NEW YORK STATE OF OPPORTUNITY. Department of Health

ANDREW M. CUOMO
Governor

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

LISA J. PINO, M.A., J.D.
Executive Deputy Commissioner

December 30, 2020

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

RE: SPA #21-0005
Non-Institutional Services

Dear Ms. McKnight:

The State requests approval of the enclosed amendment #21-0005 to the Title XIX (Medicaid) State Plan for non-institutional services to be effective January 1, 2021 (Appendix I). This amendment is being submitted based on State Regulations 14 NYCRR Part 822 and 14 NYCRR Part 841. A summary of the plan amendment is provided in Appendix II.

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

A copy of pertinent sections of the State Regulations is enclosed for your information (Appendix III). Copies of the public notice of this plan amendment, which were given in the New York State Register on October 28, 2020, and clarified on December 30, 2020 are also enclosed for your information (Appendix IV). In addition, responses to the five standard funding questions and the standard access questions are also enclosed (Appendix V and VI, respectively).

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

Sincerely,

[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: 21 — 0005

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
January 1, 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
a. FFY 01/01/21-09/30/21 $ (344.87)
b. FFY 10/01/21-09/30/22 $ (459.82)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.19-B: Pages 1(p)(iii), 10(a.7)

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*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

10. SUBJECT OF AMENDMENT
OASAS Opioid Treatment Programs (OTP) Weekly Bundles (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
December 30, 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

Instructions on Back

Appendix I
2020 Title XIX State Plan
Fourth Quarter Amendment
Amended SPA Pages

New York
1(p)(iii)

OASAS Opioid Treatment Programs (OTPs) Alternative Reimbursement Methodology – Weekly Bundles

Effective January 1, 2021, OASAS will establish regional weekly fees for hospital-based opioid treatment programs. Such fees will be available as an alternative to the reimbursement under the Ambulatory Patient Group (APG) fee methodology already in place for OTPs. Providers may bill any given week of OTP service for any given patient under either methodology (APGs or the bundled fee methodology), but not both. All such fees will be subject to approval by the NYS Division of the Budget.

For purposes of these fees there will be two regions, downstate and upstate, with the regional assignment based on program location. The downstate region includes the following counties: New York, Kings, Queens, Richmond, Bronx, Nassau, Suffolk, Westchester, Rockland, Putnam, Dutchess and Orange. The upstate region includes all other counties in the State.

The January 1, 2021 fees and rate codes are as follows:

Rate Code	Rate Description	Pre-2021 Rates (Statewide)	Jan 1, 2021 (Downstate)	Jan 1, 2021 (Upstate)
7973	HOSPITAL OTP METHADONE DISPENSING OR COUNSELING	$ 207.49	$ 209.19	$ 178.80
7974	HOSPITAL OTP METHADONE ADMIN	$ 35.28	$ 35.28	$ 35.28
7975	HOSPITAL OTP BUPRENORPHINE DISPENSING OR COUNSELNG	$ 258.47	$ 260.59	$ 222.73
7976	HOSPITAL OTP BUPRENORPHINE ADMIN	$ 86.26	$ 86.26	$ 86.26

The pre-2021 rates are under the authority of the NYS COVID-19 disaster relief SPA (20-0048) and are shown here for informational purposes only.

New York
10(a.7)

OASAS Opioid Treatment Programs (OTPs) Alternative Reimbursement Methodology – Weekly Bundles

Effective January 1, 2021, OASAS will establish regional weekly fees for community-based opioid treatment programs. Such fees will be available as an alternative to the reimbursement under the Ambulatory Patient Group (APG) fee methodology already in place for OTPs. Providers may bill any given week of OTP service for any given patient under either methodology (APGs or the bundled fee methodology), but not both. All such fees will be subject to approval by the NYS Division of the Budget.

For purposes of these fees there will be two regions, downstate and upstate, with the regional assignment based on program location. The downstate region includes the following counties: New York, Kings, Queens, Richmond, Bronx, Nassau, Suffolk, Westchester, Rockland, Putnam, Dutchess and Orange. The upstate region includes all other counties in the State.

The January 1, 2021 fees and rate codes are as follows:

Rate Code	Rate Description	Pre-2021 Rates (Statewide)	Jan 1, 2021 (Downstate)	Jan 1, 2021 (Upstate)
7969	FREESTNG OTP METHADONE DISPENSING OR COUNSELING	$ 207.49	$ 209.19	$ 178.80
7970	FREESTNG OTP METHADONE ADMIN	$ 35.28	$ 35.28	$ 35.28
7971	FREESTNG OTP BUPRENORPHINE DISPENSING OR COUNSELNG	$ 258.47	$ 260.59	$ 222.73
7972	FREESTNG OTP BUPRENORPHINE ADMIN	$ 86.26	$ 86.26	$ 86.26

The pre-2021 rates are under the authority of the NYS COVID-19 disaster relief SPA (20-0048) and are shown here for informational purposes only.

Appendix II
2020 Title XIX State Plan
Fourth Quarter Amendment
Summary

SUMMARY
SPA #21-0005

This amendment proposes to revise the State Plan to establish weekly Opioid Treatment Program (OTP) bundled fees as a permanent alternative to the OTP Ambulatory Patient Group (APG) methodology. For any given week and any given patient, the provider may choose to bill under either the new bundles or APGs.

Appendix III
2020 Title XIX State Plan
Fourth Quarter Amendment
Authorizing Provisions

PART 822
GENERAL SERVICE STANDARDS FOR SUBSTANCE USE DISORDER OUTPATIENT PROGRAMS

[Statutory Authority: Mental Hygiene Law Sections 19.07(c), 19.07(e), 19.09(b), 19.16, 19.21(b), 19.21(d), 19.40, 32.01, 32.05(b), 32.07(a) 32.09(b), 22.07(c); Penal Law Section 220.78; Public Health Law Section 3309, 2781**; 42 CFR Part 8**]

Section:

822.1 Background

This Part contains requirements applicable to substance use disorder (SUD) outpatient programs certified, licensed, funded or otherwise authorized by the Office and the services provided by such programs. For purposes of this Part, addiction or substance use disorder is a chronic illness that can be treated effectively with counseling, approved medications used consistent with their pharmacological efficacy, and supportive services such as treatment for co-occurring disorders, medical and psychiatric services, vocational rehabilitation and family intervention and support.

822.2 Legal base

(a) Section 19.07(c) of the Mental Hygiene Law (MHL) charges the Office with the responsibility to ensure that persons who have a substance use disorder and their families are provided with care and treatment that is effective and of high quality.

(b) Section 19.07(e) of the MHL authorizes the commissioner to adopt standards including necessary rules and regulations pertaining to substance use disorder treatment services.

(c) Section 19.09(b) of the MHL authorizes the commissioner to adopt regulations necessary and proper to implement any matter under their jurisdiction.

(d) Section 19.16 of the MHL requires the commissioner to establish and maintain, either directly or through contract, a central registry for purposes of preventing multiple enrollments in opioid treatment programs and provides medication dosage information during an emergency, when displaced patients may seek such treatment from an alternate program.

(e) Section 19.21(b) of the MHL requires the commissioner to establish and enforce regulations concerning the licensing, certification, and inspection of substance use disorder treatment services.

(f) Section 19.21(d) of the MHL requires the Office to establish reasonable performance standards for providers of services certified by the Office.

(g) Section 19.40 of the MHL authorizes the commissioner to issue operating certificates for the provision of substance use disorder treatment services.

(h) Section 22.07(c) of the Mental Hygiene Law authorizes the commissioner to promulgate rules and regulations to ensure that the rights of individuals who have received, and are receiving, substance use disorder services are protected.

(i) Section 32.01 of the MHL authorizes the commissioner to adopt any regulation reasonably necessary to implement and effectively exercise the powers and perform the duties conferred by Article 32 of the MHL.

(j) Section 32.05(b) of the MHL provides that a controlled substance designated by the commissioner of the New York State Department of Health (DOH) as appropriate for such use may be used by a prescribing professional to treat a**n individual with a substance use disorder** [~~chemically dependent individual~~] pursuant to section 32.09(b) of the MHL.

(k) Section 32.07(a) of the MHL authorizes the commissioner to adopt regulations to effectuate the provisions and purposes of Article 32 of the MHL.

(l) Section 32.09(b) of the MHL provides that the commissioner may, once a controlled substance is approved by the commissioner of DOH as appropriate for such use, authorize the use of such controlled substance in treating an individual with a substance use disorder.

(m) Section 220.78 of the Penal Law affords limited protections from prosecution for persons seeking medical attention for accidental overdose.

(n) Section 3309 of the Public Health Law authorizes the DOH to establish standards for approval of any opioid overdose prevention program.

(o) Section 2781 of the Public Health Law defines the rules governing HIV testing in New York.

(p) 42 CFR Part 8 relates to the federal oversight and regulation of medication assisted treatment for opioid use disorders.

822.3 Applicability

(a) Part 822 applies to any person or entity organized in accordance with this Part, operating pursuant to the provisions of this Title and certified, funded or otherwise authorized by the Office to operate an outpatient treatment program. Except as indicated in subdivision (b) of this section, to provide services pursuant to this Part, each provider must obtain and maintain an operating certificate pursuant to Part 810 of this Title. Programs providing opioid full agonist treatment medications must additionally obtain approval from a federally-approved accrediting body, and all other applicable regulatory entities.

(b) The provision of treatment services within local correctional facilities shall not require certification by the Office; however, local correctional facilities must follow any other applicable state and federal regulations. The Office reserves the right to review protocols, delivery of services and discharge planning procedures of programs providing medications for substance use disorders within local correctional facilities.

822.4 Savings and renewal clause

Any operating certificate issued by the Office prior to the promulgation of this Part for the operation of a program subject to regulations of the former Part 822 shall remain in effect until the term of such operating certificate has been renewed or such operating certificate is suspended or revoked through process of law, at which time any recertification of such program or renewal of such operating certificate shall be pursuant to the provisions of this Part.

822.5 Definitions

As used in this Part, unless otherwise indicated, the following terms shall be applicable all programs providing outpatient services:

(a) "Accrediting Body" means an entity approved by the federal Substance Abuse Mental Health Services Administration (SAMHSA) to accredit all programs pursuant to 42 CFR Part 8.1 through 8.6 using opioid full agonist treatment medications.

(b) "Active treatment" is the period from pre-admission through discharge.

(c) "Admission assessment" is a [~~pre-admission~~] service between a prospective patient and clinical staff for the purpose of determining a preliminary diagnosis, appropriateness for service, **person-centered** initial plan of treatment, including **type(s) of** services and frequency of services.

(d) "Ancillary withdrawal" is a service whereby patients in mild to moderate or persistent withdrawal receive symptom relief and/or addiction medications after an assessment of the level of withdrawal determined using a standardized assessment instrument. Providers must receive Office approved designation to provide this service.

(e) "Approved medications" means any medication approved **by state or federal authorities for the treatment of** [~~for opioid treatment by federal authorities and any medication appropriate for the treatment of~~] substance use disorder.

(f) "Brief intervention" is a [~~pre-admission~~] service between a prospective patient and clinical staff when screening results indicate at risk behavior. The brief intervention educates patients about their substance use, alerts them to possible consequences, and is intended to encourage healthier choices.

(g) "Brief treatment" is a service between an active patient and clinical staff and must include a target behavior **or health need** and an evidence-based or clinical practice upon which the treatment is based. Brief treatment may be used throughout the course of treatment to meet specific goals, motivate patients or support medicated supported recovery.

(h) "Central registry system" means the central registry established and maintained by the Office pursuant to section 19.16 of the Mental Hygiene Law.

(i) [~~"**Substance use disorder** outpatient rehabilitation services" (outpatient rehabilitation services) are services offered by programs which have been certified to provide outpatient rehabilitation services; such services are designed to assist individuals with more chronic conditions who are typically scheduled to attend the outpatient rehabilitation program three to five days per week for at least four hours per day.~~

~~(j) "**Substance use disorder** outpatient program" is an Office certified program which provides outpatient services that assist individuals who suffer from substance use disorder and their family members and/or significant others and may also provide outpatient rehabilitation services and/or intensive outpatient services (IOS); and sites where addiction medications are administered to treat opioid use disorder, as well as other SUDs following one or more medical treatment protocols as defined in this Part. This term encompasses medical and comprehensive support services including counseling, educational and vocational rehabilitation. The term also includes the Narcotic Treatment Program (NTP) as defined by the federal Drug Enforcement Agency (DEA) in 21 CFR Section 1301. An NTP or Opioid Treatment Program (OTP) requires federal and state approval.~~]

[~~(k)~~] "Collateral person" is a member of a patient's family or household, significant others, or persons who are directly affected by regular interaction with the patient, or who have the capability to affect both the patient's substance use disorder and recovery.

[~~(l)~~]**(j)** "Collateral visit" is a service between a clinical staff member and a collateral person for the purpose of providing an intervention in the service of the primary patient's progress in treatment.

[~~(m)~~]**(k)** "Complex care coordination" is a**n ancillary** service provided to **a patient when a critical event occurs, or the individual's condition requires significant coordination with other service providers.** [~~or on behalf of a patient when a critical event occurs or the patient's condition requires significant coordination with other service providers.~~] Complex care coordination is distinguished from routine case coordination activities[~~and must occur within five working days of another service~~].

[~~(n)~~]**(l)** "Continuing care treatment" is a treatment protocol that offers clinical support for the ongoing disease management needs of patients. Patients have **either** completed the goals of active treatment and are **discharged with referral** [~~admitted~~] to continuing care **or opt for continuing care any time after discharge**.

[~~(o)~~]**(m)** "Group counseling" is a service between one or more clinical staff and multiple patients at the same time, to be delivered consistent with patient treatment/recovery plans, their development or emergent issues. Group counseling sessions must be structured in size and duration to maximize therapeutic benefit for each participant. Program policies must include a

process for determining group size, group purpose, monitoring patient experience, and assessing group efficacy.

[~~(p)~~]**(n)** [~~"Initial services or pre-admission services" are services prior to admission as the first step in developing a treatment plan, focusing on issues that need to be addressed to ensure successful engagement and admission into treatment and any other urgent or emergent issues. Initial services address priority goals based on presenting problem(s) identified during the patient's admission assessment and provide focus for the critical period of treatment engagement.~~

~~(q)~~] "Individual counseling" is a service between a clinical staff member and a patient focused on the needs **and goals** of the patient to be delivered consistent with the treatment/recovery plan, its development or emergent issues.

(o) "Initial services or pre-admission services" are services prior to admission as the first step in developing a treatment/recovery plan, focusing on issues that need to be addressed to ensure successful engagement and admission into treatment and any other urgent or emergent issues. Initial/pre-admission services address priority goals based on presenting problem(s) identified during the patient's assessment and provide focus for the critical period of treatment engagement. Services which may be delivered preadmission will be identified by the Office.

(p)[~~(r)~~] "Intensive outpatient services" (IOS) is an outpatient treatment service provided by a team of clinical staff for patients who require a time-limited, multi-faceted array of services, structure, and support to achieve and sustain recovery. Programs that offer intensive outpatient treatment must make available individual and group counseling, family counseling when appropriate, skills to mitigate reoccurrence, and coping skills training, **including as appropriate,** Dialectical and Behavioral Therapy (DBT), Motivational Enhancement Therapy (MET), Cognitive Behavioral Therapy (CBT) and increased connections to recovery supports **and other evidence based practices as proven effective in meeting patient needs**.

[~~(s)~~]**(q)** "Medication administration and observation" is face-to-face administration or dispensing of a medication by medical staff, to be delivered in conjunction with observation of the patient prior to the administration and after, as appropriate to the medication and patient's condition.

[~~(t)~~]**(r)** "Medication assisted treatment" (MAT) means treatment of substance use disorder i.e., substance use disorder and concomitant conditions with medications requiring a prescription or

order from an authorized prescribing professional with counseling and behavioral therapies, as clinically appropriate.

[~~(u)~~]**(s)** "Medication management" is a service with a prescribing professional for one of the following purposes:

(1) evaluation, monitoring, observation or dosage change to a patient's medication;

(2) a comprehensive medication review of a new patient or any patient who requires a more extensive review; or

(3) the induction of a patient to a new medication requiring a period of patient observation.

[~~(v)~~]**(t)** "Naloxone emergency overdose prevention kit" means a kit as prescribed pursuant to state law and is used to reverse an opioid overdose.

[~~(w)~~]**(u)** "Opioid medical maintenance" is a designated Office-based opioid treatment ("OBOT") program limited to patients who meet specific criteria as described in this Part.

[~~(x)~~]**(v)**"Opioid taper" means a medical treatment protocol that, after a period of stabilization, utilizes approved medications in gradually decreasing doses to the point of 0 milligrams (no dose) followed by continuing care treatment as described in this Part, or discharge.

[~~(y)~~]**(w)** "Patient" is an individual including a significant other who meets with clinical and/or peer staff for the purpose of **engagement,** assessment or treatment. "Active patient" means a patient who is admitted to a program and has an active treatment/recovery plan.

[~~(z)~~]**(x)**[~~"Person centered care" is a collaborative care approach to individualized treatment resulting in the development of treatment/recovery plan goals and service provision that is respectful of the patient's needs and choices. It is guided by patients and produced in partnership with care providers for treatment and recovery. Person and family centered care planning is strength-based and focuses on individual capacities, preferences and goals. It supports patient preferences and a recovery orientation and is developed within the professional responsibilities of providers and care teams.~~

~~(aa)~~] "Peer support service" is [~~a face-to-face service (unless otherwise specified)~~] provided by a peer advocate as defined in Part 800 of this Title. Peer support services are services for the purpose of outreach for engaging an individual to consider entering treatment, reinforcing current patients' engagement in treatment, and connecting patients to community-based recovery supports consistent with treatment**/recovery** and discharge plans.

(y) "Person centered care" is a collaborative care approach to individualized treatment resulting in the development of treatment/recovery plan goals and service provision that is respectful of the patient's needs and choices. It is guided by patients and produced in partnership with care providers for treatment and recovery. Person and family centered care planning is strength-based and focuses on individual capacities, preferences and goals. It supports patient preferences and a recovery orientation and is developed within the professional responsibilities of providers and care teams.

(z)[~~(ab)~~] "Progress note" is documentation of each service delivered and serves as the treatment/recovery plan as it evolves to support person centered goals and ongoing service and care planning. Progress notes identify patient's clinical status, type of services, and **may also include** updates to goals, methods of treatment and types of services provided and includes challenges and achievements identified.

(aa)[~~(ac)~~] "Screening" is a pre-admission service with a clinical staff member for the purpose of identifying patients who have problems with substance use. Screening results must be shared by the clinical staff **with the patient**[~~in an individual face-to-face session~~].

(ab)[~~(ad)~~] "Specialized opioid services" are those not defined in this Part and are generally research-oriented in nature. Such specialized services shall be reviewed and approved by the Office prior to implementation and operation in accordance with Office policy, procedures, and requirements.

(ac) "Substance use disorder outpatient rehabilitation services" (outpatient rehabilitation services) are services offered by programs which have been certified to provide outpatient rehabilitation services; such services are designed to assist individuals with more chronic conditions as further defined in this Part who are typically scheduled to attend the outpatient rehabilitation program three to five days per week for at least two hours per day.

(ad) "Substance use disorder outpatient program" is an Office certified program which provides outpatient services that assist individuals with a substance use disorder and their family members and/or significant others and may also provide outpatient rehabilitation services and/or intensive outpatient services (IOS); and sites where addiction medications are administered to treat opioid use disorder, as well as other SUDs following one or more medical treatment protocols as defined in this Part. This term encompasses medical and

comprehensive support services including counseling, educational and vocational rehabilitation. The term also includes the Narcotic Treatment Program (NTP) as defined by the federal Drug Enforcement Agency (DEA) in 21 CFR Section 1301. An NTP or Opioid Treatment Program (OTP) requires federal and state approval.

(ae) "Transfer" is an intra-program function (i.e., between outpatient and outpatient rehabilitation within the same provider or between different Program Reporting Units (PRUs) of the same provider); and

may also be an inter-program function (i.e., between two different providers).

(af) "Treatment/recovery plan" is the plan developed by clinical staff with the patient and based on the admission assessment and initial services and includes goals, type and frequency of services and methods. Treatment/recovery plans shall be regularly updated using progress notes.

(ag) "Visit" means one or more services provided to a patient and/or collateral person on a single day.

822.6 Standards pertaining to Medicaid reimbursement

(a) For purposes of Medicaid billing, a claim may be submitted for services delivered to a patient, collateral person, or significant other (regardless of whether such significant other is connected to a current patient with a diagnosed substance use disorder).

(b) Only services delivered by an Office-certified or authorized program are eligible for Medicaid reimbursement under this Part.

(c) The content and/or outcome of all services must be fully documented in the patient record consistent with this Part.

(d) In order to qualify for reimbursement, each service must be documented as a covered Medicaid service in accordance with the following:

(1) the service must meet the standards established in this Part;

(2) the service must meet the standards established in Part 841 of this Title;

(3) the service must be provided by appropriate staff as required in this Part.

(e) The following services alone do not constitute a service eligible for Medicaid reimbursement:

(1) nutrition services;

(2) educational and vocational services;

(3) recreational and social activity services;

(4) group meetings, workshops or seminars that are primarily informational or organizational;

(5) acupuncture.

822.7 General program standards

(a) Policies and procedures. The program sponsor must approve written policies, procedures, and methods governing the provision of services to patients in compliance with Office regulations including a description of each service provided. These policies, procedures, and methods must address, at a minimum:

(1) admission and discharge, including specific criteria relating thereto, as well as transfer and referral procedures;

(2) treatment/recovery plans;

(3) services to be provided by contract or subcontract including methods for coordinating service delivery and a description of core groups offered and procedures for coordinating group, individual, and family treatment;

(4) a schedule of fees for services rendered;

(5) compliance with other requirements of applicable local, state and federal laws and regulations, OASAS guidance documents and standards of care regarding, but not limited to:

(i) education, counseling, prevention and treatment of communicable diseases, including viral hepatitis, sexually transmitted diseases and HIV/AIDS; regarding HIV, such education, counseling, prevention and treatment shall include condom use, testing, pre- and post-exposure prophylaxis and treatment;

(ii) the use of alcohol and other drug screening and toxicology tests; and

(iii) medication and the use of medication assisted treatment; and

(iv) the use of a problem gambling screen approved by the Office.

(6) infection control procedures;

(7) staffing, including but not limited to, training and use of student interns, peers and volunteers;

(8) Waiting lists. Programs must maintain a waiting list of eligible prospective patients. When an opening is available programs must make at least one good faith attempt to contact the next prospective patient on the waiting list.

(9) Certified Capacity. [~~(i)~~] In determining certified capacity for an OTP, such programs may**:**

(i) Exclude patients confirmed to be maintained on appropriate medications in a hospital, nursing home or correctional facility and who are expected to return to the program within 12 months upon discharge from such facility;

(ii) Programs may include patients previously deemed ineligible for admission for reasons other than behavioral concerns**; and**

(iii) Exclude patients maintained on buprenorphine.

(iv) Exclude a significant other(s).

(10)[~~(9)~~] Each program must maintain a policy on toxicology.

(b) Emergency medical kit. (1) All programs must maintain an emergency medical kit at each certified location; such kit must include basic first aid and at least one naloxone emergency overdose prevention kit. Programs must develop and implement a plan to have staff trained in the use of a naloxone overdose prevention kit such that it is available for use during all program hours of operation.

(2) All staff and patients should be notified of the existence of the naloxone overdose prevention kit and the authorized administering staff.

(3) Nothing in this regulation shall preclude patients from becoming authorized in the administration of the naloxone emergency overdose prevention kit, provided however, the program director must be notified of the availability of any additional authorized users.

(c) Utilization review and quality improvement. All programs must have a utilization review process, a quality improvement committee, and a written plan that identifies key performance measures.

(d) Continuous services. Programs must develop necessary procedures, including disaster plans, to assure continuous services in emergencies or disruption of operations in accordance with Office guidelines and accreditation standards.

(e) Community relations. Programs must develop and implement a community relations plan that describes actions responsive to reasonable community needs; such plans may include,

but not be limited to, formation of community patrols to ensure that patients are not loitering, and formation of a Community Committee that meets regularly to discuss actions to improve community relations.

(f) Required services. Each program must directly provide the following:

(1) admission assessment, including, if clinically indicated, a screen for problem gambling;

(2) treatment/recovery planning and review;

(3) trauma-informed individual and group counseling;

(4) medication assisted treatment;

(5) toxicology testing (not required for significant others unless clinically indicated):

(i) Each program must conduct toxicology tests to be determined by the provider as clinically appropriate provided, however, at least eight random toxicology tests must be conducted per year for each patient in an OTP.

(ii) Each program must review and discuss with the patient the toxicology result.

(iii) Laboratories used for toxicology testing must be approved by the New York State Department of Health or, in the City of New York, the New York City Department of Health and Mental Hygiene.

(iv) Each program must use a method approved by the Food and Drug Administration (FDA) and Center for Substance Abuse Treatment (CSAT) for toxicology testing.

(6) post-treatment planning;

(7) medication administration and observation;

(8) medication management;

(9) brief intervention and brief treatment;

(10) collateral visits;

(11) complex care coordination;

(12) outreach; and

(13) peer support services.

(g) Optional Services. Each program may, at its option, directly provide any of the following:

(1) intensive outpatient services (IOS);

(2) ancillary withdrawal (requires Office approved designation); or

(3) other services which may be identified by the Office from time to time.

(h) Problem gambling. A program that treats an individual and/or a significant other who has been affected by problem gambling, shall **be designated and** provide such services in accordance with Part 857 of this Title.

(i) Telepractice. Any services authorized to be delivered using telepractice shall be provided consistent with Part 830 of this Title.

(j) Staffing. Each program must provide clinical supervision and ensure and document a plan for staff training based on individual employee needs. Subject areas appropriate for training shall be identified by the Office. Staffing requirements include:

(1) Clinical Director. Each program must have a qualified health professional designated as the clinical director **working within their scope of practice** who is responsible for the daily activities and supervision of services provided. Such person must have at least three years of full-time clinical work experience in the substance use disorder field, at least one year of which must be supervisory, prior to appointment as clinical director. A program which is part of a provider comprised of multiple health, mental health or substance use disorder treatment programs may share this position provided clinical director responsibilities have been delegated to another qualified staff member and shared to the extent such assignment is sufficient to meet patient need.

(2) Medical Director. Each program must have a Medical Director as defined in Part 800 of this Title.

(3) Medical staff, as defined in Part 800 of this Title.

(i) The medical staff must be trained in emergency response treatment and must complete regular refresher courses/ drills on handling emergencies.

(ii) A physician, registered physician's assistant or nurse practitioner must provide on-site, or through telepractice, coverage as adequate and necessary.

(iii) In an OTP, anytime such program is open**,** and a physician is not present, a physician must be available for consultation, prescribing, dispensing and to attend to any emergency situation.

(iv) An OTP must have at least the equivalent of two full-time on-site nurses for up to 300 patients, one of whom shall be a registered nurse. Programs approved to serve more than 300 patients must have one additional full-time nurse for each additional 150 patients or

part thereof. A [~~registered~~] nurse must always be present when medication is being administered.

(4) Health coordinator. Each program must designate a health coordinator to assure the provision of education, risk reduction, counseling and referral services to all patients regarding HIV/AIDS (including pre- and post-exposure prophylaxis), tuberculosis, viral hepatitis, sexually transmitted diseases, and other communicable diseases. [~~This person may also serve as the program's Lesbian, Gay, Bisexual, Transgender, Queer/Questioning (LGBTQ) liaison.~~]

(5) Counselors. In every program there must be an adequate number of counselors sufficient to carry out the objectives of the program and to assure the outcomes of the program are addressed. The Office will review factors in determining whether the program's outcomes are being addressed, which may include but shall not be limited to:

(i) retention of patients in treatment;

(ii) patients' stability and progress in treatment.

(6) Full-time staffing requirements. There must be at least one full-time Credentialed Alcoholism and Substance Abuse Counselor (CASAC); and there must be at least one full-time qualified health professional, as defined in Part 800 of this Title, qualified in a discipline other than substance use disorder counseling, that maintains a professional license other than a CASAC.

(7) Qualified health professional requirements. At least 50 percent of all clinical staff must be qualified health professionals. CASAC trainees (CASAC-T) may be counted towards satisfying the 50 percent requirement; however such individuals may not be considered qualified health professionals for any other purpose under this Part. Clinical staff members who are not qualified health professionals must have qualifications appropriate to their assigned responsibilities as set forth in the personnel policies of the program and must be subject to appropriate staff supervision and continuing education and training.

(8) Each program must notify the Office of any change in medical director, on-site physician(s), or program sponsors (pursuant to Part 810 of this Title).

(k) Other staffing requirements. (1) If other specialized services are directly provided by the program, staff must be appropriately qualified to provide such services.

(2) Volunteers and student interns. In addition to staffing requirements of this Part, a program may utilize volunteers and student interns. Such volunteers or student interns must

receive supervision, training, or didactic education consistent with their assigned tasks and the services they are expected to provide.

(3) Certified Recovery Peer Advocates (CRPA). CRPAs, as defined in Part 800 of this Title, must be supervised by a clinical staff member who is credentialed or licensed and participate in a training plan appropriate to their needs. CRPAs may provide peer support services based on clinical needs as identified in the patient's treatment/recovery plan.

(4) Security staff. Programs may employ security staff who are not clinical staff and may not be involved in clinical services and must receive training on confidentiality of patient information and adhere to such federal laws.

(5) All clinical staff should be provided training related to, including but not limited to, crisis interventions, dealing with special populations, quality improvement, agency policies and procedures. Additional subject areas appropriate for training may from time to time be identified by the Office.

(6) A clinical or non-clinical staff person shall be identified to serve as the program's Lesbian, Gay, Bisexual, Transgender, Questioning/Queer (LGBTQ) liaison.

(l) Program hours of operation. Each program must operate at least five (5) days per week providing structured treatment services in accordance with treatment/recovery plans. Programs should make every effort to provide services outside of normal business hours, including evening and weekend hours. OTPs must be open at least six (6) days per week and must provide flexible dosing hours that meet patient needs, providing access for patients with varying schedules. Patients must be given an appointment for all visits including medication dispensing. Appointment times must allow for program operation with limited wait times.

822.8 Patient Records/Treatment Planning

(a) General requirements for all patient records. All programs must maintain a patient record (either electronic or paper) for each patient who receives services. The patient record must demonstrate a chronological pattern of delivered medical and treatment services consistent with the patient's prior treatment history, if any, and the patient's evolving treatment/recovery plan, updated regularly through progress notes. The patient record shall also include:

(1) the source of referral, if applicable;

(2) a notation that, prior to the first treatment visit, the patient received a copy of the program's rules and regulations, including patient's rights (Part 815) and a summary of the federal confidentiality requirements, that such rules and regulations were discussed with the patient, including their ability to designate individuals to be notified in case of an emergency and that the patient indicated he/she understood them;

(3) any clinical or non-clinical documentation or determination applicable to the delivery of medical and treatment services for a patient and/or supporting the patient's evolving treatment/recovery plan;

(4) the individual treatment/recovery plan and all reviews and updates thereto through progress notes;

(5) signed releases of consent for information;

(6) documentation of services in accordance with this Part;

(7) documentation of level of care determinations using the OASAS level of care protocol **for admission and level of care transition**;

(8) transition planning, including medication list, circumstances/reason, and referrals made;

(9) if the patient is a minor being treated without parental consent, documentation establishing that the provisions of Mental Hygiene Law section 22.11 have been met.

(10) information and documentation required in screening and admission;

(11) all lab results;

(12) current approved medication doses and justification for any changes; and

(13) include an order sheet that is displayed in the patient record and signed (physical or electronic signature) by any medical professional licensed under the appropriate state law authorizing such change and noting the date for each approved medication order and dose change.

[~~(14) Transfers. If patients are transferred between a substance use disorder outpatient program and outpatient rehabilitation services within the same provider, a single patient record may be maintained provided that it includes clinical justification for the transfer, the effective date of the transfer and a revised treatment/recovery plan.~~

~~(15) Confidentiality. Patient records maintained by the program are confidential and may only be disclosed consistent with the Health Insurance Portability and Accountability Act~~

~~(HIPAA) and the federal regulations governing the confidentiality of patients' records as set forth in 42 CFR Part 2 and other applicable law.~~

~~(16) Records retention. Patient records must be retained for six (6) years after the date of discharge or last contact, or three (3) years after the patient reaches the age of eighteen, whichever time period is longer.~~

~~(17) Patient deaths. If a patient dies while in active treatment any known details must be documented in the patient record.~~]

(b) Admission requirements applicable to all programs:

(1) **Diagnosis. (i)** Unless otherwise authorized, the program must document that the individual is determined to have a substance use disorder based on the criteria in the most recent version of the Diagnostic and Statistical Manual (DSM) or the International Classification of Diseases (ICD).

(ii) For a significant other, the program must document that the individual is determined to have a diagnosis consistent with the presenting concerns related to a close relationship with someone who has a substance use disorder.

(2) If an individual has been referred by an Office approved Driving While Intoxicated (DWI) provider/practitioner, any assessment created by such provider which meets the requirements of this section may be used to admit the patient.

(3) Documentation of admission must:

(i) **include the level of care determination;**

(ii) include an assessment, initial services and diagnosis that form the basis of the treatment/recovery plan;

(ii**i**) be made by a clinical staff member who is a qualified health professional and must be documented by the dated signature (physical or electronic) of the qualified health professional working within their scope of practice and include the basis for admitting the patient; and

(i**v**[~~ii~~]) be approved by the dated signature (physical electronic) of a **physician, physician's assistant, nurse practitioner, licensed psychologist, or licensed clinical social worker.** [~~licensed practitioner or physician.~~]

(4) Patients being admitted to an OTP must be documented to have a minimum 12-month opioid use disorder (OUD) accompanied by a [~~complete~~] physical examination. **A**

comprehensive physical examination must be completed within fourteen days, or otherwise in accordance with federal rules.

(5) If the presenting individual is determined to be inappropriate for admission to the program, a referral and connection to a more appropriate service must be made, unless the individual is already receiving substance use disorder services from another provider. Individuals deemed ineligible for admission must be informed of the reason.

(6) No individual **that meets level of care criteria** may be denied admission to a program based solely on the individual's:

(i) prior treatment history;

(ii) referral source;

(iii) pregnancy;

(iv) history of contact with the criminal justice system;

(v) HIV and AIDS status;

(vi) physical or mental disability;

(vii) lack of cooperation by significant others in the treatment process;

(viii) toxicology test results;

(ix) use of any **illicit or prescribed** substance**, including but not limited to, benzodiazepines**; **or**

(x) use of medications for substance use disorder prescribed and monitored by a physician, physician's assistant or nurse practitioner[~~; or~~

~~(xi) use of benzodiazepines~~].

(7) All prospective patients must be informed that admission to a program is on a voluntary basis and a prospective patient is free to discharge themselves from the service at any time. For prospective patients under an external mandate, the potential consequences for premature discharge must be explained, including that the external mandate does not alter the voluntary nature of admission**,** [~~and~~] continued treatment**, and toxicology screening**.

(8) A significant other may be admitted to a program regardless of whether the individual with whom they are associated is in treatment. A significant other is not appropriate for admission to an outpatient rehabilitation service.

(c) Post-admission. (1) As soon as possible after admission, **if not already complete,** every patient must be:

(i) offered viral hepatitis testing; testing may be done on site or by referral;

(ii) offered HIV testing; testing **must be conducted with patient consent in accordance with public health law**[~~may not be conducted without patient written informed consent except in situations specifically authorized by law; testing~~] **and** may be done on site or by referral; individuals on a regimen of pre- or post-exposure prophylaxis, must be permitted to continue the regimen until consultation with the prescribing professional occurs;

(iii) screened for co-occurring mental health conditions and behavioral health risk including suicide risk using validated screening instruments approved by the Office.

(2) If clinically indicated, all programs must:

(i) conduct an intradermal skin or blood-based Tuberculosis test; testing may be done on site or by referral with results as soon as possible after testing; for patients with a positive test result, refer the patient for further tuberculosis evaluation.

(ii) offer testing for other sexually transmitted diseases; testing may be done on site or by referral;

(iii) provide or recommend any other tests the examining physician or other medical staff member deems to be necessary including, but not limited to, an EKG, a chest X-ray, or a pregnancy test.

(3) As soon as possible after testing programs must explain or ensure that the [~~referring~~] provider has explained, any blood and skin test results to the patient.

(4) For those patients who have not had a physical examination within one year prior to admission, each such patient must either be assessed [~~face-to-face~~] by a member of the medical staff to ascertain the need for a physical examination or referred for a physical examination. For those patients who have had a physical examination within one year prior to admission, or for those patients being admitted directly to the outpatient program from another substance use disorder service authorized by the Office, the existing medical history and physical examination documentation may be used to comply with the requirements of this subdivision, provided such documentation has been reviewed by a medical staff member and determined to be current. Notwithstanding the foregoing, **HIV and viral hepatitis testing** [~~the following~~] shall be offered regardless of a documented history within the previous twelve months[~~: HIV and viral hepatitis testing~~]. **OTPs are exempt from this requirement but must provide physical examinations in accordance with federal rules.**

(d) Additional admission requirements for outpatient rehabilitation services. In addition to the requirements of paragraph (a) of this section, an individual must also meet the criteria in Section 822.10 of this Part to be admitted to an outpatient rehabilitation service.

(e) Additional admission requirements for OTPs. (1) The decision to admit a prospective patient for treatment is finalized on the date of administration **or prescription** of the initial approved medication dose after satisfaction of all applicable requirements of this Part. Prospective patients with a chronic immune deficiency or prospective patients who are pregnant and have a current opioid or past opioid dependency must be screened and admitted on a priority basis. No person under the age of 16 may be admitted without the prior approval of the Office. The following requirements must be met for an individual to be admitted:

(2) In order to [~~provide~~]**administer** the first medication dose, a patient must have an in-person evaluation, including a [~~complete~~] physical evaluation, to determine that they have had a physiological dependence on opioids for at least the previous 12-month period, and must diagnose and document such, provided however:

(i) a prospective patient may be admitted who voluntarily completed treatment in another program without confirming current opioid dependence if the program confirms that the:

(a) voluntary completion of treatment occurred within the previous 24 months; and

(b) previous treatment lasted at least 6 months;

(ii) a prospective patient who is less than 18 years of age may be admitted if such patient has had at least two prior treatment episodes within a 12-month period and a dependence on opioids;

(iii) a prospective patient who resided in a correctional or chronic care facility for at least one month, if assessed within 6 months after release or discharge, may be admitted if the prospective patient would have been eligible for admission prior to residing in such facility.

(3) A physician**, or other practitioner with federal approval,** must ensure that prior to first dose**,** the prospective patient is provided and signs (physical or electronic signature) an informed written consent to participate in an opioid treatment program, which shall include notice of the risks and benefits of a prescribed medicine.

(4) Each OTP must issue a photo-identification card to each patient within two weeks after admission; patients may carry the identification or, at the patient's option, have the identification maintained at the program.

(f) Readmissions to OTPs. Programs need not repeat admission procedures for any patient who is being re-admitted within three (3) months of discharge and need not repeat a medical and laboratory examination if the patient received a medical and laboratory exam within the previous year, provided:

(1) The patient's prior medical records must be combined with the new medical records within thirty days of the patient's readmission;

(2) each program must immediately readmit patients who were previously discharged from that program:

(i) after a stay of 30 days or more in a hospital, nursing home, or other health care facility, if such patient is still being maintained on an approved medication, and/or meets the eligibility requirements when released; or

(ii) after an extended incarceration (including KEEP), if clinically appropriate when such patient is released.

(g) Transfers between OTPs. (1) Each program must develop procedures regarding the transfer of patients which must ensure that the program shall:

(i) not deny a reasonable request for a temporary or permanent transfer;

(ii) not include "temporary-to-permanent" conditions, whereby a patient is temporarily provided guest medication and then evaluated as to whether or not the OTP will permanently admit**, unless otherwise authorized by the Office**;

(iii) regard transferred patients as continuing in treatment by incorporating their length of treatment and treatment**/recovery** plans from the referring program;

(iv) send or receive the reason for the transfer and provide the most current medical, counseling, and laboratory information within fourteen (14) days of the request. Receipt of this information is not required prior to acceptance and the failure to receive this information will not preclude acceptance; and

(v) continue the patient's approved medication dosage and take-home schedule unless new medical or clinical information requires medical staff to review and subsequently order a change.

(2) Each program must develop procedures for the temporary transfer of patients which must ensure that the:

(i) transferring programs forward information on fees, contact person, time and dose of medication to the receiving program;

(ii) Program sends or receives prior to the patient's arrival the reason for the temporary transfer including temporary dates and approved medication dose;

(iii) Program shall not deny a reasonable request for a temporary transfer;

(iv) transferring program remains responsible for the patient's overall treatment. The receiving program may deliver any necessary service after consultation with the transferring program; and

(v) receiving program prescribing professional must write an order to continue the patient's medication dose and take-home schedule.

(h) Treatment/recovery plan. (1) Each patient must have a written person-centered treatment/recovery plan developed by the clinical staff person with primary responsibility for the patient, in collaboration with the patient and anyone identified by the patient as supportive to recovery goals. The treatment/recovery plan begins with the assessment incorporated into the patient record and is regularly updated with progress notes.

(i) Minor patients: If the patient is a minor, the treatment/recovery plan must also be developed in consultation with the patient's parent or guardian unless the minor is being treated without parental consent as authorized by Mental Hygiene Law section 22.11.

(ii) Immediate transfer: For patients moving directly from one program to another, the existing treatment/recovery plan may be used if there is documentation that it has been reviewed and, if necessary, updated **to reflect patient goals as appropriate**[~~within fourteen (14) days of transfer~~].

(2) The treatment**/recovery** plan must:

(i) include the assessment, which identifies each diagnosis for which the patient is being treated;

(ii) be incorporated into the patient record through regular progress notes, including initial services to be offered prior to completion of the initial assessment;

(iii) address patient goals as identified through the assessment process and regularly updated as needed through progress notes;

(iv) identify a single member of the clinical staff responsible for coordinating and managing the patient's treatment who shall approve and sign (physical or electronic signature) such plan;

(v) [~~include~~] **reference to** any significant medical and psychiatric issues**, including all medications, by acknowledging review of medical/psychiatric assessment and progress notes, as well as coordination with mental and psychiatric providers** [~~identified as part of the assessment process and updated mediations as issued by the appropriate medical staff~~]; and

(vi) be reviewed and approved by the clinical staff person responsible for developing the plan, the patient and the clinical supervisor.

(i) Continuing review of treatment/recovery plans. The treatment/recovery plan must be reviewed through the ongoing assessment process and regular progress notes. [~~New and revised goals should be documented within progress notes and reviewed within the clinical supervision process. Reviews should occur more frequently when a patient is not responding to treatment as planned or if a significant incident occurs.~~]

(j) Progress Notes. Progress notes are intended to document the patient's clinical status. Service delivery should be documented in the patient record through regular progress notes that include, unless otherwise indicated, the type, content, duration and outcome of each service delivered to or on behalf of a patient, described and verified as follows:

(1) be written and signed (physical or electronic signature) by the staff member providing the service;

(2) indicate the date the service was delivered;

(3) record the relationship to the patient's developing treatment goals described in the treatment/recovery plan; and

(4) include, **as appropriate and relevant,** any recommendations, communications, or determinations for initial, continued or revised patient goals and/or treatment.

(k) The program's multidisciplinary team, as defined in Part 800 of this Title, shall meet on a regularly scheduled basis for the purpose of reviewing a sample of cases for the purpose of clinical monitoring of practice. This meeting shall be documented as to date, attendance, cases reviewed and recommendations.

(l) Pregnancies. Treatment/recovery plans must include provisions for pre-natal care for all patients who are pregnant or become pregnant. If a pregnant patient refuses or fails to obtain such care, the provider must have the patient acknowledge in writing that pre-natal care was offered, recommended, and refused. The program should also offer to develop a plan of safe care with the patient and anyone identified by the patient, such offer should be noted in the patient record.

(m) Communicable disease. Treatment/recovery plans must include provisions for the prevention, care and treatment of HIV/AIDS, viral hepatitis, tuberculosis and/or sexually transmitted diseases when present. If a patient refuses to obtain such care, the provider must have the patient acknowledge in writing that such care was offered, recommended, and refused.

(n) Transfers. If patients are transferred between a SUD outpatient program and outpatient rehabilitation services within the same provider, a single patient record may be maintained provided that it includes clinical justification for the transfer, the effective date of the transfer and a revised treatment/recovery plan, if necessary, signed (physical or electronic signature) by a clinical staff member and their supervisor.

(o) Confidentiality. Patient records maintained by the program are confidential and may only be disclosed consistent with the Health Insurance Portability and Accountability Act (HIPAA) and the federal regulations governing the confidentiality of patients' records as set forth in 42 CFR Part 2 and other applicable law.

(p) Records retention. Patient records must be retained for six (6) years after the date of discharge or last contact, or three (3) years after the patient reaches the age of eighteen, whichever time period is longer.

(q) Patient deaths. If a patient dies while in active treatment any known details must be documented in the patient record.

(r) Transition or discharge criteria. (1) Patients having no contact or intent to continue accessing services from a program should be discharged after a period not exceeding sixty (60) days unless reason for continuing treatment past that period is identified and documented in the patient record.

(2) Individuals entering treatment should progress by meeting treatment milestones including: stabilization; engagement; goal setting; and attainment of patient-centered goals. Individuals should be considered for transitions to the community or another level of care once

they have stabilized and attained the support necessary to support their goals. If an individual leaving treatment expresses a preference for a level of care or services that preference should be included in the patient record.

(3) Individuals who are discharged involuntarily must be discharged consistent with Part 815 of this Title.

(4) Transition plan.

(i) A transition plan must be developed in collaboration with the patient and any collateral person(s) the patient chooses to involve. Such plan shall specify needed referrals with appointment dates and times, all known medications (including frequency and dosage) and recommendations for continued care.

(ii) If the patient is a minor, the plan must also be developed in consultation with their parent or guardian, unless the minor is being treated without parental consent as authorized by Mental Hygiene Law section 22.11; information pertaining to the testing and treatment of sexually transmitted diseases cannot be shared with the minor patient's parent or guardian without the patient's consent, in accordance with applicable laws and regulations.

(5) No patient may be discharged without a plan which has been previously reviewed and approved by a clinical staff member and the clinical supervisor. This requirement does not apply to patients who stop attending, or otherwise fail to cooperate, or refuse continuing care or OBOT planning. That portion of the transition plan which includes referrals for continuing care must be given to the patient prior to leaving the program. The patient, and their family/significant other(s), shall be offered [~~naloxone~~] **overdose prevention** education and training, and a naloxone kit or prescription.

(s) Continuing Care. Individuals may be admitted to continuing care when they require a less intensive amount of support and services and there is a documented clinical need for ongoing clinical support to maintain gains made in treatment.

(1) The purpose of continuing care is to provide ongoing disease management services including management of life stressors, urges and cravings, mood and interpersonal relationships and to maintain gains made in treatment.

(2) Individuals in continuing care may receive counseling or peer services, rehabilitative support services including case management and medication management services as needed.

(3) [~~Persons receiving opioid full agonist medication treatment~~] **Patients receiving OTP services** are not appropriate for continuing care as defined herein.

822.9 Additional locations

(a) A certified provider of an outpatient program may operate at one or more additional locations with the approval of the commissioner pursuant to Part 810 of this Title. For purposes of this section, an "additional location" is a provider site providing [~~substance use disorder~~] outpatient **addiction** treatment services which reports to a primary certified program for its operation, administration and supervisory activities.

(b) The provisions of this section shall not apply to certified providers of outpatient rehabilitation services.

(c) Opioid Treatment Programs must comply with federal statutes, regulations and guidance regarding the development of additional locations and are not subject to the provisions of 822.7(f) of this Chapter.

822.10 Additional requirements for substance use disorder outpatient rehabilitation services

(a) These requirements are in addition to those contained in 822.7 of this Chapter and other sections applicable to all programs.

(b) As defined in 822.5 of this Part, outpatient rehabilitation services for individuals with more chronic conditions emphasize development of basic skills in prevocational and vocational competencies, personal care, nutrition, and community competency. The individual must have an inadequate support system and either substantial deficits in interpersonal and functional skills or health care needs requiring attention or monitoring by health care staff. These services are provided in combination with all other clinical services provided by programs. It is expected that services will be provided three to five days per week for at least **two** [~~four~~] hours per day.

(c) Programs must be certified by the Office to provide outpatient rehabilitation services.

(d) Staffing. There must be at least one full-time equivalent counselor or therapist for every 20 patients receiving outpatient rehabilitation services. If volunteers or student interns are used, they may not be counted in the counselor-to-patient ratio. In addition to the staffing required in section 822.7 of this Part, the following additional staff members are required:

(1) at least one half-time therapeutic recreation therapist or occupational therapist or vocational specialist, certified as a rehabilitation counselor or qualified health professional with one year of experience and/or training in providing recreation, occupation and/or rehabilitation services; and

(2) at least one part-time nurse practitioner, registered physician's assistant, or registered nurse, or a licensed practical nurse supervised by a registered nurse employed by the governing authority.

(e) If a program is providing outpatient rehabilitation services, the following services must be available either directly or through written agreements:

(1) socialization development;

(2) skill development in accessing community services;

(3) activity therapies; and

(4) information and education about nutritional requirements, including but not limited to planning, food purchasing, preparation and clean-up.

(f) A provider of outpatient rehabilitation services must assure the availability of one meal to each patient who receives outpatient rehabilitation services.

822.11 Additional requirements for opioid treatment programs

(a) Central registry system. Each such program must participate in the central registry system established and maintained by the Office to prevent a patient’s simultaneous enrollment in more than one such program and ensure accurate dispensing of medication in accordance with federal regulations. Each such program must:

(1) initiate a clearance inquiry to the central registry system by submitting all required information prior to admitting a patient;

(2) report all admissions, transfers, and discharges immediately to the central registry system;

(3) verify with the central registry system that the prospective patient is not presently enrolled in another such program and this verification must be documented in the clinical record; a program may not admit an applicant who is participating in another such program; and

(4) report any other information deemed necessary by the Office to comply with state and federal laws and regulations.

(b) Medication administration. (1) A physician must determine a patient's initial medication dose and schedule of administration and document such orders in the patient's record. Another designated practitioner, such as a nurse practitioner or physician's assistant may determine a patient's initial medication dose and schedule of administration if a federal waiver has been approved.

(2) A prescribing professional may report such orders to the registered or licensed medical personnel supervising medication administration; any subsequent change in approved medications, dose or schedule must similarly be reported to the pharmacy or to the medical staff and documented in the record before administration. The prescribing professional may issue verbal orders in emergencies only and must document such orders in writing within seventy-two (72) hours.

(3) Patients must be properly stabilized with a therapeutic dose of approved medications; a therapeutic dose means an amount sufficient to maintain comfort for at least twenty-four (24) hours, alleviate opioid craving and stop continued opioid use. [~~To assure effectiveness, measuring plasma levels and/or administering split medication doses, and/or conducting psychiatric evaluations may be considered as clinically indicated.~~] Split medication doses require prior Office approval. [~~Tests for plasma levels must be taken prior to a request to the Office for split dosing.~~]

(4) If any medical staff member observes any condition or behavior on the part of a patient that may contraindicate a regularly scheduled dose of medication, such staff member must contact the prescribing professional immediately and advise of the patient's condition which may warrant an approved medication delay, withholding or adjustment. The prescribing professional must:

(i) approve any medication delay, withholding or adjustment; and

(ii) provide follow up consistent with emergency verbal orders as otherwise required by this section.

(c) Unsupervised or take-home medication. (1) Each patient must be on a visit schedule that is most appropriate to clinical need, conducive to treatment progress, and supportive of rehabilitation. A prescribing professional may reduce a patient's visit schedule, when clinically indicated, to accommodate patient changes in need, progress, or rehabilitation.

(2) Each patient's take-home schedule must comply with the federal regulatory time in treatment requirements (42 CFR Part 8.12), unless there is a clinical justification that takes into consideration the federal eight (8) point criteria, as to why the person is not stable enough to be granted the applicable take home schedule. **The Medical Director** [~~A physician~~] must review and confirm the appropriateness for take-home medication.

(3) Any patient may receive a single take-home dose for a day that the clinic is closed for business, including Sundays and State and Federal holidays.

(4) Such determinations shall be documented in the patient's medical record. Time-in-treatment requirements do not apply to buprenorphine take-home medication per federal rules.

(5) No medications shall be dispensed to patients in short-term detoxification treatment or interim maintenance treatment for unsupervised or take-home use.

(6) Notwithstanding the requirements of this subdivision, a provider may require a patient to visit the program when concerned with diversion of medication. When this occurs the patient shall be required to bring in all remaining take-home doses. Remaining doses must match the prescribed schedule.

(7) Holidays. Notwithstanding the requirements of this subdivision, a patient may be provided with extra medication without prior Office approval if the patient's next regular visit falls on a legal or program holiday. Designation of a program holiday that is not a federal holiday must be approved annually by the Office at least thirty (30) days in advance.

(8) Exceptional circumstances. Notwithstanding the requirements of this subdivision, a prescribing professional, based on reasonable clinical judgment, may order up to thirty (30) take-home doses at any one time if a patient is unable to conform to the applicable mandatory schedule requirements due to exceptional circumstances such as illness, personal or family crisis, travel, employment, medical, or hardship, and the prescribing professional determines the patient is also responsible in handling approved medication. Such order shall not be a permanent schedule change. The prescribing professional must immediately document in the patient record the reasons for the order.

(9) Release of medication to designated third party. Program medical staff may release medication to a designated third party other than the patient only when the patient is physically unable to attend the program. The decision to permit such release to a designated third party must be based on the clinical judgment of the prescribing professional and with the consent of

the patient, both of which must be documented in the patient's record. All designated third parties must also receive prior Office approval.

(10) Patients readmitted to a program after an approved voluntary discharge may be granted the same take-home schedule at the time of discharge provided all criteria other than length of treatment are satisfied.

(d) Medication security. (1) Access to controlled substances, including approved medications, shall be limited to authorized persons in accordance with applicable state and federal law. The areas where controlled medication stocks are maintained, dispensed, or administered must be physically separated and secure from patient areas in accordance with applicable state and federal law.

(2) Immediately after administration, drug containers must be purged by rinsing, inversion, or by an acceptable alternative method that must effectively prevent the accumulation of residual medication. Containers used in the program or for take-home medications must be **in child resistant packaging** [~~child/tamper proof~~], may not be reused and must be destroyed. Each program must assure patients' take-home bottles and used containers are disposed of properly. Patients should return take-home bottles before receiving any subsequent take-home medication.

(3) Any theft or loss of approved medications must be immediately reported in accordance with applicable state and federal law.

(e) Residential programs providing opioid full agonist treatment medications. Such a residential program shall:

(1) comply with all applicable requirements of this Part;

(2) comply with all requirements of this Title applicable to substance use disorder residential services;

(3) not dispense take-home medications to any patient; and

(4) include material and schedules for development and review of treatment/recovery plans as required by regulations applicable to substance use disorder residential services, rather than the requirements of this Part.

(f) Opioid taper. (1) MAT is the standard of care for OUD; however an opioid taper may be appropriate in limited clinical situations and upon patient request.

(2) Voluntary Taper. Each program must provide an opioid taper at the program or arrange for taper at another program or in a facility approved to provide tapering as is medically and clinically appropriate:

(i) Patients may request a voluntary taper at any time and may discuss reasons and circumstances with program staff who must provide clinical feedback regarding patient readiness. No reasonable request shall be denied;

(ii) Each program must administer a voluntary taper at a pace tailored to the patient's individual needs, based on clinical judgment, medical evaluation, patient input and feedback at the start of the taper and continuously throughout.

(g) Opioid medical maintenance (OMM). (1) An OMM program requires federal and state approval. Patients admitted to OMM must meet specific criteria including:

(i) four (4) years of continuous treatment in a program providing opioid full agonist treatment;

(ii) three (3) years of no drug abuse including alcohol;

(iii) three (3) years of no criminal involvement;

(iv) three (3) years of continuous gainful employment or productive activity;

(v) three (3) years of emotional stability;

(vi) intent to continue maintenance treatment; and

(vii) verified stability in the Prescription Monitoring Program ("PMP").

(2) The individual patient record for a patient in OMM must be updated at least monthly and toxicology tests and/or a check of the PMP must be conducted as clinically indicated.

(3) The 30-day medication supply may be dispensed in dry tablet form in a single bottle.

(4) An OMM patient must return to a program when, in the prescribing professional's clinical judgment, the patient needs maintenance treatment services.

(5) An OMM program has no Office-certified capacity.

(h) Specialized opioid services. Specialized opioid services are those not defined in this Part and are generally research-oriented in nature. Such specialized services shall be reviewed and approved by the Office prior to implementation and operation in accordance with Office policy, procedures, and requirements.

822.12 Severability

If any provision of this Part or the application thereof to any person or circumstance is held invalid, such invalidity shall not affect other provisions or applications of this Part that can be given effect without the invalid provisions or applications, and to this end the provisions of this Part are declared to be severable

MEDICAL ASSISTANCE FOR CHEMICAL DEPENDENCE SERVICES

(Statutory Authority: Mental Hygiene Law Sections 19.07(e), 19.09(b), 19.40, 32.01, 32.07(a), 43.01, and 43.02; Social Services Law Section 364)

Sec.

841.14 Medical assistance payments for chemical dependence outpatient and opioid treatment programs.

(a) This Section shall govern Medicaid rates of payments for OASAS certified or co-certified ambulatory care services provided in the following categories of facilities:

(1) chemical dependence outpatient clinics certified or co-certified pursuant to Part 822 of this Title;

(2) opioid treatment clinics certified or co-certified pursuant to Part 822 of this Title;

(3) chemical dependence outpatient rehabilitation programs certified or co-certified pursuant to Part 822 of this Title.

(b) Notwithstanding subdivision (a) of this section, the provisions of this Part shall not apply to the following:

(1) hospital based chemical dependence outpatient clinics;

(2) hospital based opioid treatment providers; and

(3) payments made on behalf of persons enrolled in Medicaid managed care or in the family health plus program.

(c) Definitions

As used in this Part, the following definitions apply:

(1) "Ambulatory Patient Group (APG)" shall mean a defined group of outpatient procedures or services which reflect similar patient characteristics and resource utilization and which incorporate the ICD-9-CM diagnosis codes and CPT and HCPCS procedure codes as defined below.

(2) "Ancillary services" shall mean those laboratory and radiology tests and procedures ordered to assist in patient diagnosis and/or treatment.

(3) "APG weight" shall mean a numeric value that reflects the relative expected average resource utilization (cost) for each APG as compared to the expected average utilization for all other

APG's. Procedure-based APG weight shall mean a numeric value that reflects the relative expected average resource utilization (cost) for a specific procedure. A procedure that has been assigned to its own weight shall have its payment derived from its procedure-specific weight without regard to the weight of the APG to which the procedure groups.

(4) "Base rate" shall mean the numeric value that must be multiplied by the APG weight for a given APG to determine the total Medicaid payment for a service.

(5) "Case mix index" shall mean the actual or estimated average final APG weight for a defined group of APG visits.

(6) "Coding Improvement Factor (CIF)" is a numeric value used to adjust for more complete and accurate coding for visits upon implementation of the APG reimbursement system. The CIF will be developed to assure that New York Department of Health is in full compliance with federally approved reimbursement levels.

(7) "Consolidation/Bundling" shall mean the process for determining if a single amount is appropriate in those circumstances when a patient receives multiple APG procedures during a single patient visit. In some cases, a procedure will be considered part of a more complicated procedure. In this case, the payment for the less complicated procedure will be included in the payment for the more complicated procedure and the claim line for the less complicated procedure will show zero payment for that procedure. Consolidation logic is defined in the 3M Health Information Systems' APG Definitions Manual version 3.1 dated March 6, 2008 and as subsequently amended by 3M.

(8) "Current Procedural Terminology (CPT) Codes" is the systemic listing and coding of procedures and services provided to a patient. It is a subset of the Healthcare Procedure Coding System (HCPCS). The CPT and HCPCS are maintained by the American Medical Association and the Federal Centers for Medicare and Medicaid Services (CMS) and are updated annually.

(9) "Discounting" shall mean the reduction in APG payment that results when unrelated, additional procedures or ancillary services are performed during a single patient visit.

(10) "Episode" shall mean a unit of service consisting of all services coded on a claim. All services on the claim are considered to be part of the same APG visit and are not segmented into separate visits based on coded dates of service as would be the case with "visit" billing. Under episode billing, an episode shall consist of all medical visits and/or significant procedures that are provided to a patient on a single date of service plus any ordered ancillaries, ordered on the date of the visit or date of the significant procedure(s), resulting from the medical visits and/or significant procedures, some of which may have been done on a different date of service from that of the medical visits and/or significant procedures. Multiple episodes cannot be coded on the same claim. The

calculation of the APG payment by the APG software may be either visit based or episode-based depending on the rate code used to access the APG software logic. References to "visits" in this Part shall be deemed to refer also to "episodes" for billing purposes.

(11) "Existing Payment for Blend" shall mean the reimbursement rate/fee in effect on June 30, 2011.

(12) "Final APG weight" shall mean the allowed APG weight for a given visit as expressed by the applicable APG software, and as adjusted by all applicable consolidation, packaging, discounting and other applicable adjustments.

(13) "Healthcare common procedure coding system (HCPCS codes)" shall mean a comprehensive, standardized coding and classification system for health services and products.

(14) "Hospital based" shall mean a program that is operated by and certified as a hospital pursuant to Article 28 of the Public Health Law and identified as such by the Department of Health.

(15) "International Classification of Diseases," means the most current version of this comprehensive coding system maintained by the Federal Centers for Medicare and Medicaid Services maintained for the purpose of providing a standardized, universal coding system to identify and describe patient diagnosis, symptoms, complaints, conditions and/or causes of injury or illness. It is updated annually.

(16) "Packaging" shall mean those circumstances in which payment for routine ancillary services or drugs shall be deemed as included in the applicable APG payment for a related significant procedure or medical visit. Medical visits also package with significant procedures, unless specifically excepted in regulation. There is no packaging logic that resides outside the software.

(17) "Peer Group" shall mean a group of providers that share a common APG base rate. Peer groups may be established based on geographic region, types of services provided or categories of patients.

(18) "The Downstate Region" shall consist of the five counties comprising New York City, and the counties of Nassau, Suffolk, Westchester, Rockland, Orange, Putnam, and Dutchess.

(19) "The Upstate Region" shall consist of all counties in the state other than those counties included in the Downstate Region.

(20) "Visit" shall mean a unit of service consisting of all the APG services performed for a patient on a single date of service.

(d) System Transition. There will be a transition to APG reimbursement consisting of a blended payment. For chemical dependence outpatient clinics it will be comprised of an existing payment for blend portion of the fees established pursuant to 18 NYCRR 505.27 and the APG reimbursement

established pursuant to this Part. For opioid treatment clinics it will be comprised of an existing payment for blend portion of the fees established pursuant to 10 NYCRR 86-4.39 and the APG reimbursement established pursuant to this Part. The blended payment will be calculated as follows:

(1) The office shall identify the existing payment for blend payment for each provider based upon the reimbursement rate/fee in effect on June 30, 2011; and

(2) Payments will be made pursuant to the following transition schedule:

(i) Phase 1 shall be the 12-month period beginning on July 1, 2011. Providers shall receive 75% of the existing payment for blend payment and 25% of the calculated value of the APG reimbursement established pursuant to this Part;

(ii) Phase 2 shall be the 12-month period following Phase 1. Providers shall receive 50% of the existing payment for blend payment and 50% of the calculated value of the APG reimbursement established pursuant to this Part;

(iii) Phase 3 shall be the 6 month period following Phase 2. Providers shall receive 25% of the existing payment for blend payment and 75% of the calculated value of the APG reimbursement established pursuant to this Part;

(iv) Phase 4 providers will receive 100% APG reimbursement established pursuant to this Part.

(e) APG Categories and associated weights.

(1) APG categories shall be subject to periodic revision; the most current listing shall be published in the "APG Policy and Medicaid Billing Guidance" manual available on the OASAS website.

(2) The Department of Health, in consultation with the office, shall assign weights associated with all CPT and HCPCS procedure codes which can be used to bill any APG category. The assigned weights shall be set forth at 10 NYCRR Part 86. The office shall maintain and update a list of weights associated with APG categories as published in the "APG Policy and Medicaid Billing Guidance" manual on the OASAS website. Such list may include APG categories not specifically associated with chemical dependency outpatient and opioid treatment services, but which may appropriately be billed by providers subject to this Part.

(f) Base Rates. Base rates for chemical dependence outpatient services shall be developed by the office, and subject to the approval of the Department of Health, in accordance with the following:

(1) Separate base rates shall be established for each peer group as defined in section 841.14 of this Part. Base rates shall reflect differing regional cost factors, variations in patient population and service delivery, and capital reimbursement;

(2) Additional discrete base rates may be developed by the office for such peer groups as may be established by regulation in this Part; and

(3) Base rates may be periodically adjusted to reflect changes in provider case mix, service costs and other factors as determined by the office.

(g) System Updating.

(1) The following elements of the APG rate-setting system shall be reviewed at least annually, with all changes posted on the office's website:

(i) The listing of reimbursable APG categories and associated weights assigned to each such APG set forth in this Part;

(ii) The base rates;

(iii) The applicable ICD-9 codes, or subsequent ICD categorization, utilized in the APG software system;

(iv) The Applicable CPT/HCPCS codes utilized in the APG software system; and

(v) The APG software system.

(h) Medicaid claims.

Medicaid claims may be submitted for claims made under Medicaid fee-for-service for no more than two different services per day for any patient, not including complex care coordination, medication administration and observation, medication management and peer support services.

(i) Billing services.

Billing services include:

(1) Admission assessment services. Admission assessment services consist of three levels of billable services: brief assessment, normative assessment and extended assessment. No more than one admission assessment visit may be billed for any patient per day. No more than three admission assessment visits may be billed for any patient within an episode of care. No single program may bill for more than one extended assessment, under any circumstances, within an episode of care.

(i) Brief assessment – The program must document at least 15 minutes of face-to-face contact with the patient.

(ii) Normative assessment - The program must document at least 30 minutes of face-to-face contact with the patient.

(iii) Extended assessment - The program must document at least 75 minutes of face-to-face contact with the patient.

(2) Brief intervention. No more than one brief intervention may be billed for any patient per day. No single program may bill more than three pre-admission brief intervention services for any patient within an episode of care. The program must document at least 15 minutes of face-to-face contact with the patient.

(3) Brief treatment. No more than one brief treatment may be billed for any patient per day. The program must document at least 15 minutes of face-to-face contact with the patient.

(4) Collateral visit. No more than one collateral visit may be billed for any patient per day. No more than five collateral visits may be billed for any patient within an episode of care. The program must document at least 30 minutes of face-to-face contact with the collateral person. A collateral visit may occur at any time during an episode of care.

(5) Complex care coordination. No more than one complex care service may be billed for any patient per day. No more than three complex care services may be billed for any patient within an episode of care, unless clinical staff document in the treatment/recovery plan that additional complex care services are clinically necessary and appropriate. The program must document at least 45 minutes of services. Service time need not be consecutive. This service must occur within five working days of another program visit that includes a billable service.

(6) Group counseling. No more than one group counseling service may be billed for any patient per day. The program must document at least 60 minutes of face-to-face contact with the patient.

(7) Individual counseling. No more than one individual counseling service may be billed for any patient per day. Individual counseling consists of two billable levels of service: brief individual counseling and normative individual counseling.

(i) Brief individual counseling – The program must document at least 25 minutes of face-to-face contact with the patient.

(ii) Normative individual counseling - The program must document at least 45 minutes of face-to-face contact with the patient.

(8) Intensive outpatient services (IOS). No more than six weeks of IOS may be billed for any patient. However, additional IOS may be provided, if during the final week of scheduled IOS, clinical staff document in the treatment/recovery plan that additional IOS are clinically necessary and appropriate. The program must document a minimum of nine scheduled service hours per week to be provided in increments of at least three hours per day. Where a patient fails to receive a full daily increment of services, a program may bill for delivery of any services defined in Part 822 of this Title.

(9) Medication administration and observation. No more than one medication administration and observation service may be billed for any patient per day. This service may be of any duration. The program must document face-to-face contact with the patient.

(10) Medication management. Medication management consists of three levels of billable services: routine medication management, complex medication management and addiction medication induction. No more than one medication management service may be billed for any patient per day.

(i) Routine medication management -- The program must document at least 10 minutes of services including face-to-face contact with the patient and patient observation.

(ii) Complex medication management – The program must document at least 15 minutes of services including face-to-face contact with the patient and patient observation.

(iii) Addiction Medication Induction – The program must document at least 30 minutes of services including face-to-face contact with the patient and patient observation.

(11) Outpatient rehabilitation services. No more than one outpatient rehabilitation service may be billed for any patient per day. Programs that provide outpatient rehabilitation services may also bill for medication administration and observation, medication management, complex care coordination, peer support services and collateral visits consistent with the standards set forth in this subdivision. Programs may not bill for any other service categories while a patient is admitted to the outpatient rehabilitation service. Outpatient rehabilitation services consist of two billable levels of service: 2-4 hour duration and 4 hour and above duration.

(i) 2-4 hour duration – The program must document at least 2 hours of services but less than 4 hour hours of services.

(ii) 4 hour and above duration -- The program must document at least 4 hours of services.

(12) Peer support service – No more than one peer support service may be billed for any patient per day. No more than five peer support services may be billed for any patient within an episode of care, unless clinical staff document in the treatment/recovery plan that additional peer support services are clinically necessary and appropriate. The program must document at least 30 minutes of face-to-face contact with a patient.

(13) Screening. No more than one screening may be billed for any patient within an episode of care. The program must document at least 15 minutes of face-to-face contact with the patient.

(j) All standards of Medical Assistance reimbursement applicable to chemical dependence outpatient and opioid treatment programs shall be contingent on approval of the state plan amendment

associated with reimbursement of such programs as clinics pursuant to the ambulatory patient group fee methodology and Federal financial participation.

Appendix IV
2020 Title XIX State Plan
Fourth Quarter Amendment
Public Notice

The public is invited to review and comment on this proposed State Plan Amendment, a copy of which will be available for public review on the Department's website at http://www.health.ny.gov/regulations/state_plans/status. Individuals without Internet access may view the State Plan Amendments at any local (county) social services district.

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

New York County
250 Church Street
New York, New York 10018

Queens County, Queens Center
3220 Northern Boulevard
Long Island City, New York 11101

Kings County, Fulton Center
114 Willoughby Street
Brooklyn, New York 11201

Bronx County, Tremont Center
1916 Monterey Avenue
Bronx, New York 10457

Richmond County, Richmond Center
95 Central Avenue, St. George
Staten Island, New York 10301

For further information and to review and comment, please contact: Department of Health, Division of Finance and Rate Setting, 99 Washington Ave., One Commerce Plaza, Suite 1432, Albany, NY 12210, spa_inquiries@health.ny.gov

PUBLIC NOTICE

Department of Health

Pursuant to 42 CFR Section 447.205, the Department of Health hereby gives public notice of the following:

The Department of Health proposes to amend the Title XIX (Medicaid) State Plan for non-institutional services to comply with Title 14 NYCRR Parts 822 and 841 and 42 CFR 440.130(d). The following changes are proposed:

Non-Institutional Services

The COVID emergency SPA covering the NYS Office of Addiction Services and Supports (OASAS) Opioid Treatment Programs (OTPs) ends on January 21, 2021. That SPA permitted billing weekly OTP (Opioid Treatment Programs) bundles under a methodology similar to that of Medicare. Effective on or after January 1, 2021, OASAS proposed to establish those bundled rates as a permanent alternative to the OTP Ambulatory Patient Group (APG) methodology. Each week, for any given patient, the provider must choose to bill under either the APG methodology or the bundled weekly rates, generally based on the amount of face-to-face contact with the patient during that week and the specific services provided.

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

The public is invited to review and comment on this proposed State Plan Amendment, a copy of which will be available for public review on the Department's website at http://www.health.ny.gov/regulations/state_plans/status. Individuals without Internet access may view the State Plan Amendments at any local (county) social services district.

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PUBLIC NOTICE

Town of North Hempstead
Solid Waste Management Authority

Pursuant to Section 120-w of the New York General Municipal Law, the Town of North Hempstead Solid Waste Management Authority hereby gives notice of the following:

On October 8, 2020, the Town of North Hempstead Solid Waste Management Authority awarded a contract to Covanta Sustainable Solutions LLC pursuant to section one hundred twenty-w of the General Municipal Law for the transportation and disposal of solid waste from the North Hempstead Transfer Station, Port Washington, New York. The validity of this contract or the procedures which led to its award may be hereafter contested only by action, suit or proceeding commenced within sixty days after the date of this notice and only upon the ground or grounds that: (1) such award or procedure was not authorized pursuant to that section, or (2) any of the provisions of that section which should be complied with at the date of this publication have not been substantially complied with, or (3) a conflict of interest can be shown in the manner in which the contract was awarded; or by action, suit or proceeding commenced on the grounds that such contract was awarded in violation of the provisions of the Constitution.

PUBLIC NOTICE

Office of Parks, Recreation and Historic Preservation

Pursuant to section 14.07 of the Parks, Recreation and Historic Preservation Law, the Office of Parks, Recreation and Historic Preservation hereby gives notice of the following:

In accordance with subdivision (c) of section 427.4 of title 9 NYCRR notice is hereby given that the New York State Board for Historic Preservation will be considering nomination proposals for listing of properties in the State and National Register of Historic Places at a meeting to be held on Thursday, December 3rd, 2020 at Peebles Island State Park, 1 Delaware Avenue, Cohoes, NY 12047.

The following properties will be considered:

1. Main Street Historic District, Niagara Falls, Niagara County
2. Nassau County Courthouse, Mineola, Nassau County
3. Eagle's Nest, William K. Vanderbilt II Estate Boundary Expansion, Centerport, Suffolk County
4. Brockport West Side Historic District, Brockport, Monroe County
5. St. Stephen's Chapel, Morris, Otsego County
6. Sperry Rand, Ilion, Herkimer County
7. A.M.E. Zion Church of Kingston, Ulster County
8. New York Central & Hudson River Railroad Power Station, Westchester County
9. Wethersfield, Dutchess County
10. Harder Mill, Rensselaer, Rensselaer County

The public is invited to review and comment on this proposed State Plan Amendment, a copy of which will be available for public review on the Department's website at http://www.health.ny.gov/regulations/state_plans/status. Individuals without Internet access may view the State Plan Amendments at any local (county) social services district.

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For further information and to review and comment, please contact: Department of Health, Division of Finance and Rate Setting, 99 Washington Ave., One Commerce Plaza, Suite 1432, Albany, NY 12210, spa_inquiries@health.ny.gov

PUBLIC NOTICE

Department of Health

Pursuant to 42 CFR Section 447.57, the Department of Health hereby gives public notice of the following:

The Department of Health proposes to amend the Title XIX (Medicaid) State Plan for non-institutional services to comply with Section 367-a(6)(c)(iii) of Social Services Law. The following changes are proposed:

Non-Institutional Services:

Effective on or after January 1, 2021, this notice proposes to correct SPA 17-0029 regarding copayment for preferred brand-name prescription drugs that are not part of the Brand Less Than Generic Program, consistent with the March 29, 2017 Federal Public Notice regarding pharmacy copayments. Specifically,

• The co-pay for preferred brand-name prescription drugs will be corrected to change the copayment from $1.00 to $2.50, provided, however, that the copayments for brand name prescriptions drugs in the Fee-for-Service Brand Less Than Generic program will continue to be $1.00.

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

The public is invited to review and comment on this proposed State Plan Amendment, a copy of which will be available for public review on the Department's website at http://www.health.ny.gov/regulations/state_plans/status. Individuals without Internet access may view the State Plan Amendments at any local (county) social services district.

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For further information and to review and comment, please contact: Department of Health, Division of Finance and Rate Setting, 99 Washington Ave., One Commerce Plaza, Suite 1432, Albany, NY 12210, spa_inquiries@health.ny.gov

PUBLIC NOTICE

Department of Health

Pursuant to 42 CFR Section 447.205, the Department of Health hereby gives public notice of the following:

The Department of Health proposes to amend the Title XIX (Medicaid) State Plan for non-institutional services to comply with Title 14 NYCRR Parts 822 and 841 and 42 CFR 440.130(d). The following changes are proposed:

Non-Institutional Services

The COVID emergency SPA covering the NYS Office of Addiction Services and Supports (OASAS) Opioid Treatment Programs (OTPs) ends on January 21, 2021. That SPA permitted billing weekly OTP (Opioid Treatment Programs) bundles under a methodology similar to that of Medicare. Effective on or after January 1, 2021, OASAS proposed to establish those bundled rates as a permanent alternative to the OTP Ambulatory Patient Group (APG) methodology. Each week, for any given patient, the provider must choose to bill under either the APG methodology or the bundled weekly rates, generally based on the amount of face-to-face contact with the patient during that week and the specific services provided.

The following is a clarification to the October 28, 2020 noticed already provided. There will be a small savings in fee-for-service Medicaid associated with this initiative of approximately ($920,000) per year (all shares). The estimated annual net aggregate decrease in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2020/2021 is ($230,000).

The public is invited to review and comment on this proposed State Plan Amendment, a copy of which will be available for public review on the Department's website at http://www.health.ny.gov/regulations/state_plans/status. Individuals without Internet access may view the State Plan Amendments at any local (county) social services district.

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PUBLIC NOTICE

Department of Health

Pursuant to 42 CFR Section 447.205, the Department of Health hereby gives public notice of the following:

The Department of Health proposes to amend the Title XIX (Medicaid) State Plan for non-institutional services to comply with S.7506-B & A.9506-B, Part LL, § 3. The following changes are proposed:

Effective on or after January 22, 2021, and subject to Federal financial participation, a supplemental reimbursement program for publicly owned or operated Medicaid enrolled ground emergency medical transportation (ambulance) providers would be established or transitioned from one approved under emergency State Plan Amendment authority. Medicaid enrolled publicly owned or operated ground emergency medical transportation (ambulance) providers are currently reimbursed on a fee-for-service basis, but at a rate that is far less than the actual cost of providing these services. This proposed amendment is intended to help bridge that fiscal gap. Providers participating in the inpatient supplemental reimbursement program will no longer be reimbursed through the inpatient rates as a non-comparable add-on to the acute per discharge rate.

The additional estimated annual change to gross Medicaid expenditures as a result of this proposed amendment is estimated to be $175M. This proposed amendment presents a potential savings to local governments, counties; cities; towns; or villages, which own or operate ground emergency medical transportation (ambulance) services, and which voluntarily choose to participate.

The public is invited to review and comment on this proposed State Plan Amendment, a copy of which will be available for public review on the Department's website at http://www.health.ny.gov/regulations/state_plans/status. Individuals without Internet access may view the State Plan Amendments at any local (county) social services district.

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PUBLIC NOTICE

Department of State
Program Change

STATEWIDE — Pursuant to 15 CFR 923, the New York State Department of State (DOS) hereby gives notice that the National Oceanic and Atmospheric Administration's Office for Coastal Management (OCM) concurred on December 8, 2020 on the incorporation of the Village of Alexandria Bay and Town of Alexandria Local Waterfront Revitalization Program (LWRP) into New York State's Coastal Management Program as a Program Change. As of December 8, 2020, the enforceable policies identified in the Table of Approved Changes below shall be applicable in reviewing federal actions pursuant to the federal consistency requirements of the Coastal Zone Management Act (CZMA) and its implementing regulations found at 15 CFR part 930. DOS requested OCM's concurrence on this action on October 14, 2020, in a previous notice in the New York State Register, which further described the content of the action.

The Village of Alexandria Bay and Town of Alexandria LWRP was prepared in partnership with DOS and in accordance with the New York State Waterfront Revitalization of Coastal Areas and Inland Waterways Act and the New York State Coastal Management Program. The LWRP is a long-term management program for the waterfront resources of the Village and Town along the St. Lawrence River and Otter Creek and is based on the policies of the New York State Coastal Management Program. The Village of Alexandria Bay and Town of Alexandria LWRP provides a detailed inventory and analysis of natural, historic and cultural resources in the Local Waterfront Revitalization Area in the Village and Town, describes existing land and water uses, harbor management, and important economic activities, presents issues and opportunities for future development, and contains enforceable polices to be used for CZMA consistency review purposes.

Pursuant to the New York State Coastal Management Program and Article 42 of the New York State Executive Law, the Village of Alexandria Bay and Town of Alexandria LWRP was adopted by resolution by the Village of Alexandria Bay Board of Trustees on May 8, 2018 and by the Town of Alexandria Town Board on September 19, 2018 and approved by the New York State Secretary of State on January 6, 2020.

OCM's concurrence includes the following list of changes and qualifications:

Table of Approved Changes

Legal citation	Title of policy, section, or other descriptor	Is the change new, revised, or deleted	Date effective in state	Enforceable policy	Enforceable mechanism citation
Not applicable	Village of Alexandria Bay and Town of Alexandria Joint Local Waterfront Revitalization Program (LWRP)	Revised	01/06/2020	Yes (Section III only)	Executive Law, Article 42

Qualifications

As with previous approval of NY CMP LWRPs, the enforceable provisions of Section III are only the stated policies and sub-policies. The enforceable policies do not include the explanatory text that accompanies each policy. While the explanatory text may be advisory as to how activities can show consistency with the LWRP policies, the State may not use the explanatory text as a basis for issuing an objection under its CZMA authority. Please also note that for the review of federal actions pursuant to the CZMA, the requirements of the statute and implementing regulations at 15 CFR part 930 are controlling over any conflicting interpretation of the discussion of the CZMA federal consistency requirements within the Village of Alexandria Bay and Town of Alexandria LWRP.

As a standard qualification applying to all program changes, states

Appendix V
2020 Title XIX State Plan
Fourth Quarter Amendment
Responses to Standard Funding Questions

NON-INSTITUTIONAL SERVICES
State Plan Amendment #21-0005

CMS Standard Funding Questions

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

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

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

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

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

   The source of the appropriation is the Medicaid General Fund Local Assistance Account, which is part of the Global Cap. The Global Cap is funded by General Fund and HCRA resources.

   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: For hospital-based outpatient clinics: The 2021 Outpatient UPL has not been submitted to CMS for review.

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

   Response: These fees for hospital and freestanding OASAS clinics are benchmarked to similar Medicare fees, but either equal to or lower than the comparable Medicare fees. They are also lower than the already approved APG methodology to which these are an alternative.

ACA Assurances:

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

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

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

2. **Section 1905(y) and (z) of the Act provides for increased FMAPs for expenditures made on or after January 1, 2014 for individuals determined eligible under section 1902(a)(10)(A)(i)(VIII) of the Act. Under section 1905(cc) of the Act, the increased FMAP under sections 1905(y) and (z) would not be available for States that require local political subdivisions to contribute amounts toward the non-Federal share of the State's expenditures at a greater percentage than would have been required on December 31, 2009.**

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

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

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

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

Tribal Assurance:

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

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

a) **Please describe the process the State uses to seek advice on a regular ongoing basis from federally recognized tribes Indian Health Programs and Urban Indian Organizations on matters related to Medicaid and CHIP programs and for consultation on State Plan Amendments waiver proposals waiver extensions waiver amendments waiver renewals and proposals for demonstration projects prior to submission to CMS.**
b) **Please include information about the frequency inclusiveness and process for seeking such advice.**
c) **Please describe the consultation process that occurred specifically for the development and submission of this State Plan Amendment when it occurred and who was involved.**

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

Appendix VI
2020 Title XIX State Plan
Fourth Quarter Amendment
Responses to Standard Access Questions

APPENDIX VI
NON-INSTITUTIONAL SERVICES
State Plan Amendment # 21-0005

CMS Standard Access Questions - Hospital

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

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

   Response: First, Hospitals are required to meet licensure and certification requirements to ensure providers are qualified to deliver services to Medicaid patients. These requirements as well as other methods and procedures the state has in place to assure efficiency, economy and quality of care are not impacted in any way by the amendment. Second, all licensed hospitals currently participate in the New York State's Medicaid program and are located all across the state so that Medicaid recipients in any geographic area have access to services that are available to the general population in those communities. This amendment seeks to periodically update the weights to accurately pay providers for the service they performed.

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

   Response: The State has various ways to ensure that access levels in the Medicaid program are retained and is currently not aware of any access issues. The State monitors and considers requests in the context of access as they approve/deny changes in services. Finally, providers cannot discriminate based on source of payment.

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

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

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

   Response: This change was discussed in detail with stakeholders including the provider association (COMPA). It was also piloted in the COVID disaster relief SPA with great success. There is no opposition to this proposal.

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

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

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

   Response: The existing reimbursement methodology (APGs) will still be available. There will be no drop in access. In fact, this proposal will increase access for persons unable to go to the program on a daily or near-daily basis.