NEW YORK STATE OF OPPORTUNITY. Department of Health

ANDREW M. CUOMO
Governor

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

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

September 10, 2018

Mr. Ray Halbritter
Nation Representative
Oneida Indian Nation
528 Patrick Road
Verona, NY 13478

Dear: Mr. Halbritter

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/

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: Karina Aguilar
US Dept. of Health and Human Services

Regina Bryde
NYSDOH American Indian Health Program

NEW YORK STATE OF OPPORTUNITY. Department of Health

ANDREW M. CUOMO
Governor

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

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

September 10, 2018

Chief Sidney Hill
Onondaga Nation Territory –
Administration
Hemlock Road, Box 319-B
Nedrow, NY 13120

Dear: Chief Hill

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.

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Medicaid Director
Office of Health Insurance Programs

Enclosures

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US Dept. of Health and Human Services

Regina Bryde
NYSDOH American Indian Health Program

NEW YORK STATE OF OPPORTUNITY. Department of Health

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

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

September 10, 2018

Bryan Polite
Council of Trustees Chairman
Shinnecock Indian Nation Tribal Office
P.O. Box 5006
Southampton, NY 11969-5006

Dear: Mr. Polite

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.

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Medicaid Director
Office of Health Insurance Programs

Enclosures

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US Dept. of Health and Human Services

Regina Bryde
NYSDOH American Indian Health Program

NEW YORK STATE OF OPPORTUNITY. Department of Health

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Governor

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

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

September 10, 2018

Tonawanda Seneca Indian Nation
Chief Roger Hill, Council Chairman
Administration Office
7027 Meadville Road
Basom, NY 14013

Dear: Chief Hill

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Sincerely,

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Medicaid Director
Office of Health Insurance Programs

Enclosures

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US Dept. of Health and Human Services

Regina Bryde
NYSDOH American Indian Health Program

NEW YORK STATE OF OPPORTUNITY. Department of Health

ANDREW M. CUOMO
Governor

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

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

September 10, 2018

Tuscarora Indian Nation
Chief Leo Henry, Clerk
2006 Mount Hope Road
Lewiston, NY 14092

Dear: Chief Henry

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.

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Sincerely,

/s/

Donna Frescatore
Medicaid Director
Office of Health Insurance Programs

Enclosures

cc: Karina Aguilar
US Dept. of Health and Human Services

Regina Bryde
NYSDOH American Indian Health Program

NEW YORK STATE OF OPPORTUNITY. Department of Health

ANDREW M. CUOMO
Governor

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

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

September 10, 2018

Tuscarora Indian Nation
Chief Kenneth Patterson
1967 Upper Mountain Road
Lewiston, NY 14092

Dear: Chief Patterson

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.

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Sincerely,

/s/

Donna Frescatore
Medicaid Director
Office of Health Insurance Programs

Enclosures

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US Dept. of Health and Human Services

Regina Bryde
NYSDOH American Indian Health Program

NEW YORK STATE OF OPPORTUNITY. Department of Health

ANDREW M. CUOMO
Governor

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

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

September 10, 2018

Unkechaug Indian Territory
Chief Harry Wallace
207 Poospatuck Lane
Mastic, NY 11950

Dear: Chief Wallace

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.

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Sincerely,

/s/

Donna Frescatore
Medicaid Director
Office of Health Insurance Programs

Enclosures

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US Dept. of Health and Human Services

Regina Bryde
NYSDOH American Indian Health Program

NEW YORK STATE OF OPPORTUNITY. Department of Health

ANDREW M. CUOMO
Governor

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

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

September 10, 2018

Cayuga Nation
Mr. Clinton Halftown
Nation Representative
P.O. Box 803
Seneca Falls, NY 13148

Dear: Mr. Halftown

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.

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Sincerely,

/s/

Donna Frescatore
Medicaid Director
Office of Health Insurance Programs

Enclosures

cc: Karina Aguilar
US Dept. of Health and Human Services

Regina Bryde
NYSDOH American Indian Health Program

NEW YORK STATE OF OPPORTUNITY. Department of Health

ANDREW M. CUOMO
Governor

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

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

September 10, 2018

Saint Regis Mohawk Tribe
Chief Ronald Lafrance, Jr.
412 State Route 37
Akwesasne, NY 13655

Dear: Chief Lafrance

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.

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Sincerely,

/s/

Donna Frescatore
Medicaid Director
Office of Health Insurance Programs

Enclosures

cc: Karina Aguilar
US Dept. of Health and Human Services

Regina Bryde
NYSDOH American Indian Health Program

NEW YORK STATE OF OPPORTUNITY. Department of Health

ANDREW M. CUOMO
Governor

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

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

September 10, 2018

St. Regis Mohawk Tribe
Chief Beverly Cook
412 State Route 37
Akwesasne, NY 13655

Dear: Chief Cook

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Sincerely,

/s/

Donna Frescatore
Medicaid Director
Office of Health Insurance Programs

Enclosures

cc: Karina Aguilar
US Dept. of Health and Human Services

Regina Bryde
NYSDOH American Indian Health Program

NEW YORK STATE OF OPPORTUNITY. Department of Health

ANDREW M. CUOMO
Governor

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

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

September 10, 2018

Saint Regis Mohawk Tribe
Chief Eric Thompson
412 State Route 37
Akwesasne, NY 13655

Dear: Chief Thompson

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Sincerely,

/s/

Donna Frescatore
Medicaid Director
Office of Health Insurance Programs

Enclosures

cc: Karina Aguilar
US Dept. of Health and Human Services

Regina Bryde
NYSDOH American Indian Health Program

NEW YORK STATE OF OPPORTUNITY. Department of Health

ANDREW M. CUOMO
Governor

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

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

September 10, 2018

Unkechaug Indian Territory
Latasha Austin
Keeper of Records
P.O. 86
Mastic, NY 11950

Dear: Ms. Austin

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.

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Sincerely,

/s/

Donna Frescatore
Medicaid Director
Office of Health Insurance Programs

Enclosures

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US Dept. of Health and Human Services

Regina Bryde
NYSDOH American Indian Health Program

NEW YORK STATE OF OPPORTUNITY. Department of Health

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

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

September 10, 2018

Eugene E. Cuffee II
Sachem
Shinnecock Indian Nation Tribal Office
P.O. Box 5006
Southampton, NY 11969-5006

Dear: Mr. Cuffee

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.

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Sincerely,

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Medicaid Director
Office of Health Insurance Programs

Enclosures

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US Dept. of Health and Human Services

Regina Bryde
NYSDOH American Indian Health Program

NEW YORK STATE OF OPPORTUNITY. Department of Health

ANDREW M. CUOMO
Governor

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

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

September 10, 2018

Cayuga Nation
Tim Twoguns
Nation Representative
P.O. Box 803
Seneca Falls, NY 13148

Dear: Mr. Twoguns

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.

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Sincerely,

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Medicaid Director
Office of Health Insurance Programs

Enclosures

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US Dept. of Health and Human Services

Regina Bryde
NYSDOH American Indian Health Program

NEW YORK STATE OF OPPORTUNITY. Department of Health

ANDREW M. CUOMO
Governor

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

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

September 10, 2018

Cayuga Nation
Gary Wheeler
Nation Representative
P.O. Box 803
Seneca Falls, NY 13148

Dear: Mr. Wheeler

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Sincerely,

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Medicaid Director
Office of Health Insurance Programs

Enclosures

cc: Karina Aguilar
US Dept. of Health and Human Services

Regina Bryde
NYSDOH American Indian Health Program

NEW YORK STATE OF OPPORTUNITY. Department of Health

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

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

September 10, 2018

Seneca Nation of Indians
Maurice A. John Sr.
President
P.O. Box 231
Salamanca, NY 14779

Dear: Mr. John Sr.

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.

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NYSDOH American Indian Health Program

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

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

September 10, 2018

American Indian Community House
Ben Geboe
Interim Executive Director
39 Eldridge Street, 4th Floor
New York, NY 10002

Dear: Mr. Geboe

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.

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Sincerely,

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Donna Frescatore
Medicaid Director
Office of Health Insurance Programs

Enclosures

cc: Karina Aguilar
US Dept. of Health and Human Services

Regina Bryde
NYSDOH American Indian Health Program

SUMMARY
SPA #18-0017

This State Plan Amendment proposes to update the language for Target Group G, Medicaid enrolled clients who are served by the New York State Early Intervention Program and who are infants or toddlers from birth through age two years having or suspected of having a developmental delay or a diagnosed physical or mental condition that has a high probability of resulting in a developmental delay; have been referred to the NYS Early Intervention Program as defined in Public Health Law Title II-A of Article 25 and set forth in 10 NYCRR section 69.3 to obtain screening or a multidisciplinary evaluation to determine the need for ongoing services; and are in need of ongoing and comprehensive rather than incidental case management. The language addresses Medicaid's responsibility regarding developing Individualized Family Service Plans and includes language that documents how providers will maintain records for individuals receiving case management. In addition, the State Plan Amendment proposes to change the payment methodology for service coordination services from an hourly rate billed in fifteen minute increments to fixed rates for initial case management (service coordination) and per member per month rates for ongoing case management (service coordination) services to be established by the New York State Department of Health and approved by the Division of Budget.

ATTACHMENT A – Full Pages Being Replaced

ATTACHMENT 3.1-A SUPPLEMENT 1

Bracketed pages for full replacement:
1-G1, 1-G2, 1-G3, 1-G4, 1-G5, 1-G6, 1-G7, 1-G8, 1-G9

State Plan under Title XIX of the Social Security Act
State/Territory: New York State

TARGETED CASE MANAGEMENT SERVICES
Infants, Toddlers and Families in the New York State Early Intervention Program

Target Group G: Early Intervention Services

Medicaid enrollees who are served by the New York State Early Intervention Program because they:

- are infants or toddlers from birth through age two years who have or are suspected of having a developmental delay or a diagnosed physical or mental condition that has a high probability of resulting in a developmental delay;
- have been referred to the NYS Early Intervention Program as defined in Public Health Law Title II-A of Article 25 and set forth in 10 NYCRR section 69-4.3 to obtain screening or a multidisciplinary evaluation to determine the need for ongoing services; and
- are in need of ongoing and comprehensive rather than incidental case management.

Developmental delay means that a child has not attained developmental milestones expected for the child's chronological age, as measured by qualified professionals (a multidisciplinary team) using appropriate diagnostic instruments and/or procedures and informed clinical opinion, in one or more of the following areas of development: cognitive, physical (including vision and hearing), communication, social/emotional, or adaptive development. A developmental delay is a delay that has been documented as:

- a twelve month delay in one functional area, or,
- a 33% delay in one functional area or 25% delay in each of the two areas, or;
- if appropriate standardized instruments are individually administered in the approval process, a score of at least 2.0 standard deviations below the mean in one functional area or a score of at least 1.5 standard deviations below the mean in each of two functional areas, or;
- for children who have been found to have a delay only in the communication domain, a score of 2.0 standard deviations below the mean in the area of communication or, if no standardized test is available or appropriate for the child, or the tests are inadequate to accurately represent the child's developmental level in the informed clinical opinion of the evaluator, a delay in the area of communication shall be a severe delay or marked regression in communication development as determined by specific qualitative evidence-based criteria articulated in relevant clinical practice guidelines.

If because of a child's age, condition or type of diagnostic instruments available in specific domains, a standardized score is either inappropriate or cannot be determined, informed clinical opinion of the multidisciplinary team may be used as one factor to establish the child's eligibility. In addition, criteria such as functional status, recent rate of change in development, prognosis for change in the future based on anticipated medical/health factors and other factors relevant to the needs of the child and family shall also be considered.

Continuing need for Early Intervention Program services may be established by a multidisciplinary evaluation based upon the following criteria:

New York
1-G1

[STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

CASE MANAGEMENT SERVICES

A. Target Group: G

See attached.

B. Areas of State in which services will be provided:

[X] Entire State.

[ ] Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than statewide:

C. Comparability of Services

[ ] Services are provided in accordance with section 1902(a)(10)(B) of the Act.

[X] Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

D. Definition of Services:

See attached

E. Qualification of Providers:

See attached]

State Plan under Title XIX of the Social Security Act
State/Territory: New York State

TARGETED CASE MANAGEMENT SERVICES
Infants, Toddlers and Families in the New York State Early Intervention Program

- a delay consistent with the criteria established for initial evaluation as set forth above; or,
- a delay in one or more domains, such that the child's development is not within the normal range expected for his or her chronological age, as documented using clinical procedures, observations, assessments, and informed clinical opinion; or,
- a score of 1.0 standard deviation or greater below the mean in one or more developmental domains; or,
- the continuing presence of a diagnosed physical or mental condition with a high probability of resulting in a developmental delay.

_X_ Target group includes individuals transitioning to a community setting. Case-management services will be made available for up to 180 consecutive days of a covered stay in a medical institution. The target group does not include individuals between ages 22 and 64 who are served in Institutions for Mental Disease or individuals who are inmates of public institutions (State Medicaid Directors Letter (SMDL), July 25, 2000).

Areas of State in which services will be provided (§1915(g)(1) of the Act):
_X_ Entire State
____ Only in the following geographic areas: **[Specify areas]**

Comparability of services (§§1902(a)(10)(B) and 1915(g)(1))
___ Services are provided in accordance with §1902(a)(10)(B) of the Act.
_X_ Services are not comparable in amount duration and scope (§1915(g)(1)).

Definition of services (42 CFR 440.169): Targeted case management services are defined as services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services.

Consistent with Federal regulations at 34 CFR §303.23 and Section 1915 of the Social Security Act, case management services are service coordination services delivered by service coordinators in the New York State Early Intervention Program in a manner that is consistent with the requirements of 34 CFR Part 303 and 10 NYCRR subpart 69.4.

Case management (service coordination) means those initial and ongoing activities performed by Early Intervention Program case managers (service coordinators) to assist Medicaid enrolled infants and toddlers birth through age two years who have, or are suspected of having, a developmental delay or a diagnosed physical or mental condition that has a high probability of resulting in a developmental delay, in gaining access to necessary medical, social, educational and other appropriate services. Case management (service coordination) functions associated with referral include: assisting families in identifying available service providers; securing the services determined in the

New York
1-G2

[A. TARGET POPULATION G

The target group consists of any categorically needy or medically needy eligibles

1. who are infants or toddlers from birth through age two years who have or are suspected of having a developmental delay or a diagnosed physical or mental condition that has a high probability of resulting in developmental delay, such as, Down Syndrome or other chromosome abnormalities, sensory impairments, inborn errors of metabolism, or fetal alcohol syndrome.

2. who have been referred to the municipal early intervention agency and are known to the New York State Department of Health.

3. who are in need of ongoing and comprehensive rather than incidental case management.

Developmental delay means that a child has not attained developmental milestones expected for the child's chronological age, as measured by qualified professionals (a multidisciplinary team) using appropriate diagnostic instruments and/or procedures and informed clinical opinion, in one or more of the following areas of development: cognitive, physical (including vision and hearing), communication, social/emotional, or adaptive development. A developmental delay is a delay that has been documented as:

1. a twelve month delay in one functional area, or

2. a 33% delay in one functional area or a 25% delay in each of two areas, or,

3. if appropriate standardized instruments are individually administered in the evaluation process, a score of at least 2.0 standard deviations below the mean in one functional area or a score of at least 1.5 standards deviations below the mean in each of two functional areas, or

4. if because of a child's age, condition or type of diagnostic instruments available in specific domains, a standardized score is either inappropriate or cannot be determined, a child may be deemed eligible by the informed clinical opinion of the multidisciplinary team. Criteria such as functional status, recent rate of change in development, prognosis for change in the future based on anticipated medical/health factors and other factors relevant to the needs of that child and family shall also be considered.

B. AREAS OF STATE IN WHICH SERVICES WILL BE PROVIDED TO TARGET GROUP G

Entire State]

State Plan under Title XIX of the Social Security Act
State/Territory: New York State

TARGETED CASE MANAGEMENT SERVICES
Infants, Toddlers and Families in the New York State Early Intervention Program

plan to be appropriate through referral to agencies or to persons who are qualified to provide identified services; assisting families with scheduling appointments; resolving problems related to implementation of the IFSP; coordinating the provision of early intervention services and medical, educational, social and other services; and, assisting families in making applications for services and entitlements.

- Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social or other services. These assessment activities include:

  - taking client history;
  - identifying the individual's needs and completing related documentation; and
  - gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual.

Under the Early Intervention Program, this function consists of the initial contact to provide information concerning case management and early intervention to the parent of a Medicaid enrolled child, who is thought to be eligible for early intervention services, at a time and place convenient to the family. The case manager (service coordinator) assesses and documents the medical, educational, social and other service needs of the child, including if the child and family are presently receiving case management services or other services from public or private agencies, and assists the family in identifying the family's priorities, concerns and resources related to the child. The case manager secures (directly, or indirectly through collateral sources, with the family's permission), a determination of the nature and degree of the child's developmental status; assists the parent in arranging for the screening or evaluation after the parent selects an evaluator; coordinates the performance of evaluations and assessments; and, reviews evaluation reports with the family to assist the parent(s) in understanding the results of screenings or evaluations. The case manager assists with the periodic reassessment of the child's needs on an ongoing basis and assists the family in preparing for required six month reviews and annual evaluations of the child's and family's individualized family service plan (IFSP).

- Development (and periodic revision) of a specific care plan that is based on the information collected through the assessment that:

  - specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
  - includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
  - identifies a course of action to respond to the assessed needs of the eligible individual.

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[D. DEFINITION OF CASE MANAGEMENT RELATED TO TARGET GROUP "G"

Case management for Target Group "G" means those initial an ongoing activities performed by case management staff related to ensuring that developmentally delayed infants and toddlers are provided access to services allowing them to:

1. resolve problems which will interfere with their independence or self-sufficiency;

2. resolve problems which will interfere with attainment or maintenance of self support or economic independence;

3. maintain themselves in the community rather than reside in, or return to an institution; or

4. prevent institutionalization from occurring.

Case management is a process which will assist Medicaid eligible infants and toddlers and their families to access necessary medical, social, psychological, educational, financial and other services in accordance with the goals contained in a written individualized family services plan (IFSP).

CASE MANAGEMENT FUNCTIONS

Case Management functions are determined by the recipient's circumstances and therefore must be determined specifically in each case. In no instance will case management include the provision of clinical or treatment services. A separate case record must be established for each individual recipient of case management services and must document each case management service provided.

1. Intake.

This function consists of: the initial contact to provide information concerning case management and early intervention to the parent of an eligible child or a child thought to be eligible for early intervention services at a time and place convenient to the family; exploration of the family's receptivity to the early intervention program and the case management process; determine that the recipient is a member of the targeted population; ascertain if the child and family are presently receiving case management services or other services from public or private agencies, identification of potential payers for services; and review of due process rights concerning mediation and impartial hearing.

2. Assessment.

The case manager must secure directly, or indirectly through collateral sources, with the family's permission: a determination of the nature and degree of the recipient's developmental status; must assist the family in accessing screening and evaluation services; review evaluation reports with the family; assist the family to identify their priorities, concerns, and resources; explore options and assist the family's investigation of these options; inform the family of other program and services that may be of benefit and assist]

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For the purposes of the Early Intervention Program, the care plan is the Individualized Family Service Plan (IFSP). The local early intervention official, case manager, parent, and evaluator or designated contact from the evaluation team jointly develop an IFSP for a child who has been determined eligible for early intervention services. Agreed upon early intervention services are included in the child's IFSP and are delivered in conformity with the IFSP.

An IFSP must be in writing and include: a statement, based on objective criteria, of the child's present levels of functioning in each of the following areas: physical development, including vision and hearing; cognitive development, communication development, social or emotional development and adaptive development. The IFSP identifies the needs related to the child's diagnosed condition, disability or developmental delay, and, with parental consent, incorporates the family's description of its resources, priorities, and concerns related to enhancing the child's development. The IFSP includes a statement of the specific services to be provided to the child to address the child's needs, including the frequency, intensity, length, duration, location, method and timeframe for delivering services, as well as a statement of the measurable outcomes expected to be achieved for the child and the family.

The IFSP is reviewed at six month intervals and evaluated annually to determine the degree to which progress toward achieving the outcomes is being made, and whether or not there is a need to amend the IFSP to modify or revise the services being provided or anticipated outcomes. Upon request of the parent, or if conditions warrant, the IFSP may be reviewed at more frequent intervals to make appropriate adjustments in the IFSP and service arrangements with providers.

Case management functions related to the IFSP include: facilitating and participating in the development and review of IFSPs; implementing the service plan in the IFSP; facilitating IFSP periodic review and revision; and implementation of any adjustments in IFSP services.

- ❖ Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services including:
  - activities that help link the individual with medical, social, educational providers, or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan.

In implementing the IFSP, the case manager must assist the child and family, as needed, to secure the medical, social educational or other services determined in the plan to be appropriate. Case management (service coordination) functions associated with referral include: assisting families in identifying available service providers; securing

[in making referrals; assist the recipient in obtaining interim early intervention services when it is determined that the child has an obvious, immediate need and prepare an interim family services plan.

3. Case management plan and coordination.

For purposes of early intervention, the case management plan will be known as the individualized family services plan (IFSP). Development of the IFSP is the translation of specific goals and objectives, and specific services, providers and timeframes to reach each objective. The case manager shall convene a meeting at a time and place convenient to the family with 45 days of the child's referral to early intervention agency except under exceptional documented circumstances. Participants shall include: parent(s); early intervention official; case manager; the designated contact from the evaluation team; and other individuals the family invite or give consent to attend.

The IFSP shall be in writing and include the following:

a. A statement of the child's levels of functioning in each of the following domains: physical development; cognitive development; communication development; social or emotional development; and adaptive development.

b. A physician's order pertaining to early intervention services, which includes a diagnostic statement and purpose of treatment.

c. With parental consent, a statement of the family's strengths, priorities, concerns that relate to enhancing the development of their child.

d. A statement of the major outcomes expected to be achieved and for the child and family, including timelines, and criteria and procedures that will be used to determine whether progress toward achieving the outcomes is being made and whether modifications or revisions of the outcomes and services is necessary.

e. A statement of specific early intervention services necessary to meet the unique needs of the child and family, including the frequency, intensity, location and the method of delivering services.

f. A statement of the natural environments in which early intervention services will be provided

g. When early intervention services are to be delivered to a recipient in a group setting without typically developing peers, the IFSP shall document the reason(s).

h. A statement of other services, including medical services, that are not required under the early intervention program but are needed by the child and the family and the payment mechanism for these services.

i. A statement of other public programs under which the child and family may be eligible for benefits, and a referral, where indicated.]

the services determined in the plan to be appropriate through referral to agencies or to persons who are qualified to provide identified services; assisting families with scheduling appointments; resolving problems related to implementation of the IFSP; coordinating the provision of early intervention services and medical, educational, social and other services; and assisting families in making applications for services and entitlements.

❖ Monitoring and follow-up activities:

- activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the eligible individual's needs, and which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met:
    - services are being furnished in accordance with the individual's care plan;
    - services in the care plan are adequate; and
    - changes in the needs or status of the individual are reflected in the care plan. Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers. **[Specify the type of monitoring and justify the frequency of monitoring.]**

Monitoring and Follow Up (Ongoing Service Coordination)

Monitoring and follow up includes activities and contacts that are necessary to ensure that the services are being furnished in accordance with the child's plan of care (IFSP). Follow up may be with the individual, family members, providers or other individuals or entities and conducted as frequently as necessary. The case manager (service coordinator) must assure that the child obtains, on an ongoing basis, the services in the IFSP by maintaining contact, as necessary, with direct service providers and with the child and family to ensure that services identified in the IFSP are being appropriately delivered on a timely basis. Case managers (service coordinators) may assist both the family and providers of service to resolve disagreements, questions or problems relating to the implementation of the IFSP. Case managers (service coordinators) assist in determining whether there are changes in the needs or status of the child, and, if so, they must assist in making necessary adjustments in the care plan with the IFSP team and revising service arrangements with providers.

Transition Planning

Transition planning includes facilitating the recipient's access to other appropriate care when eligibility for targeted services ceases. The case manager (service coordinator) must facilitate the transition of each child exiting the Early Intervention Program. If the child is thought to be potentially eligible for preschool special education services, the

[j. The projected dates for initiation of services and the anticipated duration of these services.

k. The name of the case manager who will be responsible for the implementation of the IFSP.

l. If applicable, steps to be taken to support the potential transition of the recipient to special education or other services.

m. The IFSP shall reflect the family's response to the plan, consent to case management and/or declination of any part of the plan by the family must be documented.

4. Implementation of the IFSP.

In implementing the service plan, the case manager must assist the recipient and family, as needed, in securing the services determined in the plan to be appropriate through referral to agencies or to persons who are qualified to provide identified services; assist the family in making applications for services and entitlements; confirm service delivery dates with providers and supports; assist with family scheduling needs; advocate for the family with all service providers; document services that are not available or cannot be accessed; and developing alternatives services to assure continuity in the event of service disruption.

5. Reassessment and IFSP update.

Reassessment is a scheduled or event generated formal reexamination of the client's situation, functioning, clinical and psychosocial needs, to identify changes which have occurred since the initial or most recent assessment. The IFSP for a child and the child's family must be reviewed at six months intervals and evaluated annually, or more frequently if conditions warrant, or if a parent requests such a review.

6. IFSP update implementation.

The case manager is responsible for the implementation of the updated plan. Such implementation will include the same activities as described in subsection 4 above.

7. Crisis intervention.

Crisis intervention by a case manager includes when necessary: assessment of the nature of the recipient's circumstances; determination of the recipient's emergency needs; and revision of the IFSP, including any changes in activities and objectives required to achieve the established goal.

8. Monitoring and follow-up.

The case manager is responsible for:

a. assuring that quality services, as identified in the IFSP, are delivered in a cost-conscious manner;
b. assuring the family's satisfaction with the services provided;
c. collecting data and documenting the progress of the recipient in a case record;
d. making necessary revisions to the plan in conjunction with the family, early intervention official, the designated representative of the evaluation team and the service provider(s);]

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case manager (service coordinator) must inform the parent about notification to the Committee on Preschool Special Education (CPSE) and the opportunity to object to the notification. With parental consent, the case manager (service coordinator) will transfer evaluations, assessments, IFSPs, and other appropriate records to the CPSE/and or other programs that may provide services to the child after early intervention eligibility ends.

_X_ Case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs.
(42 CFR 440.169(e))

Qualifications of providers (42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b)):
[**Specify provider qualifications that are reasonably related to the population being served and the case management services furnished.]**

Early intervention case managers (service coordinators) may be located within either a public or private agency or may be individual qualified personnel approved by the State to deliver case management services.

All early intervention case managers (service coordinators) shall meet the following qualifications:

1. a minimum of one of the following educational or case management (service coordination) experience credentials:

   - two years of experience in case management activities (voluntary or part-time experience which can be verified will be accepted on a pro rata basis); or
   - one year of case management experience and an additional year of experience in a service setting with infants and toddlers with developmental delays or disabilities; or
   - one year of case management experience and an Associate's degree in a health or human service field; or
   - a Bachelor's degree in a health or human service field.

2. demonstrated knowledge and understanding in the following areas:

   - infants and toddlers who may be eligible for early intervention services;
   - state and federal laws and regulations pertaining to the Early Intervention Program;
   - principles of family centered services;

[e. making alternate arrangements when services have been denied or are unavailable; and

f. assisting both the family and providers of service to resolve disagreements, questions or problems relating to the implementation of the IFSP.

9. Counseling and exit planning.

The case manager must assure that the recipient obtains, on an ongoing basis, the maximum benefit from the services received; developing support groups for the recipient, the recipient's family and informal providers of service; mediating among the recipient, the family network and/or other informal providers when problems with service delivery occur; facilitating the recipient's access to other appropriate care when eligibility for targeted services ceases; and assisting the family to anticipate difficulties which may be encountered subsequent to from the early intervention program or admission to other programs, including other case management programs.

10. Supervisory Review/Case Conferencing.

An important component of the required quality assurance process for each case management provider will be supervisory review of case management documentation. IFSPs and other products as well as peer review or case conferencing with other case managers.

PROCEDURAL REQUIREMENTS FOR PROVISION OF SERVICE

1. Assessments.

The case management process must be initiated by the family and the case manager through a written assessment of the child and family's need for case management and early intervention services including medical, social, psychosocial, educational, financial and other services.

An assessment provides verification of the recipient's current functioning and continuing need for services, the service priorities and evaluation of the child's ability to benefit from such services. The assessment process includes, but is not limited to, those activities listed in paragraph 2 of **CASE MANAGEMENT FUNCTIONS**.

The case manager shall promptly arrange a contact with the family at a time, place and manner reasonably convenient for the parent(s) consistent with applicable timeliness requirements and initiate the assessment process. Information developed by the referral source should be included as an integral part of the case management plan.

An assessment of the recipient's need for case management and early intervention services must be completed by the case manager every six months, or sooner if required by changes in the child's condition or circumstances.

2. Case management plan.

A written IFSP must be completed by the case manager for each child eligible for early intervention services within 45 days of referral to the municipal early intervention agency and must include, but is not limited to, those functions outlined in paragraph 3 under **CASE MANAGEMENT FUNCTIONS.**]

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- the nature and scope of services available under the Early Intervention Program and the system of payments for services in the State; and,
- other pertinent information.

Case managers must participate in an introductory training session sponsored or approved by the Department of Health in the first three months and by no later than one year of direct or contractual employment as an early intervention case manager.

Case management agencies and individual qualified personnel who are billing providers must conform to the following criteria to become a provider of case management services in the New York State Early Intervention Program:

- meet character and competence and other program standards established by the Early Intervention Program;
- be approved for participation in the Program;
- enter into an agreement with the Department of Health;
- enroll in the Medicaid Program and sign a Medicaid provider agreement with the New York State Department of Health, if the agency or individual provider is directly claiming to Medicaid;
- adhere to federal and State laws and regulations governing the participation of providers in the Medicaid program;
- adhere to federal and State laws, regulations and standards related to the delivery of Early Intervention services, including case management standards;
- comply with New York State requirements for annual compliance audits.

Freedom of choice (42 CFR 441.18(a)(1):
The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Social Security Act.

1. Eligible individuals will have free choice of any qualified Medicaid provider within the specified geographic area in which they reside.
2. Eligible individuals will have free choice of any qualified Medicaid providers of other medical care under the plan.

[3. Continuity of service.

Case management services must be ongoing from the time the child is referred to the local early intervention agency for services to the time when: when the coordination of services provided through case management is not required or is no longer required by the child and his/her family; the child moves from the local social services district*; the long term goal has been reached; the family refuses to accept case management services; the family requests that its case be closed; the child is no longer eligible for services; or the child's case is appropriately transferred to another case manager.

Contact with the child, his or her family or with a collateral source on the child's behalf must be maintained by the case manager at least monthly or more frequently as specified in the provider's agreement with the New York State Department of Social Services.

* The criteria for discontinuance by a particular entity when a client moves are inaccessibility and the provider's incapability to provide adequate service to someone removed from their usual service area due to a lack of intimate knowledge of the support system in the family's new community. The current case manager is responsible to help transition the family to a case manager in their new location. Clients are free to choose among the case managers qualified to provide early intervention case management services.

LIMITATIONS TO THE PROVISION OF MEDICAID CASE MANAGEMENT SERVICES

Case management services for Target Group "G":

1. must not be utilized to restrict the choices of the case management services recipient to obtain medical care or services from any provider participating in the Medical Assistance Program who is qualified to provide such care or services and who undertakes to provide such care or service(s), including an organization which provides such care or services on a prepayment basis;

2. must not duplicate certain case management services services currently provided under the Medical Assistance Program or under any other funding sources;

3. must not be utilized by providers of case management to create a demand for unnecessary services or programs particularly those services or programs within their scope of authority;

4. must not be provided to persons receiving institutional care for more than 30 days or when discharge to community based care is not anticipated and care is reimbursed under the Medical Assistance Program or to persons in receipt of case management services under a federal Home and Community Based Services waiver or the Care At Home model waiver program.

While the activities of case management services secure access to, including referrals to and arrangements for, services for the Target Group, reimbursement for case management does not include:]

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Freedom of Choice Exception (§1915(g)(1) and 42 CFR 441.18(b)):
__X__ Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to qualified Medicaid providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services: [**Identify any limitations to be imposed on the providers and specify how these limitations enable providers to ensure that individuals within the target groups receive needed services.]**

Providers of case management services are limited to those individuals who meet character and competence, statutory and regulatory standards, and other program standards established by the Early Intervention Program and are approved for participation in the Program to ensure that they are capable of providing appropriate services to individuals with developmental disabilities or with chronic mental illness.

Authority of Section 1915(g)(1) of the Act is invoked to limit providers of early intervention case management (service coordination) services without regard to the requirement of Section 1902(a)(10)(B) of the Act, or;

☒ The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.
- Eligible recipients will have free choice of the providers of case management services within the specified geographic area identified in this plan.
- Eligible recipients will have free choice of the providers of other medical care under the plan.

Access to Services (42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6):
The State assures the following:
- Case management (including targeted case management) services will not be used to restrict an individual's access to other services under the plan.
- Individuals will not be compelled to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services; and
- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

[1. the actual provision of the service;
2. Medicaid eligibility determinations and redeterminations;
3. Medicaid preadmission screening;
4. prior authorization for Medicaid services;
5. required Medicaid utilization;
6. administration of the Child/Teen Health Program services;
7. activities in connection with "lock-in" provisions under 1915(a) of the Social Security Act;
8. institutional discharge planning;
9. client outreach.

E. QUALIFICATIONS OF PROVIDERS SPECIFIC TO TARGET GROUP "G"

1. Provider qualifications

Public or private agencies applying for participation in the Early Intervention Program must demonstrate the following:

a. character and competence, including fiscal viability;

b. the capacity to provide case management services;

c. availability to provide qualified personnel as defined in subsection 2 below;

d. adherence to applicable federal and state laws and regulations;

e. the capacity and willingness to ensure case managers participate in inservice training;

f. the assurance that all case managers will participate in training sponsored by the New York State Department of Health or another State early Intervention agency within the first twelve months of employment;

g. completion of an approved Medicaid provider agreement.

2. Case manager qualifications

Early Intervention case managers may be located within either public or private agencies, or may be individual qualified personnel. All case managers shall meet the following qualifications:

a. a minimum of one of the following educational or case management experience credentials:

i. two years experience in case management activities (voluntary or part-time experience which can be verified will be accepted on a pro rata basis); or

ii. one year of case management experience and an additional year ofexperience in a service setting with infants and toddlers with developmental delays or disabilities; or
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Payment (42 CFR 441.18(a)(4)):

Payment for case management or targeted case management services under the plan will not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Case management providers are paid a fixed rate based on services provided. The rate is based on the case management activities conducted as per program regulations. The provider does not receive payment if they fail to perform the minimum activities defined in regulation. A detailed description of the reimbursement methodology identifying the data used to develop the rate is included in Attachment 4.19B.

Case Records (42 CFR 441.18(a)(7)):

Providers maintain case records that document for all individuals receiving case management as follows: (i)The name of the individual; (ii) The dates of the case management services; (iii)The name of the provider agency (if relevant) and the person providing the case management service; (iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved; (v) Whether the individual has declined services in the care plan; (vi) The need for, and occurrences of, coordination with other case managers; (vii) A timeline for obtaining needed services; and (viii) A timeline for reevaluation of the plan.

A separate case record is established for each child receiving case management services that documents case management services provided. Providers maintain case records that documents the following for each child receiving case management services: the name of the child; dates of the case management services; the name of the provider agency (if relevant) and the person providing the case management service; the nature, content, units of the case management services received; whether goals specified in the care plan have been achieved; whether the child's family has declined services in the care plan; the need for, and occurrences of, coordination with other case managers; the timeline for obtaining needed services; and a timeline for reevaluation of the plan.

[iii. one year of case management experience and an associates degree in a health or human service field; or

iv. a bachelors degree in a health and human services field.

b. demonstrated knowledge and understanding in the following areas:

i. infants and toddlers who are eligible for early intervention services;

ii. State and federal laws and regulations pertaining to the Early Intervention Program;

iii. principles of family centered services;

iv. the nature and scope of services available under the Early Intervention Program and the system of payments and services in the State; and,

v. other pertinent information.

3. <u>Individual case managers</u>

Qualified personnel with appropriate licensure, certification, or registration shall apply to the State Department of Health for approval to provide case management services. In addition to the qualifications listed in subsection 2. above, the following factors are required for individuals not associated with a public or private agency in order to provide case management services:

a. current licensure, certification or registration in a discipline eligible to deliver services to children;

b. adherence to applicable federal and State laws and regulations;

c. the capacity and willingness to attend in-service training programs sponsored by the Department of Health and State early intervention agencies;

d. the assurance that all approved individual case managers will participate in the case manager training sponsored by the Department of Health or State early intervention agencies within the first twelve months of program participation;

e. completion of an approved Medicaid provider agreement.]

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Limitations:
Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c))

FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c)).

Case management services must not:

- duplicate certain case management services currently provided under the Medical Assistance Program or any other funding source;
- be utilized by providers of case management to create a demand for unnecessary services or programs particularly those services or programs within their scope of authority.

While the activities of case management secure access to and arrangements for services for the Target Group, reimbursement for case management services does not include:

- Medicaid eligibility determinations and redeterminations;
- Medicaid preadmission screening;
- prior authorization for Medicaid services;
- required Medicaid utilization;
- administrative functions that are purely IDEA functions such as scheduling IFSP team meetings, and providing the perquisite prior written notice;
- Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program administration;
- activities in connection with "lock-in" provisions under 1915(a) of the Social Security Act;
- services that are an integral or inseparable part of other Medicaid services;
- institutional discharge planning; or,
- outreach services that are designed to locate individuals who are potentially Medicaid eligible.

TYPE OF SERVICE:

Case Management Services
Target Group G:

Medicaid eligible clients who are served by the New York State Department of Health's Early Intervention Program and who:

1. are infants and toddlers from birth through two years who have or are suspected to have a developmental delay or a diagnosed physical or mental condition that has a high probability of resulting in developmental delay;

2. have been referred to the municipal early intervention agency; and

3. are in need of ongoing and comprehensive rather [that] than incidental case management services.

METHOD OF REIMBURSEMENT:

Reimbursement for necessary case management services provided to the client and to the family in support of the primary client under the New York State Early Intervention Program shall be [at hourly rates] two separate fixed rates for Initial Service Coordination and one monthly fixed rate for Ongoing Service Coordination established by the New York State Department of Health and approved by the Director of the Budget. Initial Service Coordination followed by no IFSP meeting will have a minimum base of two hours with no cap. Initial Service Coordination followed by an IFSP meeting will have a minimum base of three hours with no cap. Ongoing Service Coordination will have a minimum base of 1.25 hours per child per month. In the instance that the minimum base rate is lower than the regional average, the regional average will be used for the calculation of all three rates. [Providers will be allowed to bill in quarter hour units.] The newly established rate methodology will apply only to initial IFSPs and amended IFSPs developed on or after written notice of such rate methodology has been provided to Early Intervention Officials by the Department of Health.

Rates for case management will be set prospectively and will cover labor, administrative overhead, general operating and [capitol] capital costs. The rates also adjusted to reflect regional differences in costs. The regional classification system used to reflect differences in costs is described in 86-2.10(c)(5) of Attachment 4.19-A of the State Plan. Please see Fee Schedules below.

METHOD OF REIMBURSEMENT (continued):

Early Intervention Fee Schedule (Effective July 1, 2018)

Service Type	Region	Fee	Unit of Service or Frequency
Initial Service Coordination with No IFSP	Albany	135	One-time basis
Initial Service Coordination with No IFSP	Binghamton	124	One-time basis
Initial Service Coordination with No IFSP	Central Rural	118	One-time basis
Initial Service Coordination with No IFSP	Elmira	118	One-time basis
Initial Service Coordination with No IFSP	Erie	116	One-time basis
Initial Service Coordination with No IFSP	Glens Falls	109	One-time basis
Initial Service Coordination with No IFSP	Long Island	141	One-time basis
Initial Service Coordination with No IFSP	North Rural	118	One-time basis
Initial Service Coordination with No IFSP	New York City	382	One-time basis
Initial Service Coordination with No IFSP	Orange	141	One-time basis
Initial Service Coordination with No IFSP	Poughkeepsie	134	One-time basis
Initial Service Coordination with No IFSP	Rochester	118	One-time basis
Initial Service Coordination with No IFSP	Syracuse	144	One-time basis
Initial Service Coordination with No IFSP	Utica	136	One-time basis
Initial Service Coordination with No IFSP	Westchester	356	One-time basis
Initial Service Coordination with No IFSP	Western Rural	118	One-time basis
Initial Service Coordination with IFSP	Albany	173	One-time basis
Initial Service Coordination with IFSP	Binghamton	186	One-time basis
Initial Service Coordination with IFSP	Central Rural	173	One-time basis
Initial Service Coordination with IFSP	Elmira	176	One-time basis
Initial Service Coordination with IFSP	Erie	173	One-time basis
Initial Service Coordination with IFSP	Glens Falls	164	One-time basis
Initial Service Coordination with IFSP	Long Island	211	One-time basis
Initial Service Coordination with IFSP	North Rural	176	One-time basis
Initial Service Coordination with IFSP	New York City	554	One-time basis
Initial Service Coordination with IFSP	Orange	211	One-time basis
Initial Service Coordination with IFSP	Poughkeepsie	202	One-time basis
Initial Service Coordination with IFSP	Rochester	176	One-time basis
Initial Service Coordination with IFSP	Syracuse	176	One-time basis
Initial Service Coordination with IFSP	Utica	176	One-time basis
Initial Service Coordination with IFSP	Westchester	424	One-time basis
Initial Service Coordination with IFSP	Western Rural	176	One-time basis
Ongoing Service Coordination	Albany	72	Monthly
Ongoing Service Coordination	Binghamton	77	Monthly
Ongoing Service Coordination	Central Rural	72	Monthly
Ongoing Service Coordination	Elmira	74	Monthly
Ongoing Service Coordination	Erie	72	Monthly
Ongoing Service Coordination	Glens Falls	68	Monthly
Ongoing Service Coordination	Long Island	88	Monthly
Ongoing Service Coordination	North Rural	74	Monthly
Ongoing Service Coordination	New York City	138	Monthly
Ongoing Service Coordination	Orange	102	Monthly
Ongoing Service Coordination	Poughkeepsie	127	Monthly
Ongoing Service Coordination	Rochester	74	Monthly
Ongoing Service Coordination	Syracuse	74	Monthly
Ongoing Service Coordination	Utica	74	Monthly
Ongoing Service Coordination	Westchester	118	Monthly
Ongoing Service Coordination	Western Rural	74	Monthly

MISCELLANEOUS
NOTICES/HEARINGS

Notice of Abandoned Property Received by the State Comptroller

Pursuant to provisions of the Abandoned Property Law and related laws, the Office of the State Comptroller receives unclaimed monies and other property deemed abandoned. A list of the names and last known addresses of the entitled owners of this abandoned property is maintained by the office in accordance with Section 1401 of the Abandoned Property Law. Interested parties may inquire if they appear on the Abandoned Property Listing by contacting the Office of Unclaimed Funds, Monday through Friday from 8:00 a.m. to 4:30 p.m., at:

1-800-221-9311
or visit our web site at:
www.osc.state.ny.us

Claims for abandoned property must be filed with the New York State Comptroller's Office of Unclaimed Funds as provided in Section 1406 of the Abandoned Property Law. For further information contact: Office of the State Comptroller, Office of Unclaimed Funds, 110 State St., Albany, NY 12236.

PUBLIC NOTICE
Division of Criminal Justice Services
Law Enforcement Agency Accreditation Council

Pursuant to Public Officers Law § 104, the Division of Criminal Justice Services gives notice of a rescheduled meeting of the Law Enforcement Agency Accreditation Council to be held on:

Date: Monday, April 2, 2018
Time: 1:00 p.m.
Place: Division of Criminal Justice Services
Alfred E. Smith Office Bldg.
80 S. Swan St.
CrimeStat Rm. (Rm. 118)
Albany, NY 12210

Identification and sign-in are required at this location. *For further information, or if you need a reasonable accommodation to attend this meeting, please contact*: Division of Criminal Justice Services, Office of Public Safety, Alfred E. Smith Office Bldg., 80 S. Swan St., Albany, NY 12210, (518) 457-2667

Live Webcast will be available as soon as the meeting commences at: http://www.criminaljustice.ny.gov/pio/openmeetings.htm

PUBLIC NOTICE
Division of Criminal Justice Services
Municipal Police Training Council

Pursuant to Public Officers Law § 104, the Division of Criminal Justice Services gives notice of a rescheduled meeting of the Municipal Police Training Council to be held on:

Date: Friday, March 30, 2018 (tentative)
Time: 9:30 a.m.
Place: Division of Criminal Justice Services
Alfred E. Smith Office Bldg.
80 S. Swan St.
CrimeStat Rm. (Rm. 118)
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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, institutional and long-term care services to comply with proposed statutory provisions. The following changes are proposed:

Non-Institutional Services

Effective on or after April 1, 2018, this initiative proposes to eliminate the supplemental medical assistance payments of $6 million annually made to providers of emergency medical transportation.

The estimated annual net aggregate decrease in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2018/2019 is $6 million.

Effective on or after April 1, 2018, the professional dispensing fee for brand name, generic, and OTC covered outpatient drugs will be updated to $10.08, to align with current costs.

The estimated annual aggregate increase in gross Medicaid expenditures attributable to this initiative for state fiscal year 2018/2019 is $795,531.

Effective on and after October 1, 2018, Medicaid will cover ABAs. ABAs are State Education Department (SED) licensed practitioners who provide intensive treatment for persons diagnosed with autism spectrum disorder using applied behavioral analysis treatment modalities. These services and practitioners are currently covered by Early Intervention (EI), Child Health Plus (CHIP), and all major commercial payers. The Medicaid Program does not currently recognize or reimburse ABA's, which results in a break in coverage for those children who age out of the EI program.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2018/2019 is $12.1 million.

Effective on and after July 1, 2018, the physical therapy cap under both fee-for-service and mainstream managed care will be increased from 20 visits to 40 visits per member in a 12-month period. The following populations are exempt from the 40-visit limitation: children (0-21 years of age); individuals with developmental disabilities; Medicare/Medicaid dually eligible individuals when the service is

covered by Medicare; and individuals with a traumatic brain injury. Revision of the physical therapy cap will provide members an opportunity to obtain additional rehabilitation therapy to treat low back pain as well as other physical conditions which will help reduce the need for opioid treatment.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2018/2019 is $4.6 million.

Effective on and after April 1, 2018, Medicaid will begin covering Centers for Disease Control (CDC) certified National Diabetes Prevention Program (NDPP). The NDPP is a CDC recognized educational and support program designed to assist at-risk individuals from developing Type 2 diabetes. The program focuses on lifestyle interventions and the long-term effects of diet and exercise. These intense interventions demonstrate a greater influence on the reduction in diabetes risk, return to normoglycemia, and weight loss than less intense programs.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2018/2019 is $1.03 million.

Effective on or after April 1, 2018, the Early Intervention Program reimbursement methodology for the targeted case management (service coordination) services will be revised from an hourly rate billed in fifteen-minute units to two separate categories of fixed rates for initial case management services and one per member per month fixed rate for ongoing case management services. These rates are being revised to create administrative efficiencies for billing providers and adjust for administrative activities assumed by providers in direct billing to third party payers through a state fiscal agent established April 1, 2013. These revisions will make the State Plan content and format consistent with Medicaid requirements for case management.

Initial service coordination services not followed by an Individualized Family Service Plan meeting will have a minimum base of two hours with no cap; those followed by an Individualized Family Service Plan meeting will have a minimum base of three hours with no cap. Ongoing service coordination services will have a minimum base of 1.25 hours per month. Rates for case management will be set prospectively and will cover labor, administrative overhead, general operating and capital costs, and regional cost differences.

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

Effective on or after April 1, 2018, this proposal is to establish a ten percent rate increase to the Hospice Residence rates, set a benchmark rate and include specialty rates in the weighted average rate calculation. The proposal would increase Medicaid Hospice Residence rates to help cover current costs and avoid closure of Hospice Residence programs.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2018/2019 is $1.7 million.

Effective on or after April 1, 2018, continues the supplemental upper payment limit payments made to general hospitals, other than major public general hospitals under non-institutional services of $339 million annually.

For state fiscal year beginning April 1, 2018 through March 31, 2019, continues hospital outpatient payment adjustments that increase the operating cost components of rates of payment for hospital outpatient and emergency departments on and after April 1, 2011, for public general hospitals other than those operated by the State of New York or the State University of New York, which are located in a city with a population of over one million. The amount to be paid will be up to $287 million annually based on criteria and methodology set by the Commissioner of Health, which the Commissioner may periodically set through a memorandum of understanding with the New York City Health and Hospitals Corporation. Such adjustments shall be paid by means of one or more estimated payments. Payments may be added to rates of payment or made as aggregate payments.

For the state fiscal year beginning April 1, 2018 through March 31, 2019, continues upon the election of the social services district in which an eligible diagnostic and treatment center (DTC) is physically located, up to $12.6 million in additional annual Medicaid payments may be paid to public DTCs operated by the New York City Health and Hospitals Corporation. Such payments will be based on each DTC's proportionate share of the sum of all clinic visits for all facilities eligible for an adjustment for the base year two years prior to the rate year. The proportionate share payments may be added to rates of payment or made as aggregate payments to eligible DTCs.

For the state fiscal year beginning April 1, 2018 through March 31, 2019, continues up to $5.4 million in additional annual Medicaid payments may be paid to county operated free-standing clinics, not including facilities operated by the New York City Health and Hospitals Corporation, for services provided by such DTC and those provided by a county operated freestanding mental health or substance abuse DTC. Distributions shall be based on each eligible facility's proportionate share of the sum of all DTC and clinic visits for all eligible facilities receiving payments for the base year two years prior to the rate year. The proportionate share payments may be added to rates of payment or made as aggregate payments to eligible facilities.

Effective on or after April 1, 2018, The Department of Health proposes to amend the Public Health Law § 3001, create new Public Health Law § § 2805-z and 3001-a, and amend the Social Services Law § 365-a to permit health care providers to collaborate on community paramedicine programs that allow emergency medical personnel to provide care within their certification, training and experience in residential settings.

The annual increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2018/2019 is $2.3 million.

Institutional Services

Effective on or after April 1, 2018, the commissioner shall convene a temporary workgroup comprised of representatives of hospitals and residential nursing facilities, as well as representatives from the department, to develop recommendations for streamlining the capital reimbursement methodology to achieve a one-percent reduction in capital expenditures to hospitals and residential nursing facilities, including associated specialty and adult day health care units. Pending the development of the workgroup's recommendations and the implementation of any such recommendations accepted by the commissioner, the commissioner shall be authorized to reduce the overall amount of capital reimbursement as necessary to achieve a one-percent reduction in capital expenditures beginning with State fiscal year 2018/2019.

The annual decrease in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2018/2019 is $13.4 million.

Effective on or after April 1, 2018, continues the supplemental upper payment limit payments made to general hospitals, other than major public general hospitals under institutional services of $339 million annually.

For the state fiscal year beginning April 1, 2018 through March 31, 2019, continues specialty hospital adjustments for hospital inpatient services provided on and after April 1, 2012, to public general hospitals, other than those operated by the State of New York or the State University of New York, located in a city with a population of over one million and receiving reimbursement of up to $1.08 billion annually based on criteria and methodology set by the Commissioner of Health, which the Commissioner may periodically set through a memorandum of understanding with the New York City Health and Hospitals Corporation. Such adjustments shall be paid by means of one or more estimated payments. Payments to eligible public general hospitals may be added to rates of payment or made as aggregate payments.

Effective on or after April 1, 2018, payments to hospitals that meet the criteria as an enhanced safety net hospital, the criteria is as follows: In any of the previous three calendar years has had not less than fifty percent of the patients it treats receive Medicaid or are medically uninsured; not less than forty percent of its inpatient discharges are covered by Medicaid; twenty-five percent or less of its discharged patients are commercially insured; not less than three percent of the

patients it provides services to are attributed to the care of uninsured patients; provides care to uninsured patients in its emergency room, hospital based clinics and community based clinics, including the provision of important community services, such as dental care and prenatal care.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative is $20 million.

Effective on or after April 1, 2018, payments to Critical Access Hospitals, Safety Net Hospitals, and Sole Community Hospitals will be based on criteria as determined by the Commissioner of Health.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2018/2019 is $40 million.

Long Term Care Services

Effective on or after April 1, 2018, continues additional payments to non-state government operated public residential health care facilities, including public residential health care facilities located in Nassau, Westchester, and Erie counties, but excluding public residential health care facilities operated by a town or city within a county, in aggregate amounts of up to $500 million. The amount allocated to each eligible public RHCF will be in accordance with the previously approved methodology, provided, however that patient days shall be utilized for such computation reflecting actual reported data for 2016 and each representative succeeding year as applicable. Payments to eligible RHCF's may be added to rates of payment or made as aggregate payments.

The overall combined estimated annual net aggregate increase in gross Medicaid expenditures attributable to the extension of all upper payment limit (UPL) payments for state fiscal year 2018/2019 in $2.5 billion.

Effective on or after April 1, 2018, the Commissioner shall convene with New York State Nursing Home Associations and other industry experts alongside representatives from the New York State Health Department, to revise the current Case Mix collection process in an effort to promote a higher degree of accuracy in the case mix data which would result in a reduction of audit findings. Pending the development and implementation of the revised process, the commissioner shall be authorized to reduce the overall amount of case mix reimbursement as is necessary to achieve savings.

The estimated annual net aggregate decrease in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2018/2019 is $15 million.

Effective on or after April 1, 2018 this proposes legislation to authorize the department to conduct a study of Home and Community Based Services in rural areas of the state. This study will include a review and analysis of factors including but not limited to transportation costs, costs of direct care personnel including home health aides, personal care attendants and other direct service personnel, and opportunities for telehealth and/ or technological advances to improve efficiencies.

The Legislation would also authorize the department to provide a targeted, Medicaid rate enhancement if supported by the study, for fee for service personal care.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2018/2019 is $3 million.

The following is a clarification for the partial restoration of the two percent annual uniform reduction of Medicaid payments which was originally noticed on March 26, 2014. Effective on or after April 1, 2018, supplemental payments will be made to all RHCF Nursing Homes for the value of SFY 2014/15, 2015/16, 2016/17 and 2017/18 beginning SFY 2018/19 and will be paid out at $70 million each year over four years. Additional supplemental payments will be made each year beginning in SFY 2018/19 in the amount of $70 million.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2018/2019 is $140,000,000.

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.

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, or e-mail: 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 institutional care related to temporary rate adjustments to providers that are undergoing closure, merger, consolidation, acquisition or restructuring themselves or other health care providers. These payments are authorized by § 2826 of the New York Public Health Law. The following changes are proposed:

Additional temporary rate adjustments have been reviewed and approved for the following hospital:

- Strong Memorial Hospital

The aggregate payment amounts total up to $4,163,227 for the period April 1, 2018 through March 31, 2019.

The aggregate payment amounts total up to $4,594,780 for the period April 1, 2019 through March 31, 2020.

The aggregate payment amounts total up to $4,370,030 for the period April 1, 2020 through March 31, 2021.

The public is invited to review and comment on this proposed State Plan Amendment. Copies of which will be available for public review on the Department's website at http://www.health.ny.gov/regulations/state_plans/status.

Copies of the proposed State Plan Amendments will be on file in each local (county) social services district and available for public review.

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

New York County
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New York, New York 10018

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

SUMMARY
SPA #18-0021

This State Plan Amendment proposes to increase the physical therapy visit limit for fee-for-service and mainstream managed care from 20 visits to 40 visits per member in a 12-month period.

9. Services will be provided in accordance with the utilization threshold requirements described in departmental regulations which are based on medical necessity and identified for providers in the MMIS Clinic Provider Manual. Such threshold requirements are applicable to specific provider service types including adult day health services, medical clinics, dental clinics and mental health clinics certified under Article 28 of the Public Health Law and/or Article 31 of the Mental Hygiene Law. The requirements mandate that providers obtain prior authorization based on medical necessity for the provision of services in excess of prescribed utilization thresholds per recipients per benefit year, unless the services provided were urgent or emergent in nature, or otherwise excluded.

Physical Therapy Services

11a. Effective on or after [October 1, 2011] July 1, 2018, services are limited to coverage of [twenty] forty visits per year; however, this limitation does not apply to enrollees who are less than 21 years of age, to individuals with traumatic brain injury, to persons with developmental disabilities, or to Medicare/Medicaid dually eligible recipients when that service is covered by Medicare. The benefit limit does not apply to inpatient hospital settings, services provided by a certified home health agency, or to nursing home inpatients receiving therapy in skilled nursing facilities in which they reside. The benefit limit is not subject to review or exception.

Occupational Therapy Services

11b. Effective on or after October 1, 2011, services are limited to coverage of twenty visits per year; however, this limitation does not apply to enrollees who are less than 21 years of age, to individuals with traumatic brain injury, to persons with developmental disabilities, or to Medicare/Medicaid dually eligible recipients when that service is covered by Medicare. The benefit limit does not apply to inpatient hospital settings, services provided by a certified home health agency, or to nursing home inpatients receiving therapy in skilled nursing facilities in which they reside. The benefit limit is not subject to review or exception.

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PUBLIC NOTICE
Division of Criminal Justice Services
Law Enforcement Agency Accreditation Council

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Date: Monday, April 2, 2018
Time: 1:00 p.m.
Place: Division of Criminal Justice Services
Alfred E. Smith Office Bldg.
80 S. Swan St.
CrimeStat Rm. (Rm. 118)
Albany, NY 12210

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Effective on or after April 1, 2018, the commissioner shall convene a temporary workgroup comprised of representatives of hospitals and residential nursing facilities, as well as representatives from the department, to develop recommendations for streamlining the capital reimbursement methodology to achieve a one-percent reduction in capital expenditures to hospitals and residential nursing facilities, including associated specialty and adult day health care units. Pending the development of the workgroup's recommendations and the implementation of any such recommendations accepted by the commissioner, the commissioner shall be authorized to reduce the overall amount of capital reimbursement as necessary to achieve a one-percent reduction in capital expenditures beginning with State fiscal year 2018/2019.

The annual decrease in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2018/2019 is $13.4 million.

Effective on or after April 1, 2018, continues the supplemental upper payment limit payments made to general hospitals, other than major public general hospitals under institutional services of $339 million annually.

For the state fiscal year beginning April 1, 2018 through March 31, 2019, continues specialty hospital adjustments for hospital inpatient services provided on and after April 1, 2012, to public general hospitals, other than those operated by the State of New York or the State University of New York, located in a city with a population of over one million and receiving reimbursement of up to $1.08 billion annually based on criteria and methodology set by the Commissioner of Health, which the Commissioner may periodically set through a memorandum of understanding with the New York City Health and Hospitals Corporation. Such adjustments shall be paid by means of one or more estimated payments. Payments to eligible public general hospitals may be added to rates of payment or made as aggregate payments.

Effective on or after April 1, 2018, payments to hospitals that meet the criteria as an enhanced safety net hospital, the criteria is as follows: In any of the previous three calendar years has had not less than fifty percent of the patients it treats receive Medicaid or are medically uninsured; not less than forty percent of its inpatient discharges are covered by Medicaid; twenty-five percent or less of its discharged patients are commercially insured; not less than three percent of the

patients it provides services to are attributed to the care of uninsured patients; provides care to uninsured patients in its emergency room, hospital based clinics and community based clinics, including the provision of important community services, such as dental care and prenatal care.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative is $20 million.

Effective on or after April 1, 2018, payments to Critical Access Hospitals, Safety Net Hospitals, and Sole Community Hospitals will be based on criteria as determined by the Commissioner of Health.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2018/2019 is $40 million.

Long Term Care Services

Effective on or after April 1, 2018, continues additional payments to non-state government operated public residential health care facilities, including public residential health care facilities located in Nassau, Westchester, and Erie counties, but excluding public residential health care facilities operated by a town or city within a county, in aggregate amounts of up to $500 million. The amount allocated to each eligible public RHCF will be in accordance with the previously approved methodology, provided, however that patient days shall be utilized for such computation reflecting actual reported data for 2016 and each representative succeeding year as applicable. Payments to eligible RHCF's may be added to rates of payment or made as aggregate payments.

The overall combined estimated annual net aggregate increase in gross Medicaid expenditures attributable to the extension of all upper payment limit (UPL) payments for state fiscal year 2018/2019 in $2.5 billion.

Effective on or after April 1, 2018, the Commissioner shall convene with New York State Nursing Home Associations and other industry experts alongside representatives from the New York State Health Department, to revise the current Case Mix collection process in an effort to promote a higher degree of accuracy in the case mix data which would result in a reduction of audit findings. Pending the development and implementation of the revised process, the commissioner shall be authorized to reduce the overall amount of case mix reimbursement as is necessary to achieve savings.

The estimated annual net aggregate decrease in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2018/2019 is $15 million.

Effective on or after April 1, 2018 this proposes legislation to authorize the department to conduct a study of Home and Community Based Services in rural areas of the state. This study will include a review and analysis of factors including but not limited to transportation costs, costs of direct care personnel including home health aides, personal care attendants and other direct service personnel, and opportunities for telehealth and/ or technological advances to improve efficiencies.

The Legislation would also authorize the department to provide a targeted, Medicaid rate enhancement if supported by the study, for fee for service personal care.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2018/2019 is $3 million.

The following is a clarification for the partial restoration of the two percent annual uniform reduction of Medicaid payments which was originally noticed on March 26, 2014. Effective on or after April 1, 2018, supplemental payments will be made to all RHCF Nursing Homes for the value of SFY 2014/15, 2015/16, 2016/17 and 2017/18 beginning SFY 2018/19 and will be paid out at $70 million each year over four years. Additional supplemental payments will be made each year beginning in SFY 2018/19 in the amount of $70 million.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2018/2019 is $140,000,000.

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.

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, or e-mail: 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 institutional care related to temporary rate adjustments to providers that are undergoing closure, merger, consolidation, acquisition or restructuring themselves or other health care providers. These payments are authorized by § 2826 of the New York Public Health Law. The following changes are proposed:

Additional temporary rate adjustments have been reviewed and approved for the following hospital:

- Strong Memorial Hospital

The aggregate payment amounts total up to $4,163,227 for the period April 1, 2018 through March 31, 2019.

The aggregate payment amounts total up to $4,594,780 for the period April 1, 2019 through March 31, 2020.

The aggregate payment amounts total up to $4,370,030 for the period April 1, 2020 through March 31, 2021.

The public is invited to review and comment on this proposed State Plan Amendment. Copies of which will be available for public review on the Department's website at http://www.health.ny.gov/regulations/state_plans/status.

Copies of the proposed State Plan Amendments will be on file in each local (county) social services district and available for public review.

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

SUMMARY
SPA #18-0024

This State Plan Amendment proposes to change the minimum utilization of Residential Treatment Facilities for children and youth from 93 percent to 90 percent. This change will reflect rates that are more in line with current rates of occupancy.

B. RESIDENTIAL TREATMENT FACILITIES FOR CHILDREN AND YOUTH

Medicaid rates for Residential Treatment Facilities for Children and Youth ("RTFs") are established prospectively, based upon actual costs and patient days as reported on cost reports for the fiscal year two years prior to the rate year. The RTF fiscal year and rate year are for the twelve months July 1 through June 30. Actual patient days are subject to a maximum utilization of 96 percent and a minimum utilization of [93]90 percent. For the rate years July 1, 1994 through June 30, 1995 and July 1, 1995 through June 30, 1996 the base year for both rate years for the purpose of setting rates will be July 1, 1992 through June 30, 1993.

Effective July 1, 2011 through June 30, 2012, the rate of payment shall be that which was in effect June 30, 2011.

Effective July 1, 2012 through June 30, 2013, the rate of payment shall be that which was in effect June 30, 2011.

Effective July 1, 2015, such rate of payment will be lowered to reflect the removal of pharmaceutical costs, except as provided for in Section 1, below.

1. OPERATING COSTS

Allowable operating costs are subject to the review and approval of the Office of Mental Health, and will exclude eligible pharmaceuticals which will be reimbursed using the Fee-for-Service Program through the Medicaid formulary administered by the New York State Department of Health. The Fee-for-Service Program will be utilized for the purchase of eligible pharmaceuticals commencing on the date the child is determined to be Medicaid eligible. The cost of medications provided to the child before the determination of Medicaid eligibility will be the responsibility of the RTF, and considered an allowable cost in the development of the provider's reimbursement rate for inpatient stays. In determining the allowability of costs, the Office of Mental Health reviews the categories of cost, described below, with consideration given to the special needs of the patient population to be served by the RTF. The categories of costs include:

(i) Clinical Care. This category of costs includes salaries and fringe benefits for clinical staff.

(ii) Other than Clinical Care. This category of costs includes the costs associated with administration, maintenance and child support.

Allowable per diem operating costs in the category of clinical care are limited to the lesser of the reported costs or the amount derived from the number of clinical staff approved by the Commissioner multiplied by a standard salary and fringe benefit amount. Clinical services such as dental services, purchased on a contractual basis will be considered allowable and not subject to the clinical standard if the services are not uniformly provided by all RTFs and thus not considered by the Commissioner in the establishment of the approved staffing levels.

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, Bureau of Federal Relations and Provider Assessments, 99 Washington Ave., One Commerce Plaza, Suite 1430, Albany, NY 12210, (518) 474-1673, (518) 473-8825 (FAX), e-mail: spa_inquiries@health.state.ny.us

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 institutional services to comply with enacted statutory provisions. The following changes are proposed:

Institutional Services

Effective on or after July 1, 2018, the Department of Health will adjust rates of reimbursement for inpatient psychiatric services provided in general hospitals, or distinct units of general hospitals to reimburse hospitals for providing these services to individuals aged 17 and under to better meet community children's mental health needs. The Department of Health will increase the age adjustment factor for these services to these individuals from 1.0872 to 1.3597.

The estimated annual aggregate increase in gross Medicaid expenditures attributable to the increase of the age adjustment factor is $10,000,000. Funds for this increase are contained in the State budget beginning in state fiscal year 2018/2019.

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. In addition, approved SPA's beginning in 2011 are also available for viewing on this website.

Copies of the proposed State Plan Amendments will be on file in each local (county) social services district and available for public review.

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

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Kings County, Fulton Center
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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, e-mail: 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 institutional services at non-profit Residential Treatment Facilities for Children and Youth to comply with an OMH policy objective. The following changes are proposed:

Institutional Services

The amendment will reflect an adjustment to the minimum utilization range, used in the Residential Treatment Facility reimbursement methodology, from 93 percent to 90 percent, effective on or after July 1, 2018.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2018/2019 is $436,285, with an annualized value of $581,714.

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

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Richmond County, Richmond Center
95 Central Avenue, St. George
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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, e-mail: spa_inquiries@health.ny.gov

SUMMARY
SPA #18-0039

This State Plan Amendment proposes to move Early Intervention services from the Rehabilitative section of the State Plan to the Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT) section. This change is to comport with guidance received from the Centers for Medicare and Medicaid Services (CMS) through the Office of Health Insurance Programs. This amendment adds licensed applied behavior analysts and certified behavior analyst assistants as early intervention service providers. To align with CMS requirements, transportation to and from early intervention services, which is currently reimbursed as an administrative expense under the Early Intervention Program, is included under Early Intervention services.

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6e. Early and Periodic Screening, Diagnostic and Treatment services (EPSDT).

Early Intervention Services

"Early Intervention" Services provided to children who have or who are suspected of having a developmental delay or disability, are under four years of age, and are eligible for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services and for whom services are medically necessary.

These services must be:

- Medically necessary and included in a Medicaid covered category in accordance with 1905(a), 1905(r)(5), 1903(c) of the Social Security Act;
- Ordered or prescribed by a physician or other licensed practitioner acting within his or her scope of practice under New York State law;
- Included in the child's Individualized Family Service Plan (IFSP);
- Provided by qualified professionals working independently or employed by or under contract with an approved early intervention agency;
- Furnished in accordance with all requirements of the State Medicaid Program and other pertinent state and federal laws and regulations, including those for provider qualifications, comparability of services, and the amount, duration and scope provisions; and
- Included in the state's plan or available under Early Periodic Screening, Diagnostic and Treatment EPSDT) services.

Services may be rendered in the setting in which the child's IFSP will be implemented, including but not limited to Article 28 facilities, approved preschool programs, daycare settings, in private practitioners' offices, and natural environments including homes or other community settings.

Collateral visits: Collateral services are services that are provided to the child/family (caregiver) or to the parent (caregiver) in accordance with the child's IFSP. Collateral services are reimbursed as early intervention services and are provided to a family member or significant other of a Medicaid-eligible member, regardless of the family member or significant other's eligibility for Medicaid, who has an interim or final individualized family service plan (IFSP). For purposes of this section, a significant other is a person who substitutes for the recipient's family, interacts regularly with the recipient, and affects directly the recipient's developmental status. Collateral services must be included in the child's and family's IFSP, and include psychological services and social work services provided to infants and toddlers and/or their families/caregivers with an

New York
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interim or final IFSP. Payment is available for collateral services furnished pursuant to an interim or final individualized family service plan and which are provided by a qualified professional working independently or employed by or under contract with and approved early intervention agency. Collateral services must relate to the medical treatment specified in the recipient's interim or final individualized family service plan and must be for the recipient's direct benefit. Persons who receive collateral services to support the child's development must be identified in the interim or final individualized family service plan.

Early Intervention services, limited to EPSDT, which are provided by qualified professionals employed by or under contract to an Early Intervention agency or approved by the State pursuant to an interim or final Individualized Family Service Plan (IFSP) include:

1. Screening Services

Definition: Screening is a process involving those instruments, procedures, family information and observations, and clinical observations used by qualified, state-approved early intervention providers to assess a child's developmental status to indicate what type of evaluation, if any, is warranted.

Services: Screening services outlined in this section of the State Plan are available to Medicaid eligible beneficiaries, who are eligible for Early Intervention (EI) and for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services and for whom services are medically necessary.

Providers: Screening services are provided by qualified individuals with licensure, certification, or registration as applicable in a professional medical, health-related, and/or developmental discipline(s) acting within their scope of practice.

2. Evaluation Services

Definition: Evaluation services are the procedures used by appropriately qualified, state-approved early intervention providers to determine a child's initial and continuing eligibility for the Early Intervention Program and need for services.

Services: Evaluation services determine the child's level of functioning and needs in the areas of cognitive, physical, communication, social or emotional, and adaptive development and include a health assessment including a physical examination, routine vision and hearing screening, and where appropriate, a neurological assessment. When indicated, evaluation services include diagnostic procedures and review of medical and other records to identify a diagnosed physical or mental condition with a high probability of resulting in developmental delay.

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Evaluation services outlined in this section of the State Plan are available to Medicaid eligible beneficiaries, who are eligible for Early Intervention (EI) and for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services and for whom services are medically necessary.

Providers: Evaluation services are performed by qualified individuals with licensure, certification, and registration as applicable in professional medical, health, and developmental disciplines acting within their scope of practice.

3. Audiology Services

Definition: Audiological services as outlined in this section of the State Plan are available to Medicaid-eligible beneficiaries under 4 years of age, who are eligible for Early Intervention (EI) and for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services and for whom services are medically necessary.

Services: Audiology services include services provided to an individual child and/or the child's parent or caregiver when these contacts directly benefit the needs of the child as described in his or her treatment plan, the IFSP, and pursuant to a written order or prescription from a physician, physician assistant or nurse practitioner acting within his or her scope of practice under New York State law as appropriate. Covered services include services to identify, evaluate, and treat hearing loss, including identification of children with auditory impairment using at risk criteria and appropriate audiologic screening techniques; determination of the range, nature, and degree of hearing loss and communication functions, by use of audiological evaluation procedures; referral for medical and other services necessary for the habilitation or rehabilitation of children with auditory impairment; provision of auditory training, aural rehabilitation, speech reading and listening device orientation and training, and other services; and, provision of services for prevention of hearing loss; and, determination of the child's need for individual amplification, including selecting, fitting, and dispensing appropriate listening and vibrotactile devices, and evaluating the effectiveness of those devices.

Providers: Audiology services must be provided by a New York State licensed and registered audiologist, qualified in accordance with 42 CFR Section 440.6(a) and 42 CFR Section 440.110(c)(3) and other applicable state and federal law or regulations, acting within his or her scope of practice under NYS law.

4. Nursing Services

Definition: Nursing services outlined in this section of the State Plan are available to Medicaid eligible beneficiaries, who are eligible for Early Intervention (EI) and for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services and for whom services are medically necessary.

Services: Nursing services include those provided to an individual child and/or the child's parent or caregiver when such contacts directly benefit the needs of the child as described in his or her treatment plan, the IFSP, and pursuant to a written order or prescription from a physician,

physician assistant or nurse practitioner acting within his or her scope of practice under New York State law.

Nursing services include the promotion of health, prevention of illness, care of the ill and disabled people through the provision of services essential to the maintenance and restoration of health. Nursing services may include:

- Health assessments and evaluations;
- Medical treatments and procedures;
- Administering and/or monitoring medication, treatments or regimens needed by the child; and
- Consultation with licensed physicians, parents and other service / health care providers regarding the effects of medication.

Providers: Nursing services are provided by New York State licensed registered nurses qualified in accordance with the requirements at 42 CFR 440.60(a) and other applicable state and federal law and regulations, acting within his or her scope of practice; or a New York State licensed practical nurse qualified in accordance with the requirements at 42 CFR 440.60(a) and other applicable state and federal law and regulations, acting within his or her scope of practice under the direction of a licensed registered nurse, a physician, dentist or other licensed health care provider authorized under the Nurse Practice Act.

"Under the direction of" means that, with respect to each Medicaid beneficiary, the qualified clinician:

- Sees the participant at the beginning of and periodically during the course of treatment;
- Is familiar with the treatment plan as recommended by the referring physician or other licensed practitioner of the healing arts practicing under State law;
- Has continued involvement in the care provided, and reviews the need for continued services throughout treatment;
- Assumes professional responsibility for the services provided under his or her direction and monitors the need for continued services;
- Spends as much time as necessary directly supervising services to ensure beneficiaries are receiving services in a safe and efficient manner in accordance with accepted standards of practice;
- Ensures that individuals working under his or her direction have contact information to permit him or her direct contact with the supervising therapist as necessary during the course of treatment and
- Keeps documentation supporting the supervision of services and ongoing involvement in the treatment.

5. Nutrition Services

Definition: Nutrition services outlined in this section of the State Plan are available to Medicaid eligible beneficiaries, who are eligible for Early Intervention (EI) and for Early and Periodic

New York
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Screening, Diagnostic and Treatment (EPSDT) services and for whom services are medically necessary.

Services: Nutrition services include services provided to an individual child and/or the child's parent or caregiver when such contacts directly benefit the needs of the child as described in his or her treatment plan, the IFSP, and pursuant to a written order or prescription from a physician, physician assistant or nurse practitioner acting within his or her scope of practice under New York State law.

Covered services include individual assessments in nutritional history and dietary intake; anthropometric, biochemical, and clinical variables; feeding skills and feeding problems; and, food habits and food preferences; developing and monitoring appropriate plans to address the nutritional needs of an eligible child; and, making referrals to appropriate community resources to carry out nutrition goals.

Providers: Nutrition services are provided by qualified New York State registered certified dieticians/nutritionists acting within the scope of their profession.

6. Occupational Therapy Services

Definition: Occupational therapy services outlined in this section of the State Plan are available to Medicaid eligible beneficiaries, who are eligible for Early Intervention (EI) and for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services and for whom services are medically necessary.

Services: Occupational therapy services include services provided to an individual child and/or the child's parent or caregiver, and services provided to children individually or in a group when such contacts directly benefit the needs of the child as described in his or her treatment plan, the IFSP, and pursuant to a written order or prescription from a physician, physician assistant or nurse practitioner acting within his or her scope of practice under New York State law.

Covered services include services to address the functional needs of a child related to adaptive development, adaptive behavior and play, and sensory, motor, and postural development. These services are designed to improve the child's functional ability to perform tasks in home, school, and community settings, and include identification, assessment, and intervention; adaptation of the environment, and selection, design and fabrication of assistive and orthotic devices to facilitate development and promote the acquisition of functional skills; and prevention or minimization of the impact of initial or future impairment, delay in development, or loss of functional ability.

Providers: Services must be provided by:

- A New York State licensed and registered occupational therapist qualified in accordance with 42CFR 440.110(b) and applicable state and federal laws and regulations, acting within his or her scope of practice under New York State Law; or

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- a certified occupational therapy assistant "under the direction of" such a qualified licensed and registered occupational therapist, within his or her scope of practice under New York State Law.

"Under the direction of" means that, with respect to each Medicaid beneficiary, the qualified therapist:

- Sees the participant at the beginning of and periodically during the course of treatment;
- Is familiar with the treatment plan as recommended by the referring physician or other licensed practitioner of the healing arts practicing under State law;
- Has continued involvement in the care provided, and reviews the need for continued services throughout treatment;
- Assumes professional responsibility for the services provided under his or her direction and monitors the need for continued services;
- Spends as much time as necessary directly supervising services to ensure beneficiaries are receiving services in a safe and efficient manner in accordance with accepted standards of practice;
- Ensures that individuals working under his or her direction have contact information to permit him or her direct contact with the supervising therapist as necessary during the course of treatment and
- Keeps documentation supporting the supervision of services and ongoing involvement in the treatment.

7. Physical Therapy Services

Definition: Physical therapy services outlined in this section of the State Plan are available to Medicaid eligible beneficiaries, who are eligible for Early Intervention (EI) and for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services and for whom services are medically necessary.

Services: Physical therapy includes services provided to an individual child and/or the child's parent or caregiver, either individually or in a group, when such contacts directly benefit the needs of the child as described in his or her treatment plan, the IFSP, and pursuant to a written order or prescription from a physician, physician assistant or nurse practitioner acting within his or her scope of practice under New York State law.

Covered services include services to address the promotion of sensory motor function through enhancement of musculoskeletal status, neurobehavioral organization, perceptual and motor development, cardiopulmonary status and effective environmental adaptation. These services include evaluation and assessment of infants and toddlers to identify movement dysfunction; obtaining, interpreting, and integrating information appropriate to program planning to prevent, alleviate, or compensate for movement dysfunction and related functional problems; and

providing individual and group services or treatment to prevent, alleviate, or compensate for movement dysfunction and related functional problems.

Providers: Services must be provided by:

- A New York State licensed and registered physical therapist qualified in accordance with 42 CFR 440.110(a) and with applicable state and federal laws and regulations, acting within his or her scope of practice under New York State Law; or

- A certified physical therapy assistant "under the direction of" such a qualified licensed and registered physical therapist, acting within his or her scope of practice under New York State Law.

"Under the direction of" means that, with respect to each Medicaid beneficiary, the qualified therapist:

- Sees the participant at the beginning of and periodically during the course of treatment;
- Is familiar with the treatment plan as recommended by the referring physician or other licensed practitioner of the healing arts practicing under State law;
- Has continued involvement in the care provided, and reviews the need for continued services throughout treatment;
- Assumes professional responsibility for the services provided under his or her direction and monitors the need for continued services;
- Spends as much time as necessary directly supervising services to ensure beneficiaries are receiving services in a safe and efficient manner in accordance with accepted standards of practice;
- Ensures that individuals working under his or her direction have contact information to permit him or her direct contact with the supervising therapist as necessary during the course of treatment and
- Keeps documentation supporting the supervision of services and ongoing involvement in the treatment.

8. Psychological Services

Definition: Psychological services outlined in this section of the State Plan are available to Medicaid eligible beneficiaries, who are eligible for Early Intervention (EI) and for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services and for whom services are medically necessary.

Services: Psychological services include services provided to an individual child, a child and/or the child's parent or caregiver, and services provided to children and/or family members in a group when such contacts directly benefit the needs of the child as described in his or her treatment plan, the IFSP. Covered services include administering psychological and developmental tests and other assessment procedures; interpreting assessment results;

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obtaining, integrating, and interpreting information about child behavior and child and family conditions related to learning, behavioral health, and development; and planning and managing a program of psychological services, including psychological counseling for children and parents, family counseling, consultation on child development, parent training, and education programs.

Providers: Psychological services must be provided by a qualified practitioner, within his or her scope of practice in accordance with New York State law and with the qualification requirements of 42 CFR Section 440.60(a) and 440.50(a)(2) and with other applicable state and federal laws or regulations. Psychological services may only be provided by a professional whose credentials are comparable to those of providers who are able to provide psychological services in the community.

Services may be provided by:

- A New York State licensed and registered psychiatrist qualified in accordance with 42 CFR 440.50(a) and other applicable state and federal law or regulations, acting within his or her scope of practice under New York State law; or
- A New York State licensed and registered psychologist qualified in accordance with 42 CFR Section 440.60(a) and other applicable state and federal law or regulations, acting within his or her scope of practice under New York State law; or
- A New York State licensed clinical social worker (LCSW) qualified in accordance with 42 CFR Section 440.60(a) and other applicable state and federal law or regulations, acting within his or her scope of practice under New York State law; or
- A licensed master social worker (LMSW) qualified in accordance with 42 CFR Section 440.60(a) and other applicable state and federal law or regulations, acting within his or her scope of practice under New York State law, under the supervision of such a qualified licensed clinical social worker, a qualified licensed and registered psychologist, or a qualified licensed and registered psychiatrist as described above; or
- A New York State licensed Mental Health Counselor qualified in accordance with 42 CFR Section 440.60(a) and other applicable state and federal law or regulations, acting within his or her scope of practice under New York State law; or
- A New York State licensed Marriage and Family Therapist qualified in accordance with 42 CFR Section 440.60(a) and other applicable state and federal law or regulations, acting within his or her scope of practice under New York State law; or
- A New York State licensed Psychoanalyst qualified in accordance with 42 CFR Section 440.60(a) and other applicable state and federal law or regulations, acting within his or her scope of practice under New York State law; or
- A New York State licensed Creative Arts Therapist qualified in accordance with 42 CFR Section 440.60(a) and other applicable state and federal law or regulations, acting within his or her scope of practice under New York State law; or
- A New York State certified school psychologist qualified in accordance with 42 CFR 440.60(a) and other applicable state and federal law or regulations, acting within his or her scope of practice under New York State law; and is employed as a certified school psychologist in accordance with Article 153 Section 7605 of NY State Education Law by a

New York
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- school, preschool or an approved early intervention agency working in an "exempt setting."

Supervision of the clinical social work services provided by the licensed master social worker, with respect to each Medicaid beneficiary, shall consist of contact between the licensed master social worker and supervisor during which:

- The licensed master social worker apprises the supervisor of the diagnosis and treatment of each client;
- The licensed master social worker's cases are discussed;
- The supervisor provides the licensed master social worker with oversight and guidance in diagnosing and treating clients;
- The supervisor regularly reviews and evaluates the professional work of the licensed master social worker; and
- The supervisor provides at least two hours per month of in-person individual or group clinical supervision.

The supervision shall be provided by a New York State licensed and registered psychiatrist, psychologist, or licensed clinical social worker. The supervisor shall be responsible for maintaining records of the client contact hours in diagnosis, psychotherapy and assessment-based treatment planning and supervision hours provided to the qualified individual.

9. Social Work Services

Definition: Social work services outlined in this section of the State Plan are available to Medicaid eligible beneficiaries, who are eligible for Early Intervention (EI) and for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services and for whom services are medically necessary.

Services: Social work services are provided to an individual child and/or the child's parent or caregiver, and services provided to children and/or family members in a group when such contacts directly benefit the needs of the child as described in his or her treatment plan, the IFSP. Social work services include: making home visits to evaluate living conditions and patterns of parent-child interaction; preparing a social/emotional developmental assessment of the child within the family context; providing individual and family-group counseling with parents and other family members, and appropriate social skill building activities with the child and parents; working with those problems in a living situation (home, community, and any center where early intervention services are provided) that affect the maximum utilization of early intervention services; and, identifying, mobilizing, and coordinating community resources and services to enable the child and family to receive maximum benefit from early intervention services.

Providers: Clinical social work services must be provided by a qualified practitioner, within his or her scope of practice in accordance with New York State law and with the qualification requirements of 42 CFR 440.60(a) and with other applicable state and federal laws or regulations.

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Services may be provided by:

- A New York State licensed clinical social worker (LCSW) qualified in accordance with 42 CFR Section 440.60(a) and other applicable state and federal law or regulations, acting within his or her scope of practice under New York State law; or
- A licensed master social worker (LMSW) qualified in accordance with 42 CFR Section 440.60(a) and other applicable state and federal law or regulations, acting within his or her scope of practice under New York State law, under the supervision of such a qualified licensed clinical social worker, a qualified licensed and registered psychologist, or a qualified licensed and registered psychiatrist as described above.

Supervision of the clinical social work services provided by the licensed master social worker, with respect to each Medicaid beneficiary, shall consist of contact between the licensed master social worker and supervisor during which:

- The licensed master social worker apprises the supervisor of the diagnosis and treatment of each client;
- The licensed master social worker's cases are discussed;
- The supervisor provides the licensed master social worker with oversight and guidance in diagnosing and treating clients;
- The supervisor regularly reviews and evaluates the professional work of the licensed master social worker; and
- The supervisor provides at least two hours per month of in-person individual or group clinical supervision.

The supervision shall be provided by a New York State licensed and registered psychiatrist, psychologist, or licensed clinical social worker. The supervisor shall be responsible for maintaining records of the client contact hours in diagnosis, psychotherapy and assessment-based treatment planning and supervision hours provided to the qualified individual.

10. Special Instruction/Developmental Services

Definition: Special instruction services outlined in this section of the State Plan are available to Medicaid eligible beneficiaries, who are eligible for Early Intervention (EI) and for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services and for whom services are medically necessary.

Services: Special instruction services include working directly with the child to enhance the child's development. Special instruction services are provided to an individual child and/or the child's parent or caregiver, and services provided to children and/or family in a group when such contacts directly benefit the developmental needs of the child as described in his or her treatment plan, the IFSP. Special instruction includes the design of environments and activities that extend the benefits of intervention/therapy into the child's daily routine and which promote the child's

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acquisition of skills in a variety of developmental areas, including motor development, physical growth and development, sensory perception and information processing; behavioral interactions; cognitive processes; and, social interactions.

Special instruction also includes the provision of instruction, information, and support to parents and primary caregivers in assisting them in planning and maintaining a daily therapeutic regime related to enhancing the child's developmental progress, including skills such as fine and gross motor, feeding, and other adaptive skill.

Providers: Special instruction services are provided by qualified individuals possessing the following certification issued by the State Education Department pursuant to State regulations; special education teachers, teachers of students with disabilities - birth to grade two, teachers of the blind and partially sighted, teachers of the blind and visually handicapped, teachers of the blind and visually impaired, teachers of the deaf and hard of hearing, teachers of the speech and hearing handicapped, teachers of students with speech and language disabilities.

11. Speech-Language Pathology Services

Definition: Speech-language pathology services outlined in this section of the State Plan are available to Medicaid eligible beneficiaries, who are eligible for Early Intervention (EI) and for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services and for whom services are medically necessary.

Services: Speech-language pathology services are provided to an individual child and/or the child's parent or caregiver, either individually or in a group, when such contacts directly benefit the needs of the child as described in his or her treatment plan, the IFSP, and pursuant to a written order or prescription from a speech-language pathologist, physician, physician assistant or nurse practitioner acting within his or her scope of practice under New York State law.

These services include the identification of children with communicative or oropharyngeal disorders and delays in development of communication skills, including the diagnosis and appraisal of specific disorders and delays in those skills; referral for medical or other professional services necessary for the habilitation or rehabilitation of children with communicative or oropharyngeal disorders and delays in development of communication skills; and provision of services for the habilitation, rehabilitation, or prevention of communicative or oropharyngeal disorders and delays in development of communication skills.

Providers: Services must be provided by:

- A licensed and registered speech-language pathologist qualified in accordance with 42 CFR Section 440.110(c) and applicable state and federal laws and regulations, acting within his or her scope of practice under New York State law; or
- A teacher certified to provide speech and language services, under the documented direction of such a qualified licensed and registered speech-language pathologist (ASHA certified or equivalent), acting within his or her scope of practice under New York State law.

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"Under the Direction of" means that, with respect to each Medicaid beneficiary, the qualified therapist:

- Sees the participant at the beginning of and periodically during the course of treatment;
- Is familiar with the treatment plan as recommended by the referring physician or other licensed practitioner of the healing arts practicing under State Law;
- Has continued involvement in the care provided, and reviews the need for continued services throughout treatment;
- Assumes professional responsibility for the services provided under his or her direction and monitors the need for continued services;
- Spends as much time as necessary directly supervising services to ensure beneficiaries are receiving services in a safe and efficient manner in accordance with accepted standards;
- Ensures that individuals working under his or her direction have contact information to permit him or her direct contact with the supervising therapist as necessary during the course of treatment; and
- Keeps documentation supporting the supervision of services and ongoing involvement in the treatment.

12. Assistive Technology Devices and Services

Definition: Assistive technology devices and services outlined in this section of the State Plan are available to Medicaid eligible beneficiaries, who are eligible for Early Intervention (EI) and for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services and for whom services are medically necessary.

Assistive technology device means any item, piece of equipment, or product system, whether acquired commercially off the shelf, modified, or customized, provided to an individual child, that is used to increase, maintain, or improve the functional capabilities of the child.

Services: Assistive technology services are services provided to an individual child and/or the child's parent or caregiver when such contacts directly benefit the needs of the child as described in his or her treatment plan, the IFSP. Assistive technology services are services that directly assist a child with a disability in the selection, acquisition, or use of an assistive technology device. Assistive technology services include: the evaluation of the needs of a child with a disability, including a functional evaluation of the child in the customary environment; purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices by children with disabilities; selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices; coordinating and using other therapies, interventions, or services with assistive technology devices, such as those associated with existing education and rehabilitation plans and programs; training or technical assistance for a child with disabilities or, if appropriate, that family; and, training or technical assistance for professionals (including individuals providing early intervention services) or other individuals who provide services to, or are otherwise substantially involved in, the major life functions of individuals with disabilities.

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Providers: Assistive technology services are provided by medical equipment and supply dealers, clinics, hospitals, pharmacies, residential health facilities, and certified home health agencies enrolled in the medical assistance program as a medical equipment dealer. Assistive technology services may also be provided by state-licensed licensed audiologists, speech-language pathologists, physical therapists and assistants, occupational therapists and assistants, orientation and mobility specialists, physicians, practical nurses, registered nurses, and nurse practitioners and other individuals with licensure, certification, or registration in a professional medical, health-related, and/or developmental discipline, within the scope of their professions and to the extent authorized by their licenses.

13. Vision Services

Definition: Vision services outlined in this section of the State Plan are available to Medicaid eligible beneficiaries, who are eligible for Early Intervention (EI) and for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services and for whom services are medically necessary.

Services: Vision services are provided to an individual child and/or the child's parent or caregiver, and services provided to children and/or family members in a group when such contacts directly benefit the needs of the child as described in his or her treatment plan, the IFSP, pursuant to a written order or prescription from a physician, physician assistant or nurse practitioner acting within his or her scope of practice under New York State law.

Vision services include evaluation and assessment of visual functioning, including the diagnosis and appraisal of specific visual disorders, delays, and abilities; referral for medical or other professional services necessary for the habilitation or rehabilitation of visual functioning disorders, or both; and communication skills training, orientation and mobility training for all environments, visual training, independent living skills training, and additional training necessary to activate visual motor abilities.

Providers: Vision services are provided by certified low vision specialists, orientation and mobility specialists and vision rehabilitation therapists certified by the Academy for the Certification for Vision Rehabilitation and Education Professionals, state licensed physicians including ophthalmologists; and licensed optometrists, and orientation and mobility specialists, within the scope of their profession and to the extent authorized by their license or certification.

14. Applied Behavioral Analysis (ABA) Services

Definition: ABA services outlined in this section of the State Plan are available to Medicaid eligible beneficiaries, who are eligible for Early Intervention (EI) and for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services and for whom services are medically necessary.

Services: ABA services means the design, implementation, and evaluation of systematic environmental changes to produce socially significant change in human behavior through skill

acquisition and the reduction of problematic behavior. ABA includes direct observation and measurement of behavior and the identification of functional relations between behavior and the environment. These include contextual factors such as establishing operations, antecedent stimuli, positive reinforcers, and other consequences that are used to produce the desired behavior change.

Providers: Services must be provided by:

- a licensed and registered behavior analyst qualified in accordance with applicable state and federal laws and regulations, acting within his or her scope of practice under New York State law, Education Law Article 167; or
- a certified behavior analyst assistant, under the documented direction of such a qualified licensed and registered behavior analyst, acting within his or her scope of practice under New York State law, Education Law Article 167.

"Under the Direction of" means that, with respect to each Medicaid beneficiary, the qualified therapist:

- Sees the participant at the beginning of and periodically during the course of treatment;
- Is familiar with the treatment plan as recommended by the referring physician or other licensed practitioner of the healing arts practicing under State Law;
- Has continued involvement in the care provided, and reviews the need for continued services throughout treatment;
- Assumes professional responsibility for the services provided under his or her direction and monitors the need for continued services;
- Spends as much time as necessary directly supervising services to ensure beneficiaries are receiving services in a safe and efficient manner in accordance with accepted standards;
- Ensures that individuals working under his or her direction have contact information to permit him or her direct contact with the supervising therapist as necessary during the course of treatment; and
- Keeps documentation supporting the supervision of services and ongoing involvement in the treatment.

15. Transportation Services

Definition: Transportation outlined in this section of the State Plan is available to Medicaid eligible beneficiaries who are eligible for Early Intervention (EI) and for Early and Periodic Screening Diagnostic and Treatment (EPSDT) services and for whom services are medically necessary.

Services: Transportation delivered by the State's designated transportation provider pursuant to prior authorization by a municipal Early Intervention Official or Early Intervention Official Designee in the State or the City of New York must be included in the IFSP as recommended by the IFSP Team. Transportation arrangements must be identified in the IFSP.

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Transportation is limited to those situations where the child receives transportation to obtain a Medicaid covered early intervention service other than transportation and both the Medicaid covered service and the need for transportation are included in the child's IFSP. Transportation can only be billed on a day that a Medicaid reimbursable service was delivered and may only be billed at the rate for each one-way trip.

Providers: Transportation services must be provided by a qualified, Medicaid-enrolled provider. Each one-way trip must be documented in accordance with Medicaid record keeping requirements in order to bill Medicaid. To receive payment for services provided to a Medicaid recipient, a vendor must be an enrolled Medicaid transportation provider authorized to provide transportation services on the date the services are rendered.

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12a. Prior authorization or dispensing validation is required for some prescription drugs. In addition, brand-name drugs that have a FDA approved, A-rated generic equivalent must be prior authorized unless exempted by the Commissioner of Health.

Drugs for which Medical Assistance reimbursement is available are limited to the following:

1. those non-prescription drugs contained on a list established by the New York State Commissioner of Health.
2. covered outpatient drugs of any manufacturer which has entered into and complies with an agreement under Sections 1902(a) (54) and 1927 (a) of the Act which are prescribed for a medically accepted indication. (As provided by Section 1927 (d) (2) of the Act certain outpatient drugs may be excluded from coverage).

12b. Prior approval is required for all dentures.

12c. Prior approval is required for prosthetic and orthotic devices over a dollar amount established by the State Department of Health and identified for providers in the MMIS DME Provider Manual.

Prior approval is required for artificial eyes as specified in the MMIS Ophthalmic Provider Manual.
Program also includes coverage of orthotic appliances including hearing aids. All hearing aids require prior approval.

12d. Prior approval is required for certain special lenses and unlisted eye services as specified for providers in the MMIS Ophthalmic Provider Manual.

13a. Diagnostic Services (see 13.d Rehabilitative Services – Early Intervention).

13b. Screening Services (see 13.d Rehabilitative Services – Early Intervention).

13c. Preventive Services (see 13.d Rehabilitative Services – Early Intervention).

13d. Rehabilitative Services

[(1) Directly Observed Therapy (DOT) – Clients must be assessed as medically appropriate for DOT based upon the client's risk of non-adherence to a medication regimen necessary to cure an active, infectious, potentially fatal disease process and to prevent the development and spread of an infectious, potentially fatal disease which may not respond to conventional therapies.]

Off-site" services shall be provided to developmentally disabled persons whose therapeutic requirements are most effectively satisfied in an appropriate environment that is specific to the treatment needs of the developmentally disabled individual. Such services shall be provided by persons authorized pursuant to NYCRR Title 14 Part 679. "Off-site" services shall not be provided at the location of a clinic certified by NYCRR Title 14 Part 679. Coverage of "off-site" services shall end effective December 31, 2015.

["Early Intervention" Services are provided to children who have or who are suspected of having a developmental delay or disability. These services, limited to EPSDT, which are provided by or on behalf of a county or the City of New York pursuant to an Individualized Family Services Plan (IFSP) include:

1. Screening
2. Evaluation
3. Audiology
4. Nursing
5. Nutrition Services
6. Occupational Therapy
7. Physical Therapy
8. Psychological Services
9. Social Work Services
10. Anticipatory Guidance (Special Instruction and Allied Health Professional Assistance)]
11. Speech Pathology Services
12. Assistive Technology Services
13. Vision Services
14. Collateral contacts for all of the above services

13d. Rehabilitative Services (Continued)

Directly Observed Therapy (DOT)

Directly Observed Therapy for Tuberculosis (TB/DOT) is the direct observation of oral ingestion of tuberculosis medications to assure patient compliance with the prescribed medication regimen. Directly observed therapy is the standard of care for every individual with active tuberculosis. TB/DOT may be provided on an outpatient basis in a community setting (including the home) or on an inpatient basis.

Clients must be assessed as medically appropriate for DOT based upon the client's risk of non-adherence to a medication regimen necessary to cure an active, infectious, potentially fatal disease process and to prevent the development and spread of an infectious, potentially fatal disease which may not respond to conventional therapies.

Services

Outpatient TB/DOT involves the dispensing of medication and observation thereof, assessing any adverse reactions to the medications, and case follow up.

- In New York City, TB/DOT is provided in New York City Department of Health and Mental Hygiene (DOHMH) clinics, approved Health and Hospitals Corporation (HHC) hospitals (Bellevue, Elmhurst, Kings County), or in the home or other community setting.
- In the rest of the state, TB/DOT is provided in the local health department (LHD) or in the home or other community setting.

Inpatient long term treatment may be indicated where the LHD has determined the patient has a poor treatment response, has medical complications, remains infectious with no other appropriate residential placement available, or other intensive residential placement is not possible.

Providers

Servicing providers for TB/DOT include local public health agencies and New York State licensed and registered professionals acting within their scope of practice.

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6e. Early and Periodic Screening, Diagnostic and Treatment services (EPSDT).

Early Intervention Services

"Early Intervention" Services provided to children who have or who are suspected of having a developmental delay or disability, are under four years of age, and are eligible for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services and for whom services are medically necessary.

These services must be:

- Medically necessary and included in a Medicaid covered category in accordance with 1905(a), 1905(r)(5), 1903(c) of the Social Security Act;
- Ordered or prescribed by a physician or other licensed practitioner acting within his or her scope of practice under New York State law;
- Included in the child's Individualized Family Service Plan (IFSP);
- Provided by qualified professionals working independently or employed by or under contract with an approved early intervention agency;
- Furnished in accordance with all requirements of the State Medicaid Program and other pertinent state and federal laws and regulations, including those for provider qualifications, comparability of services, and the amount, duration and scope provisions; and
- Included in the state's plan or available under Early Periodic Screening, Diagnostic and Treatment EPSDT) services.

Services may be rendered in the setting in which the child's IFSP will be implemented, including but not limited to Article 28 facilities, approved preschool programs, daycare settings, in private practitioners' offices, and natural environments including homes or other community settings.

Collateral visits: Collateral services are services that are provided to the child/family (caregiver) or to the parent (caregiver) in accordance with the child's IFSP. Collateral services are reimbursed as early intervention services and are provided to a family member or significant other of a Medicaid-eligible member, regardless of the family member or significant other's eligibility for Medicaid, who has an interim or final individualized family service plan (IFSP). For purposes of this section, a significant other is a person who substitutes for the recipient's family, interacts regularly with the recipient, and affects directly the recipient's developmental status. Collateral services must be included in the child's and family's IFSP, and include psychological services and social work services provided to infants and toddlers and/or their families/caregivers with an

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interim or final IFSP. Payment is available for collateral services furnished pursuant to an interim or final individualized family service plan and which are provided by a qualified professional working independently or employed by or under contract with and approved early intervention agency. Collateral services must relate to the medical treatment specified in the recipient's interim or final individualized family service plan and must be for the recipient's direct benefit. Persons who receive collateral services to support the child's development must be identified in the interim or final individualized family service plan.

Early Intervention services, limited to EPSDT, which are provided by qualified professionals employed by or under contract to an Early Intervention agency or approved by the State pursuant to an interim or final Individualized Family Service Plan (IFSP) include:

1. Screening Services

Definition: Screening is a process involving those instruments, procedures, family information and observations, and clinical observations used by qualified, state-approved early intervention providers to assess a child's developmental status to indicate what type of evaluation, if any, is warranted.

Services: Screening services outlined in this section of the State Plan are available to Medicaid eligible beneficiaries, who are eligible for Early Intervention (EI) and for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services and for whom services are medically necessary.
Providers: Screening services are provided by qualified individuals with licensure, certification, or registration as applicable in a professional medical, health-related, and/or developmental discipline(s) acting within their scope of practice.

2. Evaluation Services

Definition: Evaluation services are the procedures used by appropriately qualified, state-approved early intervention providers to determine a child's initial and continuing eligibility for the Early Intervention Program and need for services.

Services: Evaluation services determine the child's level of functioning and needs in the areas of cognitive, physical, communication, social or emotional, and adaptive development and include a health assessment including a physical examination, routine vision and hearing screening, and where appropriate, a neurological assessment. When indicated, evaluation services include diagnostic procedures and review of medical and other records to identify a diagnosed physical or mental condition with a high probability of resulting in developmental delay.

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Evaluation services outlined in this section of the State Plan are available to Medicaid eligible beneficiaries, who are eligible for Early Intervention (EI) and for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services and for whom services are medically necessary.

Providers: Evaluation services are performed by qualified individuals with licensure, certification, and registration as applicable in professional medical, health, and developmental disciplines acting within their scope of practice.

3. Audiology Services

Definition: Audiological services as outlined in this section of the State Plan are available to Medicaid-eligible beneficiaries under 4 years of age, who are eligible for Early Intervention (EI) and for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services and for whom services are medically necessary.

Services: Audiology services include services provided to an individual child and/or the child's parent or caregiver when these contacts directly benefit the needs of the child as described in his or her treatment plan, the IFSP, and pursuant to a written order or prescription from a physician, physician assistant or nurse practitioner acting within his or her scope of practice under New York State law as appropriate. Covered services include services to identify, evaluate, and treat hearing loss, including identification of children with auditory impairment using at risk criteria and appropriate audiologic screening techniques; determination of the range, nature, and degree of hearing loss and communication functions, by use of audiological evaluation procedures; referral for medical and other services necessary for the habilitation or rehabilitation of children with auditory impairment; provision of auditory training, aural rehabilitation, speech reading and listening device orientation and training, and other services; and, provision of services for prevention of hearing loss; and, determination of the child's need for individual amplification, including selecting, fitting, and dispensing appropriate listening and vibrotactile devices, and evaluating the effectiveness of those devices.

Providers: Audiology services must be provided by a New York State licensed and registered audiologist, qualified in accordance with 42 CFR Section 440.6(a) and 42 CFR Section 440.110(c)(3) and other applicable state and federal law or regulations, acting within his or her scope of practice under NYS law.

4. Nursing Services

Definition: Nursing services outlined in this section of the State Plan are available to Medicaid eligible beneficiaries, who are eligible for Early Intervention (EI) and for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services and for whom services are medically necessary.

Services: Nursing services include those provided to an individual child and/or the child's parent or caregiver when such contacts directly benefit the needs of the child as described in his or her treatment plan, the IFSP, and pursuant to a written order or prescription from a physician,

physician assistant or nurse practitioner acting within his or her scope of practice under New York State law.

Nursing services include the promotion of health, prevention of illness, care of the ill and disabled people through the provision of services essential to the maintenance and restoration of health. Nursing services may include:

- Health assessments and evaluations;
- Medical treatments and procedures;
- Administering and/or monitoring medication, treatments or regimens needed by the child; and
- Consultation with licensed physicians, parents and other service / health care providers regarding the effects of medication.

Providers: Nursing services are provided by New York State licensed registered nurses qualified in accordance with the requirements at 42 CFR 440.60(a) and other applicable state and federal law and regulations, acting within his or her scope of practice; or a New York State licensed practical nurse qualified in accordance with the requirements at 42 CFR 440.60(a) and other applicable state and federal law and regulations, acting within his or her scope of practice under the direction of a licensed registered nurse, a physician, dentist or other licensed health care provider authorized under the Nurse Practice Act.

"Under the direction of" means that, with respect to each Medicaid beneficiary, the qualified clinician:

- Sees the participant at the beginning of and periodically during the course of treatment;
- Is familiar with the treatment plan as recommended by the referring physician or other licensed practitioner of the healing arts practicing under State law;
- Has continued involvement in the care provided, and reviews the need for continued services throughout treatment;
- Assumes professional responsibility for the services provided under his or her direction and monitors the need for continued services;
- Spends as much time as necessary directly supervising services to ensure beneficiaries are receiving services in a safe and efficient manner in accordance with accepted standards of practice;
- Ensures that individuals working under his or her direction have contact information to permit him or her direct contact with the supervising therapist as necessary during the course of treatment and
- Keeps documentation supporting the supervision of services and ongoing involvement in the treatment.

5. Nutrition Services

Definition: Nutrition services outlined in this section of the State Plan are available to Medicaid eligible beneficiaries, who are eligible for Early Intervention (EI) and for Early and Periodic

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Screening, Diagnostic and Treatment (EPSDT) services and for whom services are medically necessary.

Services: Nutrition services include services provided to an individual child and/or the child's parent or caregiver when such contacts directly benefit the needs of the child as described in his or her treatment plan, the IFSP, and pursuant to a written order or prescription from a physician, physician assistant or nurse practitioner acting within his or her scope of practice under New York State law.

Covered services include individual assessments in nutritional history and dietary intake; anthropometric, biochemical, and clinical variables; feeding skills and feeding problems; and, food habits and food preferences; developing and monitoring appropriate plans to address the nutritional needs of an eligible child; and, making referrals to appropriate community resources to carry out nutrition goals.

Providers: Nutrition services are provided by qualified New York State registered certified dieticians/nutritionists acting within the scope of their profession.

6. Occupational Therapy Services

Definition: Occupational therapy services outlined in this section of the State Plan are available to Medicaid eligible beneficiaries, who are eligible for Early Intervention (EI) and for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services and for whom services are medically necessary.

Services: Occupational therapy services include services provided to an individual child and/or the child's parent or caregiver, and services provided to children individually or in a group when such contacts directly benefit the needs of the child as described in his or her treatment plan, the IFSP, and pursuant to a written order or prescription from a physician, physician assistant or nurse practitioner acting within his or her scope of practice under New York State law.

Covered services include services to address the functional needs of a child related to adaptive development, adaptive behavior and play, and sensory, motor, and postural development. These services are designed to improve the child's functional ability to perform tasks in home, school, and community settings, and include identification, assessment, and intervention; adaptation of the environment, and selection, design and fabrication of assistive and orthotic devices to facilitate development and promote the acquisition of functional skills; and prevention or minimization of the impact of initial or future impairment, delay in development, or loss of functional ability.

Providers: Services must be provided by:

- A New York State licensed and registered occupational therapist qualified in accordance with 42CFR 440.110(b) and applicable state and federal laws and regulations, acting within his or her scope of practice under New York State Law; or

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- a certified occupational therapy assistant "under the direction of" such a qualified licensed and registered occupational therapist, within his or her scope of practice under New York State Law.

"Under the direction of" means that, with respect to each Medicaid beneficiary, the qualified therapist:

- Sees the participant at the beginning of and periodically during the course of treatment;
- Is familiar with the treatment plan as recommended by the referring physician or other licensed practitioner of the healing arts practicing under State law;
- Has continued involvement in the care provided, and reviews the need for continued services throughout treatment;
- Assumes professional responsibility for the services provided under his or her direction and monitors the need for continued services;
- Spends as much time as necessary directly supervising services to ensure beneficiaries are receiving services in a safe and efficient manner in accordance with accepted standards of practice;
- Ensures that individuals working under his or her direction have contact information to permit him or her direct contact with the supervising therapist as necessary during the course of treatment and
- Keeps documentation supporting the supervision of services and ongoing involvement in the treatment.

7. Physical Therapy Services

Definition: Physical therapy services outlined in this section of the State Plan are available to Medicaid eligible beneficiaries, who are eligible for Early Intervention (EI) and for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services and for whom services are medically necessary.

Services: Physical therapy includes services provided to an individual child and/or the child's parent or caregiver, either individually or in a group, when such contacts directly benefit the needs of the child as described in his or her treatment plan, the IFSP, and pursuant to a written order or prescription from a physician, physician assistant or nurse practitioner acting within his or her scope of practice under New York State law.

Covered services include services to address the promotion of sensory motor function through enhancement of musculoskeletal status, neurobehavioral organization, perceptual and motor development, cardiopulmonary status and effective environmental adaptation. These services include evaluation and assessment of infants and toddlers to identify movement dysfunction; obtaining, interpreting, and integrating information appropriate to program planning to prevent, alleviate, or compensate for movement dysfunction and related functional problems; and

providing individual and group services or treatment to prevent, alleviate, or compensate for movement dysfunction and related functional problems.

Providers: Services must be provided by:

- A New York State licensed and registered physical therapist qualified in accordance with 42 CFR 440.110(a) and with applicable state and federal laws and regulations, acting within his or her scope of practice under New York State Law; or

- A certified physical therapy assistant "under the direction of" such a qualified licensed and registered physical therapist, acting within his or her scope of practice under New York State Law.

"Under the direction of" means that, with respect to each Medicaid beneficiary, the qualified therapist:

- Sees the participant at the beginning of and periodically during the course of treatment;
- Is familiar with the treatment plan as recommended by the referring physician or other licensed practitioner of the healing arts practicing under State law;
- Has continued involvement in the care provided, and reviews the need for continued services throughout treatment;
- Assumes professional responsibility for the services provided under his or her direction and monitors the need for continued services;
- Spends as much time as necessary directly supervising services to ensure beneficiaries are receiving services in a safe and efficient manner in accordance with accepted standards of practice;
- Ensures that individuals working under his or her direction have contact information to permit him or her direct contact with the supervising therapist as necessary during the course of treatment and
- Keeps documentation supporting the supervision of services and ongoing involvement in the treatment.

8. Psychological Services

Definition: Psychological services outlined in this section of the State Plan are available to Medicaid eligible beneficiaries, who are eligible for Early Intervention (EI) and for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services and for whom services are medically necessary.

Services: Psychological services include services provided to an individual child, a child and/or the child's parent or caregiver, and services provided to children and/or family members in a group when such contacts directly benefit the needs of the child as described in his or her treatment plan, the IFSP. Covered services include administering psychological and developmental tests and other assessment procedures; interpreting assessment results;

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obtaining, integrating, and interpreting information about child behavior and child and family conditions related to learning, behavioral health, and development; and planning and managing a program of psychological services, including psychological counseling for children and parents, family counseling, consultation on child development, parent training, and education programs.

Providers: Psychological services must be provided by a qualified practitioner, within his or her scope of practice in accordance with New York State law and with the qualification requirements of 42 CFR Section 440.60(a) and 440.50(a)(2) and with other applicable state and federal laws or regulations. Psychological services may only be provided by a professional whose credentials are comparable to those of providers who are able to provide psychological services in the community.

Services may be provided by:

- A New York State licensed and registered psychiatrist qualified in accordance with 42 CFR 440.50(a) and other applicable state and federal law or regulations, acting within his or her scope of practice under New York State law; or
- A New York State licensed and registered psychologist qualified in accordance with 42 CFR Section 440.60(a) and other applicable state and federal law or regulations, acting within his or her scope of practice under New York State law; or
- A New York State licensed clinical social worker (LCSW) qualified in accordance with 42 CFR Section 440.60(a) and other applicable state and federal law or regulations, acting within his or her scope of practice under New York State law; or
- A licensed master social worker (LMSW) qualified in accordance with 42 CFR Section 440.60(a) and other applicable state and federal law or regulations, acting within his or her scope of practice under New York State law, under the supervision of such a qualified licensed clinical social worker, a qualified licensed and registered psychologist, or a qualified licensed and registered psychiatrist as described above; or
- A New York State licensed Mental Health Counselor qualified in accordance with 42 CFR Section 440.60(a) and other applicable state and federal law or regulations, acting within his or her scope of practice under New York State law; or
- A New York State licensed Marriage and Family Therapist qualified in accordance with 42 CFR Section 440.60(a) and other applicable state and federal law or regulations, acting within his or her scope of practice under New York State law; or
- A New York State licensed Psychoanalyst qualified in accordance with 42 CFR Section 440.60(a) and other applicable state and federal law or regulations, acting within his or her scope of practice under New York State law; or
- A New York State licensed Creative Arts Therapist qualified in accordance with 42 CFR Section 440.60(a) and other applicable state and federal law or regulations, acting within his or her scope of practice under New York State law; or
- A New York State certified school psychologist qualified in accordance with 42 CFR 440.60(a) and other applicable state and federal law or regulations, acting within his or her scope of practice under New York State law; and is employed as a certified school psychologist in accordance with Article 153 Section 7605 of NY State Education Law by a

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2(xii)(Q.8)

- school, preschool or an approved early intervention agency working in an "exempt setting."

Supervision of the clinical social work services provided by the licensed master social worker, with respect to each Medicaid beneficiary, shall consist of contact between the licensed master social worker and supervisor during which:

- The licensed master social worker apprises the supervisor of the diagnosis and treatment of each client;
- The licensed master social worker's cases are discussed;
- The supervisor provides the licensed master social worker with oversight and guidance in diagnosing and treating clients;
- The supervisor regularly reviews and evaluates the professional work of the licensed master social worker; and
- The supervisor provides at least two hours per month of in-person individual or group clinical supervision.

The supervision shall be provided by a New York State licensed and registered psychiatrist, psychologist, or licensed clinical social worker. The supervisor shall be responsible for maintaining records of the client contact hours in diagnosis, psychotherapy and assessment-based treatment planning and supervision hours provided to the qualified individual.

9. Social Work Services

Definition: Social work services outlined in this section of the State Plan are available to Medicaid eligible beneficiaries, who are eligible for Early Intervention (EI) and for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services and for whom services are medically necessary.

Services: Social work services are provided to an individual child and/or the child's parent or caregiver, and services provided to children and/or family members in a group when such contacts directly benefit the needs of the child as described in his or her treatment plan, the IFSP. Social work services include: making home visits to evaluate living conditions and patterns of parent-child interaction; preparing a social/emotional developmental assessment of the child within the family context; providing individual and family-group counseling with parents and other family members, and appropriate social skill building activities with the child and parents; working with those problems in a living situation (home, community, and any center where early intervention services are provided) that affect the maximum utilization of early intervention services; and, identifying, mobilizing, and coordinating community resources and services to enable the child and family to receive maximum benefit from early intervention services.

Providers: Clinical social work services must be provided by a qualified practitioner, within his or her scope of practice in accordance with New York State law and with the qualification requirements of 42 CFR 440.60(a) and with other applicable state and federal laws or regulations.

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Services may be provided by:

- A New York State licensed clinical social worker (LCSW) qualified in accordance with 42 CFR Section 440.60(a) and other applicable state and federal law or regulations, acting within his or her scope of practice under New York State law; or
- A licensed master social worker (LMSW) qualified in accordance with 42 CFR Section 440.60(a) and other applicable state and federal law or regulations, acting within his or her scope of practice under New York State law, under the supervision of such a qualified licensed clinical social worker, a qualified licensed and registered psychologist, or a qualified licensed and registered psychiatrist as described above.

Supervision of the clinical social work services provided by the licensed master social worker, with respect to each Medicaid beneficiary, shall consist of contact between the licensed master social worker and supervisor during which:

- The licensed master social worker apprises the supervisor of the diagnosis and treatment of each client;
- The licensed master social worker's cases are discussed;
- The supervisor provides the licensed master social worker with oversight and guidance in diagnosing and treating clients;
- The supervisor regularly reviews and evaluates the professional work of the licensed master social worker; and
- The supervisor provides at least two hours per month of in-person individual or group clinical supervision.

The supervision shall be provided by a New York State licensed and registered psychiatrist, psychologist, or licensed clinical social worker. The supervisor shall be responsible for maintaining records of the client contact hours in diagnosis, psychotherapy and assessment-based treatment planning and supervision hours provided to the qualified individual.

10. Special Instruction/Developmental Services

Definition: Special instruction services outlined in this section of the State Plan are available to Medicaid eligible beneficiaries, who are eligible for Early Intervention (EI) and for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services and for whom services are medically necessary.

Services: Special instruction services include working directly with the child to enhance the child's development. Special instruction services are provided to an individual child and/or the child's parent or caregiver, and services provided to children and/or family in a group when such contacts directly benefit the developmental needs of the child as described in his or her treatment plan, the IFSP. Special instruction includes the design of environments and activities that extend the benefits of intervention/therapy into the child's daily routine and which promote the child's

acquisition of skills in a variety of developmental areas, including motor development, physical growth and development, sensory perception and information processing; behavioral interactions; cognitive processes; and, social interactions.

Special instruction also includes the provision of instruction, information, and support to parents and primary caregivers in assisting them in planning and maintaining a daily therapeutic regime related to enhancing the child's developmental progress, including skills such as fine and gross motor, feeding, and other adaptive skill.

Providers: Special instruction services are provided by qualified individuals possessing the following certification issued by the State Education Department pursuant to State regulations; special education teachers, teachers of students with disabilities - birth to grade two, teachers of the blind and partially sighted, teachers of the blind and visually handicapped, teachers of the blind and visually impaired, teachers of the deaf and hard of hearing, teachers of the speech and hearing handicapped, teachers of students with speech and language disabilities.

11. Speech-Language Pathology Services

Definition: Speech-language pathology services outlined in this section of the State Plan are available to Medicaid eligible beneficiaries, who are eligible for Early Intervention (EI) and for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services and for whom services are medically necessary.

Services: Speech-language pathology services are provided to an individual child and/or the child's parent or caregiver, either individually or in a group, when such contacts directly benefit the needs of the child as described in his or her treatment plan, the IFSP, and pursuant to a written order or prescription from a speech-language pathologist, physician, physician assistant or nurse practitioner acting within his or her scope of practice under New York State law.

These services include the identification of children with communicative or oropharyngeal disorders and delays in development of communication skills, including the diagnosis and appraisal of specific disorders and delays in those skills; referral for medical or other professional services necessary for the habilitation or rehabilitation of children with communicative or oropharyngeal disorders and delays in development of communication skills; and provision of services for the habilitation, rehabilitation, or prevention of communicative or oropharyngeal disorders and delays in development of communication skills.

Providers: Services must be provided by:

- A licensed and registered speech-language pathologist qualified in accordance with 42 CFR Section 440.110(c) and applicable state and federal laws and regulations, acting within his or her scope of practice under New York State law; or
- A teacher certified to provide speech and language services, under the documented direction of such a qualified licensed and registered speech-language pathologist (ASHA certified or equivalent), acting within his or her scope of practice under New York State law.

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"Under the Direction of" means that, with respect to each Medicaid beneficiary, the qualified therapist:

- Sees the participant at the beginning of and periodically during the course of treatment;
- Is familiar with the treatment plan as recommended by the referring physician or other licensed practitioner of the healing arts practicing under State Law;
- Has continued involvement in the care provided, and reviews the need for continued services throughout treatment;
- Assumes professional responsibility for the services provided under his or her direction and monitors the need for continued services;
- Spends as much time as necessary directly supervising services to ensure beneficiaries are receiving services in a safe and efficient manner in accordance with accepted standards;
- Ensures that individuals working under his or her direction have contact information to permit him or her direct contact with the supervising therapist as necessary during the course of treatment; and
- Keeps documentation supporting the supervision of services and ongoing involvement in the treatment.

12. Assistive Technology Devices and Services

Definition: Assistive technology devices and services outlined in this section of the State Plan are available to Medicaid eligible beneficiaries, who are eligible for Early Intervention (EI) and for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services and for whom services are medically necessary.

Assistive technology device means any item, piece of equipment, or product system, whether acquired commercially off the shelf, modified, or customized, provided to an individual child, that is used to increase, maintain, or improve the functional capabilities of the child.

Services: Assistive technology services are services provided to an individual child and/or the child's parent or caregiver when such contacts directly benefit the needs of the child as described in his or her treatment plan, the IFSP. Assistive technology services are services that directly assist a child with a disability in the selection, acquisition, or use of an assistive technology device. Assistive technology services include: the evaluation of the needs of a child with a disability, including a functional evaluation of the child in the customary environment; purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices by children with disabilities; selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices; coordinating and using other therapies, interventions, or services with assistive technology devices, such as those associated with existing education and rehabilitation plans and programs; training or technical assistance for a child with disabilities or, if appropriate, that family; and, training or technical assistance for professionals (including individuals providing early intervention services) or other individuals who provide services to, or are otherwise substantially involved in, the major life functions of individuals with disabilities.

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Providers: Assistive technology services are provided by medical equipment and supply dealers, clinics, hospitals, pharmacies, residential health facilities, and certified home health agencies enrolled in the medical assistance program as a medical equipment dealer. Assistive technology services may also be provided by state-licensed licensed audiologists, speech-language pathologists, physical therapists and assistants, occupational therapists and assistants, orientation and mobility specialists, physicians, practical nurses, registered nurses, and nurse practitioners and other individuals with licensure, certification, or registration in a professional medical, health-related, and/or developmental discipline, within the scope of their professions and to the extent authorized by their licenses.

13. Vision Services

Definition: Vision services outlined in this section of the State Plan are available to Medicaid eligible beneficiaries, who are eligible for Early Intervention (EI) and for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services and for whom services are medically necessary.

Services: Vision services are provided to an individual child and/or the child's parent or caregiver, and services provided to children and/or family members in a group when such contacts directly benefit the needs of the child as described in his or her treatment plan, the IFSP, pursuant to a written order or prescription from a physician, physician assistant or nurse practitioner acting within his or her scope of practice under New York State law.

Vision services include evaluation and assessment of visual functioning, including the diagnosis and appraisal of specific visual disorders, delays, and abilities; referral for medical or other professional services necessary for the habilitation or rehabilitation of visual functioning disorders, or both; and communication skills training, orientation and mobility training for all environments, visual training, independent living skills training, and additional training necessary to activate visual motor abilities.

Providers: Vision services are provided by certified low vision specialists, orientation and mobility specialists and vision rehabilitation therapists certified by the Academy for the Certification for Vision Rehabilitation and Education Professionals, state licensed physicians including ophthalmologists; and licensed optometrists, and orientation and mobility specialists, within the scope of their profession and to the extent authorized by their license or certification.

14. Applied Behavioral Analysis (ABA) Services

Definition: ABA services outlined in this section of the State Plan are available to Medicaid eligible beneficiaries, who are eligible for Early Intervention (EI) and for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services and for whom services are medically necessary.

Services: ABA services means the design, implementation, and evaluation of systematic environmental changes to produce socially significant change in human behavior through skill

acquisition and the reduction of problematic behavior. ABA includes direct observation and measurement of behavior and the identification of functional relations between behavior and the environment. These include contextual factors such as establishing operations, antecedent stimuli, positive reinforcers, and other consequences that are used to produce the desired behavior change.

Providers: Services must be provided by:

- a licensed and registered behavior analyst qualified in accordance with applicable state and federal laws and regulations, acting within his or her scope of practice under New York State law, Education Law Article 167; or
- a certified behavior analyst assistant, under the documented direction of such a qualified licensed and registered behavior analyst, acting within his or her scope of practice under New York State law, Education Law Article 167.

"Under the Direction of" means that, with respect to each Medicaid beneficiary, the qualified therapist:

- Sees the participant at the beginning of and periodically during the course of treatment;
- Is familiar with the treatment plan as recommended by the referring physician or other licensed practitioner of the healing arts practicing under State Law;
- Has continued involvement in the care provided, and reviews the need for continued services throughout treatment;
- Assumes professional responsibility for the services provided under his or her direction and monitors the need for continued services;
- Spends as much time as necessary directly supervising services to ensure beneficiaries are receiving services in a safe and efficient manner in accordance with accepted standards;
- Ensures that individuals working under his or her direction have contact information to permit him or her direct contact with the supervising therapist as necessary during the course of treatment; and
- Keeps documentation supporting the supervision of services and ongoing involvement in the treatment.

15. Transportation Services

Definition: Transportation outlined in this section of the State Plan is available to Medicaid eligible beneficiaries who are eligible for Early Intervention (EI) and for Early and Periodic Screening Diagnostic and Treatment (EPSDT) services and for whom services are medically necessary.

Services: Transportation delivered by the State's designated transportation provider pursuant to prior authorization by a municipal Early Intervention Official or Early Intervention Official Designee in the State or the City of New York must be included in the IFSP as recommended by the IFSP Team. Transportation arrangements must be identified in the IFSP.

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Transportation is limited to those situations where the child receives transportation to obtain a Medicaid covered early intervention service other than transportation and both the Medicaid covered service and the need for transportation are included in the child's IFSP. Transportation can only be billed on a day that a Medicaid reimbursable service was delivered and may only be billed at the rate for each one-way trip.

Providers: Transportation services must be provided by a qualified, Medicaid-enrolled provider. Each one-way trip must be documented in accordance with Medicaid record keeping requirements in order to bill Medicaid. To receive payment for services provided to a Medicaid recipient, a vendor must be an enrolled Medicaid transportation provider authorized to provide transportation services on the date the services are rendered.

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12a. Prior authorization or dispensing validation is required for some prescription drugs. In addition, brand-name drugs that have a FDA approved, A-rated generic equivalent must be prior authorized unless exempted by the Commissioner of Health.

Drugs for which Medical Assistance reimbursement is available are limited to the following:

1. those non-prescription drugs contained on a list established by the New York State Commissioner of Health.
2. covered outpatient drugs of any manufacturer which has entered into and complies with an agreement under Sections 1902(a) (54) and 1927 (a) of the Act which are prescribed for a medically accepted indication. (As provided by Section 1927 (d) (2) of the Act certain outpatient drugs may be excluded from coverage).

12b. Prior approval is required for all dentures.

12c. Prior approval is required for prosthetic and orthotic devices over a dollar amount established by the State Department of Health and identified for providers in the MMIS DME Provider Manual.

Prior approval is required for artificial eyes as specified in the MMIS Ophthalmic Provider Manual.
Program also includes coverage of orthotic appliances including hearing aids. All hearing aids require prior approval.

12d. Prior approval is required for certain special lenses and unlisted eye services as specified for providers in the MMIS Ophthalmic Provider Manual.

13a. Diagnostic Services (see 13.d Rehabilitative Services – Early Intervention).

13b. Screening Services (see 13.d Rehabilitative Services – Early Intervention).

13c. Preventive Services (see 13.d Rehabilitative Services – Early Intervention).

13d. Rehabilitative Services

[(1) Directly Observed Therapy (DOT) – Clients must be assessed as medically appropriate for DOT based upon the client's risk of non-adherence to a medication regimen necessary to cure an active, infectious, potentially fatal disease process and to prevent the development and spread of an infectious, potentially fatal disease which may not respond to conventional therapies.]

Off-site" services shall be provided to developmentally disabled persons whose therapeutic requirements are most effectively satisfied in an appropriate environment that is specific to the treatment needs of the developmentally disabled individual. Such services shall be provided by persons authorized pursuant to NYCRR Title 14 Part 679. "Off-site" services shall not be provided at the location of a clinic certified by NYCRR Title 14 Part 679. Coverage of "off-site" services shall end effective December 31, 2015.

["Early Intervention" Services are provided to children who have or who are suspected of having a developmental delay or disability. These services, limited to EPSDT, which are provided by or on behalf of a county or the City of New York pursuant to an Individualized Family Services Plan (IFSP) include:

1. Screening
2. Evaluation
3. Audiology
4. Nursing
5. Nutrition Services
6. Occupational Therapy
7. Physical Therapy
8. Psychological Services
9. Social Work Services
10. Anticipatory Guidance (Special Instruction and Allied Health Professional Assistance)]
11. Speech Pathology Services
12. Assistive Technology Services
13. Vision Services
14. Collateral contacts for all of the above services

13d. Rehabilitative Services (Continued)

Directly Observed Therapy (DOT)

Directly Observed Therapy for Tuberculosis (TB/DOT) is the direct observation of oral ingestion of tuberculosis medications to assure patient compliance with the prescribed medication regimen. Directly observed therapy is the standard of care for every individual with active tuberculosis. TB/DOT may be provided on an outpatient basis in a community setting (including the home) or on an inpatient basis.

Clients must be assessed as medically appropriate for DOT based upon the client's risk of non-adherence to a medication regimen necessary to cure an active, infectious, potentially fatal disease process and to prevent the development and spread of an infectious, potentially fatal disease which may not respond to conventional therapies.

Services

Outpatient TB/DOT involves the dispensing of medication and observation thereof, assessing any adverse reactions to the medications, and case follow up.

- In New York City, TB/DOT is provided in New York City Department of Health and Mental Hygiene (DOHMH) clinics, approved Health and Hospitals Corporation (HHC) hospitals (Bellevue, Elmhurst, Kings County), or in the home or other community setting.
- In the rest of the state, TB/DOT is provided in the local health department (LHD) or in the home or other community setting.

Inpatient long term treatment may be indicated where the LHD has determined the patient has a poor treatment response, has medical complications, remains infectious with no other appropriate residential placement available, or other intensive residential placement is not possible.

Providers

Servicing providers for TB/DOT include local public health agencies and New York State licensed and registered professionals acting within their scope of practice.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: New York

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE

Rehabilitative Services (EPSDT only)

15. Transportation Services

The Early Intervention Program will adopt the one-way rates of payment for transportation services utilized by the Preschool Supportive Health Services Program. These rates have been set based on a statistically valid cost study that was conducted in 1999 to establish round trip transportation rates Such rates have been trended forward based on changes in the Consumer Price Index from 7/99 through 8/09 and converted to one-way rates.

Such rates shall be published on the Department of Health's website and on the eMedNY website and shall be issued in policy and billing guidance distributed to counties in the State and the City of New York responsible for local administration of the Early Intervention Program.

MISCELLANEOUS
NOTICES/HEARINGS

Notice of Abandoned Property Received by the State Comptroller

Pursuant to provisions of the Abandoned Property Law and related laws, the Office of the State Comptroller receives unclaimed monies and other property deemed abandoned. A list of the names and last known addresses of the entitled owners of this abandoned property is maintained by the office in accordance with Section 1401 of the Abandoned Property Law. Interested parties may inquire if they appear on the Abandoned Property Listing by contacting the Office of Unclaimed Funds, Monday through Friday from 8:00 a.m. to 4:30 p.m., at:

1-800-221-9311
or visit our web site at:
www.osc.state.ny.us

Claims for abandoned property must be filed with the New York State Comptroller's Office of Unclaimed Funds as provided in Section 1406 of the Abandoned Property Law. For further information contact: Office of the State Comptroller, Office of Unclaimed Funds, 110 State St., Albany, NY 12236.

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 enacted statutory provisions. The following changes are proposed:

Non-Institutional Services

Effective on or after April 1, 2018, the Early Intervention Program will amend the Medicaid State Plan to move Early Intervention Services from the Rehabilitative section of the State Plan to the Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT) section. This change is to comport with guidance received from the Centers for Medicare and Medicaid Services (CMS) through the Office of Health Insurance Programs. In addition, New York State licensed applied behavior analysts will be added as of early intervention service providers.

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

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, Bureau of Federal Relations and Provider Assessments, 99 Washington Ave., One Commerce Plaza, Suite 1430, Albany, NY 12210, (518) 474-1673, (518) 473-8825 (FAX), e-mail: spa_inquiries@health.state.ny.us

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 revise provisions of the Ambulatory Patient Group (APG) reimbursement methodology. The following change is proposed:

Non-Institutional Services

The following is a clarification to the December 27, 2017 noticed provision for the adjustment of the Article 16 APG rates intended to take into account increased labor costs resulting from statutorily required increases in the New York State minimum wage. Under the statute, increases in the minimum wage will be phased in over a number of years until the minimum wage is $15 per hour for the New York City (large and small employers) and Nassau, Suffolk and Westchester counties. The remainder of the State increases in the minimum wage will be phased in over a number of years until the minimum wage is $12.50 per hour.

The is no additional estimated annual change to gross Medicaid expenditures as a result of the proposed Article 16 APG reimbursement clarification.

The public is invited to review and comment on this proposed State Plan Amendment. Copies of which will be available for public review on the Department's website at http://www.health.ny.gov/regulations/state_plans/status.

Copies of the proposed State Plan Amendments will be on file in each local (county) social services district and available for public review.

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, Bureau of Federal Relations and Provider Assessments, 99 Washington Ave., One Commerce Plaza, Suite 1430, Albany, NY 12210, (518) 474-1673, (518) 473-8825 (FAX), e-mail: spa_inquiries@health.state.ny.us

PUBLIC NOTICE

Office of Mental Health and Department of Health

Pursuant to 42 CFR Section 447.205, the Office of Mental Health and the Department of Health hereby give public notice of the following:

The Office of Mental Health and the Department of Health propose to amend the Title XIX (Medicaid) State Plan for institutional services related to temporary rate adjustments to Article 28 Hospitals that are undergoing a closure, merger, consolidation, acquisition or restructuring of themselves or other health care providers. These payments are currently authorized by Public Health Law Section 2826. This notice clarifies the notices previously published on December 13, 2017 and January 31, 2018. The following changes are proposed:

Additional temporary rate adjustments have been reviewed and approved for the following hospitals:

- Bassett Medical Center

The aggregate payment amounts total up to $861,356 for the period April 1, 2018 through March 31, 2018.

The aggregate payment amounts total up to $861,356 for the period April 1, 2019 through March 31, 2020.

The aggregate payment amounts total up to $861,360 for the period April 1, 2020 through March 31, 2021.

The public is invited to review and comment on this proposed State Plan Amendment. Copies of which will be available for public review on the Department of Health's website at http://www.health.ny.gov/regulations/state_plans/status.

Copies of the proposed State Plan Amendments will be on file in each local (county) social services district and available for public review.

For the New York City district, copies will also 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 1460, Albany, NY 12210, e-mail: spa_inquiries@health.ny.gov

PUBLIC NOTICE

Office of Mental Health and Department of Health

Pursuant to 42 CFR Section 447.205, the Office of Mental Health and the Department of Health hereby give public notice of the following:

The Office of Mental Health and the Department of Health propose to amend the Title XIX (Medicaid) State Plan for institutional services related to temporary rate adjustments to Article 28 Hospitals that are undergoing a closure, merger, consolidation, acquisition or restructuring of themselves or other health care providers. These payments are currently authorized by Section 2826 of the New York Public Health Law. The following changes are proposed:

Additional temporary rate adjustments have been reviewed and approved for the following hospitals:

- Oswego Hospital

The aggregate payment amounts total up to $387,520 for the period April 1, 2018 through March 31, 2019.

The aggregate payment amounts total up to $737,626 for the period April 1, 2019 through March 31, 2020.

The aggregate payment amounts total up to $374,854 for the period April 1, 2020 through March 31, 2021.

The public is invited to review and comment on this proposed State Plan Amendment. Copies of which will be available for public review on the Department of Health's website at http://www.health.ny.gov/regulations/state_plans/status.

Copies of the proposed State Plan Amendments will be on file in each local (county) social services district and available for public review.

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

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

Queens County, Queens Center
3220 Northern Boulevard
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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:

SUMMARY
SPA #18-0052

This amendment proposes to remove the previously approved revision to the State Plan regarding Early & Periodic Screening, Diagnostic & Treatment Services (EPSDT) related to the expansion of behavioral health services provided to individuals under age 21. Based on the 2018-2019 enacted NYS Executive Budget, these service implementation dates were moved to early 2019 and early 2020. New amendments will be forthcoming to align with the new implementation dates.

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

b. Optometrists' services.

[X] Provided: [ ] No limitations [X] With limitations *

c. Chiropractors' services. (EPSDT only.)

[X] Provided: [ ] No limitations [X] With limitations *

[ ] Not Provided.

d. Other practitioners' services.

[X] Provided: Identified on attached sheet with description of limitations, if any.

[ ] Not Provided.

[**e. Other Licensed Practitioner services. (EPSDT only.)**

[X] Provided: Identified on attached sheet with description of limitations, if any.

[ ] Not Provided.]

7. Home health services.

a. Intermittent or part-time nursing services provided by a home health agency or by a registered nurse when no home health agency exists in the area.

Provided: [ ] No limitations [X] With limitations *

b. Home health aide services provided by a home health agency.

Provided: [ ] No limitations [X] With limitations *

c. Medical supplies, equipment, and appliances suitable for use in the home.

Provided: [ ] No limitations [X] With limitations *

* Description provided on attachment.

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2(xv)(1)

Reserved

[6e. **Other Licensed Practitioners (EPSDT only).** A non-physician licensed behavioral health practitioner (NP-LBHP) who is licensed in the State of New York. operating within the scope of practice defined in State law and in any setting permissible under State practice law.

NP-LBHPs include individuals licensed and able to practice independently as a:

- Licensed Psychoanalyst
- Licensed Clinical Social Worker (LCSW)
- Licensed Marriage & Family Therapist; or
- Licensed Mental Health Counselor

An NP-LBHP also includes the following individuals who are licensed to practice under supervision or direction of a Licensed Clinical Social Worker (LCSW), a Licensed Psychologist, or a Psychiatrist:

- Licensed Master Social Worker (LMSW)

In addition to licensure, service providers that offer addiction services must demonstrate competency as defined by state law and regulations. Any practitioner above must operate within a child serving agency that is licensed, certified, designated and/or approved by OCFS, OMH, OASAS or DOH or its designee, in settings permissible by that designation.

Inpatient hospital visits by these licensed practitioners are limited to those ordered by the child's physician. Visits to nursing facilities are allowed for licensed professionals other than social workers if a Preadmission Screening and Resident Review (PASRR) indicates it is medically necessary treatment. Social worker visits are included in the Nursing Facility Visit and may not be billed separately. Visits to ICF-IDD facilities are non-covered. All NP-LBHP services provided while a person is a resident of an (Institution for Mental Diseases) (IMD), such as a free standing psychiatric hospital or psychiatric residential treatment facility, are part of the institutional service and not otherwise reimbursable by Medicaid.
Non-physician licensed behavioral health practitioners (NP-LBHPs)will assess the child prior to developing a treatment plan for the child. Authorization of the treatment plan is required by the DOH or its designee. Evidence-based practices (EBPs) require approval, designations, and fidelity reviews on an ongoing basis as determined necessary by New York State. Treatment services must be part of a treatment plan including goals and activities necessary to correct or ameliorate conditions discovered during the initial assessment visits.

Assurances:
The State assures that all NP-LBHP services are provided to, or directed exclusively toward the treatment of, the Medicaid eligible individual in accordance with section 1902(a)(10)(A)(i) of the Act.

The State assures that NP-LBHP services do not include and FFP is not available for any of the following.

A. educational, vocational and job training services;
B. room and board;
C. habilitation services;
D. services to inmates in public institutions as defined in 42 CFR § 435.1010;
E. services to individuals residing in institutions for mental diseases as describe in 42 CFR § 435.1009;
F. recreational and social activities; and
G. services that must be covered elsewhere in the state Medicaid plan.]

New York
3

State/Territory: New York

AMOUNT DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): _____

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6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practices as defined by State law.
   a. Podiatrists' Services

      [X] Provided: [ ] No limitations [X] With limitations*

   b. Optometrists' Services

      [X] Provided: [ ] No limitations [X] With limitations*

   c. Chiropractors' Services

      [X] Provided: [ ] No limitations [X] With limitations*

   d. Other Practitioners' Services

      [X] Provided: [ ] No limitations [X] With limitations*

   [e. Other Licensed Practitioner Services (EPSDT only)

      [X] Provided: [ ] No limitations [X] With limitations*]

7. Home Health Services
   a. Intermittent or part-time nursing service provided by a home health agency or by a registered nurse when no home health agency exists in the area.

      [X] Provided: [ ] No limitations [X] With limitations*

   b. Home health aide services provided by a home health agency.

      [X] Provided: [ ] No limitations [X] With limitations*

   c. Medical supplies, equipment, and appliances suitable for use in the home.

      [X] Provided: [ ] No limitations [X] With limitations*

   d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or social rehabilitation facility.

      [ ] Provided [X] No limitations [ ] With limitations

*Description provided on attachment.

New York
2(xv)(1)

Reserved

[6e. **Other Licensed Practitioners (EPSDT only).** A non-physician licensed behavioral health practitioner (NP-LBHP) who is licensed in the State of New York. operating within the scope of practice defined in State law and in any setting permissible under State practice law.

NP-LBHPs include individuals licensed and able to practice independently as a:

- Licensed Psychoanalyst
- Licensed Clinical Social Worker (LCSW)
- Licensed Marriage & Family Therapist; or
- Licensed Mental Health Counselor

An NP-LBHP also includes the following individuals who are licensed to practice under supervision or direction of a Licensed Clinical Social Worker (LCSW), a Licensed Psychologist, or a Psychiatrist:

- Licensed Master Social Worker (LMSW)

In addition to licensure, service providers that offer addiction services must demonstrate competency as defined by state law and regulations. Any practitioner above must operate within a child serving agency that is licensed, certified, designated and/or approved by OCFS, OMH, OASAS or DOH or its designee, in settings permissible by that designation.

Inpatient hospital visits by these licensed practitioners are limited to those ordered by the child's physician. Visits to nursing facilities are allowed for licensed professionals other than social workers if a Preadmission Screening and Resident Review (PASRR) indicates it is medically necessary treatment. Social worker visits are included in the Nursing Facility Visit and may not be billed separately. Visits to ICF-IDD facilities are non-covered. All NP-LBHP services provided while a person is a resident of an (Institution for Mental Diseases) (IMD), such as a free standing psychiatric hospital or psychiatric residential treatment facility, are part of the institutional service and not otherwise reimbursable by Medicaid.
Non-physician licensed behavioral health practitioners (NP-LBHPs) will assess the child prior to developing a treatment plan for the child. Authorization of the treatment plan is required by the DOH or its designee. Evidence-based practices (EBPs) require approval, designations, and fidelity reviews on an ongoing basis as determined necessary by New York State. Treatment services must be part of a treatment plan including goals and activities necessary to correct or ameliorate conditions discovered during the initial assessment visits.

Assurances:
The State assures that all NP-LBHP services are provided to, or directed exclusively toward the treatment of, the Medicaid eligible individual in accordance with section 1902(a)(10)(A)(i) of the Act.

The State assures that NP-LBHP services do not include and FFP is not available for any of the following.

A. educational, vocational and job training services;
B. room and board;
C. habilitation services;
D. services to inmates in public institutions as defined in 42 CFR § 435.1010;
E. services to individuals residing in institutions for mental diseases as describe in 42 CFR § 435.1009;
F. recreational and social activities; and
G. services that must be covered elsewhere in the state Medicaid plan.]

Reserved

[STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: New York

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE

Non-Physician Licensed Behavioral Health Practitioner Services (EPSDT only)

Reimbursement for EPSDT NP-LBHP as outlined in Item 6.d per Attachment 3.1-A, are paid based upon Medicaid rates established by the State of New York.

Except as otherwise noted in the State Plan, the State-developed rates is the same for both governmental and private providers. The agency's rates were set as of July 1,2018 and are effective for services provided on or after that date. All rates are published on the Department of Health website:

www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/proposed_spa.htm.]

Reserved

[STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE: New York

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE

Non-Physician Licensed Behavioral Health Practitioner Services (EPSDT only - cont.)

The rate development methodology will primarily be composed of provider cost modeling, through New York provider compensation studies and cost data. Rates from similar State Medicaid programs may be considered, as well. The following list outlines the major components of the cost model to be used in rate development.

- Staffing assumptions and staff wages.
- Employee-related expenses — benefits, employer taxes (e.g., Federal Insurance Contributions Act (FICA), unemployment, and workers compensation).
- Program-related expenses (e.g., supplies).
- Provider overhead expenses.
- Program billable units.

The rates will be developed as the ratio of total annual modeled provider costs to the estimated annual billable units.]

SUMMARY
SPA #18-0053

This amendment proposes to remove the previously approved revision to the State Plan regarding Early & Periodic Screening, Diagnostic & Treatment Services (EPSDT) related to the expansion of behavioral health services provided to individuals under age 21. Based on the 2018-2019 enacted NYS Executive Budget, these service implementation dates were moved to early 2019 and early 2020. New amendments will be forthcoming to align with the new implementation dates.

New York
3b-13

Reserved

[Other Diagnostic, Screening, Preventive, and Rehabilitative Services - Rehabilitative Services
1905(a) (13)
42 CFR 440.130(d)

Item 4.b, EPSDT services - **Rehabilitative Services: 42 CFR 440.130(d)**

The State provides coverage for this benefit as defined at 42 CFR 440.130(d) and as described in this section:

Provided as an Early and Periodic Screening, Diagnostic and Treatment service for individuals who are eligible under the plan and are under the age of 21 1902(a) (43), 1905(a) (4) (B) and 1905(r)).

Rehabilitative Services Description

The rehabilitative service (or services) described below is:

- Crisis Intervention
- Community Psychiatric Support and Treatment
- Psychosocial Rehabilitation
- Youth Peer Support and Training
- Family Peer Support

Assurances:
The State assures that all rehabilitative services are provided to, or directed exclusively toward the treatment of, the Medicaid eligible individual in accordance with section 1902 (a) (10)(A)(i) of the Act.

The State assures that rehabilitative services do not include and FFP is not available for any of the following in accordance with section 1905(a) (13) of the Act.

A. educational, vocational and job training services;
B. room and board;
C. habilitation services;
D. services to inmates in public institutions as defined in 42 CFR §435.1010;
E. services to individuals residing in institutions for mental diseases as described in 42 CFR§435.1010;
F. recreational and social activities; and-
G. services that must be covered elsewhere in the state Medicaid plan.

Program Name - Crisis Intervention:
Description: Crisis Intervention (CI) Services are provided to children/youth who are identified as experiencing an acute psychological/emotional change which results in a marked increase in personal distress and which exceeds the abilities and the resources of those involved (e.g. collateral, provider, community member) to effectively resolve it. The determination of the potential crisis is defined by the behavioral health professional. A behavioral health professional will do an assessment of risk and mental status, in order to determine whether or]

New York
3b-14

Reserved

[Rehabilitative Services: EPSDT only (Continued)
Crisis Intervention (Continued):
Description (Continued):
not additional crisis response services are required to further evaluate, resolve, and/or stabilize the crisis. CI services are designed to interrupt and/or ameliorate the crisis experience and include an assessment that is culturally and linguistically sensitive and result in immediate crisis resolution and de-escalation, and development of a crisis plan. The goals of CI are engagement, symptom reduction, stabilization, and restoring individuals to a previous level of functioning or developing the coping mechanisms to minimize or prevent the crisis in the future. Family is a birth, foster, adoptive, or self-created unit of people residing together, with significant attachment to the individual, consisting of adult(s) and/or child (ren), with adult(s) performing duties of parenthood/caregiving for the child(ren) even if the individual is living outside of the home. The service is recommended by any of the following licensed practitioners of the healing arts operating within the scope of their practice of their State license, who may or may not be part of the crisis intervention team: Psychiatrist, Physician, Licensed Psychoanalyst, Registered Professional Nurse, Nurse Practitioner, Clinical Nurse Specialist, Licensed Clinical Social Worker (LCSW), Licensed Marriage and Family Therapist, Licensed Mental Health Counselor, or Licensed Psychologist. CI is a face-to-face intervention and can occur in a variety of settings including community locations where the beneficiary lives, works, attends school, engages in services (e.g. provider office sites), and/or socializes. CI includes engagement with the child, family/caregiver or other collateral sources (e.g., school personnel) that is culturally and linguistically sensitive, child centered, and family focused in addition to trauma informed to determine level of safety, risk, and to plan for the next level of services. All activities must occur within the context of a potential or actual behavioral health crisis with a desired outcome of diverting an emergency room visit and/or inpatient admission, when appropriate. Service is available with 24/7 availability and capacity to respond within one hour of call.

Practitioner qualifications: Services should be provided by a culturally competent, trauma-informed, and linguistically responsive multidisciplinary team (of at least two professionals unless noted below), for programmatic or safety purposes. One member of a two-person crisis intervention team must be a behavioral health professional and have experience with crisis intervention service delivery. If determined through triage only one team member is needed to respond to a psychiatric crisis, that team member must be a behavioral health professional and have experience with crisis intervention. If determined through triage only one team member is needed to respond to a substance use disorder (SUD) crisis, the team member may be a Credentialed Alcoholism and Substance Abuse Counselor (CASAC) and a licensed practitioner must be available via phone. A peer support specialist may not respond alone. Behavioral health professionals are practitioners possessing a license or a permit from the New York State Education Department who are qualified by credentials, training, and experience to provide direct services related to the treatment of mental illness. For Crisis Intervention, these behavioral health professionals include: Psychiatrist, Physician, Licensed Psychoanalyst, Licensed Clinical Social Worker (LCSW), Licensed Master Social Worker (LMSW), Licensed Mental Health Counselor, Licensed Psychologist, Licensed Marriage and Family Therapist, or Nurse Practitioner with experience/background treatment mental health and/or substance use disorders OR one practitioner from the above list and one practitioner from the following who is]

New York
3b-15

Reserved

[13d. Rehabilitative Services: EPSDT only (Continued)
Crisis Intervention (Continued):
Practitioner qualifications (Continued):

not considered a behavioral health professional: Certified alcoholism and substance abuse counselor, Credentialed family peer advocate with lived experience as a family member, Certified Recovery Peer Advocate-Family, Certified rehabilitation counselor, or a Registered Professional Nurse.

If one member of the crisis intervention team is a Peer support specialist, the Peer support provider must have a credential/certification as either:

1) An OMH established Family Peer Advocate credential, or
2) An OASAS established Certified Recovery Peer Advocate - Family.

Family Peer Support will be delivered by a New York State Credentialed Family Peer Advocate (FPA). To be eligible for the FPA Credential, the individual must:

- Demonstrate 'lived experience' as a parent or primary caregiver who has navigated multiple child serving systems on behalf of their child (ren) with social, emotional, developmental, health and/or behavioral healthcare needs.
- Have a high school diploma, high school equivalency preferred or a State Education Commencement Credential (e.g. SACC or CDOS). This educational requirement can be waived by the State if the person has demonstrated competencies and has relevant life experience sufficient for the peer certification.
- Completed Level One and Level Two of the Parent Empowerment Program Training for Family Peer Advocates training or approved comparable training.
- Submitted three letters of reference attesting to proficiency in and suitability for the role of a Family Peer Advocate (FPA) including one from the FPAs supervisor.
- Documented 1000 hours of experience providing Family Peer Support services.
- Agreed to practice according to the Family Peer Advocate Code of Ethics.
- Completed 20 hours of continuing education and renew their FPA credential every two years.

An FPA may obtain a provisional credential and complete all other requirements of the professional family peer advocate credential that will allow services they provide to be billed if the applicant has:

- Demonstrate 'lived experience' as a parent or primary caregiver who has navigated multiple child serving systems on behalf of their child(ren) with social, emotional, developmental, health and/or behavioral healthcare needs.]

New York
3b-16

Reserved

[13d. Rehabilitative Services: EPSDT only (Continued)
Crisis Intervention (Continued):
Practitioner qualifications (Continued):

An FPA may obtain a provisional credential if the applicant has (Continued)

- Have a high school diploma, high school equivalency preferred or a State Education Commencement Credential (e.g. SACC or CDOS). This educational requirement can be waived by the State if the person has demonstrated competencies and has relevant life experience sufficient for the peer credential.
- Completed Level One of the Parent Empowerment Program Training for Family Peer Advocates or approved comparable training.
- Submitted two letters of reference attesting to proficiency in and suitability for the role of a Family Peer Advocate (FPA).

An FPA with a provisional credential must complete all other requirements of the Professional Family Peer Advocate Credential within 18 months of commencing employment as an FPA OR Family Peer Support will be delivered by a Certified Recovery Peer Advocate (CRPA) with a Family Specialty.

To be certified as CRPA-Family, the individual must be at least 18 years of age and have the following:

- Have 'lived experience' as a family member impacted by youth substance use disorders. The CRPA – Family may be in recovery themselves.
- Have a high school diploma or a State Education Commencement Credential or General Equivalency Degree (GED).
- Completed a minimum of 46 hours of content specific training, covering the topics: advocacy, mentoring/education, recovery/wellness support, medication assisted treatment and ethical responsibility.
- Documented 1,000 hours of related work experience, or document at least 500 hours of related work experience if they: have a bachelor's degree; are credentialed by OASAS as a CASAC, CASAC Trainee, or Prevention Professional; or completed the 30-Hour Recovery Coach Academy training.
- Provided evidence of at least 25 hours of supervision specific to the performance domains of advocacy, mentoring/education, recovery/wellness support, and ethical responsibility. Supervision must be provided by an organization documented and qualified to provide supervision per job description.
- Passed the NYCB/IC & RC Peer Advocate Exam or other exam by an OASAS designated certifying body.
- Submitted two letters of recommendation.
- Demonstrated a minimum of 16 hours in the area of Family Support.
- Completed 20 hours of continuing education earned every two years, including six hours of Ethics.]

New York
3b-17

Reserved

[13d. Rehabilitative Services: EPSDT only (Continued):
Crisis Intervention (Continued):
Practitioner qualifications (Continued):

Certified Recovery Peer Advocate with a Family Specialty as defined in the NYS OASAS: An individual who is supervised by a credentialed or licensed clinical staff member to provide outreach and peer support services based on clinical need as identified in the patient's treatment/recovery plan

Crisis Intervention Team Training: All members of the Crisis Intervention team are required to have training in first aid, CPR, Mandated Reporting, Crisis De-escalation, Resolution and Debriefing, Suicide Prevention (e.g. SAFETALK), and crisis plan development.

Supervisor Qualifications: The supervisor is a competent mental health professional and must provide regularly scheduled supervision for all team members including peers. The supervisor must have the qualifications of at least a Licensed Clinical Social Worker (LCSW), Licensed Mental Health Counselor, Licensed Creative Arts Therapist, Licensed Marriage and Family Therapists, Licensed Psychoanalyst, Licensed Psychologist, Physician's Assistant, Psychiatrist, Physician, Registered Professional Nurse, or Nurse Practitioner operating within the scope of their practice, with at least 2-3 years of work experience. The supervisor must practice within the State health practice laws and ensure that providers are supervised as required under state law. For example, if a psychiatric nurse practitioner is on the team with fewer than 3,600 hours of experience, a psychiatrist must be on the team and supervise him/her. Supervisors must also be aware of and sensitive to trauma informed care and the cultural needs of the population of focus and how to best meet those needs, and be capable of training staff regarding these issues.

Provider Agency Qualifications: CI practitioners must work within agencies that possess a current license to provide crisis and/or crisis treatment services or any child serving agency or agency with children's behavioral health and health experience that is licensed, certified, designated and/or approved by OMH, OASAS, OCFS or DOH or its designee to provide comparable and appropriate crisis services referenced in the definition.]

New York
3b-18

Reserved

[13d. Rehabilitative Services: EPSDT only (Continued)
Crisis Intervention Components:

Mental Health and Substance Abuse Services Assessment:
Description: Assessment of risk and mental status and the need for further evaluation and/or other health/behavioral health services.

Practitioner qualifications: Assessments may be provided by any member of a culturally competent, trauma-informed, and linguistically responsive multidisciplinary crisis intervention team except for a peer including: Psychiatrist, Physician, Licensed Psychoanalyst, Licensed Clinical Social Worker (LCSW), Licensed Master Social Worker (LMSW), Licensed Mental Health Counselor, Licensed Psychologist, Licensed Marriage and Family Therapist, Nurse Practitioner with experience/background in treatment mental health and/or substance use, Certified alcoholism and substance abuse counselor, Certified rehabilitation counselor, or a Registered Professional Nurse.

Service Planning:
Description: Development of a safety plan, which addresses the immediate circumstances and the prevention of future crises, and signing of appropriate releases.

Practitioner qualifications: Service Planning may be provided by any member of a culturally competent, trauma-informed, and linguistically responsive multidisciplinary crisis intervention team except for a peer including: Psychiatrist, Physician, Licensed Psychoanalyst, Licensed Clinical Social Worker (LCSW), Licensed Master Social Worker (LMSW), Licensed Mental Health Counselor, Licensed Psychologist, Licensed Marriage and Family Therapist, Nurse Practitioner with experience/background treatment mental health and/or substance use, Certified alcoholism and substance abuse counselor, Certified rehabilitation counselor, or a Registered Professional Nurse.

Individual Counseling/Therapy
Describe: Crisis resolution and debriefing with the identified Medicaid eligible child, the child's family/caregiver and treatment provider.

Practitioner qualifications: Individual Counseling/Therapy may be provided by any member of a culturally competent, trauma-informed, and linguistically responsive multidisciplinary crisis intervention team including: Psychiatrist, Physician, Licensed Psychoanalyst, Licensed Clinical Social Worker (LCSW), Licensed Master Social Worker (LMSW), Licensed Mental Health Counselor, Licensed Psychologist, Licensed Marriage and Family Therapist, Nurse Practitioner with experience/background treatment mental health and/or substance use, Certified alcoholism and substance abuse counselor, Credentialed family peer advocate with lived experience as a family member, Certified Recovery Peer Advocate-Family, Certified rehabilitation counselor, or a Registered Professional Nurse.]

New York
3b-19

Reserved

[13d. Rehabilitative Services: EPSDT only (Continued)
Crisis Intervention (Continued)

Family Counseling/Therapy
Describe: Crisis resolution and debriefing with the child's family/caregiver and the treatment provider.

Practitioner qualifications: Family Counseling/Therapy may be provided by any member of a culturally competent, trauma-informed, and linguistically responsive multidisciplinary crisis intervention team including: Psychiatrist, Physician, Licensed Psychoanalyst, Licensed Clinical Social Worker (LCSW), Licensed Master Social Worker (LMSW), Licensed Mental Health Counselor, Licensed Psychologist, Licensed Marriage and Family Therapist, Nurse Practitioner with experience/background treatment mental health and/or substance use, Certified alcoholism and substance abuse counselor, Credentialed family peer advocate with lived experience as a family member, Certified Recovery Peer Advocate-Family, Certified rehabilitation counselor, or a Registered Professional Nurse.

Care Coordination:
Description: Care coordination includes:
1) Consultation with a physician or other licensed practitioner of the healing arts to assist with the child's specific crisis and planning for future service access.
2.) It is the expectation that there will be documented follow-up.
3.) Follow-up with the child and family/caregiver within 24 hours of initial contact/response, including informing existing supports/providers of the developed crisis plan. The entity that the child is referred to conducts an evaluation/assessment for additional longer term services.

Practitioner qualifications: Care Coordination may be provided by any member of a culturally competent, trauma-informed, and linguistically responsive multidisciplinary crisis intervention team except for a peer including: Psychiatrist, Physician, Licensed Psychoanalyst, Licensed Clinical Social Worker (LCSW), Licensed Master Social Worker (LMSW), Licensed Mental Health Counselor, Licensed Psychologist, Licensed Marriage and Family Therapist, Nurse Practitioner with experience/background treatment mental health and/or substance use, Certified alcoholism and substance abuse counselor, Certified rehabilitation counselor, or a Registered Professional Nurse.

Peer/Family Peer Support:
Describe: Crisis resolution with the identified Medicaid eligible child, the child's family/caregiver and the treatment provider.

Practitioner qualifications: Family Peer Support will be delivered by a New York State Credentialed Family Peer Advocate (FPA) or a Certified Recovery Peer Advocate-Family as defined above in this section.]

New York
3b-20
Reserved

[13d. Rehabilitative Services: EPSDT only (Continued)

Program Name: Community Psychiatric Support and Treatment (CPST)
Description: Community Psychiatric Support and Treatment (CPST) services are goal-directed supports and solution-focused interventions intended to address challenges associated with a behavioral health need and to achieve identified goals or objectives as set forth in the child's treatment plan. This includes the implementation of interventions using evidence-based techniques, drawn from cognitive-behavioral therapy and/or other evidence-based psychotherapeutic interventions approved by New York State. CPST is a face-to-face intervention with the child, family/caregiver or other collateral supports. This service is recommended by any of the following licensed practitioners of the healing arts operating within the scope of their practice under State license: Licensed Master Social Worker (LMSW), Licensed Clinical Social Worker (LCSW), Licensed Mental Health Counselor, Licensed Creative Arts Therapist, Licensed Marriage and Family Counselor, Licensed Psychoanalyst, Licensed Psychologist, Physician's Assistant, Psychiatrist, Physician, Registered Professional Nurse, or Nurse Practitioner. CPST is designed to provide community-based services to children and families who may have difficulty engaging in formal office settings, but can benefit from community based rehabilitative services. CPST allows for delivery of services within a variety of permissible settings including community locations where the child lives, works, attends school, engages in services (e.g. provider office sites), and/or socializes. Family is a birth, foster, adoptive or self-created unit of people residing together, with significant attachment to the individual, consisting of adult(s) and/or child (ren), with adult(s) performing duties of parenthood/caregiving for the child (ren) even if the individual is living outside of the home. CPST face-to-face interventions may include other collateral supports beyond the individual or family/caregiver, as necessary.

Practitioner qualifications: CPST may be provided by an individual who has at least a bachelor's degree level with a minimum of two years of applicable experience in children's mental health, addiction, and/or foster care/child welfare/juvenile justice. These practitioners may include: Registered Professional Nurses with one year of behavioral health experience, Licensed Occupational Therapists, and Licensed Creative Arts Therapists to the extent they are operating under the scope of their license.

Practitioners with a bachelor's degree may only perform the following activities under CPST: Family and Group Counseling/Therapy (Rehabilitative psychoeducation), Service Planning (Strengths-based treatment planning), or the Rehabilitative Supports portion of Individual and Group Counseling/Therapy.

Practitioners with at least a bachelor's degree level, certified in an Evidenced Based Practice consistent with the CPST component being delivered, and designated by the State OR a master's degree level in social work, psychology, or in related human services plus one year of applicable experience OR who has been certified in an Evidenced Based Practice may perform any of the activities under CPST listed above without any exclusions.

The interventions and skill building identified by the CPST practitioner and family may be implemented by the child and family with the assistance of a peer (under Peer Supports Services), Psychosocial Rehabilitation practitioner (under Psychosocial Rehabilitation Services) or the CPST practitioner, if necessary.]

New York
3b-21

Reserved

[13d. Rehabilitative Services: EPSDT only (Continued)
Community Psychiatric Support and Treatment (CPST) Description (Continued)
Practitioner Qualifications (Continued)

Supervisor Qualifications: Individuals providing services under CPST must receive regularly scheduled supervision from a professional meeting the qualifications of at least a Licensed Clinical Social Worker (LCSW), Licensed Mental Health Counselor, Licensed Creative Arts Therapist, Licensed Marriage and Family Therapists, Licensed Psychoanalyst, Licensed Psychologist, Physician's Assistant, Psychiatrist, Physician, Registered Professional Nurse, or Nurse Practitioner operating within the scope of their practice, with at least 2-3 years of work experience. Supervisors must also be aware of and sensitive to trauma informed care and the cultural needs of the population of focus and how to best meet those needs, and be capable of training staff regarding these issues.

Provider Agency Qualifications: Any child serving agency or agency with children's behavioral health and health experience that is licensed, certified, designated and/or approved by OCFS, OMH, OASAS or DOH or its designee, to provide comparable services referenced in the definition.

The provider agency will assess the child prior to developing a treatment plan for the child. Authorization of the treatment plan is required by the DOH or its designee. Treatment services must be part of a treatment plan including goals and activities necessary to correct or ameliorate conditions discovered during the initial assessment visits. CPST service delivery may also include collateral contact. Evidence-based practices (EBPs) require approval, designations, and fidelity reviews on an ongoing basis as determined necessary by New York State.

Service Planning (Strengths-based treatment planning):
Description: Strengths-based treatment planning - Facilitate participation in and utilization of strengths-based planning for Medicaid services and treatments related to child's behavioral health/health needs which include assisting the child and family members, caregiver or other collateral supports with identifying strengths and needs, resources, natural supports, within the context of the client's culture and developing goals and objectives to utilize personal strengths, resources, and natural supports to address functional deficits associated with their behavioral health disorder.

Practitioner Qualifications: Strengths-based treatment planning may be provided by an individual who has at least a bachelor's degree level with a minimum of two years of applicable experience in children's mental health, addiction, and/or foster care/child welfare/juvenile justice OR At least a bachelor's degree level, certified in an Evidenced Based Practice consistent with the CPST component being delivered, and designated by the State OR A master's degree level in social work, psychology, or in related human services plus one year of applicable experience OR who has been certified in an Evidenced Based Practice.]

New York
3b-22

Reserved

[13d. Rehabilitative Services: EPSDT only (Continued)
Program Name: Community Psychiatric Support and Treatment (CPST) (Continued):

Individual Counseling/Therapy (Intensive Interventions):
Description: Intensive Interventions - Provide individual supportive treatment and counseling; solution-focused interventions consistent with cognitive behavior therapy and psycho-educational therapy; harm reduction; emotional, cognitive and behavioral management; and problem behavior analysis with the child and family/caregiver, with the goal of assisting the child with social, interpersonal, self-care, daily functioning, and independent living skills to restore stability, to support functional gains and to adapt to community living. This includes the implementation of interventions using evidence-based techniques, drawn from cognitive-behavioral therapy and/or other evidence based psychotherapeutic interventions with prior authorization from NYS that ameliorate targeted symptoms and/or recover the person's capacity to cope with or prevent symptom manifestation.

Individual Counseling/Therapy (Crisis Avoidance):
Description: Crisis Avoidance - Assist the child and family/caregiver with effectively responding to or preventing identified precursors or triggers that would risk their ability to remain in a natural community location, including assisting the child and family members, caregivers or other collateral supports with identifying a potential psychiatric or personal crisis; practicing de-escalation skills; developing a crisis management plan; assessing the step-by-step plan before a crisis occurs; developing strategies to take medication regularly; and seeking other supports to restore stability and functioning.

Individual Counseling/Therapy (Rehabilitative Supports):
Description: Rehabilitative Supports - Restoration, rehabilitation, and support to minimize the negative effects of behavioral health symptoms or emotional disturbances that interfere with the individual's daily functioning. Counseling helps restore life safety skills such as ability to access emergency services, basic safety practices and evacuation, physical and behavioral health care (maintenance, scheduling physicians appointments) recognizing when to contact a physician, self-administration of medication for physical and mental health or substance use disorder conditions, understanding purpose and possible side effects of medication prescribed for conditions, other common prescription and non-prescription drugs and drug uses. Group face-to-face counseling may occur in rehabilitative supports.

Practitioner qualifications:
Rehabilitative Supports components of Individual Counseling/Therapy may be provided by an individual who has at least a bachelor's degree level with a minimum of two years of applicable experience in children's mental health, addiction, and/or foster care/child welfare/juvenile justice OR At least a bachelor's degree level, certified in an Evidenced Based Practice consistent with the CPST component being delivered, and designated by the State OR a master's degree level in social work, psychology, or in related human services plus one year of applicable experience OR who has been certified in an Evidenced Based Practice.]

New York
3b-23

Reserved

[13d. Rehabilitative Services: EPSDT only (Continued)
Community Psychiatric Support and Treatment (CPST) (Continued):
CPST Components (Continued):

Individual, family and Group Counseling/Therapy (Rehabilitative Supports) (Continued):
Practitioner Qualifications (Continued):

Intensive Interventions and Crisis avoidance may only be performed by practitioners who have at least a bachelor's degree level, certified in an Evidenced Based Practice consistent with the CPST component being delivered, and designated by the State OR a master's degree level in social work, psychology, or in related human services plus one year of applicable experience OR who has been certified in an Evidenced Based Practice.

Family and Group Counseling/Therapy (Rehabilitative psychoeducation):
Description: Rehabilitative psychoeducation - Assist the child and family members, caregivers or other collateral supports to identify appropriate strategies or treatment options for the child's behavioral health needs, with the goal of minimizing the negative effects of mental illness symptoms or emotional disturbances, substance use or associated behavioral health stressors that interfere with the child's life.

Practitioner qualifications: Rehabilitative psychoeducation may be provided by an individual who has at least a bachelor's degree level with a minimum of two years of applicable experience in children's mental health, addiction, and/or foster care/child welfare/juvenile justice OR At least a bachelor's degree level, certified in an Evidenced Based Practice consistent with the CPST component being delivered, and designated by the State OR amaster's degree level in social work, psychology, or in related human services plus one year of applicable experience OR who has been certified in an Evidenced Based Practice.

Family and Group Counseling/Therapy (Rehabilitative supports in the community):
Description: Rehabilitative supports in the community **-** Provide restoration, rehabilitation, and support to the child and family members, caregivers or other collateral supports to develop skills necessary to meet the child's goals and to sustain the identified community goals.

Practitioner qualifications: Rehabilitative supports in the community may be provided by an individual with at least a bachelor's degree level, certified in an Evidenced Based Practice consistent with the CPST component being delivered, and designated by the State OR a master's degree level in social work, psychology, or in related human services plus one year of applicable experience OR who has been certified in an Evidenced Based Practice.]

New York
3b-24

Reserved

[13d. Rehabilitative Services: EPSDT only (Continued)
Community Psychiatric Support and Treatment (CPST) (Continued):
CPST Components (Continued):

Crisis Intervention (Intermediate term crisis management):
Description: Intermediate term crisis management - Provide intermediate-term crisis management to the child and family following a crisis (beyond 72 hour period) as stated in the crisis management plan. The purpose of this activity is to stabilize the child/youth in the home and natural environment. Goal setting is focused upon the issues identified from crisis intervention, emergency room crisis and other referral. The service is intended to be stability focused and for existing clients of CPST services or for children needing longer term crisis managements services.

Practitioner qualifications: Intermediate term crisis management may be provided by an individual who has at least a bachelor's degree level, certified in an Evidenced Based Practice consistent with the CPST component being delivered, and designated by the State OR a master's degree level in social work, psychology, or in related human services plus one year of applicable experience OR who has been certified in an Evidenced Based Practice.

Rehabilitative Services: EPSDT only
Psychosocial Rehabilitation
Description: Psychosocial Rehabilitation Services (PSR) are designed for children and their families to assist with implementing interventions outlined on a treatment plan to compensate for or eliminate functional deficits and interpersonal and/or behavioral health barriers associated with a child/youth's behavioral health needs. The intent of PSR is to restore, rehabilitate, and support a child/youth's functional level as possible and as necessary for integration of the child/youth as an active and productive member of their community and family with minimal ongoing professional intervention. PSR can occur in a variety of settings including community locations where the child/youth lives, works, attends school, engages in services (e.g. provider office sites), and/or socializes. Family is a birth, foster, adoptive, or self-created unit of people residing together, with significant attachment to the individual, consisting of adult(s) and/or child(ren), with adult(s) performing duties of parenthood/caregiving for the child(ren) even if the individual is living outside of the home.

Activities included must be intended to achieve the identified goals or objectives as set forth in the child/youth individualized treatment plan. PSR is an individual or group face-to-face intervention and may include collateral contact. PSR is recommended by any of the following licensed practitioners of the healing arts operating within the scope of their practice under State license: Licensed Master Social Worker (LMSW), Licensed Clinical Social Worker (LCSW), Licensed Mental Health Counselor, Licensed Creative Arts Therapist, Licensed Marriage and Family Therapist, Licensed Psychoanalyst, Licensed Psychologist, Physician's Assistant, Psychiatrist, Physician, Registered Professional Nurse, or Nurse Practitioner.]

New York
3b-25

Reserved

[13d. Rehabilitative Services: EPSDT only (Continued)
Psychosocial Rehabilitation (Continued)

Description (Continued):

The professional uses partnerships and mutual support, as well as hands-on implementation of rehabilitation interventions to improve personal independence and autonomy including:

1) Restoration, rehabilitation and support to reduce the effect of the child's behavioral health diagnosis and re-establish social and interpersonal skills to increase community tenure, enhance personal relationships, establish support networks, increase community awareness, develop coping strategies and effective functioning in the individual's social environment, including home, work and school. This includes learning to confidently manage stress, unexpected daily events and disruptions, and behavioral health and physical health symptoms. It also includes support to establish and maintain friendships/supportive social networks, improve interpersonal skills such as social etiquette and anger management.

2) Restoration, rehabilitation and support to reduce the effect of the child's diagnosis and reestablish daily functioning skills to improve self-management of the negative effects of psychiatric or emotional symptoms that interfere with a person's daily functioning. This includes supporting the individual with implementation of interventions to re-establish daily functioning skills and daily routines necessary to remain in home, school, work and community, including managing medications and learning self-care. It also includes development of constructive and comfortable interactions with healthcare professionals, develop relapse prevention strategies, and re-establishing good health routines and practices.

3) Restoration, rehabilitation and support to reduce the effect of the child's diagnosis and re-establish social skills so that the person can remain in a natural community location and re-achieve developmentally appropriate functioning including using collaboration, partnerships and mutual supports to strengthen the individuals community integration in areas of personal interests as well as other domains of community life including home, work and school. This includes assisting the individual with generalizing coping strategies and social and interpersonal skills in community settings. The professional may assist the individual with effectively responding to or avoiding identified precursors or triggers that result in functional impairments.

Practitioner Qualifications: Must be 18 years old and have a high school diploma, high school equivalency preferred, or a State Education Commencement Credential (e.g. SACC or CDOS); with a minimum of three years' experience in children's mental health, addiction and/or foster care.]

New York
3b-26

Reserved

[13d. Rehabilitative Services: EPSDT only (Continued)
Psychosocial Rehabilitation (Continued):
Description (Continued):

Supervisor Qualifications:
The PSR provider must receive regularly scheduled supervision from a Licensed Clinical Social Worker (LCSW), Licensed Mental Health Counselor, Licensed Creative Arts Therapist, Licensed Marriage and Family Therapist, Licensed Psychoanalyst, Licensed Psychologist, Physician's Assistant, Psychiatrist, Physician, Registered Professional Nurse, or Nurse Practitioner operating within the scope of their practice. Supervisors must also be aware of and sensitive to trauma informed care and the cultural needs of the population of focus and how to best meet those needs, and be capable of training staff regarding these issues.

Provider Agency qualifications: Any child serving agency or agency with children's behavioral health and health experience that is licensed, certified, designated and/or approved by OCFS, OMH, OASAS OR DOH or its designee, to provide comparable services referenced in the definition. The caseload size must be based on the needs of the child/youth and families with an emphasis on successful outcomes and individual satisfaction and must meet the needs identified in the individual treatment plan.

The provider agency will assess the child prior to developing a treatment plan for the child. A licensed CPST practitioner or OLP must develop the treatment plan, with the PSR worker implementing the interventions identified on the services/plan. Group should not exceed more than 8 members. Authorization of the treatment plan is required by the DOH or its designee. Treatment services must be part of a treatment plan including goals and activities necessary to correct or ameliorate conditions discovered during the initial assessment visits.

Youth Peer Support and Training:
Description: Youth support and training services are formal and informal services and supports provided to youth who are experiencing social, medical, emotional, developmental, substance use, and/or behavioral challenges in their home, school, placement, and/or community centered services. These services provide the training and support necessary to ensure engagement and active participation of the youth in the treatment planning process and with the ongoing implementation and reinforcement of skills. Youth support and training is a face-to-face intervention and can occur in a variety of settings including community locations where the youth lives, works, attends school, engages in services (e.g. provider office sites), and/or socializes. Youth Peer Support and Training activities must be intended to develop and achieve the identified goals and/or objectives as set forth in the youth's individualized care plan. The structured, scheduled activities provided by this service emphasize the opportunity for the youth to expand the skills and strategies necessary to move forward in meeting their personal, individualized life goals, develop self-advocacy goals, and to support their transition into adulthood.]

New York
3b-27
Reserved

[13d. Rehabilitative Services: EPSDT only (Continued)
Youth Peer Support and Training: (Continued)

Youth Peer Support and Training is recommended by any following licensed practitioners of the healing arts operating within the scope of their practice under State license: a Licensed Master Social Worker (LMSW), Licensed Clinical Social Worker (LCSW), Licensed Mental Health Counselor, Licensed Creative Arts Therapist, Licensed Marriage and Family Therapist , Licensed Psychoanalyst, Licensed Psychologist, Physician's Assistant, Psychiatrist, Physician, Registered Professional Nurse, Nurse Practitioner, operating within the scope of their practice with the youth, family/caregiver or other collateral supports. Activities may include: Restoration, rehabilitation, and support to develop skills for coping with and managing psychiatric symptoms, trauma and substance use disorders; promote skills for wellness and recovery support; develop skills to independently navigate the service systems; develop skills to set goals; and build community living skills. To enhance resiliency/recovery-oriented attitudes such as hope, confidence and self-efficacy; Self-Advocacy & Empowerment skill building to develop, link to and facilitate the use of formal and informal resources, including connection to peer support groups in the community; serve as an advocate, mentor or facilitator for resolution of issues; and, assist in navigating the service system including assisting with engagement and bridging during transitions in care.

Practitioner qualifications:
YPST is delivered by a New York State Credentialed Youth Peer Advocate. To be eligible for the Youth Peer Advocate Professional Credential, an individual must:

- Be an individual 18 to 30 years who has self-identified as a person who has first-hand experience with social, emotional, medical, developmental, substance use, and/or behavioral challenges.
- Have a high school diploma, high school equivalency preferred or a State Education Commencement Credential (e.g. SACC or CDOS). This educational requirement can be waived by the credentialing agency if the person has demonstrated competencies and has relevant life experience sufficient for the youth peer-credential.
- Completed Level One (online) and Level Two (online and in person) training of the Youth Peer Support Services Advisory Council recommended and State approved training for YPAs followed by a minimum of three consultation calls.
- Submitted three letters of reference attesting to proficiency in and suitability for the role of a YPA including one from YPAs supervisor.
- Agree to practice according to the Youth Peer Advocate Code of Ethics.
- Documented 600 hours of experience providing Youth Peer Support services.
- Completed 20 hours of continuing education every 2 years.
- Demonstrates qualities of leadership, including: Knowledge of advocacy and group development and/or facilitation of peer-to-peer groups or activities.
- Is able to use lived experience with a disability, mental illness, juvenile justice, special education, substance use disorder, and/or foster care to assist in supporting youth in their resiliency/recovery and wellness.
- Be supervised by a credentialed YPA OR a credentialed Family Peer Advocate, both with four years direct service experience OR an individual who meets the criteria for a "qualified mental health staff person" found in 14 NYCRR 594 or 14 NYCRR 595.]

New York
3b-28

Reserved

[13d. Rehabilitative Services: EPSDT only (Continued)
Youth Peer Support and Training (Continued):
Practitioner qualifications (Continued):

A YPA may obtain a provisional credential that will allow services they provide to be billed if the applicant:

- •Is an individual 18 to 30 years who has self-identified as a person who has first-hand experience with social, emotional, medical, developmental, substance use, and/or behavioral challenges.
- •Has a high school diploma, high school equivalency preferred or a State Education Commencement Credential (e.g. SACC or CDOS). This educational credential can be waived by the certifying agency if the person has demonstrated competencies and has relevant life experience sufficient for the peer certification.
- •Has completed Level One of the Youth Peer Support Services Advisory Council recommended and State approved training for YPAs.
- •Demonstrates qualities of leadership, including: Knowledge of advocacy and group development and/or facilitation of peer-to-peer groups or activities.
- •Is able to use lived experience with a mental illness, juvenile justice, special education, substance use disorder, and/or foster care to assist in supporting youth in their resiliency/recovery and wellness.
- •Submits two letters of reference attesting to proficiency in and suitability for the role of an YPA.
- • Be supervised by a credentialed YPA OR a credentialed FPA, both with four years direct service experience OR an individual who meets the criteria for a "qualified mental health staff person" found in 14 NYCRR 594 or 14 NYCRR 595. Refer to Supervisor Qualifications for specificity.
- •Agree to practice according to the YPA Code of Ethics.

A YPA with a provisional credential must complete all other requirements of the professional credential within 18 months of employment as an YPA *OR* a Certified Recovery Peer Advocate – Youth who is an individual 18 to 30 years of age and has:

- •Lived experience defined as having been impacted or affected by substance use disorders and/or be in recovery from substance use disorders.
- •Has a high school diploma, high school equivalency preferred or a State Education Commencement Credential (e.g. SACC or CDOS).
- •Completed a minimum of 46 hours content specific training, covering topics of advocacy, mentoring/education, recovery/wellness support and ethical responsibility.
- •Documented 1,000 hours of relative work experience or document at least 500 hours of related work experience if they:
    - Have a Bachelor's Degree, is certified by OASAS as a CASAC or CASAC trainee or Prevention Professional or completed the 30 hour Recovery Coach Academy training.]

New York
3b-29

Reserved

[13d. Rehabilitative Services: EPSDT only (Continued):
Youth Peer Support and Training (Continued):

A YPA with a provisional credential must complete all other requirements of the professional credential within 18 months of employment as an YPA *OR* a Certified Recovery Peer Advocate – Youth who is an individual 18 to 30 years of age and has: (Continued)

- Provided evidence of at least 25 hours of supervision specific to the to the performance domains of advocacy, mentoring/education, recovery/wellness and ethical responsibility. Supervision must be provided by an organization documented and qualified to provide supervision per job description.
- Passed the NYCB/IC & RC Peer Advocate exam or other exam by an OASAS designated certifying body.
- Submitted two letters of recommendations.
- Demonstrated a minimum of 16 hours specifically related to Youth Peer Support.
- Completed 20 hours of continuing education earned every two years, including 6 hours of ethics.

Supervisor Qualifications: YPAs will be supervised by:

1) A credentialed YPA with four years of direct YPST service experience with access to clinical consultation as needed. The clinical supervision may be provided by a staff member or through a contract with another organization OR
2) A credentialed FPA with 4 years of experience providing FPSS that has been trained in YPST services and the role of the YPAs and efforts are made as the YPST service gains maturity in NYS to transition to supervision by an experienced credentialed YPAs within the organization.
3) A qualified "mental health staff person" found in 14 NYCRR 594 or 14 NYCRR 595 that has training in YPST services and the role of YPAs and efforts are made as the YPST service gains maturity in NYS to transition to supervision by an experienced credentialed YPA within the organization.

Additional Supervisor Qualifications:

- The individual providing consultation, guidance, mentoring, and on-going training need not be employed by the same agency.
- Supervision of these activities may be delivered in person or by distance communication methods.
- It is required that one hour of supervision be delivered for every 40 hours of Peer Support and Training duties performed.
- There may be an administrative supervisor who signs the youth peer specialist's timesheet and is the primary contact on other related human resource management issues.
- Supervisors must also be aware of and sensitive to the cultural needs of the population of focus and how to best meet those needs, and be capable of training staff regarding these issues.]

New York
3b-30

Reserved

[13d. Rehabilitative Services: EPSDT only (Continued):
Youth Peer Support and Training (Continued):

Provider Agency Qualifications: Any child serving agency or agency with children's behavioral health and health experience that is licensed, certified, designated and/or approved by OCFS, OMH, OASAS OR DOH or its designee, to provide comparable services referenced in the definition.

The provider agency will assess the child prior to developing a treatment plan for the child. Authorization of the treatment plan is required by the DOH or its designee. Treatment services must be part of a treatment plan including goals and activities necessary to correct or ameliorate conditions discovered during the initial assessment visits. Group should not exceed more than 8 members. Medicaid family support programs will not reimburse for the following:

- 12-step programs run by peers.
- General outreach and education including participation in health fairs, and other activities designed to increase the number of individuals served or the number of services received by individuals accessing services; community education services, such as health presentations to community groups, PTA's, etc.
- Contacts that are not medically necessary.
- Time spent doing, attending, or participating in recreational activities.
- Services provided to teach academic subjects or as a substitute for educational personnel such as, but not limited to, a teacher, teacher's aide, or an academic tutor.
- Time spent attending school (e.g. during a day treatment program).
- Habilitative services for the beneficiary (child) to acquire self-help, socialization, and adaptive skills necessary to reside successfully in community settings.
- Child Care services or services provided as a substitute for the parent or other individuals responsible for providing care and supervision.
- Respite care.
- Transportation for the beneficiary or family. Services provided in the car are considered transportation and time may not be billed under rehabilitation.
- Services not identified on the beneficiary's authorized treatment plan.
- Services not in compliance with the service manual and not in compliance with State Medicaid standards.
- Services provided to children, spouse, parents, or siblings of the eligible beneficiary under treatment or others in the eligible beneficiary's life to address problems not directly related to the eligible beneficiary's issues and not listed on the eligible beneficiary's treatment plan.
- Any intervention or contact not documented or consistent with the approved treatment plan/recovery plan goals, objectives, and approved services will not be reimbursed.]

New York
3b-31

Reserved

[13d. Rehabilitative Services: EPSDT only (Continued):

Family Peer Support:
Description: Family Peer Support Services (FPSS) are an array of formal and informal activities and supports provided to families caring for/raising a child who is experiencing social, emotional, medical, developmental, substance use and/or behavioral challenges in their home, school, placement, and/or community. FPSS provide a structured, strength-based relationship between a Family Peer Advocate (FPA) and the parent/family member/caregiver for the benefit of the child/youth. Family is defined as the primary care-giving unit and is inclusive of the wide diversity of primary caregiving units in our culture. Family is a birth, foster, adoptive, or self-created unit of people residing together, with significant attachment to the individual, consisting of adult(s) and/or child(ren), with adult(s) performing duties of parenthood/caregiving for the child(ren) even if the individual is living outside of the home.

Activities included must be intended to achieve the identified goals or objectives as set forth in the child/youth's treatment plan. FPSS is a face-to-face intervention, a group face-to-face intervention. A group is a composition of members should share common characteristics, such as related experiences, developmental age, chronological age, challenges or treatment goals. The Service is directed to the child, and includes contacts necessary for treatment with the family/caregiver or other collateral supports. FPSS is recommended by a licensed practitioner of the healing arts including: Licensed Master Social Worker (LMSW), Licensed Clinical Social Worker (LCSW), Licensed Mental Health Counselor, Licensed Creative Arts Therapist, Licensed Marriage and Family Therapist, Licensed Psychoanalyst, Licensed Psychologist, Physician's Assistant, Psychiatrist, Physician, Registered Professional Nurse, or Nurse Practitioner, operating within the scope of their practice. FPSS can be provided through individual and group face-to-face work and can occur in a variety of settings including community locations where the beneficiary lives, works, attends school, engages in services (e.g. provider office sites), and/or socializes. Components of FPSS include:

- Engagement, Bridging and Transition Support: Provide a bridge between families and service providers, support a productive and respectful partnership by assisting the families to express their strengths, needs and goals.
- Self-Advocacy, Self-Efficacy and Empowerment: Coach and model shared decision-making and skills that support collaboration, in addition to providing opportunities for families to self-advocate.
- Parent Skill Development: Support the efforts of families in caring for and strengthening their children's mental, and physical health, development and well-being.
- Community Connections and Natural Supports: Enhance the quality of life by supporting the integration of families into their own communities.]

New York
3b-32

Reserved

[13d. Rehabilitative Services: EPSDT only (Continued):
Family Peer Support (Continued):

Practitioner qualifications: Family Peer Support will be delivered by a New York State Credentialed Family Peer Advocate (FPA); FPA with a provisional credential; or a Certified Recovery Peer Advocate (CRPA) with a Family Specialty.

- **FPA Credential**- To be eligible for the FPA Credential, the individual must:
  - •Demonstrate 'lived experience' as a parent or primary caregiver who has navigated multiple child serving systems on behalf of their child(ren) with social, emotional, developmental, health and/or behavioral healthcare needs.
  - •Have a high school diploma, high school equivalency preferred or a State Education Commencement Credential (e.g. SACC or CDOS). This educational requirement can be waived by the State if the person has demonstrated competencies and has relevant life experience sufficient for the peer credential.
  - •Completed Level One and Level Two of the Parent Empowerment Program Training for Family Peer Advocates approved comparable training.
  - •Submitted three letters of reference attesting to proficiency in and suitability for the role of a Family Peer Advocate (FPA) including one from the FPAs supervisor.
  - •Documented 1000 hours of experience providing Family Peer Support services.
  - •Agreed to practice according to the Family Peer Advocate Code of Ethics.
  - •Completed 20 hours of continuing education and renew their FPA certification every two years.

- **A provisional FPA credential:**
  - •Demonstrated 'lived experience' as a parent or primary caregiver who has navigated multiple child serving systems on behalf of their child(ren) with social, emotional, developmental, health and/or behavioral healthcare needs.
  - •A high school diploma, high school equivalency preferred or a State Education Commencement Credential (e.g. SACC or CDOS). This educational requirement can be waived by the State if the person has demonstrated competencies and has relevant life experience sufficient for the peer certification.
  - Completed Level One of the Parent Empowerment Program Training for Family Peer Advocates or approved comparable training.
  - Submitted two letters of reference attesting to proficiency in and suitability for the role of a Family Peer Advocate (FPA). The provisional FPA must complete all other requirements of the Professional Family Peer Advocate Credential within 18 months of commencing employment as an FPA.
  - Agreed to practice according to the Family Peer Advocate Code of Ethics.]

New York
3b-33
Reserved

[13d. Rehabilitative Services: EPSDT only (Continued):
Family Peer Support (Continued):

Certified Recovery Peer Advocate (CRPA) with a Family Specialty:

To be certified as CPRA-Family, the individual must be at least 18 years of age and have the following:

- Have 'lived experience' as a family member impacted by youth substance use disorders. The CRPA – Family may be in recovery themselves.
- Have a high school diploma or a State Education Commencement Credential or General Equivalency Degree (GED).
- Completed a minimum of 46 hours of content specific training, covering the topics: advocacy, mentoring/education, recovery/wellness support and ethical responsibility.
- Documented 1,000 hours of related work experience, or document at least 500 hours of related work experience if they: Have a Bachelor's Degree; Are certified by OASAS as a CASAC, CASAC Trainee, or Prevention Professional; or Completed the 30-Hour Recovery Coach Academy training.
- Provide evidence of at least 25 hours of supervision specific to the performance domains of advocacy, mentoring/education, recovery/wellness support, and ethical responsibility. Supervision must be provided by an organization documented and qualified to provide supervision per job description.
- Pass the NYCB/IC & RC Peer Advocate Exam or other exam by an OASAS designated certifying body.
- Submitted two letters of recommendation.
- Demonstrated a minimum of 16 hours in the area of Family Support.
- Completed 20 hours of continuing education earned every two years, including 6 hours of Ethics.

Certified Recovery Peer Advocate with a Family Specialty as defined in the NYS OASAS: An individual who is supervised by a credentialed or licensed clinical staff member to provide outreach and peer support services based on clinical need as identified in the patient's treatment/recovery plan.

Supervisor Qualifications: FPAs will be supervised by:
1) Individuals who have a minimum of 4 years' experience providing FPSS services, at least 1 year of which is as a credentialed FPA with access to clinical consultation as needed. The clinical consultation may be provided by a staff member or through a contract OR
2) A "qualified mental health staff person" with a) training in FPSS and the role of FPAs b) efforts are made as the FPSS service gains maturity in NYS to transition to supervision by experienced credentialed FPA within the organization OR
3) From a competent behavioral health professional meeting the criteria for a "qualified mental health staff person" found in 14 NYCRR 594 or 14 NYCRR 595 OR
4) A Certified Alcohol and Substance Abuse Counselor (CASAC) working within an OASAS certified program.]

New York
3b-34
Reserved

[13d. Rehabilitative Services: EPSDT only (Continued):
Family Peer Support (Continued):

Supervisor Qualifications: (Continued) The individual providing consultation, guidance, mentoring, and on-going training need not be employed by the same agency. Supervision of these activities may be delivered in person or by distance communication methods. It is the expectation that 1 hour of supervision be delivered for every 40 hours of Family Peer Support Services duties performed. There may be an administrative supervisor who signs the family peer specialist's timesheet and is the primary contact on other related human resource management issues.

Provider Agency Qualifications: Any practitioner providing behavioral health services must operate within an agency licensed, certified, designated and/or approved by
Any child serving agency or agency with children's behavioral health and health experience that is licensed, certified, designated and/or approved by OCFS, OMH, OASAS OR DOH or its designee, to provide comparable services referenced in the definition.

The provider agency will assess the child prior to developing a treatment plan for the child. Authorization of the treatment plan is required by the DOH or its designee. Treatment services must be part of a treatment plan including goals and activities necessary to correct or ameliorate conditions discovered during the initial assessment visits. A group is composed may not exceed more than 12 individuals total. Medicaid family support programs will not reimburse for the following:

- 12-step programs run by peers.
- General outreach and education including participation in health fairs, and other activities designed to increase the number of individuals served or the number of services received by individuals accessing services; community education services, such as health presentations to community groups, PTA's, etc.
- Contacts that are not medically necessary.
- Time spent doing, attending, or participating in recreational activities.
- Services provided to teach academic subjects or as a substitute for educational personnel such as, but not limited to, a teacher, teacher's aide, or an academic tutor.
- Time spent attending school (e.g. during a day treatment program).
- Habilitative services for the beneficiary (child) to acquire self-help, socialization, and adaptive skills necessary to reside successfully in community settings.
- Child Care services or services provided as a substitute for the parent or other individuals responsible for providing care and supervision.
- Respite care.
- Transportation for the beneficiary or family. Services provided in the car are considered transportation and time may not be billed under rehabilitation.
- Services not identified on the beneficiary's authorized treatment plan.
- Services not in compliance with the service manual and not in compliance with State Medicaid standards.]

New York
3b-35

Reserved

[13d. Rehabilitative Services: EPSDT only (Continued):
Family Peer Support (Continued):

Limitations:

- Services provided to children, spouse, parents, or siblings of the eligible beneficiary under treatment or others in the eligible beneficiary's life to address problems not directly related to the eligible beneficiary's issues and not listed on the eligible beneficiary's treatment plan.
- Any intervention or contact not documented or consistent with the approved treatment plan/recovery plan goals, objectives, and approved services will not be reimbursed.]

New York
3b-13

Reserved

[Other Diagnostic, Screening, Preventive, and Rehabilitative Services - Rehabilitative Services
1905(a) (13)
42 CFR 440.130(d)

Item 4.b, EPSDT services - **Rehabilitative Services: 42 CFR 440.130(d)**

The State provides coverage for this benefit as defined at 42 CFR 440.130(d) and as described in this section:

Provided as an Early and Periodic Screening, Diagnostic and Treatment service for individuals who are eligible under the plan and are under the age of 21 1902(a) (43), 1905(a) (4) (B) and 1905(r)).

Rehabilitative Services Description

The rehabilitative service (or services) described below is:

- Crisis Intervention
- Community Psychiatric Support and Treatment
- Psychosocial Rehabilitation
- Youth Peer Support and Training
- Family Peer Support

Assurances:
The State assures that all rehabilitative services are provided to, or directed exclusively toward the treatment of, the Medicaid eligible individual in accordance with section 1902 (a) (10)(A)(i) of the Act.

The State assures that rehabilitative services do not include and FFP is not available for any of the following in accordance with section 1905(a) (13) of the Act.

A. educational, vocational and job training services;
B. room and board;
C. habilitation services;
D. services to inmates in public institutions as defined in 42 CFR §435.1010;
E. services to individuals residing in institutions for mental diseases as described in 42 CFR§435.1010;
F. recreational and social activities; and-
G. services that must be covered elsewhere in the state Medicaid plan.

Program Name - Crisis Intervention:
Description: Crisis Intervention (CI) Services are provided to children/youth who are identified as experiencing an acute psychological/emotional change which results in a marked increase in personal distress and which exceeds the abilities and the resources of those involved (e.g. collateral, provider, community member) to effectively resolve it. The determination of the potential crisis is defined by the behavioral health professional. A behavioral health professional will do an assessment of risk and mental status, in order to determine whether or]

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[Rehabilitative Services: EPSDT only (Continued)
Crisis Intervention (Continued):
Description (Continued):
not additional crisis response services are required to further evaluate, resolve, and/or stabilize the crisis. CI services are designed to interrupt and/or ameliorate the crisis experience and include an assessment that is culturally and linguistically sensitive and result in immediate crisis resolution and de-escalation, and development of a crisis plan. The goals of CI are engagement, symptom reduction, stabilization, and restoring individuals to a previous level of functioning or developing the coping mechanisms to minimize or prevent the crisis in the future. Family is a birth, foster, adoptive, or self-created unit of people residing together, with significant attachment to the individual, consisting of adult(s) and/or child (ren), with adult(s) performing duties of parenthood/caregiving for the child(ren) even if the individual is living outside of the home. The service is recommended by any of the following licensed practitioners of the healing arts operating within the scope of their practice of their State license, who may or may not be part of the crisis intervention team: Psychiatrist, Physician, Licensed Psychoanalyst, Registered Professional Nurse, Nurse Practitioner, Clinical Nurse Specialist, Licensed Clinical Social Worker (LCSW), Licensed Marriage and Family Therapist, Licensed Mental Health Counselor, or Licensed Psychologist. CI is a face-to-face intervention and can occur in a variety of settings including community locations where the beneficiary lives, works, attends school, engages in services (e.g. provider office sites), and/or socializes. CI includes engagement with the child, family/caregiver or other collateral sources (e.g., school personnel) that is culturally and linguistically sensitive, child centered, and family focused in addition to trauma informed to determine level of safety, risk, and to plan for the next level of services. All activities must occur within the context of a potential or actual behavioral health crisis with a desired outcome of diverting an emergency room visit and/or inpatient admission, when appropriate. Service is available with 24/7 availability and capacity to respond within one hour of call.

Practitioner qualifications: Services should be provided by a culturally competent, trauma-informed, and linguistically responsive multidisciplinary team (of at least two professionals unless noted below), for programmatic or safety purposes. One member of a two-person crisis intervention team must be a behavioral health professional and have experience with crisis intervention service delivery. If determined through triage only one team member is needed to respond to a psychiatric crisis, that team member must be a behavioral health professional and have experience with crisis intervention. If determined through triage only one team member is needed to respond to a substance use disorder (SUD) crisis, the team member may be a Credentialed Alcoholism and Substance Abuse Counselor (CASAC) and a licensed practitioner must be available via phone. A peer support specialist may not respond alone. Behavioral health professionals are practitioners possessing a license or a permit from the New York State Education Department who are qualified by credentials, training, and experience to provide direct services related to the treatment of mental illness. For Crisis Intervention, these behavioral health professionals include: Psychiatrist, Physician, Licensed Psychoanalyst, Licensed Clinical Social Worker (LCSW), Licensed Master Social Worker (LMSW), Licensed Mental Health Counselor, Licensed Psychologist, Licensed Marriage and Family Therapist, or Nurse Practitioner with experience/background treatment mental health and/or substance use disorders OR one practitioner from the above list and one practitioner from the following who is]

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[13d. Rehabilitative Services: EPSDT only (Continued)
Crisis Intervention (Continued):
Practitioner qualifications (Continued):

not considered a behavioral health professional: Certified alcoholism and substance abuse counselor, Credentialed family peer advocate with lived experience as a family member, Certified Recovery Peer Advocate-Family, Certified rehabilitation counselor, or a Registered Professional Nurse.

If one member of the crisis intervention team is a Peer support specialist, the Peer support provider must have a credential/certification as either:

1) An OMH established Family Peer Advocate credential, or
2) An OASAS established Certified Recovery Peer Advocate - Family.

Family Peer Support will be delivered by a New York State Credentialed Family Peer Advocate (FPA). To be eligible for the FPA Credential, the individual must:

- Demonstrate 'lived experience' as a parent or primary caregiver who has navigated multiple child serving systems on behalf of their child (ren) with social, emotional, developmental, health and/or behavioral healthcare needs.
- Have a high school diploma, high school equivalency preferred or a State Education Commencement Credential (e.g. SACC or CDOS). This educational requirement can be waived by the State if the person has demonstrated competencies and has relevant life experience sufficient for the peer certification.
- Completed Level One and Level Two of the Parent Empowerment Program Training for Family Peer Advocates training or approved comparable training.
- Submitted three letters of reference attesting to proficiency in and suitability for the role of a Family Peer Advocate (FPA) including one from the FPAs supervisor.
- Documented 1000 hours of experience providing Family Peer Support services.
- Agreed to practice according to the Family Peer Advocate Code of Ethics.
- Completed 20 hours of continuing education and renew their FPA credential every two years.

An FPA may obtain a provisional credential and complete all other requirements of the professional family peer advocate credential that will allow services they provide to be billed if the applicant has:

- Demonstrate 'lived experience' as a parent or primary caregiver who has navigated multiple child serving systems on behalf of their child(ren) with social, emotional, developmental, health and/or behavioral healthcare needs.]

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[13d. Rehabilitative Services: EPSDT only (Continued)
Crisis Intervention (Continued):
Practitioner qualifications (Continued):

An FPA may obtain a provisional credential if the applicant has (Continued)

- Have a high school diploma, high school equivalency preferred or a State Education Commencement Credential (e.g. SACC or CDOS). This educational requirement can be waived by the State if the person has demonstrated competencies and has relevant life experience sufficient for the peer credential.
- Completed Level One of the Parent Empowerment Program Training for Family Peer Advocates or approved comparable training.
- Submitted two letters of reference attesting to proficiency in and suitability for the role of a Family Peer Advocate (FPA).

An FPA with a provisional credential must complete all other requirements of the Professional Family Peer Advocate Credential within 18 months of commencing employment as an FPA OR Family Peer Support will be delivered by a Certified Recovery Peer Advocate (CRPA) with a Family Specialty.

To be certified as CRPA-Family, the individual must be at least 18 years of age and have the following:

- Have 'lived experience' as a family member impacted by youth substance use disorders. The CRPA – Family may be in recovery themselves.
- Have a high school diploma or a State Education Commencement Credential or General Equivalency Degree (GED).
- Completed a minimum of 46 hours of content specific training, covering the topics: advocacy, mentoring/education, recovery/wellness support, medication assisted treatment and ethical responsibility.
- Documented 1,000 hours of related work experience, or document at least 500 hours of related work experience if they: have a bachelor's degree; are credentialed by OASAS as a CASAC, CASAC Trainee, or Prevention Professional; or completed the 30-Hour Recovery Coach Academy training.
- Provided evidence of at least 25 hours of supervision specific to the performance domains of advocacy, mentoring/education, recovery/wellness support, and ethical responsibility. Supervision must be provided by an organization documented and qualified to provide supervision per job description.
- Passed the NYCB/IC & RC Peer Advocate Exam or other exam by an OASAS designated certifying body.
- Submitted two letters of recommendation.
- Demonstrated a minimum of 16 hours in the area of Family Support.
- Completed 20 hours of continuing education earned every two years, including six hours of Ethics.]

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[13d. Rehabilitative Services: EPSDT only (Continued):
Crisis Intervention (Continued):
Practitioner qualifications (Continued):

Certified Recovery Peer Advocate with a Family Specialty as defined in the NYS OASAS: An individual who is supervised by a credentialed or licensed clinical staff member to provide outreach and peer support services based on clinical need as identified in the patient's treatment/recovery plan

Crisis Intervention Team Training: All members of the Crisis Intervention team are required to have training in first aid, CPR, Mandated Reporting, Crisis De-escalation, Resolution and Debriefing, Suicide Prevention (e.g. SAFETALK), and crisis plan development.

Supervisor Qualifications: The supervisor is a competent mental health professional and must provide regularly scheduled supervision for all team members including peers. The supervisor must have the qualifications of at least a Licensed Clinical Social Worker (LCSW), Licensed Mental Health Counselor, Licensed Creative Arts Therapist, Licensed Marriage and Family Therapists, Licensed Psychoanalyst, Licensed Psychologist, Physician's Assistant, Psychiatrist, Physician, Registered Professional Nurse, or Nurse Practitioner operating within the scope of their practice, with at least 2-3 years of work experience. The supervisor must practice within the State health practice laws and ensure that providers are supervised as required under state law. For example, if a psychiatric nurse practitioner is on the team with fewer than 3,600 hours of experience, a psychiatrist must be on the team and supervise him/her. Supervisors must also be aware of and sensitive to trauma informed care and the cultural needs of the population of focus and how to best meet those needs, and be capable of training staff regarding these issues.

Provider Agency Qualifications: CI practitioners must work within agencies that possess a current license to provide crisis and/or crisis treatment services or any child serving agency or agency with children's behavioral health and health experience that is licensed, certified, designated and/or approved by OMH, OASAS, OCFS or DOH or its designee to provide comparable and appropriate crisis services referenced in the definition.]

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[13d. Rehabilitative Services: EPSDT only (Continued)
Crisis Intervention Components:

Mental Health and Substance Abuse Services Assessment:
Description: Assessment of risk and mental status and the need for further evaluation and/or other health/behavioral health services.

Practitioner qualifications: Assessments may be provided by any member of a culturally competent, trauma-informed, and linguistically responsive multidisciplinary crisis intervention team except for a peer including: Psychiatrist, Physician, Licensed Psychoanalyst, Licensed Clinical Social Worker (LCSW), Licensed Master Social Worker (LMSW), Licensed Mental Health Counselor, Licensed Psychologist, Licensed Marriage and Family Therapist, Nurse Practitioner with experience/background in treatment mental health and/or substance use, Certified alcoholism and substance abuse counselor, Certified rehabilitation counselor, or a Registered Professional Nurse.

Service Planning:
Description: Development of a safety plan, which addresses the immediate circumstances and the prevention of future crises, and signing of appropriate releases.

Practitioner qualifications: Service Planning may be provided by any member of a culturally competent, trauma-informed, and linguistically responsive multidisciplinary crisis intervention team except for a peer including: Psychiatrist, Physician, Licensed Psychoanalyst, Licensed Clinical Social Worker (LCSW), Licensed Master Social Worker (LMSW), Licensed Mental Health Counselor, Licensed Psychologist, Licensed Marriage and Family Therapist, Nurse Practitioner with experience/background treatment mental health and/or substance use, Certified alcoholism and substance abuse counselor, Certified rehabilitation counselor, or a Registered Professional Nurse.

Individual Counseling/Therapy
Describe: Crisis resolution and debriefing with the identified Medicaid eligible child, the child's family/caregiver and treatment provider.

Practitioner qualifications: Individual Counseling/Therapy may be provided by any member of a culturally competent, trauma-informed, and linguistically responsive multidisciplinary crisis intervention team including: Psychiatrist, Physician, Licensed Psychoanalyst, Licensed Clinical Social Worker (LCSW), Licensed Master Social Worker (LMSW), Licensed Mental Health Counselor, Licensed Psychologist, Licensed Marriage and Family Therapist, Nurse Practitioner with experience/background treatment mental health and/or substance use, Certified alcoholism and substance abuse counselor, Credentialed family peer advocate with lived experience as a family member, Certified Recovery Peer Advocate-Family, Certified rehabilitation counselor, or a Registered Professional Nurse.]

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[13d. Rehabilitative Services: EPSDT only (Continued)
Crisis Intervention (Continued)

Family Counseling/Therapy
Describe: Crisis resolution and debriefing with the child's family/caregiver and the treatment provider.

Practitioner qualifications: Family Counseling/Therapy may be provided by any member of a culturally competent, trauma-informed, and linguistically responsive multidisciplinary crisis intervention team including: Psychiatrist, Physician, Licensed Psychoanalyst, Licensed Clinical Social Worker (LCSW), Licensed Master Social Worker (LMSW), Licensed Mental Health Counselor, Licensed Psychologist, Licensed Marriage and Family Therapist, Nurse Practitioner with experience/background treatment mental health and/or substance use, Certified alcoholism and substance abuse counselor, Credentialed family peer advocate with lived experience as a family member, Certified Recovery Peer Advocate-Family, Certified rehabilitation counselor, or a Registered Professional Nurse.

Care Coordination:
Description: Care coordination includes:
1) Consultation with a physician or other licensed practitioner of the healing arts to assist with the child's specific crisis and planning for future service access.
2.) It is the expectation that there will be documented follow-up.
3.) Follow-up with the child and family/caregiver within 24 hours of initial contact/response, including informing existing supports/providers of the developed crisis plan. The entity that the child is referred to conducts an evaluation/assessment for additional longer term services.

Practitioner qualifications: Care Coordination may be provided by any member of a culturally competent, trauma-informed, and linguistically responsive multidisciplinary crisis intervention team except for a peer including: Psychiatrist, Physician, Licensed Psychoanalyst, Licensed Clinical Social Worker (LCSW), Licensed Master Social Worker (LMSW), Licensed Mental Health Counselor, Licensed Psychologist, Licensed Marriage and Family Therapist, Nurse Practitioner with experience/background treatment mental health and/or substance use, Certified alcoholism and substance abuse counselor, Certified rehabilitation counselor, or a Registered Professional Nurse.

Peer/Family Peer Support:
Describe: Crisis resolution with the identified Medicaid eligible child, the child's family/caregiver and the treatment provider.

Practitioner qualifications: Family Peer Support will be delivered by a New York State Credentialed Family Peer Advocate (FPA) or a Certified Recovery Peer Advocate-Family as defined above in this section.]

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[13d. Rehabilitative Services: EPSDT only (Continued)

Program Name: Community Psychiatric Support and Treatment (CPST)
Description: Community Psychiatric Support and Treatment (CPST) services are goal-directed supports and solution-focused interventions intended to address challenges associated with a behavioral health need and to achieve identified goals or objectives as set forth in the child's treatment plan. This includes the implementation of interventions using evidence-based techniques, drawn from cognitive-behavioral therapy and/or other evidence-based psychotherapeutic interventions approved by New York State. CPST is a face-to-face intervention with the child, family/caregiver or other collateral supports. This service is recommended by any of the following licensed practitioners of the healing arts operating within the scope of their practice under State license: Licensed Master Social Worker (LMSW), Licensed Clinical Social Worker (LCSW), Licensed Mental Health Counselor, Licensed Creative Arts Therapist, Licensed Marriage and Family Counselor, Licensed Psychoanalyst, Licensed Psychologist, Physician's Assistant, Psychiatrist, Physician, Registered Professional Nurse, or Nurse Practitioner. CPST is designed to provide community-based services to children and families who may have difficulty engaging in formal office settings, but can benefit from community based rehabilitative services. CPST allows for delivery of services within a variety of permissible settings including community locations where the child lives, works, attends school, engages in services (e.g. provider office sites), and/or socializes. Family is a birth, foster, adoptive or self-created unit of people residing together, with significant attachment to the individual, consisting of adult(s) and/or child (ren), with adult(s) performing duties of parenthood/caregiving for the child (ren) even if the individual is living outside of the home. CPST face-to-face interventions may include other collateral supports beyond the individual or family/caregiver, as necessary.

Practitioner qualifications: CPST may be provided by an individual who has at least a bachelor's degree level with a minimum of two years of applicable experience in children's mental health, addiction, and/or foster care/child welfare/juvenile justice. These practitioners may include: Registered Professional Nurses with one year of behavioral health experience, Licensed Occupational Therapists, and Licensed Creative Arts Therapists to the extent they are operating under the scope of their license.

Practitioners with a bachelor's degree may only perform the following activities under CPST: Family and Group Counseling/Therapy (Rehabilitative psychoeducation), Service Planning (Strengths-based treatment planning), or the Rehabilitative Supports portion of Individual and Group Counseling/Therapy.

Practitioners with at least a bachelor's degree level, certified in an Evidenced Based Practice consistent with the CPST component being delivered, and designated by the State OR a master's degree level in social work, psychology, or in related human services plus one year of applicable experience OR who has been certified in an Evidenced Based Practice may perform any of the activities under CPST listed above without any exclusions.

The interventions and skill building identified by the CPST practitioner and family may be implemented by the child and family with the assistance of a peer (under Peer Supports Services), Psychosocial Rehabilitation practitioner (under Psychosocial Rehabilitation Services) or the CPST practitioner, if necessary.]

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[13d. Rehabilitative Services: EPSDT only (Continued)
Community Psychiatric Support and Treatment (CPST) Description (Continued)
Practitioner Qualifications (Continued)

Supervisor Qualifications: Individuals providing services under CPST must receive regularly scheduled supervision from a professional meeting the qualifications of at least a Licensed Clinical Social Worker (LCSW), Licensed Mental Health Counselor, Licensed Creative Arts Therapist, Licensed Marriage and Family Therapists, Licensed Psychoanalyst, Licensed Psychologist, Physician's Assistant, Psychiatrist, Physician, Registered Professional Nurse, or Nurse Practitioner operating within the scope of their practice, with at least 2-3 years of work experience. Supervisors must also be aware of and sensitive to trauma informed care and the cultural needs of the population of focus and how to best meet those needs, and be capable of training staff regarding these issues.

Provider Agency Qualifications: Any child serving agency or agency with children's behavioral health and health experience that is licensed, certified, designated and/or approved by OCFS, OMH, OASAS or DOH or its designee, to provide comparable services referenced in the definition.

The provider agency will assess the child prior to developing a treatment plan for the child. Authorization of the treatment plan is required by the DOH or its designee. Treatment services must be part of a treatment plan including goals and activities necessary to correct or ameliorate conditions discovered during the initial assessment visits. CPST service delivery may also include collateral contact. Evidence-based practices (EBPs) require approval, designations, and fidelity reviews on an ongoing basis as determined necessary by New York State.

Service Planning (Strengths-based treatment planning):
Description: Strengths-based treatment planning - Facilitate participation in and utilization of strengths-based planning for Medicaid services and treatments related to child's behavioral health/health needs which include assisting the child and family members, caregiver or other collateral supports with identifying strengths and needs, resources, natural supports, within the context of the client's culture and developing goals and objectives to utilize personal strengths, resources, and natural supports to address functional deficits associated with their behavioral health disorder.

Practitioner Qualifications: Strengths-based treatment planning may be provided by an individual who has at least a bachelor's degree level with a minimum of two years of applicable experience in children's mental health, addiction, and/or foster care/child welfare/juvenile justice OR At least a bachelor's degree level, certified in an Evidenced Based Practice consistent with the CPST component being delivered, and designated by the State OR A master's degree level in social work, psychology, or in related human services plus one year of applicable experience OR who has been certified in an Evidenced Based Practice.]

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[13d. Rehabilitative Services: EPSDT only (Continued)
Program Name: Community Psychiatric Support and Treatment (CPST) (Continued):

Individual Counseling/Therapy (Intensive Interventions):
Description: Intensive Interventions - Provide individual supportive treatment and counseling; solution-focused interventions consistent with cognitive behavior therapy and psycho-educational therapy; harm reduction; emotional, cognitive and behavioral management; and problem behavior analysis with the child and family/caregiver, with the goal of assisting the child with social, interpersonal, self-care, daily functioning, and independent living skills to restore stability, to support functional gains and to adapt to community living. This includes the implementation of interventions using evidence-based techniques, drawn from cognitive-behavioral therapy and/or other evidence based psychotherapeutic interventions with prior authorization from NYS that ameliorate targeted symptoms and/or recover the person's capacity to cope with or prevent symptom manifestation.

Individual Counseling/Therapy (Crisis Avoidance):
Description: Crisis Avoidance - Assist the child and family/caregiver with effectively responding to or preventing identified precursors or triggers that would risk their ability to remain in a natural community location, including assisting the child and family members, caregivers or other collateral supports with identifying a potential psychiatric or personal crisis; practicing de-escalation skills; developing a crisis management plan; assessing the step-by-step plan before a crisis occurs; developing strategies to take medication regularly; and seeking other supports to restore stability and functioning.

Individual Counseling/Therapy (Rehabilitative Supports):
Description: Rehabilitative Supports - Restoration, rehabilitation, and support to minimize the negative effects of behavioral health symptoms or emotional disturbances that interfere with the individual's daily functioning. Counseling helps restore life safety skills such as ability to access emergency services, basic safety practices and evacuation, physical and behavioral health care (maintenance, scheduling physicians appointments) recognizing when to contact a physician, self-administration of medication for physical and mental health or substance use disorder conditions, understanding purpose and possible side effects of medication prescribed for conditions, other common prescription and non-prescription drugs and drug uses. Group face-to-face counseling may occur in rehabilitative supports.

Practitioner qualifications:
Rehabilitative Supports components of Individual Counseling/Therapy may be provided by an individual who has at least a bachelor's degree level with a minimum of two years of applicable experience in children's mental health, addiction, and/or foster care/child welfare/juvenile justice OR At least a bachelor's degree level, certified in an Evidenced Based Practice consistent with the CPST component being delivered, and designated by the State OR a master's degree level in social work, psychology, or in related human services plus one year of applicable experience OR who has been certified in an Evidenced Based Practice.]

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[13d. Rehabilitative Services: EPSDT only (Continued)
Community Psychiatric Support and Treatment (CPST) (Continued):
CPST Components (Continued):

Individual, family and Group Counseling/Therapy (Rehabilitative Supports) (Continued):
Practitioner Qualifications (Continued):

Intensive Interventions and Crisis avoidance may only be performed by practitioners who have at least a bachelor's degree level, certified in an Evidenced Based Practice consistent with the CPST component being delivered, and designated by the State OR a master's degree level in social work, psychology, or in related human services plus one year of applicable experience OR who has been certified in an Evidenced Based Practice.

Family and Group Counseling/Therapy (Rehabilitative psychoeducation):
Description: Rehabilitative psychoeducation - Assist the child and family members, caregivers or other collateral supports to identify appropriate strategies or treatment options for the child's behavioral health needs, with the goal of minimizing the negative effects of mental illness symptoms or emotional disturbances, substance use or associated behavioral health stressors that interfere with the child's life.

Practitioner qualifications: Rehabilitative psychoeducation may be provided by an individual who has at least a bachelor's degree level with a minimum of two years of applicable experience in children's mental health, addiction, and/or foster care/child welfare/juvenile justice OR At least a bachelor's degree level, certified in an Evidenced Based Practice consistent with the CPST component being delivered, and designated by the State OR amaster's degree level in social work, psychology, or in related human services plus one year of applicable experience OR who has been certified in an Evidenced Based Practice.

Family and Group Counseling/Therapy (Rehabilitative supports in the community):
Description: Rehabilitative supports in the community **-** Provide restoration, rehabilitation, and support to the child and family members, caregivers or other collateral supports to develop skills necessary to meet the child's goals and to sustain the identified community goals.

Practitioner qualifications: Rehabilitative supports in the community may be provided by an individual with at least a bachelor's degree level, certified in an Evidenced Based Practice consistent with the CPST component being delivered, and designated by the State OR a master's degree level in social work, psychology, or in related human services plus one year of applicable experience OR who has been certified in an Evidenced Based Practice.]

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[13d. Rehabilitative Services: EPSDT only (Continued)
Community Psychiatric Support and Treatment (CPST) (Continued):
CPST Components (Continued):

Crisis Intervention (Intermediate term crisis management):
Description: Intermediate term crisis management - Provide intermediate-term crisis management to the child and family following a crisis (beyond 72 hour period) as stated in the crisis management plan. The purpose of this activity is to stabilize the child/youth in the home and natural environment. Goal setting is focused upon the issues identified from crisis intervention, emergency room crisis and other referral. The service is intended to be stability focused and for existing clients of CPST services or for children needing longer term crisis managements services.

Practitioner qualifications: Intermediate term crisis management may be provided by an individual who has at least a bachelor's degree level, certified in an Evidenced Based Practice consistent with the CPST component being delivered, and designated by the State OR a master's degree level in social work, psychology, or in related human services plus one year of applicable experience OR who has been certified in an Evidenced Based Practice.

Rehabilitative Services: EPSDT only
Psychosocial Rehabilitation
Description: Psychosocial Rehabilitation Services (PSR) are designed for children and their families to assist with implementing interventions outlined on a treatment plan to compensate for or eliminate functional deficits and interpersonal and/or behavioral health barriers associated with a child/youth's behavioral health needs. The intent of PSR is to restore, rehabilitate, and support a child/youth's functional level as possible and as necessary for integration of the child/youth as an active and productive member of their community and family with minimal ongoing professional intervention. PSR can occur in a variety of settings including community locations where the child/youth lives, works, attends school, engages in services (e.g. provider office sites), and/or socializes. Family is a birth, foster, adoptive, or self-created unit of people residing together, with significant attachment to the individual, consisting of adult(s) and/or child(ren), with adult(s) performing duties of parenthood/caregiving for the child(ren) even if the individual is living outside of the home.

Activities included must be intended to achieve the identified goals or objectives as set forth in the child/youth individualized treatment plan. PSR is an individual or group face-to-face intervention and may include collateral contact. PSR is recommended by any of the following licensed practitioners of the healing arts operating within the scope of their practice under State license: Licensed Master Social Worker (LMSW), Licensed Clinical Social Worker (LCSW), Licensed Mental Health Counselor, Licensed Creative Arts Therapist, Licensed Marriage and Family Therapist, Licensed Psychoanalyst, Licensed Psychologist, Physician's Assistant, Psychiatrist, Physician, Registered Professional Nurse, or Nurse Practitioner.]

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[13d. Rehabilitative Services: EPSDT only (Continued)
Psychosocial Rehabilitation (Continued)

Description (Continued):

The professional uses partnerships and mutual support, as well as hands-on implementation of rehabilitation interventions to improve personal independence and autonomy including:

1) Restoration, rehabilitation and support to reduce the effect of the child's behavioral health diagnosis and re-establish social and interpersonal skills to increase community tenure, enhance personal relationships, establish support networks, increase community awareness, develop coping strategies and effective functioning in the individual's social environment, including home, work and school. This includes learning to confidently manage stress, unexpected daily events and disruptions, and behavioral health and physical health symptoms. It also includes support to establish and maintain friendships/supportive social networks, improve interpersonal skills such as social etiquette and anger management.

2) Restoration, rehabilitation and support to reduce the effect of the child's diagnosis and reestablish daily functioning skills to improve self-management of the negative effects of psychiatric or emotional symptoms that interfere with a person's daily functioning. This includes supporting the individual with implementation of interventions to re-establish daily functioning skills and daily routines necessary to remain in home, school, work and community, including managing medications and learning self-care. It also includes development of constructive and comfortable interactions with healthcare professionals, develop relapse prevention strategies, and re-establishing good health routines and practices.

3) Restoration, rehabilitation and support to reduce the effect of the child's diagnosis and re-establish social skills so that the person can remain in a natural community location and re-achieve developmentally appropriate functioning including using collaboration, partnerships and mutual supports to strengthen the individuals community integration in areas of personal interests as well as other domains of community life including home, work and school. This includes assisting the individual with generalizing coping strategies and social and interpersonal skills in community settings. The professional may assist the individual with effectively responding to or avoiding identified precursors or triggers that result in functional impairments.

Practitioner Qualifications: Must be 18 years old and have a high school diploma, high school equivalency preferred, or a State Education Commencement Credential (e.g. SACC or CDOS); with a minimum of three years' experience in children's mental health, addiction and/or foster care.]

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[13d. Rehabilitative Services: EPSDT only (Continued)
Psychosocial Rehabilitation (Continued):
Description (Continued):

Supervisor Qualifications:
The PSR provider must receive regularly scheduled supervision from a Licensed Clinical Social Worker (LCSW), Licensed Mental Health Counselor, Licensed Creative Arts Therapist, Licensed Marriage and Family Therapist, Licensed Psychoanalyst, Licensed Psychologist, Physician's Assistant, Psychiatrist, Physician, Registered Professional Nurse, or Nurse Practitioner operating within the scope of their practice. Supervisors must also be aware of and sensitive to trauma informed care and the cultural needs of the population of focus and how to best meet those needs, and be capable of training staff regarding these issues.

Provider Agency qualifications: Any child serving agency or agency with children's behavioral health and health experience that is licensed, certified, designated and/or approved by OCFS, OMH, OASAS OR DOH or its designee, to provide comparable services referenced in the definition. The caseload size must be based on the needs of the child/youth and families with an emphasis on successful outcomes and individual satisfaction and must meet the needs identified in the individual treatment plan.

The provider agency will assess the child prior to developing a treatment plan for the child. A licensed CPST practitioner or OLP must develop the treatment plan, with the PSR worker implementing the interventions identified on the services/plan. Group should not exceed more than 8 members. Authorization of the treatment plan is required by the DOH or its designee. Treatment services must be part of a treatment plan including goals and activities necessary to correct or ameliorate conditions discovered during the initial assessment visits.

Youth Peer Support and Training:
Description: Youth support and training services are formal and informal services and supports provided to youth who are experiencing social, medical, emotional, developmental, substance use, and/or behavioral challenges in their home, school, placement, and/or community centered services. These services provide the training and support necessary to ensure engagement and active participation of the youth in the treatment planning process and with the ongoing implementation and reinforcement of skills. Youth support and training is a face-to-face intervention and can occur in a variety of settings including community locations where the youth lives, works, attends school, engages in services (e.g. provider office sites), and/or socializes. Youth Peer Support and Training activities must be intended to develop and achieve the identified goals and/or objectives as set forth in the youth's individualized care plan. The structured, scheduled activities provided by this service emphasize the opportunity for the youth to expand the skills and strategies necessary to move forward in meeting their personal, individualized life goals, develop self-advocacy goals, and to support their transition into adulthood.]

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[13d. Rehabilitative Services: EPSDT only (Continued)
Youth Peer Support and Training: (Continued)

Youth Peer Support and Training is recommended by any following licensed practitioners of the healing arts operating within the scope of their practice under State license: a Licensed Master Social Worker (LMSW), Licensed Clinical Social Worker (LCSW), Licensed Mental Health Counselor, Licensed Creative Arts Therapist, Licensed Marriage and Family Therapist , Licensed Psychoanalyst, Licensed Psychologist, Physician's Assistant, Psychiatrist, Physician, Registered Professional Nurse, Nurse Practitioner, operating within the scope of their practice with the youth, family/caregiver or other collateral supports. Activities may include: Restoration, rehabilitation, and support to develop skills for coping with and managing psychiatric symptoms, trauma and substance use disorders; promote skills for wellness and recovery support; develop skills to independently navigate the service systems; develop skills to set goals; and build community living skills. To enhance resiliency/recovery-oriented attitudes such as hope, confidence and self-efficacy; Self-Advocacy & Empowerment skill building to develop, link to and facilitate the use of formal and informal resources, including connection to peer support groups in the community; serve as an advocate, mentor or facilitator for resolution of issues; and, assist in navigating the service system including assisting with engagement and bridging during transitions in care.

Practitioner qualifications:
YPST is delivered by a New York State Credentialed Youth Peer Advocate. To be eligible for the Youth Peer Advocate Professional Credential, an individual must:

- Be an individual 18 to 30 years who has self-identified as a person who has first-hand experience with social, emotional, medical, developmental, substance use, and/or behavioral challenges.
- Have a high school diploma, high school equivalency preferred or a State Education Commencement Credential (e.g. SACC or CDOS). This educational requirement can be waived by the credentialing agency if the person has demonstrated competencies and has relevant life experience sufficient for the youth peer-credential.
- Completed Level One (online) and Level Two (online and in person) training of the Youth Peer Support Services Advisory Council recommended and State approved training for YPAs followed by a minimum of three consultation calls.
- Submitted three letters of reference attesting to proficiency in and suitability for the role of a YPA including one from YPAs supervisor.
- Agree to practice according to the Youth Peer Advocate Code of Ethics.
- Documented 600 hours of experience providing Youth Peer Support services.
- Completed 20 hours of continuing education every 2 years.
- Demonstrates qualities of leadership, including: Knowledge of advocacy and group development and/or facilitation of peer-to-peer groups or activities.
- Is able to use lived experience with a disability, mental illness, juvenile justice, special education, substance use disorder, and/or foster care to assist in supporting youth in their resiliency/recovery and wellness.
- Be supervised by a credentialed YPA OR a credentialed Family Peer Advocate, both with four years direct service experience OR an individual who meets the criteria for a "qualified mental health staff person" found in 14 NYCRR 594 or 14 NYCRR 595.]

New York
3b-28

Reserved

[13d. Rehabilitative Services: EPSDT only (Continued)
Youth Peer Support and Training (Continued):
Practitioner qualifications (Continued):

A YPA may obtain a provisional credential that will allow services they provide to be billed if the applicant:

- •Is an individual 18 to 30 years who has self-identified as a person who has first-hand experience with social, emotional, medical, developmental, substance use, and/or behavioral challenges.
- •Has a high school diploma, high school equivalency preferred or a State Education Commencement Credential (e.g. SACC or CDOS). This educational credential can be waived by the certifying agency if the person has demonstrated competencies and has relevant life experience sufficient for the peer certification.
- •Has completed Level One of the Youth Peer Support Services Advisory Council recommended and State approved training for YPAs.
- •Demonstrates qualities of leadership, including: Knowledge of advocacy and group development and/or facilitation of peer-to-peer groups or activities.
- •Is able to use lived experience with a mental illness, juvenile justice, special education, substance use disorder, and/or foster care to assist in supporting youth in their resiliency/recovery and wellness.
- •Submits two letters of reference attesting to proficiency in and suitability for the role of an YPA.
- • Be supervised by a credentialed YPA OR a credentialed FPA, both with four years direct service experience OR an individual who meets the criteria for a "qualified mental health staff person" found in 14 NYCRR 594 or 14 NYCRR 595. Refer to Supervisor Qualifications for specificity.
- •Agree to practice according to the YPA Code of Ethics.

A YPA with a provisional credential must complete all other requirements of the professional credential within 18 months of employment as an YPA *OR* a Certified Recovery Peer Advocate – Youth who is an individual 18 to 30 years of age and has:

- •Lived experience defined as having been impacted or affected by substance use disorders and/or be in recovery from substance use disorders.
- •Has a high school diploma, high school equivalency preferred or a State Education Commencement Credential (e.g. SACC or CDOS).
- •Completed a minimum of 46 hours content specific training, covering topics of advocacy, mentoring/education, recovery/wellness support and ethical responsibility.
- •Documented 1,000 hours of relative work experience or document at least 500 hours of related work experience if they:
    - Have a Bachelor's Degree, is certified by OASAS as a CASAC or CASAC trainee or Prevention Professional or completed the 30 hour Recovery Coach Academy training.]

New York
3b-29

Reserved

[13d. Rehabilitative Services: EPSDT only (Continued):
Youth Peer Support and Training (Continued):

A YPA with a provisional credential must complete all other requirements of the professional credential within 18 months of employment as an YPA *OR* a Certified Recovery Peer Advocate – Youth who is an individual 18 to 30 years of age and has: (Continued)

- Provided evidence of at least 25 hours of supervision specific to the to the performance domains of advocacy, mentoring/education, recovery/wellness and ethical responsibility. Supervision must be provided by an organization documented and qualified to provide supervision per job description.
- Passed the NYCB/IC & RC Peer Advocate exam or other exam by an OASAS designated certifying body.
- Submitted two letters of recommendations.
- Demonstrated a minimum of 16 hours specifically related to Youth Peer Support.
- Completed 20 hours of continuing education earned every two years, including 6 hours of ethics.

Supervisor Qualifications: YPAs will be supervised by:

1) A credentialed YPA with four years of direct YPST service experience with access to clinical consultation as needed. The clinical supervision may be provided by a staff member or through a contract with another organization OR
2) A credentialed FPA with 4 years of experience providing FPSS that has been trained in YPST services and the role of the YPAs and efforts are made as the YPST service gains maturity in NYS to transition to supervision by an experienced credentialed YPAs within the organization.
3) A qualified "mental health staff person" found in 14 NYCRR 594 or 14 NYCRR 595 that has training in YPST services and the role of YPAs and efforts are made as the YPST service gains maturity in NYS to transition to supervision by an experienced credentialed YPA within the organization.

Additional Supervisor Qualifications:

- The individual providing consultation, guidance, mentoring, and on-going training need not be employed by the same agency.
- Supervision of these activities may be delivered in person or by distance communication methods.
- It is required that one hour of supervision be delivered for every 40 hours of Peer Support and Training duties performed.
- There may be an administrative supervisor who signs the youth peer specialist's timesheet and is the primary contact on other related human resource management issues.
- Supervisors must also be aware of and sensitive to the cultural needs of the population of focus and how to best meet those needs, and be capable of training staff regarding these issues.]

New York
3b-30

Reserved

[13d. Rehabilitative Services: EPSDT only (Continued):
Youth Peer Support and Training (Continued):

Provider Agency Qualifications: Any child serving agency or agency with children's behavioral health and health experience that is licensed, certified, designated and/or approved by OCFS, OMH, OASAS OR DOH or its designee, to provide comparable services referenced in the definition.

The provider agency will assess the child prior to developing a treatment plan for the child. Authorization of the treatment plan is required by the DOH or its designee. Treatment services must be part of a treatment plan including goals and activities necessary to correct or ameliorate conditions discovered during the initial assessment visits. Group should not exceed more than 8 members. Medicaid family support programs will not reimburse for the following:

- 12-step programs run by peers.
- General outreach and education including participation in health fairs, and other activities designed to increase the number of individuals served or the number of services received by individuals accessing services; community education services, such as health presentations to community groups, PTA's, etc.
- Contacts that are not medically necessary.
- Time spent doing, attending, or participating in recreational activities.
- Services provided to teach academic subjects or as a substitute for educational personnel such as, but not limited to, a teacher, teacher's aide, or an academic tutor.
- Time spent attending school (e.g. during a day treatment program).
- Habilitative services for the beneficiary (child) to acquire self-help, socialization, and adaptive skills necessary to reside successfully in community settings.
- Child Care services or services provided as a substitute for the parent or other individuals responsible for providing care and supervision.
- Respite care.
- Transportation for the beneficiary or family. Services provided in the car are considered transportation and time may not be billed under rehabilitation.
- Services not identified on the beneficiary's authorized treatment plan.
- Services not in compliance with the service manual and not in compliance with State Medicaid standards.
- Services provided to children, spouse, parents, or siblings of the eligible beneficiary under treatment or others in the eligible beneficiary's life to address problems not directly related to the eligible beneficiary's issues and not listed on the eligible beneficiary's treatment plan.
- Any intervention or contact not documented or consistent with the approved treatment plan/recovery plan goals, objectives, and approved services will not be reimbursed.]

New York
3b-31

Reserved

[13d. Rehabilitative Services: EPSDT only (Continued):

Family Peer Support:
Description: Family Peer Support Services (FPSS) are an array of formal and informal activities and supports provided to families caring for/raising a child who is experiencing social, emotional, medical, developmental, substance use and/or behavioral challenges in their home, school, placement, and/or community. FPSS provide a structured, strength-based relationship between a Family Peer Advocate (FPA) and the parent/family member/caregiver for the benefit of the child/youth. Family is defined as the primary care-giving unit and is inclusive of the wide diversity of primary caregiving units in our culture. Family is a birth, foster, adoptive, or self-created unit of people residing together, with significant attachment to the individual, consisting of adult(s) and/or child(ren), with adult(s) performing duties of parenthood/caregiving for the child(ren) even if the individual is living outside of the home.

Activities included must be intended to achieve the identified goals or objectives as set forth in the child/youth's treatment plan. FPSS is a face-to-face intervention, a group face-to-face intervention. A group is a composition of members should share common characteristics, such as related experiences, developmental age, chronological age, challenges or treatment goals. The Service is directed to the child, and includes contacts necessary for treatment with the family/caregiver or other collateral supports. FPSS is recommended by a licensed practitioner of the healing arts including: Licensed Master Social Worker (LMSW), Licensed Clinical Social Worker (LCSW), Licensed Mental Health Counselor, Licensed Creative Arts Therapist, Licensed Marriage and Family Therapist, Licensed Psychoanalyst, Licensed Psychologist, Physician's Assistant, Psychiatrist, Physician, Registered Professional Nurse, or Nurse Practitioner, operating within the scope of their practice. FPSS can be provided through individual and group face-to-face work and can occur in a variety of settings including community locations where the beneficiary lives, works, attends school, engages in services (e.g. provider office sites), and/or socializes. Components of FPSS include:

- Engagement, Bridging and Transition Support: Provide a bridge between families and service providers, support a productive and respectful partnership by assisting the families to express their strengths, needs and goals.
- Self-Advocacy, Self-Efficacy and Empowerment: Coach and model shared decision-making and skills that support collaboration, in addition to providing opportunities for families to self-advocate.
- Parent Skill Development: Support the efforts of families in caring for and strengthening their children's mental, and physical health, development and well-being.
- Community Connections and Natural Supports: Enhance the quality of life by supporting the integration of families into their own communities.]

New York
3b-32

Reserved

[13d. Rehabilitative Services: EPSDT only (Continued):
Family Peer Support (Continued):

Practitioner qualifications: Family Peer Support will be delivered by a New York State Credentialed Family Peer Advocate (FPA); FPA with a provisional credential; or a Certified Recovery Peer Advocate (CRPA) with a Family Specialty.

- **FPA Credential**- To be eligible for the FPA Credential, the individual must:
  - •Demonstrate 'lived experience' as a parent or primary caregiver who has navigated multiple child serving systems on behalf of their child(ren) with social, emotional, developmental, health and/or behavioral healthcare needs.
  - •Have a high school diploma, high school equivalency preferred or a State Education Commencement Credential (e.g. SACC or CDOS). This educational requirement can be waived by the State if the person has demonstrated competencies and has relevant life experience sufficient for the peer credential.
  - •Completed Level One and Level Two of the Parent Empowerment Program Training for Family Peer Advocates approved comparable training.
  - •Submitted three letters of reference attesting to proficiency in and suitability for the role of a Family Peer Advocate (FPA) including one from the FPAs supervisor.
  - •Documented 1000 hours of experience providing Family Peer Support services.
  - •Agreed to practice according to the Family Peer Advocate Code of Ethics.
  - •Completed 20 hours of continuing education and renew their FPA certification every two years.

- **A provisional FPA credential:**
  - •Demonstrated 'lived experience' as a parent or primary caregiver who has navigated multiple child serving systems on behalf of their child(ren) with social, emotional, developmental, health and/or behavioral healthcare needs.
  - •A high school diploma, high school equivalency preferred or a State Education Commencement Credential (e.g. SACC or CDOS). This educational requirement can be waived by the State if the person has demonstrated competencies and has relevant life experience sufficient for the peer certification.
  - Completed Level One of the Parent Empowerment Program Training for Family Peer Advocates or approved comparable training.
  - Submitted two letters of reference attesting to proficiency in and suitability for the role of a Family Peer Advocate (FPA). The provisional FPA must complete all other requirements of the Professional Family Peer Advocate Credential within 18 months of commencing employment as an FPA.
  - Agreed to practice according to the Family Peer Advocate Code of Ethics.]

New York
3b-33
Reserved

[13d. Rehabilitative Services: EPSDT only (Continued):
Family Peer Support (Continued):

Certified Recovery Peer Advocate (CRPA) with a Family Specialty:

To be certified as CPRA-Family, the individual must be at least 18 years of age and have the following:

- Have 'lived experience' as a family member impacted by youth substance use disorders. The CRPA – Family may be in recovery themselves.
- Have a high school diploma or a State Education Commencement Credential or General Equivalency Degree (GED).
- Completed a minimum of 46 hours of content specific training, covering the topics: advocacy, mentoring/education, recovery/wellness support and ethical responsibility.
- Documented 1,000 hours of related work experience, or document at least 500 hours of related work experience if they: Have a Bachelor's Degree; Are certified by OASAS as a CASAC, CASAC Trainee, or Prevention Professional; or Completed the 30-Hour Recovery Coach Academy training.
- Provide evidence of at least 25 hours of supervision specific to the performance domains of advocacy, mentoring/education, recovery/wellness support, and ethical responsibility. Supervision must be provided by an organization documented and qualified to provide supervision per job description.
- Pass the NYCB/IC & RC Peer Advocate Exam or other exam by an OASAS designated certifying body.
- Submitted two letters of recommendation.
- Demonstrated a minimum of 16 hours in the area of Family Support.
- Completed 20 hours of continuing education earned every two years, including 6 hours of Ethics.

Certified Recovery Peer Advocate with a Family Specialty as defined in the NYS OASAS: An individual who is supervised by a credentialed or licensed clinical staff member to provide outreach and peer support services based on clinical need as identified in the patient's treatment/recovery plan.

Supervisor Qualifications: FPAs will be supervised by:
1) Individuals who have a minimum of 4 years' experience providing FPSS services, at least 1 year of which is as a credentialed FPA with access to clinical consultation as needed. The clinical consultation may be provided by a staff member or through a contract OR
2) A "qualified mental health staff person" with a) training in FPSS and the role of FPAs b) efforts are made as the FPSS service gains maturity in NYS to transition to supervision by experienced credentialed FPA within the organization OR
3) From a competent behavioral health professional meeting the criteria for a "qualified mental health staff person" found in 14 NYCRR 594 or 14 NYCRR 595 OR
4) A Certified Alcohol and Substance Abuse Counselor (CASAC) working within an OASAS certified program.]

New York
3b-34
Reserved

[13d. Rehabilitative Services: EPSDT only (Continued):
Family Peer Support (Continued):

Supervisor Qualifications: (Continued) The individual providing consultation, guidance, mentoring, and on-going training need not be employed by the same agency. Supervision of these activities may be delivered in person or by distance communication methods. It is the expectation that 1 hour of supervision be delivered for every 40 hours of Family Peer Support Services duties performed. There may be an administrative supervisor who signs the family peer specialist's timesheet and is the primary contact on other related human resource management issues.

Provider Agency Qualifications: Any practitioner providing behavioral health services must operate within an agency licensed, certified, designated and/or approved by
Any child serving agency or agency with children's behavioral health and health experience that is licensed, certified, designated and/or approved by OCFS, OMH, OASAS OR DOH or its designee, to provide comparable services referenced in the definition.

The provider agency will assess the child prior to developing a treatment plan for the child. Authorization of the treatment plan is required by the DOH or its designee. Treatment services must be part of a treatment plan including goals and activities necessary to correct or ameliorate conditions discovered during the initial assessment visits. A group is composed may not exceed more than 12 individuals total. Medicaid family support programs will not reimburse for the following:

- 12-step programs run by peers.
- General outreach and education including participation in health fairs, and other activities designed to increase the number of individuals served or the number of services received by individuals accessing services; community education services, such as health presentations to community groups, PTA's, etc.
- Contacts that are not medically necessary.
- Time spent doing, attending, or participating in recreational activities.
- Services provided to teach academic subjects or as a substitute for educational personnel such as, but not limited to, a teacher, teacher's aide, or an academic tutor.
- Time spent attending school (e.g. during a day treatment program).
- Habilitative services for the beneficiary (child) to acquire self-help, socialization, and adaptive skills necessary to reside successfully in community settings.
- Child Care services or services provided as a substitute for the parent or other individuals responsible for providing care and supervision.
- Respite care.
- Transportation for the beneficiary or family. Services provided in the car are considered transportation and time may not be billed under rehabilitation.
- Services not identified on the beneficiary's authorized treatment plan.
- Services not in compliance with the service manual and not in compliance with State Medicaid standards.]

New York
3b-35

Reserved

[13d. Rehabilitative Services: EPSDT only (Continued):
Family Peer Support (Continued):

Limitations:

- Services provided to children, spouse, parents, or siblings of the eligible beneficiary under treatment or others in the eligible beneficiary's life to address problems not directly related to the eligible beneficiary's issues and not listed on the eligible beneficiary's treatment plan.
- Any intervention or contact not documented or consistent with the approved treatment plan/recovery plan goals, objectives, and approved services will not be reimbursed.]

Reserved

[STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: New York

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE

Rehabilitative Services (EPSDT only)

Reimbursement for EPSDT Rehabilitative Services as outlined in item 13.d per Attachment 3.1-A, are paid based upon Medicaid rates established by the State of New York.

Except as otherwise noted in the State Plan, the State-developed rates is the same for both governmental and private providers and the rates. The agency's rates were set as of July 1, 2018 and are effective for services provided on or after that date. All rates are published on the Department of Health website:

www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/proposed_spa.htm.

The rate development methodology will primarily be composed of provider cost modeling, through New York provider compensation studies and cost data. Rates from similar State Medicaid programs may be considered, as well. The following list outlines the major components of the cost model to be used in rate development.

- Staffing assumptions and staff wages.
- Employee-related expenses — benefits, employer taxes (e.g., Federal Insurance Contributions Act (FICA), unemployment, and workers compensation).
- Program-related expenses (e.g., supplies).
- Provider overhead expenses.
- Program billable units.

The rates will be developed as the ratio of total annual modeled provider costs to the estimated annual billable units.]

SUMMARY
SPA #18-0054

This State Plan Amendment proposes to modify the temporary rate adjustment for additional hospitals which are subject to or impacted by the closure, merger, acquisition, consolidation or restructuring of a health care provider. The additional providers for which approval is being requested are Eastern Niagara Hospital; St. John's Riverside Hospital; South Nassau Communities Hospital; Jamaica Hospital Medical Center; Interfaith Medical Center; St. Barnabas Hospital; and Richmond University Medical Center.

New York
136(b)

[b. Temporary rate adjustments have been approved for the following hospital providers in the amounts and for the effective periods listed:

Hospitals:

Provider Name	Gross Medicaid Rate Adjustment	Rate Period Effective
Beth Israel Medical Center	$15,000,000	11/01/2014 – 03/31/2015
	$33,200,000	04/01/2015 – 03/31/2016
	$33,200,000	04/01/2016 – 03/31/2017
Brookdale University Hospital and Medical Center	$14,000,000	02/01/2014 – 03/31/2014
Brooklyn Hospital Center	$5,000,000	02/01/2014 – 03/31/2014
	$5,000,000	04/01/2014 – 03/31/2015
Canton Potsdam Hospital/EJ Noble	$2,000,000	01/01/2014 – 03/31/2014
	$400,000	04/01/2014 – 03/31/2015
Catskill Regional Medical Center	$889,105	01/01/2014 – 03/31/2014
	$1,040,305	04/01/2014 – 03/31/2015
	$1,164,505	04/01/2015 – 03/31/2016
Champlain Valley Physicians Hospital Medical Center	$1,450,852	05/01/2017 - 03/31/2018
	$ 981,422	04/01/2018 - 03/31/2019
	$ 660,708	04/01/2019 - 03/31/2020
Healthalliance Mary's Ave Campus Benedictine Hospital	$2,500,000	02/01/2014 – 03/31/2014
Interfaith Medical Center	$12,900,000	11/01/2013 – 03/31/2014
Kingsbrook Jewish Medical Center	$1,480,000	11/01/2013 – 12/31/2013
	$2,320,000	01/01/2014 – 03/31/2014
Kings County Hospital Center	$1,000,000	01/01/2014 – 03/31/2014
Lewis County General Hospital*	$ 65,564	01/01/2014 – 03/31/2014
	$262,257	04/01/2014 – 03/31/2015
	$262,257	04/01/2015 – 03/31/2016
Lincoln Medical Center	$963,687	04/01/2012 – 03/31/2013
	$963,687	04/01/2013 – 03/31/2014
Little Falls Hospital*	$21,672	01/01/2014 – 03/31/2014
	$86,688	04/01/2014 – 03/31/2015
	$86,688	04/01/2015 – 03/31/2016

*Denotes this provider is a Critical Access Hospital (CAH).]

New York
136(b)

b. Temporary rate adjustments have been approved for the following hospital providers in the amounts and for the effective periods listed:

Hospitals:

Provider Name	Gross Medicaid Rate Adjustment	Rate Period Effective
Beth Israel Medical Center	$15,000,000	11/01/2014 – 03/31/2015
	$33,200,000	04/01/2015 – 03/31/2016
	$33,200,000	04/01/2016 – 03/31/2017
Brookdale University Hospital and Medical Center	$14,000,000	02/01/2014 – 03/31/2014
Brooklyn Hospital Center	$5,000,000	02/01/2014 – 03/31/2014
	$5,000,000	04/01/2014 – 03/31/2015
Canton Potsdam Hospital/EJ Noble	$2,000,000	01/01/2014 – 03/31/2014
	$400,000	04/01/2014 – 03/31/2015
Catskill Regional Medical Center	$889,105	01/01/2014 – 03/31/2014
	$1,040,305	04/01/2014 – 03/31/2015
	$1,164,505	04/01/2015 – 03/31/2016
Champlain Valley Physicians Hospital Medical Center	$1,450,852	05/01/2017 - 03/31/2018
	$ 981,422	04/01/2018 - 03/31/2019
	$ 660,708	04/01/2019 - 03/31/2020
Eastern Niagara Hospital	$1,425,000	07/01/2018 – 03/31/2019
	$1,575,000	04/01/2019 – 03/31/2020
Healthalliance Mary's Ave Campus Benedictine Hospital	$2,500,000	02/01/2014 – 03/31/2014
Interfaith Medical Center	$12,900,000	11/01/2013 – 03/31/2014
	$11,110,190	07/01/2018 – 03/31/2019
	$13,505,285	04/01/2019 – 03/31/2020
	$13,384,525	04/01/2020 – 03/31/2021
Jamaica Hospital Medical Center	$8,365,000	07/01/2018 – 03/31/2019
Kingsbrook Jewish Medical Center	$1,480,000	11/01/2013 – 12/31/2013
	$2,320,000	01/01/2014 – 03/31/2014
Kings County Hospital Center	$1,000,000	01/01/2014 – 03/31/2014

*Denotes this provider is a Critical Access Hospital (CAH).

New York
136(c)

[Hospitals (Continued):

Provider Name	Gross Medicaid Rate Adjustment	Rate Period Effective
Maimonides Medical Center	$2,500,000	11/01/2014 – 03/31/2015
Montefiore Medical Center	$6,000,000	11/01/2013 – 03/31/2014
	$ 750,000	10/01/2016 – 03/31/2017
	$ 454,545	04/01/2017 – 03/31/2018
	$ 454,546	04/01/2018 – 03/31/2019
	$ 340,909	04/01/2019 – 09/30/2019
New York Methodist Hospital	$3,005,000	01/01/2014 – 03/31/2014
	$3,201,500	04/01/2014 – 03/31/2015
	$3,118,500	04/01/2015 – 03/31/2016
Niagara Falls Memorial Medical Center	$228,318	04/01/2012 – 03/31/2013
	$171,238	04/01/2013 – 12/31/2013
	$318,755	01/01/2014 – 03/31/2014
	$501,862	04/01/2014 – 03/31/2015
	$260,345	04/01/2015 – 03/31/2016
Nassau University Medical Center	$4,000,000	04/01/2012 – 03/31/2013
	$6,500,000	04/01/2013 – 03/31/2014
	$7,000,000	04/01/2014 – 03/31/2015
Richmond University Medical Center	$8,897,955	01/01/2013 – 03/31/2013
	$2,355,167	04/01/2013 – 03/31/2014
	$1,634,311	04/01/2014 – 03/31/2015
St. Barnabas Hospital	$2,588,278	01/01/2013 – 03/31/2013
	$1,876,759	04/01/2013 – 03/31/2014
	$1,322,597	04/01/2014 – 03/31/2015
	$ 2,500,000	01/01/2017 – 03/31/2017
	$10,000,000	04/01/2017 – 03/31/2018
	$10,000,000	04/01/2018 – 03/31/2019
	$ 7,500,000	04/01/2019 – 12/31/2019
Soldiers & Sailors Memorial Hospital	$ 19,625	02/01/2014 – 03/31/2014
	$117,252	04/01/2014 – 03/31/2015
	$134,923	04/01/2015 – 03/31/2016
South Nassau Communities Hospital	$3,000,000	11/01/2014 – 03/31/2015
	$1,000,000	04/01/2015 – 03/31/2016
Strong Memorial Hospital	$4,163,227	04/01/2018 – 03/31/2019
	$4,594,780	04/01/2019 – 03/31/2020
	$4,370,030	04/01/2020 – 03/31/2021
Wyckoff Heights Medical Center	$1,321,800	01/01/2014 – 03/31/2014
	$1,314,158	04/01/2014 – 03/31/2015
	$1,344,505	04/01/2015 – 03/31/2016

]

New York
136(c)

Hospitals (Continued):

Provider Name	Gross Medicaid Rate Adjustment	Rate Period Effective
Lewis County General Hospital*	$ 65,564	01/01/2014 – 03/31/2014
	$262,257	04/01/2014 – 03/31/2015
	$262,257	04/01/2015 – 03/31/2016
Lincoln Medical Center	$963,687	04/01/2012 – 03/31/2013
	$963,687	04/01/2013 – 03/31/2014
Little Falls Hospital*	$ 21,672	01/01/2014 – 03/31/2014
	$ 86,688	04/01/2014 – 03/31/2015
	$ 86,688	04/01/2015 – 03/31/2016
Maimonides Medical Center	$2,500,000	11/01/2014 – 03/31/2015
Montefiore Medical Center	$6,000,000	11/01/2013 – 03/31/2014
	$ 750,000	10/01/2016 – 03/31/2017
	$ 454,545	04/01/2017 – 03/31/2018
	$ 454,546	04/01/2018 – 03/31/2019
	$ 340,909	04/01/2019 – 09/30/2019
New York Methodist Hospital	$3,005,000	01/01/2014 – 03/31/2014
	$3,201,500	04/01/2014 – 03/31/2015
	$3,118,500	04/01/2015 – 03/31/2016
Niagara Falls Memorial Medical Center	$228,318	04/01/2012 – 03/31/2013
	$171,238	04/01/2013 – 12/31/2013
	$318,755	01/01/2014 – 03/31/2014
	$501,862	04/01/2014 – 03/31/2015
	$260,345	04/01/2015 – 03/31/2016
Nassau University Medical Center	$4,000,000	04/01/2012 – 03/31/2013
	$6,500,000	04/01/2013 – 03/31/2014
	$7,000,000	04/01/2014 – 03/31/2015
Richmond University Medical Center	$8,897,955	01/01/2013 – 03/31/2013
	$2,355,167	04/01/2013 – 03/31/2014
	$1,634,311	04/01/2014 – 03/31/2015
	$9,966,329	07/01/2018 – 03/31/2019
	$9,869,000	04/01/2019 – 03/31/2020
	$9,711,500	04/01/2020 – 03/31/2021

*Denotes this provider is a Critical Access Hospital (CAH)

New York
136(c.1)

Hospitals (Continued):

Provider Name	Gross Medicaid Rate Adjustment	Rate Period Effective
St. Barnabas Hospital	$ 2,588,278	01/01/2013 – 03/31/2013
	$ 1,876,759	04/01/2013 – 03/31/2014
	$ 1,322,597	04/01/2014 – 03/31/2015
	$ 2,500,000	01/01/2017 – 03/31/2017
	$10,000,000	04/01/2017 – 03/31/2018
	$10,000,000	04/01/2018 – 03/31/2019
	$ 7,500,000	04/01/2019 – 12/31/2019
	$12,000,000	07/01/2018 – 03/31/2019
St. John's Riverside-St. John's Division	$1,800,000	07/01/2018 – 03/31/2019
	$ 700,000	04/01/2019 – 03/31/2020
	$ 500,000	04/01/2020 – 03/31/2021
Soldiers & Sailors Memorial Hospital	$ 19,625	02/01/2014 – 03/31/2014
	$ 117,252	04/01/2014 – 03/31/2015
	$ 134,923	04/01/2015 – 03/31/2016
South Nassau Communities Hospital	$3,000,000	11/01/2014 – 03/31/2015
	$1,000,000	04/01/2015 – 03/31/2016
	$4,000,000	07/01/2018 – 03/31/2019
	$4,000,000	04/01/2019 – 03/31/2020
	$4,000,000	04/01/2020 – 03/31/2021
Strong Memorial Hospital	$4,163,227	04/01/2018 – 03/31/2019
	$4,594,780	04/01/2019 – 03/31/2020
	$4,370,030	04/01/2020 – 03/31/2021
Wyckoff Heights Medical Center	$1,321,800	01/01/2014 – 03/31/2014
	$1,314,158	04/01/2014 – 03/31/2015
	$1,344,505	04/01/2015 – 03/31/2016

The Department of Health proposes to amend the Title XIX (Medicaid) State Plan for non-institutional services to revise provisions of the Ambulatory Patient Group (APG) reimbursement methodology on or after July 1, 2018. The following changes are proposed:

The Ambulatory Patient Group (APG) reimbursement methodology is revised to include recalculated weight and component updates that will become effective on or after July 1, 2018. The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2018/2019 is $7,541,000.

The public is invited to review and comment on this proposed State Plan Amendment. Copies of which will be available for public review on the Department's website at http://www.health.ny.gov/regulations/state_plans/status.

Copies of the proposed State Plan Amendments will be on file in each local (county) social services district and available for public review.

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, Bureau of Federal Relations & Provider Assessments, 99 Washington Ave., One Commerce Plaza, Suite 1430, Albany, NY 12210, (518) 474-1673, (518) 473-8825 (FAX), spa_inquiries@health.state.ny.us

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 institutional services related to temporary rate adjustments to Article 28 Hospitals that are undergoing closure, merger, consolidation, acquisition or restructuring themselves or other health care providers. These payments are authorized by Section 2826 of the New York Public Health Law.

The temporary rate adjustments have been reviewed and approved for the following 7 hospitals with aggregate payment amounts totaling up to $48,666,519 for the period July 1, 2018 through March 31, 2019, $29,649,285 for the period April 1, 2019 through March 31, 2020 and $27,596,025 for the period April 1, 2020 through March 31, 2021. The approved providers along with their individual estimated aggregate amounts include:

1. Eastern Niagara Hospital, up to $1,425,000 for SFY 18/19 and $1,575,000 for SFY 19/20;

2. St. John's Riverside Hospital – St. John's Division, up to $1,800,000 for SFY 18/19, $700,000 for SFY 19/20, and $500,000 for SFY 20/21;

3. South Nassau Communities Hospital, up to $4,000,000 for SFY 18/19, $4,000,000 for SFY 19/20, and $4,000,000 for SFY 20/21;

4. Jamaica Hospital Medical Center, up to $8,365,000 for SFY 18/19;

5. Interfaith Medical Center, up to $11,110,190 for SFY 18/19, $13,505,285 for SFY 19/20, and $13,384,525 for SFY 20/21;

6. St. Barnabas Hospital, up to $12,000,000 for SFY 18/19;

7. Richmond University Medical Center, up to $9,966,329 for SFY 18/19, $9,869,000 for SFY 19/20, and $9,711,500 for SFY 20/21.

The public is invited to review and comment on this proposed State Plan Amendment. Copies of which will be available for public review on the Department's website at http://www.health.ny.gov/regulations/state_plans/status.

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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 1460, Albany, NY 12210, spa_inquiries@health.ny.gov

PUBLIC NOTICE

New York City Deferred Compensation Plan & NYCE IRA

The New York City Deferred Compensation Plan & NYCE IRA (the "Plan") is seeking proposals from qualified vendors to provide unbundled recordkeeping services for the City of New York Deferred Compensation Plan. The Request for Proposals ("RFP") will be available beginning on Thursday, June 7, 2018. Responses are due no later than 4:30 p.m. Eastern Time on Tuesday, July 17, 2018. To obtain a copy of the RFP, please visit www1.nyc.gov/site/olr/about/about-rfp.page and download the RFP along with the applicable documents.

If you have any questions, please submit them by fax to Georgette Gestely, Director, at (212) 306-7376.

Consistent with the policies expressed by the City, proposals from New York City certified minority-owned and/or women-owned businesses or proposals that include partnering arrangements with New York City certified minority-owned and/or women-owned firms are encouraged. Additionally, proposals from small and New York City-based businesses are also encouraged.

PUBLIC NOTICE

Department of State
Uniform Code Variance / Appeal Petitions

Pursuant to 19 NYCRR Part 1205, the variance and appeal petitions below have been received by the Department of State. Unless other-

SUMMARY
SPA #18-0055

This State Plan Amendment proposes to reflect the recalculated weights, with component updates, to become effective July 1, 2018. The requirement to reweight using updated Medicaid claims data is being revised from no less frequently than every six years to no less frequently than every seven years.

New York
2(g)(2)

APG Reimbursement Methodology – Freestanding Clinics

The following links direct users to the various definitions and factors that comprise the APG reimbursement methodology, which can also be found in aggregate on the APG website at http://www.health.ny.gov/health_care/medicaid/rates/apg/index.htm. In addition, prior period information associated with these links is available upon request to the Department of Health.

Contact Information:
http://www.health.ny.gov/health_care/medicaid/rates/apg/index.htm Click on "Contacts."

3M APG Crosswalk*:
http://www.health.ny.gov/health_care/medicaid/rates/apg/index.htm Click on "3M Versions and Crosswalks," then on "3M APG Crosswalk" toward bottom of page, and finally on "Accept" at bottom of page.

APG Alternative Payment Fee Schedule; updated as of 01/01/11:
http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm Click on "Alternative Payment Fee Schedule."

APG Consolidation Logic; logic is from version 3.13.18.1, updated as of 01/01/18:
http://www.health.ny.gov/health_care/medicaid/rates/bundling/ Click on "2018"

APG 3M Definitions Manual; version 3.13 updated as of [01/01/18 and 04/01/18] 07/01/18 and 10/01/18:
http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm Click on "3M Versions and Crosswalk."

APG Investments by Rate Period; updated as of 07/01/10:
http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm Click on "Investments by Rate Period."

APG Relative Weights; updated as of [01/01/18] 07/01/18:
http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm Click on "Weights, Proc Weights, and APG Fee Schedule Amounts."

Associated Ancillaries; updated as of 07/01/15:
http://www.health.ny.gov/health_care/medicaid/rates/apg/index.htm Click on "Ancillary Policy."

*Older 3M APG crosswalk versions available upon request.

New York
2(g)(3)

Carve-outs; updated as of 10/01/12. The full list of carve-outs is contained in Never Pay APGs and Never Pay Procedures:
http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm Click on "Carve Outs."

Coding Improvement Factors (CIF); updated as of 04/01/12 and 07/01/12:
http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm Click on "CIFs by Rate Period."

If Stand Alone, Do Not Pay APGs; updated 01/01/15:
http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm Click on "If Stand Alone, Do Not Pay APGs."

If Stand Alone, Do Not Pay Procedures; updated 01/01/18:
http://www.health.state.ny.us/health_care/medicaid/rates/methodology/index.htm Click on "If Stand Alone, Do Not Pay Procedures."

Modifiers; updated as of [01/01/15] 07/01/18:
http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm Click on "Modifiers."

Never Pay APGs; updated as of 07/01/17:
http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm Click on "Never Pay APGs."

Never Pay Procedures; updated as of [01/01/18] 07/01/18:
http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm Click on "Never Pay Procedures."

No-Blend APGs; updated as of 04/01/10:
http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm Click on "No Blend APGs."

No-Blend Procedures; updated as of 01/01/11:
http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm Click on "No-Blend Procedures."

No Capital Add-on APGs: updated as of 10/1/12 and 01/01/13:
http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm Click on "No Capital Add-on APGs."

New York
2(k)

Reimbursement Methodology – Freestanding Clinics

I. The criteria for using a procedure-based weight or the relative weight in the methodology is as follows: If a procedure-based weight is available for a particular procedure code, then the procedure-based weight is used. If a procedure-based weight is not available for a particular procedure code, then the relative weight (i.e., "APG weight") is used.

II. The initial calculation of the APG relative weights were developed using line level charges from 2005 New York Medicaid hospital claims converted to cost using the ratio of cost to charges methodology. The line level costs were brought up to the APG level to determine the average cost of each APG.

a. The APG relative weights will be updated no less frequently than every [six] seven years based on hospital claims data. These APG and weights are set as of September 1, 2009, and are effective for specified services on and after that date. A link to the list of APGs and their relative weights is available in the APG Reimbursement Methodology – Freestanding Clinics section.

b. The APG relative weights shall be re-weighted prospectively. The initial reweighting will be based on Medicaid claims data for hospitals from the December 1, 2008 through September 30, 2009 period. Subsequent re-weightings will be based on Medicaid hospital claims data from the most recent twelve-month period and will be based on complete and accurate line level procedure and charge data and ratio of cost to charge data.

c. The Department shall correct material errors of any given APG relative weight. Such corrections shall make use of benchmarking data consisting of payment information from other payers (including Medicare) reimbursing comparable services. Corrections to material errors in individual APG relative weights shall be made on a prospective basis.

III. The case mix index is an expression of the average paid APG weight for a given peer group after consolidation, packaging, and discounting. Case mix indices shall be calculated by running applicable freestanding D&TC and ambulatory surgery center claims data through the latest version of the APG software to determine the average final APG weight of the visits. Outlier claims or claim lines may be excluded from this calculation to assure overall accuracy of the final case mix index. Recalculations of case mix indices for periods prior to January 1, 2010, will be based on freestanding D&TC and ambulatory surgery center Medicaid data for 2007. Such revisions for the period commencing January 1, 2010, will be based on such data from the January 1, 2009 through November 15, 2009 period. Subsequent recalculations will be based on freestanding D&TC and ambulatory surgery center Medicaid claims data from the most recent twelve month period.

MISCELLANEOUS
NOTICES/HEARINGS

Notice of Abandoned Property Received by the State Comptroller

Pursuant to provisions of the Abandoned Property Law and related laws, the Office of the State Comptroller receives unclaimed monies and other property deemed abandoned. A list of the names and last known addresses of the entitled owners of this abandoned property is maintained by the office in accordance with Section 1401 of the Abandoned Property Law. Interested parties may inquire if they appear on the Abandoned Property Listing by contacting the Office of Unclaimed Funds, Monday through Friday from 8:00 a.m. to 4:30 p.m., at:

1-800-221-9311
or visit our web site at:
www.osc.state.ny.us

Claims for abandoned property must be filed with the New York State Comptroller's Office of Unclaimed Funds as provided in Section 1406 of the Abandoned Property Law. For further information contact: Office of the State Comptroller, Office of Unclaimed Funds, 110 State St., Albany, NY 12236.

NOTICE OF PUBLIC HEARING

Department of Financial Services

Plan of Conversion by Medical Liability Mutual Insurance Company

PURSUANT TO THE PROVISIONS OF THE State Administrative Procedure Act, NOTICE is hereby given of the following proposed rule:

Proposed Action: Approval of a plan by Medical Liability Mutual Insurance Company to convert from a mutual property and casualty insurance company to a stock property and casualty insurance company.

Statutory authority: N.Y. Insurance Law Section 7307.

Subject: Plan of Conversion by Medical Liability Mutual Insurance Company.

Purpose: To convert a mutual property and casualty insurance company to a stock property and casualty insurance company.

Public hearing will be held at: 10:00 a.m., August 23, 2018 at One State Street, 6th Floor, New York, NY 10004.

Interpreter Service: Interpreter services will be made available to hearing impaired persons, at no charge, upon written request submitted within reasonable time prior to the scheduled public hearing. The written request must be addressed to the agency representative designated below.

Accessibility: All public hearings have been scheduled at places reasonably accessible to persons with mobility impairment.

Substance of proposed rule: Medical Liability Mutual Insurance Company has submitted a plan pursuant to N.Y. Insurance Law Section 7307 to convert from a mutual property and casualty insurance company to a stock property and casualty insurance company.

Text of proposed rule and any required statements and analyses may be obtained from: Bernard Lott, Department of Financial Services, One State St., New York, NY 10004, (212) 709-7763

Data, views or arguments may be submitted to: Linda Krebs, New York State Department of Financial Services, One State Street, 4th Floor, New York, NY 10004, (212) 709-3870, email: mlmicdemutualization@dfs.ny.gov

Public comment will be received until: Five days after the scheduled public hearing.

Regulatory Impact Statement, Regulatory Flexibility Analysis, Rural Area Flexibility Analysis, and Job Impact Statement: Statements and analyses are not submitted with this notice because the proposed rule comes within the definition contained in section 102(2)(a)(ii) of the State Administrative Procedure Act.

PUBLIC NOTICE

Department of Agriculture and Markets

Pursuant to Agriculture and Markets Law § 284-a, Notice is hereby given that the Department of Agriculture and Markets has designated the "Lewis County Cuisine Trail," described as:

"Beginning at the intersection of Shady Ave and S State Street (5406 Shady Ave) in the town of Lowville travel southeast towns Elm Street for.548 miles and make a slight left to stay on S State Street and continue onto NY-12 S/Utica Blvd for 3.58 miles and turn left onto E Martinsburg Rd for 2.60 miles and turn right onto Number 4 Rd for.523 miles and then turn left onto Snell Rd for 4.32 mi and turn right onto NY-812 N and travel for 5.07 miles and turn left onto NY-126/W Shady Ave for 5.58 miles and turn left onto NY-410 W for 3.97 miles and turn right onto NY-26 N for 4.38 miles and turn left onto Roberts Rd for 4.85 miles and turn left onto NY-12 S and travel for 11.7 miles into the town of Lowville"

For further information, please contact: Marcy Kugeman, Agricultural Development, Department of Agriculture, 10B Airline Dr., Albany, NY 12235, (518) 457-1977, (518) 457- 2716 (Fax)

PUBLIC NOTICE

Office of General Services

Pursuant to Section 33 of the Public Lands Law, the Office of General Services hereby gives notice to the following:

Notice is hereby given that the Department of Correctional and Community Supervision has determined a certain piece or parcel of land, known as 7874 State Route 11, Town of Chateaugay, Franklin County, State of New York, a former correctional facility, improved with approximately 30 various building structures totaling over 98,000 square feet of gross building area on a 99.03 +/- acre lot of land, with tax map identifier 061-2-5 on the Franklin County Tax Rolls, as surplus and no longer useful or necessary for state program purposes and has been abandoned for sale or disposition as Unappropriated State land.

For further information, please contact: Thomas Pohl, Esq., Office of General Services, Legal Services, 41st Fl., Corning Tower, Empire State Plaza, Albany, NY 12242, (518) 474-8831, (518) 473- 4973 fax

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 revise provisions of the Ambulatory Patient Group (APG) reimbursement methodology on or after July 1, 2018. The following changes are proposed:

The Ambulatory Patient Group (APG) reimbursement methodology is revised to include recalculated weight and component updates that will become effective on or after July 1, 2018. The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2018/2019 is $7,541,000.

The public is invited to review and comment on this proposed State Plan Amendment. Copies of which will be available for public review on the Department's website at http://www.health.ny.gov/regulations/state_plans/status.

Copies of the proposed State Plan Amendments will be on file in each local (county) social services district and available for public review.

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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
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For further information and to review and comment, please contact: Department of Health, Bureau of Federal Relations & Provider Assessments, 99 Washington Ave., One Commerce Plaza, Suite 1430, Albany, NY 12210, (518) 474-1673, (518) 473-8825 (FAX), spa_inquiries@health.state.ny.us

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 institutional services related to temporary rate adjustments to Article 28 Hospitals that are undergoing closure, merger, consolidation, acquisition or restructuring themselves or other health care providers. These payments are authorized by Section 2826 of the New York Public Health Law.

The temporary rate adjustments have been reviewed and approved for the following 7 hospitals with aggregate payment amounts totaling up to $48,666,519 for the period July 1, 2018 through March 31, 2019, $29,649,285 for the period April 1, 2019 through March 31, 2020 and $27,596,025 for the period April 1, 2020 through March 31, 2021. The approved providers along with their individual estimated aggregate amounts include:

1. Eastern Niagara Hospital, up to $1,425,000 for SFY 18/19 and $1,575,000 for SFY 19/20;

2. St. John's Riverside Hospital – St. John's Division, up to $1,800,000 for SFY 18/19, $700,000 for SFY 19/20, and $500,000 for SFY 20/21;

3. South Nassau Communities Hospital, up to $4,000,000 for SFY 18/19, $4,000,000 for SFY 19/20, and $4,000,000 for SFY 20/21;

4. Jamaica Hospital Medical Center, up to $8,365,000 for SFY 18/19;

5. Interfaith Medical Center, up to $11,110,190 for SFY 18/19, $13,505,285 for SFY 19/20, and $13,384,525 for SFY 20/21;

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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 1460, Albany, NY 12210, spa_inquiries@health.ny.gov

PUBLIC NOTICE

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If you have any questions, please submit them by fax to Georgette Gestely, Director, at (212) 306-7376.

Consistent with the policies expressed by the City, proposals from New York City certified minority-owned and/or women-owned businesses or proposals that include partnering arrangements with New York City certified minority-owned and/or women-owned firms are encouraged. Additionally, proposals from small and New York City-based businesses are also encouraged.

PUBLIC NOTICE

Department of State
Uniform Code Variance / Appeal Petitions

Pursuant to 19 NYCRR Part 1205, the variance and appeal petitions below have been received by the Department of State. Unless other-

SUMMARY
SPA #18-0056

This State Plan Amendment proposes to revise the Ambulatory Patient Group (APG) methodology for hospital-based clinic and ambulatory surgery services, including emergency room services, to reflect the recalculated weights with component updates to become effective July 1, 2018. The reweighting requirement using updated Medicaid claims data is being revised from no less frequently than every six years to no less frequently than every seven years.

New York
1(e)(2)

APG Reimbursement Methodology – Hospital Outpatient

The following links direct users to the various definitions and factors that comprise the APG reimbursement methodology, which can also be found in aggregate on the APG website at http://www.health.ny.gov/health_care/medicaid/rates/apg/index.htm. In addition, prior period information associated with these links is available upon request to the Department of Health.

Contact Information:
http://www.health.ny.gov/health_care/medicaid/rates/apg/index.htm Click on "Contacts."

3M APG Crosswalk, version 3.13; updated as of [01/01/18 and 04/01/18] 07/01/18 and 10/01/18:
http://www.health.ny.gov/health_care/medicaid/rates/crosswalk/index.htm
http://dashboard.emedny.org/CrossWalk/html/cwAgreement.html Click on "Accept" at bottom of page to gain access.

APG Alternative Payment Fee Schedule; updated as of 01/01/11:
http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm Click on "Alternative Payment Fee Schedule."

APG Consolidation Logic; logic is from the version of 4/01/08, updated as of 01/01/18:
http://www.health.ny.gov/health_care/medicaid/rates/bundling/ Click on "2018"

APG 3M Definitions Manual Versions; updated as of [01/01/18 and 04/01/18] 07/01/18 and 10/01/18:
http://www.health.ny.gov/health_care/medicaid/rates/crosswalk/index.htm

APG Investments by Rate Period; updated as of 01/01/11:
http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm Click on "Investments by Rate Period."

APG Relative Weights; updated as of [01/01/18] 07/01/18:
http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm Click on "Weights, Proc Weights, and APG Fee Schedule Amounts" file.

Associated Ancillaries; updated as of 07/01/15:
http://www.health.ny.gov/health_care/medicaid/rates/apg/index.htm Click on "Ancillary Policy."

New York
1(e)(2.1)

Carve-outs; updated as of 10/01/12:
http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm Click on "Carve Outs."

Coding Improvement Factors (CIF); updated as of 07/01/12:
http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm Click on "CIFs by Rate Period."

If Stand Alone, Do Not Pay APGs; updated as of 01/01/15:
http://www.health.state.ny.us/health_care/medicaid/rates/methodology/index.htm Click on "If Stand Alone, Do Not Pay APGs."

If Stand Alone, Do Not Pay Procedures; updated as of 01/01/18:
http://www.health.state.ny.us/health_care/medicaid/rates/methodology/index.htm Click on "If Stand Alone, Do Not Pay Procedures."

Modifiers; updated as of [01/01/15] 07/01/18:
http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm Click on "Modifiers."

Never Pay APGs; updated as of 07/01/17:
http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm Click on "Never Pay APGs."

Never Pay Procedures; updated as of [01/01/18] 07/01/18:
http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm Click on "Never Pay Procedures."

No-Blend APGs; updated as of 04/01/10:
http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm Click on "No Blend APGs."

No-Blend Procedures; updated as of 01/01/11:
http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm Click on "No Blend Procedures."

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Reimbursement Methodology – Hospital Outpatient

I. The criteria for using a procedure-based weight or the relative weight in the methodology is as follows: If a procedure-based weight is available for a particular procedure code, then the procedure-based weight is used. If a procedure-based weight is not available for a particular procedure code, then the relative weight (i.e., "APG weight") is used.

II. The initial calculation of the APG relative weights were developed using line level charges from 2005 New York Medicaid claims converted to cost using the ratio of cost to charges methodology. The line level costs were brought up to the APG level to determine the average cost of each APG.

a. The APG relative weights will be updated no less frequently than every [six] seven years. These APG and weights are set as of December 1, 2008, and are effective for specified services on and after that date. A link to the list of APGs and their relative weights is available in the APG Reimbursement Methodology – Reimbursement Components section.

b. The APG relative weights will be reweighted prospectively. The initial reweighting will be based on Medicaid claims data from the December 1, 2008 through September 30, 2009 period. Subsequent reweighting's will be based on Medicaid claims data from the most recent twelve month period and will be based on complete and accurate line level procedure and charge data and ratio of cost to charge data.

c. The Department will correct material errors of any given APG relative weight. Such corrections will make use of benchmarking data consisting of payment information from other payers (including Medicare) reimbursing comparable services. Corrections to material errors in individual APG relative weights will be made on a prospective basis.

III. Case mix index is an expression of the average paid APG weight for a given peer group after consolidation, packaging, and discounting. Case mix indices will be calculated by running applicable claims data through the latest version of the APG software to determine the average final APG weight of the visits. Outlier claims or claim lines may be excluded from this calculation to assure overall accuracy of the final case mix. The initial calculation of case mix indices for periods prior to January 1, 2010, will be based on Medicaid data from the December 1, 2008, through April 30, 2009 period. The January 1, 2010, calculation of case-mix indices will be based on Medicaid data for the period December 1, 2008, through September 30, 2009. Subsequent calculations will be based on Medicaid claims data from the most recent twelve-month period.

MISCELLANEOUS
NOTICES/HEARINGS

Notice of Abandoned Property Received by the State Comptroller

Pursuant to provisions of the Abandoned Property Law and related laws, the Office of the State Comptroller receives unclaimed monies and other property deemed abandoned. A list of the names and last known addresses of the entitled owners of this abandoned property is maintained by the office in accordance with Section 1401 of the Abandoned Property Law. Interested parties may inquire if they appear on the Abandoned Property Listing by contacting the Office of Unclaimed Funds, Monday through Friday from 8:00 a.m. to 4:30 p.m., at:

1-800-221-9311
or visit our web site at:
www.osc.state.ny.us

Claims for abandoned property must be filed with the New York State Comptroller's Office of Unclaimed Funds as provided in Section 1406 of the Abandoned Property Law. For further information contact: Office of the State Comptroller, Office of Unclaimed Funds, 110 State St., Albany, NY 12236.

NOTICE OF PUBLIC HEARING

Department of Financial Services

Plan of Conversion by Medical Liability Mutual Insurance Company

PURSUANT TO THE PROVISIONS OF THE State Administrative Procedure Act, NOTICE is hereby given of the following proposed rule:

Proposed Action: Approval of a plan by Medical Liability Mutual Insurance Company to convert from a mutual property and casualty insurance company to a stock property and casualty insurance company.

Statutory authority: N.Y. Insurance Law Section 7307.

Subject: Plan of Conversion by Medical Liability Mutual Insurance Company.

Purpose: To convert a mutual property and casualty insurance company to a stock property and casualty insurance company.

Public hearing will be held at: 10:00 a.m., August 23, 2018 at One State Street, 6th Floor, New York, NY 10004.

Interpreter Service: Interpreter services will be made available to hearing impaired persons, at no charge, upon written request submitted within reasonable time prior to the scheduled public hearing. The written request must be addressed to the agency representative designated below.

Accessibility: All public hearings have been scheduled at places reasonably accessible to persons with mobility impairment.

Substance of proposed rule: Medical Liability Mutual Insurance Company has submitted a plan pursuant to N.Y. Insurance Law Section 7307 to convert from a mutual property and casualty insurance company to a stock property and casualty insurance company.

Text of proposed rule and any required statements and analyses may be obtained from: Bernard Lott, Department of Financial Services, One State St., New York, NY 10004, (212) 709-7763

Data, views or arguments may be submitted to: Linda Krebs, New York State Department of Financial Services, One State Street, 4th Floor, New York, NY 10004, (212) 709-3870, email: mlmicdemutualization@dfs.ny.gov

Public comment will be received until: Five days after the scheduled public hearing.

Regulatory Impact Statement, Regulatory Flexibility Analysis, Rural Area Flexibility Analysis, and Job Impact Statement: Statements and analyses are not submitted with this notice because the proposed rule comes within the definition contained in section 102(2)(a)(ii) of the State Administrative Procedure Act.

PUBLIC NOTICE

Department of Agriculture and Markets

Pursuant to Agriculture and Markets Law § 284-a, Notice is hereby given that the Department of Agriculture and Markets has designated the "Lewis County Cuisine Trail," described as:

"Beginning at the intersection of Shady Ave and S State Street (5406 Shady Ave) in the town of Lowville travel southeast towns Elm Street for.548 miles and make a slight left to stay on S State Street and continue onto NY-12 S/Utica Blvd for 3.58 miles and turn left onto E Martinsburg Rd for 2.60 miles and turn right onto Number 4 Rd for.523 miles and then turn left onto Snell Rd for 4.32 mi and turn right onto NY-812 N and travel for 5.07 miles and turn left onto NY-126/W Shady Ave for 5.58 miles and turn left onto NY-410 W for 3.97 miles and turn right onto NY-26 N for 4.38 miles and turn left onto Roberts Rd for 4.85 miles and turn left onto NY-12 S and travel for 11.7 miles into the town of Lowville"

For further information, please contact: Marcy Kugeman, Agricultural Development, Department of Agriculture, 10B Airline Dr., Albany, NY 12235, (518) 457-1977, (518) 457- 2716 (Fax)

PUBLIC NOTICE

Office of General Services

Pursuant to Section 33 of the Public Lands Law, the Office of General Services hereby gives notice to the following:

Notice is hereby given that the Department of Correctional and Community Supervision has determined a certain piece or parcel of land, known as 7874 State Route 11, Town of Chateaugay, Franklin County, State of New York, a former correctional facility, improved with approximately 30 various building structures totaling over 98,000 square feet of gross building area on a 99.03 +/- acre lot of land, with tax map identifier 061-2-5 on the Franklin County Tax Rolls, as surplus and no longer useful or necessary for state program purposes and has been abandoned for sale or disposition as Unappropriated State land.

For further information, please contact: Thomas Pohl, Esq., Office of General Services, Legal Services, 41st Fl., Corning Tower, Empire State Plaza, Albany, NY 12242, (518) 474-8831, (518) 473- 4973 fax

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 revise provisions of the Ambulatory Patient Group (APG) reimbursement methodology on or after July 1, 2018. The following changes are proposed:

The Ambulatory Patient Group (APG) reimbursement methodology is revised to include recalculated weight and component updates that will become effective on or after July 1, 2018. The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2018/2019 is $7,541,000.

The public is invited to review and comment on this proposed State Plan Amendment. Copies of which will be available for public review on the Department's website at http://www.health.ny.gov/regulations/state_plans/status.

Copies of the proposed State Plan Amendments will be on file in each local (county) social services district and available for public review.

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, Bureau of Federal Relations & Provider Assessments, 99 Washington Ave., One Commerce Plaza, Suite 1430, Albany, NY 12210, (518) 474-1673, (518) 473-8825 (FAX), spa_inquiries@health.state.ny.us

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 institutional services related to temporary rate adjustments to Article 28 Hospitals that are undergoing closure, merger, consolidation, acquisition or restructuring themselves or other health care providers. These payments are authorized by Section 2826 of the New York Public Health Law.

The temporary rate adjustments have been reviewed and approved for the following 7 hospitals with aggregate payment amounts totaling up to $48,666,519 for the period July 1, 2018 through March 31, 2019, $29,649,285 for the period April 1, 2019 through March 31, 2020 and $27,596,025 for the period April 1, 2020 through March 31, 2021. The approved providers along with their individual estimated aggregate amounts include:

1. Eastern Niagara Hospital, up to $1,425,000 for SFY 18/19 and $1,575,000 for SFY 19/20;

2. St. John's Riverside Hospital – St. John's Division, up to $1,800,000 for SFY 18/19, $700,000 for SFY 19/20, and $500,000 for SFY 20/21;

3. South Nassau Communities Hospital, up to $4,000,000 for SFY 18/19, $4,000,000 for SFY 19/20, and $4,000,000 for SFY 20/21;

4. Jamaica Hospital Medical Center, up to $8,365,000 for SFY 18/19;

5. Interfaith Medical Center, up to $11,110,190 for SFY 18/19, $13,505,285 for SFY 19/20, and $13,384,525 for SFY 20/21;

6. St. Barnabas Hospital, up to $12,000,000 for SFY 18/19;

7. Richmond University Medical Center, up to $9,966,329 for SFY 18/19, $9,869,000 for SFY 19/20, and $9,711,500 for SFY 20/21.

The public is invited to review and comment on this proposed State Plan Amendment. Copies of which will be available for public review on the Department's website at http://www.health.ny.gov/regulations/state_plans/status.

Copies of the proposed State Plan Amendments will be on file in each local (county) social services district and available for public review.

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

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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 1460, Albany, NY 12210, spa_inquiries@health.ny.gov

PUBLIC NOTICE

New York City Deferred Compensation Plan & NYCE IRA

The New York City Deferred Compensation Plan & NYCE IRA (the "Plan") is seeking proposals from qualified vendors to provide unbundled recordkeeping services for the City of New York Deferred Compensation Plan. The Request for Proposals ("RFP") will be available beginning on Thursday, June 7, 2018. Responses are due no later than 4:30 p.m. Eastern Time on Tuesday, July 17, 2018. To obtain a copy of the RFP, please visit www1.nyc.gov/site/olr/about/about-rfp.page and download the RFP along with the applicable documents.

If you have any questions, please submit them by fax to Georgette Gestely, Director, at (212) 306-7376.

Consistent with the policies expressed by the City, proposals from New York City certified minority-owned and/or women-owned businesses or proposals that include partnering arrangements with New York City certified minority-owned and/or women-owned firms are encouraged. Additionally, proposals from small and New York City-based businesses are also encouraged.

PUBLIC NOTICE

Department of State
Uniform Code Variance / Appeal Petitions

Pursuant to 19 NYCRR Part 1205, the variance and appeal petitions below have been received by the Department of State. Unless other-

SUMMARY
SPA #18-0057

This State Plan Amendment proposes to update effective July 1, 2018 the cost base used for the non-comparable components of the acute hospital inpatient rates from the 2010 cost base to 2015, the acute rate statewide base price and the service intensity weights.

b. Medicaid costs associated with schools of nursing operated by the facility and reported as inpatient costs in the ICR; and

c. Medicaid costs associated with hospital-based physicians at hospitals designated under the Medicare program as meeting the criteria set forth in §1861(b)(7) of the federal Social Security Act.

13. *Transfers,* For purposes of transfer per diem payments, a transfer patient will mean a patient who is not discharged as defined in this Section, is not transferred among two or more divisions of merged or consolidated facilities as defined in the Mergers, Acquisitions, Consolidations, Restructurings and Closure Section, is not assigned to a DRG specifically identified as a DRG for transferred patients only, and meets one of the following conditions:

a. is transferred from an acute care facility reimbursed under the DRG case-based payment system to another acute care facility reimbursed under this system; or

b. is transferred to an out-of-state acute care facility; or

c. is a neonate who is being transferred to an exempt hospital for neonatal services.

14. *Discharges*, as used in this Section, will mean those inpatients whose discharge from the facility occurred on and after July 1, [2014]2018, and:

a. the patient is released from the facility to a non-acute care setting; or

b. the patient dies in the facility; or

c. the patient is transferred to a facility or unit that is exempt from the case-based payment system, except when the patient is a newborn transferred to an exempt hospital for neonatal services and thus classified as a transfer patient pursuant to this Section; or

d. the patient is a neonate being released from a hospital providing neonatal specialty services back to the community hospital of birth for weight gain.

15. *Average [Inlier] Length of Stay (ALOS)* will mean the arithmetic average of the number of days a patient is in the hospital per admission as calculated by counting the number of days from and including the day of admission up to, but not including, the day of discharge. The ALOS will be calculated for each DRG on a statewide basis.

16. *General hospital*, as used in this Section, will mean a hospital engaged in providing medical or medical and surgical services primarily to inpatients by or under the supervision of a physician on a twenty-four hour basis with provisions for admission or treatment of persons in need of emergency care and with an organized medical staff and nursing service, including facilities providing services relating to particular diseases, injuries, conditions, or deformities.

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17. *Charge converter* will mean the ratio of cost to charges using total inpatient costs and total inpatient charges as reported by the hospital in its annual institutional cost reports submitted to the Department.

18. *IPRO* will mean the Island Peer Review Organization, Inc., a New York not-for-profit corporation providing health related services.

19. *Medicaid,* for the Medicaid Acute Rate, will mean Medicaid Fee-for-Service (FFS) and Medicaid Managed Care (MC). Acute rates are developed using the FFS claims data and the MC encounter data using the methodologies described in this Attachment.

20. *Base year* will mean the period as determined pursuant to the applicable provisions of this Attachment and applies to the DRG case-based payment per discharge, based on the following:

    a. For periods beginning on and after July 1, [2014]2018, the base year will be the [2010]2015 calendar year and the data and statistics will be the audited costs reported by each facility to the Department pursuant to the Financial and Statistical Data Required and Audits Sections.

    b. [For those hospitals operated by New York City Health and Hospitals Corporation (NYC H+H), the base year will be for the 12 months ended June 30, 2010, for those hospitals operated by New York State, excluding the hospitals operated by the State University of New York (SUNY), the base year will be the 12-month period which ended March 31, 2011.] For hospitals with a fiscal filing period that is other than a calendar year, the base year will be the 12-month period which ended between June 30, 2015 and May 31, 2016.

21. *Divisor for add-ons to the acute rates per discharge*, as used in this Section, will mean the discharges used in the development of the add-ons pursuant to the Add-Ons to the Acute Rate Per Discharge Section of this Attachment.

    a. For the period beginning on and after July 1, [2014]2018, the discharges used as the divisor will be the [2011]2015 [calendar] base year reported to the Department prior to [August 1, 2013] April 25, 2017.

22. *The year discharges* will mean the latest calendar year utilized pursuant to the Service Intensity Weights (SIWs) and Average Length of Stay (ALOS) Section of this Section.

    a. For the period beginning on and after July 1, [2014]2018, the latest calendar year will be [2011]2014.

23. *Goal Seek* is the process of finding the correct input when only the output is known.

    a. Wikipedia definition states, “In computing, goal seeking is the ability to calculate backward to obtain an input that would result in a given output. This can also be called “what-if analysis” or “back-solving.”

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Statewide Base Price

1. For periods on and after July 1, [2014]2018, a statewide base price (SBP) will be established for operating cost payments and will be used in the calculation of the payment of a Medicaid acute claim as follows:

	RATE ELEMENT	STATE PLAN SECTION
	Operating cost neutral statewide base price per discharge	Statewide Base Price
x	(1+ Budget neutrality factor)	Statewide Base Price
x	(1 + Trend factor)	Trend Factor
x	Institution-specific wage equalization factor (WEF) adjustment	Wage Equalization Factor (WEF)
x	(1 + Transition adjustment factor)	Transition
x	(1 + Potentially Preventable negative outcome reduction factor)	Potentially Preventable Negative Outcomes (PPNOs)
x	APR-DRG weight with severity level	Service Intensity Weights (SIW) and Average Length-of-Stay (ALOS)
=	FFS adjusted statewide base price per discharge	
+	IME per discharge add-on	Add-Ons to the Acute Rate Per Discharge
+	DGME per discharge add-on	Add-Ons to the Acute Rate Per Discharge
+	Capital per discharge add-on	Capital expense reimbursement for DRG case-based rates of payment
+	Non-comparable cost per discharge add-on	Add-Ons to the Acute Rate Per Discharge
=	Medicaid FFS rate per discharge	

a. The rate elements included in the chart are developed as described within the sections of this Attachment.

Service Intensity Weights (SIW) and Average Length-of-Stay (ALOS).

1. The table of SIWs and statewide ALOS effective on and after July 1, [2014]2018 is published on the New York State Department of Health website at:

   http://www.health.ny.gov/facilities/hospital/reimbursement/apr-drg/weights/

   and reflects the cost weights and ALOS assigned to each All-Patient Refined (APR) diagnosis related group (DRG) patient classification category. The SIWs assigned to each APR-DRG indicates the relative cost variance of that APR-DRG classification from the average cost of all inpatients in all APR-DRGs. Such SIWs are developed using three years of Medicaid fee-for-service cost data, Medicaid managed care data and commercial third party payor data as reported to the Statewide Planning and Research Cooperative System (SPARCS) for the years set forth in paragraph (3) of this section. Costs associated with hospitals that do not have an ancillary charge structure or associated with hospitals and services exempt from the case payment methodology, and costs associated with statistical outliers are excluded from the SIW calculations.

2. For periods beginning on and after July 1, [2014]2018, the SIWs and statewide ALOS table will be computed using SPARCS and reported cost data from the [2009, 2010, and 2011]2012, 2013 and 2014 calendar years as submitted to the Department.

3. The DRG classification system used in rates, as defined in paragraph (1) of the Definitions Section of this Attachment, will be as follows:

   a. Effective July 1, [2014]2018 through December 31, 2014, Version [31]34 of the APR-DRG classification system will be used.

   [b. Effective January 1, 2015 through September 30, 2015, Version 32 of the APR-DRG classification system will be used.]

   [c. Effective beginning on and after October 1, 2015, Version 33 of the APR-DRG classification system will be used.]

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Add-Ons to the Acute Rate Per Discharge.

Rates of payment computed pursuant to this Attachment will include operating cost add-on payments to the statewide base price payment as follows:

1. The base period used for the add-on development will be as defined in the Definitions Section.
2. The costs and discharges used in the development of the add-ons will be total acute inpatient costs and discharges.

[3. Medicaid costs will be calculated based on a percentage ratio of Medicaid acute days to Total acute days using the base year days, as defined in the Definitions Section. For the purpose of this Section, Medicaid is as defined in the Definitions Section.]

[4]3. All add-on components of the acute operating per discharge rate will be reduced by the Budget Neutrality Factor pursuant to the Statewide Base Price Section of this Attachment.

[5]4. A direct graduate medical education (DGME) payment per discharge will be added to the acute rates of teaching general hospitals after the application of SIW, WEF, and Indirect Graduate Medical Education (IME) adjustments to the statewide base price. The DGME will be calculated for each hospital by dividing the facility's total reported [Medicaid] DGME costs by its total reported [Medicaid] discharges pursuant to paragraphs (1) through (3) of this Section. DGME costs will be those costs defined in the Definitions Section and trended forward to such rate period in accordance with applicable provisions of this Attachment

[6]5. a. An indirect GME payment per discharge will be added to the acute rates of teaching general hospitals after the application of SIW and WEF adjustments to the statewide base price and will be calculated by multiplying such rates by the indirect teaching cost percentage determined by the following formula:

$$(1 - (1 / (1 + 1.03(((1 + r)\ ^0.0405) - 1))))$$

where "r" equals the ratio of residents and fellows to beds based on the medical education statistics for the hospital based on paragraph (7) of this Section and the staffed beds for the general hospital reported in the base period, as defined in the Definitions Section, but excluding exempt unit beds and nursery bassinettes.

b. Indirect GME costs are those costs defined in the Definitions Section, derived from the base year, as also defined in the Definitions Section, and trended forward to such rate period in accordance with applicable provisions of this Attachment.

[7]6. [Hospitals will furnish to the Department such reports and information as will be required by the Department to access the cost, quality, and health system needs for medical education. Such reports and information will include, but not be limited to, the Indirect Medical Education Survey.]For rates beginning on and after July 1, 2018, the ratio of residents and fellows to bed will be based on the medical education statistics as reported on Exhibit 3 of the Hospital Institutional Cost report for the base year, as defined in the Definitions Section.

[a. The Indirect Medical Education Survey is completed annually by hospitals and collects the actual interns and residents in a program year.

i. For rates beginning on and after July 1, 2014, the ratio of residents and fellows to bed will be based on the medical education statistics for the hospital for the period ended June 30, 2011 as contained in the Indirect Medical Education survey document submitted by the hospital to the Department as of June 30, 2013.]

[8]7. A non-comparable payment per discharge will be added to acute rates after the application of SIW, WEF, and IME adjustments to the statewide base price and the addition of the DGME payment and will be calculated for each hospital by dividing the facility's total reported [Medicaid] costs, pursuant to paragraphs (1) through (3) of this Section, for qualifying non-comparable cost categories by its total reported [Medicaid] discharges pursuant to the Definitions Section. Non-comparable hospital costs are those costs defined in the Definitions Section, derived from the base year, as also defined in the Definitions Section, and trended forward to such rate period in accordance with applicable provisions of this Attachment.

[9]8. At the time non-comparable base year costs are updated in accordance with applicable provisions of this Section, cost transfers between affiliated facilities, for non-comparable costs as defined in the Definitions Section for other than DME or IME, due to the transfer of an entire service for organizational restructuring, will be adjusted in the payment rate. The non-comparable costs will be eliminated from the rate for the hospital closing the service and included in the rate for the receiving hospital. The costs transferred and utilized in the receiving hospital's rate will be the base year costs of the facility closing the service as defined in the Definitions Section. No revisions to the costs will be allowed.

[10]9. The add-ons described in this section will be adjusted to reflect [potentially preventable negative outcomes (PPNOs) in accordance with the Potentially Preventable Negative Outcomes (PPNO) Section of this Attachment and] the transition factor per paragraph (1)(a)(ii) of the Transition Section of this Attachment.

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1. **Transition**

a. For discharges beginning on July 1, [2014]2018 through December 31, [2017]2021, a transition factor will be applied as follows:

i. The factor will be applied to the operating statewide base price as stated in paragraph (5) of the Statewide Base Price Section of this Attachment.

ii. The factor will be applied to all add-on operating cost components of the acute case per discharge rate as stated in paragraph (10) of the Add-ons to the Case Payment Rate per Discharge Section of this Attachment.

b. Hospital estimated losses and gains for the transition development will be calculated by comparing the estimated revenue, by provider, based on the newly developed rate using the updated base year and associated policy updates in comparison to the last rate developed with the previous base year and policy.

c. Hospital estimated losses which are due to the implementation of the updated base year pursuant to the Definitions Section of this Attachment and associated policy updates, will be limited as follows:

i. for the period July 1, [2014]2018 through December 31, [2015]2018, hospital specific estimated losses will be limited to[2]1% of the hospital's current revenues;

ii. for the period January 1, [2016]2019 through December 31, [2016]2019, the limitation on estimated losses will be increased to 2[.5]% of the hospital's current revenues;

iii. for the period January 1, [2017]2020 through December 31, [2017]2020, the limitation on estimated losses will be increased to 3[.5]% of the hospital's current revenues.

iv. for the period January 1, 2021 through December 31, 2021, the limitation on estimated losses will be increased to 4% of the hospital's current revenues.

d. The transition limitation on estimated losses, defined in paragraph (1)(b) of this section, shall be funded as follows:

i. Utilizing [sixty percent of the historical estimated revenues, valued at forty-two]two million four-hundred thousand dollars[,] for hospitals that have closed since January 1, [2011]2014;

ii. A cap on a hospital's estimated gain, as described in paragraph (1)(b) of this Section, shall be applied as necessary each year in order to achieve budget neutrality pursuant to the Statewide Base Price Section of this Attachment. This will be accomplished as follows:

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[1. A hospital's estimated gain shall be adjusted to exclude the portion of the gain related to an increase in the teaching resident count. The increase in resident count shall be determined by comparing the medical education statistics supplied to the Department of Health pursuant to the Add-ons to the Case Payment Rate per Discharge Section of this Attachment.]

[2]1. The cap on the [adjusted] estimated gain is derived through the "Goal Seek" programming in Microsoft excel, as defined in the Definitions Section, to determine the percentage necessary to hold payments budget neutral to the target total Medicaid operating payments, per the Statewide Base Price Section of this Attachment, with the limit on the losses.

[3]2. For the period July 1, [2014]2018 through December 31, [2015]2018, the cap on gains is [3.4308]3.5633%. When the cap on losses is revised, based on paragraph (c) of this section, the cap on gains will be increased.

e. The facility specific transition factor is determined by dividing the dollars associated with the total transition adjustment from gains or losses by the total facility specific projected revenue based on the newly developed rates using the updated base year and associated policy updates.

i. The total projected facility specific revenue excludes revenue from cost outlier cases since the transition factor does not apply to cost outlier payments.

f. The transition factor will not be subject to reconciliation.

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Outlier Rates of Payment.

1. High cost outlier rates of payment will be calculated by converting 100% of the total billed patient charges, as approved by IPRO, to cost by applying the hospital's charge converter as defined in the Definitions Section. Such calculation will use the most recent charge converter available as subsequently updated to reflect the data from the year in which the discharge occurred, and will equal the excess costs above the high cost outlier threshold.

   i. For payment, the high cost outlier threshold will be adjusted by the hospital specific wage equalization factor (WEF), as defined in the Definitions Section of this Attachment, prior to determining the excess costs above the high cost outlier threshold as stated in paragraph (1)(a) of this Section.

2. The high cost outlier threshold will be developed for each Diagnosis Related Group (DRG) using acute Medicaid operating costs which are derived from the year discharges used in the Statewide Base Price Section and defined in the Definitions Section of this Attachment. The high cost thresholds will be scaled to maintain budget neutrality[,] to targeted outlier payments developed pursuant to the Statewide Base Price Section.

   i. The high cost outlier thresholds will be updated at the time the Service Intensity Weights (SIWs) are updated in accordance with the SIW and ALOS Section.

   ii. Cost outlier thresholds for each base APR-DRG effective on and after July 1, [2014]<u>2018</u>, have been posted to the Department of Health's public website at the following:

   http://www.health.ny.gov/facilities/hospital/reimbursement/apr-drg/tresholds/

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Alternate Level of Care Payments (ALC).

1. For rates beginning on and after July 1, [2014]2018, hospitals will be reimbursed for ALC days at the appropriate 2013 group average operating cost component of rates of payment for hospital-based residential health care facilities established pursuant to Attachment 4.19-D, trended to the rate year.

   The determination of the group average operating rate for hospital-based residential health care facilities specified in this paragraph will be based on the combination of residential health care facilities as follows:

   a. The downstate group will consist of residential health care facilities located in the New York counties of Bronx, New York, Kings, Queens, Richmond, Nassau, Suffolk, Westchester, Rockland, Orange, Putnam, and Dutchess.

   b. The upstate group will consist of all other residential health care facilities in the State.

2. Hospitals that convert medical/surgical beds to residential health care beds will be reimbursed for services provided in the converted beds in accordance with Attachment 4.19-D.

MISCELLANEOUS
NOTICES/HEARINGS

Notice of Abandoned Property Received by the State Comptroller

Pursuant to provisions of the Abandoned Property Law and related laws, the Office of the State Comptroller receives unclaimed monies and other property deemed abandoned. A list of the names and last known addresses of the entitled owners of this abandoned property is maintained by the office in accordance with Section 1401 of the Abandoned Property Law. Interested parties may inquire if they appear on the Abandoned Property Listing by contacting the Office of Unclaimed Funds, Monday through Friday from 8:00 a.m. to 4:30 p.m., at:

1-800-221-9311
or visit our web site at:
www.osc.state.ny.us

Claims for abandoned property must be filed with the New York State Comptroller's Office of Unclaimed Funds as provided in Section 1406 of the Abandoned Property Law. For further information contact: Office of the State Comptroller, Office of Unclaimed Funds, 110 State St., Albany, NY 12236.

PUBLIC NOTICE

Office of General Services

Pursuant to Section 33 of the Public Lands Law, the Office of General Services hereby gives notice to the following:

Notice is hereby given that the Office for People with Developmental Disabilities has determined that 733 Euclid Avenue, City of Syracuse, Onondaga County, New York State, improved with a 2,648 ± square foot dwelling situated on a 0.12 ± acre lot, as surplus and no longer useful or necessary for state program purposes, and has abandoned the property to the Commissioner of General Services for sale or other disposition as Unappropriated State land.

For further information, please contact: Thomas Pohl, Esq., Office of General Services, Legal Services, 41st Fl., Corning Tower, Empire State Plaza, Albany, NY 12242, (518) 474-8831, (518) 473-4973 fax

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 acute inpatient hospital services to comply with proposed regulatory provisions. The following changes are proposed:

Institutional Services

• The case based general hospital acute inpatient rebasing rate initiative will be implemented effective for discharges on or after July 1, 2018 with the following updates to the acute rate development:

- The rebased acute rates will reflect an update to the 2010 Institutional Cost Report (ICR), as reported by each facility to the department, which was utilized in the acute rates effective for discharges beginning on July 1, 2014, to the audited 2015 ICR for the operating components of the rates.

- Medicaid costs used in the rate development will be calculated based on a ratio of 2015 total Medicaid acute days (fee-for-service and managed care) to 2015 total acute days.

- The 2014 Medicaid fee-for-service paid claims and Medicaid managed care encounter claims will be used as the divisor for the non-comparable operating cost components of the rate.

- The costs used for the direct medical education (DME) component of the rates will be based on the audited 2015 ICR and only the costs reported for cost center 013 (I&R Services – Salary & Fringes), cost center 033 (I&R Services – Other Program Costs), and cost center 014 (Supervising Physician – Teaching) will be included in the DME cost development for the rates.

- The indirect medical education (IME) percentage will be based on the resident count provided to the Department of Health in the audited 2015 ICR, Exhibit 3, in addition to the 2015 provider ICR data.

- The ambulance non-comparable cost will be included only for providers stating they provide ambulance services per the 2010 Ambulance Survey completed by providers and submitted to the Department of Health during July, 2013.

- The provider specific wage equalization factor will be calculated using a 3-year average (2016 through 2018 data) of provider specific Medicare occupational-mix adjusted wages and hours in addition to the 2015 provider ICR data to determine the labor share.

- The case mix neutral statewide price and all non-comparable add-on operating cost components of the rate will be adjusted for a budget neutrality factor to equitably reduce all rate payment components to maintain budget neutrality to current expenditures.

- A transition factor, if applicable, will be applied to the case mix neutral statewide price and all non-comparable add-on operating cost components of the rate to limit losses and gains due to the implementation of the audited 2015 cost base and associated policy changes. The transition factor, if applied, will not be subject to reconciliation.

• The alternate level of care (ALC) rate effective for days of service on July 1, 2018 and thereafter will be updated to reflect the January 1, 2018 skilled nursing home rate and implemented budget neutral on a statewide basis.

• For discharges on or after July 1, 2018, the acute hospital inpatient claims will be processed with the rates as calculated with the provisions above and will use the following:

- 2018 APR DRG grouper (Version 34);

- 2018 Service Intensity Weights (SIWs) and average length of stay;

- 2018 cost outlier thresholds scaled to maintain budget neutrality to estimated outlier payments using the 2018 thresholds.

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. Copies of which will be available for public review on the Department's website at http://www.health.ny.gov/regulations/state_plans/status.

Copies of the proposed State Plan Amendments will be on file in each local (county) social services district and available for public review.

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, Bureau of Federal Relations and Provider Assessments, 99 Washington Ave., One Commerce Plaza, Suite 1430, Albany, NY 12210, (518) 474-1673, (518) 473-8825 (FAX), e-mail: spa_inquiries@health.state.ny.us

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 institutional services to comply with enacted statutory provisions. The following changes are proposed:

Institutional Services

Effective on or after July 1, 2018, the Department of Health will adjust rates of reimbursement for inpatient psychiatric services provided in general hospitals, or distinct units of general hospitals to reimburse hospitals for providing these services to individuals aged 17 and under to better meet community children's mental health needs. The Department of Health will increase the age adjustment factor for these services to these individuals from 1.0872 to 1.3597.

The estimated annual aggregate increase in gross Medicaid expenditures attributable to the increase of the age adjustment factor is $10,000,000. Funds for this increase are contained in the State budget beginning in state fiscal year 2018/2019.

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. In addition, approved SPA's beginning in 2011 are also available for viewing on this website.

Copies of the proposed State Plan Amendments will be on file in each local (county) social services district and available for public review.

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, e-mail: 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 institutional services at non-profit Residential Treatment Facilities for Children and Youth to comply with an OMH policy objective. The following changes are proposed:

Institutional Services

The amendment will reflect an adjustment to the minimum utilization range, used in the Residential Treatment Facility reimbursement methodology, from 93 percent to 90 percent, effective on or after July 1, 2018.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2018/2019 is $436,285, with an annualized value of $581,714.

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, e-mail: spa_inquiries@health.ny.gov

SUMMARY
SPA #18-0058

This State Plan Amendment implements changes to sunset provisions of SPA 12-0030 pertaining to the Medicaid Service Coordinator Program, and put into place the Basic HCBS Plan Support as a replacement for those persons electing NOT to enroll in a Health Home. Also prescribes provider qualifications for provision of the Basic HCBS Plan Support benefit.

State Plan under Title XIX of the Social Security Act
State/Territory: New York

TARGETED CASE MANAGEMENT SERVICES
Target Group B – Medicaid Service Coordination (MSC)

Office of People With Development Disabilities (OPWDD) -
Individuals with Intellectual and Developmental Disabilities (II/DD)

Target Group (42 Code of Federal Regulations 441.18(8)(i) and 441.18(9)):

Persons enrolled in Medical Assistance who:

(1) Have a developmental disability as defined in New York Mental Hygiene Law §1.03, and

(2) Are in need of the support of Care Manager to assist in coordinating the Medicaid-funded Long Term Supports that the person receives or would benefit from receiving, and

(3) Have chosen to receive the services and not to receive comprehensive Health Home Care Management through the Health Home model, and

(4) Reside in their own or family home, live in an OPWDD certified residence (Individualized Residential Alternative, Community Residence or Family Care Home). However, persons who receive Basic Home and Community-Based Services (HCBS) Plan Support and are receiving institutional care reimbursed under the Medical Assistance Program may continue to receive Basic HCBS Plan Support for up to 30 days when persons are temporarily institutionalized, and when the admission to the institution is initially expected to be 30 days or less.

___ **Target group includes individuals transitioning to a community setting. Case-management services will be made available for up to 0 (zero) consecutive days of a covered stay in a medical institution. The target group does not include individuals between ages 22 and 64 who are served in Institutions for Mental Disease or individuals who are inmates of public institutions). (State Medicaid Directors Letter (SMDL), July 25, 2000)**

Areas of State in which services will be provided (§1915(g)(1) of the Act):

X Entire State

___ Only in the following geographic areas: **[Specify areas]**

Comparability of services (§§1902(a)(10)(B) and 1915(g)(1))

__ Services are provided in accordance with §1902(a)(10)(B) of the Act.

X Services are not comparable in amount duration and scope (§1915(g)(1)).

Definition of services (42 CFR 440.169): Targeted case management services are defined as services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Targeted Case Management includes the following assistance:

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- **Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social or other services. These assessment activities include**
  - **Gathering pertinent individual and family history;**
  - **identifying the individual's needs and completing related documentation; and**
  - **gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual;**

Assessment activities include taking the person's history, identifying needs of the individual, and completing related documentation. It also includes gathering information from other sources such as family members, medical providers, clinical assessments, educators, and other individuals/providers associated with the person, if necessary, to form a complete assessment (i.e., picture) of the person and his/her needs and goals. Re-assessment should occur when the care plan (known as an Individualized Service Plan (ISP) or Life Plan) is reviewed semi-annually or more frequently if necessary based on the changing needs of the person or his or her request for a reassessment. The Care Manager may recommend an individual seek more comprehensive services through the Health Home model if the needs of the individual require more frequent reviews and re-assessments than is available under this option. Basic HCBS Plan Support provides care management and does not provide the comprehensive, core services available through the Health Home model. The individual may choose to enroll in the Health Home service at any time. A request to change from between Basic HCBS Plan Support and Health Home Care Management may be submitted to the OPWDD Development Disabilities Regional Office (DDRO) which can authorize the new service for the first date of the following month.

- **Development (and periodic revision) of a specific care plan that is based on the information collected through the assessment that**
  - **specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;**
  - **includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and**
  - **identifies a course of action to respond to the assessed needs of the eligible individual;**

- **Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services including activities that help link the individual with medical, social, educational providers, or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan; and**

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Individuals with Intellectual and Developmental Disabilities (II/DD)

❖ **Monitoring and follow-up activities:**

- **activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the eligible individual's needs, and which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met:**
  - **services are being furnished in accordance with the individual's care plan;**
  - **services in the care plan are adequate; and**
  - **changes in the needs or status of the individual are reflected in the care plan. Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.**

This is the service provided by the Care Manager. It includes direct contacts on a bi-annual or up to a quarterly basis:

- Assessing the person's satisfaction with his or her supports and services as identified within the care plan, known as an ISP or Life Plan, and making adjustments as necessary;
- Supporting the person towards achievement of valued outcomes;
- Establishing and maintaining an effective communication network with service providers;
- Keeping up to date with changes, choices, temporary setbacks;
- Accomplishments relating to the persons supports and services as reflected in the ISP or Life Plan;
- Managing through difficulties or problems or crises as they occur;
- Assisting the person in assuring that his or her rights, protections and health and safety needs are met pursuant to state law and regulations;
- Keeping the ISP or Life Plan document current by adapting it to change; and
- Reviewing the ISP or Life Plan at least semi-annually.

X **Case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs.**

(42 CFR 440.169(e))

Qualifications of providers (42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b)):

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TARGETED CASE MANAGEMENT SERVICES
Target Group B – Medicaid Service Coordination (MSC)

Office of People With Development Disabilities (OPWDD) -
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Effective 07/01/2018, provider organizations will be known as CCO/HH. The following are the general provider qualifications under the Health Home model:

- CCO/HH providers must be enrolled (or be eligible for enrollment) in the NYS Medicaid program and agree to comply with all Medicaid program requirements and CCO/HH standards, requirements and guidance issued by the State.
- CCO/HH providers eligible to deliver Basic HCBS Plan Support must also be designated by NYSDOH and the OPWDD to deliver Health Home Care Management Services and Basic HCBS plan support.
- CCO/HH providers must also have:
    - the capacity to conduct IT-enabled planning services for the I/DD population; and
    - a Regional Network for referrals to developmental disability, health and behavioral health services.

Effective 07/01/2018, Care Managers will be regulated by the Health Home model. The following are the educational and experience qualifications a Care Manager employed by the CCO/HH.

1) A Bachelor's degree with two (2) years of relevant experience, OR

2) A License as a Registered Nurse with two (2) years or relevant experience, which can include any employment experience and is not limited to case management/service coordination duties OR

3) A Master's degree with one (1) year of relevant experience.

To support the transition to CCO/HH and Basic HCBS Plan Support services, the following special allowance is made for Care Managers who served as a MSC Service Coordinator and do not meet the above educational requirements.

1) Care Managers who served as an MSC Service Coordinators prior to July 1, 2018 are "grandfathered" to facilitate continuity for the individual receiving coordination. Documentation of the employee's prior status as an MSC Service Coordinator may include a resume or other record created by the MSC Agency or the CCO/HH demonstrating that the person was employed as an MSC Service Coordinator prior to July 1, 2018.
2) CCO/HHs will be required to provide the CCO/HH core services training for current MSC Service Coordinators transitioning to CCO/HH Care Management and who do not meet the minimum education and experience requirements. Such training shall be provided by the CCO/HH within one (1) year of contracting with an MSC Service

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Coordinator. The CCO/HH will adjust training activities for Care Managers serving individuals enrolled in Basic HCBS Plan Support, but all Care Managers must be able to deliver both the Health Home Care Management service and Basic HCBS Plan Support.

Care Managers who serve Willowbrook Class members must be Qualified Intellectual Disabilities Professionals (QIDP).

Freedom of choice (42 CFR 441.18(a)(1):
The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. **Eligible individuals will have free choice of any qualified Medicaid provider within the specified geographic area identified in this plan.**
2. **Eligible individuals will have free choice of any qualified Medicaid providers of other medical care under the plan.**

Access to Services (42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6):
The State assures the following:

- **Case management (including targeted case management) services will not be used to restrict an individual's access to other services under the plan.**
- **Individuals will not be compelled to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services; and**
- **Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.**

Payment (42 CFR 441.18(a)(4)):
Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Case Records (42 CFR 441.18(a)(7)):
Providers maintain case records that document for all individuals receiving case management as follows: (i)The name of the individual; (ii) The dates of the case management services; (iii)The name of the provider agency (if relevant) and the person providing the case management service; (iv) The nature, content, units of the case management services received and whether goals specified in the care plan

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have been achieved; (v) Whether the individual has declined services in the care plan; (vi) The need for, and occurrences of, coordination with other case managers; (vii) A timeline for obtaining needed services; (viii) A timeline for reevaluation of the plan.

Limitations:

Freedom of Choice Exception (§1915(g)(1) and 42 CFR 441.18(b)):
X Target group consists of eligible individuals with developmental disabilities. Providers are limited to qualified Medicaid providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services:

A CCO/HH is a Health Home that is tailored to meet the needs of individuals with intellectual and/or developmental disabilities (I/DD). CCO/HHs will be designated by the NYSDOH in collaboration with the NYS OPWDD. CCO/HHs and Care Managers provide person-centered care management, planning and coordination services that are tailored specifically to help people with I/DD and their families coordinate all services.

Effective 07/01/2018, entities must demonstrate they are controlled (at least 51 percent) by one or more non-profit organizations with a history of providing or coordinating developmental disability, health, and long-term care services to persons with II/DD, including MSC and/or I/DD long term supports and services (LTSS). New York State's expectation is that the governance structure and leadership of the I/DD Health Home (board members and officers) will have extensive experience coordinating care for individuals with I/DD in New York State; prior experience in overseeing and operating entities that have delivered MSC or I/DD HCBS waiver services to individuals with I/DD, and are in good standing with the State.

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §44[1]0.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §44[1]0.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing

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transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c))

FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c))

While the activities of Care Managers secure access to an individual's needed services, the activities of care coordination do not include:

1. The actual provision of the service;
2. Medicaid eligibility determinations/redetermination;
3. Medicaid pre-admission screening;
4. Prior authorization for Medicaid services;
5. Required Medicaid utilization review;
6. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) administration;
7. Activities in connection with "lock-in" provisions under §1915(a) of the Social Security Act;
8. Institutional discharge planning as required of hospitals, Skilled Nursing Facilities (SNFs), and ICFs/IIDs; and
9. Client outreach considered necessary for the proper and efficient administration of the Medicaid State Plan.

New York
Page 3(h.15)

Effective July 1, 2018 the following fees will be in effect for the Targeted Case Management Service. One unit of Basic HCBS Plan Support may be billed per quarter (up to four units per year).

Rate Code	Rate Code Definition	Locator Code	Fee
5210	Basic HCBS Plan Support- initial	03	$729.73
5210	Basic HCBS Plan Support-on-going	04	$243.24

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 to reflect changes in its non-institutional Targeted Case Management program for Individuals with Intellectual and/or Developmental Disabilities. This amendment will allow federal financial participation for the Basic Home and Community Based (HCB) Plan Support Care Management program that will be provided by Care Coordination Organizations (CCOs).

Non-Institutional Services

The basis for this program change is to ensure that individuals who have an intellectual and/or developmental disability have the choice to receive an alternative to Health Home Care Management services provided by regional Care Coordination Organizations (CCOs) effective on or after July 1, 2018.

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

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

Copies will also be available at the following places:

Finger Lakes DDRO
620 Westfall Rd., Suite 108
Rochester, NY 14620

Western NY DDRO
1200 East and West Rd.
West Seneca, NY 14224

Broome DDRO
229-231 State St., 2nd Floor
Binghamton, NY 13901

Central NY DDRO
187 Northern Concourse
North Syracuse, NY 13212

Sunmount DDRO
2445 State Route 30
Tupper Lake, NY 12986

Capital District DDRO
500 Balltown Rd.
Schenectady, NY 12304

Hudson Valley DDRO
9 Wilbur Rd.
Thiells, NY 10984

Taconic DDRO
38 Firemens Way
Poughkeepsie, NY 12603

Bernard Fineson DDRO
PO Box 280507
Queens Village, NY 11428-0507

Metro NY DDRO/Bronx
2400 Halsey St.
Bronx, NY 10461

Brooklyn DDRO
888 Fountain Ave., Bldg. 1, 2nd Fl.
Brooklyn, NY 11239

Metro NY DDRO/Manhattan
25 Beaver St., 4th Floor
New York, NY 10004

Staten Island DDRO
1150 Forest Hill Rd., Bldg. 12, Suite A
Staten Island, NY 10314-6316

Long Island DDRO
415-A Oser Ave.
Hauppauge, NY 11788

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, e-mail: spa_inquiries@health.ny.gov and Office for People With Developmental Disabilities, Division of Person Centered Services, 44 Holland Ave., Albany, NY 12229

PUBLIC NOTICE
New York City Deferred Compensation Plan & NYCE IRA

The New York City Deferred Compensation Plan & NYCE IRA (the "Plan") is seeking proposals from qualified vendors to provide unbundled recordkeeping services for the City of New York Deferred Compensation Plan. The Request for Proposals ("RFP") will be available beginning on Thursday, June 7, 2018. Responses are due no later than 4:30 p.m. Eastern Time on Tuesday, July 17, 2018. To obtain a copy of the RFP, please visit www1.nyc.gov/site/olr/about/about-rfp.page and download the RFP along with the applicable documents.

If you have any questions, please submit them by fax to Georgette Gestely, Director, at (212) 306-7376.

Consistent with the policies expressed by the City, proposals from New York City certified minority-owned and/or women-owned businesses or proposals that include partnering arrangements with New York City certified minority-owned and/or women-owned firms are

SUMMARY
SPA #18-0059

This State Plan Amendment proposes to increase reimbursement for Article 28 hospital children's inpatient psychiatric services to better meet community children's mental health needs.

772	1	Alcohol & Drug Dependence w Rehab or Rehab/Detox Therapy, SOI-1	0.8373
772	2	Alcohol & Drug Dependence w Rehab or Rehab/Detox Therapy, SOI-2	0.8373
772	3	Alcohol & Drug Dependence w Rehab or Rehab/Detox Therapy, SOI-3	0.8373
772	4	Alcohol & Drug Dependence w Rehab or Rehab/Detox Therapy, SOI-4	0.8373
773	1	Opioid Abuse & Dependence, SOI-1	1.0204
773	2	Opioid Abuse & Dependence, SOI-2	1.0204
773	3	Opioid Abuse & Dependence, SOI-3	1.0361
773	4	Opioid Abuse & Dependence, SOI-4	1.0361
774	1	Cocaine Abuse & Dependence, SOI-1	0.9807
774	2	Cocaine Abuse & Dependence, SOI-2	1.0360
774	3	Cocaine Abuse & Dependence, SOI-3	1.0513
774	4	Cocaine Abuse & Dependence, SOI-4	1.0513
775	1	Alcohol Abuse & Dependence, SOI-1	1.0196
775	2	Alcohol Abuse & Dependence, SOI-2	1.0709
775	3	Alcohol Abuse & Dependence, SOI-3	1.0709
775	4	Alcohol Abuse & Dependence, SOI-4	1.0709
776	1	Other Drug Abuse & Dependence, SOI-1	0.9363
776	2	Other Drug Abuse & Dependence, SOI-2	1.0926
776	3	Other Drug Abuse & Dependence, SOI-3	1.0926
776	4	Other Drug Abuse & Dependence, SOI-4	1.0926

iii. A rural adjustment factor of 1.2309 will be applied to the operating per diem for those hospitals designated as rural hospitals. A rural facility is a general hospital with a service area which has an average population of less than 175 persons per square mile, or a general hospital with a service area which has an average population of less than 200 persons per square mile measured as population density by zip code. For dates of service beginning on or after July 1, 2014, rural designation will be applicable to hospitals located in an upstate region, as defined in subparagraph (l) of this section, and with population densities of 225 persons or fewer per square mile as determined based on the New York State 2010 Vital Statistics table of estimated population, land area, and population density. Accordingly, there are 27 rural facilities that provide inpatient psychiatric services.

iv. An age adjustment payment factor of [1.0872] <u>1.3597</u> will be applied to the per diem operating component for adolescents ages 17 and under. For ages 18 and over, an adjustment payment factor of 1 will be applied.

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, Bureau of Federal Relations and Provider Assessments, 99 Washington Ave., One Commerce Plaza, Suite 1430, Albany, NY 12210, (518) 474-1673, (518) 473-8825 (FAX), e-mail: spa_inquiries@health.state.ny.us

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 institutional services to comply with enacted statutory provisions. The following changes are proposed:

Institutional Services

Effective on or after July 1, 2018, the Department of Health will adjust rates of reimbursement for inpatient psychiatric services provided in general hospitals, or distinct units of general hospitals to reimburse hospitals for providing these services to individuals aged 17 and under to better meet community children's mental health needs. The Department of Health will increase the age adjustment factor for these services to these individuals from 1.0872 to 1.3597.

The estimated annual aggregate increase in gross Medicaid expenditures attributable to the increase of the age adjustment factor is $10,000,000. Funds for this increase are contained in the State budget beginning in state fiscal year 2018/2019.

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. In addition, approved SPA's beginning in 2011 are also available for viewing on this website.

Copies of the proposed State Plan Amendments will be on file in each local (county) social services district and available for public review.

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
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Long Island City, New York 11101

Kings County, Fulton Center
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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, e-mail: 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 institutional services at non-profit Residential Treatment Facilities for Children and Youth to comply with an OMH policy objective. The following changes are proposed:

Institutional Services

The amendment will reflect an adjustment to the minimum utilization range, used in the Residential Treatment Facility reimbursement methodology, from 93 percent to 90 percent, effective on or after July 1, 2018.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2018/2019 is $436,285, with an annualized value of $581,714.

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
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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, e-mail: spa_inquiries@health.ny.gov