



## 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

February 11, 2021

Dear Health Clinic Administrator:

Pursuant to our tribal consultation policy, enclosed please find a summary of each proposed amendment to the New York State Plan. We encourage you to review the enclosed information and use the link below to also view the plan pages and Federal Public Notices for each proposal. Please provide any comments or request a personal meeting to discuss the proposed changes within two weeks of the date of this letter.

[https://www.health.ny.gov/regulations/state\\_plans/tribal/](https://www.health.ny.gov/regulations/state_plans/tribal/)

We appreciate the opportunity to share this information with you and if there are any comments or concerns please feel free to contact Regina Deyette, Medicaid State Plan Coordinator, Office of Health Insurance Programs at 518-473-3658.

Sincerely,

/s/

Donna Frescatore  
Medicaid Director  
Office of Health Insurance Programs

Enclosures

cc: Sean Hightower  
US Dept. of Health and Human Services

Nancy Grano  
CMS Native American Contact

Michele Hamel  
NYSDOH American Indian Health Program

**SUMMARY**  
**SPA #20-0069**

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

DRAFT

**Section 7 – General Provisions**

**7.4. Medicaid Disaster Relief for the COVID-19 National Emergency**

On March 13, 2020, the President of the United States issued a proclamation that the COVID-19 outbreak in the United States constitutes a national emergency by the authorities vested in him by the Constitution and the laws of the United States, including sections 201 and 301 of the National Emergencies Act (50 U.S.C. 1601 et seq.), and consistent with section 1135 of the Social Security Act (Act). On March 13, 2020, pursuant to section 1135(b) of the Act, the Secretary of the United States Department of Health and Human Services invoked his authority to waive or modify certain requirements of titles XVIII, XIX, and XXI of the Act as a result of the consequences COVID-19 pandemic, to the extent necessary, as determined by the Centers for Medicare & Medicaid Services (CMS), to ensure that sufficient health care items and services are available to meet the needs of individuals enrolled in the respective programs and to ensure that health care providers that furnish such items and services in good faith, but are unable to comply with one or more of such requirements as a result of the COVID-19 pandemic, may be reimbursed for such items and services and exempted from sanctions for such noncompliance, absent any determination of fraud or abuse. This authority took effect as of 6PM Eastern Standard Time on March 15, 2020, with a retroactive effective date of March 1, 2020. The emergency period will terminate, and waivers will no longer be available, upon termination of the public health emergency, including any extensions.

The State Medicaid agency (agency) seeks to implement the policies and procedures described below, which are different than the policies and procedures otherwise applied under the Medicaid state plan, during the period of the Presidential and Secretarial emergency declarations related to the COVID-19 outbreak (or any renewals thereof), or for any shorter period described below:

*Describe shorter period here.*

NOTE: States may not elect a period longer than the Presidential or Secretarial emergency declaration (or any renewal thereof). States may not propose changes on this template that restrict or limit payment, services, or eligibility, or otherwise burden beneficiaries and providers.

**Request for Waivers under Section 1135**

  X   The agency seeks the following under section 1135(b)(1)(C) and/or section 1135(b)(5) of the Act:

- a.   X   SPA submission requirements – the agency requests modification of the requirement to submit the SPA by March 31, 2020, to obtain a SPA effective date during the first calendar quarter of 2020, pursuant to 42 CFR 430.20.
- b.   X   Public notice requirements – the agency requests waiver of public notice requirements that would otherwise be applicable to this SPA submission. These requirements may include those specified in 42 CFR 440.386 (Alternative Benefit Plans), 42 CFR 447.57(c) (premiums and cost sharing), and 42 CFR 447.205 (public notice of changes in statewide methods and standards for setting payment rates).

- c.  X  Tribal consultation requirements – the agency requests modification of tribal consultation timelines specified in [insert name of state] Medicaid state plan, as described below:

*New York will reduce the tribal consultation to zero days before submission to CMS. Tribal consultation will still be completed and mailed as per guidelines in New York's approved state plan.*

**Section A – Eligibility**

1. \_\_\_\_\_ The agency furnishes medical assistance to the following optional groups of individuals described in section 1902(a)(10)(A)(ii) or 1902(a)(10)(c) of the Act. This may include the new optional group described at section 1902(a)(10)(A)(ii)(XXIII) and 1902(ss) of the Act providing coverage for uninsured individuals.

*Include name of the optional eligibility group and applicable income and resource standard.*

2. \_\_\_\_\_ The agency furnishes medical assistance to the following populations of individuals described in section 1902(a)(10)(A)(ii)(XX) of the Act and 42 CFR 435.218:

- a. \_\_\_\_\_ All individuals who are described in section 1905(a)(10)(A)(ii)(XX)

Income standard: \_\_\_\_\_

-or-

- b. \_\_\_\_\_ Individuals described in the following categorical populations in section 1905(a) of the Act:

\_\_\_\_\_

Income standard: \_\_\_\_\_

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

Less restrictive income methodologies:

\_\_\_\_\_

Less restrictive resource methodologies:

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

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

6. \_\_\_\_ The agency provides for an extension of the reasonable opportunity period for non-citizens declaring to be in a satisfactory immigration status, if the non-citizen is making a good faith effort to resolve any inconsistencies or obtain any necessary documentation, or the agency is unable to complete the verification process within the 90-day reasonable opportunity period due to the disaster or public health emergency.

**Section B – Enrollment**

1. \_\_\_\_ The agency elects to allow hospitals to make presumptive eligibility determinations for the following additional state plan populations, or for populations in an approved section 1115 demonstration, in accordance with section 1902(a)(47)(B) of the Act and 42 CFR 435.1110, provided that the agency has determined that the hospital is capable of making such determinations.

*Please describe the applicable eligibility groups/populations and any changes to reasonable limitations, performance standards or other factors.*

2. \_\_\_\_ The agency designates itself as a qualified entity for purposes of making presumptive eligibility determinations described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L.

*Please describe any limitations related to the populations included or the number of allowable PE periods.*

3.        The agency designates the following entities as qualified entities for purposes of making presumptive eligibility determinations or adds additional populations as described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L. Indicate if any designated entities are permitted to make presumptive eligibility determinations only for specified populations.

*Please describe the designated entities or additional populations and any limitations related to the specified populations or number of allowable PE periods.*

4.        The agency adopts a total of        months (not to exceed 12 months) continuous eligibility for children under age enter age        (not to exceed age 19) regardless of changes in circumstances in accordance with section 1902(e)(12) of the Act and 42 CFR 435.926.
5.        The agency conducts redeterminations of eligibility for individuals excepted from MAGI-based financial methodologies under 42 CFR 435.603(j) once every        months (not to exceed 12 months) in accordance with 42 CFR 435.916(b).
6.        The agency uses the following simplified application(s) to support enrollment in affected areas or for affected individuals (a copy of the simplified application(s) has been submitted to CMS).
- a.        The agency uses a simplified paper application.
  - b.        The agency uses a simplified online application.
  - c.        The simplified paper or online application is made available for use in call-centers or other telephone applications in affected areas.

**Section C – Premiums and Cost Sharing**

1.        The agency suspends deductibles, copayments, coinsurance, and other cost sharing charges as follows:

*Please describe whether the state suspends all cost sharing or suspends only specified deductibles, copayments, coinsurance, or other cost sharing charges for specified items and services or for specified eligibility groups consistent with 42 CFR 447.52(d) or for specified income levels consistent with 42 CFR 447.52(g).*

2.        The agency suspends enrollment fees, premiums and similar charges for:
- a.        All beneficiaries

- b.        The following eligibility groups or categorical populations:

*Please list the applicable eligibility groups or populations.*

3.        The agency allows waiver of payment of the enrollment fee, premiums and similar charges for undue hardship.

*Please specify the standard(s) and/or criteria that the state will use to determine undue hardship.*

**Section D – Benefits**

*Benefits:*

1.        The agency adds the following optional benefits in its state plan (include service descriptions, provider qualifications, and limitations on amount, duration or scope of the benefit):

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

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

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

- a.        The agency assures that these newly added and/or adjusted benefits will be made available to individuals receiving services under ABPs.
- b.        Individuals receiving services under ABPs will not receive these newly added

and/or adjusted benefits, or will only receive the following subset:

*Please describe.*

**Telehealth:**

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

*Please describe.*

**Drug Benefit:**

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

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

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

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

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

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

**Section E – Payments**

Optional benefits described in Section D:

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

- a.        Published fee schedules –  
Effective date (enter date of change): \_\_\_\_\_  
Location (list published location): \_\_\_\_\_
- b.        Other:

*Describe methodology here.*



*Increases to state plan payment methodologies:*

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

- 1) Alternate Level of Care (ALC) Medicaid per diem rates in an acute hospital setting.
- 2) Enhanced Medicaid per diem rates in certain skilled nursing facilities.

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

1) Establish new COVID-19 ALC Medicaid per diem reimbursement rates for ALC hospital stays for patients who meet all of the following criteria: the patient was admitted as an inpatient to the same hospital immediately prior to the ALC stay with COVID-19 as a primary or secondary diagnosis; the patient has been determined appropriate for discharge from the hospital, however, subacute care is medically necessary; the patient continues to test positive for COVID-19 and cannot be discharged or transferred to a nursing home or other setting.

2) Effective January 1, 2021, establish COVID-19 only skilled nursing facilities/physical building which will serve persistent positive nursing home eligible residents who are beyond the infectious period as defined by the Center for Disease Control. Such nursing homes must be able to provide a building which is physically isolated and separate, or stand alone such as there is no air flow between such building and any other building that is not part of the COVID only facility. The facility staff must be dedicated and staff assigned shall have no duties that require entry to any nursing home building outside of the COVID positive only facility. The COVID positive nursing home shall provide daily reports to the Department of Health on current census, planned admissions and planned discharges. Any violations of the terms of the Memorandum of Understanding entered into and between the COVID only nursing home and the New York State Department of Health may result in nursing home facing penalties under any law, rule, or regulation of the Department of Health, including suspension or revocation of its operating certificate. In addition, the COVID only nursing home must comply with any and all new or amended Executive Orders, directives or advisories issued by the New York State Governor or the New York State Department of Health. In addition, the New York State Department of Health reserves the right to require a compliance officer to oversee compliance with all state and federal statutes, regulations and guidance pertaining to nursing home operation including but not limited to infection control.

b. Payments are increased through:

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

1) 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. The current national emergency has exacerbated this fiscal gap, by increasing the operating costs of publicly owned or operated ground emergency medical transportation (ambulance) providers, while simultaneously increasing the public need for the vital services that they provide. This proposed amendment is intended to help bridge this fiscal gap.

Effective April 1, 2020, and throughout the duration of the declared national emergency; subject to Federal financial participation, a supplemental reimbursement program for publicly owned or operated ground emergency medical transportation (ambulance) providers would be established.

Concurrent with the adoption of this amendment, publicly owned or operated ground emergency medical transportation (ambulance) providers, which are 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. This will eliminate the risk overpayments to providers.

Additionally, in accordance with 42 C.F.R. section 433.51, or any successor regulation(s), the claimed expenditures for the ground emergency medical transportation services eligible for federal financial participation, when combined with amounts received from all other sources of reimbursement from the Medicaid program, shall not exceed one hundred percent of the public providers' actual cost of providing ground emergency transportation (ambulance) services.

2) The rate add-on for certain skilled nursing facilities will be provided for those residents who have a positive COVID diagnosis as defined above.

ii. X An increase to rates as described below.

Rates are increased:

2 Uniformly by the following percentage: 50%

     Through a modification to published fee schedules –

Effective date (enter date of change): \_\_\_\_\_

Location (list published location): \_\_\_\_\_

     Up to the Medicare payments for equivalent services.

1 By the following factors:

Six mutually exclusive COVID-19 ALC Medicaid per diem rates will be established for COVID-19 ALC patient days as shown below. These new ALC rates will vary based on geographic location of the patient and whether the patient is on a ventilator and/or is receiving dialysis. Hospitals will be required to test patients in COVID-19 ALC stays twice a week. The COVID-19 ALC Medicaid per diem rates will be paid for each ALC day in the hospital until the day following the day on which the first negative COVID-19 test results are available to the hospital. After such time, should the patient remain in an ALC stay, the per diem rates shall revert to the current lower ALC per diem rates under the previously approved State Plan Amendment.

	<b>Non-Ventilator Dependent</b>	<b>Ventilator Dependent</b>	<b>Ventilator w Dialysis</b>
Upstate	\$657.84	\$955.63	\$1,066.72
Downstate	\$859.23	\$1,212.25	\$1,353.34

*Payment for services delivered via telehealth:*

3.  For the duration of the emergency, the state authorizes payments for telehealth services that:
- a.  Are not otherwise paid under the Medicaid state plan;
  - b.  Differ from payments for the same services when provided face to face;
  - c.  Differ from current state plan provisions governing reimbursement for telehealth;

*Describe telehealth payment variation.*

- d.  Include payment for ancillary costs associated with the delivery of covered services via telehealth, (if applicable), as follows:
  - i.  Ancillary cost associated with the originating site for telehealth is incorporated into fee-for-service rates.
  - ii.  Ancillary cost associated with the originating site for telehealth is separately reimbursed as an administrative cost by the state when a Medicaid service is delivered.

*Other:*

4.  Other payment changes:

*Please describe*

**Section F – Post-Eligibility Treatment of Income**

1. \_\_\_ The state elects to modify the basic personal needs allowance for institutionalized individuals. The basic personal needs allowance is equal to one of the following amounts:
  - a. \_\_\_ The individual’s total income
  - b. \_\_\_ 300 percent of the SSI federal benefit rate
  - c. \_\_\_ Other reasonable amount: \_\_\_\_\_
  
2. \_\_\_ The state elects a new variance to the basic personal needs allowance. (Note: Election of this option is not dependent on a state electing the option described the option in F.1. above.)

The state protects amounts exceeding the basic personal needs allowance for individuals who have the following greater personal needs:

*Please describe the group or groups of individuals with greater needs and the amount(s) protected for each group or groups.*

**Section G – Other Policies and Procedures Differing from Approved Medicaid State Plan /Additional Information**

**PRA Disclosure Statement**

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