Department of Health

KATHY HOCHUL
Governor

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

MEGAN E. BALDWIN
Acting Executive Deputy Commissioner

March 31, 2023

Dear Health Clinic Administrator:

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

https://www.health.ny.gov/regulations/state_plans/tribal/

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/

Amir Bassiri
Medicaid Director
Office of Health Insurance Programs

Enclosures

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

Nancy Grano
CMS Native American Contact

Michele Hamel
NYSDOH American Indian Health Program

SUMMARY
SPA #20-0069-A

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

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Section 7 – General Provisions
7.4. Medicaid Disaster Relief for the COVID-19 National Emergency

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

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

Effective April 1, 2020

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

Request for Waivers under Section 1135

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

a. ____ SPA submission requirements – the agency requests modification of the requirement to submit the SPA by March 31, 2020, to obtain a SPA effective date during the first calendar quarter of 2020, pursuant to 42 CFR 430.20.

b. __X__ Public notice requirements – the agency requests waiver of public notice requirements that would otherwise be applicable to this SPA submission. These requirements may include those specified in 42 CFR 440.386 (Alternative Benefit Plans), 42 CFR 447.57(c) (premiums and cost sharing), and 42 CFR 447.205 (public notice of changes in statewide methods and standards for setting payment rates).

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

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

Section A – Eligibility

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

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

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

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

Income standard: _____________

-or-

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

Income standard: _____________

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

Less restrictive income methodologies:

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Less restrictive resource methodologies:

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

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

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

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Section B – Enrollment

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

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

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

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

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

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

4. _____ The agency adopts a total of _____ months (not to exceed 12 months) continuous eligibility for children under age enter age _____ (not to exceed age 19) regardless of changes in circumstances in accordance with section 1902(e)(12) of the Act and 42 CFR 435.926.

5. _____ The agency conducts redeterminations of eligibility for individuals excepted from MAGI-based financial methodologies under 42 CFR 435.603(j) once every _____ months (not to exceed 12 months) in accordance with 42 CFR 435.916(b).

6. _____ The agency uses the following simplified application(s) to support enrollment in affected areas or for affected individuals (a copy of the simplified application(s) has been submitted to CMS).

   a. _____ The agency uses a simplified paper application.

   b. _____ The agency uses a simplified online application.

   c. _____ The simplified paper or online application is made available for use in call-centers or other telephone applications in affected areas.

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Section C – Premiums and Cost Sharing

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

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

2. _____ The agency suspends enrollment fees, premiums and similar charges for:

   a. _____ All beneficiaries

b. _____ The following eligibility groups or categorical populations:

Please list the applicable eligibility groups or populations.

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

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

Section D – Benefits

Benefits:

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

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

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

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

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

   b. ____ Individuals receiving services under ABPs will not receive these newly added

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

Please describe.

Telehealth:

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

Please describe.

Drug Benefit:

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

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

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

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

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

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

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Section E – Payments

Optional benefits described in Section D:

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

   a. ____ Published fee schedules –
   Effective date (enter date of change): ______________

   Location (list published location): ______________

   b. ____ Other:

Increases to state plan payment methodologies:

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

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

b. Payments are increased through:

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

1) Publicly owned or operated ground emergency medical transportation (ambulance) providers are currently reimbursed on a fee-for-service basis, but at a rate that is far less than the actual cost of providing these services. The current national emergency has exacerbated this fiscal gap, by increasing the operating costs of publicly owned or operated ground emergency medical transportation (ambulance) providers, while simultaneously increasing the public need for the vital services that they provide. This proposed amendment is intended to help bridge this fiscal gap.

Only Medicaid enrolled, publicly owned or operated ground emergency medical transportation (ambulance) providers will be eligible to participate in these programs. Any private emergency medical transportation providers that may have contracted with governmental entities to provide this service are not eligible to participate.

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

Concurrent with the adoption of this amendment, any publicly owned or operated ground emergency medical transportation (ambulance) providers, which are also participating in the inpatient supplemental reimbursement program, will no longer be reimbursed through the inpatient rates as a non-comparable add-on to the acute per discharge rate. This will eliminate the risk of overpayments to providers.

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This program will provide supplemental payments to New York State Department of Health (NYS DOH) certified publicly owned or operated ambulance services that meet specified requirements and provide emergency medical transportation services to Medicaid beneficiaries. Participation in this program by any publicly owned or operated ambulance services is voluntary. A publicly owned or operated ambulance service is one that is owned or operated by a county, city, town, or village.

Supplemental payments provided by this program are available only for allowable costs that are in excess of other Medicaid revenue that the approved publicly owned or operated ambulance services receive for emergency medical transportation services to Medicaid approved recipients. Approved publicly owned or operated ambulance services must provide certification to the New York State Department of Health (NYS DOH) of: (a) a certification for the total expenditure of funds, and (b) a certification of federal financial participation (FFP) eligibility for the amount claimed.

Approved publicly owned or operated ambulance services must submit cost reports for the previous cost approved by CMS and the state. Participating providers will have six months following the completion of a cost reporting period to submit reports. Only one (1) extension of time shall be granted to a provider for a cost reporting year and no extension of time shall exceed (60) days.

Costs will be identified using a cost report in a format prescribed by the DOH and presented to CMS for review. NYS DOH will review all cost report submissions. Payments will not be disbursed as increases to current reimbursement rates for specific services.

Costs covered will include the following applicable Medicaid emergency services: Basic Life Support Ambulance Service, and Advanced Life Support Ambulance Service. All services must be provided by NYS DOH-certified and publicly owned or operated ambulance services.

This supplemental payment program will be in effect beginning April 1, 2020 under SPA #20-0069A and will transition to SPA #21-0006 upon the effective date of this SPA.

Supplemental Payment Methodology

Supplemental payments provided by this program to an approved publicly owned or operated ambulance services will consist of FFP for Medicaid emergency medical transportation costs based on the difference between the prevailing Medicaid reimbursement amount and the providers' actual and allowable costs for providing ambulance services to approved Medicaid beneficiaries. The supplemental payment methodology is as follows:

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1. The expenditures certified by the approved publicly owned or operated ambulance services to NYS DOH will represent the payment approved for FFP. Allowable certified public expenditures will determine the amount of FFP claimed.

2. In no instance will the amount certified pursuant to Paragraph D.1, when combined with the amount received for emergency medical transportation services pursuant to any other provision of this State Plan or any Medicaid waiver granted by CMS, exceed 100 percent of the allowable costs for such emergency medical transportation services.

3. Pursuant to Paragraph D.1, the approved publicly owned or operated ambulance service will annually certify to NYS DOH the total costs for providing ambulance services for Medicaid beneficiaries, offset by the received Medicaid payments for the same cost and claiming period. The supplemental Medicaid reimbursement received pursuant to this segment of the State Plan will be distributed in one annual lump-sum payment after submission of such annual certification.

4. For the subject year, the emergency medical transportation service costs that are certified pursuant to Paragraph D.1 will be computed in a manner consistent with Medicaid cost principles regarding allowable costs and will only include costs that satisfy applicable Medicaid requirements. Consistent with CMCS Informational Bulletin, August 17, 2022, Applicable Federal Cost Principles for GEMT, only relevant costs associated with the personnel, vehicle, and equipment used to transport a beneficiary to a facility for treatment will be included for the supplemental payment. Costs associated with other emergency response personnel, vehicles, and equipment that are not involved in the provision of a Medicaid-covered service, such as police and their vehicles and equipment, should not be included in GEMT cost identification and allocation. Costs such as fire and rescue personnel and equipment are generally

not directly related to Medicaid covered services and will not be considered when calculating the supplemental payment.

5. The publicly owned or operated ambulance services shall submit a certified annual cost report to the Department. The certified annual cost report shall clearly identify the total direct costs of providing ambulance services, all ambulance service volume, Medicaid ambulance service volume, and total Medicaid payments received for Medicaid ambulance services.

   For personnel calculations, the publicly owned or operated ambulances will use the Computer Aided Dispatch (CAD) System to identify the direct personnel costs of providing ambulance services. Only direct costs associated with the emergency ambulance personnel involved in the transport should be included. The CAD system must be able to be queried by trip type to isolate emergency ambulance trips. CAD will be used to 1) sum all "time on duty" across all ambulance units per year for the participating publicly owned or operated ambulance service and 2) sum all "time on task" across all ambulance units per year for the participating publicly owned or operated ambulance service. Time on task begins at the moment an emergency ambulance is dispatched to an emergency medical services incident and ends at the moment that the ambulance returns to service; having transferred care of the patient to the hospital (or other medical destination) thereby making the ambulance available for the next emergency medical response. A "time on task" proportion will be calculated as the time on task for the year divided by the time on duty for the year. Ambulance personnel costs for the year are multiplied by the time on task proportion to determine the portion of salary and personnel costs considered to be direct, on task, costs.

   The sum of annual direct personnel costs will be added to other direct Medical Transportation Services (MTS) non-personnel costs (vehicles and equipment), and divided across all ambulance service volume to determine direct costs per ambulance service.

   This cost per ambulance service will be multiplied by total number of Medicaid ambulance services, gleaned from billing data, to calculate the total Medicaid ambulance service cost. Ambulance Medicaid payments shall be subtracted from the estimated total Medicaid ambulance service cost. The supplemental payment shall be the Federal Financial Participation (FFP) amount of the difference between the Medicaid ambulance service cost and the actual Medicaid payments made.

   Note: Costs such as fire and rescue personnel and equipment are generally not directly related to Medicaid covered services and will not be considered in the methodology.

6. Computation of allowable costs and their allocation methodology must be determined in accordance with the CMS Provider Reimbursement Manual (CMSPub. 15-1)

   https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-

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Manuals-Items/CMS021929

CMS non-institutional reimbursement policies, and OMB Circular A-87, codified at: 2CFR Part 225,

https://www.govinfo.gov/content/pkg/CFR-2012-title2-vol1/pdf/CFR-2012-title2-vol1-part225.pdf

which establish principles and standards for determining allowable costs and the methodology for allocating and apportioning those expenses to the Medicaid program, except as expressly modified below.

7. Medicaid base payments to the publicly owned or operated ambulance services for providing ambulance services are derived from the fees established for each county, for reimbursements payable by the Medicaid program.

8. For each approved publicly owned or operated ambulance service in this supplemental program, the total supplemental payment available for reimbursement will be no greater than the shortfall resulting from the allowable costs calculated using the Cost Determination Protocols (Section C.). Each approved provider must provide ambulance services to Medicaid beneficiaries in excess of payments made from the Medicaid program and all other sources of reimbursement for such ambulance services provided to Medicaid beneficiaries. Approved providers that do not have any such excess costs will not receive a supplemental payment under this supplemental reimbursement program.

A. Cost Determination Protocols

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1. An approved publicly owned or operated ambulance service's specific allowable cost per-ambulance service rate will be calculated based on the provider's audited financial data reported on the CMS cost report.

The per-ambulance service cost rate will be the sum of actual allowable direct costs of providing medical transport services divided by the actual number of ambulance services provided for the applicable service period as reported in billing records provided for the applicable service period. Consistent with CMS Informational Bulletin: Applicable Cost Principles for GEMT, only those direct costs associated with the provision of emergency ambulance transportation should be used.

2. Medicaid's portion of the total allowable cost for providing ambulance services by each approved publicly owned or operated ambulance service is calculated by multiplying the total number of Medicaid FFS ambulance services provided by the provider's specific per-ambulance service cost rate for the applicable service period.

B. Responsibilities and Reporting Requirements of the Approved publicly owned or operated ambulance service

An approved publicly owned or operated ambulance service must:

1. Certify that the claimed expenditures for emergency ambulance services made by the approved entity are approved for FFP;
2. Provide evidence supporting the certification as specified by NYS DOH;
3. Submit data as specified by NYS DOH to determine the appropriate amounts to claim as qualifying expenditures for FFP through the CMS cost report and cost identification methodology; and
4. Keep, maintain, and have readily retrievable any records required by NYS DOH or CMS.

C. NYS DOH's Responsibilities

1. NYS DOH will submit claims for FFP for the expenditures for services that are allowable expenditures under federal law.
2. NYS DOH will, on an annual basis, submit to the federal government CMS cost report in order to provide assurances that FFP will include only those expenditures that are allowable under federal law.

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D. Interim Supplemental Payment

1. NYS DOH will make annual interim Medicaid supplemental payments to approved providers. The interim supplemental payments for each provider are based on the provider's completed annual cost report in the format prescribed by NYS DOH and approved by CMS for the prior cost reporting year.
2. Each approved publicly owned or operated ambulance service must compute the annual cost in accordance with the Cost Determination Protocols (Section C.)and must submit the completed annual as-filed cost report to NYS DOH no later than six months after the close of the interim reporting period.
3. The interim supplemental payment is calculated by subtracting the total Medicaid base payments (Paragraph B.6.) and other payments, such as Medicaid co- payments, received by the providers for ambulance services to Medicaid beneficiaries from the Medicaid portion of the total allowable costs (Paragraph C.2.) reported in the as-filed cost report or the as-filed cost report adjusted by NYS DOH (Paragraph F.1.).
4. Cost reports may be utilized from the period immediately prior to the effectivedate of this state plan in order to set a supplemental payment amount for the first year

of this program. Going forward, each annual cost report will be used to calculate a final reconciliation (described in paragraph G) as well as an interim supplemental payment for the subsequent reporting period.

E. Final Reconciliation

1. Providers must submit auditable documentation to NYS DOH within two years following the end of the July to June reporting period in which payments have been

   received. NYS DOH will perform a final reconciliation where it will settle the provider's annual cost report as audited, three years following the July to June reporting period end. NYS DOH will compute the net Medicaid allowable cost using audited per-ambulance service cost, and the number of Medicaid FFS ambulance services data from the updated NY MMIS reports. Actual net Medicaid allowable cost will be compared to the total base and interim supplemental payments and settlement payments made, and any other source of reimbursement received by the provider for the period.

2. If at the end of the final reconciliation it is determined that the publicly owned or operated ambulance service has been overpaid, the provider will return the overpayment to NYS DOH, and NYS DOH will return the overpayment to the federal government pursuant to 42 CFR 433.316

   https://www.govinfo.gov/content/pkg/CFR-2012-title42-vol4/pdf/CFR-2012-title42- vol4-sec433-316.pdf

   If at the end of the final reconciliation it is determined that the publicly owned or operated ambulance service has been underpaid, the provider will receive a final supplemental payment in the amount of the underpayment.

3. All cost report information for which Medicaid payments are calculated and reconciled are subject to CMS review and must be furnished upon request.

ii. ___ An increase to rates as described below.

Rates are increased:

____ Uniformly by the following percentage:

____ Through a modification to published fee schedules –

Effective date (enter date of change): ______________

Location (list published location): ______________

_____ Up to the Medicare payments for equivalent services.

____ By the following factors:

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Payment for services delivered via telehealth:

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

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

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

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

Describe telehealth payment variation.

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

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

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

Other:

4. ______ Other payment changes:

Section F – Post-Eligibility Treatment of Income

1. _____ The state elects to modify the basic personal needs allowance for institutionalized individuals. The basic personal needs allowance is equal to one of the following amounts:

    a. _____ The individual's total income

    b. _____ 300 percent of the SSI federal benefit rate

    c. _____ Other reasonable amount: _______________

2. _____ The state elects a new variance to the basic personal needs allowance. (Note: Election of this option is not dependent on a state electing the option described the option in F.1. above.)

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

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

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this

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information collection is 0938-1148 (Expires 03/31/2021). The time required to complete this information collection is estimated to average 1 to 2 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. Your response is required to receive a waiver under Section 1135 of the Social Security Act. All responses are public and will be made available on the CMS web site. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. ***CMS Disclosure*** Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact the Centers for Medicaid & CHIP Services at 410-786-3870.

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SUMMARY
SPA #20-0081

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Section 7 – General Provisions
7.4. Medicaid Disaster Relief for the COVID-19 National Emergency

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

For the period beginning 07/01/2020 – 12/31/21

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

Request for Waivers under Section 1135

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

a.__ SPA submission requirements – the agency requests modification of the requirement to submit the SPA by March 31, 2020, to obtain a SPA effective date during the first calendar quarter of 2020, pursuant to 42 CFR 430.20.

b. __x____ Public notice requirements – the agency requests waiver of public notice requirements that would otherwise be applicable to this SPA submission. These requirements may include those specified in 42 CFR 440.386 (Alternative Benefit Plans), 42 CFR 447.57(c) (premiums and cost sharing), and 42 CFR 447.205 (public notice of changes in statewide methods and standards for setting payment rates).

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

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

Section A – Eligibility

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

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

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

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

   Income standard: ______________

   -or-

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

   Income standard: ______________

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

   Less restrictive income methodologies:

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Less restrictive resource methodologies:

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

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

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

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Section B – Enrollment

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

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

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

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

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

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

4. _ The agency adopts a total of __________ months (not to exceed 12 months) continuous eligibility for children under age enter age _____ (not to exceed age 19) regardless of changes in circumstances in accordance with section 1902(e)(12) of the Act and 42 CFR 435.926.

5. _ The agency conducts redeterminations of eligibility for individuals excepted from MAGI- based financial methodologies under 42 CFR 435.603(j) once every __________ months (not to exceed 12 months) in accordance with 42 CFR 435.916(b).

6. _ The agency uses the following simplified application(s) to support enrollment in affected areas or for affected individuals (a copy of the simplified application(s) has been submitted to CMS).

    a.__ The agency uses a simplified paper application.

    b. _ The agency uses a simplified online application.

    c.__ The simplified paper or online application is made available for use in call-centers or other telephone applications in affected areas.

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Section C – Premiums and Cost Sharing

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

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

2. _ The agency suspends enrollment fees, premiums and similar charges for:

    a.__ All beneficiaries

    b. _ The following eligibility groups or categorical populations:

Please list the applicable eligibility groups or populations.

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

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

Section D – Benefits

Benefits:

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

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

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

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

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

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

Please describe.

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State/Territory: ____New York______

Telehealth:

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

Please describe.

Drug Benefit:

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

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

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

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

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

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

Section E – Payments

Optional benefits described in Section D:

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

    a.__ Published fee schedules –

    Effective date (enter date of change): _____________

    Location (list published location): _____________

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b. _ Other:

Describe methodology here.

Increases to state plan payment methodologies:

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

Psychiatric Residential Treatment Facility (PRTF)

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

Please describe criteria.

b. Payments are increased through:

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

Please describe.

ii.__X__ An increase to rates as described below.

Rates are increased:

_____ Uniformly by the following percentage: _____________

_____ Through a modification to published fee schedules –

Effective date (enter date of change): _____________

Location (list published location): _____________

_____ Up to the Medicare payments for equivalent services.

__X__ By the following factors:

The current State Plan authority utilizes the cost reports of two-years prior to determine rates; however, this method alone cannot be used to accurately determine the unprecedented impacts of the COVID-19 Public Health Emergency (PHE), which affected the operational efforts

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of providers within the Psychiatric Residential Treatment Facility (PRTF) program due to difficulties in maintaining staffing levels required to ensure the health and safety of admitted residents.

To address shortfalls in Clinical/Direct Care (C/DC) reimbursement during the PHE, resulting from the utilization of historic cost report data, and to maintain necessary bed capacity, the DOH intends to increase PRTF rates of payment in accordance with the below:

Other State Provider ID Number	Provider Name	7/1/20 - 12/31/20 Disaster SPA Per Diem Add-on Applicable to 2021 UPL Demonstration	1/1/21 - 6/30/21 Disaster SPA Per Diem Add-on Applicable to 2021 UPL Demonstration	7/1/21 - 12/31/21 Disaster SPA Per Diem Add-on Applicable to 2022 UPL Demonstration
7211040	Astor	$0.00	$0.00	$0.00
8385004	A. Aichhorn JJ –Brooklyn RTF	$0.00	$0.00	$0.00
7577040	Baker Victory Services/OLV	$0.00	$0.00	$0.00
7484163	Hillside – Stillwater (050)	$57.93	$57.93	$0.00
7511022	Conners RTF	$5.34	$5.34	$119.29
7484049	Hillside – Crestwood (036)	$0.00	$0.00	$86.95
6709041	J. Goldsmith RTF	$0.00	$0.00	$0.00
7484040	Hillside – Rochester (014)	$10.97	$10.97	$128.86
7484041	Hillside - Finger Lakes (004)	$10.82	$10.82	$23.97
8927040	House of the Good Shepherd	$35.48	$35.48	$65.83
6709040	Ittleson Center RTF	$119.13	$0.00	$0.00
6709042	Linden Hill	$0.00	$0.00	$0.00
6277040	Madonna Heights	$74.10	$74.10	$0.00
6223040	Parsons	$48.29	$48.29	$122.42
7573040	St. Christopher's – Ottilie	$54.12	$0.00	$0.00
7598040	St. Joseph's – Villa of Hope	$84.42	$84.42	$347.70
6734037	The Child Center of NY, INC	$0.00	$0.00	$27.63

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If upon filing of the actual Consolidated Fiscal Report (CFR) for the period it is determined that provider costs for applicable periods are less than those utilized to calculate the per-diem add-on, rates of payment shall be retroactively

updated to remove C/DC reimbursements in excess of provider costs for the period.

Payment for services delivered via telehealth:

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

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

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

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

Describe telehealth payment variation.

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

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

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

Other:

4. _ Other payment changes:

Please describe.

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Section F – Post-Eligibility Treatment of Income

1. _ The state elects to modify the basic personal needs allowance for institutionalized individuals. The basic personal needs allowance is equal to one of the following amounts:

   a.__ The individual's total income

   b. _ 300 percent of the SSI federal benefit rate

   c.__ Other reasonable amount: ___________________

2. _ The state elects a new variance to the basic personal needs allowance. (Note: Election of this option is not dependent on a state electing the option described the option in F.1. above.)

State/Territory: New York

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

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

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

PRA Disclosure Statement

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

SUMMARY
SPA #21-0054

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

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Section 7 – General Provisions
7.4. Medicaid Disaster Relief for the COVID-19 National Emergency

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

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

This provision for rate increases for Child and Family Treatment and Support Services is effective April 1, 2021 through September 30, 2022. The provision for rate increase for Article 29-I Core Health Related Services will be effective July 1, 2021 through September 30, 2022. The administrative fee for Health Homes Serving Children to conduct HCBS level of care eligibility determinations will be effective April 1, 2021, through September 30, 2022.

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

Request for Waivers under Section 1135

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

a. _____ SPA submission requirements – the agency requests modification of the requirement to submit the SPA by March 31, 2020, to obtain a SPA effective date during the first calendar quarter of 2020, pursuant to 42 CFR 430.20.

b. ___x__ Public notice requirements – the agency requests waiver of public notice requirements that would otherwise be applicable to this SPA submission. These requirements may include those specified in 42 CFR 440.386 (Alternative Benefit Plans),

42 CFR 447.57(c) (premiums and cost sharing), and 42 CFR 447.205 (public notice of changes in statewide methods and standards for setting payment rates).

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

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

Section A – Eligibility

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

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

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

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

   Income standard: _____________

   -or-

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

   Income standard: _____________

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

Less restrictive income methodologies:

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Less restrictive resource methodologies:

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

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

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

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Section B – Enrollment

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

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

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

State/Territory: ____New York_____

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

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

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

4. _____ The agency adopts a total of _____ months (not to exceed 12 months) continuous eligibility for children under age enter age _____ (not to exceed age 19) regardless of changes in circumstances in accordance with section 1902(e)(12) of the Act and 42 CFR 435.926.

5. _____ The agency conducts redeterminations of eligibility for individuals excepted from MAGI-based financial methodologies under 42 CFR 435.603(j) once every _____ months (not to exceed 12 months) in accordance with 42 CFR 435.916(b).

6. _____ The agency uses the following simplified application(s) to support enrollment in affected areas or for affected individuals (a copy of the simplified application(s) has been submitted to CMS).

    a. _____ The agency uses a simplified paper application.

    b. _____ The agency uses a simplified online application.

    c. _____ The simplified paper or online application is made available for use in call-centers or other telephone applications in affected areas.

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Section C – Premiums and Cost Sharing

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

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

2. _____ The agency suspends enrollment fees, premiums and similar charges for:

a. _____ All beneficiaries

b. _____ The following eligibility groups or categorical populations:

Please list the applicable eligibility groups or populations.

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

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

Section D – Benefits

Benefits:

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

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

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

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

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

   b. ____ Individuals receiving services under ABPs will not receive these newly added

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

Please describe.

Telehealth:

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

Please describe.

Drug Benefit:

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

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

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

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

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

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

Section E – Payments

Optional benefits described in Section D:

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

a. ____ Published fee schedules –

Effective date (enter date of change): _____________

Location (list published location): _____________

b. ____ Other:

Describe methodology here.

Increases to state plan payment methodologies:

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

"Home and Community-Based Services Eligible for the ARP Section 9817 Temporary Increased FMAP" *Based upon the NYS Department of Health approved Spending Plan for Implementation of Section 9817 of the American Rescue Plan Act of 2021; increased rates for State Plan Services including Children and Family Treatment and Support Services (CFTSS) – PSR, CPST, Crisis, Family Peer Support Services and Youth Peer Support and Training and for Voluntary Foster Care Agencies 29I Health Facilities Core Health Services. This also includes an administrative fee for Health Homes Serving Children to conduct HCBS level of care eligibility determinations for the 1915(c) Children's Waiver.*

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

NYS DOH will increase payment for the providers that provide CFTSS, and 29-I Core Health Services, and will begin reimbursing Health Homes to conduct HCBS assessments, as referenced in the NYS DOH Spending Plan for Implementation of American Rescue Plan Act of 2021, Section 9817 and that are listed in Appendix B, or could be listed in Appendix B, of the American Rescue Plan Act, State Medicaid Director Letter, SMD#21-003 Implementation of American Rescue Plan Act of 2021 Section 9817. *These time limited funds for all claims for the identified services for dates of services between April 1, 2021, through September 30, 2022, for CFTSS and July 1, 2021, through September 30, 2022, for the 29I Health Facilities to build service capacity.* *The HCBS Level of Care determination fee is based upon the annual assessment being conducted timely as outlined in the Children's Waiver. One-time assessment fee*

annually per member within the period of April 1, 2021, through September 30, 2022. A Health Home SPA will be submitted to continue this fee beyond the noted timeframe.

b. Payments are increased through:

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

ii. _X___ An increase to rates as described below.

Rates are increased:

__X___ Uniformly by the following percentage: _25% on CFTSS (an additional 14% above the current 11% authorized under NY SPA 20-0036 and 25% on 29I Health Facilities Core Per Diem rates (based upon current rates). $200 for the HCBS level of care annual assessment.

__X___ Through a modification to published fee schedules –

Effective date (enter date of change): ___April 1, 2021__________

Location (list published location): _ Children and Family Treatment and Support Services (ny.gov)__and 29-I Health Facility (VFCA transition) (ny.gov)_________

_____ Up to the Medicare payments for equivalent services.

_____ By the following factors:

Please describe.

Payment for services delivered via telehealth:

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

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

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

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

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Describe telehealth payment variation.

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

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

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

Other:

4. ______ Other payment changes:

Please describe.

Section F – Post-Eligibility Treatment of Income

1. ____ The state elects to modify the basic personal needs allowance for institutionalized individuals. The basic personal needs allowance is equal to one of the following amounts:

   a. ____ The individual's total income

   b. ____ 300 percent of the SSI federal benefit rate

   c. ____ Other reasonable amount: _______________

2. ____ The state elects a new variance to the basic personal needs allowance. (Note: Election of this option is not dependent on a state electing the option described the option in F.1. above.)

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

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

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State/Territory: ____New York_____

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

Based upon the NYS Spending Plan for Implementation of the American Rescue Plan Act of 2021, section 9817, the following supplemental payment/grants will be provided to Children and Family Treatment and Support Services (CFTSS) and 29I Volunteer Foster Care Agencies Health Center providers:

1. CFTSS Rate Adjustment
Funding: $2.3M State Funds Equivalent
Lead Agency: DOH
Expenditure Authority: State Plan Amendment
Background: Since 2019, Medicaid has applied a rate adjustment on CFTSS rates based on the articulated need of providers for implementation funding and to develop capacity to meet the needs of children, youth, and families. CFTSS providers previously had an enhanced rate that reduced gradually to meet the base rate. Providers and stakeholders are reporting capacity concerns, resulting in access issues and waitlists for CFTSS. Additionally, more children and youth are presenting for behavioral health services, including CFTSS, due to the impact of COVID-19. These clinical Medicaid services are the entry point to assist children, youth and families in early intervention and prevent the need for institutional levels of care.
Proposal:
Eligible Providers: CFTSS providers
Description: Apply the 25% rate adjustment to CFTSS rates, including "off-site" rates, retroactive to April 1, 2021
Evaluation and Reporting: DOH, in conjunction with state agency partners will monitor utilization of these services to ensure expanded access

2.Health Home Serving Children (HHSC) Rate Adjustment
Funding: $0.6M State Funds Equivalent
Lead Agency: DOH
Expenditure Authority: State Plan Amendment
Background: HHSC was implemented in 2016 to provide care management and coordination to children and youth who had two or more chronic condition or a single qualifying condition. The HHSC program serves a variety of children and youth with physical and behavioral health needs. In 2019, with the inception of the consolidated HCBS Children´s Waiver, Health Home care management services were required to meet the care coordination requirements of the 1915(c) Children´s HCBS Waiver. Accordingly, Health Home care managers were now the entity that determined HCBS eligibility by conducting an additional assessment.

The HHSC program has an acuity assessment that is necessary within the program and incorporates a one-time assessment fee when assessing for a new enrollee. This assessment cannot be used for HCBS eligibility determination. The assessment that is now required for HCBS eligibility determination is an additional assessment for which Health Homes are not separately reimbursed but is nonetheless required to ensure proper service eligibility and delivery. The HCBS assessment requires additional training and skills to conduct. The Medicaid program pays Health Home care managers to conduct HCBS eligibility determinations for adults, but not children.

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Proposal:
Eligible Providers: Health Homes Servicing Children.
Description: Provide a temporary annual assessment fee of $200 to Health Homes for conducting an HCBS eligibility determination retroactive to April 1, 2021.
Evaluation and Reporting: DOH, in conjunction with state agency partners will monitor utilization of these services to ensure expanded access and will monitor the length of time it takes for a child with a potential need for HCBS to be assessed and begin receiving services.

3.Support the Transition to Article 29-I Health Facility Core Limited Health Related Services

Funding: $8.6M State Funds Equivalent
Lead Agencies: DOH, OCFS
Expenditure Authority: State Plan Amendment

Background: New York Medicaid-covered children and youth in the care of Voluntary Foster Care Agencies (VFCAs) or placed in foster homes certified by LDSS are in the process of being enrolled in MMC Plans on July 1, 2021, including Mainstream MMC plans and HIV Special Needs Plans (HIV-SNPs), unless they are otherwise excluded or exempt from mandatory MMC. As a result of the pandemic, the transition date has been significantly impacted.

Access to comprehensive, high quality health care is essential to children and youth placed in foster care. Children and youth in the foster care system have higher rates of birth defects, developmental delays, mental/behavioral health needs, and physical disabilities than children and youth from similar socio-economic backgrounds outside of the foster care system. Children and youth in foster care have a high prevalence of medical and developmental problems and utilize inpatient and outpatient mental health services at a rate 15 – 20 times higher than the general pediatric Medicaid population. The impact of the trauma these children/youth experience is profound.[4] For this reason, it is essential that there be immediate access to services upon a child or youth´s placement in foster care, and no interruption in the provision of ongoing services as a result of this transition.

All Licensed Article 29-I Health Facilities are required to provide, or make available through a contract arrangement, all Core Limited Health-Related Services. The five Core Limited Health-Related Services play a vital role in assuring all necessary services are provided in the specified time frames; children, parents and caregivers are involved in the planning and support of treatment, as applicable; information is shared appropriately among professionals involved in the child´s care; and all health-related information and documentation results in a comprehensive, person-centered treatment plan. Core Limited Health-Related Services are reimbursed with a Medicaid residual per diem rate paid to 29-I Health Facilities on a per child, per day basis to cover the costs of these services. The services include: Skill Building (provided by Licensed Behavioral Health Practitioners (LBHPs) as described in Article 29-I VFCA Health Facilities License Guidelines and any subsequent updates); Nursing Services; Medicaid Treatment Planning and Discharge Planning; Clinical Consultation and Supervision Services; and VFCA Medicaid Managed Care Liaison and Administrator services.

The per diem rates established for these services were established prior to the pandemic and do not take into account the significant impact of the pandemic on children in the care of the 29-I Health Facilities, or the additional administrative burden on the providers of the delays in the transition of this population and the 29-I services into managed care.

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State/Territory: New York

Proposal:
Eligible Providers: Article 29-I Health Facilities

Description: Implement a rate adjustment of 25 percent, retroactive to April 1, 2021 for Article 29-I Health Facility Core Limited Health Related Services Per Diem Rates. This temporary increase would assist providers to build capacity to meet the increasing needs of children.

Evaluation and Reporting: DOH, in conjunction with state agency partners will monitor utilization of these services.

PRA Disclosure Statement

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