NEW YORK STATE OF OPPORTUNITY. Department of Health

KATHY HOCHUL
Governor

JAMES V. McDONALD, M.D., M.P.H.
Acting Commissioner

MEGAN E. BALDWIN
Acting Executive Deputy Commissioner

March 30, 2023

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

RE: SPA #21-0073

Dear Mr. Scott:

The State requests approval of the enclosed amendment #21-0073 to the Title XIX (Medicaid) State Plan effective October 1, 2021.

This amendment is being sent to you for your review and approval based on the current global pandemic, COVID-19.

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]

Amir Bassiri
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: 21 — 0073

2. STATE: NY

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

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

4. PROPOSED EFFECTIVE DATE
October 1, 2021

5. FEDERAL STATUTE/REGULATION CITATION
§ 1905(a)(13),1905(a)(8)

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 10/01/21-09/30/22 $ 64,181,274
b. FFY 10/01/22-09/30/23 $ 10,000,000

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment: TBD

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment: NEW

9. SUBJECT OF AMENDMENT
Private Duty Nursing, OASAS HCBS and Rehab, OMH ACT, PROs and Rehab

10. GOVERNOR'S REVIEW *(Check One)*
(●) GOVERNOR'S OFFICE REPORTED NO COMMENT
( ) COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
( ) NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
( ) OTHER, AS SPECIFIED:

11. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

12. TYPED NAME
Amir Bassiri

13. TITLE
Medicaid Director

14. DATE SUBMITTED
March 30, 2023

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

FOR CMS USE ONLY

16. DATE RECEIVED

17. DATE APPROVED

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL

19. SIGNATURE OF APPROVING OFFICIAL

20. TYPED NAME OF APPROVING OFFICIAL

21. TITLE OF APPROVING OFFICIAL

22. REMARKS

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:

SPA effective date is October 1, 2021

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. _____ 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 [insert name of 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 income methodologies:

Less restrictive resource methodologies:

4. _____ The agency considers individuals who are evacuated from the state, who leave the state for medical reasons related to the disaster or public health emergency, or who are otherwise absent from the state due to the disaster or public health emergency and who intend to return to the state, to continue to be residents of the state under 42 CFR 435.403(j)(3).

5. _____ The agency provides Medicaid coverage to the following individuals living in the state, who are non-residents:

6. _____ The agency provides for an extension of the reasonable opportunity period for non-citizens declaring to be in a satisfactory immigration status, if the non-citizen is making a good faith effort to resolve any 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 underage 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:

Home and Community-Based Services Eligible (Rehab Services - Addiction) for the ARP Section 9817 Temporary Increased FMAP Effective November 1, 2021, the Office of Addiction Services and Supports (OASAS) is adding the third element of OASAS Residential Reintegration to its FFS Medicaid benefit. The other two elements of the service, Residential Stabilization and Residential Rehabilitation, are already approved in FFS by CMS (SPA 16-0004). All three residential service elements must be recommended by a physician or other licensed practitioner of the healing arts. The Medicaid coverable services in Residential Reintegration (with the allowable practitioner types in parentheses) includes the following:
• individual or group counseling (Qualified Health Professional, CASAC, LCSW, LMHC etc.) • adult life/living development (CASAC and certified peer, counseling staff) • employment support (Certified Rehabilitation Counselor, certified peer, counselors) • management of urges, cravings or lapses (CASAC, Licensed staff, counselors) • emotional regulation as individuals experience more community stressors (CASAC, Licensed staff, counselors)

- skills in accessing services to support social needs that may include support to transition to long term housing, employment and education readiness (case manager, certified rehab counselor, CASAC, counselors)
- therapeutic recreation (recreation therapist, CASAC, Licensed staff, counselors)
- peer supports (certified peers)
- medication management support (Registered nurse to train certified counseling staff to observe self – medication, RN, LPN)
- care coordination (case manager, licensed staff, CASAC, counselors)
- discharge planning (case manager, licensed staff, CASAC, counselors)

Therapeutic recreation must be provided by a therapeutic recreation therapist certified by the National Council on Therapeutic Recreation or the American Therapeutic Recreation Association; or a person who holds a baccalaureate degree in a field allied to therapeutic recreation and, either before or after receiving such degree, has five years of full-time, paid work experience in an activities program in a health care setting. Recreational therapy is used to help individuals regain their psychological and physical health.

3. _____ The agency assures that newly added benefits or adjustments to benefits comply with all applicable statutory requirements, including the statewideness requirements found at 1902(a)(1), comparability requirements found at 1902(a)(10)(B), and free choice of provider requirements found at 1902(a)(23).

4. _____ Application to Alternative Benefit Plans (ABP). The state adheres to all ABP provisions in 42 CFR Part 440, Subpart C. This section only applies to states that have an approved ABP(s).

    a. ____ The agency assures that these newly added and/or adjusted benefits will be made available to individuals receiving services under ABPs.

    b. ____ Individuals receiving services under ABPs will not receive these newly added and/or adjusted benefits, or will only receive the following subset:

Please describe.

Telehealth:

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

Please describe.

State/Territory: ____New York_____

Drug Benefit:

6. _____ The agency makes the following adjustments to the day supply or quantity limit for covered outpatient drugs. The agency should only make this modification if its current state plan pages have limits on the amount of medication dispensed.

Please describe the change in days or quantities that are allowed for the emergency period and for which drugs.

7. _____ Prior authorization for medications is expanded by automatic renewal without clinical review, or time/quantity extensions.

8. _____ The agency makes the following payment adjustment to the professional dispensing fee when additional costs are incurred by the providers for delivery. States will need to supply documentation to justify the additional fees.

Please describe the manner in which professional dispensing fees are adjusted.

9. _____ The agency makes exceptions to their published Preferred Drug List if drug shortages occur. This would include options for covering a brand name drug product that is a multi-source drug if a generic drug option is not available.

Section E – Payments

Optional benefits described in Section D:

1. _____ Newly added benefits described in Section D are paid using the following methodology:

   a. __X__ Published fee schedules – ***Home and Community-Based Services Eligible (Rehab Services - Addiction) for the ARP Section 9817 Temporary Increased FMAP***

   Effective, November 1, 2021, the OASAS residential reintegration service is added to the already approved elements of the service, stabilization and reintegration, including temporary rate enhancements ending on June 30, 2022 for all three elements (see Section E for stabilization and rehabilitation fee changes), with proposed fees for reintegration as follows:

Service Type	Pre 11-1-21 CMS Approved Fee		Proposed 11-1-21 Fee		Proposed 7-1-22 Fee	
	Upstate	Downstate	Upstate	Downstate	Upstate	Downstate

Residential Reintegration	NA - New to Medicaid 11/1/21	NA - New to Medicaid 11/1/21	$173.13	$202.55	$115.42	$135.03

Effective date (enter date of change): _____11/1/2021_____

Location (list published location): Table above and on OASAS website (upon approval)

b. __X__ Other:

Home and Community-Based Services Eligible (Rehab Services - Addiction) for the ARP Section 9817 Temporary Increased FMAP

The third element of the residential program, reintegration, had not previously been reimbursed under the FFS NYS Medicaid program. OASAS has calculated fees, in conjunction with the NYS Department of Health and an their actuary, for the reintegration element of the service. The calculated fees are based on a hypothetical model program; utilizing reasonable and appropriate Medicaid-eligibility assumptions for staffing, administration, fringe, and non-personal service, and excluding room and board as non-allowable under Medicaid reimbursement for residential programs. This is the same methodology used for the stabilization and rehabilitation fees that were previously approved by CMS in SPA 16-0004. The calculated fees for reintegration have been verified as efficient and economical by OASAS using actual cost data for the service element (excluding room and board), which has been operated since 2016 as an OASAS-certified, non-Medicaid program.

Reintegration programs will receive 150% of the calculated fees for the period November 1, 2021 through June 30, 2022. The initial reintegration fees are to be set 50% higher than the level of the ongoing fees (beginning July 1, 2022), on a time-limited basis, in order to cover the cost of programs gearing up to meet Medicaid billing and record keeping requirements, as well as to encourage lower intensity residential programs to recruit and train staff and make other investments necessary to meet the regulatory requirements associated with a Medicaid-eligible level of care. On July 1, 2022, the reintegration service will move down to 100% of the calculated fees.

Increases to state plan payment methodologies:

2. ___X__ The agency increases payment rates for the following services:

NYS Department of Health (DOH) Private Duty Nursing: Effective November 1, 2021, Private duty nursing provided to fee-for-service individuals who have aged out of the medically fragile children's reimbursement program. Fees will be increased as described in a., b.i., and b.ii. below.

NYS Office of Mental Health (OMH) Assertive Community Treatment (ACT) – as described in b.ii. below.

OMH Rehabilitation Services in Community Residences – as described in b.ii. below.

OMH Personalized Recovery Oriented Services (PROS) – as described in b.ii. below.

OASAS Residential Rehabilitation Services and Off-site Addiction Rehab Services – as described in b.ii. below.

a. __X___ Payment increases are targeted based on the following criteria:

DOH Private Duty Nursing - Individuals are 23 and older, receiving private duty nursing services.

OMH ACT, PROS, and Rehab Services in Community Residences – All services under these headings, with increases as described in b.ii. below.

OASAS HCBS and Rehab programs – The Stabilization and Rehabilitation elements of the OASAS Residential Rehabilitation service, as well as (in-community) off-site outpatient addiction rehab services.

b. Payments are increased through:

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

Private Duty Nursing: This is an add-on payment for providers who are enrolled in the program, are willing to be listed in a web-based database available to the public, and who provide services to medically fragile adults.

ii. __X___ An increase to rates as described below.

Rates are increased:

__X___ Uniformly by the following percentage: ____75_____
Private Duty Nursing

_____ Through a modification to published fee schedules –

Effective date (enter date of change): _____

Location (list published location): _____X_____

Private Duty Nursing: Additional information (for providers) can be found here: https://health.ny.gov/health_care/medicaid/redesign/pdn_children/providers/regional_fees.htm and https://health.ny.gov/health_care/medicaid/redesign/pdn_children/providers/directory_benefits.htm (Note: this page has been updated for 2022 while this SPA is applicable to 2021-2023)

ACT, PROs, and Rehab Services in Community Residences – proposed fees are described below and can be found at:

https://omh.ny.gov/omhweb/medicaid_reimbursement/

_____ Up to the Medicare payments for equivalent services.

__X___ By the following factors:

American Rescue Plan Act Section 9817 temporary increased FMAP for Home and Community-Based Services:

OMH increases payment for providers of services referenced in New York's American Rescue Plan Act Home and Community Based Services Enhanced Funding Spending Plan. Providers are Social Security Act Section 1905(a) Rehabilitative Services providers listed in Appendix B of the American Rescue Plan Act, State Medicaid Director Letter, SMD# 21-003 Implementation of American Rescue Plan Act of 2021 Section 9817.

The time-limited rate increases described in this section will be used to expand, enhance or strengthen mental health rehabilitative services programs through workforce recruitment and retention strategies and other implementation or expansion activities, consistent with New York's American Rescue Plan Act Home and Community Based Services Enhanced Funding Spending Plan. Rate increases will not extend beyond March 31, 2024, except where approved by CMS.

1. For all Assertive Community Treatment services, effective for dates of service from October 7, 2021, through March 31, 2022, rates are increased 18.9%.

2. For Assertive Community Treatment services for children/youth, effective for dates of service from October 7, 2021, through June 30, 2022, rates are increased an additional 50%.

3. For Personalized Recovery Oriented Services, effective for dates of service from October 14, 2021, through March 31, 2022, rates are increased 35.4%.

4. For Rehabilitation Services in Community Residences, effective for dates of service from October 1, 2021, through March 31, 2022, rates are increased 29.7%.

Please describe. **OASAS Residential Rehabilitation Services and Off-site (In-Community) Outpatient Addiction Rehab -** ***(Rehab Services - Addiction) for the ARP Section 9817 Temporary Increased FMAP***

Freestanding outpatient addiction services will receive a time-limited ten percent increase to existing CMS-approved fees, in SPA 16-0004, for the period November 1, 2021, through June 30, 2022. On July 1, 2022, these fees will return to levels previously approved by CMS. All fees, both existing and proposed, are shown in the tables below and will be posted on the OASAS website upon approval by CMS.

Outpatient addiction services, when provided in the community (outside of a brick-and-mortar setting), will receive an additional in-community increase for the same period (November 1, 2021, through June 30, 2022). The in-community fee enhancement will apply only to Ambulatory Patient Group (APG) fees and will not apply to the Opioid Treatment Program weekly bundle fees. As part of an effort towards fee rationalization, all freestanding outpatient addiction services will share the same in-community APG fees based on an additional ten percent for in-community outpatient addiction day rehabilitation, as shown in the applicable fee table below. All three services will revert to identical rationalized (i.e., using the same Ambulatory Patient Group conversion factors) in-community APG fees on July 1, 2022.

Residential addiction services will receive a time-limited ten percent fee enhancement for the period November 1, 2021, through June 30, 2022 for the stabilization and rehabilitation elements of the service. On July 1, 2022, the stabilization and rehabilitation fees will return to the levels previously approved by CMS in SPA 16-0004.

The fee regions for both outpatient addiction services and residential addiction services are as follows:
Downstate – The counties of Bronx, Kings, New York, Queens, Richmond, Nassau, Suffolk, Westchester, Rockland, Orange, Putnam, and Dutchess.
Upstate – All other counties in the State.

Freestanding outpatient addiction services fees

	Pre 11-1-21 CMS Approved Fee		Proposed 11-1-21 Fee		Proposed 7-1-22 Fee	
Service Type	**Upstate**	**Downstate**	**Upstate**	**Downstate**	**Upstate**	**Downstate**
Outpatient Addiction Rehab (reimbursed using APGs)	$150.11	$175.64	$165.12	$193.20	$150.11	$175.64
Outpatient Addiction Day Rehab (APGs)	$150.52	$176.12	$165.57	$193.73	$150.52	$176.12
Opioid Treatment Program (APGs)	$138.31	$161.82	$152.14	$178.00	$138.31	$161.82
OTP Weekly Bundle (Methadone Full Bundle)	$178.80	$209.19	$196.68	$230.11	$178.80	$209.19
OTP Weekly Bundle (Methadone Take-Home Only)	$35.28	$35.28	$38.81	$38.81	$35.28	$35.28

OTP Weekly Bundle (Buprenorphine Full Bundle)	$222.73	$260.59	$245.00	$286.65	$222.73	$260.59
OTP Weekly Bundle (Buprenorphine Take-Home Only)	$86.26	$86.26	$94.89	$94.89	$86.26	$86.26

Freestanding outpatient addiction services fees (off-site)

	Pre 11-1-21 CMS Approved Fee		Proposed 11-1-21 Fee		Proposed 7-1-22 Fee	
Service Type	**Upstate**	**Downstate**	**Upstate**	**Downstate**	**Upstate**	**Downstate**
Outpatient Addiction Rehab (APGs)	NA - New to Medicaid 11/1/21	NA - New to Medicaid 11/1/21	$182.13	$213.11	$150.52	$176.12
Outpatient Addiction Day Rehab (APGs)	NA - New to Medicaid 11/1/21	NA - New to Medicaid 11/1/21	$182.13	$213.11	$150.52	$176.12
Opioid Treatment Program (APGs)	NA - New to Medicaid 11/1/21	NA - New to Medicaid 11/1/21	$182.13	$213.11	$150.52	$176.12

Residential addiction services (stabilization and rehabilitation)

	Pre 11-1-21 CMS Approved Fee		Proposed 11-1-21 Fee		Proposed 7-1-22 Fee	
Service Type	**Upstate**	**Downstate**	**Upstate**	**Downstate**	**Upstate**	**Downstate**
Residential Stabilization	$151.53	$165.27	$166.68	$181.80	$151.53	$165.27
Residential Rehabilitation	$142.01	$163.56	$156.21	$179.92	$142.01	$163.56

Payment for services delivered via telehealth:

3. _____ For the duration of the emergency, the state authorizes payments for telehealth services that:

    a. ____ Are not otherwise paid under the Medicaid state plan;

    b. ____ Differ from payments for the same services when provided face to face;

    c. ____ Differ from current state plan provisions governing reimbursement for telehealth;

Describe telehealth payment variation.

    d. ____ Include payment for ancillary costs associated with the delivery of covered services via telehealth, (if applicable), as follows:

i. ____ Ancillary cost associated with the originating site for telehealth is incorporated into fee-for-service rates.

ii. ____ Ancillary cost associated with the originating site for telehealth is separately reimbursed as an administrative cost by the state when a Medicaid service is delivered.

Other:

4. _____ Other payment changes:

Please describe.

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

State/Territory: ____New York_____

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148 (Expires 03/31/2021). The time required to complete this information collection is estimated to average 1 to 2 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. Your response is required to receive a waiver under Section 1135 of the Social Security Act. All responses are public and will be made available on the CMS web site. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. ***CMS Disclosure*** Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact the Centers for Medicaid & CHIP Services at 410-786-3870.

SUMMARY
SPA #21-0073

This State Plan Amendment is a temporary amendment in response to COVID-19 Emergency Relief.

NON-INSTITUTIONAL SERVICES
State Plan Amendment #21-0073

CMS Standard Funding Questions

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

   Response: Providers receive and retain the total Medicaid expenditures claimed by the State and any assessment or surcharge is processed as a separate transaction and the "D'Amato provision Federal PHL section 105-33 4722 (c)" does not impact the amount the State reimburses the provider for services. The surcharge portion of the expenditure is included on the CMS-64.

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

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

Response: The State share Medicaid provider payment (normal per diem and supplemental) is funded by a combination of the following funds/funding sources through enacted appropriations authority to the Department of Health (DOH) for the New York State Medicaid program. The non-federal share of the Upper Payment Limit is funded by an IGT transferred from the counties.

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

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

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

2) Special Revenue Funds:

a. Health Care Reform Act (HCRA) Resource Fund: as authorized in section 92-dd of New York State Finance Law and was established in 1996, pursuant to New York State Public Health Law 2807-j. HCRA resources include health care related surcharges, assessments on hospital revenues, and a "covered lives" assessment paid by insurance carriers pursuant to chapter 820 of the laws of 2021.

b. Health Facility Cash Assessment Program (HFCAP) Fund: HFCAP requires New York State designated providers to pay an assessment on cash operating receipts on a monthly basis. The assessment includes Article 28 Residential Health Care Facilities, Article 28 General Hospitals, Article 36

Long Term Home Health Care Programs, Article 36 Certified Home Health Agencies and Personal Care Providers that possess a Title XIX (i.e. Medicaid) contract with a Local Social Services District for the delivery of personal care services pursuant to Section 367-i of the New York State Social Services Law.

NOTE: New York's Health Care taxes are either broad based and uniform (as in all HFCAP assessments except for the Personal Care Provider Cash Assessment) or have a specific exemption known as the "D'Amato provision (Federal PHL section 105-33 4722 (c)" which allows the HCRA surcharges to exist in their current format. The single tax which has been determined by the State to be an impermissible provider tax is the HFCAP charge on Personal Care Providers. The State does not claim any Federal dollars for the surcharge collected in this manner in order to comply with all Federal provider tax rules.

3) Additional Resources for State Share Funding:

a. County Contribution: In State Fiscal Year 2006, through enacted State legislation (Part C of Chapter 58 of the laws of 2005), New York State "capped" the amount localities contributed to the non-Federal share of providers claims. This was designed to relieve pressure on county property taxes and the NYC budget by limiting local contributions having New York State absorb all local program costs above this fixed statutory inflation rate (3% at the time).

   However, in State Fiscal Year 2013 New York State provided additional relief to Localities by reducing local contributions annual growth from three precent to zero over a three-year period. Beginning in State Fiscal Year 2016, counties began paying a fixed cost in perpetuity. By eliminating the growth in localities Medicaid costs, the State has statutorily capped total Statewide County Medicaid expenditures at 2015 levels. All additional county Medicaid costs are funded by the State through State funding as described above. DOH provides annual letters to counties providing weekly contributions. Contributions are deposited directly into State escrow account (Key Bank) and used to offset 'total' State share Medicaid funding.

   NOTE: The Local Contribution is not tied to a specific claim or service category and instead is a capped amount based on 2015 county spending levels as stated above.

4) IGT Funding:

New York requests the transfer of the IGT amounts in September (50%) and March (50%) prior to the release of payments to the providers. Please note that counties have taxing authority and the State does not provide appropriations to the counties for IGTs.

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. Under regulations at 42 CFR 447.272, States are prohibited from setting payment rates for Medicaid inpatient services that exceed a reasonable estimate of the amount that would be paid under Medicare payment principals.**

   Response: The clinic and outpatient UPL demonstrations utilize cost-to-payment methodologies to estimate the upper payment limit for each class of providers. The State and CMS are in the process of reviewing the 2021 clinic and outpatient UPLs as well as the Procedural Manuals which describes the methodology for eligible providers.

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: There are various state agencies that perform audits each year to determine the appropriateness of Medicaid payments. In the event that inappropriate payments are determined, recoupments would be initiated, and the Federal share would be returned to CMS within the associated quarterly expenditure report.