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State/Territory Name: NY

State Plan Amendment (SPA) #: 21-0058

This file contains the following documents in the order listed:

1) Approval Letter
2) CMS 179 Form/Summary Form (with 179-like data)
3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
233 North Michigan Ave., Suite 600
Chicago, Illinois 60601

Financial Management Group

June 6, 2022

Brett R. Friedman
Acting Medicaid Director
99 Washington Ave – One Commerce Plaza Suite 1432
Albany, NY 12210

RE: TN 21-0058

Dear Mr. Friedman:

We have reviewed the proposed New York State Plan Amendment (SPA) to Attachment 4.19-B NY 21-0058, which was submitted to the Centers for Medicare & Medicaid Services (CMS) on December 30, 2021. This plan amendment provides two separate ACT rate increases adjusted by a uniform percentage, 1.) Minimum Wage increase and; and 2.) continuing program enhancement.

Based upon the information provided by the State, we have approved the amendment with an effective date of December 31, 2021. We are enclosing the approved CMS-179 and a copy of the new state plan pages.

If you have any additional questions or need further assistance, please contact Kristina Mack-Webb at 617-565-1225 or Kristina.Mack-Webb@cms.hhs.gov.

Sincerely,

[redacted]

Todd McMillion
Director
Division of Reimbursement Review

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 — 0058

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
~~October 7, 2021~~ December 31, 2021

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

7. FEDERAL BUDGET IMPACT 12/31/21 - 09/30/22
a. FFY ~~10/07/21-09/30/22~~ $ ~~9,576.00~~ $1,530,043.75
b. FFY 10/01/22-09/30/23 $ ~~3,050.00~~ $3,056,725.00

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment: 4.19-B Page: 3M

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment: 4.19-B Page: 3M

10. SUBJECT OF AMENDMENT
Assertive Community Treatment Rate Increases (ACT)
~~(FMAP=60% in through 3/31/22, 50% thereafter)~~

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
Brett R. Friedman

14. TITLE
Acting Medicaid Director, Department of Health

15. DATE SUBMITTED
December 30, 2021

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
December 30, 2021

18. DATE APPROVED
June 6, 2022

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL
December 31, 2021

20. SIGNATURE OF REGIONAL OFFICIAL
[redacted]

21. TYPED NAME
Todd McMillion

22. TITLE
Director, Division of Reimbursement Review

23. REMARKS

05/10/22 - The state authorized pen and ink changes.

New York
3M

1905(a)(13) Other diagnostic, screening, preventive, and rehabilitative services

13d. Rehabilitative Services

Assertive Community Treatment (ACT) Reimbursement

ACT services are reimbursed regional monthly fees per individual for ACT teams serving either 36, 48, or 68 individuals, as follows. Except as otherwise noted in the plan, monthly fees are the same for both governmental and non-governmental providers of ACT services. The agency's fee schedule rate was set as of December 31, 2021 and is effective for services provided on or after that date. Further, the agency's fee schedule rate is adjusted as of April 1, 2022 and such rate is effective for services provided on or after that date. All rates are published at the following link:

https://www.omh.ny.gov/omhweb/medicaid_reimbursement/excel/act.xlsx

Monthly fees are based on projected costs necessary to operate an ACT team of each size and are calculated by dividing allowable projected annual costs by 12 months and by team size. Such monthly fee is then adjusted by a factor to account for fluctuations in case load or when the provider cannot submit full or partial month claims because the minimum contact threshold cannot be met. No costs for room and board are included when calculating ACT reimbursement rates.

ACT services are reimbursed either the full or partial/stepdown fee based on the number of discrete contacts of at least 15 minutes in duration in which ACT services are provided during a month. Providers may not bill more than one monthly fee for the same individual in the same month.

ACT services are reimbursed the full fee for a minimum of six contacts per month, at least three of which must be face-to-face with the individual. ACT services are reimbursed the partial/stepdown fee for a minimum of two and fewer than six contacts per month, of which two must be face-to-face with the individual. ACT services are also reimbursed the partial/stepdown fee for a maximum of five months for a minimum of two contacts per month for individuals admitted to a general hospital for the entire month, however the full fee may be reimbursed in the month of the individual's admission or discharge if the provider meets the minimum of six contacts per month, of which up to two contacts may be provided while the individual was in the hospital. For purposes of this provision, an inpatient admission is considered continuous if the individual is readmitted within 10 days of discharge.