NEW YORK STATE OF OPPORTUNITY | Department of Health

ANDREW M. CUOMO HOWARD A. ZUCKER, M.D., J.D. LISA J. PINO, M.A., J.D.

August 25, 2020

Mr. Frank Walsh
Chief Budget Examiner
Division of the Budget
Health Unit
State Capitol
Albany, NY 12224

Dear Mr. Walsh:

Enclosed for your review and assistance in obtaining the Governor's approval is submittal #20-0048, which is an amendment to this Department's State Plan under Title XIX (Medicaid).

This amendment proposes to revise the State Plan based on the global pandemic, COVID-19.

To assist in your review of this proposal, enclosed are copies of amendment #20-0048 and the fiscal analysis. We are requesting a March 1, 2020 effective date.

If you or your staff have any questions or need further assistance, please do not hesitate to contact Regina Deyette of my staff at (518) 473-3658.

Sincerely,

[redacted]

Donna Frescatore
Medicaid Director
Office of Health Insurance Programs

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER	2. STATE
2 0 – 0 0 4 8	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
March 1, 2020

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
Section 1135 of SSA and Title XIX of SSA

7. FEDERAL BUDGET IMPACT
a. FFY 03/01/20-09/30/20 $ (11,429.82)
b. FFY 10/01/20-09/30/21 $ (32,063.74)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT

Attachment: 7.4 Page: 1,2,3,4,5,6,7,8,9 10,11 12,13,14,15,16

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*

Attachment: NEW

10. SUBJECT OF AMENDMENT
COVID 19 Emergency Relief
(FMAP=50%)

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

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

12. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

13. TYPED NAME
Donna Frescatore

14. TITLE
Medicaid Director, Department of Health

15. DATE SUBMITTED August 25, 2020

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

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED

18. DATE APPROVED

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL

20. SIGNATURE OF REGIONAL OFFICIAL

21. TYPED NAME

22. TITLE

23. REMARKS

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).

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. _____ The agency applies less restrictive financial methodologies to individuals excepted from financial methodologies based on modified adjusted gross income (MAGI) as follows.

Less restrictive resource methodologies:

4. __X___ 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 inconsistences 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.

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. _X__ The agency makes the following adjustments to benefits currently covered in the state plan:

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.

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"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."

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 clinical assessment process may be modified as needed.

"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."

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."

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:

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"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."

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."

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:

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"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. In addition, services may be provided to residents and eligible for reimbursement during a period of non-residence, if the resident's absence from the residence is due to COVID-19."

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.

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."

10. During the Public Health Emergency, New York State seeks permission to expand medical sites to include locations that would not otherwise serve as places to receive health care. This request includes alternate locations for specimen collection and laboratory testing, an exemption to 42 CFR 440.30(b). These temporary locations include but are not limited to the following: non-hospital buildings, parking lots, vehicles, community sites and patient homes. Providing specimen collection and laboratory testing at these additional temporary locations will prevent the potential spread of the virus.

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11. During the Public Health Emergency, New York State also seeks permission to expand medical sites for patient evaluation and management 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. The CPT codes for evaluation and management (E&M) are 99201-99205 and 99211-99215. This exemption will allow clinic/outpatient E&Ms to occur outside of the facilities four walls to prevent potential exposure to the virus.

3. __X__ 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. __X___ 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. __X__ 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. __X___ The agency utilizes telehealth in the following manner, which may be different than outlined in the state's approved state plan:

During the emergency **all** Medicaid providers in **all** situations may 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. Varying levels of reimbursement for telephonic assessment, monitoring, and evaluation and management services provided to members are available 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. 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 applies to all Medicaid providers and providers contracted to serve Medicaid members under Medicaid managed care plans.
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.

Additional telehealth reimbursement information during the emergency can be found in the Telehealth Payment section of this document.

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. __X__ 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.

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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. _X_ A supplemental payment or add-on within applicable upper payment limits:

Effective March 17, 2020, for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID) a supplemental payment will be made available to reimburse ICF/IID providers for day-time weekday service hours when the provision of active treatment outside the residence is not possible because the external treatment facility is closed or not accepting patients due to the COVID-19 public health emergency. The additional funding will be provided as a supplemental payment to ICF/IID providers. The supplemental payment will be available to ICF/IID providers until the end of the public health emergency or at such a time when outside treatment facilities are permitted to safely resume operations. Government-operated ICFs/IID are not eligible for the supplemental payments described in this section. The supplemental payment will be a regional fee as follows:

Rate Setting Region	Week-Day Daily Fee
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. __X___ For the duration of the emergency, the state authorizes payments for telehealth services that:

   a. __X__ 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.
Telephonic Reimbursement: Reimbursement for telephonic services provided during the emergency is available as follows: 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. Clinic Rate Chart:

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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	

Store and Forward:
Reimbursement for store and forward services during the emergency period is increased from 75% to 100% of a face-to-face visit.

Remote Patient Monitoring:
Remote Patient Monitoring requires a minimum of 30 minutes of time per month. During the Public Health
Emergency, the time requirement for monitoring COVID-19 positive patients has been lowered from a minimum of 30 minutes to 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.

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. __X___ 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:

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.

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

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.

Adjustments to Outpatient Addiction Rehabilitative Services certified or designated by the New York State Office of Addiction Services and Supports, as follows:

1. Adjustments to Outpatient Addiction Rehabilitative Services - adjust the methodology specified on pages 10(a.2)-10 (a.3) of Attachment 4.19-B of the Plan to permit providers to bill identified base rates and associated procedure codes, 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.

2. Adjustments to Opioid Treatment Services – adjust the methodology specified on pages 10(a.2)-10 (a.3) of Attachment 4.19-B of the Plan to permit services delivered by Opioid Treatment Agencies to be billed in weekly intervals when patients receive at least 7 days of take home medication, consistent with state-issued guidance and utilizing the following rate codes:

Rate Codes 7969 (COS 0160) and 7973 (COS 0287) - Methadone Dispensing or Counseling

Rate Codes 7970 (COS 0160) and 7974 (COS 0287) – Methadone Administration

Rate Codes 7971 (COS 0160) and 7975 (COS 0287) – Buprenorphine Dispensing or Counseling

Rate Codes 7972 (COS 0160) and 7976 (COS 0287) – Buprenorphine Administration

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

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.

CMS Standard Funding Questions

The following questions should be answered in relation to all payments made to all providers reimbursed pursuant to a methodology for each of the applicable services that are submitted pursuant to SMDL #13-003.

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 nonfederal 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. For services delivered by non-State operated mental hygiene service providers,

the source of funds for the State share are appropriations made to the mental hygiene agencies as part of the State's Budget development process.

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

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

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

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

   Response: The state and CMS are working toward completing and approval of current year clinic and outpatient hospital UPLs.

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 current rate methodologies approved in the State Plan are based on the prospective payment system or fee schedules. We are unaware of any requirement under current federal law or regulation that limits individual provider payments to their actual costs.