



# 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 28, 2019

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

RE: SPA #19-0042  
Non-Institutional Services

Dear Mr. Holligan:

The State requests approval of the enclosed amendment #19-0042 to the Title XIX (Medicaid) State Plan for non-institutional services to be effective April 1, 2019 (Appendix I). This amendment is being submitted based on enacted State legislation. A summary of the plan amendment is provided in Appendix II.

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

Copies of pertinent sections of enacted State legislation are enclosed for your information (Appendix III). Copies of the public notice of this plan amendment, which was given in the New York State Register on March 27, 2019 and clarified on May 29, 2019, are also enclosed for your information (Appendix IV). In addition, responses to the five standard funding questions and the standard access questions are also enclosed (Appendix V and VI, respectively).

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

Sincerely,



Donna Frescatore  
Medicaid Director  
Office of Health Insurance Programs

Enclosures

<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTERS FOR MEDICARE &amp; MEDICAID SERVICES</b>	1. TRANSMITTAL NUMBER <u>1</u> <u>9</u> — <u>0</u> <u>0</u> <u>4</u> <u>2</u>	2. STATE New York
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID) TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE & MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE April 1, 2019	

5. TYPE OF PLAN MATERIAL (*Check One*)

NEW STATE PLAN       AMENDMENT TO BE CONSIDERED AS NEW PLAN       AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (*Separate transmittal for each amendment*)

6. FEDERAL STATUTE/REGULATION CITATION Chapter 57 of the Laws of 2019, Part E, Public Health Law §2807-c(8)(g), Public Health Law §3614(7)	7. FEDERAL BUDGET IMPACT a. FFY <u>04/01/19-09/30/19</u> \$ <u>(25,000.00)</u> b. FFY <u>10/01/19-09/30/20</u> \$ <u>(50,000.00)</u>
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT  Attachment 4.19-B Pages: 1(b), 1(b)(i), 2(b)(ii), 4(1), 4(2), 4(a)(iii), 4(a)(iii)(A), 4(a)(iv), 4(a)(iv)(1), 4(a)(iv)(2), 4(a)(v), 6(a)(1), 7(a)(ii)	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT ( <i>If Applicable</i> )  Attachment 4.19-B Pages: 1(b), 1(b)(i), 2(b)(ii), 4(1), 4(2), 4(a)(iii), 4(a)(iii)(A), 4(a)(iv), 4(a)(iv)(1), 4(a)(iv)(2), 4(a)(v), 6(a)(1), 7(a)(ii)

10. SUBJECT OF AMENDMENT  
Cost Containment-OP  
(FMAP=50%)

11. GOVERNOR'S REVIEW (*Check One*)

GOVERNOR'S OFFICE REPORTED NO COMMENT       OTHER, AS SPECIFIED  
 COMMENTS OF GOVERNOR'S OFFICE ENCLOSED  
 NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

12. SIGNATURE OF STATE AGENCY OFFICIAL 	16. RETURN TO New York State Department of Health Division of Finance and Rate Setting 99 Washington Ave – One Commerce Plaza Suite 1432 Albany, NY 12210
13. TYPED NAME Donna Frescatore	
14. TITLE Medicaid Director, Department of Health	
15. DATE SUBMITTED      June 28, 2019	

**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED	18. DATE APPROVED
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**PLAN APPROVED - ONE COPY ATTACHED**

19. EFFECTIVE DATE OF APPROVED MATERIAL	20. SIGNATURE OF REGIONAL OFFICIAL
21. TYPED NAME	22. TITLE

23. REMARKS

**Appendix I**  
**2019 Title XIX State Plan**  
**Second Quarter Amendment**  
**Amended SPA Pages**

**New York  
1(b)**

(two year trend movement) on a per visit basis, except that commencing April 1, 1995 through March 31, 1999 and on and after July 1, 1999 through March 31, 2000 and on and after April 1, 2000 through March 31, 2003, and on and after April 1, 2003 through March 31, 2009, and on and after April 1, 2009 through March 31, 2011, and on and after April 1, 2011 through March 31, 2013, and on and after April 1, 2013 through March 31, 2015, and on and after April 1, 2015 through March 31, 2017, and on and after April 1, 2017 through March 31, 2019, and on and After April 1, 2019, for rates of payment for patients eligible for payments made by state governmental agencies, the capital cost per visit components will be adjusted by the Commissioner to exclude such expenses related to 1) forty-four percent of the costs of major moveable equipment and 2) staff housing. A return on equity is recognized in those instances where the hospital is organized under the auspices of proprietary sponsorship. MMTP services may be reimbursed on a uniform fixed weekly fee per enrolled patient basis. Renal dialysis services are reimbursed on the lower of a facility's actual cost or statewide ceiling of \$150.00 per procedure. Payment rates for renal dialysis services are adjusted to reflect utilization patterns for CAPD, CCPD, hemodialysis and extended peritoneal dialysis services. Effective October 1, 1995, the rate for primary care clinic services provided in primary care hospitals, will be a per visit rate based on allowable reportable operating costs subject to a cap on operating costs of \$67.50 per visit. For dates of service beginning on December 1, 2008 through March 31, 2010, primary care clinic and renal dialysis services will be reimbursed using the Ambulatory Patient Group classification and reimbursement system. Allowable reportable capital costs will be reimbursed on a per visit basis not subject to a ceiling on reimbursement, provided however that for the period October 1, 1995 through March 31, 1999 and on and after July 1, 1999 through March 31, 2000 and on and after April 1, 2000 through March 31, 2003, and on and after April 1, 2003 through March 31, 2009, and on and after April 1, 2009 through March 31, 2011, and on and after April 1, 2011 through March 31, 2013, and on and after April 1, 2013 through March 31, 2015, and on and after April 1, 2015 through March 31, 2017, and on and after April 1, 2017 through March 31, 2019, and on and after April 1, 2019, the capital cost per visit components will be adjusted by the Commissioner to exclude such expenses related to 1) forty-four percent of the cost of major movable equipment and 2) staff housing. A return on equity is recognized in those instances where the hospital is organized under the auspices of proprietary sponsorship.

Effective October 1, 1995, the rate for emergency services provided in primary care hospitals, will be a per visit rate based upon allowable reportable operating costs and limited to a cap on operating costs of \$95 per visit provided however, that for the period January 1, 2007 through December 31, 2007 the maximum payment for the operating component will be \$125 per visit; and during the period January 1, 2008 through December 31, 2008, the maximum payment for the operating cost component will be \$140 per visit; and during the period January 1, 2009 through March 31, 2010 emergency department services will be reimbursed through the Ambulatory Patient Group (APG) classification and reimbursement system. Allowable reportable capital costs will be reimbursed on a per visit basis not subject to a ceiling on reimbursement, provided however, that for the period of October 1, 1995 through March 31, 1999 and on and after July 1, 1999 through March 31, 2000, and on and after April 1, 2000 through March 31, 2003, and on and after April 1, 2003 through March 31, 2009, and on and after April 1, 2009 through March 31, 2011, and on and after April 1, 2011 through March 31, 2013, and on and after April 1, 2013 through March 31, 2015, and on and after April 1, 2015 through March 31, 2017, and on and after April 1, 2017 through March 31, 2019, and on and after April 1, 2019, the capital costs per visit components will be adjusted by the Commissioner to exclude such expenses related to 1) forty-four percent of the cost of major movable equipment and 2) staff housing. A return on equity is recognized in those instances where the hospital is organized under the auspices of proprietary sponsorship.

**TN**     #19-0042    

**Approval Date** \_\_\_\_\_

**Supersedes TN**   #17-0034  

**Effective Date** \_\_\_\_\_

**New York**  
**1(b)(i)**

For outpatient services provided by general hospitals as noted in the proceeding paragraphs of this Section, beginning on and after April 1, 2006, the Commissioner of Health [shall] will apply a trend factor projection of 2.25% attributable to the period January 1, 2006 through December 31, 2006. Upon reconciliation of this trend factor, in accordance with the previously approved state methodology, the final 2006 trend factor [shall] will be the U.S. Consumer Price Index (CPI) for all Urban Consumers, as published by the U.S. Department of Labor, Bureau of Labor Statistics, minus 0.25%.

For reimbursement of outpatient hospital services provided on and after April 1, 2007, the Commissioner of Health [shall] will apply a trend factor projection equal to 75% of the otherwise applicable trend factor for calendar year 2007.

For reimbursement of outpatient hospital services provided on and after April 1, 2008, the Commissioner of Health [shall] will apply a trend factor projection equal to 65% of the otherwise applicable trend factor for calendar year 2008, as calculated in accordance with the general Trend Factor section of this Attachment.

For rates of payment effective for outpatient hospital 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 [shall] will be adjusted such that any increase to the average trend factor for the period April 1, 2008 through December 31, 2008 [shall] 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 [shall] will be zero.

For rates of payment effective for outpatient hospital 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% [shall] will be applied. Effective on and after April 1, 2009, the otherwise applicable final trend factor attributable to the 2009 calendar year period [shall] will be zero.

For rates of payment effective for outpatient hospital 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 [shall] will be zero.

For rates of payment effective for outpatient hospital services provided on and after April 1, 2010, the otherwise applicable trend factor attributable to the 2010 calendar year period [shall] will be zero.

For rates of payment effective for outpatient hospital services provided on and after April 1, 2011, the otherwise applicable trend factors attributable to the 2011 through 2014 calendar year periods [shall] 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 [shall] will be no greater than zero. For rates of payment effective for outpatient hospital 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 final trend factor attributable to the 2016 and 2017 calendar year periods [shall] will be zero. For rates of payment effective for outpatient hospital 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 final trend factor attributable to the 2018 and 2019 calendar year periods [shall] will be zero. For rates of payment effective for outpatient hospital services provided on and after January 1, 2020 through March 31, 2021, the otherwise applicable final trend factor attributable to the 2020 and 2021 calendar year periods will be zero.

**TN**   #19-0042  

**Approval Date** \_\_\_\_\_

**Supersedes TN**   #17-0034  

**Effective Date** \_\_\_\_\_

**New York  
2(b)(ii)**

For rates of payment effective for outpatient hospital 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 [shall] will be adjusted such that any increase to the average trend factor for the period April 1, 2008 through December 31, 2008 [shall] 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 [shall] will be zero.

For rates of payment effective for outpatient hospital 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% [shall] will be applied. Effective on and after April 1, 2009, the otherwise applicable final trend factor attributable to the 2009 calendar year period [shall] will be zero.

For rates of payment effective for outpatient hospital 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 [shall] will be zero.

For rates of payment effective for outpatient hospital services provided on and after April 1, 2010, the otherwise applicable trend factor attributable to the 2010 calendar year period [shall] will be zero.

For rates of payment effective for outpatient hospital services provided on and after April 1, 2011, the otherwise applicable trend factors attributable to the 2011 through 2014 calendar year periods [shall] 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 [shall] will be no greater than zero. For rates of payment effective for outpatient hospital 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 final trend factor attributable to the 2016 and 2017 calendar year periods [shall] will be zero. For rates of payment effective for outpatient hospital 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 final trend factor attributable to the 2018 and 2019 calendar year periods [shall] will be zero. For rates of payment effective for outpatient hospital services provided on and after January 1, 2020 through March 31, 2021, the otherwise applicable final trend factor attributable to the 2020 and 2021 calendar year periods will be zero.

**TN #19-0042** \_\_\_\_\_

**Approval Date** \_\_\_\_\_

**Supersedes TN #17-0034** \_\_\_\_\_

**Effective Date** \_\_\_\_\_

New York  
4(1)

**Home Health Services/Certified Home Health Agencies**

Prospective, cost based hourly and per visit rates for five services [shall] will be calculated by the Department of Health and approved by Division of the Budget. Rates are based on the lower of cost or ceiling, trended or, if lower, the charge provided, however, for services on and after April 1, 2008, the Commissioner of Health [shall] will apply a trend factor projection equal to 65% of the otherwise applicable trend factor for calendar year 2008, as calculated in accordance with the general Trend Factor section of this Attachment.

For rates of payment effective for 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 [shall] will be adjusted such that any increase to the average trend factor for the period April 1, 2008 through December 31, 2008 [shall] 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 [shall] will be zero.

For rates of payment effective for 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% [shall] will be applied. Effective on and after April 1, 2009 the otherwise applicable final trend factor attributable to the 2009 calendar year period [shall] 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 [shall] will be zero.

For rates of payment effective for services provided on and after April 1, 2010, the otherwise applicable trend factor attributable to the 2010 calendar year period [shall] will be zero.

For rates of payment effective for services provided on and after April 1, 2011, the otherwise applicable trend factors attributable to the 2011 through 2014 calendar year periods [shall] 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 [shall] will be no greater than zero. For rates of payment effective for 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 final trend factor attributable to the 2016 and 2017 calendar year periods [shall] will be zero. For rates of payment effective for 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 final trend factor attributable to the 2018 and 2019 calendar year periods [shall] will be zero. For rates of payment effective for services provided on and after January 1, 2020 through March 31, 2021, the otherwise applicable final trend factor attributable to the 2020 and 2021 calendar year periods will be zero.

**TN #19-0042** \_\_\_\_\_

**Approval Date** \_\_\_\_\_

**Supersedes TN #17-0034** \_\_\_\_\_

**Effective Date** \_\_\_\_\_

**New York  
4(2)**

Providers are grouped geographically into upstate/downstate and by sponsorship, public/voluntary. Ceilings are calculated using the group cost experience. For purposes of establishing rates of payment by governmental agencies for certified home health agencies for the period April 1, 1995 through December 31, 1995, and for rate periods beginning on or after January 1, 1996 through March 31, 1999, and on July 1, 1999 through March 31, 2000, and on and after April 1, 2000 through March 31, 2003, and on and after April 1, 2003 through March 31, 2009, and on and after April 1, 2009 through March 31, 2011, and on and after April 1, 2011 through March 31, 2013, and on and after April 1, 2013 through March 31, 2015, and on and after April 1, 2015 through March 31, 2017, and on and after April 1, 2017 through March 31, 2019, and on and after April 1, 2019, the reimbursable base year administrative and general costs of a provider of services, excluding a provider of services reimbursed on an initial budget basis, and a new provider, excluding changes in ownership or changes in name, who begins operations in the year prior to the year which is used as base year in determining rates of payment, will not exceed the statewide average of total reimbursable base year administrative and general costs of such providers of services. In the 1996, 1997, 1998, 1999, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, and 2009, rate periods respectively the amount of such reduction in certified home health agency rates of payments made during the twelve month period running from April 1, of the year prior to the respective rate period through March 31, of such respective rate period will be adjusted in the respective rate period on a pro-rate basis, if it is determined upon post-audit review by June 15, of the respective rate period and reconciliation, that the savings for the state share, excluding the federal and local government shares, of medical assistance payments is in excess of one million five hundred thousand dollars or is less than one million five hundred thousand dollars for payments made on or before March 31, of the applicable twelve month period to reflect the amount by which such savings are in excess of or lower than one million five hundred thousand dollars. The amount of such reduction in certified home health agency rates of payment made during the period July 1, 1999 through March 31, 2000, will be adjusted in the 2000 rate period on a pro-rate basis, if it is determined upon post-audit review by June 15, 2000 and reconciliation, that the savings for the state share, excluding the federal and local government shares, of medical assistance payments is in excess of one million one hundred twenty-five thousand dollars or is less than one million one hundred twenty-five thousand dollars for payments made on or before March 31, 2000, to reflect the amount by which such savings are in excess of or lower than one million one hundred twenty-five thousand dollars.

**TN #19-0042**\_\_\_\_\_

**Approval Date**\_\_\_\_\_

**Supersedes TN #17-0034**\_\_\_\_\_

**Effective Date**\_\_\_\_\_

**New York  
4(a)(iii)**

Effective for the period August 1, 1996 through November 30, 2009, certified home health agencies (CHHAs) will be required to increase their Medicare revenues relative to their Medicaid revenues measured from a base period (calendar year 1995) to a target period (the 1996 target period is August 1, 1996 through March 31, 1997, the 1997 target period is January 1, 1997 through November 30, 1997, the 1998 target period will mean January 1, 1998 through November 30, 1998, the 1999 target period will mean January 1, 1999 through November 30, 1999, the 2000 target period will mean January 1, 2000 through November 30, 2000, the 2001 target period will mean January 1, 2001 through November 30, 2001, the 2002 target period will mean January 1, 2002 through November 30, 2002, the 2003 target period will mean January 1, 2003 through November 30, 2003, the 2004 target period will mean January 1, 2004 through November 30, 2004, the 2005 target period will mean January 1, 2005 through November 30, 2005, the 2006 target period will mean January 1, 2006 through November 30, 2006, the 2007 target period will mean January 1, 2007 through November 30, 2007, the 2008 target period will mean January 1, 2008 through November 30, 2008, and the 2009 target period will mean January 1, 2009 through November 30, 2009, and the 2010 target period will mean January 1, 2010 through November 30, 2010, and the 2011 target period will mean January 1, 2011 through November 30, 2011, and the 2012 target period will mean January 1, 2012 through November 30, 2012 and the 2013 target period will mean January 1, 2013 through November 30, 2013, and the 2014 target period will mean January 1, 2014 through November 30, 2014, and the 2015 target period will mean January 1, 2015 through November 30, 2015, and the 2016 target will mean January 1, 2016 through November 30, 2016, and the 2017 target period will mean January 1, 2017 through November 30, 2017, and the 2018 target will mean January 1, 2018 through November 30, 2018, and the 2019 target period will mean January 1, 2019 through November 30, 2019, and the 2020 target period will mean January 1, 2020 through November 30, 2020, and the 2021 target period will mean January 1, 2021 through November 30, 2021, and for each subsequent target period thereafter the period will mean January through November of the target period year or receive a reduction in their Medicaid payments. For this purpose, regions will consist of a downstate region comprised of Kings, New York, Richmond, Queens, Bronx, Nassau and Suffolk counties and an upstate region comprised of all other New York State counties. A certified home health agency will be located in the same county utilized by the Commissioner of Health for the establishment of rates pursuant to Article 36 of the Public Health Law. Regional group will mean all those CHHAs located within a region. Medicaid revenue percentage will mean CHHA revenues attributable to services provided to persons eligible for payments pursuant to Title 11 of Article 5 of the Social Services law divided by such revenues plus CHHA revenues attributable to services provided to beneficiaries of Title XVIII of the Federal Social Security Act (Medicare).

**TN**   #19-0042  

**Approval Date** \_\_\_\_\_

**Supersedes TN**   #17-0034  

**Effective Date** \_\_\_\_\_

**New York  
4(a)(iii)(A)**

Prior to February 1, 1997, for each regional group, 1996 Medicaid revenue percentage for the period commencing August 1, 1996, to the last date for which such data is available and reasonably accurate will be calculated. Prior to February 1, 1998, prior to February 1, 1999, prior to February 1, 2000, prior to February 1, 2001, prior to February 1, 2002, prior to February 1, 2003, prior to February 1, 2004, prior to February 1, 2005, prior to February 1, 2006, prior to February 1, 2007, prior to February 1, 2008, prior to February 1, 2009, prior to February 1, 2010, prior to February 1, 2011, prior to February 1, 2012, prior to February 1, 2013, prior to February 1, 2014, prior to February 1, 2015, prior to February 1, 2016, prior to February 1, 2017, prior to February 1, 2018, [and] prior to February 1, 2019, prior to February 1, 2020 and prior to February 1 of each year thereafter, for each regional group, the Commissioner of Health will calculate the prior years Medicaid revenue percentages for the period beginning January 1 through November 30 of such prior year. By September 15, 1996, for each regional group, the base period Medicaid revenue percentage will be calculated.

For each regional group, the 1996 target Medicaid revenue percentage will be calculated by subtracting the 1996 Medicaid revenue reduction percentages from the base period Medicaid revenue percentages. The 1996 Medicaid revenue reduction percentage, taking into account regional and program differences in utilization of Medicaid and Medicare services, for the following regional groups will be equal to:

- one and one-tenth percentage points for CHHAs located within the downstate region;
- and,
- six-tenths of one percentage point for CHHAs located within the upstate region.

**TN**     #19-0042    

**Approval Date** \_\_\_\_\_

**Supersedes TN**   #17-0034  

**Effective Date** \_\_\_\_\_

New York  
4(a)(iv)

For 1997, 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, and 2019, for each regional group, the target Medicaid revenue percentage for the respective year will be calculated by subtracting the respective year's Medicaid revenue reduction percentage from the base period Medicaid revenue percentage. The Medicaid revenue reduction percentages for 1997, 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, [and] 2019, 2020 and thereafter, taking into account regional and program differences in utilization of Medicaid and Medicare services, for the following regional groups will be equal to:

one and one-tenth percentage points for CHHAs located within the downstate region;  
and,

six-tenths of one percentage point for CHHAs located within the upstage region.

For each regional group, the 1999 target Medicaid revenue percentage will be calculated by subtracting the 1999 Medicaid revenue reduction percentage from the base period Medicaid revenue percentage. The 1999 Medicaid revenue reduction percentages, taking into account regional and program differences in utilization of Medicaid and Medicare services, for the following regional groups will be equal to:

eight hundred twenty-five thousandths (.825) of one percentage point for CHHAs located within the downstate region;

forty-five hundredths (.45) of one percentage point for CHHAs located within the upstate region;

For each regional group, if the 1996 Medicaid revenue percentage is not equal to or less than the 1996 target Medicaid revenue percentage, a 1996 reduction factor will be calculated by comparing the 1996 Medicaid revenue percentage to the 1996 target Medicaid revenue percentage to determine the amount of the shortfall and dividing such shortfall by the 1996 Medicaid revenue reduction percentage. These amounts, expressed as a percentage, will not exceed one hundred percent. If the 1996 Medicaid revenue percentage is equal to or less than 1996 target Medicaid revenue percentage, the 1996 reduction factor will be zero. For each regional group, the 1996 reduction factor will be multiplied by the following amounts to determine each regional group's applicable 1996 state share reduction amount.

two million three hundred ninety thousand dollars (\$2,390,000) for CHHAs located within the downstate region;

seven hundred fifty thousand dollars (\$750,000) for CHHAs located within the upstate region.

TN   #19-0042  

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Supersedes TN   #17-0034  

Effective Date \_\_\_\_\_

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

For each regional group reduction, if the 1996 reduction factor will be zero, there will be no 1996 state share reduction amount.

For 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, [and] 2019, 2020 and thereafter, for each regional group, if the Medicaid revenue percentage for the respective year is not equal to or less than the target Medicaid revenue percentage for such respective year, the Commissioner of Health will compare such respective year's Medicaid revenue percentage to such respective year's target Medicaid revenue percentage to determine the amount of the shortfall which, when divided by the respective year's Medicaid revenue reduction percentage, will be called the reduction factor for such respective year. These amounts, expressed as a percentage, will not exceed one hundred percent. If the Medicaid revenue percentage for a particular year is equal to or less than the target Medicaid revenue percentage for that year, the reduction factor for that year will be zero.

For 1997, 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, [and] 2019, 2020 and thereafter, for each regional group, the reduction factor for the respective year will be multiplied by the following amounts to determine each regional group's applicable state share reduction amount for such respective year.

**TN**     #19-0042    

**Supersedes TN**     #17-0034    

**Approval Date** \_\_\_\_\_

**Effective Date** \_\_\_\_\_

**New York  
4(a)(iv)(2)**

two million three hundred ninety thousand dollars (\$2,390,000) for CHHAs located within the downstate region;

seven hundred fifty thousand dollars (\$750,000) for CHHAs located within the upstate region;

For each regional group reduction, if the reduction factor for a particular year is zero, there will be no state share reduction amount for such year.

For each regional group, the 1999 reduction factor will be multiplied by the following amounts to determine each regional group's applicable 1999 state share reduction amount:

one million seven hundred ninety-two thousand five hundred dollars (\$1,792,500) for CHHAs located within the downstate region;

five hundred sixty-two thousand five hundred dollars (\$562,500) for CHHAs located within the upstate region;

For each regional group reduction, if the 1999 reduction factor is zero, there will be no 1999 state share reduction amount.

For each regional group, the 1996 state share reduction amount will be allocated among CHHAs on the basis of the extent of each CHHA's failure to achieve the 1996 target Medicaid revenue percentage, calculated on a provider specific basis utilizing revenues for this purpose, expressed as a proportion of the total of each CHHA's failure to achieve the 1996 target Medicaid revenue percentage within the applicable regional group. This proportion will be multiplied by the applicable 1996 state share reduction amount. This amount will be called the 1996 provider specific state share reduction amount.

The 1996 provider specific state share reduction amount will be due to the state from each CHHA and may be recouped by the State by March 31, 1997, in a lump sum amount or amounts from payments due to the CHHA pursuant to Title 11 of Article 5 of the Social Services Law.

For 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, [and] 2019, 2020 and thereafter, for each regional group, the state share reduction amount for the respective year will be allocated among CHHAs on the basis of the extent of each CHHA's failure to achieve the target Medicaid revenue percentage for the applicable year, calculated on a provider specific basis utilizing revenues for this purpose, expressed as a proportion of the total of each CHHA's failure to achieve the target Medicaid revenue percentage for the applicable year within the applicable regional group. This proportion will be multiplied by the applicable year's state share reduction amount for the applicable regional group. This amount will be called the provider specific state share reduction amount for the applicable year.

**TN #19-0042** \_\_\_\_\_

**Approval Date** \_\_\_\_\_

**Supersedes TN #17-0034** \_\_\_\_\_

**Effective Date** \_\_\_\_\_

**New York  
4(a)(v)**

The provider specific state share reduction amount for 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, [and] 2019, 2020 and thereafter, respectively, will be due to the state from each CHHA and the amount due for each respective year may be recouped by the state by March 31 of the following year in a lump sum amount or amounts from payments due to the CHHA pursuant to Title 11 of Article 5 of the Social Services Law.

CHHAs will submit such data and information at such times as the Commissioner of Health may require. The Commissioner of Health may use data available from third party payors.

On or about June 1, 1997, for each regional group, the Commissioner of Health will calculate for the period of August 1, 1996 through March 31, 1997, a Medicaid revenue percentage, a reduction factor, a state share reduction amount, and a provider specific state share reduction amount in accordance with the methodology provided herein for calculating such amounts for the 1996 target period. The provider specific state share reduction amount calculated will be compared to the 1996 provider specific state share reduction amount. Any amount in excess of the 1996 provider specific state share reduction amount will be due to the state from each CHHA and may be recouped. If the amount is less than the 1996 provider specific state share reduction amount, the difference will be refunded to the CHHA by the state no later than July 15, 1997. CHHAs will submit data for the period August 1, 1996 through March 31, 1997, to the Commissioner of Health by April 15, 1997.

If a CHHA fails to submit data and information as required, such CHHA will be presumed to have no decrease in Medicaid revenue percentage between the base period and the applicable target period for purposes of the calculations described herein and the Commissioner of Health will reduce the current rate paid to such CHHA by state governmental agencies pursuant to Article 36 of the Public Health Law by one percent for the period beginning on the first day of the calendar month following the applicable due date as established by the Commissioner of Health and continuing until the last day of the calendar month in which the required data and information are submitted.

Notwithstanding any inconsistent provision set forth herein, the annual percentage reductions as set forth above, will be prorated by the Commissioner of Health for the period April 1, 2007 through March 31, 2009.

**TN**   #19-0042  

**Approval Date** \_\_\_\_\_

**Supersedes TN**   #17-0034  

**Effective Date** \_\_\_\_\_

New York  
6(a)(1)

**Personal Care Services**

For personal care services provided pursuant to a contract between a social services district and a voluntary, proprietary or public personal care services provider, payment is made at the lower of the provider's charge to the general public for personal care services or a rate the Department establishes for the provider, subject to the approval of the Director of the Budget, in accordance with a cost-based methodology. Under the cost-based methodology, the Department determines a provider's rate based upon the provider's reported allowable costs, as adjusted by annual trend factors provided, however, for services on and after April 1, 2008, the Commissioner of Health [shall] will apply a trend factor projection equal to 65% of the otherwise applicable trend factor for calendar year 2008, as calculated in accordance with the general trend factor methodology contained on page 1(c)(i) in this Attachment.

For rates of payment effective for personal 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 [shall] will be adjusted such that any increase to the average trend factor for the period April 1, 2008 through December 31, 2008 [shall] 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 [shall] will be zero.

For rates of payment effective for personal 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% [shall] will be applied. Effective on and after April 1, 2009 the otherwise applicable trend factor attributable to the 2009 calendar year period [shall] 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 [shall] will be zero.

For rates of payment effective for personal care services provided on and after April 1, 2010, the otherwise applicable trend factor attributable to the 2010 calendar year period [shall] will be zero.

For rates of payment effective for personal care services provided on and after April 1, 2011, the otherwise applicable trend factors attributable to the 2011 through 2014 calendar year periods [shall] 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 [shall] will be no greater than zero. For rates of payment effective for 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 final trend factor attributable to the 2016 and 2017 calendar year periods [shall] will be zero. For rates of payment effective for 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 final trend factor attributable to the 2018 and 2019 calendar year periods [shall] will be zero. For rates of payment effective for services provided on and after January 1, 2020 through March 31, 2021, the otherwise applicable final trend factor attributable to the 2020 and 2021 calendar year periods will be zero.

**TN #19-0042** \_\_\_\_\_

**Approval Date** \_\_\_\_\_

**Supersedes TN #17-0034** \_\_\_\_\_

**Effective Date** \_\_\_\_\_

New York  
7(a)(ii)

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 [shall] will be adjusted such that any increase to the average trend factor for the period April 1, 2008 through December 31, 2008 [shall] 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 [shall] 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% [shall] will be applied. Effective on and after April 1, 2009 the otherwise applicable trend factor attributable to the 2009 calendar year period [shall] 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 [shall] 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 [shall] 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 [shall] 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 [shall] 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 [shall] 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 [shall] will be zero. For rates of payment effective for adult day health care services provided on and after January 1, 2020 through March 31, 2021, the otherwise applicable trend factor attributable to the 2020 and 2021 calendar year periods will be zero.

TN #19-0042 \_\_\_\_\_

Approval Date \_\_\_\_\_

Supersedes TN #17-0034 \_\_\_\_\_

Effective Date \_\_\_\_\_

**Appendix II**  
**2019 Title XIX State Plan**  
**Second Quarter Amendment**  
**Summary**

**SUMMARY**  
**SPA #19-0042**

This State Plan Amendment proposes to continue for services provided on and after April 1, 2019, the following previously enacted cost containment measures:

- limit the trend factor to an amount no greater than zero for outpatient services provided by general hospitals, home health services including services provided to home care patients diagnosed with AIDS, personal care services and adult day health care services provided;
- the cap on administrative and general component of rates for certified home health agencies;
- continues to appropriately allocate capital costs for outpatient and emergency department rates, and
- continues home health care maximization initiatives.

**Appendix III**  
**2019 Title XIX State Plan**  
**Second Quarter Amendment**  
**Authorizing Provisions**

SPA #19-0042

**Article VII Budget Bill for 2019, Part E, Chapter 57 of the Laws of 2019:**

**Trend elimination:**

32 § 14. Section 4-a of part A of chapter 56 of the laws of 2013, amend-  
33 ing chapter 59 of the laws of 2011 amending the public health law and  
34 other laws relating to general hospital reimbursement for annual rates,  
35 as amended by section 5 of part T of chapter 57 of the laws of 2018, is  
36 amended to read as follows:

37 § 4-a. Notwithstanding paragraph (c) of subdivision 10 of section  
38 2807-c of the public health law, section 21 of chapter 1 of the laws of  
39 1999, or any other contrary provision of law, in determining rates of  
40 payments by state governmental agencies effective for services provided  
41 on and after January 1, 2017 through March 31, [~~2019~~] 2021, for inpa-  
42 tient and outpatient services provided by general hospitals, for inpa-  
43 tient services and adult day health care outpatient services provided by  
44 residential health care facilities pursuant to article 28 of the public  
45 health law, except for residential health care facilities or units of  
46 such facilities providing services primarily to children under twenty-  
47 one years of age, for home health care services provided pursuant to  
48 article 36 of the public health law by certified home health agencies,  
49 long term home health care programs and AIDS home care programs, and for  
50 personal care services provided pursuant to section 365-a of the social  
51 services law, the commissioner of health shall apply no greater than  
52 zero trend factors attributable to the 2017, 2018, [~~and~~] 2019, 2020, and  
53 2021 calendar years in accordance with paragraph (c) of subdivision 10  
54 of section 2807-c of the public health law, provided, however, that such  
55 no greater than zero trend factors attributable to such 2017, 2018,  
56 [~~and~~] 2019, 2020, and 2021 calendar years shall also be applied to rates  
1 of payment provided on and after January 1, 2017 through March 31,  
2 [~~2019~~] 2021 for personal care services provided in those local social  
3 services districts, including New York city, whose rates of payment for  
4 such services are established by such local social services districts  
5 pursuant to a rate-setting exemption issued by the commissioner of  
6 health to such local social services districts in accordance with appli-  
7 cable regulations; and provided further, however, that for rates of  
8 payment for assisted living program services provided on and after Janu-  
9 ary 1, 2017 through March 31, [~~2019~~] 2021, such trend factors attribut-  
10 able to the 2017, 2018, [~~and~~] 2019, 2020, and 2021 calendar years shall  
11 be established at no greater than zero percent.

30 § 11. Subdivision 1 of section 89-a of part C of chapter 58 of the  
31 laws of 2007, amending the social services law and other laws relating  
32 to enacting the major components of legislation necessary to implement  
33 the health and mental hygiene budget for the 2007-2008 state fiscal  
34 year, as amended by section 5 of part I of chapter 57 of the laws of  
35 2017, is amended to read as follows:

36 1. Notwithstanding paragraph (c) of subdivision 10 of section 2807-c  
37 of the public health law and section 21 of chapter 1 of the laws of  
38 1999, as amended, and any other inconsistent provision of law or regu-  
39 lation to the contrary, in determining rates of payments by state  
40 governmental agencies effective for services provided beginning April 1,  
41 2006, through March 31, 2009, and on and after April 1, 2009 through  
42 March 31, 2011, and on and after April 1, 2011 through March 31, 2013,  
43 and on and after April 1, 2013 through March 31, 2015, and on and after  
44 April 1, 2015 through March 31, 2017, and on and after April 1, 2017  
45 through March 31, 2019, and on and after April 1, 2019 through March 31,  
46 2021 for inpatient and outpatient services provided by general hospitals

47 and for inpatient services and outpatient adult day health care services  
48 provided by residential health care facilities pursuant to article 28 of  
49 the public health law, the commissioner of health shall apply a trend  
50 factor projection of two and twenty-five hundredths percent attributable  
51 to the period January 1, 2006 through December 31, 2006, and on and  
52 after January 1, 2007, provided, however, that on reconciliation of such  
53 trend factor for the period January 1, 2006 through December 31, 2006  
54 pursuant to paragraph (c) of subdivision 10 of section 2807-c of the  
55 public health law, such trend factor shall be the final US Consumer  
56 Price Index (CPI) for all urban consumers, as published by the US  
1 Department of Labor, Bureau of Labor Statistics less twenty-five  
2 hundredths of a percentage point.

**Public Health Law §2807-c(8) (g)**

\* (g) Notwithstanding any inconsistent provision of this article, commencing April first, nineteen hundred ninety-five for rates of payment for patients eligible for payments made by state governmental agencies, the capital related inpatient expenses component determined in accordance with paragraph (a) of this subdivision and the capital cost per visit components determined in accordance with subparagraphs (i) and (ii) of paragraph (g) of subdivision two of section twenty-eight hundred seven of this article shall be adjusted by the commissioner to exclude such expenses related to:

- (i) forty-four percent of the costs of major movable equipment; and
- (ii) staff housing.

**Public Health Law §3614 (7) & Chapter 57 of the Laws of 2019:**

7. \* Notwithstanding any inconsistent provision of law or regulation, for purposes of establishing rates of payment by governmental agencies for certified home health agencies for the period April first, nineteen hundred ninety-five through December thirty-first, nineteen hundred ninety-five and for rate periods beginning on or after January first, nineteen hundred ninety-six, the reimbursable base year administrative and general costs of a provider of services shall not exceed the statewide average of total reimbursable base year administrative and general costs of such providers of services. The amount of such reduction in certified home health agency rates of payments made during the period April first, nineteen hundred ninety-five through March thirty-first, nineteen hundred ninety-six shall be adjusted in the nineteen hundred ninety-six rate period on a pro-rata basis, if it is determined upon post-audit review by June fifteenth, nineteen hundred ninety-six and reconciliation that the savings for the state share, excluding the federal and local government shares, of medical assistance payments pursuant to title eleven of article five of the social services law based on the limitation of such payment pursuant to this subdivision is in excess of one million five hundred thousand dollars or is less than one million five hundred thousand dollars for payments made on or before March thirty-first, nineteen hundred ninety-six to reflect the amount by which such savings are in excess of or lower than one million five hundred thousand dollars. For rate periods on and after January first, two thousand five through December thirty-first, two thousand six, there shall be no such reconciliation of the amount of savings in excess of or lower than one million five hundred thousand dollars.

\* NB Effective until March 31, 2021

17 § 13. Section 64-b of chapter 81 of the laws of 1995, amending the  
18 public health law and other laws relating to medical reimbursement and

19 welfare reform, as amended by section 7 of part I of chapter 57 of the  
20 laws of 2017, is amended to read as follows:

21 § 64-b. Notwithstanding any inconsistent provision of law, the  
22 provisions of subdivision 7 of section 3614 of the public health law, as  
23 amended, shall remain and be in full force and effect on April 1, 1995  
24 through March 31, 1999 and on July 1, 1999 through March 31, 2000 and on  
25 and after April 1, 2000 through March 31, 2003 and on and after April 1,  
26 2003 through March 31, 2007, and on and after April 1, 2007 through  
27 March 31, 2009, and on and after April 1, 2009 through March 31, 2011,  
28 and on and after April 1, 2011 through March 31, 2013, and on and after  
29 April 1, 2013 through March 31, 2015, and on and after April 1, 2015  
30 through March 31, 2017 and on and after April 1, 2017 through March 31,  
31 2019, and on and after April 1, 2019 through March 31, 2021.

**Appendix IV**  
**2019 Title XIX State Plan**  
**Second Quarter Amendment**  
**Public Notice**

Bernard Fineson DDRO  
PO Box 280507  
Queens Village, NY 11428-0507

Metro NY DDRO/Bronx  
2400 Halsey St.  
Bronx, NY 10461

Brooklyn DDRO  
888 Fountain Ave.  
Bldg. 1, 2nd Floor  
Brooklyn, NY 11239

Metro NY DDRO/Manhattan  
25 Beaver St., 4th Floor  
New York, NY 10004

Staten Island DDRO  
1150 Forest Hill Rd.  
Bldg. 12, Suite A  
Staten Island, NY 10314-6316

Long Island DDRO  
415-A Oser Ave.  
Hauppauge, NY 11788

*For further information and to review and comment, please contact:*  
Office for People With Developmental Disabilities, Division of  
Person-Centered Services, Waiver Unit, 44 Holland Ave., Albany, NY  
12229, Peoplefirstwaiver@opwdd.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 non-institutional, institutional and long-term care services to comply with proposed statutory provisions. The following changes are proposed:

#### All Services

Effective on or after April 1, 2019 through March 31, 2021 all non-exempt Medicaid payments, as referenced below, will be uniformly reduced. Such reductions will be applied only if an alternative method that achieves at least \$190.2 million in Medicaid state share savings annually is not implemented.

Exemptions from the uniform reduction are as follows:

- Any reductions that would violate federal law including, but not limited to, payments required pursuant to the federal Medicare program;
- Payments pursuant to the mental hygiene law;
- Payments the state is obligated to make pursuant to court orders or judgments;
- Payments for which the non-federal share does not reflect any state funding; and
- Payments where applying the reduction would result in a lower Federal Medical Assistance Percentage as determined by the Commissioner of Health and the Director of the Budget.

The estimated annual net aggregate decrease in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2019/2020 is (\$380.4 million).

Effective on and after April 1, 2019, no greater than zero trend factors attributable to services through March 31, 2024 pursuant to the provisions of Public Health Law § 2807-c(10)(c) to rates of payment for hospital inpatient and outpatient services, inpatient and adult day health care outpatient services provided by residential health care fa-

ilities pursuant to Article 28 of the Public Health Law, except for residential health care facilities or units of such facilities providing services primarily to children under 21 year of age, for certified home health agencies, long term home health care programs, AIDS home care programs, and for personal care services pursuant to section 365-a of the Social Services Law, including personal care services provided in those local social services districts, including New York City, whose rates of payment for services is established by such social services districts pursuant to a rate-setting exemption granted by the Department, and assisted living program services.

The estimated annual net aggregate decrease in gross Medicaid expenditures for state fiscal year 2019/2020 is (\$208.8 million).

#### Non-Institutional Services

Effective on or after April 1, 2019, the reimbursement rate for Early Intervention services furnished by licensed physical therapists (PTs), occupational therapists (OTs), and speech-language pathologists (SLPs) will increase by 5%. This increase would also apply to supplemental evaluations performed by licensed PTs, OTs and SLPs. These rates are being revised to address capacity issues that municipalities are facing statewide for these qualified professionals.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2019/20 is estimated to be \$7.2 million.

Effective on or after April 1, 2019, 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, 2019 through March 31, 2020, 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 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 may be added to rates of payment or made as aggregate payments.

For state fiscal year beginning April 1, 2019 through March 31, 2020, 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, 2019 through March 31, 2020, 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.

Capital related costs of a general hospital excluding 44% of the major movable costs and excluding staff housing costs will continue effective April 1, 2019 through March 31, 2024 and thereafter.

The estimated annual net aggregate decrease in gross Medicaid expenditures for state fiscal year 2019/2020 is (\$35.1 million).

Extends current provisions for services on April 1, 2019 through March 31, 2024 and thereafter, the reimbursable operating cost component for general hospital inpatient rates will be established with

# 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](http://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

Division of Criminal Justice Services  
Commission on Forensic Science

Pursuant to Public Officers Law section 104, the Division of Criminal Justice Services gives notice of a meeting of the New York State Commission on Forensic Science to be held on:

Date: June 7, 2019  
Time: 9:00 a.m.-1:00 p.m.  
Place: Empire State Development Corporation  
(ESDC)  
633 3rd Ave.  
37th Fl./Conference Rm.  
New York, NY  
\* Identification and sign-in required

Video Conference Site:  
Division of Criminal Justice Services  
Alfred E. Smith Office Bldg.  
CrimeStat Rm. 118  
80 S. Swan St.  
Albany, NY

\* Identification and sign-in is required at this location. For further information, or if you need a reasonable accommodation to attend this meeting, contact: Catherine White, Division of Criminal Justice Services, Office of Forensic Services, 80 Swan St., Albany, NY 12210, (518) 485-5052

## PUBLIC NOTICE Deferred Compensation Plan for Employees of Cortland County

The Deferred Compensation Plan for Employees of Cortland County is soliciting proposals from administrative service agencies relating to trust service, and administration and/or funding of a Deferred Compensation Plan for the employees of Cortland County. They must meet the requirements of section 457 of the Internal Revenue Code and Section 5 of the State Finance Law, including all rules and regulations issued pursuant thereto.

A copy of the proposal questionnaire may be obtained from: Cortland County Personnel/Civil Service, Pamela Abbott, Personnel Technician, 60 Central Ave., Cortland, NY 13045, (607) 753-5207, e-mail: [pabbott@cortland-co.org](mailto:pabbott@cortland-co.org)

All proposals must be received no later than 30 days from the date of publication in the *New York State Register*.

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

### All Services

The following is a clarification to the March 27, 2019 noticed provision which extended the zero trend factors attributable to services on or after April 1, 2019 to March 31, 2024. This notice clarifies that the provision was extended through March 31, 2021.

The estimated annual net aggregate decrease in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2019/2020 is (\$208.8 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](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 State  
F-2019-0116

Date of Issuance – May 29, 2019

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-2019-0116 or the “Palagonia Dock”, the applicant Tiffany Palagonia, is proposing the construction of a new 4' x 15' open grate catwalk, a 3' x 12' ramp, and a 6' x 20' float-with two 8" piles, and two 8" mooring piles. This project is located at 182 Dune Road, Westhampton Beach on Moneybog Bay.

The applicant's consistency certification and supporting information are available for review at: [http://www.dos.ny.gov/opd/programs/pdfs/Consistency/F-2019-0116\\_Palagonia\\_App.pdf](http://www.dos.ny.gov/opd/programs/pdfs/Consistency/F-2019-0116_Palagonia_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, June 28, 2019.

*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 e-mail at: CR@dos.ny.gov

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

## PUBLIC NOTICE

Department of State  
F-2019-0175

Date of Issuance – May 29, 2019

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

The applicant has certified that the proposed activity complies with and will be conducted in a manner consistent with the approved New York State Coastal Management Program. The applicant's consistency certification and accompanying public information and data are available for inspection at the New York State Department of State offices located at One Commerce Plaza, 99 Washington Avenue, in Albany, New York and are available for review at: [http://www.dos.ny.gov/opd/programs/pdfs/Consistency/F-2019-0175\\_Application.pdf](http://www.dos.ny.gov/opd/programs/pdfs/Consistency/F-2019-0175_Application.pdf)

In F 2019 0175, PSEG Long Island is proposing the Circuit 9Z-807 Utility Pole Replacement Project. The proposed activity would replace

27 timber utility poles in tidal wetlands along the existing utility corridor on the eastern side of Napeague Meadow Road between Cranberry Hole Road and Montauk Highway, Town of East Hampton, Suffolk County. Total disturbance to tidal wetlands is estimated to be 675 square feet. All disturbed areas shall be backfilled with native soils and planted with native vegetation. The stated purpose of the activity is to upgrade the existing utility poles for increased protection of the electric distribution grid from high winds and storm events.

The proposed activity would be located within or has the potential to affect the following Special Management or Regulated Area(s):

- Town of East Hampton Local Waterfront Revitalization Program: [https://www.dos.ny.gov/opd/programs/WFRevitalization/LWRP\\_status.html](https://www.dos.ny.gov/opd/programs/WFRevitalization/LWRP_status.html)

- Napeague Harbor Significant Coastal Fish and Wildlife Habitat: <https://www.dos.ny.gov/opd/programs/consistency/scfwhabitats.html>

- Napeague Meadows Scenic Area of Statewide Significance: <https://www.dos.ny.gov/opd/programs/consistency/scenicass.html>

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., 15 days from the date of publication of this notice, or, June 13, 2019.

*Comments should be addressed to:* Department of State, Office of Coastal, Local Government and Community Sustainability, One Commerce Plaza, 99 Washington Ave., Albany, NY 12231, (518) 474 6000, Fax (518) 473 2464

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

## PUBLIC NOTICE

Department of State

The New York State Real Estate Board will hold an open board meeting on May 31, 2019, 10:30 a.m. at Department of State, 99 Washington Ave., Rm. 505, Albany; 123 William St., Rm. 231, New York City; and 276 Waring Rd., Rochester. The Board will hold a public hearing on general real estate issues immediately following the board meeting at the same locations.

*Should you require further information, please contact:* Adaiha Murdock at Adaiha Murdock@dos.ny.gov or (518) 408-4750

## 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.

2019-0262 Matter of Brookhaven Expeditors, Andrew Malguarnera, 713 Main Street, Port Jefferson, NY 11777, for a variance concerning safety requirements, including the required ceiling height and height under a girder/soffit. Involved is an existing one family dwelling located at 22 Howell Street; Town of Brookhaven, NY 11772 County of Suffolk, State of New York.

2019-0267 Matter of Building Permits Plus, Jason Allen, 19 Stillwood Road, Brookhaven, NY 11719, for a variance concerning safety requirements, including the required height under a girder/soffit. Involved is an existing one family dwelling located at 98 Granny Road; Town of Brookhaven, NY 11738 County of Suffolk, State of New York.

2019-0268 Matter of Nassau Expeditors Inc., Scott Tirone, 75 Albertson Avenue, Albertson, NY 11507, for a variance concerning safety requirements, including the required height under a girder/soffit. Involved is an existing one family dwelling located at 13 North Drive;

**Appendix V**  
**2019 Title XIX State Plan**  
**Second Quarter Amendment**  
**Responses to Standard Funding Questions**

**NON-INSTITUTIONAL SERVICES  
State Plan Amendment #19-0042**

**CMS Standard Funding Questions**

The following questions are being asked and should be answered in relation to all payments made to all providers reimbursed pursuant to a methodology described in Attachment 4.19-B of the state plan. For SPAs that provide for changes to payments for clinic or outpatient hospital services or for enhanced or supplemental payments to physician or other practitioners, the questions must be answered for all payments made under the state plan for such service.

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

**Response:** Providers do retain the payments made pursuant to this amendment. However, this requirement in no way prohibits the public provider, including county providers, from reimbursing the sponsoring local government for appropriate expenses incurred by the local government on behalf of the public provider. The State does not regulate the financial relationships that exist between public health care providers and their sponsoring governments, which are extremely varied and complex. Local governments may provide direct and/or indirect monetary subsidies to their public providers to cover on-going unreimbursed operational expenses and assure achievement of their mission as primary safety net providers. Examples of appropriate expenses may include payments to the local government which include reimbursement for debt service paid on a provider's behalf, reimbursement for Medicare Part B premiums paid for a provider's retirees, reimbursement for contractually required health benefit fund payments made on a provider's behalf, and payment for overhead expenses as allocated per federal Office of Management and Budget Circular 2 CFR 200 regarding Cost Principles for State, Local, and Indian Tribal Governments. The existence of such transfers should in no way negate the legitimacy of these facilities' Medicaid payments or result in reduced Medicaid federal financial participation for the State. This position was further supported by CMS in review and approval of SPA 07-07C when an on-site audit of these transactions for New York City's Health and Hospitals Corporation was completed with satisfactory results.

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

- (i) a complete list of the names of entities transferring or certifying funds;**
- (ii) the operational nature of the entity (state, county, city, other);**
- (iii) the total amounts transferred or certified by each entity;**
- (iv) clarify whether the certifying or transferring entity has general taxing authority: and,**
- (v) whether the certifying or transferring entity received appropriations (identify level of appropriations).**

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

The source of the appropriation is the Medicaid General Fund Local Assistance Account, which is part of the Global Cap. The Global Cap is funded by General Fund and HCRA resources. The saving from these initiatives help to fund the Global Cap.

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

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

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

- 4. For clinic or outpatient hospital services please provide a detailed description of the methodology used by the state to estimate the upper payment limit (UPL) for each class of providers (State owned or operated, non-state government owned or operated, and privately owned or operated). Please provide a current (i.e., applicable to the current rate year) UPL demonstration.**

**Response:** The State submitted the 2012 and 2013 Clinic UPL demonstration on March 21, 2014 and will await feedback based on CMS review.

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

**Response:** The rate methodologies included in the State Plan for outpatient hospital, home health services including services provided to home care patients diagnosed with AIDS, personal care services, and adult day health care services are either cost-based subject to ceilings or based upon the Ambulatory Patient Group (APG) system. We are unaware of any requirement under current federal law or regulation that limits individual providers' payments to their actual costs.

#### **ACA Assurances:**

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

#### **MOE Period.**

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

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

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

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

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

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

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

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

**Tribal Assurance:**

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

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

- a) Please describe the process the State uses to seek advice on a regular ongoing basis from federally recognized tribes Indian Health Programs and Urban Indian Organizations on matters related to Medicaid and CHIP programs and for consultation on State Plan Amendments waiver proposals waiver extensions waiver amendments waiver renewals and proposals for demonstration projects prior to submission to CMS.**
- b) Please include information about the frequency inclusiveness and process for seeking such advice.**

**c) Please describe the consultation process that occurred specifically for the development and submission of this State Plan Amendment when it occurred and who was involved.**

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

**Appendix VI**  
**2019 Title XIX State Plan**  
**Second Quarter Amendment**  
**Responses to Standard Access Questions**

**APPENDIX VI  
NON-INSTITUTIONAL SERVICES  
State Plan Amendment #19-0042**

**CMS Standard Access Questions**

The following questions have been asked by CMS and are answered by the State in relation to all payments made to all providers under Attachment 4.19-B of the state plan.

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

**Response:** This amendment seeks to continue cost saving measures previously enacted. This is an overall effort to control Medicaid spending resulting from the 2019-20 New York State Budget. The change should not significantly impact providers since overall reimbursement rates are being held constant, not being reduced.

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

**Response:** The State has various ways to ensure that access levels in the Medicaid program are retained and is currently not aware of any access issues, particularly since there is excess bed capacity for both hospitals and nursing homes. Additionally, hospital and nursing home providers must notify and receive approval from the Department's Office of Health Systems Management (OHSM) in order to discontinue services. This Office monitors and considers such requests in the context of access as they approve/deny changes in services. Finally, providers cannot discriminate based on source of payment.

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

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

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

**Response:** This change was enacted by the State Legislature as part of the negotiation of the 2019-20 Budget. The impact of this change was weighed in the context of the overall Budget in the State. The legislative process provides opportunities for all stakeholders to lobby their concerns, objections, or support for various legislative initiatives. In addition, NY published notice in the state register of the proposed policy and did not receive any comment.

- 4. What action(s) does the State plan to implement after the rate change takes place to counter any decrease to access if the rate decrease is found to prevent sufficient access to care?**

**Response:** Should any essential community provider experience Medicaid or other revenue issues that would prevent access to needed community services, per usual practice, the State would meet with them to explore the situation and discuss possible solutions, if necessary.

- 5. Is the State modifying anything else in the State Plan which will counterbalance any impact on access that may be caused by the decrease in rates (e.g. increasing scope of services that other provider types may provide or providing care in other settings)?**

**Response:** The State continues to implement Medicaid reform initiatives to better align reimbursement and to ensure access to quality of care in the appropriate setting. The Delivery System Reform Incentive Payment (DSRIP) program, whereby up to \$6.42 billion is reinvested in the Medicaid program over a five-year period, is still under implementation. Further, the New York State Budget continues to provide a Quality Pool for hospital inpatient services up to \$57.8M for SFY 2019/2020 which will be paid through the Medicaid Managed Care Health Plan rates. The Budget also provides for a \$132M investment in Enhanced Safety Net hospitals which will also be paid through the Medicaid Managed Care Health Plans. The State offers other programs to hospitals, such as the Vital Access Provider (VAP) program, to help sustain key health care services. While some of these initiatives are outside the scope of the State Plan, they represent some of the measures the State is taking to ensure quality care for the State's most vulnerable population.