates correlate with better care outcomes and avoided hospital stays. This training program will be developed in cooperation between Nursing Home providers and union representatives offering training opportunities for staff or other qualifying training programs.

These programs and their curricula will be submitted to DOH for review. In addition to offering a training program, eligible facilities must have direct care staff retention rates above the state median. However, hospital-based nursing homes and free standing nursing homes already receiving VAP payments would not be eligible to participate.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2020/2021 is \$46 million.

The public is invited to review and comment on this proposed State Plan Amendment, a copy of which will be available for public review on the Department's website at http://www.health.ny.gov/regulations/state_plans/status. In addition, approved SPA's beginning in 2011 are also available for viewing on this website.

Copies of the proposed State Plan Amendments will be on file in each local (county) social services district and available for public review.

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

SUMMARY
SPA #20-0030

This state plan amendment proposes to continue the Advanced Training Program (ATI), first introduced in State fiscal year 2015/2016. ATI is a training program aimed at teaching staff to detect early changes in a resident's physical, mental, or functional status that could lead to hospitalization. Clinical findings show early detection of patient decline by front line workers, coupled with clinical care models aimed at fostering consistent and continuous care between care givers and patients results in better care outcomes.

Training programs and their curricula from the previous ATI program may be used by facilities, new training programs must be submitted for Department review before implementation. In addition to offering a training program, eligible facilities must also have direct care staff retention above the statewide median. Hospital-based facilities and those receiving VAP funds will not be eligible to participate.

The estimated net aggregate cost contained in the budget for the continuation of the ATI program for State fiscal year 2020/2021 is \$46 million.

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Nursing Home Advanced Training Incentive Payments (cont'd)

Excluded Facilities are:

- Hospital based nursing facilities; and
- Nursing Facilities that have been approved to receive Vital Access Provider (VAP) payments during the same state fiscal year the incentive payment is available.

Calculation Statewide Median and Staff Retention Percentage: Data from Schedule P (Staff Turnover) of the most recently filed Cost Report will be used to measure staff turnover and retention rates for direct care staff. For the [2016] current payment, the State will use the [2014] latest available cost report. For example, for the 2017 payment, the state will use the 2015 cost report. The staff retention percentage will be equal to the number of employees retained as of December 31, who were employed on January 1 of the same year by the number of staff as of January 1 of that year.

(# of Employees Retained as of December 31, 20XX, who were Employed on January 1, 20XX)
= Staff Retention %
divided by (# of Staff as of January 1, 20XX)

XX = [2014 or 2015] latest available cost report as applicable.

A statewide staff retention median was derived by sorting the provider percentages from high to low and selecting the percentage in the middle of the range.

Restorative (Intensive) Care in a Nursing Home

Effective December 1, 2016 NYSDOH will implement a Restorative Care Unit Program to reduce hospital admissions and readmissions from residential health care facilities through the establishment of restorative care units. These restorative care units will provide higher-intensity treatment services to residents who are at risk of hospitalization upon an acute change in condition and seeks to improve the capacity of nursing facilities to identify and treat higher acuity patients with multiple co-morbidities as effectively as possible in place, rather than through admission to an acute care facility. Eligible facilities are required to institute new programs through which residents normally transported to hospital will be cared for in the nursing facility through the use of more intensive nursing home units.

The targeted population receiving restorative care unit services are participating in the restorative care program, post hospital admission and have an overall goal of discharging to the community.

Rate payments will be provided, semi-annually, to eligible residential health care facilities which meet the criteria of providing intensive treatments to nursing home residents in the facility and thereby avoid hospitalization. The rate adjustment is intended to:

TN #20-0030
Supersedes TN #16-0051

Approval Date _____
Effective Date April 1, 2020

cally set through a memorandum of understanding with the New York City Health and Hospitals Corporation. Such adjustments shall be paid by means of one or more estimated payments. Payments may be added to rates of payment or made as aggregate payments.

For state fiscal year beginning April 1, 2020 through March 31, 2021, continues upon the election of the social services district in which an eligible diagnostic and treatment center (DTC) is physically located, up to \$12.6 million in additional annual Medicaid payments may be paid to public DTCs operated by the New York City Health and Hospitals Corporation. Such payments will be based on each DTC's proportionate share of the sum of all clinic visits for all facilities eligible for an adjustment for the base year two years prior to the rate year. The proportionate share payments may be added to rates of payment or made as aggregate payments to eligible DTCs.

For state fiscal year beginning April 1, 2020 through March 31, 2021, continues up to \$5.4 million in additional annual Medicaid payments may be paid to county operated free-standing clinics, not including facilities operated by the New York City Health and Hospitals Corporation, for services provided by such DTC and those provided by a county operated freestanding mental health or substance abuse DTC. Distributions shall be based on each eligible facility's proportionate share of the sum of all DTC and clinic visits for all eligible facilities receiving payments for the base year two years prior to the rate year. The proportionate share payments may be added to rates of payment or made as aggregate payments to eligible facilities.

Institutional Services

Effective on or after April 1, 2020, the temporary rate adjustment has been reviewed and approved for the St. Joseph's Hospital Health Center with aggregate payment amounts totaling up to \$4,000,000 for the period April 1, 2020 through March 31, 2021.

Effective on or after April 1, 2020, continues the supplemental upper payment limit payments made to general hospitals, other than major public general hospitals under institutional services of \$339 million annually.

For state fiscal year beginning April 1, 2020 through March 31, 2021, continues adjustments for hospital inpatient services provided on and after April 1, 2012, to public general hospitals, other than those operated by the State of New York or the State University of New York, located in a city with a population of over one million and receiving reimbursement of up to \$1.08 billion annually based on criteria and methodology set by the Commissioner of Health, which the Commissioner may periodically set through a memorandum of understanding with the New York City Health and Hospitals Corporation. Such adjustments shall be paid by means of one or more estimated payments. Payments to eligible public general hospitals may be added to rates of payment or made as aggregate payments.

For state fiscal year beginning April 1, 2020 through March 31, 2021, supplemental payments will be made to State government owned hospitals. These payments will not exceed the upper payment limit for inpatient services provided by state government-owned hospitals when aggregated with other Medicaid payments.

Effective on or after April 1, 2020, the temporary rate adjustment has been reviewed and approved for Long Island Jewish Medical Center with aggregate payment amounts totaling up to \$1,000,000 for the period April 1, 2020 through March 31, 2021.

Long Term Care Services

Effective on or after April 1, 2020, continues additional payments to non-state government operated public residential health care facilities, including public residential health care facilities located in Nassau, Westchester, and Erie Counties, but excluding public residential health care facilities operated by a town or city within a county, in aggregate amounts of up to \$500 million. The amount allocated to each eligible public RHCF will be in accordance with the previously approved methodology, provided, however that patient days shall be utilized for such computation reflecting actual reported data for 2018 and each representative succeeding year as applicable. Payments to eligible RHCF's may be added to rates of payment or made as aggregate payments.

Effective on or after April 1, 2020, the Department of Health

proposes to amend the Title XIX (Medicaid) State Plan for institutional services related to temporary rate adjustments to long term care providers that are undergoing closure, merger, consolidation, acquisition or restructuring themselves or other health care providers. These payments are authorized by current State statutory and regulatory provisions. The temporary rate adjustments will be reviewed and approved by the CINERGY Collaborative.

The estimated net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2020-2021 is \$30 million.

Effective on or after April 1, 2020, the Department of Health (DOH) will continue the nursing home advanced training program, aimed at teaching staff how to detect early changes in a resident's physical and mental or functional status that could lead to hospitalization. Clinical findings show early detection of patient decline by front line workers, coupled with clinical care models aimed at fostering consistent and continuous care between care givers and patients/families result in better care outcomes. Similarly, nursing homes with higher staff retention rates correlate with better care outcomes and avoided hospital stays. This training program will be developed in cooperation between Nursing Home providers and union representatives offering training opportunities for staff or other qualifying training programs.

These programs and their curricula will be submitted to DOH for review. In addition to offering a training program, eligible facilities must have direct care staff retention rates above the state median. However, hospital-based nursing homes and free standing nursing homes already receiving VAP payments would not be eligible to participate.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2020/2021 is \$46 million.

The public is invited to review and comment on this proposed State Plan Amendment, a copy of which will be available for public review on the Department's website at http://www.health.ny.gov/regulations/state_plans/status. In addition, approved SPA's beginning in 2011 are also available for viewing on this website.

Copies of the proposed State Plan Amendments will be on file in each local (county) social services district and available for public review.

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

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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

SUMMARY
SPA #20-0031

This State Plan Amendment proposes to revise the State Plan to assist safety net hospitals by providing a temporary rate adjustment under the closure, merger, consolidation, acquisition, or restructuring of a health care provider.

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pursuant to section 6056.4(c)(4) or 6056.4(c)(5) of this Title, may apply to the commissioner for leave to substitute satisfactory completion of a course of basic training completed in such other jurisdiction or may apply to the commissioner for leave to substitute satisfactory completion of the pre-employment police basic training program in satisfaction of all or part of the requirements of an approved basic course for peace officers imposed under section 2.30 of the Criminal Procedure Law. The commissioner shall review and evaluate all such applications and may require the applicant to submit such additional documentation as he or she shall deem necessary. If, upon review and evaluation of such application, the commissioner determines that a program of peace officer basic training completed by the applicant in another jurisdiction or the pre-employment police basic training program completed by the application meets or exceeds all or part of the minimum standards prescribed in section 6025.3 of this Part, the commissioner may authorize such training to be substituted for such requirements of the basic course as he or she shall deem appropriate. The commissioner shall certify, in writing, the extent to which all or part of the curriculum of the basic course may be waived and any noted deficiencies must be satisfactorily completed at a basic course approved by the commissioner, within the period of time prescribed in section 6025.7 of this Part. Applicants for equivalency certificates shall be subject to the same limitations and requirements as prescribed in sections 6025.6 and 6025.7 of this Part and section 2.30 of the Criminal Procedure Law.

PUBLIC NOTICE

Division of Criminal Justice Services

I, Andrew M. Cuomo, Governor of the State of New York, do hereby adopt and promulgate the following regulations that have been recommended by the Municipal Police Training Council pursuant to the provisions of section eight hundred forty of the Executive Law. This action is taken pursuant to the authority vested in me by section eight hundred forty-two of such law and, as such, it is exempted from the rule making provisions of the State Administrative Procedure Act.

NOW, THEREFORE, be it known that the amendments to Part 6024 of Title 9 of the New York State Official Compilation of Codes, Rules and Regulations are hereby adopted and promulgated and shall be effective upon publication in the State Register.

1. Subdivision (d) of Section 6024.1 of Title 9 of NYCRR is renumbered to be subdivision (e). A new subdivision (d) is added to section 6024.1 to read as follows:

(d) The term federal law enforcement officer shall have the same meaning as set forth in section 2.15 of the Criminal Procedure Law.

2. Subdivisions (b) and (c) of Section 6024.2 of Title 9 of NYCRR are amended to read as follows:

(b) Have a minimum of three years of police [or], peace officer or federal law enforcement officer experience. The peace officer and federal law enforcement officer experience requirement can only be satisfied by those persons who have carried a firearm in the course of their official duties and have done so for the prescribed period of time.

(c) Successfully complete a Municipal Police Training Council approved basic course for police officers or basic course for peace officers, as appropriate [.] or a requisite basic training course prescribed by a federal law enforcement officer employer.

3. Section 6024.4 of Title 9 of NYCRR is amended to read as follows:

Firearms instructor certification shall be valid from the date of issuance and shall remain valid during the holder's continuous service as a police officer [or], peace officer, or federal law enforcement officer, or while the holder is employed by a sponsoring police officer or peace officer agency, unless revoked by the commissioner.

PUBLIC NOTICE

Division of Criminal Justice Services

I, Andrew M. Cuomo, Governor of the State of New York, do hereby adopt and promulgate the following regulations that have been recommended by the Law Enforcement Agency Accreditation Council pur-

suant to Executive Law § 846-h(1)(c). This action is taken pursuant to the authority vested in me by such law, and, as such, it is exempted from the rule making provisions of the State Administrative Procedure Act.

NOW, THEREFORE, be it known that the amendment to section 6035.1(a) of Title 9 of the New York State Official Compilation of Codes, Rules and Regulations is hereby adopted and promulgated, and shall be effective upon publication in the State Register.

Subdivision (a) of section 6035.1 of Title 9 NYCRR is amended to read as follows:

(a) The term law enforcement agency shall mean any law enforcement agency or department of any municipality, any police district, or any agency, department, commission, authority or public benefit corporation of the state of New York employing a police officer or police officers as that term is defined in paragraphs (a), (b), (c), (d), (e), (f), (j), (k), (l), (o), (p) [and], (s), and (u) of subdivision thirty-four of section 1.20 of the Criminal Procedure Law. For the purposes of this definition, the term shall not include any entity that employs police officers in a capacity which may require the use of their law enforcement authority but is supplementary to the primary official responsibilities for which they have been hired.

PUBLIC NOTICE

Office of General Services

Pursuant to Section 33 of the Public Lands Law, the Office of General Services hereby gives notice to the following:

Notice is hereby given that the New York State Department of Transportation has determined that:

Address: 3628 NYS Route 281, Town of Cortlandville, Cortland County, N:V 13045 DOT Map 118-D, Parcel 119

a.23 acre+ lot, is surplus and no longer useful or necessary for state program purposes and has abandoned the property to the Commissioner of General Services for sale or other disposition as Unappropriated State land.

For further information, please contact: Thomas Pohl, Esq., Office of General Services, Legal Services, 41st Fl., Coming Tower, Empire State Plaza, Albany, NY 12242, (518) 474-8831, (518) 473-4973 fax

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 institutional, non-institutional and long-term care services to comply with enacted statutory provisions. The following changes are proposed:

Non-Institutional Services

Effective for days of service on or after April 1, 2020, The Department of Health will eliminate the limitations on amount and duration of partial hospitalization services. The State Plan Amendment is necessary to comply with the Mental Health Parity and Addiction Equity Act of 2008.

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

Effective on or after April 1, 2020, continues the supplemental upper payment limit payments made to general hospitals, other than major public general hospitals under non-institutional services of \$339 million annually.

For state fiscal year beginning April 1, 2020 through March 31, 2021, continues hospital outpatient payment adjustments that increase the operating cost components of rates of payment for hospital outpatient and emergency departments on and after April 1, 2011, for public general hospitals other than those operated by the State of New York or the State University of New York, which are located in a city with a population of over one million. The amount to be paid will be up to \$287 million annually based on criteria and methodology set by the Commissioner of Health, which the Commissioner may periodi-

cally set through a memorandum of understanding with the New York City Health and Hospitals Corporation. Such adjustments shall be paid by means of one or more estimated payments. Payments may be added to rates of payment or made as aggregate payments.

For state fiscal year beginning April 1, 2020 through March 31, 2021, continues upon the election of the social services district in which an eligible diagnostic and treatment center (DTC) is physically located, up to \$12.6 million in additional annual Medicaid payments may be paid to public DTCs operated by the New York City Health and Hospitals Corporation. Such payments will be based on each DTC's proportionate share of the sum of all clinic visits for all facilities eligible for an adjustment for the base year two years prior to the rate year. The proportionate share payments may be added to rates of payment or made as aggregate payments to eligible DTCs.

For state fiscal year beginning April 1, 2020 through March 31, 2021, continues up to \$5.4 million in additional annual Medicaid payments may be paid to county operated free-standing clinics, not including facilities operated by the New York City Health and Hospitals Corporation, for services provided by such DTC and those provided by a county operated freestanding mental health or substance abuse DTC. Distributions shall be based on each eligible facility's proportionate share of the sum of all DTC and clinic visits for all eligible facilities receiving payments for the base year two years prior to the rate year. The proportionate share payments may be added to rates of payment or made as aggregate payments to eligible facilities.

Institutional Services

Effective on or after April 1, 2020, the temporary rate adjustment has been reviewed and approved for the St. Joseph's Hospital Health Center with aggregate payment amounts totaling up to \$4,000,000 for the period April 1, 2020 through March 31, 2021.

Effective on or after April 1, 2020, continues the supplemental upper payment limit payments made to general hospitals, other than major public general hospitals under institutional services of \$339 million annually.

For state fiscal year beginning April 1, 2020 through March 31, 2021, continues adjustments for hospital inpatient services provided on and after April 1, 2012, to public general hospitals, other than those operated by the State of New York or the State University of New York, located in a city with a population of over one million and receiving reimbursement of up to \$1.08 billion annually based on criteria and methodology set by the Commissioner of Health, which the Commissioner may periodically set through a memorandum of understanding with the New York City Health and Hospitals Corporation. Such adjustments shall be paid by means of one or more estimated payments. Payments to eligible public general hospitals may be added to rates of payment or made as aggregate payments.

For state fiscal year beginning April 1, 2020 through March 31, 2021, supplemental payments will be made to State government owned hospitals. These payments will not exceed the upper payment limit for inpatient services provided by state government-owned hospitals when aggregated with other Medicaid payments.

Effective on or after April 1, 2020, the temporary rate adjustment has been reviewed and approved for Long Island Jewish Medical Center with aggregate payment amounts totaling up to \$1,000,000 for the period April 1, 2020 through March 31, 2021.

Long Term Care Services

Effective on or after April 1, 2020, continues additional payments to non-state government operated public residential health care facilities, including public residential health care facilities located in Nassau, Westchester, and Erie Counties, but excluding public residential health care facilities operated by a town or city within a county, in aggregate amounts of up to \$500 million. The amount allocated to each eligible public RHCF will be in accordance with the previously approved methodology, provided, however that patient days shall be utilized for such computation reflecting actual reported data for 2018 and each representative succeeding year as applicable. Payments to eligible RHCF's may be added to rates of payment or made as aggregate payments.

Effective on or after April 1, 2020, the Department of Health

proposes to amend the Title XIX (Medicaid) State Plan for institutional services related to temporary rate adjustments to long term care providers that are undergoing closure, merger, consolidation, acquisition or restructuring themselves or other health care providers. These payments are authorized by current State statutory and regulatory provisions. The temporary rate adjustments will be reviewed and approved by the CINERGY Collaborative.

The estimated net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2020-2021 is \$30 million.

Effective on or after April 1, 2020, the Department of Health (DOH) will continue the nursing home advanced training program, aimed at teaching staff how to detect early changes in a resident's physical and mental or functional status that could lead to hospitalization. Clinical findings show early detection of patient decline by front line workers, coupled with clinical care models aimed at fostering consistent and continuous care between care givers and patients/families result in better care outcomes. Similarly, nursing homes with higher staff retention rates correlate with better care outcomes and avoided hospital stays. This training program will be developed in cooperation between Nursing Home providers and union representatives offering training opportunities for staff or other qualifying training programs.

These programs and their curricula will be submitted to DOH for review. In addition to offering a training program, eligible facilities must have direct care staff retention rates above the state median. However, hospital-based nursing homes and free standing nursing homes already receiving VAP payments would not be eligible to participate.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2020/2021 is \$46 million.

The public is invited to review and comment on this proposed State Plan Amendment, a copy of which will be available for public review on the Department's website at http://www.health.ny.gov/regulations/state_plans/status. In addition, approved SPA's beginning in 2011 are also available for viewing on this website.

Copies of the proposed State Plan Amendments will be on file in each local (county) social services district and available for public review.

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Bronx County, Tremont Center
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Bronx, New York 10457

Richmond County, Richmond Center
95 Central Avenue, St. George
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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

SUMMARY
SPA #20-0032

This State Plan Amendment proposes to provide a supplemental payment to State government-owned hospitals which are below for the upper payment limit for inpatient services.

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**VII. ADDITIONAL INPATIENT STATE PUBLIC HOSPITAL UPPER PAYMENT LIMIT
(UPL) ADJUSTMENTS**

1. Effective for State UPL demonstrations for calendar year 2019 and after, if CMS determines that payments for inpatient hospital services provided by State government-owned hospitals exceed the UPL, the State will remit such amount in excess of the UPL as follows: The State will process a lump sum reduction equivalent to the value of the UPL excess upon approval of the UPL.
2. For the period beginning January 1, 2019 and each calendar year thereafter, the State will provide a supplemental payment for all inpatient services provided by State government-owned hospitals. The amount of the supplemental payment, when aggregated with other Medical assistance payments, will not exceed 100% of a reasonable estimate of the amount that would be paid for such services under Medicare payment principles for State government-owned hospitals. Such a supplemental payment will be allocated and paid to OMH-operated hospitals based on the proportionate share of total base year Medicaid days used for the inpatient rate calculation and will be factored into facility-specific Disproportionate Share (DSH) limit calculations.

For the period January 1, [2019] 2020 through December 31, [2019] 2021, the supplemental payment will be \$5,046,499 and will be payable as a one-time lump sum.

TN #20-0032

Approval Date _____

Supersedes TN #18-0066

Effective Date April 1, 2020

cally set through a memorandum of understanding with the New York City Health and Hospitals Corporation. Such adjustments shall be paid by means of one or more estimated payments. Payments may be added to rates of payment or made as aggregate payments.

For state fiscal year beginning April 1, 2020 through March 31, 2021, continues upon the election of the social services district in which an eligible diagnostic and treatment center (DTC) is physically located, up to \$12.6 million in additional annual Medicaid payments may be paid to public DTCs operated by the New York City Health and Hospitals Corporation. Such payments will be based on each DTC's proportionate share of the sum of all clinic visits for all facilities eligible for an adjustment for the base year two years prior to the rate year. The proportionate share payments may be added to rates of payment or made as aggregate payments to eligible DTCs.

For state fiscal year beginning April 1, 2020 through March 31, 2021, continues up to \$5.4 million in additional annual Medicaid payments may be paid to county operated free-standing clinics, not including facilities operated by the New York City Health and Hospitals Corporation, for services provided by such DTC and those provided by a county operated freestanding mental health or substance abuse DTC. Distributions shall be based on each eligible facility's proportionate share of the sum of all DTC and clinic visits for all eligible facilities receiving payments for the base year two years prior to the rate year. The proportionate share payments may be added to rates of payment or made as aggregate payments to eligible facilities.

Institutional Services

Effective on or after April 1, 2020, the temporary rate adjustment has been reviewed and approved for the St. Joseph's Hospital Health Center with aggregate payment amounts totaling up to \$4,000,000 for the period April 1, 2020 through March 31, 2021.

Effective on or after April 1, 2020, continues the supplemental upper payment limit payments made to general hospitals, other than major public general hospitals under institutional services of \$339 million annually.

For state fiscal year beginning April 1, 2020 through March 31, 2021, continues adjustments for hospital inpatient services provided on and after April 1, 2012, to public general hospitals, other than those operated by the State of New York or the State University of New York, located in a city with a population of over one million and receiving reimbursement of up to \$1.08 billion annually based on criteria and methodology set by the Commissioner of Health, which the Commissioner may periodically set through a memorandum of understanding with the New York City Health and Hospitals Corporation. Such adjustments shall be paid by means of one or more estimated payments. Payments to eligible public general hospitals may be added to rates of payment or made as aggregate payments.

For state fiscal year beginning April 1, 2020 through March 31, 2021, supplemental payments will be made to State government owned hospitals. These payments will not exceed the upper payment limit for inpatient services provided by state government-owned hospitals when aggregated with other Medicaid payments.

Effective on or after April 1, 2020, the temporary rate adjustment has been reviewed and approved for Long Island Jewish Medical Center with aggregate payment amounts totaling up to \$1,000,000 for the period April 1, 2020 through March 31, 2021.

Long Term Care Services

Effective on or after April 1, 2020, continues additional payments to non-state government operated public residential health care facilities, including public residential health care facilities located in Nassau, Westchester, and Erie Counties, but excluding public residential health care facilities operated by a town or city within a county, in aggregate amounts of up to \$500 million. The amount allocated to each eligible public RHCF will be in accordance with the previously approved methodology, provided, however that patient days shall be utilized for such computation reflecting actual reported data for 2018 and each representative succeeding year as applicable. Payments to eligible RHCF's may be added to rates of payment or made as aggregate payments.

Effective on or after April 1, 2020, the Department of Health

proposes to amend the Title XIX (Medicaid) State Plan for institutional services related to temporary rate adjustments to long term care providers that are undergoing closure, merger, consolidation, acquisition or restructuring themselves or other health care providers. These payments are authorized by current State statutory and regulatory provisions. The temporary rate adjustments will be reviewed and approved by the CINERGY Collaborative.

The estimated net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2020-2021 is \$30 million.

Effective on or after April 1, 2020, the Department of Health (DOH) will continue the nursing home advanced training program, aimed at teaching staff how to detect early changes in a resident's physical and mental or functional status that could lead to hospitalization. Clinical findings show early detection of patient decline by front line workers, coupled with clinical care models aimed at fostering consistent and continuous care between care givers and patients/families result in better care outcomes. Similarly, nursing homes with higher staff retention rates correlate with better care outcomes and avoided hospital stays. This training program will be developed in cooperation between Nursing Home providers and union representatives offering training opportunities for staff or other qualifying training programs.

These programs and their curricula will be submitted to DOH for review. In addition to offering a training program, eligible facilities must have direct care staff retention rates above the state median. However, hospital-based nursing homes and free standing nursing homes already receiving VAP payments would not be eligible to participate.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2020/2021 is \$46 million.

The public is invited to review and comment on this proposed State Plan Amendment, a copy of which will be available for public review on the Department's website at http://www.health.ny.gov/regulations/state_plans/status. In addition, approved SPA's beginning in 2011 are also available for viewing on this website.

Copies of the proposed State Plan Amendments will be on file in each local (county) social services district and available for public review.

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

SUMMARY
SPA #20-0033

This State Plan Amendment proposes to reduce Worker Recruitment and Retention by 25 percent for Certified Home Health Agencies (CHHA) and Hospice programs effective April 2, 2020.

DRAFT

New York
4(a)

For the rate periods on and after January 1, 2005 through December 31, 2006, and April 1, 2007 through March 31, 2009, there will be no such reconciliation of the amount of savings in excess of or lower than one million five hundred thousand dollars.

In addition, separate payment rates for nursing services provided to patients diagnosed with Acquired Immune Deficiency Syndrome (AIDS) will be established based upon regional services prices. Such prices will be computed based upon average nursing costs per visit calculated by aggregating base year allowable costs and statistics reported by certified home health agencies within each of four state regions, and increased by a case mix adjustment factor which represents the relative ratio of additional resources needed to provide home care nursing services to AIDS patients when compared to the average case mix of home care patients. Such AIDS regional nursing prices will be trended annually.

Effective for services provided on and after April 1, 2011, separate payment rates will no longer be established for nursing services provided to patients diagnosed with AIDS; the rate for nursing services provided to patients diagnosed with AIDS will be the prospective certified home health agency rate for nursing services established for the effective period.

The Commissioner will adjust medical assistance rates of payment for services provided by AIDS home care programs for purposes of improving recruitment and retention of non-supervisory home care services workers or any worker with direct patient care responsibility in the following amounts for services provided on and after December first, two thousand two.

Rates of payment by governmental agencies for AIDS home care programs (including services provided through contracts with licensed home care services agencies) will be increased by up to three percent.

Providers which have their rates adjusted for this purpose will use such funds solely for the recruitment and retention of non-supervisory home care services workers or any worker with direct patient care responsibility. Providers are prohibited from using such funds for any other purpose.

The Commissioner is authorized to audit each provider to ensure compliance with this purpose and will recoup any funds determined to have been used for purposes other than recruitment and retention of non-supervisory home care services workers or any worker with direct patient care responsibility.

In the case of services provided by providers through contracts with licensed home care services agencies, rate increases received by providers will be reflected in either the fees paid or benefits or other supports provided to non-supervisory home care services workers or any worker with direct patient care responsibility of such contracted licensed home care services agencies and such fees, benefits or other supports will be proportionate to the contracted

TN #20-0033 Approval Date _____
Supersedes TN #11-0053 Effective Date April 2, 2020

New York
4(a)(i)

volume of services attributable to each contracted agency. Such agencies [shall] will submit to providers with which they contract written certifications attesting that such funds will be used solely for the purposes of recruitment and retention of non-supervisory home care services workers or any worker with direct patient care responsibility and [shall] will maintain in their files expenditure plans specifying how such funds will be used for such purposes. The Commissioner is authorized to audit such agencies to ensure compliance with such certifications and expenditure plans and [shall] will recoup any funds determined to have been used for purposes other than those set forth in this section.

The Commissioner of Health will additionally adjust rates of payment for AIDS home care service providers, for the purpose of improving recruitment and retention of home health aides or non-supervisory personnel with direct patient care responsibility.

These additional adjustments to rates of payments [shall] will be calculated by allocating the available funding proportionally based on each AIDS home care service provider's, home health aide or other direct care services total annual hours of service provided to Medicaid patients, as reported in each such agency's most recently available cost report as submitted to the Department. The total aggregate available funding for AIDS home care service providers is as follows:

For the period June 1, 2006 through December 31, 2006 - \$540,000.
For the period January 1, 2007 through June 30, 2007 - \$540,000.
For the period July 1, 2007 through March 31, 2008 - \$1,080,000.
For the period April 1, 2008 through March 31, 2009 - \$1,080,000.
For the period April 1, 2009 through March 31, 2010 - \$1,080,000.
For the period April 1, 2010 through March 31, 2011 - \$1,080,000.
For the period April 1, 2011 through March 31, 2012 - \$1,080,000.
For the period April 1, 2012 through March 31, 2013 - \$1,080,000.
For the period April 1, 2013 through March 31, 2014 - \$1,080,000.
For the period June 5, 2014 through March 31, 2015 - \$1,080,000.
For the period April 1, 2015 through March 31, 2016 - \$1,080,000.
For the period April 1, 2016 through March 31, 2017 - \$1,080,000.
For the period April 1, 2017 through March 31, 2018 - \$1,080,000.
For the period April 1, 2018 through March 31, 2019 - \$1,080,000.
For the period April 1, 2019 through March 31, 2020 - \$1,080,000.
For the period April 2, 2020 through March 31, 2021, and thereafter - \$1,080,000.

Payments made pursuant to this section [shall] will not be subject to subsequent adjustment or reconciliation.

For providers established after November 1, 2005, the Department utilizes Medicaid data from the initial cost report submitted to the Department, which would allow the inclusion of those providers in the distribution.

TN #20-0033 Approval Date _____
Supersedes TN #14-0025 Effective Date April 2, 2020

New York
4(a)(vii)

The Commissioner of Health is authorized to require group health insurance plans and employer based group health plans to report to the Department, insofar as such reporting does not violate any provisions the Federal Employee Retirement Income Security Act (ERISA), at such times and in such manner as the Commissioner [shall] will decide, any information needed, including but not limited to, the number of people in such plans who become ineligible each month for the continuation coverage described herein. In addition, every certified health maintenance organization and every insurer licensed by the Superintendent of Insurance will submit reports in such form and at such times as may be required.

Recruitment And Retention

The Commissioner will adjust medical assistance rates of payment for services provided by certified home health agencies for purposes of improving recruitment and retention of non-supervisory home care services workers or any worker with direct patient care responsibility in the following amounts for services provided on and after December 1, 2002.

Rates of payment by governmental agencies for certified home health agency services (including services provided through contracts with licensed home care services agencies) will be increased by up to three percent.

Providers, which have their rates adjusted for this purpose will use such funds solely for the recruitment and retention of non-supervisory home care services workers or any worker with direct patient care responsibility. Providers are prohibited from using such funds for any other purpose.

The Commissioner is authorized to audit each provider to ensure compliance with this purpose and will recoup any funds determined to have been used for purposes other than recruitment and retention of non-supervisory home care services workers or any worker with direct patient care responsibility.

In the case of services provided by providers through contracts with licensed home care services agencies, rate increases received by providers will be reflected in either the fees paid or benefits or other supports provided to non-supervisory home care services workers or any worker with direct patient care responsibility of such contracted licensed home care services agencies and such fees, benefits or other supports will be proportionate to the contracted volume of services attributable to each contracted agency. Such agencies will submit to providers with which they contract written certifications attesting that such funds will be used solely for the purposes of recruitment and retention of non-supervisory home care services workers or any worker with direct patient care responsibility and will maintain in their files expenditure plans specifying how such funds will be used for such purposes. The Commissioner is authorized to audit such agencies to ensure compliance with such certifications and expenditure plans and will recoup any funds determined to have been used for purposes other than those set forth in this section.

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Supersedes TN #05-0049 Effective Date April 2, 2020

**New York
4(a)(viii)(1)**

Recruitment and Retention of Direct Patient Care Personnel

The Commissioner of Health will additionally adjust rates of payment for certified home health agencies, for purposes of improving recruitment and retention of home health aides or non-supervisory personnel with direct patient care responsibility.

These additional adjustments to rates of payments [shall] will be calculated by allocating the available funding proportionally based on each certified home health agency's, home health aide or other direct care services total annual hours of service provided to Medicaid patients, as reported in each such agency's most recently available cost report as submitted to the Department. For home health services paid under the episodic payment system, allocation of the recruitment and retention payment is included in episodic payment prices paid under that system. The total aggregate available funding for all eligible certified home health agency providers is as follows:

For the period June 1, 2006 through December 31, 2006 - \$20,100,000.
 For the period January 1, 2007 through June 30, 2007 - \$20,100,000.
 For the period July 1, 2007 through March 31, 2008 - \$40,200,000.
 For the period April 1, 2008 through March 31, 2009 - \$40,200,000.
 For the period April 1, 2009 through March 31, 2010 - \$40,200,000.
 For the period April 1, 2010 through March 31, 2011 - \$40,200,000.
 For the period April 1, 2011 through March 31, 2012 - \$40,200,000.
 For the period April 1, 2012 through March 31, 2013 - \$40,200,000.
 For the period April 1, 2013 through March 31, 2014 - \$40,200,000.
 For the period June 5, 2014 through March 31, 2015 - \$26,736,000.
 For the period April 1, 2015 through March 31, 2016 - \$26,736,000.
 For the period April 1, 2016 through March 31, 2017 - \$26,736,000.
 For the period April 1, 2017 through March 31, 2018 - \$26,736,000.
 For the period April 1, 2018 through March 31, 2019 - \$26,736,000.
 For the period April 1, 2019 through March 31, 2020 - \$26,736,000.
For the period April 2, 2020 through March 31, 2021 and thereafter - \$26,736,000.

Payments made pursuant to this section will not be subject to subsequent adjustment or reconciliation.

For providers established after November 1, 2005, the Department utilizes Medicaid data from the initial cost report submitted to the Department, which would allow the inclusion of those providers in the distribution.

TN #20-0033

Approval Date

Supersedes TN #14-0025

Effective Date April 2, 2020

New York
10

Hospice Services: Routine Home Care, Continuous Home Care, Inpatient Respite Care, And General Inpatient Care

Medicaid payment for hospice care will be in amounts no lower than the Medicare rates for: general inpatient, inpatient respite, routine home care and continuous home care using the same methodology as used under Part A of Title XVIII Annual adjustments [shall] will be made to these rates commencing October 1, 1990, using inflation factors developed by the State.

The Commissioner of Health will increase medical assistance rates of payment by up to three percent for hospice services provided on and after December first, two thousand two, for purposes of improving recruitment and retention of non-supervisory workers or workers with direct patient care responsibility.

Rates of payment will be additionally adjusted for the purpose of further enhancing the provider's ability to recruit and retain non-supervisory workers or workers with direct patient care responsibility. These additional adjustments to rates of payment will be allocated proportionally based on each hospice provider's non-supervisory workers' or direct patient care workers' total annual hours of service provided to Medicaid patients as reported in each such provider's most recently available cost report as submitted to the Department. The total aggregate available funding for all eligible hospice providers is as follows:

For the period June 1, 2006 through December 31, 2006 - \$730,000.
 For the period January 1, 2007 through June 30, 2007 - \$730,000.
 For the period July 1, 2007 through March 31, 2008 - \$1,460,000.
 For the period April 1, 2008 through March 31, 2009 - \$1,460,000.
 For the period April 1, 2009 through March 31, 2010 - \$1,460,000.
 For the period April 1, 2010 through March 31, 2011 - \$1,460,000.
 For the period April 1, 2011 through March 31, 2012 - \$1,460,000.
 For the period April 1, 2012 through March 31, 2013 - \$1,460,000.
 For the period April 1, 2013 through March 31, 2014 - \$1,460,000.
 For the period June 5, 2014 through March 31, 2015 - \$1,460,000.
 For the period April 1, 2015 through March 31, 2016 - \$1,460,000.
 For the period April 1, 2016 through March 31, 2017 - \$1,460,000.
 For the period April 1, 2017 through March 31, 2018 - \$1,460,000.
 For the period April 1, 2018 through March 31, 2019 - \$1,460,000.
 For the period April 1, 2019 through March 31, 2020 - \$1,460,000.
For the period April 2, 2020 through March 31, 2021 and thereafter - \$1,460,000.

For providers established after November 1, 2005, the Department utilizes Medicaid data from the initial cost report submitted to the Department, which would allow the inclusion of those providers in the distribution.

Hospice services providers that have their rates adjusted for this purpose [shall] will use such funds solely for the purposes of recruitment and retention of non-supervisory workers or workers with direct patient care responsibility and are prohibited from using such funds for any other purposes. Each hospice provider receiving funds [shall] will submit, at a time and in a manner determined by the Commissioner, a written certification attesting that such funds will be used solely for the purpose of recruitment and retention of non-supervisory workers or workers with

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Approval Date _____

Supersedes TN #14-0025

Effective Date April 2, 2020

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 Health

The Department of Health proposes to amend the Title XIX (Medicaid) State Plan for inpatient, long term care, and non-institutional services to comply with recently proposed statutory provisions. The following significant changes are proposed:

All Services

Effective for dates of service April 1, 2020 through March 31, 2021, and each state fiscal year thereafter, all non-exempt Department of Health state funds Medicaid payments will be uniformly reduced by \$2.5 billion. Such reductions will be applied only to the extent that alternative methods that achieve Medicaid state share savings annually are not implemented. Medicaid payments that will be exempted from the uniform reduction include:

1. Payments whereby federal law precludes such reduction, including:
 - Federally Qualified Health Center services;
 - Indian Health Services and services provided to Native Americans;
 - Supplemental Medical Insurance – Part A and Part B;
 - State Contribution for Prescription Drug Benefit (aka Medicare Part D payments);
 - Any local share cap payment required by the Federal Medical Assistance Percentage (FMAP) increase legislation;
 - Services provided to American citizen repatriates; and
 - Hospice Services.
2. Payments funded exclusively with federal and/or local funds include, but are not limited to, the following:
 - Upper payment limit payments to non-state owned or operated governmental providers certified under Article 28 of the NYS Public Health Law;
 - Certified public expenditure payments to the NYC Health and Hospital Corporation;
 - Certain disproportionate share payments to non-state operated 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.
3. 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;
 - Court orders and judgments; and
 - Family Planning services.

Copies of the proposed state plan amendments will be on file in each local (county) social services district and available for public review.

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 institutional, non-institutional or long term care services to comply with proposed Medicaid Redesign Team II (MRT) initiatives. The following changes are proposed:

All Services

Effective for dates of service April 1, 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 1.875 percent. Medicaid payments that will be exempted from the uniform reduction include:

- Payments whereby federal law precludes such reduction, including:
 - Federally Qualified Health Center services;
 - Indian Health Services and services provided to Native Americans;
 - Supplemental Medical Insurance – Part A and Part B;
 - State Contribution for Prescription Drug Benefit (aka Medicare Part D payments);
 - Any local share cap payment required by the Federal Medical Assistance Percentage (FMAP) increase legislation;
 - Services provided to American citizen repatriates; and
 - Hospice Services.
- Payments funded exclusively with federal and/or local funds include, but are not limited to, the following:
 - Upper payment limit payments to non-state owned or operated governmental providers certified under Article 28 of the NYS Public Health Law;
 - Certified public expenditure payments to the NYC Health and Hospitals Corporation;
 - Certain disproportionate share payments to non-state oper-

- 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-

SUMMARY
SPA #20-0034

This State Plan Amendment proposes to amend the Title XIX (Medicaid) State Plan Amendment for non-institutional services to comply with enacted statutory provisions. The changes proposed in this State Plan Amendment will eliminate separate per member per month payments for outreach to Health Homes Serving Adults and Health Homes Serving Children.

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[Records](#) / [Submission Packages - Your State](#)

NY - Submission Package - NY2020MS0004O - (NY-20-0034) - Health Homes

[Summary](#) [Reviewable Units](#) [News](#) [Related Actions](#)

CMS-10434 OMB 0938-1188

Package Information

Package ID	NY2020MS0004O	Submission Type	Official
Program Name	NYS Health Home Program	State	NY
SPA ID	NY-20-0034	Region	New York, NY
Version Number	1	Package Status	Pending

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Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | NY2020MS00040 | NY-20-0034 | NYS Health Home Program

Package Header

Package ID	NY2020MS00040	SPA ID	NY-20-0034
Submission Type	Official	Initial Submission Date	N/A
Approval Date	N/A	Effective Date	N/A
Superseded SPA ID	N/A		

State Information

State/Territory Name: New York

Medicaid Agency Name: Department of Health

Submission Component

- State Plan Amendment
- Medicaid
- CHIP

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Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | NY2020MS0004O | NY-20-0034 | NYS Health Home Program

Package Header

Package ID NY2020MS0004O	SPA ID NY-20-0034
Submission Type Official	Initial Submission Date N/A
Approval Date N/A	Effective Date N/A
Superseded SPA ID N/A	

SPA ID and Effective Date

SPA ID NY-20-0034

Reviewable Unit	Proposed Effective Date	Superseded SPA ID
Health Homes Intro	7/1/2020	NY-18-0051
Health Homes Population and Enrollment Criteria	7/1/2020	NY-17-0053
Health Homes Providers	7/1/2020	NY-16-0034
Health Homes Payment Methodologies	7/1/2020	NY-19-0007

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Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | NY2020MS00040 | NY-20-0034 | NYS Health Home Program

Package Header

Package ID	NY2020MS00040	SPA ID	NY-20-0034
Submission Type	Official	Initial Submission Date	N/A
Approval Date	N/A	Effective Date	N/A
Superseded SPA ID	N/A		

Executive Summary

Summary Description Including Goals and Objectives The Department of Health proposes to amend the Title XIX (Medicaid) State Plan Amendment for non-institutional services to comply with enacted statutory provisions. The changes proposed in this State Plan Amendment will eliminate separate per member per month payments for outreach to Health Homes Serving Adults and Health Homes Serving Children.

Federal Budget Impact and Statute/Regulation Citation

Federal Budget Impact

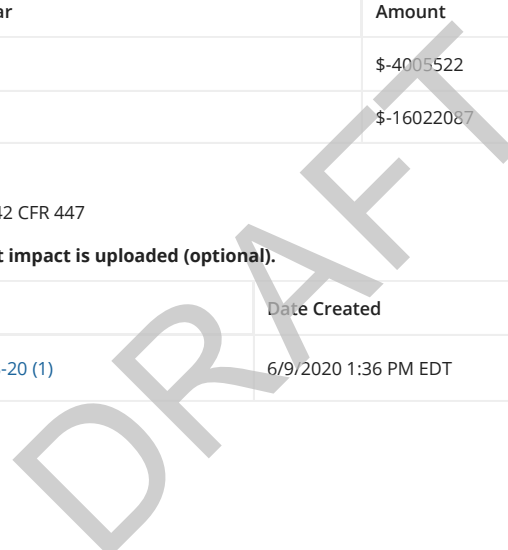
	Federal Fiscal Year	Amount
First	2020	\$-4005522
Second	2021	\$-16022087

Federal Statute / Regulation Citation

§1902(a) of the Social Security Act and 42 CFR 447

Supporting documentation of budget impact is uploaded (optional).

Name	Date Created	
2- Fiscal Calculations SPA 20-0034_5-8-20 (1)	6/9/2020 1:36 PM EDT	



Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | NY2020MS00040 | NY-20-0034 | NYS Health Home Program

Package Header

Package ID	NY2020MS00040	SPA ID	NY-20-0034
Submission Type	Official	Initial Submission Date	N/A
Approval Date	N/A	Effective Date	N/A
Superseded SPA ID	N/A		

Governor's Office Review

- No comment
- Comments received
- No response within 45 days
- Other

DRAFT

Submission - Medicaid State Plan

MEDICAID | Medicaid State Plan | Health Homes | NY2020MS00040 | NY-20-0034 | NYS Health Home Program

CMS-10434 OMB 0938-1188

The submission includes the following:

- Administration
- Eligibility
- Benefits and Payments
- Health Homes Program

Do not use "Create New Health Homes Program" to amend an existing Health Homes program. Instead, use "Amend existing Health Homes program," below.

- Create new Health Homes program
- Amend existing Health Homes program
- Terminate existing Health Homes program

NYS Health Home Program

Health Homes SPA - Reviewable Units

Only select Reviewable Units to include in the package which you intend to change.

*

<input type="checkbox"/>	Reviewable Unit Name	in-cluded in Another Submission Package	Source Type
<input checked="" type="checkbox"/>	Health Homes Intro	<input checked="" type="radio"/>	APPROVED
<input type="checkbox"/>	Health Homes Geographic Limitations	<input checked="" type="radio"/>	APPROVED
<input checked="" type="checkbox"/>	Health Homes Population and Enrollment Criteria	<input checked="" type="radio"/>	APPROVED
<input checked="" type="checkbox"/>	Health Homes Providers	<input checked="" type="radio"/>	APPROVED
<input type="checkbox"/>	Health Homes Service Delivery Systems	<input checked="" type="radio"/>	APPROVED
<input checked="" type="checkbox"/>	Health Homes Payment Methodologies	<input checked="" type="radio"/>	APPROVED
<input type="checkbox"/>	Health Homes Services	<input type="radio"/>	APPROVED

		●	
<input type="checkbox"/>	Health Homes Monitoring, Quality Measurement and Evaluation	●	APPROVED
			1 - 8 of 8

DRAFT

Submission - Public Notice/Process

MEDICAID | Medicaid State Plan | Health Homes | NY2020MS00040 | NY-20-0034 | NYS Health Home Program

Package Header


Package ID NY2020MS00040	SPA ID NY-20-0034
Submission Type Official	Initial Submission Date N/A
Approval Date N/A	Effective Date N/A
Superseded SPA ID N/A	

Name of Health Homes Program

NYS Health Home Program

Public notice was provided due to proposed changes in methods and standards for setting payment rates for services, pursuant to 42 CFR 447.205.

Upload copies of public notices and other documents used

Name	Date Created	
4 - NYS Register (4-1-20) (002)	6/9/2020 1:39 PM EDT	

DRAFT

Submission - Tribal Input

MEDICAID | Medicaid State Plan | Health Homes | NY2020MS00040 | NY-20-0034 | NYS Health Home Program

Package Header

Package ID	NY2020MS00040	SPA ID	NY-20-0034
Submission Type	Official	Initial Submission Date	N/A
Approval Date	N/A	Effective Date	N/A
Superseded SPA ID	N/A		

Name of Health Homes Program:

NYS Health Home Program

One or more Indian Health Programs or Urban Indian Organizations furnish health care services in this state

- Yes
- No

This state plan amendment is likely to have a direct effect on Indians, Indian Health Programs or Urban Indian Organizations, as described in the state consultation plan.

- Yes
- No

Explain why this SPA is not likely to have a direct effect on Indians, Indian Health Programs or Urban Indian Organizations:

Indian Health Programs and Urban Indian Organizations are encouraged, but not required, to participate in health home delivery as a care management agency or network provider to provide culturally competent care for tribe members, and so would not be impacted by the elimination of the outreach rate.

DRAFT

Submission - Other Comment

MEDICAID | Medicaid State Plan | Health Homes | NY2020MS00040 | NY-20-0034 | NYS Health Home Program

Package Header

Package ID NY2020MS00040	SPA ID NY-20-0034
Submission Type Official	Initial Submission Date N/A
Approval Date N/A	Effective Date N/A
Superseded SPA ID N/A	

SAMHSA Consultation

Name of Health Homes Program

NYS Health Home Program

The State provides assurance that it has consulted and coordinated with the Substance Abuse and Mental Health Services Administration (SAMHSA) in addressing issues regarding the prevention and treatment of mental illness and substance abuse among eligible individuals with chronic conditions.

Date of consultation
11/20/2014

DRAFT

Health Homes Intro

MEDICAID | Medicaid State Plan | Health Homes | NY2020MS00040 | NY-20-0034 | NYS Health Home Program

Package Header

Package ID	NY2020MS00040	SPA ID	NY-20-0034
Submission Type	Official	Initial Submission Date	N/A
Approval Date	N/A	Effective Date	7/1/2020
Superseded SPA ID	NY-18-0051 System-Derived		

Program Authority

1945 of the Social Security Act

The state elects to implement the Health Homes state plan option under Section 1945 of the Social Security Act.

Name of Health Homes Program

NYS Health Home Program

Executive Summary

Provide an executive summary of this Health Homes program including the goals and objectives of the program, the population, providers, services and service delivery model used

Summary description including goals and objectives
 New state plan amendment supersedes transmittal# 19-0007
 Transmittal# 20-0034

Part I: Summary of new State Plan Amendment (SPA) #20-0034

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

- Effective July 1, 2020, eliminate the Health Home per member per month (pmpm) "outreach" payment for all members (adults and children) in the case finding group from \$75 pmpm to a rate of \$0 pmpm.

General Assurances

- The state provides assurance that eligible individuals will be given a free choice of Health Homes providers.
- The states provides assurance that it will not prevent individuals who are dually eligible for Medicare and Medicaid from receiving Health Homes services.
- The state provides assurance that hospitals participating under the state plan or a waiver of such plan will be instructed to establish procedures for referring eligible individuals with chronic conditions who seek or need treatment in a hospital emergency department to designated Health Homes providers.
- The state provides assurance that FMAP for Health Homes services shall be 90% for the first eight fiscal quarters from the effective date of the SPA. After the first eight quarters, expenditures will be claimed at the regular matching rate.
- The state provides assurance that it will have the systems in place so that only one 8-quarter period of enhanced FMAP for each health homes enrollee will be claimed.
- The state provides assurance that there will be no duplication of services and payment for similar services provided under other Medicaid authorities.

Health Homes Population and Enrollment Criteria

MEDICAID | Medicaid State Plan | Health Homes | NY2020MS00040 | NY-20-0034 | NYS Health Home Program

Package Header

Package ID	NY2020MS00040	SPA ID	NY-20-0034
Submission Type	Official	Initial Submission Date	N/A
Approval Date	N/A	Effective Date	7/1/2020
Superseded SPA ID	NY-17-0053 System-Derived		

Categories of Individuals and Populations Provided Health Homes Services

The state will make Health Homes services available to the following categories of Medicaid participants

- Categorically Needy (Mandatory and Options for Coverage) Eligibility Groups
- Medically Needy Eligibility Groups
 - Mandatory Medically Needy
 - Medically Needy Pregnant Women
 - Medically Needy Children under Age 18
 - Optional Medically Needy (select the groups included in the population)
 - Families and Adults**
 - Medically Needy Children Age 18 through 20
 - Medically Needy Parents and Other Caretaker Relatives
 - Aged, Blind and Disabled**
 - Medically Needy Aged, Blind or Disabled
 - Medically Needy Blind or Disabled Individuals Eligible in 1973

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Health Homes Population and Enrollment Criteria

MEDICAID | Medicaid State Plan | Health Homes | NY2020MS00040 | NY-20-0034 | NYS Health Home Program

Package Header

Package ID NY2020MS00040	SPA ID NY-20-0034
Submission Type Official	Initial Submission Date N/A
Approval Date N/A	Effective Date 7/1/2020
Superseded SPA ID NY-17-0053 System-Derived	

Population Criteria

The state elects to offer Health Homes services to individuals with:

Two or more chronic conditions

Specify the conditions included:

- Mental Health Condition
- Substance Use Disorder
- Asthma
- Diabetes
- Heart Disease
- BMI over 25
- Other (specify):

Name	Description
BMI over 25	BMI is defined as, at or above 25 for adults, and BMI at or above the 85 percentile for children.

One chronic condition and the risk of developing another

Specify the conditions included:

- Mental Health Condition
- Substance Use Disorder
- Asthma
- Diabetes
- Heart Disease
- BMI over 25
- Other (specify):

Name	Description
HIV/AIDS	see description below
One Serious Mental illness	see description below
SED/Complex Trauma	see description below

Specify the criteria for at risk of developing another chronic condition:

HIV, Serious Mental Illness (SMI) and Serious Emotional Disturbance (SED) and complex trauma are each single qualifying conditions for which NYS was approved. Providers do not need to document a risk of developing another condition in these cases. New York's Medicaid program serves over 5 million enrollees with a

broad array of health care needs and challenges. While many Medicaid enrollees are relatively healthy and access practitioners to obtain episodic and preventive health care, the Medicaid program also has several population groups who have complex medical, behavioral, and long term care needs that drive a high volume of high cost services including inpatient and long term institutional care.

Of the 5.4M Medicaid enrollees who access services on a fee for service or managed care basis, 975,000 (including dual eligibles) have been identified as high cost/high need enrollees with two or more chronic conditions and/or a Serious Persistent Mental Illness. These high cost/high need enrollees are categorized into four groups representing enrollees with intellectual disabilities, enrollees in need of long term care services, enrollees with behavioral health issues, and enrollees with two or more chronic medical conditions. One of NY's first health home initiatives will focus on enrollees with behavioral health and/or chronic medical conditions.

The NYS Medicaid program plans to certify health homes that build on current provider partnerships. Applicant health home providers will be required to meet State defined health home requirements that assure access to primary, specialty and behavioral health care that support the integration and coordination of all care. Recently passed New York State Law provides the Commissioners of Health, Mental Health, Alcoholism and Substance Abuse Services, and People with Developmental Disabilities the authority to integrate care delivery by synching health care, substance abuse services, and mental health certification requirements for health homes. Approved health homes will directly provide, or contract for, health home services to the identified eligible beneficiaries. To meet this goal, it is expected that health home providers will develop health home networks with primary, medical, specialty and mental health providers, substance abuse service providers, community based organizations, managed care plans and others to provide enrollees access to needed services.

To facilitate the use of health information technology by health homes to improve service delivery and coordination across the care continuum, NY has developed initial and final HIT standards for health homes that are consistent with NYS' Operational Plan for Health Information Technology and Exchange approved by CMS. Providers must meet initial HIT standards to implement a health home. Furthermore, applicants must provide a plan to achieve the final standards within eighteen months of program initiation in order to be approved as a health home provider.

To the extent possible health home providers will be encouraged to utilize regional health information organizations or qualified entities to access patient data and to develop partnerships that maximize the use of HIT across providers (i.e. hospitals, TCMS). Health home providers will be encouraged to utilize HIT as feasible to create, document, execute and update a plan of care that is accessible to the interdisciplinary team of providers for every patient. Health home providers will also be encouraged to utilize HIT as feasible to process and follow up on patient testing, treatments, community based services and provider referrals.

NY will target populations for health homes services in the major categories and the associated 3M Clinical Risk Group categories of chronic behavioral and medical conditions listed below.

Major Category: Alcohol and Substance Abuse

3M Clinical Risk Group (3M CRGs) Category

1. Alcohol Liver Disease
2. Chronic Alcohol Abuse
3. Cocaine Abuse
4. Drug Abuse - Cannabis/NOS/NEC
5. Substance Abuse
6. Opioid Abuse
7. Other Significant Drug Abuse

Major Category: Mental Health

3M Clinical Risk Group (3M CRGs) Category

1. Bi-Polar Disorder
2. Conduct, Impulse Control, and Other Disruptive Behavior Disorders
3. Dementing Disease
4. Depressive and Other Psychoses
5. Eating Disorder
6. Major Personality Disorders
7. Psychiatric Disease (Except Schizophrenia)
8. Schizophrenia

Major Category: Cardiovascular Disease
3M Clinical Risk Group (3M CRGs) Category

1. Advanced Coronary Artery Disease
2. Cerebrovascular Disease
3. Congestive Heart Failure
4. Hypertension
5. Peripheral Vascular Disease

Major Category: HIV/AIDS
3M Clinical Risk Group (3M CRGs) Category

1. HIV Disease

Major Category: Metabolic Disease
3M Clinical Risk Group (3M CRGs) Category

1. Chronic Renal Failure
2. Diabetes

Major Category: Respiratory Disease
3M Clinical Risk Group (3M CRGs) Category

1. Asthma
2. Chronic Obstructive Pulmonary Disease

Major Category: Other
3M Clinical Risk Group (3M CRGs) Category

1. Other Chronic Disease -conditions listed above as well as other specific diagnoses of the population.

Description of population selection criteria

The target population to receive health home services under this amendment includes categorically needy and medically needy beneficiaries served by Medicaid managed care or fee for service and Medicare/Medicaid dual eligible beneficiaries who meet health home selection criteria. NY will offer Health Home Services to individuals with two or more chronic conditions, individuals with HIV/AIDS, individuals with one serious mental illness, individuals with SED, and individuals with complex trauma.

Enrollees in the behavioral health category have been identified through claims and encounter data analysis as having received mental health or substance abuse services and/or having select mental health diagnoses. These enrollees often have co-morbid chronic, medical conditions. In addition, based on experience in working with this population, many of these enrollees have social issues, such as lack of permanent housing, that take priority to these individuals over their health care conditions. Enrollees in the chronic medical condition category have been identified through claims and encounter data analysis as having two or three chronic medical conditions.

Complex trauma exposure in childhood has been shown to impair brain development and the ability to learn and develop social and emotional skills during childhood, consequently increasing the risks of developing serious or chronic diseases in adolescence and adulthood. Children who have experienced complex trauma and who are not old enough to have experienced long-term impacts are uniquely vulnerable. Childhood exposure to child maltreatment, including emotional abuse and neglect, exposure to violence, sexual and physical abuse are often traumatic events that continue to be distressing for children even after the maltreatment has ceased, with negative physical, behavioral, and/or psychological effects on the children. Since child maltreatment occurs in the context of the child's relationship with a caregiver, the child's ability to form secure

attachment bonds, sense of safety and stability are disrupted. Without timely and effective intervention during childhood, a growing body of research shows that a child's experience of these events (simultaneous or sequential maltreatment) can create wide-ranging and lasting adverse effects on developmental functioning, and physical, social, emotional or spiritual well-being. Enrolling children who are experiencing complex trauma in Health Homes will work to prevent, while an individual is still in childhood, the development of other more complex chronic conditions in adulthood.

Enrollees in the complex trauma category will be identified for referral to Health Homes by various entities, including child welfare systems (i.e., foster care and local departments of social services), health and behavioral health care providers, and other systems (e.g., education) that impact children.

Enrollees in the behavioral health category have been identified through claims and encounter data analysis as having received mental health or substance abuse services and/or having select mental health diagnoses. These enrollees often have co-morbid chronic, medical conditions. In addition, based on experience in working with this population, many of these enrollees have social issues, such as lack of permanent housing, that take priority to these individuals over their health care conditions. Enrollees in the chronic medical condition category have been identified through claims and encounter data analysis as having two or three chronic medical conditions.

One serious and persistent mental health condition

Specify the criteria for a serious and persistent mental health condition:

The guidance on complex trauma draws upon the domains within the definition of serious emotional disturbance (SED). While there may be similarities in the condition(s) and symptoms that arise in either complex trauma or SED, the therapeutic approaches associated with the same diagnoses may vary significantly when the symptoms arising from traumatic experiences are identified as such. Trauma experts indicate that with complex trauma, the clinical diagnoses may be more severe and typically present as comorbidities or multiple diagnoses. 1. Definition of Complex Trauma

a. The term complex trauma incorporates at least:

- i. Infants/children/or adolescents' exposure to multiple traumatic events, often of an invasive, interpersonal nature, and
- ii. the wide ranging long-term impact of this exposure.

b. Nature of the traumatic events:

- i. often is severe and pervasive, such as abuse or profound neglect
- ii. usually begins early in life
- iii. can be disruptive of the child's development and the formation of a healthy sense of self (with self-regulatory, executive functioning, self-perceptions, etc.)
- iv. often occur in the context of the child's relationship with a caregiver, and
- v. can interfere with the child's ability to form a secure attachment bond, which is considered a prerequisite for healthy social-emotional functioning.

c. Many aspects of a child's healthy physical and mental development rely on this secure attachment, a primary source of safety and stability.

d. Wide-ranging, long-term adverse effects can include impairments in

- i. physiological responses and related neurodevelopment
- ii. emotional responses
- iii. cognitive processes including the ability to think, learn, and concentrate
- iv. impulse control and other self-regulating behavior
- v. self-image, and
- vi. relationships with others and
- vii. dissociation.

Effective October 1, 2016 complex trauma and SED will each be a single qualifying condition.

Health Homes Population and Enrollment Criteria

MEDICAID | Medicaid State Plan | Health Homes | NY2020MS00040 | NY-20-0034 | NYS Health Home Program

Package Header

Package ID	NY2020MS00040	SPA ID	NY-20-0034
Submission Type	Official	Initial Submission Date	N/A
Approval Date	N/A	Effective Date	7/1/2020
Superseded SPA ID	NY-17-0053 System-Derived		

Enrollment of Participants


Participation in a Health Homes is voluntary. Indicate the method the state will use to enroll eligible Medicaid individuals into a Health Home:

- Opt-In to Health Homes provider
- Referral and assignment to Health Homes provider with opt-out
- Other (describe)

Describe the process used:

Any Individual, including those for which consent to enroll in a health home will be provided by a parent or guardian, will be referred to health homes by health homes, care managers, managed care plans and other providers and entities, including local departments of social services, and local government units. Referrals will be processed for assignment, and such assignments will take into account existing relationships with health care providers or health care delivery system relationships, geography, and/or qualifying condition. Such individuals/parents/guardians will be given the option to choose another health home when available, or opt out of enrollment of a health home.

The state provides assurance that it will clearly communicate the individual's right to opt out of the Health Homes benefit or to change Health Homes providers at any time and agrees to submit to CMS a copy of any letter or communication used to inform the individuals of the Health Homes benefit and their rights to choose or change Health Homes providers or to elect not to receive the benefit.

Name	Date Created	
NY Health Home Brochure	9/14/2016 10:08 AM EDT	

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Health Homes Providers

MEDICAID | Medicaid State Plan | Health Homes | NY2020MS00040 | NY-20-0034 | NYS Health Home Program

Package Header

Package ID	NY2020MS00040	SPA ID	NY-20-0034
Submission Type	Official	Initial Submission Date	N/A
Approval Date	N/A	Effective Date	7/1/2020
Superseded SPA ID	NY-16-0034		
	System-Derived		

Types of Health Homes Providers

Designated Providers

Indicate the Health Homes Designated Providers the state includes in its program and the provider qualifications and standards

- Physicians
- Clinical Practices or Clinical Group Practices
- Rural Health Clinics
- Community Health Centers
- Community Mental Health Centers
- Home Health Agencies
- Case Management Agencies
- Community/Behavioral Health Agencies
- Federally Qualified Health Centers (FQHC)
- Other (Specify)

Provider Type	Description
Designated Providers as described in section 1945(h)(5)	please see text below

Teams of Health Care Professionals

Health Teams

Provider Infrastructure

Describe the infrastructure of provider arrangements for Health Home Services

New York's health home provider infrastructure will include designated providers working with multidisciplinary teams as described below. NYS Medicaid providers eligible to become health homes include managed care plans; hospitals; medical, mental and chemical dependency treatment clinics; primary care practitioner practices; PCMHs; FQHCs; Targeted Case Management (TCM) providers; certified home health care agencies and any other Medicaid enrolled provider that meet health home provider standards. To assure that NY health homes meet the proposed federal health home model of service delivery and NYS standards, health home provider qualification standards were developed. The standards were developed with input from a variety of stakeholders including hospitals, clinics, physicians, mental health experts, chemical dependency treatment experts and housing providers. Representatives from the Department of Health's Offices of Health Systems Management, Health IT Transformation, and the AIDS Institute and the NYS Offices of Mental Health and Office of Addiction Services and Supports also participated in the development of these standards. The standards set the ground work for assuring that health home enrollees will receive appropriate, and timely access to medical, behavioral, and social services in a coordinated and integrated manner.

NY health homes will use multidisciplinary teams of medical, mental health, chemical dependency treatment providers, social workers, nurses and other care providers led by a dedicated care manager who will assure that enrollees receive needed medical, behavioral, and social services in accordance with a single plan of care. Optional team members may include nutritionists/dieticians, pharmacists, outreach workers including

peer specialists and other representatives as appropriate to meet the enrollee needs (housing representatives, entitlement, employment). All members of the team will be responsible for reporting back to the care manager on patient status, treatment options, actions taken and outcomes as a result of those interventions. All members of the team will also be responsible for ensuring that care is person-centered, culturally competent and linguistically capable.

A single care management record will be agreed to and shared by all team professionals and case reviews will be conducted on a regular basis. The care manager will be responsible for overall management and coordination of the enrollee's care plan which will include both medical/behavioral health and social service needs and goals.

In order to ensure the delivery of quality health home services, the State will provide educational opportunities for health home providers, such as webinars, regional meetings and/ or learning collaboratives to foster shared learning, information sharing and problem solving. Educational opportunities will be provided to support the provision of timely, comprehensive, high-quality health homes services that are whole person focused and that

integrate medical, behavioral health and other needed supports and social services. The State will maintain a highly collaborative and coordinated working relationship with individual health home providers through frequent communication and feedback. Learning activities and technical assistance will also support providers of health home services to address the following health home functional components:

1. Provide quality-driven, cost-effective, culturally appropriate, and person- and family-centered health home services;
2. Coordinate and provide access to high-quality health care services informed by evidence-based clinical practice guidelines;
3. Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders;
4. Coordinate and provide access to mental health and substance abuse services;
5. Coordinate and provide access to comprehensive care management, care coordination, and transitional care across settings. Transitional care includes appropriate follow-up from inpatient to other settings, such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of health care;
6. Coordinate and provide access to chronic disease management, including self-management support to individuals and their families;
7. Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services;
8. Coordinate and provide access to long-term care supports and services;
9. Develop a person-centered care plan for each individual that coordinates and integrates all of his or her clinical and non-clinical health-care related needs and services;
10. Demonstrate a capacity to use health information technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate; and
11. Establish a continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level.

The Department of Health in partnership with the Office of Mental Health and the Office of Addiction Services and Supports will closely monitor health home providers to ensure that health home services are being provided that meet the NYS health home provider standards and CMS' health home core functional requirements. Oversight activities will include, but not be limited to: medical chart and care management record review, site audits, team composition analysis, and review of types and number of contacts, etc.

Supports for Health Homes Providers

Describe the methods by which the state will support providers of Health Homes services in addressing the following components

1. Provide quality-driven, cost-effective, culturally appropriate, and person- and family- centered Health Homes services
2. Coordinate and provide access to high quality health care services informed by evidence-based clinical practice guidelines
3. Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders
4. Coordinate and provide access to mental health and substance abuse services
5. Coordinate and provide access to comprehensive care management, care coordination, and transitional care across settings. Transitional care includes appropriate follow-up from inpatient to other settings, such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of health care
6. Coordinate and provide access to chronic disease management, including self-management support to individuals and their families
7. Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services
8. Coordinate and provide access to long-term care supports and services
9. Develop a person-centered care plan for each individual that coordinates and integrates all of his or her clinical and non-clinical health-care related needs and services
10. Demonstrate a capacity to use health information technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate
11. Establish a continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level

Description

Other Health Homes Provider Standards

The state's requirements and expectations for Health Homes providers are as follows

The state's minimum requirements and expectations for Health Home providers are as follows: Under New York State's approach to health home implementation, a health home provider is the central point for directing patient-centered care and is accountable for reducing avoidable health care costs, specifically preventable hospital admissions/readmissions and avoidable emergency room visits; providing timely post discharge follow-up, and improving patient outcomes by addressing primary medical, specialist and behavioral health care through direct provision, or through contractual arrangements with appropriate service providers, of comprehensive, integrated services.

General Qualifications

1. Health home providers/plans must be enrolled (or be eligible for enrollment) in the NYS Medicaid program and agree to comply with all Medicaid program requirements.

2. Health home providers can either directly provide, or subcontract for the provision of, health home services. The health home provider remains responsible for all health home program requirements, including services performed by the subcontractor.

3. Care coordination and integration of health care services will be provided to all health home enrollees by an interdisciplinary team of providers, where each individual's care is under the direction of a dedicated care manager who is accountable for assuring access to medical and behavioral health care services and community social supports as defined in the enrollee care plan.

4. Hospitals that are part of a health home network must have procedures in place for referring any eligible individual with chronic conditions who seek or need treatment in a hospital emergency department to a DOH designated health home provider.

5. Health home providers must demonstrate their ability to perform each of the eleven CMS health home core functional components. (Refer to section iii. Provider Infrastructure) Including:

i. processes used to perform these functions;

ii. processes and timeframes used to assure service delivery takes place in the described manner; and

iii. description of multifaceted health home service interventions that will be provided to promote patient engagement, participation in their plan of care and that ensures patients appropriate access to the continuum of physical and behavioral health care and social services.

6. Health home providers must meet the following core health home requirements in the manner described below. Health home providers must provide written documentation that clearly demonstrates how the requirements are being met.

* Please note whenever the individual/ patient /enrollee is stated when applicable, the term is interchangeable with guardian.

I. Comprehensive Care Management

Policies and procedures are in place to create, document, execute and update an individualized, patient centered plan of care for each individual.

1a. A comprehensive health assessment that identifies medical, mental health, chemical dependency and social service needs is developed.

1b. The individual's plan of care integrates the continuum of medical, behavioral health services, rehabilitative, long term care and social service needs and clearly identifies the primary care physician/nurse practitioner, specialist(s), behavioral health care provider(s), care manager and other providers directly involved in the individual's care.

1c. The individual (or their guardian) play a central and active role in the development and execution of their plan of care and should agree with the goals, interventions and time frames contained in the plan.

1d. The individual's plan of care clearly identifies primary, specialty, behavioral health and community networks and supports that address their needs.

1e. The individual's plan of care clearly identifies family members and other supports involved in the patient's care. Family and other supports are included in the plan and execution of care as requested by the individual.

1f. The individual's plan of care clearly identifies goals and timeframes for improving the patient's health and health care status and the interventions that will produce this effect.

1g. The individual's plan of care must included outreach and engagement activities that will support engaging patients in care and promoting continuity of care.

1h. The individual's plan of care includes periodic reassessment of the individual needs and clearly identifies the patient's progress in meeting goals and changes in the plan of care based on changes in patient's need.

II. Care Coordination and Health Promotion

2a. The health home provider is accountable for engaging and retaining health home enrollees in care; coordinating and arranging for the provision of services; supporting adherence to treatment recommendations; and monitoring and evaluating a patient's needs, including prevention, wellness, medical, specialist and behavioral health treatment, care transitions, and social and community services where appropriate through the creation of an individual plan of care.

2b. The health home provider will assign each individual a dedicated care manager who is responsible for overall management of the patient's care plan. The health home care manager is clearly identified in the patient record. Each individual enrolled with a health home will have one dedicated care manager who has overall responsibility and accountability for coordinating all aspects of the individual's care. The individual cannot be enrolled in more than one care management program funded by the Medicaid program.

2c. The health home provider must describe the relationship and communication between the dedicated care manager and the treating clinicians that assure that the care manager can discuss with clinicians on an as needed basis, changes in patient condition that may necessitate treatment change (i.e., written orders and/or prescriptions).

2d. The health home provider must define how patient care will be directed when conflicting treatment is being provided.

2e. The health home provider has policies, procedures and accountabilities (contractual agreements) to support

effective collaborations between primary care, specialist and behavioral health providers, evidence-based referrals and follow-up and consultations that clearly define roles and responsibilities.

2f. The health home provider supports continuity of care and health promotion through the development of a treatment relationship with the individual and the interdisciplinary team of providers.

2g. The health home provider supports care coordination and facilitates collaboration through the establishment of regular case review meetings, including all members of the interdisciplinary team on a schedule determined by the health home provider. The health home provider has the option of utilizing technology conferencing tools including audio, video and /or web deployed solutions when security protocols and precautions are in place to protect PHI.

2h. The health home provider ensures 24 hours/seven days a week availability to a care manager to provide information and emergency consultation services.

2i. The health home provider will ensure the availability of priority appointments for health home enrollees to medical and behavioral health care services within their health home provider network to avoid unnecessary, inappropriate utilization of emergency room and inpatient hospital services.

2j. The health home provider promotes evidence based wellness and prevention by linking health home enrollees with resources for smoking cessation, diabetes, asthma, hypertension, self help recovery resources, and other services based on individual needs and preferences.

2k. The health home provider has a system to track and share patient information and care needs across providers and to monitor patient outcomes and initiate changes in care, as necessary, to address patient need.

III. Comprehensive Transitional Care

3a. The health home provider has a system in place with hospitals and residential/rehabilitation facilities in their network to provide the health home prompt notification of an individual's admission and/or discharge to/from an emergency room, inpatient, or residential/rehabilitation setting.

3b. The health home provider has policies and procedures in place with local practitioners, health facilities including emergency rooms, hospitals, and residential/rehabilitation settings, providers and community-based services to help ensure coordinated, safe transitions in care for its patients who require transfers in the site of care.

3c. The health home provider utilizes HIT as feasible to facilitate interdisciplinary collaboration among all providers, the patient, family, care givers, and local supports.

3d. The health home provider has a systematic follow-up protocol in place to assure timely access to follow-up care post discharge that includes at a minimum receipt of a summary care record from the discharging entity, medication reconciliation, timely scheduled appointments at recommended outpatient providers, care manager verification with outpatient provider that the patient attended the appointment, and a plan to outreach and reengage the patient in care if the appointment was missed.

IV. Patient and Family Support

4a. Patient's individualized plan of care reflects patient and family or caregiver preferences, education and support for self-management; self help recovery, and other resources as appropriate.

4b. Patient's individualized plan of care is accessible to the individual and their families or other caregivers based on the individual's preference.

4c. The health home provider utilizes peer supports, support groups and self-care programs to increase patients' knowledge about their disease, engagement and self management capabilities, and to improve adherence to prescribed treatment.

4d. The health home provider discusses advance directives with enrollees and their families or caregivers.

4e. The health home provider communicates and shares information with individuals and their families and other caregivers with appropriate consideration for language, literacy and cultural preferences.

4f. The health home provider gives the patient access to care plans and options for accessing clinical information.

V. Referral to Community and Social Support Services

5a. The health home provider identifies available community-based resources and actively manages appropriate referrals, access, engagement, follow-up and coordination of services.

5b. The health home provider has policies, procedures and accountabilities (contractual agreements) to support effective collaborations with community-based resources, which clearly define roles and responsibilities.

5c. The plan of care should include community-based and other social support services as well as healthcare services that respond to the patient's needs and preferences and contribute to achieving the patient's goals.

VI. Use of Health Information Technology to Link Services

Health home providers will make use of available HIT and accesses data through the regional health information organization (RHIOs)/Qualified Entities (QE) to conduct these processes as feasible, to comply with the initial standards cited in items 6a.-6d for implementation of health homes. In order to be approved as health home provider, applicants must provide a plan to achieve the final standards cited in items 6e.-6i. within eighteen (18) months of program initiation.

Initial Standards

6a. Health home provider has structured information systems, policies, procedures and practices to create, document, execute, and update a plan of care for every patient.

6b. Health home provider has a systematic process to follow-up on tests, treatments, services and, and referrals which is incorporated into the patient's plan of care.

6c. Health home provider has a health record system which allows the patient's health information and plan of care to be accessible to the interdisciplinary team of providers and which allows for population management and identification of gaps in care including preventive services.

6d. Health home provider makes use of available HIT and accesses data through the RHIO/QE to conduct these processes, as feasible.

Final Standards

6e. Health home provider has structured interoperable health information technology systems, policies, procedures and practices to support the creation, documentation, execution, and ongoing management of a plan of care for every patient.

- 6f. Health home provider uses an electronic health record system that qualifies under the Meaningful Use provisions of the HITECH Act, which allows the patient's health information and plan of care to be accessible to the interdisciplinary team of providers. If the provider does not currently have such a system, they will provide a plan for when and how they will implement it.
- 6g. Health home provider will be required to comply with the current and future version of the Statewide Policy Guidance (http://health.ny.gov/technology/statewide_policy_guidance.htm) which includes common information policies, standards and technical approaches governing health information exchange.
- 6h. Health home provider commits to joining regional health information networks or qualified health IT entities for data exchange and includes a commitment to share information with all providers participating in a care plan. RHIOs/QE provides policy and technical services required for health information exchange through the Statewide Health Information Network of New York (SHIN-NY).
- 6i. Health home provider supports the use of evidence based clinical decision making tools, consensus guidelines, and best practices to achieve optimal outcomes and cost avoidance. One example of such a tool is PSYCKES.

VII. Quality Measures Reporting to State

- 7a. The health home provider has the capability of sharing information with other providers and collecting and reporting specific quality measures as required by NYS and CMS.
- 7b. The health home provider is accountable for reducing avoidable health care costs specifically preventable hospital admissions/readmissions and avoidable emergency room visits; providing timely post discharge follow up, and improving patient outcomes as measured by NYS and CMS required quality measures.

Name	Date Created
No items available	

Health Homes Payment Methodologies

MEDICAID | Medicaid State Plan | Health Homes | NY2020MS00040 | NY-20-0034 | NYS Health Home Program

Package Header

Package ID	NY2020MS00040	SPA ID	NY-20-0034
Submission Type	Official	Initial Submission Date	N/A
Approval Date	N/A	Effective Date	7/1/2020
Superseded SPA ID	NY-19-0007 System-Derived		

Payment Methodology

The State's Health Homes payment methodology will contain the following features

- Fee for Service
 - Individual Rates Per Service
 - Per Member, Per Month Rates
 - Fee for Service Rates based on
 - Severity of each individual's chronic conditions
 - Capabilities of the team of health care professionals, designated provider, or health team
 - Other
 - Comprehensive Methodology Included in the Plan
 - Incentive Payment Reimbursement
- see text below

Describe any variations in payment based on provider qualifications, individual care needs, or the intensity of the services provided

- PCCM (description included in Service Delivery section)
- Risk Based Managed Care (description included in Service Delivery section)
- Alternative models of payment, other than Fee for Service or PMPM payments (describe below)

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Agency Rates

Describe the rates used

- FFS Rates included in plan
- Comprehensive methodology included in plan
- The agency rates are set as of the following date and are effective for services provided on or after that date

Effective Date

7/1/2020

Website where rates are displayed

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/policy/docs/outreach_elimination_guidance.pdf

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Health Homes Payment Methodologies

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	System-Derived		

Rate Development

Provide a comprehensive description in the SPA of the manner in which rates were set

1. In the SPA please provide the cost data and assumptions that were used to develop each of the rates
2. Please identify the reimbursable unit(s) of service
3. Please describe the minimum level of activities that the state agency requires for providers to receive payment per the defined unit
4. Please describe the state's standards and process required for service documentation, and
5. Please describe in the SPA the procedures for reviewing and rebasing the rates, including
 - the frequency with which the state will review the rates, and
 - the factors that will be reviewed by the state in order to understand if the rates are economic and efficient and sufficient to ensure quality services.

Comprehensive Description Provide a comprehensive description of the rate-setting policies the State will use to establish Health Homes provider reimbursement fee for service or PMPM rates. Explain how the methodology is consistent with the goals of efficiency, economy, and quality of care. Within your description, please explain: the reimbursable unit(s) of service, the cost assumptions and other relevant factors used to determine the payment amounts, the minimum level of activities that the State agency requires for providers to receive payment per the defined unit, and the State's standards and process required for service documentation.

Provider Type

NYS Medicaid providers eligible to become health homes include managed care plans; hospitals; medical, mental and chemical dependency treatment clinics; primary care practitioner practices; PCMHs; FQHCs; Targeted Case Management (TCM) providers; certified home health care agencies and any other Medicaid enrolled providers that meet health home provider standards.

Care Management Fee:

Health Homes meeting State and Federal standards will be paid a per member per month care management fee that is adjusted based on region and case mix method for adults, or the Child and Adolescent Needs and Strength Assessment of New York (CANS-NY) for children age 0 through 20). The total cost relating to a care manager (salary, fringe benefits, non-personal services, capital and administration costs) in conjunction with caseload assumptions were used to develop the Health Home rates. The state periodically reviews the Health Home payments in conjunction with Department of Labor salary data to ensure that the Health Home rates are sufficient to ensure quality services.

Effective May 1, 2018, the per member per month care management fee for adults will be based on region and case mix defined by populations as indicated below. Health Home rates for children will continue to be determined by an algorithm applied to the CANS-NY assessment. The risk adjusted payments will allow providers to receive a diverse population of patients and assign patients to various levels of care management intensity without having to meet preset standards for contact counts. Providers will be able to respond to and adjust the intensity and frequency of intervention based on patient's current condition and needs (from tracking to high touch). All rates will be published on the DOH website. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers. Rates for Health Home services to children are effective October 1, 2016 and apply to services furnished on and after October 1, 2016.

For dates of service beginning June 1, 2018 through December 31, 2018, the per member per month care management fee for Health Homes that are, as of June 1, 2018, designated to serve children only, or designated to serve children in 43 counties and adults and children in one county, shall be adjusted to provide \$4 million in payments to supplement care management fees. The supplemental payments shall be paid no later than March 31, 2019 and will be allocated proportionately among such Health Homes based on services provided between June 1, 2018 and December 1, 2018. The supplement shall be a lump sum payments.

Rates for Health Home services furnished to other populations are effective as noted below and apply to services furnished on and after such dates.

State Health Home Rates and Rate Codes Effective October 1, 2017 can be found at:

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/hh_rates_eective_october_2017.xlsx

State Health Home Rates and Rate Codes Effective May 1, 2018 can be found at:

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/hh_rates_eective_october_2017.xlsx

State Health Home Rates and Rate Codes Effective October 1, 2018 can be found at:

https://health.ny.gov/health_care/medicaid/program/medicaid_health_homes/billing/docs/hh_rates_effective_october_2018.xlsx

State Health Home Rates and Rate Codes Effective July 1, 2020, can be found at:

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/policy/docs/outreach_elimination_guidance.pdf

Population Case Mix Definitions for Health Home Adult Rates

Health Home Plus/Care Management Rates include adults with active AOT order or expired AOT order within last year; adults stepping down from State PC and ACT; Health and Recovery Plan (HARP) members that meet high risk criteria (recent incarceration, homelessness, multiple hospital admissions, etc.); and members identified at the discretion of the Medicaid Managed Care Plan or state designated entity for adults not currently enrolled in a Medicaid Managed Care Plan.

Health Home High Risk/Need Care Management Rates, include adults that are HARP enrolled members not included in the Health Home Plus/Care Management; any adult member meeting high risk criteria based on the high, medium and low, Clinical and Functional Assessment; and members identified at the discretion of the Medicaid Managed Care Plan or state designated entity for adults not currently enrolled in a Medicaid Managed Care Plan.

Health Home Care Management Rates, include all other adults not meeting criteria for Health Home Services Adult Home Transition Rates, Health Home Plus/Care Management or High Risk /High Need Care Management Rates.

Health Home Services Adult Home Transition Rates apply to individuals, under the terms of a Stipulation and Order of Settlement between the U.S. Department of Justice and New York State, that are Adult Home Residents with serious mental illness (SMI) that are required to transition from Adult Homes located in New York City to the community.

Effective July 1, 2020, the PMPM for case finding will be reduced to \$0 as indicated in the State Health Home Rates and Rate Codes posted to the State's website as indicated above.

A unit of service will be defined as a billable unit per service month. In order to be reimbursed for a billable unit of service per month health home providers must, at a minimum, provide one of the core health home services per month. The monthly payment will be paid via the active care management PMPM. Once a patient has consented to received services and been assigned a care manager and is enrolled in the health home program the active care management PMPM may be billed. Care managers must document all services provided to the member in the member's care plan.

Managed Care Considerations:

Similar to the NY patient centered Medical Home program, it is the intention of the State to coordinate and pay for health home services through health plans but at State set rates for the service. The State will address any existing care management resources in the current plan premium for health home enrollees under CMS guidelines (bring this resource out of the capitation and create federal matching for those resources under the health home payment). Plans will pay health home providers State set rates when providers are contracted to provide all health home services. In the case where the plan does a portion of the health home service (e.g. telephonic post discharge tracking) and downstream providers do a separate portion (e.g. face to face care management) the plan will then split the State generated PMPM proportional to the contracted effort.

The Medicaid/FHP Model Contract has been modified to include language similar to that outlined below which addresses any duplication of payment between the MCO capitation payments and health home payments. The delivery design and payment methodology will not result in any duplication of payment between Health Homes and managed care.

- The managed care plan is not required to provide services that would duplicate the CMS reimbursed Health Home services for members participating in the State's Health Home program.
- The managed care organization will be informed of members assigned to a Health Home or will assign its members to a Health Home for health home services. Plans may need to expand their networks to include additional State designated health home providers to ensure appropriate access.
- Plans will need to have signed contracts including clearly established responsibilities with the provider

based health homes.

- The managed care plan will be required to inform either the individual's Health Home or the State of any inpatient admission or discharge of a Health Home member that the plan learns of through its inpatient admission initial authorization and concurrent review processes as soon as possible to promote appropriate follow-up and coordination of services.
- Plans will assist State designated Health Home providers in their network with coordinating access to data, as needed.
- Plans will, as appropriate, assist with the collection of required care management and patient experience of care data from State designated Health Home providers in its' network.

The State has a health home advisory committee of providers and managed care plans through which any issues with payment would be raised and addressed. Directions have been given to health plans to match health home payment to providers based on relative health home care management effort. Further information on specific construction on health home rates includes specific administration compensation to guide rate differential construct.

Targeted Case Management (TCM) Conversion Considerations:

The State envisions that eventually all targeted case management programs operating in New York will convert to or become part of health homes, and these providers will require time to meet State and Federal health home standards. The State will allow TCM providers that can meet health home standards to convert to health homes or join with larger health homes. TCM providers that convert to health homes will be governed under NYS Health Home Provider Qualification Standards, not TCM standards. The payment method will be designed to transition all existing TCM capacity from the current rates to the new Health Home payment structure. Effective January 1, 2015 TCM programs for adults will be paid their existing TCM rates until November 30, 2016. Effective October 1, 2016 through September 30, 2018 TCM programs for children will be paid a transitional rate that is as financially equivalent as practicable to their current rate.

Health Home care management services may be provided to children that are eligible and enrolled in both the Early Intervention Program and Health Home, and will meet and fulfill the requirements of the ongoing service coordination required to be provided to children enrolled in the Early Intervention Program.

All payments will be made under the health home payment detailed above in the care management fee section if they convert to or become part of a health home. Effective October 1, 2017, the case finding PMPM will be paid under the provisions described in the care management fee section.

Children's Transitional Rates

Providers delivering Individualized Care Coordination (ICC) under the 1915c SED or Health Care Integration (HCI) under the 1915c B2H waivers, who shall provide Health Home Care Management services in accordance with this section effective on January 1, 2019, shall be eligible for a transition rate add-on for two years to enable providers to transition to Health Home rates. Health Home Care Management Services eligible for the transition rate add-on shall be limited to services provided to the number of children such providers served as of December 31, 2018. Services provided to a greater number of children than such providers served as of December 31, 2018 shall be reimbursed the Health Home rate without the add-on. The transition methodology is set forth in the transitional rate chart.

Children's Health Home Transition Rates

January 1, 2019 through June 30, 2019

Health Home	Add-On		Transitional Rate	
	Upstate	Downstate	Upstate	Downstate
1869: Low	\$225.00	\$240.00	7926: SED (L) \$948.00	\$992.00
1870: Medium	\$450.00	\$479.00	7925: SED (M) \$723.00	\$753.00
1871: High	\$750.00	\$799.00	7924: SED (H) \$423.00	\$433.00

July 1, 2019 through December 31, 2019

Health Home	Add-On		Transitional Rate	
	Upstate	Downstate	Upstate	Downstate
1869: Low	\$225.00	\$240.00	7926: SED (L) \$711.00	\$744.00
1870: Medium	\$450.00	\$479.00	7925: SED (M) \$542.00	\$565.00
1871: High	\$750.00	\$799.00	7924: SED (H) \$317.00	\$325.00

January 1, 2020 through June 30, 2020

Health Home	Add-On		Transitional Rate	
	Upstate	Downstate	Upstate	Downstate
1869: Low	\$225.00	\$240.00	7926: SED (L) \$474.00	\$496.00
1870: Medium	\$450.00	\$479.00	7925: SED (M) \$362.00	\$377.00
1871: High	\$750.00	\$799.00	7924: SED (H) \$212.00	\$217.00

July 1, 2020 through December 31, 2020

Health Home	Add-On		Transitional Rate					
	Upstate	Downstate	Upstate	Downstate	Upstate	Downstate		
1869: Low	\$225.00	\$240.00	7926: SED (L)	\$237.00	\$248.00	SED (L)	\$462.00	\$488.00
1870: Medium	\$450.00	\$479.00	7925: SED (M)	\$181.00	\$188.00	SED (M)	\$631.00	\$667.00
1871: High	\$750.00	\$799.00	7924: SED (H)	\$106.00	\$108.00	SED (H)	\$856.00	\$907.00

January 1, 2019 through June 30, 2019

Health Home	Add-On		Transitional Rate					
	Upstate	Downstate	Upstate	Downstate	Upstate	Downstate		
1869: Low	\$225.00	\$240.00	8002: B2H (L)	\$925.00	\$960.00	B2H (L)	\$1,150.00	\$1,200.00
1870: Medium	\$450.00	\$479.00	8001: B2H (M)	\$700.00	\$721.00	B2H (M)	\$1,150.00	\$1,200.00
1871: High	\$750.00	\$799.00	8000: B2H (H)	\$400.00	\$401.00	B2H (H)	\$1,150.00	\$1,200.00

July 1, 2019 through December 31, 2019

Health Home	Add-On		Transitional Rate					
	Upstate	Downstate	Upstate	Downstate	Upstate	Downstate		
1869: Low	\$225.00	\$240.00	8002: B2H (L)	\$694.00	\$720.00	B2H (L)	\$919.00	\$960.00
1870: Medium	\$450.00	\$479.00	8001: B2H (M)	\$525.00	\$541.00	B2H (M)	\$975.00	\$1,020.00
1871: High	\$750.00	\$799.00	8000: B2H (H)	\$300.00	\$301.00	B2H (H)	\$1,050.00	\$1,100.00

January 1, 2020 through June 30, 2020

Health Home	Add-On		Transitional Rate					
	Upstate	Downstate	Upstate	Downstate	Upstate	Downstate		
1869: Low	\$225.00	\$240.00	8002: B2H (L)	\$463.00	\$480.00	B2H (L)	\$688.00	\$720.00
1870: Medium	\$450.00	\$479.00	8001: B2H (M)	\$350.00	\$361.00	B2H (M)	\$800.00	\$840.00
1871: High	\$750.00	\$799.00	8000: B2H (H)	\$200.00	\$201.00	B2H (H)	\$950.00	\$1,000.00

July 1, 2020 through December 31, 2020

Health Home	Add-On		Transitional Rate					
	Upstate	Downstate	Upstate	Downstate	Upstate	Downstate		
1869: Low	\$225.00	\$240.00	8002: B2H (L)	\$231.00	\$240.00	B2H (L)	\$456.00	\$480.00
1870: Medium	\$450.00	\$479.00	8001: B2H (M)	\$175.00	\$180.00	B2H (M)	\$625.00	\$659.00
1871: High	\$750.00	\$799.00	8000: B2H (H)	\$100.00	\$100.00	B2H (H)	\$850.00	\$899.00

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Health Homes Payment Methodologies

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Package Header

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Assurances

The State provides assurance that it will ensure non-duplication of payment for services similar to Health Homes services that are offered/covered under a different statutory authority, such as 1915(c) waivers or targeted case management.

Describe below how non-duplication of payment will be achieved All rates are published on the DOH website. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers. All of the above payment policies have been developed to assure that there is no duplication of payment for health home services.

http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/rate_information.htm.

The state has developed payment methodologies and rates that are consistent with section 1902(a)(30)(A).

The State provides assurance that all governmental and private providers are reimbursed according to the same rate schedule, unless otherwise described above.

The State provides assurance that it shall reimburse providers directly, except when there are employment or contractual arrangements consistent with section 1902(a)(32).

Optional Supporting Material Upload

Name	Date Created	
6 - Standard Funding Questions-NI (20-0034)(4-20-20)	6/9/2020 1:45 PM EDT	

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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).

SUMMARY
SPA #20-0035

This State Plan Amendment proposes to:

- 1) Apply a 5% reduction to the both the budgeted and actual inpatient capital add-ons for rates beginning on or after April 2, 2020; and
- 2) For all inpatient rate add-ons reconciled on or after April 2, 2020, if the difference between the budgeted and actual capital add-on results in a positive add-on, the positive add-on will be reduced by 10%. Conversely, if the difference results in a negative add-on, the negative add-on will be increased by 10%.

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5. *Payment for budgeted allocated capital costs.*

- a. Capital per diems for exempt units and hospitals [shall] will be calculated by dividing the budgeted capital costs allocated to such rates pursuant to paragraph (4) above by budgeted exempt unit days, reconciled to rate year days and actual rate year exempt unit or hospital-approved capital expense. Effective on or after April 2, 2020, the budgeted and actual capital per diem rates will be reduced by five percent (5%). Additionally, for capital per diem rates reconciled on or after April 2, 2020, if the difference between the budgeted and actual capital per diem rate results in a positive rate adjustment, that rate adjustment will be reduced by ten percent (10%). Conversely, if the difference between the budgeted and actual capital per diem rate results in a negative rate adjustment, that rate adjustment will be increased by ten percent (10%).
- b. Capital payments for APR-DRG case rates [shall] will be determined by dividing the budgeted capital allocated to such rates pursuant to paragraph (4) above by the hospital's budgeted, nonexempt unit discharges, reconciled to rate year discharges and actual rate year nonexempt unit or hospital-approved capital expense. Effective on or after April 2, 2020, the budgeted and actual capital per APR-DRG case rates will be reduced by five percent (5%). Additionally, for capital per APR-DRG case rates reconciled on or after April 2, 2020, if the difference between the budgeted and actual capital per APR-DRG case rate results in a positive rate adjustment, that rate adjustment will be reduced by ten percent (10%). Conversely, if the difference between the budgeted and actual capital per APR-DRG case rate results in a negative rate adjustment, that rate adjustment will be increased by ten percent (10%).
- c. Capital payments for transferred patients [shall] will be the determined by dividing the budgeted capital allocated to the APR-DRG case rate by the hospital's budgeted non-exempt unit days, reconciled to rate year days and actual rate year non-exempt unit or hospital approved capital expense.

6. *Depreciation.*

- a. Reported depreciation based on historical cost is recognized as a proper element of cost. Useful lives [shall] will be the higher of the reported useful life or those useful lives from the Estimated Useful Lives of Depreciable Hospital Assets, American Hospital Association, consistent with title XVIII provisions. Copies of this publication are available from the American Hospital Association, 840 North Lake Shore Drive, Chicago, IL 60611, and a copy is available for inspection and copying at the offices of the Records Access Officer of the Department of Health, Corning Tower, Empire State Plaza, Albany, NY 12237.
- b. In the computation of rates for voluntary facilities, depreciation [shall] will be included on a straight line method on plant and non-movable equipment.

TN #20-0035

Approval Date _____

Supersedes TN #09-0034

Effective Date April 2, 2020

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 Health

The Department of Health proposes to amend the Title XIX (Medicaid) State Plan for inpatient, long term care, and non-institutional services to comply with recently proposed statutory provisions. The following significant changes are proposed:

All Services

Effective for dates of service April 1, 2020 through March 31, 2021, and each state fiscal year thereafter, all non-exempt Department of Health state funds Medicaid payments will be uniformly reduced by \$2.5 billion. Such reductions will be applied only to the extent that alternative methods that achieve Medicaid state share savings annually are not implemented. Medicaid payments that will be exempted from the uniform reduction include:

1. Payments whereby federal law precludes such reduction, including:
 - Federally Qualified Health Center services;
 - Indian Health Services and services provided to Native Americans;
 - Supplemental Medical Insurance – Part A and Part B;
 - State Contribution for Prescription Drug Benefit (aka Medicare Part D payments);
 - Any local share cap payment required by the Federal Medical Assistance Percentage (FMAP) increase legislation;
 - Services provided to American citizen repatriates; and
 - Hospice Services.
2. Payments funded exclusively with federal and/or local funds include, but are not limited to, the following:
 - Upper payment limit payments to non-state owned or operated governmental providers certified under Article 28 of the NYS Public Health Law;
 - Certified public expenditure payments to the NYC Health and Hospital Corporation;
 - Certain disproportionate share payments to non-state operated 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.
3. 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;
 - Court orders and judgments; and
 - Family Planning services.

Copies of the proposed state plan amendments will be on file in each local (county) social services district and available for public review.

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 institutional, non-institutional or long term care services to comply with proposed Medicaid Redesign Team II (MRT) initiatives. The following changes are proposed:

All Services

Effective for dates of service April 1, 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 1.875 percent. Medicaid payments that will be exempted from the uniform reduction include:

- Payments whereby federal law precludes such reduction, including:
 - Federally Qualified Health Center services;
 - Indian Health Services and services provided to Native Americans;
 - Supplemental Medical Insurance – Part A and Part B;
 - State Contribution for Prescription Drug Benefit (aka Medicare Part D payments);
 - Any local share cap payment required by the Federal Medical Assistance Percentage (FMAP) increase legislation;
 - Services provided to American citizen repatriates; and
 - Hospice Services.
- Payments funded exclusively with federal and/or local funds include, but are not limited to, the following:
 - Upper payment limit payments to non-state owned or operated governmental providers certified under Article 28 of the NYS Public Health Law;
 - Certified public expenditure payments to the NYC Health and Hospitals Corporation;
 - Certain disproportionate share payments to non-state oper-

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-

SUMMARY
SPA #20-0036

This State Plan Amendment proposes to continue additional 11% enhanced transition rate to the following Children and Family Treatment and Support Services (CFTSS) as follows:

- Other Licensed Practitioner (OLP), Community Psychiatric Support and Treatment (CPST) and Psychosocial Rehabilitation (PSR), April 2, 2020 through March 31, 2021.
- Family Peer Support Service (FPSS) July 1, 2020 through March 31, 2021.
- Crisis Intervention (CI) and Youth Peer Supports (YPS) January 1, 2021 – March 31, 2021

All of the above will return to Base Rate effective April 1, 2021 and forward.

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Page 1(a)(i)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: New York

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE

Non-Physician Licensed Behavioral Health Practitioner Services (EPSDT only)

Reimbursement for EPSDT NP-LBHP as outlined in Item 6.d(i). per Attachment 3.1-A, are paid based upon Medicaid rates established by the State of New York.

Except as otherwise noted in the State Plan, the State-developed rates are the same for both governmental and private providers. The provider agency's rates were set as of January 1, 2019 for Other Licensed Practitioner, Community Psychiatric Support and Treatment, and Psychosocial Rehabilitation Supports, and are effective for these services provided on or after that date.

Provider agency's rates were set as of July 1, 2019 for Family Peer Support Services and are effective for these services provided on or after that date. Additionally, the agency's rates were set as of January 1, 2020 for Crisis Intervention and Youth Peer Supports and Training are effective for these services provided on or after that date.

As of April 2, 2020 the rates will be updated to reflect changes in reimbursements for the following services:

- Other Licensed Practitioner
- Community Psychiatric Support and Treatment
- Psychosocial Rehabilitation Supports
- Family Peer Support Services
- Crisis Intervention
- Youth Peer Supports and Training

All rates are published on the Department of Health website:

https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/proposed_spa.htm

[Crisis Intervention Rates]

[https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/docs/2019-12-19_child-family_rate_summary.pdf]

[Family Peer Supports Services and Youth Peer Supports Rates]

[https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/docs/fpss_bh_kids_ffs_rates.pdf]

[Other Licensed Practitioner, Community Psychiatric Support and Treatment, and Psychosocial Rehabilitation Supports Rates]

[https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/docs/bh_kids_ffs_rates.pdf]

TN # #20-0036

Approval Date _____

Supersedes TN # 20-0001

Effective Date April 2, 2020

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: New York

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE

Rehabilitative Services (EPSDT only)

Reimbursement for EPSDT Rehabilitative Services as outlined in item 13.d per Attachment 3.1-A, are paid based upon Medicaid rates established by the State of New York.

Except as otherwise noted in the State Plan, the State-developed rates are the same for both governmental and private providers. The provider agency's rates were set as of January 1, 2019 for Other Licensed Practitioner, Community Psychiatric Support and Treatment, and Psychosocial Rehabilitation Supports, and are effective for these services provided on or after that date.

Provider agency's rates were set as of July 1, 2019 for Family Peer Support Services and are effective for these services provided on or after that date. Additionally, the agency's rates were set as of January 1, 2020 for Crisis Intervention and Youth Peer Supports and Training and are effective for these services provided on or after that date.

As of April 2, 2020 the rates will be updated to reflect changes in reimbursements for the following services:

- Other Licensed Practitioner
- Community Psychiatric Support and Treatment
- Psychosocial Rehabilitation Supports
- Family Peer Support Services
- Crisis Intervention
- Youth Peer Supports and Training

All rates are published on the Department of Health website:

https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/proposed_spa.htm

[Crisis Intervention Rates]

https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/docs/2019-12-19_child-family_rate_summary.pdf

[Family Peer Supports Services and Youth Peer Supports Rates]

https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/docs/fpssbh_kids_ffs_rates.pdf

The rate development methodology will primarily be composed of provider cost modeling, through New York provider compensation studies and cost data. Rates from similar State Medicaid programs may be considered, as well. The following list outlines the major components of the cost model to be used in rate development.

- Staffing assumptions and staff wages.
- Employee-related expenses — benefits, employer taxes (e.g., Federal Insurance Contributions Act (FICA), unemployment, and workers compensation).
- Program-related expenses (e.g., supplies).
- Provider overhead expenses.
- Program billable units.

The rates will be developed as the ratio of total annual modeled provider costs to the estimated annual billable units.

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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 Health

The Department of Health proposes to amend the Title XIX (Medicaid) State Plan for inpatient, long term care, and non-institutional services to comply with recently proposed statutory provisions. The following significant changes are proposed:

All Services

Effective for dates of service April 1, 2020 through March 31, 2021, and each state fiscal year thereafter, all non-exempt Department of Health state funds Medicaid payments will be uniformly reduced by \$2.5 billion. Such reductions will be applied only to the extent that alternative methods that achieve Medicaid state share savings annually are not implemented. Medicaid payments that will be exempted from the uniform reduction include:

1. Payments whereby federal law precludes such reduction, including:
 - Federally Qualified Health Center services;
 - Indian Health Services and services provided to Native Americans;
 - Supplemental Medical Insurance – Part A and Part B;
 - State Contribution for Prescription Drug Benefit (aka Medicare Part D payments);
 - Any local share cap payment required by the Federal Medical Assistance Percentage (FMAP) increase legislation;
 - Services provided to American citizen repatriates; and
 - Hospice Services.
2. Payments funded exclusively with federal and/or local funds include, but are not limited to, the following:
 - Upper payment limit payments to non-state owned or operated governmental providers certified under Article 28 of the NYS Public Health Law;
 - Certified public expenditure payments to the NYC Health and Hospital Corporation;
 - Certain disproportionate share payments to non-state operated 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.
3. 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;
 - Court orders and judgments; and
 - Family Planning services.

Copies of the proposed state plan amendments will be on file in each local (county) social services district and available for public review.

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 institutional, non-institutional or long term care services to comply with proposed Medicaid Redesign Team II (MRT) initiatives. The following changes are proposed:

All Services

Effective for dates of service April 1, 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 1.875 percent. Medicaid payments that will be exempted from the uniform reduction include:

- Payments whereby federal law precludes such reduction, including:
 - Federally Qualified Health Center services;
 - Indian Health Services and services provided to Native Americans;
 - Supplemental Medical Insurance – Part A and Part B;
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 - 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).

SUMMARY
SPA #20-0037

This State Plan Amendment proposes to eliminate the reimbursement of residual equity for all nursing facilities.

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factor for any facility for which he determines that continued capital cost reimbursement is appropriate; provided, however, that such payment factor [shall] will not exceed one half of the capital cost reimbursement received by such facility in the final year of useful facility life.

Effective on April 2, 2020, and thereafter, the capital cost component of the rate for all residential health care facilities will be adjusted to reflect the removal of residual equity reimbursement.

(8) Capital improvement cost reimbursement.

- (i) The capital improvement cost [shall] will be reimbursed by adjusting the initial allowed facility cost, capital indebtedness, equity determinations and limitations as stated in paragraph (5) of this subdivision, to include the capital improvement cost.
- (ii) Adjustments in accordance with subparagraph (i) of this paragraph [shall] will be made in the following manner:
 - (a) if the cost of an improvement is \$100,000 or more, and certificate of need approval has been granted by the commissioner, then component useful life for the improvement will be permitted. Such component useful life will be equivalent to the estimated asset life in accordance with the *Medicare Provider Reimbursement Manual* or the remaining useful life of the facility, whichever is less. Where a capital improvement adjusts the expected useful life of the facility beyond the remaining portion of the original useful facility life, the limitation set

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 - Certain disproportionate share payments to non-state oper-

- 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

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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 foat 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.

SUMMARY
SPA #20-0038

This State Plan Amendment proposes to reduce the capital component of the Medicaid rates for all residential health care facilities by 5%.

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New York
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- xii. Utilization Review
 - xiii. Other Ancillary
 - xiv. Plant Operations and maintenance – (cost for facilities and real estate and occupancy taxes only).
- (3) The allowable facility specific non-comparable component of the rate [shall] will be reimbursed at a payment rate equal to adjusted reported non-comparable costs, after first deducting capital costs and allowable items not subject to trending, divided by the facility's total 1983 patient days.

(g) Capital Component of the Rate.

The allowable facility specific capital component of the rate [shall] will include allowable capital costs determined in accordance with section 86-2.19, 86-2.20, 86-2.21 and 86-2.22 of this Subpart and costs of other allowable items determined by the department to be non-trendable divided by the facility's patient days in the base year determined applicable by the department.

(g)(1) Effective on April 2, 2020, the capital component of all Medicaid rates for residential health care facilities will be reduced by 5%.

(h) A facility's payment rate for 1986 and subsequent rate years [shall] will be equal to the sum of the operating portion of the rate as defined in paragraph (2) of subdivision (b) of this section and the capital component as defined in subdivision (g) of this section.

(i) Specialty Facilities.

Facilities which provide extensive nursing, medical, psychological and counseling support services to children with diverse and complex medical, emotional and social problems [shall] will be considered

TN #20-0038

Approval Date _____

Supersedes TN #86-4

Effective Date April 2, 2020

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 Health

The Department of Health proposes to amend the Title XIX (Medicaid) State Plan for inpatient, long term care, and non-institutional services to comply with recently proposed statutory provisions. The following significant changes are proposed:

All Services

Effective for dates of service April 1, 2020 through March 31, 2021, and each state fiscal year thereafter, all non-exempt Department of Health state funds Medicaid payments will be uniformly reduced by \$2.5 billion. Such reductions will be applied only to the extent that alternative methods that achieve Medicaid state share savings annually are not implemented. Medicaid payments that will be exempted from the uniform reduction include:

1. Payments whereby federal law precludes such reduction, including:
 - Federally Qualified Health Center services;
 - Indian Health Services and services provided to Native Americans;
 - Supplemental Medical Insurance – Part A and Part B;
 - State Contribution for Prescription Drug Benefit (aka Medicare Part D payments);
 - Any local share cap payment required by the Federal Medical Assistance Percentage (FMAP) increase legislation;
 - Services provided to American citizen repatriates; and
 - Hospice Services.
2. Payments funded exclusively with federal and/or local funds include, but are not limited to, the following:
 - Upper payment limit payments to non-state owned or operated governmental providers certified under Article 28 of the NYS Public Health Law;
 - Certified public expenditure payments to the NYC Health and Hospital Corporation;
 - Certain disproportionate share payments to non-state operated 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.
3. 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;
 - Court orders and judgments; and
 - Family Planning services.

Copies of the proposed state plan amendments will be on file in each local (county) social services district and available for public review.

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 institutional, non-institutional or long term care services to comply with proposed Medicaid Redesign Team II (MRT) initiatives. The following changes are proposed:

All Services

Effective for dates of service April 1, 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 1.875 percent. Medicaid payments that will be exempted from the uniform reduction include:

- Payments whereby federal law precludes such reduction, including:
 - Federally Qualified Health Center services;
 - Indian Health Services and services provided to Native Americans;
 - Supplemental Medical Insurance – Part A and Part B;
 - State Contribution for Prescription Drug Benefit (aka Medicare Part D payments);
 - Any local share cap payment required by the Federal Medical Assistance Percentage (FMAP) increase legislation;
 - Services provided to American citizen repatriates; and
 - Hospice Services.
- Payments funded exclusively with federal and/or local funds include, but are not limited to, the following:
 - Upper payment limit payments to non-state owned or operated governmental providers certified under Article 28 of the NYS Public Health Law;
 - Certified public expenditure payments to the NYC Health and Hospitals Corporation;
 - Certain disproportionate share payments to non-state oper-

- 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-

SUMMARY
SPA #20-0040

This State Plan Amendment proposes extending the Indigent Care Pool (ICP) Methodology through March 31, 2023 and implement the following changes included in the FY 2021 Enacted Budget:

- Eliminate the 'Transition Collar' and corresponding \$25 million (gross) in funding;
- Implement a \$150 million (gross) reduction in ICP Payments to Voluntary hospitals; and,
- Implement a \$64.6 million (gross) Safety Net transition collar for Enhanced Safety Net hospitals who have a year over year reduction in ICP payments as a result of the elimination of the transition collar.

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Indigent Care Pool Reform – effective [January 1] April 2, [2013] 2020

The provisions of this section will be effective for the period [January 1] April 2, [2013] 2020 through December 31, [2020] 2022.

(a) Indigent Care Pool Reform Methodology. Each hospital's uncompensated care nominal need will be calculated in accordance with the following:

1. Inpatient Uncompensated Care. Inpatient units of service for uninsured (self-pay and charity) patients, as reported in Exhibit 32 of the Institutional Cost Report (ICR) for the calendar year two years prior to the distribution year for each inpatient service area which has a distinct reimbursement rate, excluding hospital-based residential health care facility (RHCF) and hospice units of service, will be multiplied by the applicable Medicaid inpatient rates in effect for January 1 of the distribution year.

Medicaid inpatient rates for acute and psychiatric services will be the statewide base price adjusted for hospital-specific factors including an average case mix adjustment plus all rate add-ons except the public goods surcharge. Medicaid inpatient rates for all other inpatient services will be the per diem rate, excluding the public goods surcharge add-on. Units of service for acute care services will be uninsured patient discharges; units of service for all other inpatient services will be uninsured patient days, not including alternate level of care (ALC) days.

2. Outpatient Uncompensated Care. Outpatient units of service for those uninsured (self-pay and charity) patients reported in Exhibit 33 of the ICR for the calendar year two years prior to the distribution year, excluding referred ambulatory services and home health units of service, will be multiplied by the average paid Medicaid outpatient rates that reflect the exclusive utilization of the ambulatory patient groups (APG) rate-setting methodology; however, for those services for which APG rates are not available the applicable Medicaid rate in effect for January 1 of the distribution year will be utilized. The outpatient rates used are exclusive of the public goods surcharge.

Units of service for ambulatory surgery services will be uninsured procedures, not including those which result in inpatient admissions; units of service for all other outpatient services will be uninsured visits, not including those which result in inpatient admissions.

TN #20-0040 _____

Approval Date _____

Supersedes TN #19-0001 _____

Effective Date April 2, 2020 _____

New York
161(g)

(b) Indigent Care Pool. Indigent care pool distributions will be made to eligible hospitals in the following amounts, which will be paid in twelve, approximately equal lump sum, monthly installments:

- 1. Major Government General Hospital Pool Distributions.** \$139.4 million, less the amount allocated pursuant to the Financial Assistance Compliance Pool section in subparagraph (7) below, will be distributed as Medicaid disproportionate share hospital (DSH) payments to major government general hospitals, including the hospitals operated by public benefit corporations, on the basis of each hospital's relative share of uncompensated care nominal need to the aggregate uncompensated care nominal need for all major government general hospitals determined in accordance with the Indigent Care Pool Reform methodology described in [sub]paragraph [3] (a) of this section.

Major government general hospitals are defined as all State-operated general hospitals, all general hospitals operated by the New York City Health and Hospital Corporation, and all other government general hospitals having annual inpatient operating costs in excess of \$25 million. Hospitals eligible for distributions from this pool will be all such major government general hospitals which are open for all or part of the distribution year. Hospitals open for a partial year will receive a pro-rated share based on the number of months open.

- 2. Voluntary General Hospital Pool Distributions.** [~~\$994.9~~]\$969.9 million, less the amount allocated pursuant to the Financial Assistance Compliance Pool section in subparagraph (7) below and the Voluntary ICP Reduction in subparagraph (3) below, plus the Enhanced Safety Net Transition Collar Pool in subparagraph (4) below will be distributed as Medicaid disproportionate share hospital (DSH) payments to eligible voluntary general hospitals, other than major public general hospitals, on the basis of each hospital's relative share of uncompensated care nominal need to the aggregate uncompensated care nominal need for all eligible voluntary general hospitals as determined in accordance with the Indigent Care Pool Reform methodology described in [sub]paragraph [3] (a) of this section.

Voluntary general hospitals are defined as all voluntary non-profit, private proprietary, and government general hospitals other than major government general hospitals. Hospitals eligible for distributions from this pool will be all such voluntary hospitals which are open for all or part of the distribution year. Hospitals open for a partial year will receive a pro-rated share based on the number of months open.

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Supersedes TN #13-0013 _____

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[**3. Transition Pool.** A eight-year transition pool utilizing a floor/ceiling model has been established to help hospitals avoid large funding swings. The transition pool funding will be generated through a redistribution of dollars from those hospitals which experience an increase in distributions using the new Indigent Care Reform Methodology to those that experience a decrease. Transition amounts will be determined based on a comparison of the distributions for the applicable calendar year 2013 through 2020 to an average of the annual distributions for the three year period January 1, 2010 through December 31, 2012.

A separate transition pool will be established for major government general hospitals and voluntary general hospitals. Individual hospital gains and losses in each pool will be capped by means of the following transition adjustments.

- a. Distribution Amount.** A hospital's distribution will be determined by means of a comparison between their allocation as calculated in accordance with the Indigent Care Reform Methodology described in section (a)(1) through (a)(7), the Floor Amount in 3(c) below, and the Ceiling Amount in 3(d) below. If the Indigent Care Reform Methodology allocation is:
- i. less than or equal to the Floor Amount, the hospital will receive the Floor Amount.
 - ii. greater than or equal to the Ceiling Amount, the hospital will receive the Ceiling Amount.
 - iii. greater than the Floor Amount but less than the Ceiling Amount, the hospital will receive the Indigent Care Reform Methodology allocation payment.
- b.** Separate uniform Floor percentages and uniform Ceiling percentages are calculated for each of the major governmental and voluntary pools.
- c.** The Floor Amount for each hospital is equal to the average payment received in the three year period between 1/1/10 and 12/31/12 multiplied by the Floor Percentage for its respective pool. The Floor percentage is:
- i. 97.5% for 2013
 - ii. 95.0% for 2014
 - iii. 92.5% for 2015
 - iv. 90.0% for 2016
 - v. 87.5% for 2017
 - vi. 85.0% for 2018
 - vii. 82.5% for 2019
 - viii. 80.0% for 2020
- d.** The Ceiling Amount for each hospital is equal to the average payment received in the three year period between 1/1/10 and 12/31/12 multiplied by the Ceiling Percentage for its respective pool. The ceiling percentage is calculated using an iterative process to obtain the unique percentage value such that:
- i. The total payments to all providers in each pool equals the amount of the respective pool in subdivision (b)(1) or (b)(2) and
 - ii. The individual hospital payments will comply with the requirements described in paragraphs 3(a) through (c) above
- e.** For 2014 through 2020, these amounts will be further adjusted to carve out amounts used to fund the Financial Assistance Compliance Pool payments in paragraph 6]

TN #20-0040 _____ **Approval Date** _____

Supersedes TN #19-0001 _____ **Effective Date** April 2, 2020

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Sample Transition Period DSH Pool Payment Calculations											
			Floor Pct.:	Ceiling Pct.:							
CY 2014			95.0%	109.9%							
			(i)	(ii)							
Hospital Name	Indigent Care Pool Payment Before Transition Period Adjustment	Three Year Historical Average of Pool Payments (2010-2012)	Floor Amount	Ceiling Amount	Tentative Transition Period Payment	Financial Assistance Compliance Pool Carve-out (2014-2015)	Actual Transition Period Payment	Allocation Before Adjustment as Pct. of Three Year Avg	Tentative Transition Period Payment as Pct. of Three Year Avg		
(a)	(b)	(c)	(d)	(e)	(f)						
Hospital A	\$25,000,000	\$18,000,000	\$17,100,000	\$19,782,000	\$19,782,000	\$454,106	\$19,327,894	138.9%	109.9%		
Hospital B	\$14,000,000	\$12,000,000	\$11,400,000	\$13,188,000	\$13,188,000	\$302,737	\$12,885,263	116.7%	109.9%		
Hospital C	\$20,000,000	\$19,600,000	\$18,620,000	\$21,540,400	\$20,000,000	\$459,110	\$19,540,890	102.0%	102.0%		
Hospital D	\$30,000,000	\$30,400,000	\$28,880,000	\$33,409,600	\$30,000,000	\$688,666	\$29,311,334	98.7%	98.7%		
Hospital E	\$27,000,000	\$31,000,000	\$29,450,000	\$34,069,000	\$29,450,000	\$676,040	\$28,773,960	87.1%	95.0%		
Hospital F	\$19,000,000	\$23,000,000	\$21,850,000	\$25,277,000	\$21,850,000	\$501,578	\$21,348,422	82.6%	95.0%		
Hospital G	\$4,400,000	\$5,400,000	\$5,130,000	\$5,934,600	\$5,130,000	\$117,762	\$5,012,238	81.5%	95.0%		
Statewide Totals	\$139,400,000	\$139,400,000	\$132,430,000	\$153,200,600	\$139,400,000	\$3,200,000	\$136,200,000				
<p>(1) Tentative Transition Period Payment:</p> <p>(a) Hospital name</p> <p>(b) The unadjusted amount that would otherwise be paid to each hospital under the new DSH pool allocation methodology beginning 1/1/2013</p> <p>(c) The actual average amount paid to each hospital under the prior DSH pool allocation methodology in CY's 2010 - 2012</p> <p>(d) The amount for each hospital in (c) multiplied by the Floor Percentage in (i)</p> <p>(e) The amount for each hospital in (c) multiplied by the Ceiling Percentage in (ii)</p> <p>(f) For each individual hospital, if the Indigent Care Pool Actual Transition Period Payment is:</p> <p>(1) < the Floor Amount, the Transition Period Payment is the Floor Amount</p> <p>(2) > the Ceiling Amount, the Transition Period Payment is the Ceiling Amount</p> <p>(3) Otherwise it is the amount in (b) calculated using the new DSH pool allocation methodology effective 1/1/2013.</p> <p>Using the formula =IF(Bn<Dn,Dn,IF(Bn>En,En,Bn))</p>											
<p>(2) Percentages:</p> <p>(i) The Floor Percentage equals 97.5% in 2013, 95.0% in 2014, and 92.5% in 2015</p> <p>(ii) A unique Ceiling Percentage is calculated using an iterative set of calculations where both:</p> <p>(1) the total transition payments equal the respective pool amounts, and</p> <p>(2) all the constraints in (f) are respected</p> <p>For instance, using the Excel Goal Seek data tool:</p> <p>Set Cell F15</p> <p>Equal to \$139,400,000</p> <p>By Changing Cell E2</p>											
<p>(3) Financial Assistance Compliance Pool Carve-out for 2014 & 2015:</p> <p>The carve out will be calculated by using each hospital's share of the \$139.4M allocation and applying that percentage to the \$3.2M in compliance pool funds.</p>											
<p>(4) This same process would apply to the Voluntary Allocations of \$994.9M</p>											

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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 Health

The Department of Health proposes to amend the Title XIX (Medicaid) State Plan for inpatient, long term care, and non-institutional services to comply with recently proposed statutory provisions. The following significant changes are proposed:

All Services

Effective for dates of service April 1, 2020 through March 31, 2021, and each state fiscal year thereafter, all non-exempt Department of Health state funds Medicaid payments will be uniformly reduced by \$2.5 billion. Such reductions will be applied only to the extent that alternative methods that achieve Medicaid state share savings annually are not implemented. Medicaid payments that will be exempted from the uniform reduction include:

1. Payments whereby federal law precludes such reduction, including:
 - Federally Qualified Health Center services;
 - Indian Health Services and services provided to Native Americans;
 - Supplemental Medical Insurance – Part A and Part B;
 - State Contribution for Prescription Drug Benefit (aka Medicare Part D payments);
 - Any local share cap payment required by the Federal Medical Assistance Percentage (FMAP) increase legislation;
 - Services provided to American citizen repatriates; and
 - Hospice Services.
2. Payments funded exclusively with federal and/or local funds include, but are not limited to, the following:
 - Upper payment limit payments to non-state owned or operated governmental providers certified under Article 28 of the NYS Public Health Law;
 - Certified public expenditure payments to the NYC Health and Hospital Corporation;
 - Certain disproportionate share payments to non-state operated 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.
3. 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;
 - Court orders and judgments; and
 - Family Planning services.

Copies of the proposed state plan amendments will be on file in each local (county) social services district and available for public review.

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 institutional, non-institutional or long term care services to comply with proposed Medicaid Redesign Team II (MRT) initiatives. The following changes are proposed:

All Services

Effective for dates of service April 1, 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 1.875 percent. Medicaid payments that will be exempted from the uniform reduction include:

- Payments whereby federal law precludes such reduction, including:
 - Federally Qualified Health Center services;
 - Indian Health Services and services provided to Native Americans;
 - Supplemental Medical Insurance – Part A and Part B;
 - State Contribution for Prescription Drug Benefit (aka Medicare Part D payments);
 - Any local share cap payment required by the Federal Medical Assistance Percentage (FMAP) increase legislation;
 - Services provided to American citizen repatriates; and
 - Hospice Services.
- Payments funded exclusively with federal and/or local funds include, but are not limited to, the following:
 - Upper payment limit payments to non-state owned or operated governmental providers certified under Article 28 of the NYS Public Health Law;
 - Certified public expenditure payments to the NYC Health and Hospitals Corporation;
 - Certain disproportionate share payments to non-state oper-

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-

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.

SUMMARY
SPA #20-0042

This State Plan Amendment proposes to convert the value of Upper Payment Limit (UPL) payments for eligible 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 into Medicaid reimbursement inpatient rates.

DRAFT

**New York
131(a)**

Upper Payment Limit (UPL) Rate Add-ons

Effective April 2, 2020 through March 31, 2021, and each state fiscal year thereafter, rates of payment computed pursuant to this Attachment will be adjusted in accordance with the following:

1. A UPL payment per discharge will be added to acute rates, after the application of the Service Intensity Weight and Wage Equalization Factor adjustments to the statewide base price. 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 Additional Inpatient Governmental Hospital Payments (AIGHP) section of this Attachment, by its Medicaid fee-for-service acute discharges, 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 AIGHP section of this Attachment, the add-ons will be adjusted, as necessary.

2. A UPL payment per diem will be added to specialty long term acute care hospital 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 AIGHP section of this Attachment, by its Medicaid fee-for-service specialty hospital days, 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 AIGHP section of this Attachment, the add-ons will be adjusted, as necessary.

TN #20-0042

Approval Date _____

Supersedes TN NEW

Effective Date April 2, 2020

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 Health

The Department of Health proposes to amend the Title XIX (Medicaid) State Plan for inpatient, long term care, and non-institutional services to comply with recently proposed statutory provisions. The following significant changes are proposed:

All Services

Effective for dates of service April 1, 2020 through March 31, 2021, and each state fiscal year thereafter, all non-exempt Department of Health state funds Medicaid payments will be uniformly reduced by \$2.5 billion. Such reductions will be applied only to the extent that alternative methods that achieve Medicaid state share savings annually are not implemented. Medicaid payments that will be exempted from the uniform reduction include:

1. Payments whereby federal law precludes such reduction, including:
 - Federally Qualified Health Center services;
 - Indian Health Services and services provided to Native Americans;
 - Supplemental Medical Insurance – Part A and Part B;
 - State Contribution for Prescription Drug Benefit (aka Medicare Part D payments);
 - Any local share cap payment required by the Federal Medical Assistance Percentage (FMAP) increase legislation;
 - Services provided to American citizen repatriates; and
 - Hospice Services.
2. Payments funded exclusively with federal and/or local funds include, but are not limited to, the following:
 - Upper payment limit payments to non-state owned or operated governmental providers certified under Article 28 of the NYS Public Health Law;
 - Certified public expenditure payments to the NYC Health and Hospital Corporation;
 - Certain disproportionate share payments to non-state operated 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.
3. 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;
 - Court orders and judgments; and
 - Family Planning services.

Copies of the proposed state plan amendments will be on file in each local (county) social services district and available for public review.

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 institutional, non-institutional or long term care services to comply with proposed Medicaid Redesign Team II (MRT) initiatives. The following changes are proposed:

All Services

Effective for dates of service April 1, 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 1.875 percent. Medicaid payments that will be exempted from the uniform reduction include:

- Payments whereby federal law precludes such reduction, including:
 - Federally Qualified Health Center services;
 - Indian Health Services and services provided to Native Americans;
 - Supplemental Medical Insurance – Part A and Part B;
 - State Contribution for Prescription Drug Benefit (aka Medicare Part D payments);
 - Any local share cap payment required by the Federal Medical Assistance Percentage (FMAP) increase legislation;
 - Services provided to American citizen repatriates; and
 - Hospice Services.
- Payments funded exclusively with federal and/or local funds include, but are not limited to, the following:
 - Upper payment limit payments to non-state owned or operated governmental providers certified under Article 28 of the NYS Public Health Law;
 - Certified public expenditure payments to the NYC Health and Hospitals Corporation;
 - Certain disproportionate share payments to non-state oper-

- 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-

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.

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Upper Payment Limit (UPL) Rate Add-ons

IX. Effective April 2, 2020 through March 31, 2021, and each state fiscal 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

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 foat 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.

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 Health

The Department of Health proposes to amend the Title XIX (Medicaid) State Plan for inpatient, long term care, and non-institutional services to comply with recently proposed statutory provisions. The following significant changes are proposed:

All Services

Effective for dates of service April 1, 2020 through March 31, 2021, and each state fiscal year thereafter, all non-exempt Department of Health state funds Medicaid payments will be uniformly reduced by \$2.5 billion. Such reductions will be applied only to the extent that alternative methods that achieve Medicaid state share savings annually are not implemented. Medicaid payments that will be exempted from the uniform reduction include:

1. Payments whereby federal law precludes such reduction, including:
 - Federally Qualified Health Center services;
 - Indian Health Services and services provided to Native Americans;
 - Supplemental Medical Insurance – Part A and Part B;
 - State Contribution for Prescription Drug Benefit (aka Medicare Part D payments);
 - Any local share cap payment required by the Federal Medical Assistance Percentage (FMAP) increase legislation;
 - Services provided to American citizen repatriates; and
 - Hospice Services.
2. Payments funded exclusively with federal and/or local funds include, but are not limited to, the following:
 - Upper payment limit payments to non-state owned or operated governmental providers certified under Article 28 of the NYS Public Health Law;
 - Certified public expenditure payments to the NYC Health and Hospital Corporation;
 - Certain disproportionate share payments to non-state operated 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.
3. 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;
 - Court orders and judgments; and
 - Family Planning services.

Copies of the proposed state plan amendments will be on file in each local (county) social services district and available for public review.

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 institutional, non-institutional or long term care services to comply with proposed Medicaid Redesign Team II (MRT) initiatives. The following changes are proposed:

All Services

Effective for dates of service April 1, 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 1.875 percent. Medicaid payments that will be exempted from the uniform reduction include:

- Payments whereby federal law precludes such reduction, including:
 - Federally Qualified Health Center services;
 - Indian Health Services and services provided to Native Americans;
 - Supplemental Medical Insurance – Part A and Part B;
 - State Contribution for Prescription Drug Benefit (aka Medicare Part D payments);
 - Any local share cap payment required by the Federal Medical Assistance Percentage (FMAP) increase legislation;
 - Services provided to American citizen repatriates; and
 - Hospice Services.
- Payments funded exclusively with federal and/or local funds include, but are not limited to, the following:
 - Upper payment limit payments to non-state owned or operated governmental providers certified under Article 28 of the NYS Public Health Law;
 - Certified public expenditure payments to the NYC Health and Hospitals Corporation;
 - Certain disproportionate share payments to non-state oper-

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-

SUMMARY
SPA #20-0048

This State Plan Amendment is a temporary amendment in response to COVID-19 Emergency Relief.

DRAFT

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Section 7 – General Provisions

7.4. Medicaid Disaster Relief for the COVID-19 National Emergency

On March 13, 2020, the President of the United States issued a proclamation that the COVID-19 outbreak in the United States constitutes a national emergency by the authorities vested in him by the Constitution and the laws of the United States, including sections 201 and 301 of the National Emergencies Act (50 U.S.C. 1601 et seq.), and consistent with section 1135 of the Social Security Act (Act). On March 13, 2020, pursuant to section 1135(b) of the Act, the Secretary of the United States Department of Health and Human Services invoked his authority to waive or modify certain requirements of titles XVIII, XIX, and XXI of the Act as a result of the consequences COVID-19 pandemic, to the extent necessary, as determined by the Centers for Medicare & Medicaid Services (CMS), to ensure that sufficient health care items and services are available to meet the needs of individuals enrolled in the respective programs and to ensure that health care providers that furnish such items and services in good faith, but are unable to comply with one or more of such requirements as a result of the COVID-19 pandemic, may be reimbursed for such items and services and exempted from sanctions for such noncompliance, absent any determination of fraud or abuse. This authority took effect as of 6PM Eastern Standard Time on March 15, 2020, with a retroactive effective date of March 1, 2020. The emergency period will terminate, and waivers will no longer be available, upon termination of the public health emergency, including any extensions.

The State Medicaid agency (agency) seeks to implement the policies and procedures described below, which are different than the policies and procedures otherwise applied under the Medicaid state plan, during the period of the Presidential and Secretarial emergency declarations related to the COVID-19 outbreak (or any renewals thereof), or for any shorter period described below:

Describe shorter period here. – N/A

NOTE: States may not elect a period longer than the Presidential or Secretarial emergency declaration (or any renewal thereof). States may not propose changes on this template that restrict or limit payment, services, or eligibility, or otherwise burden beneficiaries and providers.

Request for Waivers under Section 1135

 X The agency seeks the following under section 1135(b)(1)(C) and/or section 1135(b)(5) of the Act:

- a. X SPA submission requirements – the agency requests modification of the requirement to submit the SPA by March 31, 2020, to obtain a SPA effective date during the first calendar quarter of 2020, pursuant to 42 CFR 430.20.
- b. X Public notice requirements – the agency requests waiver of public notice requirements that would otherwise be applicable to this SPA submission. These requirements may include those specified in 42 CFR 440.386 (Alternative Benefit Plans), 42 CFR 447.57(c) (premiums and cost sharing), and 42 CFR 447.205 (public notice of changes in statewide methods and standards for setting payment rates).

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- c. X Tribal consultation requirements – the agency requests modification of tribal consultation timelines specified in New York State Medicaid state plan, as described below:

New York will reduce the tribal consultation to zero days before submission to CMS. Tribal consultation will still be completed and mailed as per guidelines in New York's approved state plan.

Section A – Eligibility

1. The agency furnishes medical assistance to the following optional groups of individuals described in section 1902(a)(10)(A)(ii) or 1902(a)(10)(c) of the Act. This may include the new optional group described at section 1902(a)(10)(A)(ii)(XXIII) and 1902(ss) of the Act providing coverage for uninsured individuals.

Include name of the optional eligibility group and applicable income and resource standard.

2. The agency furnishes medical assistance to the following populations of individuals described in section 1902(a)(10)(A)(ii)(XX) of the Act and 42 CFR 435.218:

- a. All individuals who are described in section 1905(a)(10)(A)(ii)(XX)

Income standard: _____

-or-

- b. Individuals described in the following categorical populations in section 1905(a) of the Act:

Income standard: _____

3. X The agency applies less restrictive financial methodologies to individuals excepted from financial methodologies based on modified adjusted gross income (MAGI) as follows.

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Less restrictive income methodologies:

New York is electing to disregard changes in income that occur after a determination of eligibility and before the next scheduled redetermination for the following non-MAGI categories:

- Aged, Blind or Disabled individuals receiving SSI - 42 CFR 435.120
- Blind or disabled individuals under 65 receiving SSI - 1902(a)(10)(A)(i)(II) and 1905(q)
- Individuals over 18 who lose SSI due to receiving survivor's benefits - 1634(c)
- Individuals who would be receiving SSI but are not due to a non-Title XIX reason - 42 CFR 435.122
- Individuals receiving SSP - 45 CFR 435.130
- Essential spouse eligible for MA in December 1973 and is living with the ABD spouse - 45 CFR 425.131
- Individuals institutionalized in December 1973 - 42 CFR 435.132
- Blind and disabled individuals who were eligible in Dec 1973 - 42 CFR 435.133
- Individuals who would be receiving SSI/SSP but are not because of receiving survivor's benefits (Aug 1972) - 42 CFR 435.134
- Individuals who would be receiving SSI/SSP but are not because of receiving survivor's benefits (Apr 1977) - 42 CFR 435.135
- Disabled widow(er)s who would be receiving SSI/SSP but are not because of the elimination of reduction factor in PL 98-21 - 1634
- Disabled widow(er)s who would be receiving SSI/SSP but are not because of early SSD, no Part A - 1634 (d)
- Qualified Medicare Beneficiaries - 1902(a)(10)(E)(iv)
- Qualified disabled and working - 1902(a)(10)(E)(ii), 1905(p)(3)(A)(i), 1905(p), 1860D-14(a)(3)(D)
- Specified Low-income Medicare Beneficiaries - 1902(a)(10)(E)(iii) 1905(p)(3)(A)(ii) 1860D-14(a)(3)(D)
- Qualified Individuals - 1902(a)(10)(E)(iv) 1905(p)(3)(A)(ii) 1860D-14(a)(3)(D)
- Individuals who would be receiving SSI but aren't due to Section 1611(e)(3)(A)(i) or (v) - 1634(e)
- Individuals who meet the income and resource requirement of AFDC, SSI, on an optional state supplement as specified 42 CFR 435.230 but do not receive cash assistance - 42 CFR 435.210, 1902(a)(10)(A)(ii) and 1905(a)
- Individuals who would be eligible for 42 CFR 435.230 if they were not in medical institution
- Waiver recipients under 1915(c) - 42 CFR 435.217
- Aged, blind, or disabled individuals receiving SSP only - 42 CFR 435.232
- Aged or disabled individuals with income at or below 100%, resources below the threshold (SSI, MN or more restrictive methodology) - 1902(a)(ii)(X) 1902(m)(1) and (3)
- COBRA - 1902(a)(10)(F) and 1902(u)(1)
- Breast and Cervical Cancer & PE - 1902(a)(10)(A)(ii)(XVIII), 1920B
- TWWIIA Basic Coverage Group (16-65) - 1902(a)(10)(A)(ii)(XV)
- TWWIIA Medical Improvement Group (16-65) - 1902(a)(10)(A)(ii)(XVI)
- Medically needy pregnant women - 42 CFR 435.301 1902(e)
- Medically needy children under 18 - 1902(a)(10)(C)(ii)(I)

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- Medically needy children under 21 - 42 CFR 435.308
- Medically needy caretaker relatives - 42 CFR 435.310
- Medically needy aged - 42 CFR 435.320 and 435.330
- Medically needy blind - 42 CFR 435.322 and 435.330
- Medically needy disabled - 42 CFR 435.324 and 435.330
- Blind and disabled individuals who were medically needy in Dec 1973 and have been continuously eligible - 42 CFR 435.340

Less restrictive resource methodologies:

New York is electing to disregard changes in resources that occur after a determination of eligibility and before the next scheduled redetermination for the following non-MAGI categories:

- Aged, Blind or Disabled individuals receiving SSI - 42 CFR 435.120
- Blind or disabled individuals under 65 receiving SSI - 1902(a)(10)(A)(i)(II) and 1905(q)
- Individuals over 18 who lose SSI due to receiving survivor's benefits - 1634(c)
- Individuals who would be receiving SSI but are not due to a non-Title XIX reason - 42 CFR 435.122
- Individuals receiving SSP - 45 CFR 435.130
- Essential spouse eligible for MA in December 1973 and is living with the ABD spouse - 45 CFR 425.131
- Individuals institutionalized in December 1973 - 42 CFR 435.132
- Blind and disabled individuals who were eligible in Dec 1973 - 42 CFR 435.133
- Individuals who would be receiving SSI/SSP but are not because of receiving survivor's benefits (Aug 1972) - 42 CFR 435.134
- Individuals who would be receiving SSI/SSP but are not because of receiving survivor's benefits (Apr 1977) - 42 CFR 435.135
- Disabled widow(er)s who would be receiving SSI/SSP but are not because of the elimination of reduction factor in PL 98-21 - 1634
- Disabled widow(er)s who would be receiving SSI/SSP but are not because of early SSD, no Part A - 1634 (d)
- Qualified Medicare Beneficiaries - 1902(a)(10)(E)(iv)
- Qualified disabled and working - 1902(a)(10)(E)(ii), 1905(p)(3)(A)(i), 1905(p), 1860D-14(a)(3)(D)
- Specified Low-income Medicare Beneficiaries - 1902(a)(10)(E)(iii) 1905(p)(3)(A)(ii) 1860D-14(a)(3)(D)
- Qualified Individuals - 1902(a)(10)(E)(iv) 1905(p)(3)(A)(ii) 1860D-14(a)(3)(D)
- Individuals who would be receiving SSI but aren't due to Section 1611(e)(3)(A)(i) or (v) - 1634(e)
- Individuals who meet the income and resource requirement of AFDC, SSI, on an optional state supplement as specified 42 CFR 435.230 but do not receive cash assistance - 42 CFR 435.210, 1902(a)(10)(A)(ii) and 1905(a)
- Individuals who would be eligible for 42 CFR 435.230 if they were not in medical institution
- Waiver recipients under 1915(c) - 42 CFR 435.217

- Aged, blind, or disabled individuals receiving SSP only - 42 CFR 435.232
- Aged or disabled individuals with income at or below 100%, resources below the threshold (SSI, MN or more restrictive methodology) - 1902(a)(ii)(X) 1902(m)(1) and (3)
- COBRA - 1902(a)(10)(F) and 1902(u)(1)
- Breast and Cervical Cancer & PE - 1902(a)(10)(A)(ii)(XVIII), 1920B
- TWWIIA Basic Coverage Group (16-65) - 1902(a)(10)(A)(ii)(XV)
- TWWIIA Medical Improvement Group (16-65) - 1902(a)(10)(A)(ii)(XVI)
- Medically needy pregnant women - 42 CFR 435.301 1902(e)
- Medically needy children under 18 - 1902(a)(10)(C)(ii)(I)
- Medically needy children under 21 - 42 CFR 435.308
- Medically needy caretaker relatives - 42 CFR 435.310
- Medically needy aged - 42 CFR 435.320 and 435.330
- Medically needy blind - 42 CFR 435.322 and 435.330
- Medically needy disabled - 42 CFR 435.324 and 435.330
- Blind and disabled individuals who were medically needy in Dec 1973 and have been continuously eligible - 42 CFR 435.340

4. The agency considers individuals who are evacuated from the state, who leave the state for medical reasons related to the disaster or public health emergency, or who are otherwise absent from the state due to the disaster or public health emergency and who intend to return to the state, to continue to be residents of the state under 42 CFR 435.403(j)(3).
5. The agency provides Medicaid coverage to the following individuals living in the state, who are non-residents:

6. The agency provides for an extension of the reasonable opportunity period for non-citizens declaring to be in a satisfactory immigration status, if the non-citizen is making a good faith effort to resolve any inconsistencies or obtain any necessary documentation, or the agency is unable to complete the verification process within the 90-day reasonable opportunity period due to the disaster or public health emergency.

Section B – Enrollment

1. The agency elects to allow hospitals to make presumptive eligibility determinations for the following additional state plan populations, or for populations in an approved section 1115 demonstration, in accordance with section 1902(a)(47)(B) of the Act and 42 CFR 435.1110, provided that the agency has determined that the hospital is capable of making such determinations.

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Please describe the applicable eligibility groups/populations and any changes to reasonable limitations, performance standards or other factors.

2. _____ The agency designates itself as a qualified entity for purposes of making presumptive eligibility determinations described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L.

Please describe any limitations related to the populations included or the number of allowable PE periods.

3. _____ The agency designates the following entities as qualified entities for purposes of making presumptive eligibility determinations or adds additional populations as described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L. Indicate if any designated entities are permitted to make presumptive eligibility determinations only for specified populations.

Please describe the designated entities or additional populations and any limitations related to the specified populations or number of allowable PE periods.

4. _____ The agency adopts a total of _____ months (not to exceed 12 months) continuous eligibility for children under age enter age _____ (not to exceed age 19) regardless of changes in circumstances in accordance with section 1902(e)(12) of the Act and 42 CFR 435.926.
5. _____ The agency conducts redeterminations of eligibility for individuals excepted from MAGI-based financial methodologies under 42 CFR 435.603(j) once every _____ months (not to exceed 12 months) in accordance with 42 CFR 435.916(b).
6. _____ The agency uses the following simplified application(s) to support enrollment in affected areas or for affected individuals (a copy of the simplified application(s) has been submitted to CMS).
- a. _____ The agency uses a simplified paper application.
 - b. _____ The agency uses a simplified online application.
 - c. _____ The simplified paper or online application is made available for use in call-centers or other telephone applications in affected areas.

Section C – Premiums and Cost Sharing

1. The agency suspends deductibles, copayments, coinsurance, and other cost sharing charges as follows:

Please describe whether the state suspends all cost sharing or suspends only specified deductibles, copayments, coinsurance, or other cost sharing charges for specified items and services or for specified eligibility groups consistent with 42 CFR 447.52(d) or for specified income levels consistent with 42 CFR 447.52(g).

2. The agency suspends enrollment fees, premiums and similar charges for:
- a. All beneficiaries
 - b. The following eligibility groups or categorical populations:

Please list the applicable eligibility groups or populations.

3. The agency allows waiver of payment of the enrollment fee, premiums and similar charges for undue hardship.

Please specify the standard(s) and/or criteria that the state will use to determine undue hardship.

Section D – Benefits

Benefits:

1. The agency adds the following optional benefits in its state plan (include service descriptions, provider qualifications, and limitations on amount, duration or scope of the benefit):

2. The agency makes the following adjustments to benefits currently covered in the state plan:

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Due to the federal and state-declared disaster emergency, New York State has directed individuals to remain at home as much as possible to stop the spread of Novel Coronavirus 2019. In order to ensure individuals with mental health conditions are able to receive medically necessary mental health services during this time and ensure providers of such services are reimbursed for the services they are able to perform consistent with State-issued guidance, the State requests the following adjustments to benefits currently covered in the state plan:

1. For Clinic Treatment Services, authorized under the clinic and outpatient hospital services benefit, adjust requirement related to formal treatment plan review, as specified on page 2(a)(v) of the Supplements to Attachments 3.1-A and B of the Plan, as follows:

“A physician must see the patient at least once, approve the patient’s treatment plan, and periodically review the need for continued care. However, during the disaster emergency, initial treatment plans shall be developed within practicable timeframes and periodic reviews shall be postponed. Providers may work under existing, physician-approved treatment plans, provide additional services as needed to ensure continuity of care and address mental health needs related to the disaster emergency, and document such services in a progress note, which will be incorporated into the treatment plan and approved by a physician at the earliest practicable time during or after the disaster emergency.”

“Medically necessary Clinic Treatment Services are documented in a treatment plan which is signed by a physician and reviewed on a periodic basis. However, during the disaster emergency, initial treatment plans shall be developed within practicable timeframes and periodic reviews shall be postponed. Providers may work under existing, physician-approved treatment plans, provide additional services as needed to ensure continuity of care and address mental health needs related to the disaster emergency, and document such services in a progress note, which will be incorporated into the treatment plan and approved by a physician at the earliest practicable time during or after the disaster emergency.”

2. For Partial Hospitalization Services, authorized under the clinic and outpatient hospital services benefit, adjust requirements related to clinical assessment and formal treatment plan review, as specified on page 2(a)(v)-(vi) of the Supplements to Attachments 3.1-A and B of the Plan, as follows:

“Partial Hospitalization Services are provided based upon the clinical assessment of an individual’s mental, physical and behavioral condition and history, which is the basis for establishing the individual’s diagnosis, functional deficits, and recovery goals. However, during the disaster emergency, the formal, clinical assessment process is not required.”

“Medically necessary Partial Hospitalization Services are documented in a treatment plan which is signed by a physician and reviewed on a periodic basis. However, during the disaster emergency, initial treatment plans shall be developed within practicable timeframes and periodic reviews shall be postponed. Providers may work under existing, physician-approved treatment plans, provide additional services as needed to ensure continuity of care and address

mental health needs related to the disaster emergency, and document such services in a progress note, which will be incorporated into the treatment plan and approved by a physician at the earliest practicable time during or after the disaster emergency.”

3. For Continuing Day Treatment Services, authorized under the clinic and outpatient hospital services benefit, adjust requirements related to formal treatment plan review and assessment as specified on page 2(a)(vi)-(vii) of the Supplements to Attachments 3.1-A and B of the Plan, as follows:

“Continuing Day Treatment Services are provided based upon the clinical assessment of an individual’s mental, physical and behavioral condition and history, which is the basis for establishing the individual’s diagnosis, functional deficits, and recovery goals. However, during the disaster emergency, the formal, clinical assessment process is not required.

“Medically necessary Continuing Day Treatment Services are documented in a treatment plan which is signed by a physician and reviewed on a periodic basis. However, during the disaster emergency, initial treatment plans shall be developed within practicable timeframes and periodic reviews shall be postponed. Providers may work under existing, physician-approved treatment plans, provide additional services as needed to ensure continuity of care and address mental health needs related to the disaster emergency, and document such services in a progress note, which will be incorporated into the treatment plan and approved by a physician at the earliest practicable time during or after the disaster emergency.”

4. For Day Treatment Services for Children, authorized under the clinic and outpatient hospital services benefit, adjust requirements related to formal treatment plan review specified on page 2(v) of the Supplements to Attachments 3.1-A and B of the Plan, as follows:

“A physician must see the patient at least once, approve the patient’s treatment plan, and periodically review the need for continued care. However, during the disaster emergency, initial treatment plans shall be developed within practicable timeframes and periodic reviews shall be postponed. Providers may work under existing, physician-approved treatment plans, provide additional services as needed to ensure continuity of care and address mental health needs related to the disaster emergency, and document such services in a progress note, which will be incorporated into the treatment plan and approved by a physician at the earliest practicable time during or after the disaster emergency.”

5. For Personalized Recovery Oriented Services, authorized under the other rehabilitative services benefit, adjust requirements related to individualized recovery plans, as specified on pages 3b-2-3b-12.1 of the Supplements to Attachments 3.1-A and B of the Plan, as follows:

“PROS services are delivered in accordance with documented Individualized Recovery Plans which, at a minimum, must include a description of the individual's strengths, resources, including collaterals, and mental health-related barriers that interfere with functioning: a statement of the individual's recovery goals and program participation objectives: an individualized course of action to be taken, including the specific services to be provided, the

expected frequency of service delivery, the expected duration of the course of service delivery, and the anticipated outcome: criteria to determine when goals and objectives have been met: a relapse prevention plan: and a description and goals of any linkage and coordination activities with other service providers.

“For individuals receiving Intensive Rehabilitation, Ongoing Rehabilitation and Support or Clinical Treatment Services, the Individualized Recovery Plan shall identify the reasons why these services are needed, in addition to Community Rehabilitation and Support services, to achieve the individual's recovery goals. However, during the disaster emergency, individualized recovery plans shall be developed within practicable timeframes. Additionally, services may be provided under existing, approved recovery plans and additional services may be provided as needed to ensure continuity of care and address mental health needs related to the disaster emergency, which must be documented in a progress note and be incorporated into the recovery plan at the earliest practicable time during or after the disaster emergency.”

6. For Assertive Community Treatment Services, adjust minimum contact requirements specified on page 3b-1 of the Supplements to Attachments 3.1-A and B of the Plan, as follows:

“Services will be provided under the supervision of a psychiatrist by a multidisciplinary team which meets with the recipient or the recipient’s significant others a minimum of three times per month. Such contacts may occur using approved telehealth technology. Of these three contacts, at least two of the contacts must be with the Medicaid recipient. Step down services may be provided to clients found by the team to be no longer in need of full ACT team services. A client who is receiving ACT step down must receive a minimum of one contact per month. This contact may also be with a collateral for the benefit of the beneficiary.”

7. For Rehabilitative Services for residents of community-based residential programs licensed by the Office of Mental Health, adjust approved service plan requirement as specified on pages 3a-3b of the Supplements to Attachments 3.1-A and B of the Plan, as follows:

“All services must be provided pursuant to a physician’s written authorization and provided in accordance with an approved service plan, as described in 14 NYCRR 593. However, during the disaster emergency, services may be provided under existing, approved service plans and additional services may be provided as needed to ensure continuity of care and address mental health needs related to the disaster emergency, which must be documented in a progress note and be incorporated into the service plan at the earliest practicable time during or after the disaster emergency.”

For all services outlined above:

Covered Services also include flexible supportive services to address the physical and emotional needs of individuals with disabling mental health conditions during the emergency and assist such individuals through the provision of health education and functional skill building, to understand and implement COVID-19 mitigation strategies recommended by the Center for Disease Control and Prevention (CDC) and New York State and Local Health Departments.

8. For Rehabilitative Services for residents of residential addiction providers certified by the Office of Addiction Services and Supports, adjust approved service plan requirement as specified on pages 3a-37(vii) and 3b-37(vii) of the Supplements to Attachments 3.1-A and B of the Plan, as follows:

Services are subject to prior approval, must be medically necessary and must be recommended “by a licensed practitioner or physician, who is acting within the scope of his/her professional license and applicable state law ... to promote the maximum reduction of symptoms and/or restoration of an individual to his/her best age-appropriate functional level according to an individualized treatment plan.” However, during the disaster emergency, services may be provided under existing, approved treatment plans and additional services may be provided as needed to ensure continuity of care and address addiction needs related to the disaster emergency, which must be documented in a progress note and be incorporated into the treatment plan at the earliest practicable time during or after the disaster emergency.

The following language shall be added to pages 3a-37(vii) and 3b-37(vii) of the Supplements to Attachments 3.1-A and B of the Plan: During a declared state of emergency, Residential Addiction providers are authorized to deliver rehabilitative services to individuals in a variety of settings in the community who have been discharged from the residential setting or were not admitted due to adjustments to programs necessitated by the emergency.

9. For Rehabilitative Services delivered by Outpatient Addiction providers certified by the Office of Addiction Services and Supports, adjust approved service plan requirement as specified on pages 3a-37 (iii) and 3b-37 (iii) of the Supplements to Attachments 3.1-A and B of the Plan, as follows:

“Services must be medically necessary and must be recommended by a licensed practitioner or physician, who is acting within the scope of his/her professional license and applicable state law ... to promote the maximum reduction of symptoms and/or restoration of an individual to his/her best age-appropriate functional level according to an individualized treatment plan. However, during the disaster emergency, services may be provided under existing, approved treatment plans and additional services may be provided as needed to ensure continuity of care and address addiction needs related to the disaster emergency, which must be documented in a progress note and be incorporated into the service plan at the earliest practicable time during or after the disaster emergency.”

10. In response to the emergency, reimbursement for six additional laboratory tests and specimen collection have been added for Medicaid members. The six COVID-19 tests include the following: two diagnostic tests (CPT codes 87635 and U0002), two high throughput diagnostic tests (CPT codes U0003 and U0004), and two antibody tests (CPT codes 86328 and 86769). The fees set for these six tests mirror Medicare. Some COVID-19 tests, represented by these codes are appropriate for point of care use and can be billed by practitioner offices, clinics, and pharmacies with a permit from Wadsworth Center. Reimbursement for COVID-19 specimen collection (CPT code G2023) has also been added and can be billed by pharmacies or practitioners and clinics when specimen collection is the only service performed. Reimbursement for specimen collection also mirrors Medicare.

11. For evaluation, specimen collection, testing and medical treatment delivered during the disaster emergency, New York State seeks permission to expand medical sites to include locations that would not otherwise serve as places to receive health care. These temporary locations include but are not limited to the following: non-hospital buildings, parking lots, vehicles, community sites and patient homes. Providing care at these additional temporary locations will prevent the potential spread of the virus.

3. The agency assures that newly added benefits or adjustments to benefits comply with all applicable statutory requirements, including the statewideness requirements found at 1902(a)(1), comparability requirements found at 1902(a)(10)(B), and free choice of provider requirements found at 1902(a)(23).
4. Application to Alternative Benefit Plans (ABP). The state adheres to all ABP provisions in 42 CFR Part 440, Subpart C. This section only applies to states that have an approved ABP(s).
- a. The agency assures that these newly added and/or adjusted benefits will be made available to individuals receiving services under ABPs.
- b. Individuals receiving services under ABPs will not receive these newly added and/or adjusted benefits, or will only receive the following subset:

Please describe.

Telehealth:

5. The agency utilizes telehealth in the following manner, which may be different than outlined in the state's approved state plan:

For Office for People With Developmental Disabilities' (OPWDD) Freestanding (non-hospital based) Clinics certified pursuant to Mental Hygiene Law Article 16, adjust policy regarding off-site services, as specified at Section 1(1) on page 2(t) of Attachment 4.19-B as follows:

Medicaid will only claim expenditures for off-site clinic services when the services meet the exception in 42 CFR 440.90 (b) that permits Medicaid payment for services furnished outside of the clinic by clinic personnel under the direction of a physician to an eligible individual who does not reside in a permanent dwelling or does not have a fixed home or mailing address. Off-site services provided by OPWDD licensed clinics to other than homeless individuals will be reimbursed with State-only funding and federal financial participation will not be claimed. However, during the disaster emergency, Medicaid may claim expenditures and seek federal financial participation for OPWDD Freestanding Article 16 Clinics that are delivered off-site and/or via telehealth pursuant to State-issued telehealth guidance.

Provide broad expansion for the ability of **all** Medicaid providers in **all** situations to use a wide variety of communication methods to deliver services remotely, to the extent it is appropriate for the care of the member, the type of service, and is within the provider's scope of practice. Allow for reimbursement of telephonic assessment, monitoring, and evaluation and management services provided to members in cases where face-to-face visits may not be recommended and it is appropriate for the member to be evaluated and managed by telephone. This expansion is to support the policy that members should be treated through telehealth provided by all Medicaid qualified practitioners and service providers, including telephonically, wherever possible to avoid member congregation with potentially sick patients. Telephonic communication will be covered when provided by any qualified practitioner or service provider. All telephonic encounters documented as appropriate by the provider would be considered medically necessary for payment purposes in Medicaid FFS or Medicaid Managed Care.

This expansion of coverage applies to all Medicaid providers and providers contracted to serve Medicaid members under Medicaid managed care plans.

For purposes of this request, telehealth is defined as the use of electronic information and communication technologies to deliver health care to patients at a distance. Medicaid covered services provided via telehealth include assessment, diagnosis, consultation, treatment, education, care management and/or self-management of a Medicaid member. For purposes of the State of Emergency, this definition is expanded to include telephone conversations. Telephonic service uses two-way electronic audio-only communications over the telephone to deliver services to a patient at an originating site by a telehealth provider located at a distant site.

Therefore, during the State of Emergency, telehealth includes telephonic, telemedicine, store and forward, and remote patient monitoring. Telemedicine is the term used in this guidance to denote two-way audiovisual communication. During the State of Emergency, all telehealth applications will be covered at all originating and distant sites as appropriate to properly care for the patient.

The distant site is the site where the telehealth provider is located while delivering health care services by means of telehealth. During the State of Emergency, any site within the fifty United States or United States' territories, is eligible to be a distant site for delivery and payment purposes, including Federally Qualified Health Centers and providers' homes, for all patients including patients dually eligible for Medicaid and Medicare.

Remote Patient Monitoring

Remote Patient Monitoring requires a minimum of 30 minutes of time per month. During the State of Emergency the time requirement for monitoring COVID-19 positive patients has been lowered to a minimum of 10 minutes per month. The fee and all other billing requirements remain the same. During the emergency a clinic or practitioner may bill rate code "Q3014" for administrative expenses in addition to a bill for the telemedicine (audio/visual) services provided. Reimbursement for "Q3014" is \$25.76.

FQHCs

Wrap payments are available for any telehealth services, including telephonic services reimbursed by a managed care plan, under qualifying PPS and offsite rate codes

Telephonic Reimbursement:

Provider Reimbursement:
 Physician/NP/PA/Midwife CPT Code 99421 = \$12.56, CPT Code 99422 = \$23.48, CPT Code 99423 = \$37.41
 Dentist CPT Code D9991 = \$14.

Rate code	Description	Upstate	Downstate
4012	FQHC OFF-SITE SERVICES (INDIV)	\$64.97	\$72.73
4015	FQHC OFF-SITE SERVICES (SBHC)*	\$64.97	\$72.73
7961	NON-FQHC OFF-SITE SERVICES (INDIV)	\$64.97	\$72.73
7962	NON-FQHC OFF-SITE SERVICES (SBHC)*	\$64.97	\$72.73
7963	TELEPHONE E & M; 5-10 MINUTES	\$12.56	
7964	TELEPHONE E & M; 11-20 MINUTES	\$23.48	
7965	TELEPHONE E & M; 21-30 MINUTES	\$37.41	
7966	TELEPHONE E & M; 5-10 MINUTES (SBHC)*	\$12.56	
7967	TELEPHONE E & M; 11-20 MINUTES (SBHC)*	\$23.48	
7968	TELEPHONE E & M; 21-30 MINUTES (SBHC)*	\$37.41	

Drug Benefit:

6. The agency makes the following adjustments to the day supply or quantity limit for covered outpatient drugs. The agency should only make this modification if its current state plan pages have limits on the amount of medication dispensed.

Please describe the change in days or quantities that are allowed for the emergency period and for which drugs.

7. Prior authorization for medications is expanded by automatic renewal without clinical review, or time/quantity extensions.
8. The agency makes the following payment adjustment to the professional dispensing fee when additional costs are incurred by the providers for delivery. States will need to supply documentation to justify the additional fees.

Please describe the manner in which professional dispensing fees are adjusted.

9. The agency makes exceptions to their published Preferred Drug List if drug shortages occur. This would include options for covering a brand name drug product that is a multi-source drug if a generic drug option is not available.

Section E – Payments

Optional benefits described in Section D:

1. Newly added benefits described in Section D are paid using the following methodology:

a. Published fee schedules –

Effective date (enter date of change): _____

Location (list published location): _____

b. Other:

Describe methodology here.

Increases to state plan payment methodologies:

2. The agency increases payment rates for the following services:

Please list all that apply.

a. Payment increases are targeted based on the following criteria:

Please describe criteria.

b. Payments are increased through:

i. A supplemental payment or add-on within applicable upper payment limits:

Effective March 1, 2020, for Outpatient Hospital, Clinic, and Other Rehabilitative Services, licensed or designated by the New York State Office of Mental Health or the Office for People With Developmental Disabilities and Other Licensed Practitioner services (EPSDT only), non-governmental providers and provider agencies may be eligible for provider-specific supplemental payments to reimburse such providers up to each provider's average monthly revenue during calendar year 2019, at the discretion of the Office of Mental

Health or the Office for People With Developmental Disabilities , which may take into consideration community access to behavioral health and/or developmental disability services, providers’ reported cost and revenue, and receipt of other available supplemental funding, including but not limited to funding available under a 1115 waiver amendment, during the public health emergency. Supplemental payments may be equal to the provider’s average monthly revenue during calendar year 2019, less the provider’s actual revenue for the month. Providers will not be eligible for this supplemental payment if monthly revenue equals or exceeds their average monthly revenue during calendar year 2019. The State may audit claim and encounter data to ensure supplemental payments do not result in reimbursement above the provider’s average monthly revenue during calendar year 2019 and may recover any portion of supplemental payments representing such overpayment.

Effective March 17, 2020, for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID) a supplemental payment will be made available to reimburse agencies for day-time weekday service hours when the provision of active treatment outside the residence is not possible. The additional funding will be provided as a supplemental payment to providers. The supplemental payment will be a regional fee as follows: The additional funding will be provided as a supplemental payment to providers.

<u>Rate Setting Region</u>	<u>Week-Day Daily Fee</u>
1	\$111.02
2	\$124.89
3	\$103.39

ii. An increase to rates as described below.

Rates are increased:

 Uniformly by the following percentage:

 Through a modification to published fee schedules –

Effective date (enter date of change):

Location (list published location):

 Up to the Medicare payments for equivalent services.

 By the following factors:

Please describe.

Payment for services delivered via telehealth:

3. For the duration of the emergency, the state authorizes payments for telehealth services that:
- a. Are not otherwise paid under the Medicaid state plan;
 - b. Differ from payments for the same services when provided face to face;
 - c. Differ from current state plan provisions governing reimbursement for telehealth;

Describe telehealth payment variation.

For Office for People With Developmental Disabilities' (OPWDD) Freestanding (non-hospital based) Clinics certified pursuant to Mental Hygiene Law Article 16, adjust policy regarding off-site services, as specified at Section 1(1) on page 2(t) of Attachment 4.19-B as follows:

Medicaid will only claim expenditures for off-site clinic services when the services meet the exception in 42 CFR 440.90 (b) that permits Medicaid payment for services furnished outside of the clinic by clinic personnel under the direction of a physician to an eligible individual who does not reside in a permanent dwelling or does not have a fixed home or mailing address. Off-site services provided by OPWDD licensed clinics to other than homeless individuals will be reimbursed with State-only funding and federal financial participation will not be claimed. However, during the disaster emergency, Medicaid may claim expenditures and seek federal financial participation for OPWDD Freestanding Article 16 Clinics that are delivered off-site and/or via telehealth pursuant to State-issued telehealth guidance.

- d. Include payment for ancillary costs associated with the delivery of covered services via telehealth, (if applicable), as follows:
 - i. Ancillary cost associated with the originating site for telehealth is incorporated into fee-for-service rates.
 - ii. Ancillary cost associated with the originating site for telehealth is separately reimbursed as an administrative cost by the state when a Medicaid service is delivered.

Other:

4. Other payment changes:

Adjustments to Outpatient Hospital, Clinic, and Other Rehabilitative Services, licensed or designated by the New York State Office of Mental Health for the treatment of mental health conditions, as follows:

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1. For Partial Hospitalization Services, adjust the methodology specified on page 3k-3k(1) of Attachment 4.19-B of the Plan to change units of service to permit providers to bill rate codes 4351 and 4353 for the provision of services to recipients and collaterals, respectively, for the delivery of services for shorter durations due to the COVID-19 pandemic, consistent with State-issued guidance.
 2. For Continuing Day Treatment Services, adjust the methodology specified on page 3(j.1)-3(j.2) of Attachment 4.19-B of the Plan to change units of service to permit providers to bill rate codes 4311 and 4317 for the provision of services to recipients and rate code 4325 for the provision of services to collaterals, for the delivery of services for shorter durations due to the COVID-19 pandemic, including documented attempts to contact clients, consistent with State-issued guidance.
 3. For Day Treatment Services for Children adjust the methodology specified on page 3k(2)-3k(4) of Attachment 4.19-B of the Plan to change units of service to permit providers to bill rate codes 4060 and 4061 for the provision of services to recipients and rate code 4066 for the provision of services to collaterals, for the delivery of services for shorter durations due to the COVID-19 pandemic, including documented attempts to contact clients, consistent with State-issued guidance.
 4. For Personalized Recovery Oriented Services, adjust the methodology specified on pages 3L-2-3L-4 of Attachment 4.19-B of the Plan to change units of service to permit providers to be reimbursed at the tier 1 or tier 3 monthly base rates for the delivery of services for shorter durations due to the COVID-19 pandemic, including documented attempts to contact clients, consistent with State-issued guidance.
 5. For Assertive Community Treatment Services, adjust the methodology specified on page 3M of Attachment 4.19-B of the Plan to provide for full payment for rendering services a minimum of three times per month, or one time per month for partial payment. For full ACT payment, at least two of the three contacts must be with the Medicaid recipient. For partial payment, contact can be with either the Medicaid recipient or a collateral for the benefit of the recipient.
- For all services outlined above, the New York State Office of Mental Health will review claims submitted during the emergency period and may recoup any reimbursement in excess of historical revenues or actual cost.
6. Adjustments to Clinic Treatment Program Services certified by the New York State Office for People With Developmental Disabilities, as specified on page 3 of Attachment 4.19-B, to allow for payment of services for shorter durations due to the COVID-19 pandemic, consistent with State-issued guidance.
 7. Adjustments to Children and Family Treatment and Support Services, i.e. Other Licensed Practitioner, Crisis Intervention, Community Psychiatric Supports and Treatment, Psychosocial Rehabilitation, Family Peer Support Services, and Youth Peer Support Services, as specified on

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pages 3b of Attachment 3.1-A, to allow for payment of shorter durations due to the COVID-19 pandemic, consistent with State-issued guidance.

Adjustments to Children's Home and Community Based Services, as specified in the Consolidated 1915(c) Children's Waiver to allow for payment of shorter durations due to the COVID-19 pandemic, consistent with State-issued guidance.

Suspend continuing education and in-person training requirements for providers of Other Licensed Practitioner, Crisis Intervention, Community Psychiatric Supports and Treatment, Psychosocial Rehabilitation, Family Peer Support Services, and Youth Peer Support Services, as specified on pages 3b of Attachment 3.1-A. Such trainings will be conducted remotely, whenever possible.

Section F – Post-Eligibility Treatment of Income

1. The state elects to modify the basic personal needs allowance for institutionalized individuals. The basic personal needs allowance is equal to one of the following amounts:
 - a. The individual's total income
 - b. 300 percent of the SSI federal benefit rate
 - c. Other reasonable amount: _____
2. The state elects a new variance to the basic personal needs allowance. (Note: Election of this option is not dependent on a state electing the option described the option in F.1. above.)

The state protects amounts exceeding the basic personal needs allowance for individuals who have the following greater personal needs:

Please describe the group or groups of individuals with greater needs and the amount(s) protected for each group or groups.

Section G – Other Policies and Procedures Differing from Approved Medicaid State Plan /Additional Information

For Health Homes serving Adults, Children and Care Coordination Organization/Health Homes:

1. Waive all face-to-face requirements for Health Home Serving Adults, Health Homes Serving Children, and Care Coordination Organization/Health Homes and that CMS waive the requirements for written member consents and member signatures on plans of care and life plans; verbal consents would be documented in the member record.

2. Annual reassessment and the requirement to annually update the life plans/plan of care be waived until further notification by the DOH

Eligibility:

1) Waiving certain conditions of eligibility that would otherwise require individuals to take action and provide documentation that is virtually impossible to obtain during this COVID-19 emergency period, such as:

- Applying for other benefits, including but not limited to Medicare and Social Security benefits;
- Referrals for Veterans Benefits;
- Providing documentation of available Third-Party Health Insurance; and
- Referrals for cash medical support enforcement.

2) Extending attestation of income and resources to individuals applying for Medicaid coverage of nursing home care during this emergency, and waiting to verify financial assets using AVS until renewal following the end of the emergency period. This includes attesting to any transfer of assets in the look-back period and accepting attestation that an applicant has named the State as beneficiary of any remainder interest in an annuity in order to determine eligibility; however, proof/document submission of this, and verification of financial assets, will be required at renewal.

3) Extending grace periods for individuals in the Medicaid Buy-In Program for Working People with Disabilities who have experienced job loss as a result of the COVID-19 emergency. If applicable, the grace period will be extended for six (6) additional months.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148 (Expires 03/31/2021). The time required to complete this information collection is estimated to average 1 to 2 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. Your response is required to receive a waiver under Section 1135 of the Social Security Act. All responses are public and will be made available on the CMS web site. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. ***CMS Disclosure*** Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact the Centers for Medicaid & CHIP Services at 410-786-3870.

SUMMARY
SPA #20-0049

This State Plan Amendment proposes to eliminate capital reimbursement for residual equity payments and reduce capital reimbursement by 5% for all Adult Day Health Care Facilities.

DRAFT

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For rates of payment effective for adult day health care services provided on and after January 1, 2009 through March 31, 2009, the otherwise applicable final trend factor attributable to the 2008 calendar year period will be adjusted such that any increase to the average trend factor for the period April 1, 2008 through December 31, 2008 will be reduced, on an annualized basis, by 1.3%. However, no retroactive adjustment to such trend factor will be made for the period April 1, 2008 through December 31, 2008. Effective on and after April 1, 2009, the otherwise applicable final trend factor attributable to the 2008 calendar year period will be zero.

For rates of payment effective for adult day health care services provided on and after January 1, 2009 through March 31, 2009, a trend factor equal to the otherwise applicable trend factor attributable to the period January 1, 2009 through December 31, 2009, less 1% will be applied. Effective on and after April 1, 2009 the otherwise applicable trend factor attributable to the 2009 calendar year period will be zero.

For rates of payment effective for services provided on and after January 1, 2010 through March 31, 2010, the otherwise applicable final trend factor attributable to the 2010 calendar year period will be zero.

For rates of payment effective for adult day health care services provided on and after April 1, 2010, the otherwise applicable trend factor attributable to the 2010 calendar year period will be zero.

For rates of payment effective for adult day health care services provided on and after April 1, 2011, the otherwise applicable trend factors attributable to the 2011 through 2014 calendar year periods will be no greater than zero. For such rates effective for the period January 1, 2015 through March 31, 2015 and for the period April 23, 2015 through December 31, 2015 otherwise applicable trend factors attributable to the 2015 calendar year period will be no greater than zero. For rates of payment effective for adult day health care services provided on and after January 1, 2016 through March 31, 2017 and for the period April 1, 2017 through December 31, 2017, the otherwise applicable trend factor attributable to the 2016 and 2017 calendar year periods will be zero. For rates of payment effective for adult day health care services provided on and after January 1, 2018 through March 31, 2019 and for the period April 1, 2019 through December 31, 2019, the otherwise applicable trend factor attributable to the 2018 and 2019 calendar year periods will be zero. For rates of payment effective for adult day health care services provided on and after January 1, 2020, the otherwise applicable trend factor will be zero.

Effective on April 2, 2020, the capital component of the Medicaid rate will be adjusted to eliminate reimbursement for residual equity payments and reduce capital reimbursement by 5% for all Adult Day Health Care Facilities.

TN #20-0049 _____

Approval Date _____

Supersedes TN #19-0042 _____

Effective Date April 2, 2020 _____

- 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.

SUMMARY
SPA #20-0050

This State Plan Amendment proposes to provide for a 2% increase to total salaries for direct care staff, direct support professionals, clinical staff and associated fringe compensation effective 4/1/2020.

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VI. APG Base Rates for OPWDD certified or operated clinics.

Peer Group	Base Rate	Effective Date of Base Rate
Peer Group A	\$180.95	7/1/11
Peer Group B	\$186.99	7/1/11
Peer Group C	\$270.50	7/1/11
Peer Group A	\$182.21	4/1/15
Peer Group B	\$189.07	4/1/15
Peer Group C	\$272.70	4/1/15
Peer Group A	\$182.57	4/1/16
Peer Group B	\$189.45	4/1/16
Peer Group C	\$273.24	4/1/16
Peer Group A	\$184.65	4/1/18
Peer Group B	\$192.90	4/1/18
Peer Group C	\$276.88	4/1/18
<u>Peer Group A</u>	<u>\$185.97</u>	<u>4/1/20</u>
<u>Peer Group B</u>	<u>\$195.09</u>	<u>4/1/20</u>
<u>Peer Group C</u>	<u>\$279.20</u>	<u>4/1/20</u>

TN # 20-0050

Approval Date

Supersedes TN #18-0048

Effective Date April 1, 2020

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 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 institutional, non-institutional and long term care services to comply with proposed statutory provisions. The following changes are proposed:

All Services

Effective for dates of service on or after January 1, 2020, through March 31, 2020, and each State Fiscal Year thereafter, all non-exempt Department of Health state funds Medicaid payments will be uniformly reduced by 1.0%. Medicaid payments that will be exempted from the uniform reduction include:

Payments based on federal law prohibitions include, but are not limited to, the following:

- Federally Qualified Health Center services;
- Indian Health Services and services provided to Native Americans;
- Supplemental Medical Insurance – Part A and Part B;
- State Contribution for Prescription Drug Benefit (aka Medicare Part D payments);
- Any local share cap payment required by the Federal Medical Assistance Percentage (FMAP) increase legislation;
- Required payments related to the School Supportive Health Services Program and Preschool Supportive Health Services Program;
- Services provided to American citizen repatriates;
- Payments pursuant to the mental hygiene law;
- Court orders and judgments; and
- Hospice Services.

Payments funded exclusively with federal and/or local funds include, but are not limited to the following:

- Upper payment limit payments to non-state owned or operated governmental providers certified under Article 28 of the NYS Public Health Law;
- Certified public expenditure payments to the NYC Health and Hospital Corporation;
- Certain disproportionate share payments to non-state operated 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.

Payments where applying the reduction would result in a lower FMAP as determined by the Commissioner of Health and the Director of the Budget will also be exempt.

The estimated annual net aggregate decrease in gross Medicaid expenditures attributable to this initiative contained in the budget for State Fiscal Year 2019-20 is (\$124,000,000) and (\$496,000,000) for each State Fiscal Year thereafter.

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, e-mail: 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 qualifying Mental Hygiene services to comply with enacted statutory provisions. The following changes are proposed:

Long Term Care

Effective on or after January 1, 2020, the State will change the methods and standards for determining payment rates for all qualifying Mental Hygiene Services to provide funding to support a two percent increase in annual salary and salary-related fringe benefits to direct care staff and direct support professionals.

Effective on or after April 1, 2020, a new two percent increase in annual salary and salary-related fringe benefits will be applied to direct care staff, direct support professionals and clinical staff for all qualifying Mental Hygiene Services. For the purposes of the January 1 and April 1, 2020, funding increases, direct support professionals are individuals employed in consolidated fiscal reporting position title codes ranging from 100 to 199; direct care staff are individuals employed in consolidated fiscal reporting position title codes ranging from 200 to 299; and clinical staff are individuals employed in consolidated fiscal reporting position title codes ranging from 300 to 399.

The estimated annual net aggregate increase in gross Medicaid expenditure attributable to this initiative enacted into law as part of the budget for SFY 2019/2020 is \$140 million.

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

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

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

Queens County, Queens Center
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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, Bureau of Federal Relations & Provider Assessments, 99 Washington Ave., One Commerce Plaza, Suite 1430, Albany, NY 12210, (518) 474-1673, Fax (518) 473-8825, spa_inquiries@health.state.ny.us

PUBLIC NOTICE

Department of Health

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

The Department of Health proposes to amend the Title XIX (Medicaid) State Plan for non-institutional services to revise provisions of the Ambulatory Patient Group (APG) reimbursement methodology and Independent Practitioner Services for Individuals with Developmental Disabilities (IPSIDD) fees. The following changes are proposed:

Non-Institutional

For the effective period January 1, 2020 through December 31, 2020, the Ambulatory Patient Group (APG) reimbursement methodology is extended.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative is \$0.

Effective on or after January 1, 2020, the Ambulatory Patient Group (APG) reimbursement methodology is revised to include recalculated weight and component updates.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative is \$3.87 million.

Effective on or after January 1, 2020, the Independent Practitioner Services for Individuals with Developmental Disabilities (IPSIDD) fees are revised.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative is \$0.

The public is invited to review and comment on this proposed State Plan Amendment. Copies of which will be available for public review on the Department's website at http://www.health.ny.gov/regulations/state_plans/status.

Copies of the proposed State Plan Amendments will be on file in each local (county) social services district and available for public review.

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, Bureau of Federal Relations & Provider Assessments, 99 Washington Ave., One Commerce Plaza, Suite 1430, Albany, NY 12210, (518) 474-1673, Fax (518) 473-8825, spa_inquiries@health.state.ny.us

PUBLIC NOTICE

Nassau County

The Deferred Compensation Plan for Employees of Nassau Health Care Corporation (the "Plan"), a 457(b) plan created under the laws of the State of New York and pursuant to Section 457(b) of the Internal Revenue Code, is seeking proposals from qualified firms to:

Provide consulting services to the Plan regarding monitoring the performance of the current plan record keeper/administrative service agent, investment manager, and trustee, and overall plan investment performance.

Proposals will be accepted until 4:00 p.m. on Monday, February 10, 2020.

A copy of the Request for Proposals may be obtained during normal business hours (9:00 a.m. to 5:00 p.m. – Weekdays) from: Richard

SUMMARY
SPA #20-0051

This amendment proposes to revise the State Plan to apply an additional one-half percent (0.5%) reduction, for a total one and one-half percent (1.5%) reduction, uniformly across most hospital inpatient payments made under the State's Institutional State Plan section 4.19-A for dates of service effective on or after April 2, 2020 and thereafter.

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**Across the Board 1% Payment Reduction – effective 1/1/2020 and thereafter;
additional 0.5% Across-the-Board Payment Reduction – effective on or after 4/2/2020
and thereafter**

(1) For dates of service on and after January 1, 2020, payments for services as specified in paragraph ~~[(2)](3)~~ of this Section will be reduced by one percent (1%).

(2) For dates of service on or after April 2, 2020, payments for services as specified in paragraph (3) of this Section will be reduced by an additional one-half percent (0.5%) to the percent referenced in paragraph (1), resulting in a one and one-half percent (1.5%) reduction.

~~[(2)](3)~~ Payments pursuant to Part I in this Attachment subject to the reduction in paragraphs (1) and (2) are the following:

Part I – Methods and Standards for Establishing Payments – Inpatient Hospital Care

- a) Hospital Inpatient Reimbursement.
- b) Capital Expense Reimbursement.
- c) Adding or Deleting Hospital Services or Units.
- d) New Hospitals and Hospital on Budgeted Rates.
- e) Swing Bed Reimbursement.
- f) Mergers, Acquisitions, Consolidations, Restructurings and Closures.
- g) Administrative Rate Appeals.
- h) Out-of-State Providers.
- i) Hospital Physician Billing.
- j) Graduate Medical Education – Medicaid Managed Care Reimbursement.
- k) Government General Hospital Additional Disproportionate Share Payments.
- l) Government General Hospital Indigent Care Adjustment.
- m) Voluntary Supplemental Inpatient Payments.
- n) Indigent Care Pool Reform.

TN #20-0051
Supersedes TN #20-0015

Approval Date _____
Effective Date April 2, 2020

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 Health

The Department of Health proposes to amend the Title XIX (Medicaid) State Plan for inpatient, long term care, and non-institutional services to comply with recently proposed statutory provisions. The following significant changes are proposed:

All Services

Effective for dates of service April 1, 2020 through March 31, 2021, and each state fiscal year thereafter, all non-exempt Department of Health state funds Medicaid payments will be uniformly reduced by \$2.5 billion. Such reductions will be applied only to the extent that alternative methods that achieve Medicaid state share savings annually are not implemented. Medicaid payments that will be exempted from the uniform reduction include:

1. Payments whereby federal law precludes such reduction, including:
 - Federally Qualified Health Center services;
 - Indian Health Services and services provided to Native Americans;
 - Supplemental Medical Insurance – Part A and Part B;
 - State Contribution for Prescription Drug Benefit (aka Medicare Part D payments);
 - Any local share cap payment required by the Federal Medical Assistance Percentage (FMAP) increase legislation;
 - Services provided to American citizen repatriates; and
 - Hospice Services.
2. Payments funded exclusively with federal and/or local funds include, but are not limited to, the following:
 - Upper payment limit payments to non-state owned or operated governmental providers certified under Article 28 of the NYS Public Health Law;
 - Certified public expenditure payments to the NYC Health and Hospital Corporation;
 - Certain disproportionate share payments to non-state operated 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.
3. 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;
 - Court orders and judgments; and
 - Family Planning services.

Copies of the proposed state plan amendments will be on file in each local (county) social services district and available for public review.

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 institutional, non-institutional or long term care services to comply with proposed Medicaid Redesign Team II (MRT) initiatives. The following changes are proposed:

All Services

Effective for dates of service April 1, 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 1.875 percent. Medicaid payments that will be exempted from the uniform reduction include:

- Payments whereby federal law precludes such reduction, including:
 - Federally Qualified Health Center services;
 - Indian Health Services and services provided to Native Americans;
 - Supplemental Medical Insurance – Part A and Part B;
 - State Contribution for Prescription Drug Benefit (aka Medicare Part D payments);
 - Any local share cap payment required by the Federal Medical Assistance Percentage (FMAP) increase legislation;
 - Services provided to American citizen repatriates; and
 - Hospice Services.
- Payments funded exclusively with federal and/or local funds include, but are not limited to, the following:
 - Upper payment limit payments to non-state owned or operated governmental providers certified under Article 28 of the NYS Public Health Law;
 - Certified public expenditure payments to the NYC Health and Hospitals Corporation;
 - Certain disproportionate share payments to non-state oper-

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).

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
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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.

SUMMARY
SPA #20-0052

This amendment proposes to revise the State Plan to apply an additional one-half percent (0.5%) reduction, for a total one and one-half percent (1.5%) reduction, uniformly across most payments made under the State's Non-Institutional State Plan section 4.19-B for dates of service effective on or after April 2, 2020 and thereafter.

DRAFT

**New York
A (7.5)**

**Across the Board 1% Payment Reduction – effective 1/1/2020 and thereafter; additional 0.5%
Across-the-Board Payment Reduction – effective on or after 4/2/2020 and thereafter**

- (1) For dates of service on and after January 1, 2020, payments for services as specified in paragraph [(2)](3) of this Attachment will be reduced by 1%, with the exception of the services listed below that are provided in clinics designated as Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs) and Indian Health Services, as well as services provided to Native Americans, where applicable.
- (2) For dates of service on or after April 2, 2020, payments for services as specified in paragraph (3) of this Section will be reduced by an additional one-half percent (0.5%) to the percent referenced in paragraph (1), resulting in a one and one-half percent (1.5%) reduction, with the exception of the services listed below that are provided in clinics designated as Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs) and Indian Health Services, as well as services provided to Native Americans, where applicable.
- (3) [(2)] Payments in this Attachment subject to the reduction in paragraphs (1) and (2) are the following:
- a) Physician Services.
 - b) Statewide Patient Centered Medical Home – Physicians and/or Nurse Practitioners, Statewide Patient Centered Medical Home – Hospital Based Clinics and Statewide Patient Centered Medical Home – Freestanding Clinics.
 - c) Advanced Primary Care – Physicians and/or Nurse Practitioners, Advanced Primary Care – Hospital Based Clinics and Advanced Primary Care – Freestanding Clinics.
 - d) Adirondack Medical Home Multipayor Program – Physicians and/or Nurse Practitioners, Adirondack Medicaid Home Multipayor Program – Hospital Based Clinics and Adirondack Medical Home Multipayor Program – Freestanding Clinics.
 - e) Dental Services (including dentures), Podiatrists, Optometrists, Chiropractor's Services, Nurse Midwives, Nurse Practitioners and Clinical Psychologists.
 - f) Exempt Acute Care Children's Hospitals.
 - g) Ordered Ambulatory Services (specific services performed by a hospital on an ambulatory basis upon the order of a qualified physician, physician's assistant, dentist or podiatrist to test, diagnose or treat a recipient or specimen taken from a recipient).
 - h) Ordered Ambulatory Services (specific services performed by a free-standing clinic on an ambulatory basis upon the order of a qualified physician, physician's assistant, dentist or podiatrist to test, diagnose or treat a recipient or specimen taken from a recipient).
 - i) Adult Day Health Care Services for Persons with HIV/AIDS and Other High-Need Populations Diagnostic and Treatment Centers.
 - j) Ambulatory Patient Group System: Hospital-Based Outpatient (Article 28 Services Only).
 - k) Hospital Outpatient Supplemental Payments – Non-Government Owned or Operated General Hospitals.

TN #20-0052
Supersedes TN #20-0016

Approval Date _____
Effective Date _____

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 Health

The Department of Health proposes to amend the Title XIX (Medicaid) State Plan for inpatient, long term care, and non-institutional services to comply with recently proposed statutory provisions. The following significant changes are proposed:

All Services

Effective for dates of service April 1, 2020 through March 31, 2021, and each state fiscal year thereafter, all non-exempt Department of Health state funds Medicaid payments will be uniformly reduced by \$2.5 billion. Such reductions will be applied only to the extent that alternative methods that achieve Medicaid state share savings annually are not implemented. Medicaid payments that will be exempted from the uniform reduction include:

1. Payments whereby federal law precludes such reduction, including:
 - Federally Qualified Health Center services;
 - Indian Health Services and services provided to Native Americans;
 - Supplemental Medical Insurance – Part A and Part B;
 - State Contribution for Prescription Drug Benefit (aka Medicare Part D payments);
 - Any local share cap payment required by the Federal Medical Assistance Percentage (FMAP) increase legislation;
 - Services provided to American citizen repatriates; and
 - Hospice Services.
2. Payments funded exclusively with federal and/or local funds include, but are not limited to, the following:
 - Upper payment limit payments to non-state owned or operated governmental providers certified under Article 28 of the NYS Public Health Law;
 - Certified public expenditure payments to the NYC Health and Hospital Corporation;
 - Certain disproportionate share payments to non-state operated 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.
3. 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;
 - Court orders and judgments; and
 - Family Planning services.

Copies of the proposed state plan amendments will be on file in each local (county) social services district and available for public review.

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 institutional, non-institutional or long term care services to comply with proposed Medicaid Redesign Team II (MRT) initiatives. The following changes are proposed:

All Services

Effective for dates of service April 1, 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 1.875 percent. Medicaid payments that will be exempted from the uniform reduction include:

- Payments whereby federal law precludes such reduction, including:
 - Federally Qualified Health Center services;
 - Indian Health Services and services provided to Native Americans;
 - Supplemental Medical Insurance – Part A and Part B;
 - State Contribution for Prescription Drug Benefit (aka Medicare Part D payments);
 - Any local share cap payment required by the Federal Medical Assistance Percentage (FMAP) increase legislation;
 - Services provided to American citizen repatriates; and
 - Hospice Services.
- Payments funded exclusively with federal and/or local funds include, but are not limited to, the following:
 - Upper payment limit payments to non-state owned or operated governmental providers certified under Article 28 of the NYS Public Health Law;
 - Certified public expenditure payments to the NYC Health and Hospitals Corporation;
 - Certain disproportionate share payments to non-state oper-

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).

MISCELLANEOUS NOTICES/HEARINGS

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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:

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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:

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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.

SUMMARY
SPA #20-0053

This State Plan Amendment proposes to apply a 0.5% reduction uniformly across most long term care payments made under the State's Long Term Care State Plan section 4.19-D effective April 2, 2020 and each state fiscal year thereafter.

DRAFT

New York
A(1)(i)

1% Across-the-Board Reductions to Payments – Effective January 1, 2020 through March 31, 2020; additional 0.5% Across-the-Board Payment Reduction – effective on or after 4/2/2020 and Thereafter

- (1) For dates of service on and after January 1, 2020, the rates of reimbursement for Article 28 nursing homes will be adjusted to reflect an across the board reduction of one percent (1%).
- (2) For dates of service on or after April 2, 2020, the rates of reimbursement for Article 28 nursing homes will be adjusted by an additional one-half percent (0.5%) to reflect an across the board reduction of one and one half percent (1.5%).
 - a. Sections subjected to the one percent (1%) and one and one half percent (1.5%) reduction are as follows:
 - i. Nursing Home Reimbursement
 - ii. Specialty Care Facilities

DRAFT

MISCELLANEOUS NOTICES/HEARINGS

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PUBLIC NOTICE Department of Health

The Department of Health proposes to amend the Title XIX (Medicaid) State Plan for inpatient, long term care, and non-institutional services to comply with recently proposed statutory provisions. The following significant changes are proposed:

All Services

Effective for dates of service April 1, 2020 through March 31, 2021, and each state fiscal year thereafter, all non-exempt Department of Health state funds Medicaid payments will be uniformly reduced by \$2.5 billion. Such reductions will be applied only to the extent that alternative methods that achieve Medicaid state share savings annually are not implemented. Medicaid payments that will be exempted from the uniform reduction include:

1. Payments whereby federal law precludes such reduction, including:
 - Federally Qualified Health Center services;
 - Indian Health Services and services provided to Native Americans;
 - Supplemental Medical Insurance – Part A and Part B;
 - State Contribution for Prescription Drug Benefit (aka Medicare Part D payments);
 - Any local share cap payment required by the Federal Medical Assistance Percentage (FMAP) increase legislation;
 - Services provided to American citizen repatriates; and
 - Hospice Services.
2. Payments funded exclusively with federal and/or local funds include, but are not limited to, the following:
 - Upper payment limit payments to non-state owned or operated governmental providers certified under Article 28 of the NYS Public Health Law;
 - Certified public expenditure payments to the NYC Health and Hospital Corporation;
 - Certain disproportionate share payments to non-state operated 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.
3. 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;
 - Court orders and judgments; and
 - Family Planning services.

Copies of the proposed state plan amendments will be on file in each local (county) social services district and available for public review.

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 institutional, non-institutional or long term care services to comply with proposed Medicaid Redesign Team II (MRT) initiatives. The following changes are proposed:

All Services

Effective for dates of service April 1, 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 1.875 percent. Medicaid payments that will be exempted from the uniform reduction include:

- Payments whereby federal law precludes such reduction, including:
 - Federally Qualified Health Center services;
 - Indian Health Services and services provided to Native Americans;
 - Supplemental Medical Insurance – Part A and Part B;
 - State Contribution for Prescription Drug Benefit (aka Medicare Part D payments);
 - Any local share cap payment required by the Federal Medical Assistance Percentage (FMAP) increase legislation;
 - Services provided to American citizen repatriates; and
 - Hospice Services.
- Payments funded exclusively with federal and/or local funds include, but are not limited to, the following:
 - Upper payment limit payments to non-state owned or operated governmental providers certified under Article 28 of the NYS Public Health Law;
 - Certified public expenditure payments to the NYC Health and Hospitals Corporation;
 - Certain disproportionate share payments to non-state oper-

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).

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.