NEW YORK STATE OF OPPORTUNITY. Department of Health

ANDREW M. CUOMO
Governor

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

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

June 29, 2021

James G. Scott, Director
Division of Program Operations
Centers for Medicare & Medicaid Services
601 E. 12th St., Room 355
Kansas City, Missouri 64106

RE: SPA #21-0012
Non-Institutional Services

Dear Mr. Scott:

The State requests approval of the enclosed amendment #21-0012 to the Title XIX (Medicaid) State Plan for non-institutional services to be effective April 1, 2021 (Appendix I). This amendment is being submitted based on enacted legislation. A summary of the plan amendment is provided in Appendix II.

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

A copy of pertinent sections of enacted legislation is enclosed for your information (Appendix III). A copy of the public notice of this plan amendment, which was given in the New York State Register on March 31, 2021 is also enclosed for your information (Appendix IV). In addition, responses to the five standard funding questions are also enclosed (Appendix V).

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

Sincerely,

[redacted]

Donna Frescatore
Medicaid Director
Office of Health Insurance Programs

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

# TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

**FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES**

1. TRANSMITTAL NUMBER: 21 — 0012

2. STATE: New York

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)
TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
April 1, 2021

5. TYPE OF PLAN MATERIAL *(Check One)*

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION
§ 1902(a) of the Social Security Act and 42 CFR 447

7. FEDERAL BUDGET IMPACT
a. FFY 04/01/21-09/30/21 $ 17.55
b. FFY 10/01/21-09/30/22 $ 35.10

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT

Attachment: 3.1-A Supp: Page 2(xv)
3.1-B Supp: Page 2(xv)
4.19-B: Page 1

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

Attachment: 3.1-A Supp: Page 2(xv)
3.1-B Supp: Page 2(xv)
4.19-B: Page 1

10. SUBJECT OF AMENDMENT

Collaborative Care addition of Nurse Practitioners (FMAP=50%)

11. GOVERNOR'S REVIEW *(Check One)*

☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED

12. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

13. TYPED NAME
Donna Frescatore

14. TITLE
Medicaid Director, Department of Health

15. DATE SUBMITTED
June 29, 2021

16. RETURN TO
New York State Department of Health
Division of Finance and Rate Setting
99 Washington Ave – One Commerce Plaza
Suite 1432
Albany, NY 12210

**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED

18. DATE APPROVED

**PLAN APPROVED - ONE COPY ATTACHED**

19. EFFECTIVE DATE OF APPROVED MATERIAL

20. SIGNATURE OF REGIONAL OFFICIAL

21. TYPED NAME

22. TITLE

23. REMARKS



***Instructions on Back***

**Appendix I**
**2021 Title XIX State Plan**
**First Quarter Amendment**
**Amended SPA Pages**

**New York**
**2(xv)**

**6d. Nurse Practitioner's Services**

New York State covers all nurse practitioner specialties recognized under State Law with no limitations.

Collaborative Care Services: Effective April 1, 2021, Nurse Practitioner services will include Collaborative Care Services as set forth in item 9 of the Supplement to Attachment 3.1-A of the Plan. Nurse Practitioner Services are provided in accordance with 42 CFR §440.166.

**New York**
**2(xv)**

6d. Nurse Practitioners' Services

New York State covers all nurse practitioner specialties recognized under State Law with no limitations.

Collaborative Care Services: Effective April 1, 2021, Nurse Practitioner services will include Collaborative Care Services as set forth in item 9 of the Supplement to Attachment 3.1-B of the Plan. Nurse Practitioner Services are provided in accordance with 42 CFR §440.166.

**New York**
**1.0**

**Collaborative Care Services: Reimbursement for Physicians' and Nurse Practitioners' Services**

Effective January 1, 2015[,] for physicians and April 1, 2021 for nurse practitioners, reimbursement will be provided [to physicians] for Collaborative Care Services provided to patients diagnosed with depression pursuant to the methodology for Collaborate Care Services for Freestanding Clinics outlined in Attachment 4.19-B, except reimbursement for Physicians' and Nurse Practitioners' Services do[es] not include a retainage withholding or payment. Reimbursement [shall] will be a monthly case rate of $112.50 per month for each patient enrolled in Collaborative Care Services. Reimbursement will be provided for a maximum of 12 months. With the approval of the New York State Office of Mental Health, reimbursement will be provided for an additional 12 months at a rate of $75.00 per month. Physicians and Nurse Practitioners must provide the minimum amount of services to enrollees as set forth in item 9 of the Supplement to Attachment 3.1-A of the Plan. Effective January 1, 2018 for physicians and April 1, 2021 for Nurse Practitioners, reimbursement will be provided [to physicians] for Collaborative Care Services provided to patients with other mental illness diagnoses pursuant to the methodology described in this paragraph.

Payment for nurse practitioner services are reimbursed through an independent provider agreement between the state and the nurse practitioner or their employing provider pursuant to 42 C.F.R. § 441.22.

**Appendix II**
**2021 Title XIX State Plan**
**First Quarter Amendment**
**Summary**

**SUMMARY**
**SPA #21-0012**

This State Plan Amendment proposes to authorize nurse practitioners designated by the Office of Mental Health to provide Collaborative Care Services, including screening for mental illness, diagnosis of patients who screen positive, the provision of evidence-based care, ongoing tracking of patient progress, and care management. Collaborative Care Services also include consultation between a designated psychiatric practitioner, care manager and primary care physician for the purpose of managing mental health conditions in primary care settings.

**Appendix III**
**2021 Title XIX State Plan**
**First Quarter Amendment**
**Authorizing Provisions**

**SPA 21-0012**

CHAPTER 60 OF THE LAWS OF 2014

§ 12. Notwithstanding any law, rule, or regulation to the contrary, the commissioner of health, in consultation with the commissioner of the office of mental health and the commissioner of the office of alcoholism and substance abuse services, is authorized to establish an evidence-based, collaborative care clinical delivery model in clinics licensed under article 28 of the public health law, for the purpose of improving the detection of depression and other diagnosed mental or substance use disorders and the treatment of individuals with such conditions in an integrated manner. Such commissioner shall be authorized to develop criteria for the designation of clinics to be providers of collaborative care services. At a minimum, such designated clinics shall provide screening for depression and substance use disorders, medical diagnosis of patients who screen positive, evidence-based depression care and substance use disorder referrals, ongoing tracking of patient progress, care management, and a designated behavioral health practitioner who consults with the care manager and primary care physician. The rates of payment and billing rules for this service will be developed by the commissioner of health, in consultation with the commissioner of the office of mental health and the commissioner of the office of alcoholism and substance abuse services, and with the approval of the director of the budget. Such commissioners are authorized to waive any duplicative regulatory requirements as may be necessary to allow this service to function in an effective and efficient manner; provided, however, that regulations pertaining to patient safety may not be waived, nor shall any regulation be waived if such waiver would risk patient safety. Such waiver shall not exceed the life of the project, or such shorter time period as the authorizing commissioner may determine. The commissioner of health shall include details regarding the implementation of the collaborative care clinical delivery model, including any regulations waived and the frequency and rationale for such waivers, in the annual report under section 45-c of part A of chapter 56 of the laws of 2013.

**Appendix IV**
**2021 Title XIX State Plan**
**First Quarter Amendment**
**Public Notice**

114 Willoughby Street
Brooklyn, New York 11201

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

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

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

## PUBLIC NOTICE

### Department of Health

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

The Department of Health proposes to amend the Title XIX (Medicaid) State Plan for non-institutional services to comply with enacted statutory provisions. The following changes are proposed:

Non-Institutional Services

Effective on or after April 1, 2021, New York State will authorize nurse practitioners designated by the Office of Mental Health to provide Collaborative Care Services, including screening for mental illness, diagnosis of patients who screen positive, the provision of evidence-based care, ongoing tracking of patient progress, and care management. Collaborative Care Services also include consultation between a designated psychiatric practitioner, care manager and primary care physician for the purpose of managing mental health conditions in primary care settings.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for State Fiscal Year 2021/2022 is $70 thousand.

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

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

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

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

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

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

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

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

## PUBLIC NOTICE

### Department of Health

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

The Department of Health proposes to amend the Title XIX (Medicaid) State Plan for institutional, non-institutional and long-term care services to comply with statutory provisions. The following changes are proposed:

All Services

Effective for dates of service on or after April 1, 2021 and each State Fiscal Year thereafter, all non-exempt Department of Health state funds Medicaid payments will be uniformly reduced by an additional 1.0%, totaling 2.5%.

Medicaid payments that will be exempted from the uniform reduction include:

1. Payments whereby Federal law precludes such reduction, including:

o Federally Qualified Health Center services and Residential Health Clinics;

o Indian Health Services and services provided to Native Americans;

o Supplemental Medical Insurance - Part A and Part B;

o State Contribution for Prescription Drug Benefit (aka Medicare Part D payments);

o Any local share cap payment required by the Federal Medical Assistance Percentage (FMAP) increase legislation;

o Services provided to American citizen repatriates; and

o Hospice Services.

2. Payments funded exclusively with federal and/or local funds include, but are not limited to, the following:

o Upper payment limit payments to non-state owned or operated governmental providers certified under Article 28 of the NYS Public Health Law;

o Certified public expenditure payments to the NYC Health and Hospital Corporation;

o Certain disproportionate share payments to non-state operated or owned governmental hospitals;

o Services provided to inmates of local correctional facilities.

3. Payments where applying the reduction would result in a lower FMAP as determined by the Commissioner of Health and the Director of the Budget will also be exempt.

4. Other Payments that are not subject to the reduction include:

o Payments pursuant to Article 32, Article 31 and Article 16 of the Mental Hygiene Law;

o Required payments related to the School Supportive Health Services Program and Preschool Supportive Health Services Program;

o Early Intervention;

o Traumatic Brain Injury Waiver (TBI);

o Nursing Home Transition and Diversion Waiver (NHTD);

o Payments for services provided by Other State Agencies including Office of Children and Family Services, State Education Department, and the Department of Corrections and Community Supervision.

o Value Based Payment Quality Improvement Program;

o Vital Access Providers and Vital Access Provider Assurance Program;

o Physician Administered Drugs;

o Court orders and judgments;

o Family Planning services;

o Children´s Home and Community Based services; and

o Children´s Health Home services.

The estimated annual net aggregate decrease in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2021/2022 is ($188.0 million).

Effective on and after April 1, 2021 through March 31, 2023, no

**Appendix V**
**2021 Title XIX State Plan**
**First Quarter Amendment**
**Responses to Standard Funding Questions**

**NON-INSTITUTIONAL SERVICES**
**State Plan Amendment #21-0012**

## CMS Standard Funding Questions

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

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

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

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

   **Response:** Payments made to service providers under the provisions of this SPA are funded through a general appropriation received by the State agency that oversees medical assistance (Medicaid), which is the Department of Health. The source of the appropriation is the Local Assistance Account under the General Fund/Aid to Localities.

3. **Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan. If supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to each provider type.**

   **Response:** The payments authorized for this provision are not supplemental or enhanced payments.

4. **For clinic or outpatient hospital services please provide a detailed description of the methodology used by the state to estimate the upper payment limit (UPL) for each class of providers (State owned or operated,**

**non-state government owned or operated, and privately owned or operated). Please provide a current (i.e., applicable to the current rate year) UPL demonstration.**

**Response:** Not applicable.

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

   **Response:** Not applicable.

**ACA Assurances:**

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

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

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

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

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

**order to anticipate potential violations and/or appropriate corrective actions by the States and the Federal government.**

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

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

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

**Tribal Assurance:**

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

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

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

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