Department of Health

KATHY HOCHUL
Governor

MARY T. BASSETT, M.D., M.P.H.
Commissioner

KRISTIN M. PROUD
Acting Executive Deputy Commissioner

June 30, 2022

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 #22-0026
Non-Institutional Services

Dear Mr. Scott:

The State requests approval of the enclosed amendment #22-0026 to the Title XIX (Medicaid) State Plan for non-institutional services to be effective April 1, 2022 (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 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 30, 2022, 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,

Amir Bassiri
Acting 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

2. STATE

3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT XIX XXI

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE

5. FEDERAL STATUTE/REGULATION CITATION

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY ______ $ 1,069,424
b. FFY ______ $ 23,726,896

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*

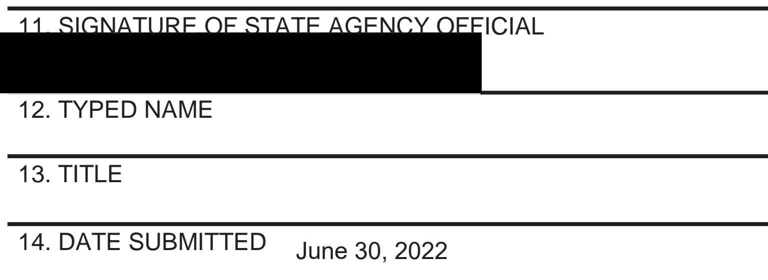
9. SUBJECT OF AMENDMENT

10. 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:

11. SIGNATURE OF STATE AGENCY OFFICIAL



12. TYPED NAME

13. TITLE

14. DATE SUBMITTED June 30, 2022

15. RETURN TO

FOR CMS USE ONLY

16. DATE RECEIVED

17. DATE APPROVED

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL

19. SIGNATURE OF APPROVING OFFICIAL

20. TYPED NAME OF APPROVING OFFICIAL

21. TITLE OF APPROVING OFFICIAL

22. REMARKS

Appendix I
2022 Title XIX State Plan
Second Quarter Amendment
Amended SPA Pages

1905(a)(13) Other Diagnostic, Screening, Preventive, and Rehabilitative Services - Rehabilitative Services

42 CFR 440.130(d)

Item 4.b, EPSDT services - **Rehabilitative Services: 42 CFR 440.130(d)**
The State provides coverage for this benefit as defined at 42 CFR 440.130(d) and as described in this section:

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

Rehabilitative Services Description

The rehabilitative service (or services) described below is:
[• Crisis Intervention]
• Community Psychiatric Support and Treatment
• Psychosocial Rehabilitation
• Youth Peer Support
• Family Peer Support

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

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

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

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

Reserved
[Rehabilitative Services: EPSDT only (Continued)

Crisis Intervention (Continued):
Description (Continued):
not additional crisis response services are required to further evaluate, resolve, and/or stabilize the crisis. CI services are designed to interrupt and/or ameliorate the crisis experience and include an assessment that is culturally and linguistically competent and result in immediate crisis resolution and de-escalation, and development of a crisis plan. The goals of CI are engagement, symptom reduction, stabilization, and restoring individuals to a previous level of functioning or developing the coping mechanisms to minimize or prevent the crisis in the future. CI includes developing crisis diversion plans, safety plans or relapse prevention plans, providing support during and after a crisis and connecting an individual with identified supports and linkages to community services. All activities must occur within the context of a potential or actual behavioral health crisis with a desired outcome of resolving and/or stabilizing the crisis episode and diverting an emergency room visit and/or inpatient admission, when appropriate.

CI includes engagement with the child, family/caregiver or other collateral sources (e.g., school personnel) that is culturally and linguistically competent, child centered, and family focused in addition to trauma informed to determine level of safety, risk, and to plan for the next level of services. Family is a birth, foster, adoptive, or self-created unit of people residing together, with significant attachment to the individual, consisting of adult(s) and/or child(ren), with adult(s) performing duties of parenthood/caregiving for the child(ren) even if the individual is living outside of the home. All services including family or collaterals are for the direct benefit of the beneficiary.

The service is recommended by any of the following licensed practitioners of the healing arts operating within the scope of their practice of their State license, who may or may not be part of the crisis intervention team: Physician (MD), including Psychiatrist and Addictionologist/Addiction Specialist; Nurse Practitioner; Registered Nurse; Clinical Nurse Specialist; Physician Assistant; Licensed Psychologist; Licensed Psychoanalyst; Licensed Social Worker (Licensed Masters Social Worker – LMSW or Licensed Clinical Social Worker- LCSW); Licensed Marriage and Family Therapist; and Licensed Mental Health Counselor.

Practitioner qualifications: Crisis Intervention Professionals (CI Professionals) are practitioners possessing a license or authority under State licensure law by the New York State Education Department who are qualified by credentials, training, and experience to provide direct services related to the treatment of mental illness. CI Professionals include one of the following individuals licensed in NYS: Physician (MD), including Psychiatrist and Addictionologist/ Addiction Specialist; Nurse Practitioner; Registered Nurse/; Clinical Nurse Specialist; Physician Assistant; Licensed Psychologist; Licensed Psychoanalyst; Licensed Social Worker (Licensed Masters Social Worker – LMSW or Licensed Clinical Social Worker- LCSW); Licensed Marriage and Family Therapist; Licensed Mental Health Counselor; and Licensed Creative Arts Therapist. Note: A Licensed psychologist is a professional who is currently licensed as a psychologist by the New York State Education Department or possesses a permit from the New York State Education Department and who possesses a doctoral degree in psychology, or an individual who has obtained at least a master's degree in psychology who works in a Federal, State, county or municipally operated clinic. Such master's degree level psychologists may use the title "psychologist," may be considered professional staff, but may not be assigned supervisory responsibility. (14 CRR-NY XIII 599) Any reference to supervision by a CI Professional excludes these Master's level psychologists who may not supervise under this authority.]

Reserved

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

Crisis Intervention Staff (CI Staff) include practitioners who are at least 18 years of age and have a high school diploma, high school equivalency, or State Education Commencement Credential (e.g. Career Development and Occupational Studies Commencement Credential (CDOS) and the Skills and Achievement Commencement Credential (SACC)) with one of the following:

- Two years of work experience in children's mental health, addiction, or foster care,
- A student, intern, or other practitioner with a permit practicing under the supervision of a licensed CI Professional within a DOH approved New York State Education Department program to obtain experience required for licensure,
- A Licensed Practical Nurse,
- Credentialed Alcoholism and Substance Abuse Counselor (CASAC), or
- Qualified Peer Specialist who has 'lived experience' as an individual with emotional, behavioral or co-occurring disorders or as a parent/primary caregiver with a child having emotional, behavioral or co-occurring disorders. The educational requirement can be waived by DOH or its designee if the individual has demonstrated competencies and has relevant life experience sufficient for the peer certification, and credentialed as one of the following:
  - Family Peer Advocate who has completed Level One and Level Two of the Parent Empowerment Program Training or approved comparable training. The practitioner completes the certification's required hours of continuing education annually and renews their credential every two years. An FPA may obtain a provisional credential for no longer than 18 months to complete all requirements of the professional family peer advocate.
  - Certified Recovery Peer Advocate who has completed their content specific training, work-related experience, evidence of supervision, and passed the Peer Advocate Exam or other exam by an OASAS designated certifying body. The practitioner completes the certification's required hours of continuing education annually and renews their credential every two years.
  - Youth Peer Advocate (YPA) who has completed Level One and Level Two of the Youth Peer Support Services Advisory Council recommended and State approved training for YPAs, work-related experience, and provided evidence of supervision. The practitioner completes the certification's required hours of continuing education and renews their credential every two years. An YPA may obtain a provisional credential for no longer than 18 months to complete all requirements of the professional youth peer advocate.
  - A practitioner who has completed the required training and has a current certification from the New York State Peer Specialist Certification Board.

CI staff are eligible to provide crisis intervention services within their scope of practice when under supervision of a CI Professional. CI staff including Qualified Peer Specialists may accompany a CI Professional providing a mobile crisis and may also assist with developing, crisis diversion plans, safety plans or relapse prevention plans, provide support during and after a crisis and assist with connecting an individual with identified supports and linkages to community services.]

Reserved

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

Crisis Intervention Training: All CI Professionals and CI Staff are required to have training on the administration of Naloxone (Narcan) and have training to provide crisis intervention in a manner that is trauma informed and culturally and linguistically competent.

Supervisor Qualifications: The supervisor is a qualified CI Professional and must provide regularly scheduled supervision for CI Professionals and CI Staff including peer specialists. The supervisor must have the qualifications of at least a Licensed Clinical Social Worker (LCSW), Licensed Mental Health Counselor, Licensed Creative Arts Therapist, Licensed Marriage and Family Therapists, Licensed Psychoanalyst, Licensed Psychologist, Physician's Assistant, Psychiatrist, Physician, Registered Professional Nurse (RN), or Nurse Practitioner operating within the scope of their practice, with at least 2- years of work experience. The supervisor must practice within the State health practice laws and ensure that CI Professionals and CI Staff are supervised as required under state law.

Provider Agency Qualifications: CI Professionals and CI Staff must work within a child serving agency or agency with children's behavioral health and health experience that is licensed, certified, designated and/or approved by OMH, OASAS, OCFS or DOH or its designee to provide the crisis services referenced in the definition.

Service Modalities
Crisis Intervention includes two modalities:

- Mobile Crisis is a face-to-face intervention typically comprised of mobile two-person response teams that includes telephonic triage and can occur in a variety of settings including community locations where the beneficiary lives, works, attends school, engages in services (e.g. provider office sites), and/or socializes. The service is available with 24 hours a day, 7 days a week and 365 days a year with capacity to respond immediately or within three hours of determination of need.

  Mobile Crisis is provided by two team members, for programmatic or safety purposes unless otherwise determined through triage. One member of a two-person mobile crisis intervention team must be a CI Professional and have experience with crisis intervention service delivery. If determined through triage that only one team member is needed to respond, an experienced CI Professional must respond to a mental health crisis. Similarly, a Credentialed Alcoholism and Substance Abuse Counselor (CASAC) may respond to a Substance Use Disorder crisis with a licensed practitioner available via phone. A Qualified Peer Specialist or other CI Staff member may not respond alone, except for the CASAC as noted. Mobile Crisis may include any of the following components, which are defined below:

  - Mental Health and Substance use Disorder Assessment by a CI Professional or CASAC,
  - Service Planning by a CI Professional or CI Staff member.
  - Individual and Family Counseling by a CI Professional or CASAC,
  - Care Coordination by a CI Professional or CI Staff member.
  - Peer/Family Support by a Qualified Peer Specialist.]

Reserved

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

Crisis Stabilization/Residential Supports
Short-term Crisis Stabilization/Residential Supports is a voluntary non-hospital, non-IMD sub-acute crisis intervention provided for up to 28 days to stabilize and resolve the crisis episode, with 24-hour supervision.

Short-term Crisis Stabilization/Residential Supports is staffed using CI Professionals and CI Staff to meet the high need of children experiencing a crisis through a multidisciplinary team that focus on crisis stabilization and well-coordinated transitions into services that align with the on-going needs of the individual. Crisis Stabilization/Residential Supports may include any of the following components, which are defined below:

- Mental Health and Substance use Disorder Assessment by a CI Professional or CASAC,
- Service Planning by a CI Professional or CI staff member.
- Individual and Family Counseling by a CI Professional or CASAC,
- Care Coordination by a CI Professional or CI staff member.
- Peer/Family Support by a Qualified Peer Specialist.

Service Components
Mobile crisis and residential supports modalities include the following service components:

Mental Health and Substance Abuse Services Assessment includes: both initial and on-going assessments to determine the need for further evaluation, and to make treatment recommendations and/or referral to other health and/or behavioral health services as clinically indicated. The expectation is that the assessment includes, but may not be limited to:

- Risk of harm to self or others, current mental status, current and recent history of substance use, assessment of intoxication and potential for serious withdrawal;
- History of psychiatric treatment and medical stability;
- Prescribed medications, including medical, psychiatric and medication assisted treatments for substance use
- Presenting problem and review of immediate needs; and
- Identification of supports.

Qualifications: A CI Professional or a Credentialed Alcoholism and Substance Abuse Counselor (CASAC) supervised by a CI Professional with 2 years of work experience.]

Reserved

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

Service Planning includes:

- Developing a crisis diversion plan, safety plan or crisis relapse prevention plan;
- Connecting an individual with identified supports and linkages to community services including referral and linkage to appropriate behavioral health community services as an alternative to more restrictive levels of care,
- Facilitating timely access to services required to address the crisis-related needs of the individual, including mobile crisis, observation, stabilization, withdrawal management, local SUD such as 24/7 open access centers, respite, and/or secure access to higher levels of care, if required such as psychiatric or substance use disorder (SUD) inpatient hospitalization.

Qualifications: A CI Professional or CI Staff member supervised by a qualified CI Professional with 2 years of work experience may perform Service Planning.

Individual and Family Counseling includes:

- Alleviating psychiatric or substance use symptoms, maintaining stabilization following a crisis episode, and preventing escalation of BH symptoms.
- Consulting with psychiatric prescribers and urgent psychopharmacology intervention, as needed.
- Resolving conflict, de-escalating crises and monitoring high-risk behavior.

Qualifications: A CI Professional or a Credentialed Alcoholism and Substance Abuse Counselor (CASAC) may provide Individual and Family Counseling. A CI Staff member may also support a CI Professional providing Individual and Family Counseling during and after a crisis. The team is supervised by a qualified CI Professional with 2 years of work experience.]

Reserved

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

Care Coordination includes:

- Involvement of identified family and friends to resolve the individual's crisis
- Follow up and documentation of follow up with child and family/caregiver within 24 hours of initial contact/response and up to 14 days post contact/response.
- Facilitation of engagement in outpatient BH services, care coordination, medical health or basic needs related to the original crisis service;
- Confirmation with service providers of connections to care and support to the recipient in the community while he or she is awaiting initiation or resumption of services;
- Contact with the individual's existing primary care and BH treatment providers, adult or children's Single Point of Access (SPOA) where applicable, and and/or care coordinator of the developed crisis plan;
- Contact with the individual's natural support network with consent;
- Referral and engagement/re-engagement with health homes and appropriate BH community and certified peer services to avoid more restrictive levels of treatment, and
- Follow-up with the individual and the individual's family/support network to confirm enrollment in care coordination, outpatient treatment, or other community services has occurred or is scheduled.

Qualifications: A CI Professional or CASAC may perform any aspect of Care Coordination. A CI Staff member may assist with connecting an individual with identified supports and linkages to community services under Care Coordination. The team is supervised by a qualified CI Professional with 2 years of work experience.

Peer/Family Peer Supports include**:**

- Crisis resolution with the identified Medicaid eligible child, the child's family/caregiver and the treatment provider including engagement;
- Assistance with developing crisis diversion plans or relapse prevention plans; and
- Assistance with the identification of natural supports and access to community services during and after a crisis.

Qualifications: Qualified Peer Specialist supervised by a qualified CI Professional with 2 years of work experience.]

1905(a)(13) Other Diagnostic, Screening, Preventive, and Rehabilitative Services

Item 13d. Rehabilitative Services:
Outpatient and Residential Crisis Intervention Services

The State provides coverage for this benefit as defined at 42 CFR 440.130(d).

Assurances:

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

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

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

Outpatient and Residential Crisis Intervention Services Description:

Outpatient and Residential Crisis Intervention (CI) Services are provided to individuals who are identified as experiencing an acute psychological or emotional change which results in a marked increase in personal distress and which exceeds the abilities and the resources of the individual and those involved (e.g., collateral, provider, community member) to effectively resolve.

CI services are recommended by any of the following licensed practitioners of the healing arts operating within the scope of their practice of their State license, who may or may not be part of the crisis intervention team: Physician (MD), including Psychiatrist and Addictionologist/Addiction Specialist; Nurse Practitioner; Registered Nurse; Physician Assistant; Licensed Psychologist; Licensed Psychoanalyst; Licensed Social Worker (Licensed Masters Social Worker – LMSW or Licensed Clinical Social Worker — LCSW); Licensed Marriage and Family Therapist; Licensed Creative Arts Therapists; Licensed Mental Health Counselor; and Licensed Occupational Therapist.

1905(a)(13) Other Diagnostic, Screening, Preventive, and Rehabilitative Services

Item 13d. Rehabilitative Services:
Outpatient and Residential Crisis Intervention Services (continued):

CI services are designed to interrupt and ameliorate the crisis experience and include an assessment that is culturally and linguistically competent and result in timely crisis resolution and de-escalation, and development of a crisis plan. The goals of CI services are engagement in services, symptom reduction, stabilization, restoring individuals to a previous level of functioning, and developing the coping mechanisms to minimize or prevent the crisis in the future. CI services are provided in multiple modalities as described herein, and include developing crisis diversion plans, safety plans or relapse prevention plans, providing support during and after a crisis and connecting an individual with identified supports and linkages to community services. All activities must occur within the context of a potential or actual behavioral health crisis with a desired outcome of resolving or stabilizing the crisis episode and diverting an emergency room visit or inpatient admission, if appropriate.

CI services include engagement with the individual adult or child/youth or other identified collateral supports (e.g., family, friends, or activated community resources) that is culturally and linguistically competent, person-centered, and trauma-informed to determine level of safety, risk, and to plan for the next level of services. For children and youth, CI services include family-focused engagement, where “family” may include a birth, foster, adoptive, or self-created unit of people residing together, with significant attachment to the individual, consisting of adult(s) and/or child(ren), with adult(s) performing duties of parenthood/caregiving for the child(ren) even if the individual is living outside of the home. All services including family or other collaterals are for the direct benefit of the beneficiary.

Practitioner qualifications:

Crisis Intervention Professionals (CI Professionals) are practitioners possessing a license or authority under State licensure law by the New York State Education Department who are qualified by credentials, training, and experience to provide direct services related to the treatment of behavioral health conditions. CI Professionals include the following individuals licensed or permitted in NYS: Physician, including Psychiatrist and Addictionologist/Addiction Specialist; Nurse Practitioner; Registered Nurse; Physician Assistant; Licensed Psychologist; Licensed Psychoanalyst; Licensed Social Worker (Licensed Masters Social Worker – LMSW or Licensed Clinical Social Worker — LCSW); Licensed Marriage and Family Therapist; Licensed Mental Health Counselor; Licensed Creative Arts Therapist, Licensed Behavioral Analyst, and Occupational Therapist who meet the qualifications set forth in 42 C.F.R. 440.110(b)(2).

For individuals age 21 and over, CI Professionals also include Certified Psychiatric Rehabilitation Practitioners certified by the Psychiatric Rehabilitation Association, Certified Rehabilitation Counselors certified by the Commission on Rehabilitation Counselor Certification, Therapeutic Recreation Therapists certified by the National Council on Therapeutic Recreation or the American Therapeutic Recreation Association, and Counselors certified by and currently registered with the National Board for Certified Counselors.

1905(a)(13) Other Diagnostic, Screening, Preventive, and Rehabilitative Services

Item 13d. Rehabilitative Services:
Outpatient and Residential Crisis Intervention Services (continued):

Note: A Licensed psychologist is a professional who is currently licensed as a psychologist by the New York State Education Department or possesses a permit from the New York State Education Department and who possesses a doctoral degree in psychology, or an individual who has obtained at least a master's degree in psychology who works in a Federal, State, county or municipally operated program or services. Such master's degree-level psychologists may use the title "psychologist," and may be considered professional staff, but may not be assigned supervisory responsibility. Any reference to supervision by a CI Professional excludes these Master's level psychologists who may not supervise CI services.

Crisis Intervention Staff (CI Staff) include practitioners who are at least 18 years of age and have a bachelor's degree, which may be substituted for a high school diploma, high school equivalency, or State Education Commencement Credential. Individuals without a Bachelor's degree must also meet one or more of the following qualifications:

- For CI services for adults, possess 1-3 years of experience working with individuals with serious mental illness or substance use disorders; or for CI services for children/youth, two years of work experience in children's mental health, addiction, or foster care;
- A student or intern within a DOH-approved New York State Education Department program;
- Licensed Practical Nurse;
- Credentialed Alcoholism and Substance Abuse Counselor (CASAC); or
- Individuals with lived-experience as an individual with emotional, behavioral, addiction, or co-occurring disorders or as a parent/primary caregiver of a child with emotional, behavioral, addiction, or co-occurring disorders and who are not qualified peers. DOH or its designee may also waive the education requirement for these individuals to provide services as CI Staff.

CI Services are also provided by qualified peers who are individuals with lived experience as an individual with emotional, behavioral, addiction, or co-occurring disorders or as a parent/primary caregiver of a child with emotional, behavioral, addiction, or co-occurring disorders and who are certified or credentialled as follows:

- Credentialed or Provisionally Credentialed Family Peer Advocate (FPA) who has completed Level One and Level Two of the Parent Empowerment Program Training or approved comparable training. Credentialed FPAs complete the certification's required hours of continuing education annually and renew their credential every two years. A FPA may obtain a provisional credential for no longer than 18 months to complete all requirements of the full credential.

1905(a)(13) Other Diagnostic, Screening, Preventive, and Rehabilitative Services

Item 13d. Rehabilitative Services:
Outpatient and Residential Crisis Intervention Services (continued):

- Certified or Provisionally Certified Recovery Peer Advocate (CRPA) who has completed their content specific training, work-related experience, evidence of supervision, and passed the Peer Advocate Exam or other exam by an OASAS designated certifying body. The practitioner completes the certification's required hours of continuing education annually and renews their credential every two years.
- Credentialed or Provisionally Credentialed Youth Peer Advocate (YPA) who has completed Level One and Level Two of the Youth Peer Support Services State approved training for YPAs, work-related experience, and provided evidence of supervision. Credentialed YPAs complete the certification's required hours of continuing education and renew their credential every two years. A YPA may obtain a provisional credential for no longer than 18 months to complete all requirements of the full credential.
- Certified Peer Specialist who has completed the required training and has a current or provisional certification as a Peer Specialist from the New York State Peer Specialist Certification Board.

CI staff are eligible to provide CI services within their applicable scope of practice and under supervision of a CI Professional as provided herein. Only CI professionals and CASACs may conduct assessments. Qualified peers provide peer and family peer support services under the supervision of competent mental health professionals as provided herein.

Supervisor Qualifications: The supervisor is a qualified CI Professional, including a Licensed Clinical Social Worker (LCSW), Licensed Mental Health Counselor, Licensed Creative Arts Therapist, Licensed Marriage and Family Therapist, Licensed Psychoanalyst, Licensed Psychologist, Physician's Assistant, Physician, Registered Professional Nurse, or Nurse Practitioner operating within the scope of their practice. For purposes of peer and family peer support services, competent mental health professionals include CI professionals, CASACs, other CI Staff with a master's degree in a human services field, and qualified peers with at least three years of direct experience providing peer or family peer services. Experienced FPAs may supervise YPAs upon completion of State approved Youth Peer Support training. Supervisors shall provide regularly scheduled supervision for CI Staff and qualified peers.

Provider Agency Qualifications: For Mobile CI services for children/youth, CI Professionals and Staff must work within a child-serving agency or agency with children's behavioral health and health experience that is licensed, certified, designated, and/or approved by OMH, OASAS, OCFS, or DOH or its designee to provide the crisis services referenced in the definition. For Mobile CI services for adults, CI professional and Staff must work in an agency licensed, certified, designated, or approved by OMH or OASAS. For Crisis Stabilization CI Services for adults and children/youth, CI Professionals and Staff shall work within OMH and OASAS programs licensed pursuant to Article 36 of the Mental Hygiene Law. For Residential CI Services for adults and children/youth, CI Professionals and Staff shall work within crisis residential programs licensed or certified by OMH or OASAS.

1905(a)(13) Other Diagnostic, Screening, Preventive, and Rehabilitative Services

Item 13d. Rehabilitative Services:
Outpatient and Residential Crisis Intervention Services (continued):

Crisis Intervention Training: All CI Professionals, CI Staff, and qualified peers are required to have training on the administration of opioid antagonists and trauma-informed care, de-escalation strategies, harm reduction, and culturally and linguistically competent service provision.

CI Service Modalities
Crisis Intervention includes five modalities: Mobile Crisis, Crisis Stabilization, Children's Crisis Residence, Residential Crisis Support for adults, and Intensive Residential Crisis for adults.

1. Mobile Crisis Intervention is provided by a multidisciplinary team of CI Professionals, CI Staff, and qualified peers that includes telephonic triage and mobile or telephonic follow-up and can occur in a variety of settings including community locations where the beneficiary lives, works, attends school, engages in services, or socializes. Mobile Crisis Intervention is available 24 hours a day, 7 days a week, and 365 days a year with capacity to respond immediately or within three hours of determination of need. Mobile Crisis Services may be provided by telehealth consistent with state guidance.

   Mobile Crisis Intervention services are typically provided by response teams comprised of two team members, unless otherwise determined through triage. One member of a two-person response team must be a CI Professional. If determined through triage that only one team member is needed to respond, either a CI Professional or a CI staff member with a Master's degree may respond alone with a licensed practitioner available via telehealth and a CASAC may respond alone to an individual experiencing a substance use disorder crisis with a licensed practitioner available via telehealth. After an initial Mobile Crisis Intervention service is provided, CI Staff with a Bachelor's degree can respond alone in a follow-up visit to provide service planning, safety planning, and care coordination services, and qualified peers may respond alone to provide peer/family support services. CI staff and qualified peers may also accompany a CI Professional or other qualified CI Staff to assist with de-escalation or other service components.

   Crisis Intervention Services components provided in this modality include the following, as further defined below:

   - Mental Health and Substance Use Assessments
   - Service Planning
   - Crisis/Safety Planning
   - Individual and Family Counseling
   - Care Coordination; and
   - Peer/Family Peer Support

1905(a)(13) Other Diagnostic, Screening, Preventive, and Rehabilitative Services

Item 13d. Rehabilitative Services:
Outpatient and Residential Crisis Intervention Services (continued):

2. Crisis Stabilization provides urgently needed immediate evaluation, treatment, and support services, including coordination with other mental health and substance use services, for children and adults experiencing or at risk of a mental health or substance use disorder crisis. CI Services are provided on-site by Crisis Stabilization Centers licensed by the New York State Offices of Mental Health and Addiction Services and Supports pursuant to Article 36 of the New York State Mental Hygiene Law that employ or contract with qualified CI Professionals, CI Staff and qualified peers.

   Crisis Intervention Services components provided in this modality include the following, as further defined below:

   - Mental Health and Substance Use Assessments
   - Service Planning
   - Crisis/Safety Planning
   - Individual and Family Counseling
   - Care Coordination
   - Peer/Family Peer Support
   - Medication Therapy
   - Medication Management and Training
   - Medication Assisted Treatment (MAT); and
   - Mild to Moderate Detoxification Services

1905(a)(13) Other Diagnostic, Screening, Preventive, and Rehabilitative Services

Item 13d. Rehabilitative Services:
Outpatient and Residential Crisis Intervention Services (continued):

3. Children's Crisis Residence is a short-term, voluntary, non-IMD, sub-acute crisis intervention modality for children under age 21 to stabilize a child's psychiatric or other behavioral health crisis symptoms and restore the child to a level of functioning and stability that supports their transition back to the community and to prevent or reduce future crises. Children's Crisis Residences provide 24-hour monitoring and supervision, as well as treatment and support services in Crisis Residential facilities licensed by the New York State Office of Mental Health or certified by the NYS Office of Addiction Services and Supports that employ qualified CI Professionals and CI Staff.
Crisis Intervention Services components provided in this modality include the following, as further defined below:

- Mental Health and Substance Use Assessment
- Service Planning
- Crisis/Safety Planning
- Individual, Family, Group Counseling
- Care Coordination
- Health Screening
- Medication Monitoring
- Medication Management and Training
- Psychiatric Crisis Rehabilitation and Skills Training
- Family Psychoeducation and Support
- Medication Assisted Treatment; and
- Mild to Moderate Detoxification Services

1905(a)(13) Other Diagnostic, Screening, Preventive, and Rehabilitative Services

Item 13d. Rehabilitative Services:
Outpatient and Residential Crisis Intervention Services (continued):

4. Intensive Residential Crisis is a short-term, voluntary, non-IMD, sub-acute crisis intervention modality for individuals aged 21 and over who are experiencing an acute escalation of behavioral health symptoms or who are at imminent risk for loss of functional abilities and may raise safety concerns for themselves and others without intensive residential services. CI Services provided in this modality provide 24-hour monitoring and supervision and intensive treatment and support services to stabilize and address an individual's psychiatric symptoms in Crisis Residential facilities licensed by the New York State Office of Mental Health or certified by the NYS Office of Addiction Services and Supports that employ or contract with qualified CI Professionals, CI Staff and qualified peers.

   Crisis Intervention Services components provided in this modality include the following, as further defined below:

   - Mental Health and Substance Use Assessments
   - Service Planning
   - Crisis/Safety Planning
   - Individual, Family, and Group Counseling
   - Care Coordination
   - Peer Support
   - Medication Therapy
   - Medication Monitoring
   - Medication Management and Training
   - Psychiatric Crisis Rehabilitation and Skills Training
   - Co-occurring Disorder Treatment
   - Medication Assisted Treatment; and
   - Mild to Moderate Detoxification Services

1905(a)(13) Other Diagnostic, Screening, Preventive, and Rehabilitative Services

Item 13d. Rehabilitative Services:
Outpatient and Residential Crisis Intervention Services (continued):

5. Residential Crisis Support is a short-term, voluntary, non-IMD, sub-acute crisis intervention modality for individuals aged 21 and older to stabilize crisis symptoms, address the cause of the crisis, and avert or delay the need for acute psychiatric inpatient hospitalization or emergency services. Residential Crisis Support is appropriate for individuals who are experiencing challenges in daily life that create risk for an escalation of psychiatric symptoms or a period of acute stress significantly impairing their ability to cope with normal life circumstances. CI Services provided in this modality provide respite, 24-hour supervision, and treatment and support services in Crisis Residential facilities licensed by the New York State Office of Mental Health or certified by the NYS Office of Addiction Services and Supports that employ or contract with qualified CI Professionals, CI Staff and qualified peers.

   Crisis Intervention Services Components provided in this modality include the following, as further defined below:

   - Mental Health and Substance Use Assessments
   - Service Planning
   - Crisis/Safety Planning
   - Care Coordination
   - Peer Support
   - Medication Monitoring
   - Medication Management and Training
   - Psychiatric Crisis Rehabilitation and Skills Training
   - Medication Assisted Treatment; and
   - Mild to Moderate Detoxification Services

1905(a)(13) Other Diagnostic, Screening, Preventive, and Rehabilitative Services

Item 13d. Rehabilitative Services:
Outpatient and Residential Crisis Intervention Services (continued):

Service Components
Crisis intervention Services provided in the modalities described above include the following:

Mental Health and Substance Use Assessments

Service Description: Assessment services, including initial and on-going assessments to determine the need for further evaluation and to make treatment recommendations and referral to other health or behavioral health services as clinically indicated. Assessments may include:

- Risk of harm to self or others, current mental status, current and recent history of substance use, assessment of intoxication and potential for serious withdrawal;
- History of psychiatric and medical treatment;
- Prescribed medications, including medical, psychiatric and medication for substance use disorders;
- Presenting problem and review of immediate needs; and
- Identification of supports.

Qualifications: A CI Professional or a Credentialed Alcoholism and Substance Abuse Counselor (CASAC) supervised by a CI Professional.

Service Planning

Service Description: With the active involvement of the individual where developmentally appropriate or an individual's family members or other collaterals as necessary for the benefit of the beneficiary, services include:

- Developing, reviewing and modifying a care plan to address the mental health and substance use disorder treatment and support needs of the individual;
- Connecting an individual with identified supports and linkages to community services including referral and linkage to appropriate behavioral health community services as an alternative to more restrictive levels of care; and
- Facilitating timely access to services required to address the crisis-related needs of the individual, including mobile crisis, observation, stabilization, withdrawal management, local SUD services such as open access centers and centers of opioid treatment innovation (COTI), respite, and/or secure access to higher levels of care, if required such as psychiatric or substance use disorder inpatient hospitalization.

Qualifications: A CI Professional or CI Staff member supervised by a CI Professional.

1905(a)(13) Other Diagnostic, Screening, Preventive, and Rehabilitative Services

Item 13d. Rehabilitative Services:
Outpatient and Residential Crisis Intervention Services (continued):

Crisis/Safety Planning

Services description: A service planning and rehabilitative skills training service to assist individuals to effectively avoid or respond to mental health and substance use crises by identifying triggers that risk their remaining in the community or that result in functional impairments. Services assist the individual or family members, or other collaterals as necessary for the benefit of the beneficiary, with identifying a potential psychiatric or personal crisis, developing a crisis management, safety or wellness plan to assist individuals to prevent relapse, identify early warning signs of decompensation, and cope or seek supports to restore stability and functioning.

Qualifications: A CI Professional or CI Staff member supervised by a CI Professional.

Individual, Family, and Group Counseling

Services description: Services include psychotherapy and psychosocial rehabilitation counseling services to remediate psychiatric or substance use symptoms, resolve conflict, de-escalate crises, monitor for and address high-risk behaviors, maintain stabilization following a crisis episode, and prevent escalation of behavioral health symptoms. Services also include clinical consultation with psychiatric prescribers and urgent psychopharmacology intervention, as needed. Crisis intervention services provided in crisis residences also include group counseling.

Qualifications: A CI Professional or a Credentialed Alcoholism and Substance Abuse Counselor (CASAC) may provide Individual, Family and Group Counseling. A CI Staff member may assist a CI Professional providing Individual, Family and Group Counseling during and after a crisis.

Medication Therapy

Service description: Medication Therapy Services include prescribing and administering medication and monitoring the effects and side effects of the medication on an individual's mental and physical health. Services include the process of determining the medication to be utilized during the course of treatment or reviewing the appropriateness of an existing medication regimen.

Qualifications: Prescribing medications, monitoring the effects of medications, evaluating target symptom response to medications is provided by a Physician, Nurse practitioner, or Physician's assistant. Preparing, administering and monitoring the injection of intramuscular medications is provided by a Physician, Nurse practitioner, Physician's assistant, Registered professional nurse or Licensed practical nurse.

1905(a)(13) Other Diagnostic, Screening, Preventive, and Rehabilitative Services

Item 13d. Rehabilitative Services:
Outpatient and Residential Crisis Intervention Services (continued):

Medication Monitoring

Service description: Medication Monitoring Services include appropriate storage, recordkeeping, monitoring, and supervision associated with the use of medication. Medication Monitoring Services may also include reviewing of the appropriateness of an existing medication regimen with the prescribing clinician.

Qualifications: A CI Professional.

Medication Assisted Treatment (MAT)

Service description: Services include the evidence-based use of FDA approved medications in combination with counseling and behavioral therapies to comprehensively address and ameliorate the symptoms of substance use disorders. Reimbursement for medications to treat Opioid Use Disorder is covered under the MAT for OUD benefit and medications to treat other addiction disorders is covered under the Medicaid pharmacy benefit.

Qualifications: A CI Professional in compliance with state and federal laws regarding the prescribing of FDA approved medications to treat substance use disorders or CI Staff member under the supervision of a CI Professional.

Mild to Moderate Detoxification Services

Service description: Services include a withdrawal and stabilization regimen to reduce the amount of an addictive substance on which a person is physiologically dependent or to provide reasonable control of active withdrawal symptoms including with the use of FDA approved medications to treat substance use disorders.

Qualifications: A CI Professional in compliance with state and federal laws regarding the prescribing of FDA approved medications to treat substance use disorders or CI Staff member under the supervision of a CI Professional.

1905(a)(13) Other Diagnostic, Screening, Preventive, and Rehabilitative Services

Item 13d. Rehabilitative Services:
Outpatient and Residential Crisis Intervention Services (continued):

Care Coordination

Service description: Services include:

- Involvement of an individual's natural support network, including identified family and friends to resolve the individual's crisis;
- Follow up and documentation of follow up with the individual and family/caregiver in the case of a child, after the initial contact or response.
- Referral to and facilitation of engagement in outpatient behavioral services, care coordination, medical, health or basic needs related to the original crisis service and other crisis intervention services, if appropriate;
- Confirmation with Medicaid service providers of connections to care and support to the recipient in the community while he or she is awaiting initiation or resumption of services;
- Contact with the individual's existing primary care and behavioral health treatment providers, other entities responsible for services or housing referrals, or care coordinator of the developed crisis plan;
- Referral and engagement or re-engagement with health homes and appropriate behavioral health community and certified peer services to avoid more restrictive levels of treatment; and
- Follow-up with the individual and the individual's family/support network to confirm enrollment in care coordination, outpatient treatment, or other Medicaid community services has occurred or is scheduled.

Qualifications: CI Professional or CI Staff member under the supervision of a CI Professional.

1905(a)(13) Other Diagnostic, Screening, Preventive, and Rehabilitative Services

Item 13d. Rehabilitative Services:
Outpatient and Residential Crisis Intervention Services (continued):

Peer/Family Peer Support

Service description: Services for adults and children/youth include age-appropriate psychoeducation, counseling, person-centered goal planning, modeling effective coping skills, and facilitating community connections and crisis support to reduce symptomology and restore functionality. Family Peer Support Services also include engagement, bridging support, parent skill development, and crisis support for families caring for a child who is experiencing social, emotional, medical, developmental, substance use or behavioral challenges in their home, school, placement, or community. Services are provided in individual or group settings to promote recovery, self-advocacy, and the development of natural supports and community living skills. Services are directed toward achievement of the specific, individualized, and result-oriented goals contained in an individual's treatment plan developed under the supervision of a competent mental health professional.

Qualifications: Services are provided by certified or provisionally certified Peer Specialists, certified or provisionally certified Recovery Peer Advocates, or credentialed or provisionally credentialled Family Peer Advocates and Youth Peer Advocates under supervision as described in this section.

Psychiatric Crisis Rehabilitation and Skills Training

Service description: Psychiatric Crisis Rehabilitation and Skills Training services are psychosocial rehabilitation and skills training services, including therapeutic communication and interactions to maintain stabilization following a crisis episode and prevent escalation of symptoms, including the proactive involvement of identified family or other collaterals identified by the individual to resolve the crisis. For children, services provide guidance and training in behavior intervention techniques and practice of skills to increase the child's capacity to manage their behavior from everyday life situations to acute emotional stress. Services assist in identifying internal or external stressors and developing coping strategies to address them.

Qualifications: CI Professional or CI Staff member under the supervision of a CI Professional.

1905(a)(13) Other Diagnostic, Screening, Preventive, and Rehabilitative Services

Item 13d. Rehabilitative Services:
Outpatient and Residential Crisis Intervention Services (continued):

Family Psychoeducation and Support

Service description: Family Psychoeducation and Support Services are psychoeducation and skills training services to maintain or facilitate positive relationships with family members and promote skills needed for success in the discharge living environment and to assist families in supporting a child's return to the community, such as implementation of a safety plan, and skills for eliciting positive interactions among family members. Services may involve the facilitation of home visiting and linkages for the family with local community services such as peer support.

Qualifications: CI Professional or CI Staff member under the supervision of a CI Professional.

Co-occurring Disorder Treatment

Service description: A psychosocial rehabilitation service to assist individuals recognize and address alcohol and substance use disorders through education and evidence-based practices such as motivational interviewing, cognitive-behavioral and harm reduction techniques designed to restore functionality and promote recovery for persons with both mental health and substance use disorders. Services also include skills training to identify and manage the symptoms of co-occurring disorders and enable more active participation in social networks and recovery groups.

Qualifications: CI Professional or CI Staff member under the supervision of a CI Professional.

1905(a)(13) Other Diagnostic, Screening, Preventive, and Rehabilitative Services - Rehabilitative Services

42 CFR 440.130(d)

Item 4.b, EPSDT services - **Rehabilitative Services: 42 CFR 440.130(d)**
The State provides coverage for this benefit as defined at 42 CFR 440.130(d) and as described in this section:

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

Rehabilitative Services Description

The rehabilitative service (or services) described below is:
[• Crisis Intervention]
• Community Psychiatric Support and Treatment
• Psychosocial Rehabilitation
• Youth Peer Support
• Family Peer Support

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

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

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

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

Reserved

[Rehabilitative Services: EPSDT only (Continued)

Crisis Intervention (Continued):
Description (Continued):
not additional crisis response services are required to further evaluate, resolve, and/or stabilize the crisis. CI services are designed to interrupt and/or ameliorate the crisis experience and include an assessment that is culturally and linguistically competent and result in immediate crisis resolution and de-escalation, and development of a crisis plan. The goals of CI are engagement, symptom reduction, stabilization, and restoring individuals to a previous level of functioning or developing the coping mechanisms to minimize or prevent the crisis in the future. CI includes developing crisis diversion plans, safety plans or relapse prevention plans, providing support during and after a crisis and connecting an individual with identified supports and linkages to community services. All activities must occur within the context of a potential or actual behavioral health crisis with a desired outcome of resolving and/or stabilizing the crisis episode and diverting an emergency room visit and/or inpatient admission, when appropriate.

CI includes engagement with the child, family/caregiver or other collateral sources (e.g., school personnel) that is culturally and linguistically competent, child centered, and family focused in addition to trauma informed to determine level of safety, risk, and to plan for the next level of services. Family is a birth, foster, adoptive, or self-created unit of people residing together, with significant attachment to the individual, consisting of adult(s) and/or child(ren), with adult(s) performing duties of parenthood/caregiving for the child(ren) even if the individual is living outside of the home. All services including family or collaterals are for the direct benefit of the beneficiary.

The service is recommended by any of the following licensed practitioners of the healing arts operating within the scope of their practice of their State license, who may or may not be part of the crisis intervention team: Physician (MD), including Psychiatrist and Addictionologist/Addiction Specialist; Nurse Practitioner; Registered Nurse; Clinical Nurse Specialist; Physician Assistant; Licensed Psychologist; Licensed Psychoanalyst; Licensed Social Worker (Licensed Masters Social Worker – LMSW or Licensed Clinical Social Worker- LCSW); Licensed Marriage and Family Therapist; and Licensed Mental Health Counselor.

Practitioner qualifications: Crisis Intervention Professionals (CI Professionals) are practitioners possessing a license or authority under State licensure law by the New York State Education Department who are qualified by credentials, training, and experience to provide direct services related to the treatment of mental illness. CI Professionals include one of the following individuals licensed in NYS: Physician (MD), including Psychiatrist and Addictionologist/ Addiction Specialist; Nurse Practitioner; Registered Nurse/; Clinical Nurse Specialist; Physician Assistant; Licensed Psychologist; Licensed Psychoanalyst; Licensed Social Worker (Licensed Masters Social Worker – LMSW or Licensed Clinical Social Worker- LCSW); Licensed Marriage and Family Therapist; Licensed Mental Health Counselor; and Licensed Creative Arts Therapist. Note: A Licensed psychologist is a professional who is currently licensed as a psychologist by the New York State Education Department or possesses a permit from the New York State Education Department and who possesses a doctoral degree in psychology, or an individual who has obtained at least a master's degree in psychology who works in a Federal, State, county or municipally operated clinic. Such master's degree level psychologists may use the title "psychologist," may be considered professional staff, but may not be assigned supervisory responsibility. (14 CRR-NY XIII 599) Any reference to supervision by a CI Professional excludes these Master's level psychologists who may not supervise under this authority.]

Reserved

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

Crisis Intervention Staff (CI Staff) include practitioners who are at least 18 years of age and have a high school diploma, high school equivalency, or State Education Commencement Credential (e.g. Career Development and Occupational Studies Commencement Credential (CDOS) and the Skills and Achievement Commencement Credential (SACC)) with one of the following:

- Two years of work experience in children's mental health, addiction, or foster care,
- A student, intern, or other practitioner with a permit practicing under the supervision of a licensed CI Professional within a DOH approved New York State Education Department program to obtain experience required for licensure,
- A Licensed Practical Nurse,
- Credentialed Alcoholism and Substance Abuse Counselor (CASAC), or
- Qualified Peer Specialist who has 'lived experience' as an individual with emotional, behavioral or co-occurring disorders or as a parent/primary caregiver with a child having emotional, behavioral or co-occurring disorders. The educational requirement can be waived by DOH or its designee if the individual has demonstrated competencies and has relevant life experience sufficient for the peer certification, and credentialed as one of the following:
    - Family Peer Advocate who has completed Level One and Level Two of the Parent Empowerment Program Training or approved comparable training. The practitioner completes the certification's required hours of continuing education annually and renews their credential every two years. An FPA may obtain a provisional credential for no longer than 18 months to complete all requirements of the professional family peer advocate.
    - Certified Recovery Peer Advocate who has completed their content specific training, work-related experience, evidence of supervision, and passed the Peer Advocate Exam or other exam by an OASAS designated certifying body. The practitioner completes the certification's required hours of continuing education annually and renews their credential every two years.
    - Youth Peer Advocate (YPA) who has completed Level One and Level Two of the Youth Peer Support Services Advisory Council recommended and State approved training for YPAs, work-related experience, and provided evidence of supervision. The practitioner completes the certification's required hours of continuing education and renews their credential every two years. An YPA may obtain a provisional credential for no longer than 18 months to complete all requirements of the professional youth peer advocate.
    - A practitioner who has completed the required training and has a current certification from the New York State Peer Specialist Certification Board.

CI staff are eligible to provide crisis intervention services within their scope of practice when under supervision of a CI Professional. CI staff including Qualified Peer Specialists may accompany a CI Professional providing a mobile crisis and may also assist with developing, crisis diversion plans, safety plans or relapse prevention plans, provide support during and after a crisis and assist with connecting an individual with identified supports and linkages to community services.]

Reserved

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

Crisis Intervention Training: All CI Professionals and CI Staff are required to have training on the administration of Naloxone (Narcan) and have training to provide crisis intervention in a manner that is trauma informed and culturally and linguistically competent.

Supervisor Qualifications: The supervisor is a qualified CI Professional and must provide regularly scheduled supervision for CI Professionals and CI Staff including peer specialists. The supervisor must have the qualifications of at least a Licensed Clinical Social Worker (LCSW), Licensed Mental Health Counselor, Licensed Creative Arts Therapist, Licensed Marriage and Family Therapists, Licensed Psychoanalyst, Licensed Psychologist, Physician's Assistant, Psychiatrist, Physician, Registered Professional Nurse (RN), or Nurse Practitioner operating within the scope of their practice, with at least 2- years of work experience. The supervisor must practice within the State health practice laws and ensure that CI Professionals and CI Staff are supervised as required under state law.

Provider Agency Qualifications: CI Professionals and CI Staff must work within a child serving agency or agency with children's behavioral health and health experience that is licensed, certified, designated and/or approved by OMH, OASAS, OCFS or DOH or its designee to provide the crisis services referenced in the definition.

Service Modalities
Crisis Intervention includes two modalities:

- Mobile Crisis is a face-to-face intervention typically comprised of mobile two-person response teams that includes telephonic triage and can occur in a variety of settings including community locations where the beneficiary lives, works, attends school, engages in services (e.g. provider office sites), and/or socializes. The service is available with 24 hours a day, 7 days a week and 365 days a year with capacity to respond immediately or within three hours of determination of need.

  Mobile Crisis is provided by two team members, for programmatic or safety purposes unless otherwise determined through triage. One member of a two-person mobile crisis intervention team must be a CI Professional and have experience with crisis intervention service delivery. If determined through triage that only one team member is needed to respond, an experienced CI Professional must respond to a mental health crisis. Similarly, a Credentialed Alcoholism and Substance Abuse Counselor (CASAC) may respond to a Substance Use Disorder crisis with a licensed practitioner available via phone. A Qualified Peer Specialist or other CI Staff member may not respond alone, except for the CASAC as noted. Mobile Crisis may include any of the following components, which are defined below:

  - Mental Health and Substance use Disorder Assessment by a CI Professional or CASAC,
  - Service Planning by a CI Professional or CI Staff member.
  - Individual and Family Counseling by a CI Professional or CASAC,
  - Care Coordination by a CI Professional or CI Staff member.
  - Peer/Family Support by a Qualified Peer Specialist.]

Reserved

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

Crisis Stabilization/Residential Supports
Short-term Crisis Stabilization/Residential Supports is a voluntary non-hospital, non-IMD sub-acute crisis intervention provided for up to 28 days to stabilize and resolve the crisis episode, with 24-hour supervision.

Short-term Crisis Stabilization/Residential Supports is staffed using CI Professionals and CI Staff to meet the high need of children experiencing a crisis through a multidisciplinary team that focus on crisis stabilization and well-coordinated transitions into services that align with the on-going needs of the individual. Crisis Stabilization/Residential Supports may include any of the following components, which are defined below:

- Mental Health and Substance use Disorder Assessment by a CI Professional or CASAC,
- Service Planning by a CI Professional or CI staff member.
- Individual and Family Counseling by a CI Professional or CASAC,
- Care Coordination by a CI Professional or CI staff member.
- Peer/Family Support by a Qualified Peer Specialist.

Service Components
Mobile crisis and residential supports modalities include the following service components:

Mental Health and Substance Abuse Services Assessment includes: both initial and on-going assessments to determine the need for further evaluation, and to make treatment recommendations and/or referral to other health and/or behavioral health services as clinically indicated. The expectation is that the assessment includes, but may not be limited to:

- Risk of harm to self or others, current mental status, current and recent history of substance use, assessment of intoxication and potential for serious withdrawal;
- History of psychiatric treatment and medical stability;
- Prescribed medications, including medical, psychiatric and medication assisted treatments for substance use
- Presenting problem and review of immediate needs; and
- Identification of supports.

Qualifications: A CI Professional or a Credentialed Alcoholism and Substance Abuse Counselor (CASAC) supervised by a CI Professional with 2 years of work experience.]

Reserved

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

Service Planning includes:
- Developing a crisis diversion plan, safety plan or crisis relapse prevention plan;
- Connecting an individual with identified supports and linkages to community services including referral and linkage to appropriate behavioral health community services as an alternative to more restrictive levels of care,
- Facilitating timely access to services required to address the crisis-related needs of the individual, including mobile crisis, observation, stabilization, withdrawal management, local SUD such as 24/7 open access centers, respite, and/or secure access to higher levels of care, if required such as psychiatric or substance use disorder (SUD) inpatient hospitalization.

Qualifications: A CI Professional or CI Staff member supervised by a qualified CI Professional with 2 years of work experience may perform Service Planning.

Individual and Family Counseling includes:
- Alleviating psychiatric or substance use symptoms, maintaining stabilization following a crisis episode, and preventing escalation of BH symptoms.
- Consulting with psychiatric prescribers and urgent psychopharmacology intervention, as needed.
- Resolving conflict, de-escalating crises and monitoring high-risk behavior.

Qualifications: A CI Professional or a Credentialed Alcoholism and Substance Abuse Counselor (CASAC) may provide Individual and Family Counseling. A CI Staff member may also support a CI Professional providing Individual and Family Counseling during and after a crisis. The team is supervised by a qualified CI Professional with 2 years of work experience.]

Reserved

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

Care Coordination includes:

- Involvement of identified family and friends to resolve the individual's crisis
- Follow up and documentation of follow up with child and family/caregiver within 24 hours of initial contact/response and up to 14 days post contact/response.
- Facilitation of engagement in outpatient BH services, care coordination, medical health or basic needs related to the original crisis service;
- Confirmation with service providers of connections to care and support to the recipient in the community while he or she is awaiting initiation or resumption of services;
- Contact with the individual's existing primary care and BH treatment providers, adult or children's Single Point of Access (SPOA) where applicable, and and/or care coordinator of the developed crisis plan;
- Contact with the individual's natural support network with consent;
- Referral and engagement/re-engagement with health homes and appropriate BH community and certified peer services to avoid more restrictive levels of treatment, and
- Follow-up with the individual and the individual's family/support network to confirm enrollment in care coordination, outpatient treatment, or other community services has occurred or is scheduled.

Qualifications: A CI Professional or CASAC may perform any aspect of Care Coordination. A CI Staff member may assist with connecting an individual with identified supports and linkages to community services under Care Coordination. The team is supervised by a qualified CI Professional with 2 years of work experience.

Peer/Family Peer Supports include**:**

- Crisis resolution with the identified Medicaid eligible child, the child's family/caregiver and the treatment provider including engagement;
- Assistance with developing crisis diversion plans or relapse prevention plans; and
- Assistance with the identification of natural supports and access to community services during and after a crisis.

Qualifications: Qualified Peer Specialist supervised by a qualified CI Professional with 2 years of work experience.]

1905(a)(13) Other Diagnostic, Screening, Preventive, and Rehabilitative Services

Item 13d. Rehabilitative Services:
Outpatient and Residential Crisis Intervention Services

The State provides coverage for this benefit as defined at 42 CFR 440.130(d).

Assurances:

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

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

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

Outpatient and Residential Crisis Intervention Services Description:

Outpatient and Residential Crisis Intervention (CI) Services are provided to individuals who are identified as experiencing an acute psychological or emotional change which results in a marked increase in personal distress and which exceeds the abilities and the resources of the individual and those involved (e.g., collateral, provider, community member) to effectively resolve.

CI services are recommended by any of the following licensed practitioners of the healing arts operating within the scope of their practice of their State license, who may or may not be part of the crisis intervention team: Physician (MD), including Psychiatrist and Addictionologist/Addiction Specialist; Nurse Practitioner; Registered Nurse; Physician Assistant; Licensed Psychologist; Licensed Psychoanalyst; Licensed Social Worker (Licensed Masters Social Worker – LMSW or Licensed Clinical Social Worker — LCSW); Licensed Marriage and Family Therapist; Licensed Creative Arts Therapists; Licensed Mental Health Counselor; and Licensed Occupational Therapist.

1905(a)(13) Other Diagnostic, Screening, Preventive, and Rehabilitative Services

Item 13d. Rehabilitative Services:
Outpatient and Residential Crisis Intervention Services (continued):

CI services are designed to interrupt and ameliorate the crisis experience and include an assessment that is culturally and linguistically competent and result in timely crisis resolution and de-escalation, and development of a crisis plan. The goals of CI services are engagement in services, symptom reduction, stabilization, restoring individuals to a previous level of functioning, and developing the coping mechanisms to minimize or prevent the crisis in the future. CI services are provided in multiple modalities as described herein, and include developing crisis diversion plans, safety plans or relapse prevention plans, providing support during and after a crisis and connecting an individual with identified supports and linkages to community services. All activities must occur within the context of a potential or actual behavioral health crisis with a desired outcome of resolving or stabilizing the crisis episode and diverting an emergency room visit or inpatient admission, if appropriate.

CI services include engagement with the individual adult or child/youth or other identified collateral supports (e.g., family, friends, or activated community resources) that is culturally and linguistically competent, person-centered, and trauma-informed to determine level of safety, risk, and to plan for the next level of services. For children and youth, CI services include family-focused engagement, where "family" may include a birth, foster, adoptive, or self-created unit of people residing together, with significant attachment to the individual, consisting of adult(s) and/or child(ren), with adult(s) performing duties of parenthood/caregiving for the child(ren) even if the individual is living outside of the home. All services including family or other collaterals are for the direct benefit of the beneficiary.

Practitioner qualifications:

Crisis Intervention Professionals (CI Professionals) are practitioners possessing a license or authority under State licensure law by the New York State Education Department who are qualified by credentials, training, and experience to provide direct services related to the treatment of behavioral health conditions. CI Professionals include the following individuals licensed or permitted in NYS: Physician, including Psychiatrist and Addictionologist/Addiction Specialist; Nurse Practitioner; Registered Nurse; Physician Assistant; Licensed Psychologist; Licensed Psychoanalyst; Licensed Social Worker (Licensed Masters Social Worker – LMSW or Licensed Clinical Social Worker — LCSW); Licensed Marriage and Family Therapist; Licensed Mental Health Counselor; Licensed Creative Arts Therapist, Licensed Behavioral Analyst, and Occupational Therapist who meet the qualifications set forth in 42 C.F.R. 440.110(b)(2).

For individuals age 21 and over, CI Professionals also include Certified Psychiatric Rehabilitation Practitioners certified by the Psychiatric Rehabilitation Association, Certified Rehabilitation Counselors certified by the Commission on Rehabilitation Counselor Certification, Therapeutic Recreation Therapists certified by the National Council on Therapeutic Recreation or the American Therapeutic Recreation Association, and Counselors certified by and currently registered with the National Board for Certified Counselors.

1905(a)(13) Other Diagnostic, Screening, Preventive, and Rehabilitative Services

Item 13d. Rehabilitative Services:
Outpatient and Residential Crisis Intervention Services (continued):

Note: A Licensed psychologist is a professional who is currently licensed as a psychologist by the New York State Education Department or possesses a permit from the New York State Education Department and who possesses a doctoral degree in psychology, or an individual who has obtained at least a master's degree in psychology who works in a Federal, State, county or municipally operated program or services. Such master's degree-level psychologists may use the title "psychologist," and may be considered professional staff, but may not be assigned supervisory responsibility. Any reference to supervision by a CI Professional excludes these Master's level psychologists who may not supervise CI services.

Crisis Intervention Staff (CI Staff) include practitioners who are at least 18 years of age and have a bachelor's degree, which may be substituted for a high school diploma, high school equivalency, or State Education Commencement Credential. Individuals without a Bachelor's degree must also meet one or more of the following qualifications:

- For CI services for adults, possess 1-3 years of experience working with individuals with serious mental illness or substance use disorders; or for CI services for children/youth, two years of work experience in children's mental health, addiction, or foster care;
- A student or intern within a DOH-approved New York State Education Department program;
- Licensed Practical Nurse;
- Credentialed Alcoholism and Substance Abuse Counselor (CASAC); or
- Individuals with lived-experience as an individual with emotional, behavioral, addiction, or co-occurring disorders or as a parent/primary caregiver of a child with emotional, behavioral, addiction, or co-occurring disorders and who are not qualified peers. DOH or its designee may also waive the education requirement for these individuals to provide services as CI Staff.

CI Services are also provided by qualified peers who are individuals with lived experience as an individual with emotional, behavioral, addiction, or co-occurring disorders or as a parent/primary caregiver of a child with emotional, behavioral, addiction, or co-occurring disorders and who are certified or credentialled as follows:

- Credentialed or Provisionally Credentialed Family Peer Advocate (FPA) who has completed Level One and Level Two of the Parent Empowerment Program Training or approved comparable training. Credentialed FPAs complete the certification's required hours of continuing education annually and renew their credential every two years. A FPA may obtain a provisional credential for no longer than 18 months to complete all requirements of the full credential.

1905(a)(13) Other Diagnostic, Screening, Preventive, and Rehabilitative Services

Item 13d. Rehabilitative Services:
Outpatient and Residential Crisis Intervention Services (continued):

- Certified or Provisionally Certified Recovery Peer Advocate (CRPA) who has completed their content specific training, work-related experience, evidence of supervision, and passed the Peer Advocate Exam or other exam by an OASAS designated certifying body. The practitioner completes the certification's required hours of continuing education annually and renews their credential every two years.
- Credentialed or Provisionally Credentialed Youth Peer Advocate (YPA) who has completed Level One and Level Two of the Youth Peer Support Services State approved training for YPAs, work-related experience, and provided evidence of supervision. Credentialed YPAs complete the certification's required hours of continuing education and renew their credential every two years. A YPA may obtain a provisional credential for no longer than 18 months to complete all requirements of the full credential.
- Certified Peer Specialist who has completed the required training and has a current or provisional certification as a Peer Specialist from the New York State Peer Specialist Certification Board.

CI staff are eligible to provide CI services within their applicable scope of practice and under supervision of a CI Professional as provided herein. Only CI professionals and CASACs may conduct assessments. Qualified peers provide peer and family peer support services under the supervision of competent mental health professionals as provided herein.

Supervisor Qualifications: The supervisor is a qualified CI Professional, including a Licensed Clinical Social Worker (LCSW), Licensed Mental Health Counselor, Licensed Creative Arts Therapist, Licensed Marriage and Family Therapist, Licensed Psychoanalyst, Licensed Psychologist, Physician's Assistant, Physician, Registered Professional Nurse, or Nurse Practitioner operating within the scope of their practice. For purposes of peer and family peer support services, competent mental health professionals include CI professionals, CASACs, other CI Staff with a master's degree in a human services field, and qualified peers with at least three years of direct experience providing peer or family peer services. Experienced FPAs may supervise YPAs upon completion of State approved Youth Peer Support training. Supervisors shall provide regularly scheduled supervision for CI Staff and qualified peers.

Provider Agency Qualifications: For Mobile CI services for children/youth, CI Professionals and Staff must work within a child-serving agency or agency with children's behavioral health and health experience that is licensed, certified, designated, and/or approved by OMH, OASAS, OCFS, or DOH or its designee to provide the crisis services referenced in the definition. For Mobile CI services for adults, CI professional and Staff must work in an agency licensed, certified, designated, or approved by OMH or OASAS. For Crisis Stabilization CI Services for adults and children/youth, CI Professionals and Staff shall work within OMH and OASAS programs licensed pursuant to Article 36 of the Mental Hygiene Law. For Residential CI Services for adults and children/youth, CI Professionals and Staff shall work within crisis residential programs licensed or certified by OMH or OASAS.

1905(a)(13) Other Diagnostic, Screening, Preventive, and Rehabilitative Services

Item 13d. Rehabilitative Services:
Outpatient and Residential Crisis Intervention Services (continued):

Crisis Intervention Training: All CI Professionals, CI Staff, and qualified peers are required to have training on the administration of opioid antagonists and trauma-informed care, de-escalation strategies, harm reduction, and culturally and linguistically competent service provision.

CI Service Modalities
Crisis Intervention includes five modalities: Mobile Crisis, Crisis Stabilization, Children's Crisis Residence, Residential Crisis Support for adults, and Intensive Residential Crisis for adults.

1. Mobile Crisis Intervention is provided by a multidisciplinary team of CI Professionals, CI Staff, and qualified peers that includes telephonic triage and mobile or telephonic follow-up and can occur in a variety of settings including community locations where the beneficiary lives, works, attends school, engages in services, or socializes. Mobile Crisis Intervention is available 24 hours a day, 7 days a week, and 365 days a year with capacity to respond immediately or within three hours of determination of need. Mobile Crisis Services may be provided by telehealth consistent with state guidance.

   Mobile Crisis Intervention services are typically provided by response teams comprised of two team members, unless otherwise determined through triage. One member of a two-person response team must be a CI Professional. If determined through triage that only one team member is needed to respond, either a CI Professional or a CI staff member with a Master's degree may respond alone with a licensed practitioner available via telehealth and a CASAC may respond alone to an individual experiencing a substance use disorder crisis with a licensed practitioner available via telehealth. After an initial Mobile Crisis Intervention service is provided, CI Staff with a Bachelor's degree can respond alone in a follow-up visit to provide service planning, safety planning, and care coordination services, and qualified peers may respond alone to provide peer/family support services. CI staff and qualified peers may also accompany a CI Professional or other qualified CI Staff to assist with de-escalation or other service components.

   Crisis Intervention Services components provided in this modality include the following, as further defined below:

   - Mental Health and Substance Use Assessments
   - Service Planning
   - Crisis/Safety Planning
   - Individual and Family Counseling
   - Care Coordination; and
   - Peer/Family Peer Support

1905(a)(13) Other Diagnostic, Screening, Preventive, and Rehabilitative Services

Item 13d. Rehabilitative Services:
Outpatient and Residential Crisis Intervention Services (continued):

2. Crisis Stabilization provides urgently needed immediate evaluation, treatment, and support services, including coordination with other mental health and substance use services, for children and adults experiencing or at risk of a mental health or substance use disorder crisis. CI Services are provided on-site by Crisis Stabilization Centers licensed by the New York State Offices of Mental Health and Addiction Services and Supports pursuant to Article 36 of the New York State Mental Hygiene Law that employ or contract with qualified CI Professionals, CI Staff and qualified peers.

   Crisis Intervention Services components provided in this modality include the following, as further defined below:

   - Mental Health and Substance Use Assessments
   - Service Planning
   - Crisis/Safety Planning
   - Individual and Family Counseling
   - Care Coordination
   - Peer/Family Peer Support
   - Medication Therapy
   - Medication Management and Training
   - Medication Assisted Treatment (MAT); and
   - Mild to Moderate Detoxification Services

1905(a)(13) Other Diagnostic, Screening, Preventive, and Rehabilitative Services

Item 13d. Rehabilitative Services:
Outpatient and Residential Crisis Intervention Services (continued):

3. Children's Crisis Residence is a short-term, voluntary, non-IMD, sub-acute crisis intervention modality for children under age 21 to stabilize a child's psychiatric or other behavioral health crisis symptoms and restore the child to a level of functioning and stability that supports their transition back to the community and to prevent or reduce future crises. Children's Crisis Residences provide 24-hour monitoring and supervision, as well as treatment and support services in Crisis Residential facilities licensed by the New York State Office of Mental Health or certified by the NYS Office of Addiction Services and Supports that employ qualified CI Professionals and CI Staff.
   Crisis Intervention Services components provided in this modality include the following, as further defined below:

   - Mental Health and Substance Use Assessment
   - Service Planning
   - Crisis/Safety Planning
   - Individual, Family, Group Counseling
   - Care Coordination
   - Health Screening
   - Medication Monitoring
   - Medication Management and Training
   - Psychiatric Crisis Rehabilitation and Skills Training
   - Family Psychoeducation and Support
   - Medication Assisted Treatment; and
   - Mild to Moderate Detoxification Services

1905(a)(13) Other Diagnostic, Screening, Preventive, and Rehabilitative Services

Item 13d. Rehabilitative Services:
Outpatient and Residential Crisis Intervention Services (continued):

4. Intensive Residential Crisis is a short-term, voluntary, non-IMD, sub-acute crisis intervention modality for individuals aged 21 and over who are experiencing an acute escalation of behavioral health symptoms or who are at imminent risk for loss of functional abilities and may raise safety concerns for themselves and others without intensive residential services. CI Services provided in this modality provide 24-hour monitoring and supervision and intensive treatment and support services to stabilize and address an individual's psychiatric symptoms in Crisis Residential facilities licensed by the New York State Office of Mental Health or certified by the NYS Office of Addiction Services and Supports that employ or contract with qualified CI Professionals, CI Staff and qualified peers.

   Crisis Intervention Services components provided in this modality include the following, as further defined below:

   - Mental Health and Substance Use Assessments
   - Service Planning
   - Crisis/Safety Planning
   - Individual, Family, and Group Counseling
   - Care Coordination
   - Peer Support
   - Medication Therapy
   - Medication Monitoring
   - Medication Management and Training
   - Psychiatric Crisis Rehabilitation and Skills Training
   - Co-occurring Disorder Treatment
   - Medication Assisted Treatment; and
   - Mild to Moderate Detoxification Services

1905(a)(13) Other Diagnostic, Screening, Preventive, and Rehabilitative Services

**Item 13d. Rehabilitative Services:
Outpatient and Residential Crisis Intervention Services (continued):**

5. Residential Crisis Support is a short-term, voluntary, non-IMD, sub-acute crisis intervention modality for individuals aged 21 and older to stabilize crisis symptoms, address the cause of the crisis, and avert or delay the need for acute psychiatric inpatient hospitalization or emergency services. Residential Crisis Support is appropriate for individuals who are experiencing challenges in daily life that create risk for an escalation of psychiatric symptoms or a period of acute stress significantly impairing their ability to cope with normal life circumstances. CI Services provided in this modality provide respite, 24-hour supervision, and treatment and support services in Crisis Residential facilities licensed by the New York State Office of Mental Health or certified by the NYS Office of Addiction Services and Supports that employ or contract with qualified CI Professionals, CI Staff and qualified peers.

   Crisis Intervention Services Components provided in this modality include the following, as further defined below:

   - Mental Health and Substance Use Assessments
   - Service Planning
   - Crisis/Safety Planning
   - Care Coordination
   - Peer Support
   - Medication Monitoring
   - Medication Management and Training
   - Psychiatric Crisis Rehabilitation and Skills Training
   - Medication Assisted Treatment; and
   - Mild to Moderate Detoxification Services

1905(a)(13) Other Diagnostic, Screening, Preventive, and Rehabilitative Services

Item 13d. Rehabilitative Services:
Outpatient and Residential Crisis Intervention Services (continued):

Service Components
Crisis intervention Services provided in the modalities described above include the following:

Mental Health and Substance Use Assessments

Service Description: Assessment services, including initial and on-going assessments to determine the need for further evaluation and to make treatment recommendations and referral to other health or behavioral health services as clinically indicated. Assessments may include:

- Risk of harm to self or others, current mental status, current and recent history of substance use, assessment of intoxication and potential for serious withdrawal;
- History of psychiatric and medical treatment;
- Prescribed medications, including medical, psychiatric and medication for substance use disorders;
- Presenting problem and review of immediate needs; and
- Identification of supports.

Qualifications: A CI Professional or a Credentialed Alcoholism and Substance Abuse Counselor (CASAC) supervised by a CI Professional.

Service Planning

Service Description: With the active involvement of the individual where developmentally appropriate or an individual's family members or other collaterals as necessary for the benefit of the beneficiary, services include:

- Developing, reviewing and modifying a care plan to address the mental health and substance use disorder treatment and support needs of the individual;
- Connecting an individual with identified supports and linkages to community services including referral and linkage to appropriate behavioral health community services as an alternative to more restrictive levels of care; and
- Facilitating timely access to services required to address the crisis-related needs of the individual, including mobile crisis, observation, stabilization, withdrawal management, local SUD services such as open access centers and centers of opioid treatment innovation (COTI), respite, and/or secure access to higher levels of care, if required such as psychiatric or substance use disorder inpatient hospitalization.

Qualifications: A CI Professional or CI Staff member supervised by a CI Professional.

1905(a)(13) Other Diagnostic, Screening, Preventive, and Rehabilitative Services

Item 13d. Rehabilitative Services:
Outpatient and Residential Crisis Intervention Services (continued):

Crisis/Safety Planning

Services description: A service planning and rehabilitative skills training service to assist individuals to effectively avoid or respond to mental health and substance use crises by identifying triggers that risk their remaining in the community or that result in functional impairments. Services assist the individual or family members, or other collaterals as necessary for the benefit of the beneficiary, with identifying a potential psychiatric or personal crisis, developing a crisis management, safety or wellness plan to assist individuals to prevent relapse, identify early warning signs of decompensation, and cope or seek supports to restore stability and functioning.

Qualifications: A CI Professional or CI Staff member supervised by a CI Professional.

Individual, Family, and Group Counseling

Services description: Services include psychotherapy and psychosocial rehabilitation counseling services to remediate psychiatric or substance use symptoms, resolve conflict, de-escalate crises, monitor for and address high-risk behaviors, maintain stabilization following a crisis episode, and prevent escalation of behavioral health symptoms. Services also include clinical consultation with psychiatric prescribers and urgent psychopharmacology intervention, as needed. Crisis intervention services provided in crisis residences also include group counseling.

Qualifications: A CI Professional or a Credentialed Alcoholism and Substance Abuse Counselor (CASAC) may provide Individual, Family and Group Counseling. A CI Staff member may assist a CI Professional providing Individual, Family and Group Counseling during and after a crisis.

Medication Therapy

Service description: Medication Therapy Services include prescribing and administering medication and monitoring the effects and side effects of the medication on an individual's mental and physical health. Services include the process of determining the medication to be utilized during the course of treatment or reviewing the appropriateness of an existing medication regimen.

Qualifications: Prescribing medications, monitoring the effects of medications, evaluating target symptom response to medications is provided by a Physician, Nurse practitioner, or Physician's assistant. Preparing, administering and monitoring the injection of intramuscular medications is provided by a Physician, Nurse practitioner, Physician's assistant, Registered professional nurse or Licensed practical nurse.

1905(a)(13) Other Diagnostic, Screening, Preventive, and Rehabilitative Services

Item 13d. Rehabilitative Services:
Outpatient and Residential Crisis Intervention Services (continued):

Medication Monitoring

Service description: Medication Monitoring Services include appropriate storage, recordkeeping, monitoring, and supervision associated with the use of medication. Medication Monitoring Services may also include reviewing of the appropriateness of an existing medication regimen with the prescribing clinician.

Qualifications: A CI Professional.

Medication Assisted Treatment (MAT)

Service description: Services include the evidence-based use of FDA approved medications in combination with counseling and behavioral therapies to comprehensively address and ameliorate the symptoms of substance use disorders. Reimbursement for medications to treat Opioid Use Disorder is covered under the MAT for OUD benefit and medications to treat other addiction disorders is covered under the Medicaid pharmacy benefit.

Qualifications: A CI Professional in compliance with state and federal laws regarding the prescribing of FDA approved medications to treat substance use disorders or CI Staff member under the supervision of a CI Professional.

Mild to Moderate Detoxification Services

Service description: Services include a withdrawal and stabilization regimen to reduce the amount of an addictive substance on which a person is physiologically dependent or to provide reasonable control of active withdrawal symptoms including with the use of FDA approved medications to treat substance use disorders.

Qualifications: A CI Professional in compliance with state and federal laws regarding the prescribing of FDA approved medications to treat substance use disorders or CI Staff member under the supervision of a CI Professional.

1905(a)(13) Other Diagnostic, Screening, Preventive, and Rehabilitative Services

Item 13d. Rehabilitative Services:
Outpatient and Residential Crisis Intervention Services (continued):

Care Coordination

Service description: Services include:

- Involvement of an individual's natural support network, including identified family and friends to resolve the individual's crisis;
- Follow up and documentation of follow up with the individual and family/caregiver in the case of a child, after the initial contact or response.
- Referral to and facilitation of engagement in outpatient behavioral services, care coordination, medical, health or basic needs related to the original crisis service and other crisis intervention services, if appropriate;
- Confirmation with Medicaid service providers of connections to care and support to the recipient in the community while he or she is awaiting initiation or resumption of services;
- Contact with the individual's existing primary care and behavioral health treatment providers, other entities responsible for services or housing referrals, or care coordinator of the developed crisis plan;
- Referral and engagement or re-engagement with health homes and appropriate behavioral health community and certified peer services to avoid more restrictive levels of treatment; and
- Follow-up with the individual and the individual's family/support network to confirm enrollment in care coordination, outpatient treatment, or other Medicaid community services has occurred or is scheduled.

Qualifications: CI Professional or CI Staff member under the supervision of a CI Professional.

1905(a)(13) Other Diagnostic, Screening, Preventive, and Rehabilitative Services

Item 13d. Rehabilitative Services:
Outpatient and Residential Crisis Intervention Services (continued):

Peer/Family Peer Support

Service description: Services for adults and children/youth include age-appropriate psychoeducation, counseling, person-centered goal planning, modeling effective coping skills, and facilitating community connections and crisis support to reduce symptomology and restore functionality. Family Peer Support Services also include engagement, bridging support, parent skill development, and crisis support for families caring for a child who is experiencing social, emotional, medical, developmental, substance use or behavioral challenges in their home, school, placement, or community. Services are provided in individual or group settings to promote recovery, self-advocacy, and the development of natural supports and community living skills. Services are directed toward achievement of the specific, individualized, and result-oriented goals contained in an individual's treatment plan developed under the supervision of a competent mental health professional.

Qualifications: Services are provided by certified or provisionally certified Peer Specialists, certified or provisionally certified Recovery Peer Advocates, or credentialed or provisionally credentialled Family Peer Advocates and Youth Peer Advocates under supervision as described in this section.

Psychiatric Crisis Rehabilitation and Skills Training

Service description: Psychiatric Crisis Rehabilitation and Skills Training services are psychosocial rehabilitation and skills training services, including therapeutic communication and interactions to maintain stabilization following a crisis episode and prevent escalation of symptoms, including the proactive involvement of identified family or other collaterals identified by the individual to resolve the crisis. For children, services provide guidance and training in behavior intervention techniques and practice of skills to increase the child's capacity to manage their behavior from everyday life situations to acute emotional stress. Services assist in identifying internal or external stressors and developing coping strategies to address them.

Qualifications: CI Professional or CI Staff member under the supervision of a CI Professional.

1905(a)(13) Other Diagnostic, Screening, Preventive, and Rehabilitative Services

Item 13d. Rehabilitative Services:
Outpatient and Residential Crisis Intervention Services (continued):

Family Psychoeducation and Support

Service description: Family Psychoeducation and Support Services are psychoeducation and skills training services to maintain or facilitate positive relationships with family members and promote skills needed for success in the discharge living environment and to assist families in supporting a child's return to the community, such as implementation of a safety plan, and skills for eliciting positive interactions among family members. Services may involve the facilitation of home visiting and linkages for the family with local community services such as peer support.

Qualifications: CI Professional or CI Staff member under the supervision of a CI Professional.

Co-occurring Disorder Treatment

Service description: A psychosocial rehabilitation service to assist individuals recognize and address alcohol and substance use disorders through education and evidence-based practices such as motivational interviewing, cognitive-behavioral and harm reduction techniques designed to restore functionality and promote recovery for persons with both mental health and substance use disorders. Services also include skills training to identify and manage the symptoms of co-occurring disorders and enable more active participation in social networks and recovery groups.

Qualifications: CI Professional or CI Staff member under the supervision of a CI Professional.

1905(a)(13) Other Diagnostic, Screening, Preventive, and Rehabilitative Services

13d. Rehabilitative Services:

Outpatient and Residential Crisis Intervention Services
42 CFR 440.130(d)
1905(a)(13)

Reimbursement for Outpatient and Residential Crisis Intervention Services as outlined in item 13.d per Attachment 3.1-A are paid based upon Medicaid rates established by the State of New York.

Except as otherwise noted in the State Plan, the State-developed rates are the same for both governmental and private providers. Provider agency rates were set as of April 1, 2022, for Outpatient and Residential Crisis Intervention Services and are effective for these services provided on or after that date. All rates are published on the Office of Mental Health website:

Mobile Crisis Intervention Services:

https://www.omh.ny.gov/omhweb/medicaid_reimbursement/excel/crisis_mobile_telephonic.xlsx

Crisis Residential Services:

https://www.omh.ny.gov/omhweb/medicaid_reimbursement/excel/crisis_residential.xlsx

Crisis Stabilization Services:

https://www.omh.ny.gov/omhweb/medicaid_reimbursement/excel/crisis_stabilization.xlsx

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

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

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

Appendix II
2022 Title XIX State Plan
Second Quarter Amendment
Summary

SUMMARY
SPA #22-0026

This State Plan Amendment proposes to expand access to crisis intervention services previously available to children and populations under the 1115 waiver only under the State Plan. This State Plan Amendment also authorizes crisis intervention services provided in crisis stabilization centers to both adults and children under the State Plan.

Appendix III
2022 Title XIX State Plan
Second Quarter Amendment
Authorizing Provisions

SPA 22-0026

American Rescue Plan Act of 2021 §9813

STATE OPTION TO PROVIDE QUALIFYING COMMUNITY-BASED MOBILE CRISIS INTERVENTION SERVICES.

Title XIX of the Social Security Act is amended by adding after section 1946 (42 U.S.C. 1396w–5) the following new section:

<< 42 USCA § 1396w–6 >>

“SEC. 1947. STATE OPTION TO PROVIDE QUALIFYING COMMUNITY-BASED MOBILE CRISIS INTERVENTION SERVICES.

“(a) IN GENERAL.—Notwithstanding section 1902(a)(1) (relating to Statewideness), section 1902(a)(10)(B) (relating to comparability), section 1902(a)(23)(A) (relating to freedom of choice of providers), or section 1902(a)(27) (relating to provider agreements), a State may, during the 5-year period beginning on the first day of the first fiscal year quarter that begins on or after the date that is 1 year after the date of the enactment of this section, provide medical assistance for qualifying community-based mobile crisis intervention services.

“(b) QUALIFYING COMMUNITY-BASED MOBILE CRISIS INTERVENTION SERVICES DEFINED.—For purposes of this section, the term ‘qualifying community-based mobile crisis intervention services’ means, with respect to a State, items and services for which medical assistance is available under the State plan under this title or a waiver of such plan, that are—

“(1) furnished to an individual otherwise eligible for medical assistance under the State plan (or waiver of such plan) who is—

“(A) outside of a hospital or other facility setting; and
“(B) experiencing a mental health or substance use disorder crisis;

“(2) furnished by a multidisciplinary mobile crisis team—

“(A) that includes at least 1 behavioral health care professional who is capable of conducting an assessment of the individual, in accordance with the professional's permitted scope of practice under State law, and other professionals or paraprofessionals with appropriate expertise in behavioral health or mental health crisis response, including nurses, social workers, peer support specialists, and others, as designated by the State through a State plan amendment (or waiver of such plan);

“(B) whose members are trained in trauma-informed care, de-escalation strategies, and harm reduction;

“(C) that is able to respond in a timely manner and, where appropriate, provide—

“(i) screening and assessment;
“(ii) stabilization and de-escalation; and
“(iii) coordination with, and referrals to, health, social, and other services and supports as needed, and health services as needed;

“(D) that maintains relationships with relevant community partners, including medical and behavioral health providers, primary care providers, community health centers, crisis respite centers, and managed care organizations (if applicable); and

“(E) that maintains the privacy and confidentiality of patient information consistent with Federal and State requirements; and

“(3) available 24 hours per day, every day of the year.

“(c) PAYMENTS.—Notwithstanding section 1905(b) or 1905(ff) and subject to subsections (y) and (z) of section 1905, during each of the first 12 fiscal quarters occurring during the period described in subsection (a) that a State meets the requirements described in subsection (d), the Federal medical assistance percentage applicable to amounts expended by the State for medical assistance for qualifying community-based mobile crisis intervention services furnished during such quarter shall be equal to 85 percent. In no case shall the application of the previous sentence result in the Federal medical assistance percentage applicable to amounts expended by a State for medical assistance for such qualifying community-based mobile crisis intervention services furnished during a quarter being less than the Federal medical assistance percentage that would apply to such amounts expended by the State for such services furnished during such quarter without application of the previous sentence.

“(d) REQUIREMENTS.—The requirements described in this subsection are the following:

“(1) The State demonstrates, to the satisfaction of the Secretary that it will be able to support the provision of qualifying community-based mobile crisis intervention services that meet the conditions specified in subsection (b).

“(2) The State provides assurances satisfactory to the Secretary that—

“(A) any additional Federal funds received by the State for qualifying community-based mobile crisis intervention services provided under this section that are attributable to the increased Federal medical assistance percentage under subection (c) will be used to supplement, and not supplant, the level of State funds expended for such services for the fiscal year preceding the first fiscal quarter occurring during the period described in subsection (a);

“(B) if the State made qualifying community-based mobile crisis intervention services available in a region of the State in such fiscal year, the State will continue to make such services available in such region under this section during each month occurring during the period described in subsection (a) for which the Federal medical assistance percentage under subsection (c) is applicable with respect to the State.

“(e) FUNDING FOR STATE PLANNING GRANTS.—There is appropriated, out of any funds in the Treasury not otherwise appropriated, $15,000,000 to the Secretary for purposes of implementing, administering, and making planning grants to States as soon as practicable for purposes of developing a State plan amendment or section 1115, 1915(b), or 1915(c) waiver request (or an amendment to such a waiver) to provide qualifying community-based mobile crisis intervention services under this section, to remain available until expended.”.

New York State Mental Hygiene Laws §7.15

(a) The commissioner shall plan, promote, establish, develop, coordinate, evaluate, and conduct programs and services of prevention, diagnosis, examination, care, treatment, rehabilitation, training, and research for the benefit of the mentally ill. Such programs shall include but not be limited to in-patient, out-patient, partial hospitalization, day care, emergency, rehabilitative, and other appropriate treatments and services. He or she shall take all actions that are necessary, desirable, or proper to implement the purposes of this chapter and to carry out the purposes and objectives of the department within the amounts made available therefor by appropriation, grant, gift, devise, bequest, or allocation from the mental health services fund established under section ninety-seven-f of the state finance law.

(b) The activities described in subdivision (a) of this section may be undertaken in cooperation and agreement with other offices of the department and with other departments or agencies of the state, local or federal government, or with other organizations and individuals.

New York State Mental Hygiene Laws §36.01

(a)(1) The commissioners are authorized to jointly license crisis stabilization centers subject to the availability of state and federal funding.

(2) A crisis stabilization center shall serve as a voluntary and urgent service provider for persons at risk of a mental health or substance abuse crisis or who are experiencing a crisis related to a psychiatric and/or substance use disorder that are in need of crisis stabilization services. Each crisis stabilization center shall provide or contract to provide person centered and patient driven crisis stabilization services for mental health or substance use twenty-four hours per day, seven days per week, including but not limited to:

(i) Engagement, triage and assessment;
(ii) Continuous observation;
(iii) Mild to moderate detoxification;
(iv) Sobering services;
(v) Therapeutic interventions;

(vi) Discharge and after care planning;
(vii) Telemedicine;
(viii) Peer support services; and
(ix) Medication assisted treatment.

(3) The commissioners shall require each crisis stabilization center to submit a plan. The plan shall be approved by the commissioners prior to the issuance of a license pursuant to this article. Each plan shall include:

(i) a description of the center's catchment area,
(ii) a description of the center's crisis stabilization services,
(iii) agreements or affiliations with hospitals as defined in section 1.03 of this chapter,
(iv) agreements or affiliations with general hospitals or law enforcement to receive persons,
(v) a description of local resources available to the center to prevent unnecessary hospitalizations of persons,
(vi) a description of the center's linkages with local police agencies, emergency medical services, ambulance services and other transportation agencies,
(vii) a description of local resources available to the center to provide appropriate community mental health and substance use disorder services upon release,
(viii) written criteria and guidelines for the development of appropriate planning for persons in need of post community treatment or services,
(ix) a statement indicating that the center has been included in an approved local services plan developed pursuant to article forty-one of this chapter for each local government located within the center's catchment area; and
(x) any other information or agreements required by the commissioners.

(4) Crisis stabilization centers shall participate in county and community planning activities annually, and as additionally needed, in order to participate in local community service planning processes to ensure, maintain, improve or develop community services that demonstrate recovery outcomes. These outcomes include, but are not limited to, quality of life, socio-economic status, entitlement status, social networking, coping skills and reduction in use of crisis services.

(b) Each crisis stabilization center shall be staffed with a multidisciplinary team capable of meeting the needs of individuals experiencing all levels of crisis in the community, which shall include, but not be limited to, at least one psychiatrist or psychiatric nurse practitioner, a credentialed alcoholism and substance abuse counselor and one peer support specialist on duty and available at all times.

(c) The commissioners shall promulgate regulations necessary to the operation of such crisis stabilization centers.

(d) Where a crisis stabilization center has been established prior to the effective date of this article, the previously established center may be issued a license where the provider can demonstrate substantial compliance with minimum crisis service standards necessary for patient safety and program efficacy.

(e) For the purpose of addressing unique rural service delivery needs and conditions, the commissioners shall provide technical assistance for the establishment of crisis stabilization centers otherwise approved under the provisions of this section, including technical assistance to promote and facilitate the establishment of such centers in rural areas in the state or combinations of rural counties.

(f) The commissioners shall develop guidelines for educational materials to assist crisis stabilization centers in educating local practitioners, community mental health and substance abuse programs, hospitals, law enforcement and peers. Such materials shall include appropriate education relating to de-escalation techniques, cultural competency, the recovery process, mental health, substance use, and avoidance of aggressive confrontation.

(g) Within the amounts appropriated, the commissioners shall arrange for appropriate training to law enforcement entities, first responders, and any other entities deemed appropriate by the commissioners, located within the catchment area of a crisis stabilization center. The training may include but not be limited to:

(1) crisis intervention team training;
(2) mental health first aid;
(3) implicit bias training; and
(4) naloxone training.

Such training may be provided in an electronic format or other format as deemed appropriate by the commissioners. The commissioners may contract with an organization with the knowledge and expertise in providing the training required under this subdivision.

New York State Mental Hygiene Laws §31.36

The commissioner shall be authorized, in conjunction with the commissioner of the office of addiction services and supports, to create crisis stabilization centers within New York state in accordance with article thirty-six of this title, including the promulgation of joint regulations and implementation of a financing mechanism to allow for the sustainable operation of such programs.

New York State Mental Hygiene Laws §43.01

(a) The department shall charge fees for its services to patients and residents, provided, however, that no person shall be denied services because of inability or failure to pay a fee.

(b) The commissioner may establish, at least annually, schedules of rates for inpatient services that reflect the costs of services, care, treatment, maintenance, overhead, and administration which assure maximum recovery of such costs.

In addition, the commissioner may establish, at least annually, schedules of fees for noninpatient services which need not reflect the costs of services, care, treatment, maintenance, overhead, and administration.

(c) The executive budget, as recommended, shall reflect, by individual facility, the costs of

services, care, treatment, maintenance, overhead, and administration.

(d) All schedules of fees and rates which are established by the commissioner, shall be subject to the approval of the director of the division of the budget. Immediately upon their approval, copies of all schedules of fees and rates established pursuant to this section shall be forwarded to the chairman of the assembly ways and means committee and the chairman of the senate finance committee.

New York State Mental Hygiene Laws §43.02

(a) Notwithstanding any inconsistent provision of law, payment made by government agencies pursuant to title eleven of article five of the social services law for services provided by any facility licensed by the office of mental health pursuant to article thirty-one of this chapter or certified by the office of alcoholism and substance abuse services pursuant to this chapter to provide inpatient chemical dependence services, as defined in section 1.03 of this chapter, shall be at rates or fees certified by the commissioner of the respective office and approved by the director of the division of the budget, provided, however, the commissioner of mental health shall annually certify such rates or fees which may vary for distinct geographical areas of the state and, provided, further, that rates or fees for service for inpatient psychiatric services or inpatient chemical dependence services, at hospitals otherwise licensed pursuant to article twenty-eight of the public health law shall be established in accordance with section two thousand eight hundred seven of the public health law and, provided, further, that rates or fees for services provided by any facility or program licensed, operated or approved by the office for people with developmental disabilities, shall be certified by the commissioner of health; provided, however, that such methodologies shall be subject to approval by the office for people with developmental disabilities and shall take into account the policies and goals of such office.

(b) Operators of facilities licensed by the office of mental health pursuant to article thirty-one of this chapter, licensed by the office for people with developmental disabilities pursuant to article sixteen of this chapter or certified by the office of alcoholism and substance abuse services pursuant to this chapter to provide inpatient chemical dependence services shall provide to the commissioner of the respective office such financial, statistical and program information as the commissioner may determine to be necessary. The commissioner of the appropriate office shall have the power to conduct on-site audits of books and records of such facilities.

(c) The commissioner of the office of mental health, the commissioner of the office for people with developmental disabilities and the commissioner of the office of alcoholism and substance abuse services shall adopt rules and regulations to effectuate the provisions of this section. Such rules and regulations shall include, but not be limited to, provisions relating to:

(i) the establishment of a uniform statewide system of reports and audits relating to the quality of care provided, facility utilization and costs of providing services; such a uniform statewide system may provide for appropriate variation in the application of the system to different classes or subclasses of facilities licensed by the office of mental health pursuant to article thirty-one of this chapter or licensed or operated by the office for people with developmental disabilities pursuant to article sixteen of this chapter, or certified by the office of alcoholism and

substance abuse services pursuant to this chapter to provide inpatient chemical dependence services; and

(ii) methodologies used in the establishment of the schedules of rates or fees pursuant to this section provided, however, that the commissioner of health shall adopt rules and regulations including methodologies developed by him or her for services provided by any facility or program licensed, operated or approved by the office for people with developmental disabilities; provided, however, that such rules and regulations shall be subject to the approval of the office for people with developmental disabilities and shall take into account the policies and goals of such office.

Section 22 of Part AA of Chapter 57 of the laws of 2021

§ 22. The commissioner of health, in consultation with the office of mental health and the office of addiction services and supports, shall seek Medicaid federal financial participation from the federal centers for Medicare and Medicaid services for the federal share of payments for the services authorized pursuant to this part.

(Pending Final Adoption) A new Part 600 is added to Title 14 of the NYCRR to read as follows:
Part 600 Crisis Stabilization Centers

Part 600.1 Background and Intent

(a) The purpose of Crisis Stabilization Centers for those individuals with a known or suspected mental health condition and/or substance use disorder is to provide observation, evaluation, care, and treatment in a safe and comfortable environment. Such centers shall be open twenty-four (24) hours per day, seven (7) days per week.
(b) The purpose of this Part is to establish standards for a Crisis Stabilization Center which provides a full range of psychiatric emergency and substance use services within a defined geographic area. Crisis Stabilization Centers will provide an array of services as set forth in this Part and any guidance and standards issued by the Office of Mental Health (OMH) and the Office of Addiction Services and Supports (OASAS).
(c) Crisis Stabilization Centers are hereby developed under the authority of the Office of Mental Health (OMH) and the Office of Addiction Services and Supports (OASAS) and all provisions of the Mental Hygiene Law are accordingly integrated. Existing OMH and OASAS Mental Hygiene Law provisions will be relied upon to support Center implementation and operation as referenced herein, unless otherwise specified.

Part 600.2 Legal Base

(a) Section 31.36 of the Mental Hygiene Law provides the Commissioner of Mental Health (OMH) with the authority to coordinate with the Office of Addiction Services and Supports (OASAS) to create and operate Crisis Stabilization Centers within New York State and promulgate joint regulations for the operation of such centers.
(b) Section 32.36 of the Mental Hygiene Law provides the Commissioner of OASAS with the authority to coordinate with the OMH to create and operate Crisis Stabilization Centers within New York State and promulgate joint regulations for the operation of such centers.
(c) Section 36.01 of the Mental Hygiene Law grants the Commissioners of OMH and OASAS the authority to jointly license Crisis Stabilization Centers.
(d) Sections 31.05, 31.07, 31.09, 31.13, 31.19 and 31.27 of the Mental Hygiene Law, further authorize the Commissioner of Mental Health or their representative, to examine and inspect such Centers to determine their suitability and proper operation.
(e) Sections 31.16 and 31.17 of the Mental Hygiene Law authorize the Commissioner of Mental Health to suspend, revoke or limit any operating certificate.
(f) Sections 9.41, 9.43, 9.45 and 9.58 of the Mental Hygiene Law provide authority to assess and transport individuals to such Crisis Stabilization Centers.
(g) Section 33.21 of the Mental Hygiene Law authorizes the voluntary treatment of minors.
(h) Section 22.09 of the Mental Hygiene Law authorizes the Commissioner of OASAS to designate appropriate facilities as providers of emergency services for Recipients intoxicated, impaired or incapacitated including the voluntary retention of such Recipient.
(i) Section 32.07 of the Mental Hygiene Law grants the Commissioner of OASAS the authority to regulate the standards of quality and adequacy, physical plant and ongoing compliance for providers of substance use disorder services.

(j) Section 32.09 of the Mental Hygiene Law grants the Commissioner of OASAS the authority to regulate the issuance, temporary approval of and/or revocation of, operating certificates for substance use disorder programs.
(k)Section 22.11 of the Mental Hygiene Law authorizes treatment for minors for substance use disorder without consent from a parent or guardian.
(l) Parts 800-857 of Title 14 of the New York Codes, Rules and Regulations (NYCRR) outline provisions for the operation, administration and responsibilities for substance use disorder treatment programs.
(m) Parts 500-599 of Title 14 of the NYCRR outlining provisions for the operation administration and responsibilities for mental health services.
(n) Section 405.2 of Title 10 of the NYCRR provides additional regulatory requirements for the Governing Body of hospital-based programs.
(o)Sections 424-a and 495 of the Social Services Law relates to the register of category one substantiated cases of abuse and neglect referenced herein for purposes of criminal history reviews.
(p) Parts 160 and 164 of Title 45 of the Code of Federal Rules (CFR) relates to the Health Insurance Portability and Accountability Act (HIPAA) rules regarding confidentiality of health records.
(q) Part 2 of Title 45 of the CFR relates to the confidentiality of substance use treatment records.

Part 600.3 Applicability

(a) This Part applies to any provider of services who operates or proposes to operate a Crisis Stabilization Center for individuals who are experiencing a psychiatric or substance use crisis. The goal is to address and stabilize mental health and substance use needs as early as possible. The availability of Crisis Stabilization Centers provides more resources for law enforcement responding to individuals in emotional distress, the courts, and directors of community services, to allow non-violent individuals to be brought to such certified centers for assessment.

Part 600.4 Definitions.

(a) For purposes of this Part the following general definitions apply:
(1) *Approved medication* means any medication approved by state or federal authorities for the treatment of medical and psychiatric conditions, including those conditions caused by the use of substances.
(2) *Crisis Stabilization Center* shall mean a center certified pursuant to this Part, that offers voluntary crisis stabilization services to individuals experiencing mental health and substance use symptoms regardless of their ability to pay.
(3) *Supportive Crisis Stabilization Center* means a center that provides support and assistance to individuals with mental health or substance use crisis symptoms and who are experiencing challenges in daily life that create risk for an escalation of behavioral health symptoms that cannot reasonably be managed in the Recipient's home and/or community environment without onsite supports, and do not pose likelihood of serious harm. The center provides voluntary services for those who require support with an emphasis on peer and recovery services. Supportive Crisis Stabilization Centers provide or contract to provide behavioral health observation/stabilization services twenty-four hours per day, seven days per week.

(4) *Intensive Crisis Stabilization Center* means a center that provides urgent treatment to individuals experiencing an acute mental health or substance use crisis. This service provides diversion from higher levels of care by rapid treatment interventions and stabilization of acute symptoms. The center provides voluntary crisis treatment services in a safe and therapeutic environment with twenty-four hour observation. Intensive Crisis Stabilization Centers shall provide or contract to provide behavioral health stabilization and referral services twenty-four hours per day, seven days per week.
(5) *Catchment area* means the geographic area being served by the Center.
(6) *Commissioners* means the Commissioners of both the Office of Mental Health and the Office of Addiction Services and Supports.
(7) *Collateral* means a person who is a member of the Recipient's family or household, or other individual who interacts with the Recipient and is directly affected by, or has the capability of, affecting their condition and is identified in the treatment plan as having a role in treatment, and/or is necessary for participation in the evaluation and assessment of the Recipient.
(8) *Co-occurring disorder* means the diagnosis of at least one disorder in both of the following areas: substance use disorder (e.g. addiction to alcohol and/or legal or illegal drugs) and mental health disorder (e.g. personality disorder; a mood disorder including but not limited to, depression, or bipolar; a psychotic disorder such as schizophrenia; an anxiety disorder such as panic disorder or post-traumatic stress disorder).
(9) *Family* means those members of the Recipient's natural family, family of choice, or identified caregivers.
(10) *Individual service plan* means a written plan developed by the individual and clinical staff based on screening, assessment(s) and initial services.
(11) *Mental illness* means a health condition involving changes in behavior, emotion, thinking or judgment (or a combination of these) that are associated with distress and/or problems functioning in social, work or family activities.
(12) *Medication for addiction treatment (MAT)* means the treatment of substance use disorder (SUD) and concomitant conditions with medications requiring a prescription or order from an authorized prescribing professional with counseling and behavioral therapies, as clinically appropriate.
(13) *Medication management and training* means activities which provide information to ensure appropriate management of medication through understanding the role and effects of medication in treatment, identification of side effects of medication and discussion of potential dangers of
consuming other substances while on medication. Training in self-medication skills is also an appropriate activity when developmentally and clinically indicated.
(14) *Medication therapy* means the process of determining the medication to be utilized during the course of treatment; reviewing the appropriateness of the Recipient's existing medication regimen through review of the Recipient's medication record and consultation with the Recipient and, as appropriate, their family or guardian; prescribing and/or administering medication; and monitoring the effects and side effects of the medication on the Recipient's mental and physical health.
(15) *Naloxone emergency overdose prevention kit* means a kit as prescribed pursuant to state law and used to reverse an opioid overdose.
(16) *Office* means jointly the Office of Mental Health and the Office of Addiction Services and Supports.

(17) *On-call*, for the purposes of this Part, shall mean the individual is not physically present at the center but can be contacted immediately for clinical consultation as needed and be on-site as necessary
(18) *On duty*, for purposes of this Part, shall include the individual being physically present or on-call and available which includes the ability to come on-site as needed.
(19) *Recipient* means a person who is receiving services at a Crisis Stabilization Center.
(20) *Sponsor* means the provider of service or an entity that substantially controls or has the ability to substantially control the Crisis Stabilization Center. For the purpose of this Part, factors used to determine whether there is substantial control shall include but not be limited to:
(i) the right to appoint and remove directors or officers;
(ii) the right to approve bylaws or articles of incorporation;
(iii) the right to approve strategic or financial plans for a provider of service; or
(iv) the right to approve operating or capital budgets for a provider of services.
(21) *Substance use disorder* means a group of cognitive, behavioral, and physiological symptoms indicating that an individual continues using substances despite significant substance-related physical, psychological and social problems as determined through assessment and diagnosis using the most recent version of the Diagnostic and Statistical Manual (DSM), as incorporated by reference in Part 800 of this Title.
(22) *State licensing agency* means jointly the Office of Mental Health and the Office of Addiction Services and Supports.
(b) For purposes of this Part the following staffing definitions apply:
(1) *Clinical staff,* for purposes of this Part, are all staff members who provide services directly to Recipients and include professional staff as defined herein. Students and trainees may qualify if they are participating in a program leading to a degree, credential or certificate appropriate to the goals, objectives and services of the Crisis Stabilization Center, are supervised in accordance with the policies governing the training program and are included in the staffing plan approved by the Office.
(i) Students or trainees may qualify as clinical staff under the following conditions:
(*a*) the students and trainees are actively participating in a program leading to attainment of a recognized degree or certificate in a field related to mental health and substance use disorder at an institution chartered or approved by the New York State Education Department. Limited-permit practitioners are considered students or trainees;
(*b*) the students or trainees are supervised and trained by professional staff meeting the qualifications specified in this section and are appropriately supervised;
(*c*) the students or trainees use titles that clearly indicate their status; and
(*d*) written policies and procedures pertaining to the integration of students and trainees within the overall operation of the Crisis Stabilization Center shall receive approval by the Office.
(2) *Professional staff*, for the purpose of this Part, are individuals who are qualified by credentials, training and experience to provide supervision and direct service related to the treatment of a mental health condition and/or substance use disorder in a Crisis Stabilization Center and may include the following:
(i) *Creative arts therapist* is an individual who is currently licensed as a creative arts therapist by the New York State Education Department or possesses a creative arts therapist permit from the New York State Education Department.
(ii) *Credentialed alcoholism and substance use counselor* is an individual who has a current valid credential issued by the OASAS, or a comparable credential, certificate or license from another recognized certifying body as determined by the OASAS.

(iii) *Licensed practical nurse* is an individual who is currently licensed as a licensed practical nurse by the New York State Education Department or possesses a licensed practical nurse permit from the New York State Education Department.
(iv) *Licensed psychoanalyst* is an individual who is currently licensed as a psychoanalyst by the New York State Education Department or possesses a permit from the New York State Education Department.
(v) *Marriage and family therapist* is an individual who is currently licensed as a marriage and family therapist by the New York State Education Department or possesses a permit from the New York State Education Department.
(vi) *Mental health counselor* is an individual who is currently licensed as a mental health counselor by the New York State Education Department or possesses a permit from the New York State Education Department.
(vii) *Nurse practitioner* is an individual who is currently certified as a nurse practitioner by the New York State Education Department or possesses a permit from the New York State Education Department.
(viii) *Nurse practitioner in psychiatry* is an individual who is currently certified as a nurse practitioner with an approved specialty area of psychiatry (NPP) by the New York State Education Department or possesses a permit from the New York State Education Department.
(ix) *Physician* is an individual who is currently licensed as a physician by the New York State Education Department.
(x) *Physician assistant* is an individual who is currently registered as a physician assistant by the New York State Education Department or possesses a permit from the New York State Education Department.
(xi) *Psychiatrist* is an individual who is currently licensed as a physician by the New York State Education Department and who is certified by, or eligible to be certified by, the American Board of Psychiatry and Neurology.
(xii) *Psychologist* is an individual who is currently licensed as a psychologist by the New York State Education Department.
(xiii) *Registered professional nurse* is an individual who is currently licensed as a registered professional nurse by the New York State Education Department.
(xiv) *Rehabilitation counselor* is an individual who has either a master's degree in rehabilitation counseling from a program approved by the New York State Education Department or current certification by the Commission on Rehabilitation Counselor Certification.
(xv) *Social worker* is an individual who is either currently licensed as a licensed master social worker or as a licensed clinical social worker by the New York State Education Department or has a master's degree in social work from a program approved by the New York State Education Department.
(3) *Certified peer specialist* means an individual who is certified as a peer in New York State from a certifying authority recognized by the Commissioner of OMH.
(4) *Certified recovery peer advocate* means an individual who holds a certification issued by an entity approved and recognized by the Commissioner of OASAS.
(5) *Certified or credentialed family peer advocate* means an individual who is credentialed as a peer in New York State from a certifying authority recognized by the Commissioner of OMH or OASAS.
(6) *Certified or credentialed youth peer advocate* means an individual who is credentialed as a peer in New York State from a certifying authority recognized by the Commissioner of OMH or OASAS.

(7) Other professional disciplines may be included as professional staff, provided that the discipline is approved as part of the staffing plan submitted to the Office. The discipline shall be from a field related to the treatment of a mental health condition and/or substance use. For rural areas, individuals who have obtained at least a master's degree in psychology may be considered professional staff for the purposes of calculating professional staff but may not be assigned supervisory responsibility.

Part 600.5 Certification

(a) Application and Approval Process.
(1) Applicants must show relevant mental health and/or addictions experience and be licensed, certified or otherwise authorized by OMH, OASAS or the NYS Department of Health (DOH).
(2) Applications shall be submitted in a format prescribed for all applicants and reviewed by the Office.
(3) Applications shall include information needed to demonstrate that the provider is:
(i) licensed, certified or otherwise authorized by OMH, OASAS or the NYS Department of Health (DOH).
(ii) in compliance with all applicable requirements of the Office;
(iii) in good standing at the time of application approval; and
(iv) in compliance with the physical plant requirements set forth in guidance issued by the Office.
(4) Applications may include, but not be limited to, requests for information regarding services to be added and the plan for implementation, staffing, environment, operating expenses and revenues, and utilization of services as they relate to Crisis Stabilization Center services as described in this Part.
(5) The applicant shall supply any additional documentation or information requested by the Office, within a stated timeframe of such request, unless an extension is obtained. The granting of a request for an extension shall be at the discretion of the Office. Failure to provide the additional documentation or information within the time prescribed shall constitute an abandonment or withdrawal of the application without any further action from the Office.
(6) The Office shall approve or disapprove an application in writing.
(7) Applicants may appeal the denial of an application with the Office.
(b) Each Crisis Stabilization Center shall be issued an operating certificate that specifies the type of Crisis Stabilization Center the provider of services is authorized to operate:
(1)Intensive Crisis Stabilization
(i) The purpose of an Intensive Crisis Stabilization Center is to provide urgent treatment to individuals experiencing an acute mental health or substance use crisis. This service provides diversion from higher levels of care by rapid treatment interventions and stabilization of acute symptoms.
(ii) Screening and assessment is performed by the Crisis Stabilization Center to determine the services and referrals needed by the Recipient.
(iii) Intensive Crisis Stabilization Centers must provide all services, as described in Part 600.9.
(2)Supportive Crisis Stabilization
(i) The purpose of a Supportive Crisis Stabilization Center is to provide support and assistance to individuals with mental health or substance use crisis symptoms or who are experiencing challenges in daily life that places them at risk for an escalation of
behavioral health symptoms that cannot reasonably be managed in the Recipient's home and/or community environment without onsite supports, and do not pose likelihood of immediate harm to self or others. Supportive Crisis Stabilization Centers provide assistance for individuals who

demonstrate mental health and substance use symptoms that can be stabilized through supportive interventions.
(ii) Screening and assessment is performed by the Crisis Stabilization Center to determine the services and referrals needed by the Recipient.
(iii)Supportive Crisis Stabilization Centers must have agreements and/or demonstrate linkages to services described in Part 600.9(c) that are not provided by the Crisis Stabilization Center.

Part 600.6 Inspection

(a) The Office shall have initial and ongoing inspection responsibility for all Crisis Stabilization Centers established pursuant to this Part. The purpose of the inspection is to ensure compliance with all applicable laws, rules, regulations, and guidance as well as to determine the renewal term of the operating certificate.
(b) The Office review shall be performed by staff with expertise as necessary to ensure Recipient health and safety. Any significant deficiencies will immediately be referred for enforcement. If at any point during the inspection, findings are identified that suggest imminent risk of serious harm or injury to Recipients, the inspector(s) will immediately contact their supervisor.
(c) Inspections shall be conducted utilizing a single oversight instrument. All deficiencies and/or corrective action will be overseen by the Office. Each Crisis Stabilization Center shall undergo an unannounced inspection which will occur prior to renewal of the Operating Certificate.
(d) At the start of the inspection, the inspector(s) will meet with the Crisis Stabilization Center administrative staff to explain the purpose and scope of the inspection and request any documentation (e.g., policies; staffing information; etc.) that may be needed to facilitate the review.
(e) The inspection will include, but not be limited to, the following areas of review:
(1) on-site inspection of service appearance, conditions and general safety;
(2) evaluation of the sponsor, its management systems, and procedures;
(3) Recipient case record review;
(4) interviews of staff and Recipients;
(5) examination of staffing patterns and staff qualifications;
(6) analysis of statistical information contained in reports required to be submitted by the service;
(7) compliance with the reporting requirements;
(8) verification of staff credentials, and staff training, as applicable;
(9) incident reporting requirements; and
(10) such other operating areas of activities as may be necessary or appropriate to determine compliance with applicable laws and regulations.
(f) At the conclusion of the inspection, the inspector(s) will meet with the Crisis Stabilization Center's administrative staff to discuss all deficiencies identified during the inspection.
(g) Upon completion of the inspection, a written report will be provided to the Crisis Stabilization Center which describes the results of the inspection, including each regulatory deficiency identified, if any. The Crisis Stabilization Center shall take all actions necessary to correct all deficiencies reported. The Crisis Stabilization Center shall submit a plan of correction to the Office within 30 days, which shall state the specific actions taken or planned actions to achieve compliance with identified requirements. Any planned actions described in the plan of correction must be accompanied with a timetable for their implementation.

(h) If the Crisis Stabilization Center fails, within the specified or an otherwise reasonable time, to correct any reported deficiencies, or fails to maintain satisfactory compliance with applicable laws, rules and regulations, the Office may revoke, suspend or limit the operating certificate or license or levy a civil fine for such failures, in accordance with applicable regulations.
(i) Concurrently, each Crisis Stabilization Center shall undergo a fiscal viability review which will include an assessment of the financial information of the Crisis Stabilization Center. Such information shall be submitted in intervals and in a form prescribed by the Office, for compliance with minimum standards established by the Office, in order to determine the Crisis Stabilization Center's fiscal capability to effectively support the authorized services.
(j) Crisis Stabilization Centers that fail to meet the minimum standards of the Office shall be required to submit a corrective action plan setting forth the specific actions to be taken to meet the minimum standards within a reasonable time frame.

Part 600.7 Organization and administration

(a) Governing Body or Sponsor: The Crisis Stabilization Center shall identify a Governing Body or Sponsor (Governing Body) which shall have overall responsibility for the operation of the Center. The Governing Body may delegate responsibility for the day-to-day management of the Center to appropriate staff in accordance with the organizational plan approved by the Office. No individual shall serve as both a member of the Governing Body and as paid staff of the Crisis Stabilization Center without prior approval of the Office.
(b) For hospital-based Crisis Stabilization Centers, the Governing Body of the hospital shall be responsible for the overall operation and management of the Crisis Stabilization Center. The Governing Body may delegate responsibility for the day-to-day management of the Center to appropriate staff pursuant to an organizational plan approved by the Office. No individual shall serve as both member of the Governing Body and of the paid staff of the Crisis Stabilization Center without prior approval of the Office.
(c) For Crisis Stabilization Centers, the Governing Body shall delegate responsibility for the day-to-day management of the Crisis Stabilization Center in accordance with the written plan of organization provided for in paragraph (e)(2) of this section.
(1)Onsite direction shall be delegated to an individual who shall be known as the Program Director and who shall meet the qualifications specified in section 600.11(f) of this Part.
(2) The Program Director shall be employed by the Crisis Stabilization Center as a full-time employee.
(3)Overall administrative direction may be the responsibility of the Program Director or may be delegated by the Governing Body to an individual who shall meet qualifications that are acceptable to the Office.
(d)The Governing Body shall comply with all requirements set forth in 10 NYCRR Part 405**.2** as well as requirements established by appropriate local, State and Federal standard-setting bodies.
(e) The Governing Body shall be responsible for the following duties:
(1) to develop an organizational plan which indicates lines of accountability and the qualifications required for staff positions. Such plan may include the delegation of the responsibility for the day-to-day management of the program to a Program Director who shall be a member of the professional staff employed by the Crisis Stabilization Center. Where such Crisis Stabilization Center is hospital-based, the Program Director shall report to the Director of Psychiatry or Medical Director of the host hospital.

(2) to develop written personnel policies which shall prohibit discrimination on the basis of race or ethnicity, religion, disability, gender identity or sexual orientation, marital status, age, documentation status, or national origin, as well as, written policies on affirmative action which are consistent with the affirmative action and equal employment opportunity obligations imposed by title VII of the Civil Rights Act, Federal Executive Order 11246, the Rehabilitation Act of 1973, section 504, as amended, and the Vietnam Era Veteran's Readjustment Act;
(f) The Governing Body shall develop, approve, periodically review and revise as appropriate all programmatic and administrative policies and procedures. Such policies and procedures shall include, but are not limited to the following:
(1) policies that guide efforts to reduce disparities in access, quality of care and treatment outcomes for underserved/unserved and/or marginalized populations, including but not limited to: people of color, members of the LBGTQ+ community, older adults, pregnant persons, Veterans, individuals who are hearing impaired, individuals with limited English proficiency, immigrants, individuals with intellectual/developmental disabilities and all justice system-involved populations;
(2) policies that ensure that efforts are made to employ staff that are proficient in the most prevalent languages spoken by service Recipient;
(3) policies and procedures governing Recipient records which ensure confidentiality consistent with the Mental Hygiene Law, sections 33.13, 33.14 and 33.16, 45 C.F.R. parts 160 and 164 and which provide for appropriate retention of such records pursuant to section 590.12 of this Title;
(4) policies regarding the confidentiality of substance use disorder treatment records in accordance with state and federal law including 42 CFR Part 2 and HIPAA;
(5) policies that ensure the protection of Recipients' rights;
(i) At a minimum these policies shall establish and describe a Recipient's grievance procedure.
(ii) The Crisis Stabilization Center shall post a statement of Recipients' rights in a conspicuous location easily accessible to the public and provide a copy to service Recipients.
(6) policies for training staff to recognize the signs and symptoms of severe reactions to or overdose on substances including but not limited to alcohol, sedative-hypnotics, opioids, stimulants, cannabis and synthetic cannabinoids, and the appropriate interventions when overdose occurs in accordance with guidance from the Office
(i) Training on these interventions shall include but not be limited to education about the use of naloxone overdose prevention kits.
(ii) Centers must develop and implement a plan to have staff trained in the use of a naloxone overdose prevention kit and must ensure that such kit and appropriately trained staff are available during all program hours of operation.
(iii) Staff should be trained that overdose risk can exist with any illicit substance use, not limited to known opioid use or intended substance of choice.
(7)policies for the provision of overdose prevention education and training and availability of overdose prevention kits or prescriptions for service Recipients and their collaterals.
(g)Cultural and linguistic competency.
(1) Crisis Stabilization Centers shall review demographic data for the Crisis Stabilization Center's Catchment Area to determine the cultural and linguistic needs of the population as well as disparities in access to treatment. Staff shall be trained to be aware and respond appropriately to the cultural and linguistic needs of the Catchment Area and develop a plan to address disparities in treatment access.
(2) Crisis Stabilization Centers shall ensure provision of language assistance services at no cost to the Recipient and/or their family/collaterals and shall make all necessary documents available

in the Recipient's preferred language. Language access services will be made available in such a way that assessment or treatment activities will not be delayed. Crisis Stabilization Centers are responsible for ensuring the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.
(3) Crisis Stabilization Centers shall provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area, with a focus on the varied literacy levels among the service user population.
(h) County planning.
(1) Crisis Stabilization Centers shall participate in county and community planning activities annually, and as additionally needed, to ensure, maintain, improve or develop community services that demonstrate recovery outcomes. These outcomes include, but are not limited to, quality of life, socio-economic status, entitlement status, social networking, coping skills and reduction in use of crisis services.
(i)Incidents.
(1) The Crisis Stabilization Center shall ensure the timely reporting, investigation, review, monitoring and documentation of incidents pursuant to the Mental Hygiene Law and 14 NYCRR Part 524.
(i) The Crisis Stabilization Center shall utilize New York Incident Management Reporting System reports or other available incident/data analysis reports to assist in risk management activities and compile and analyze incident data for the purpose of identifying and addressing possible patterns and trends to improve service delivery.
(2) Incident Training.
(i)All new staff shall receive training which must include at a minimum, the definition of incidents, reporting procedures, an overview of the review process, and the role of risk management.
(ii)Refresher incident reporting training shall be conducted at least annually for all staff and evidence of such training must be recorded in the staff personnel file.
(3) For hospital-based Centers , the hospital's incident review committee shall review incidents, make recommendations and ensure implementation of action plans with the Crisis Stabilization Center's Program Director.
(j) Non-discrimination. No Recipient that meets the criteria for treatment may be denied a based solely on the Recipient's:
(1) prior treatment history;
(2) referral source;
(3) pregnancy;
(4) history of contact with the criminal justice system;
(5) HIV and AIDS status;
(6) physical or mental disability;
(7) lack of cooperation by collaterals in the treatment process;
(8) toxicology test results;
(9) use of any illicit or prescribed substances, including but not limited to, benzodiazepines;
(10) use of medications for substance use disorder prescribed and monitored by a physician, physician's assistant or nurse practitioner;
(11)age;
(12) actual or perceived gender;
(13)national origin;
(14) race/color;

(15) actual or perceived sexual orientation;
(16)marital status;
(17)military status;
(18)familial status; or
(19)religion.
(k)Posting notices. The Crisis Stabilization Center shall ensure the posting of notices displaying the availability of on-site peer counseling/mutual-aid services and the address and telephone number of local off-site peer counseling/mutual aid services.
(l) The Crisis Stabilization Center will have memorandums of understanding (MOUs) with any available crisis residential services or comparable services for Recipients determined to need crisis stabilization beyond 23 hours and 59 minutes.
(m) Crisis Stabilization Centers shall develop policies and procedures describing Recipient drop off from law enforcement, emergency medical services, mobile crisis and other outreach and treatment teams.
(n) Supportive Crisis Stabilization Centers shall develop policies and procedures describing how Recipients will access services identified in screening and assessment that are not provided by the Crisis Stabilization Center and follow-up to ensure such services are accessed.
(o)The Commissioners or their designee may prevent new presentations to the Crisis Stabilization Center emanating from emergency medical services, ambulance services and law enforcement if a conclusion is reached that the ability of the Crisis Stabilization Center to deliver quality service would be jeopardized.
(1) The Commissioners or their designee shall review the continued necessity for such prevention at least once every twenty-four hours according to a mutually developed plan.
(2) The Crisis Stabilization Center shall develop a contingency plan with other local affiliated hospitals, emergency medical services and law enforcement for the prevention of new presentations during periods of high demand and overcrowding.
(3)Where a Crisis Stabilization Center prevents new presentations pursuant to this paragraph, the Crisis Stabilization Center must notify the appropriate OMH Field Office and OASAS Regional Office according to a mutually developed plan.

Part 600.8 Screening and Assessment

(a)Each Crisis Stabilization Center shall maintain service criteria which are consistent with its goals and objectives, and which are subject to the approval of the Office. Screening, assessment and services shall be in accordance with the provisions of this Part and on the forms prescribed therefore.
(b) Information gathering.
(1) The Crisis Stabilization Center shall access the Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES) or other available electronic health records or database(s) with the Recipient's consent, to identify the Recipient's treatment providers and prior medication use and/or treatment engagement history.
(2) The Crisis Stabilization Center shall document demonstrated efforts to identify and contact with the Recipient's consent, the Recipient's treatment team and other relevant providers (e.g., housing providers, care coordination, managed care organizations), and collaterals.
(c)Screening and assessment.
(1) Screening:
(i) all presenting individuals shall be screened for risk of harm to self and others;
(ii)staff shall collaborate with collaterals as appropriate and available;

(iii) for individuals determined to be of moderate risk of harm to self or others, efforts shall be documented which demonstrate the Crisis Stabilization Center's steps made to obtain or develop a safety plan with the presenting individuals;
(iv)all presenting individuals shall be screened for substance use, substance use disorders, and the risk of substance withdrawal; and
(v) screening tools should be evidence based and validated where possible.
(2)Assessment:
(i)Any individual requesting an assessment at the Crisis Stabilization Center must be evaluated by professional staff upon presentation; and
(ii)assessments shall be strength-based and person-centered.

Part 600.9 Services

(a) Receiving services at a Crisis Stabilization Center is determined through screening and assessment by professional staff. Stabilization services are identified in an individual service plan.
(b) Crisis Stabilization Centers shall operate, or develop a MOU with, the following program types in order to facilitate rapid access and documented linkages to follow-up services:
(1) OASAS inpatient withdrawal and stabilization certified pursuant to Part 816 of this Title;
(2)OASAS residential treatment consisting of at minimum stabilization services, certified pursuant to Part 820 of this Title;
(3)Emergency Department and/or Comprehensive Psychiatric Emergency Services;
(4) OMH Licensed Crisis Residential Services;
(5)OASAS and OMH certified and licensed outpatient programs;
(6)Other behavioral health crisis or emergency services;
(7)Agencies delivering harm reduction services; and
(8)Other supportive services as appropriate.
(c) All Crisis Stabilization Centers must provide the following:
(1) Triage, Screening and Assessment of all presenting individuals which includes screening for risk of harm to self and/or others, risk of substance use/withdrawal and any immediate physical health needs;
(2) Therapeutic interventions that may include crisis counseling, psychoeducation, crisis de-escalation/intervention services;
(3)Peer Support Services;
(4) Ongoing observation;
(5) Care collaboration with a Recipient's friends, family and/or care providers (with consent); and
(6)Discharge and After Care Planning
(d)In addition to the above-mentioned services, Intensive Crisis Stabilization Centers must also provide, where appropriate:
(1)Psychiatric Diagnostic Evaluation and Plan;
(2)Psychosocial Assessment;
(3)Medication Management and Training;
(4)Medication for Addiction Treatment (MAT);
(5)Medication Therapy; and
(6) Mild to Moderate Detoxification Services.

Part 600.10 Discharge Planning and Referral

(a)Discharge criteria.
(1)The provisions of section 29.15 of the Mental Hygiene Law shall not apply to the discharge of a Recipient from a Crisis Stabilization Center.
(2)Discharge planning shall be conducted for all Recipients at a Crisis Stabilization Center who have been determined to require additional mental health and/or substance use services.
(3)Discharge planning criteria shall include at least the following activities prior to a Recipient leaving the Crisis Stabilization Center:
(i)a review of the Recipient's psychiatric, substance use and physical health needs;
(ii) completion of referrals which include documented linkages to appropriate community services providers, in collaboration with the Recipient and Center staff, to address the Recipient's identified needs;
(iii) in collaboration with the Recipient receiving services, the Center shall arrange for appointments with community providers which shall be made as soon as possible after leaving the Center;
(iv)each Recipient shall be given the opportunity to participate in the development of their person-centered discharge plan. Absent the objection of the Recipient and when clinically appropriate, reasonable attempts shall be made to contact collaterals for their participation in the transition planning program. However, no person or collaterals shall be required to agree to the Recipient's discharge. A notation shall be made in the Recipient's record if such Recipient objects to the discharge plan or any part thereof; and
(v)contact information for local and national mental health and substance use disorder crisis services.
(4) The discharge plan, or at a minimum that portion of the Plan which includes referral information, must be given to the Recipient, and any collateral with Recipient consent, prior to the Recipient leaving the program.
(5) The Crisis Stabilization Center shall document linkages to after-care appointment(s) and verify those appointments occurred and follow up with Recipients to ensure satisfactory linkage to care.
(6) Where there is the risk of opioid related overdose, the Recipient, and their family/collateral(s), shall be offered overdose prevention education and training, and a naloxone kit or prescription.

Part 600.11 Staffing

(a) Crisis Stabilization Centers shall continuously employ an adequate number of staff and an appropriate staff composition to carry out their goals and objectives as well as to ensure the continuous provision of sufficient ongoing and emergency supervision. Each Crisis Stabilization Center shall submit a staffing plan which includes the qualifications and duties of each staff position by title. The staffing plan and its rationale shall be subject to approval by the Office. The Office must be notified of and approve significant changes from the approved staffing plan.
(b) This staffing plan shall be based on the population to be served and the services to be provided.
(c) All clinical staff must have at least a high-school diploma or its equivalent.
(d) Supervisory staff: Crisis Stabilization Centers shall have a continuous provision of sufficient ongoing and emergency supervision.
(e)Intensive Crisis Stabilization Centers shall be overseen by a Medical Director who is a physician licensed and currently registered as such as by the New York State Education

Department and shall have at least one year of education, training, and/or experience in mental health or substance use disorder services.
(f) Intensive Crisis Stabilization Centers shall have prescribing professionals on duty or on call at all times who can prescribe approved medications, including buprenorphine, consistent with state and federal rules.
(g) Program Director. Crisis Stabilization Centers shall have a Program Director pursuant to this Part for administrative oversight and quality assurance. Program director is a professional staff or certified or credentialed peer with at least two years of full-time clinical work experience in the mental health or substance use disorder treatment field and at least one year of which included supervisory responsibilities.
(h) All staff shall have qualifications appropriate to assigned responsibilities as set forth in the staffing plan and shall practice within the scope of their professional discipline and/or assigned responsibility. All staff shall submit documentation of their training and experience. Such documentation shall be verified and retained on file by the agency.
(i) The staffing plan shall include those clinical and professional staff as defined in this Part in sufficient type, schedules and numbers to meet projected volume and Recipient need.
(j) Criminal history information reviews required pursuant to Sections 19.20, 19.20a and 31.35 of the Mental Hygiene Law, Sections 424-a and 495 of the Social Services Law, and 14 NYCRR 550 and 805, shall be conducted in accordance with such laws and regulations and any guidance issued by the Offices. All prospective employees, contractors and volunteers of Crisis Stabilization Centers licensed pursuant to article 36 of the Mental Hygiene Law who have the potential for, or may be permitted, regular and substantial unsupervised or unrestricted contact with Recipients shall submit to a criminal history information review. All staff with the potential for regular and substantial contact with Recipients in performance of their duties shall submit to clearance by the New York Statewide Central Register of
Child Abuse and Maltreatment. Staff who have not been screened by the New York Statewide Central Register of Child Abuse and Maltreatment shall not perform duties requiring contact with Recipients unless there is another staff member present.
(k) Multi-disciplinary team: A Crisis Stabilization Center as approved pursuant to this Part, shall be staffed with a multidisciplinary team capable of meeting the needs of presenting individuals which shall include, but not be limited to:
(1) Registered Nurse, who is onsite twenty-four hours a day, seven days a week, to ensure adequate screening, assessment and care for all Recipients.
(2) A psychiatrist or psychiatric nurse practitioner;
(3) A credentialed alcoholism and substance abuse counselor, and
(4)A certified peer specialist, as defined in this Part .

Part 600.12 Case record

(a)There shall be a complete legible case record maintained for each Recipient at a Crisis Stabilization Center.
(b)The case record shall be available to all clinical staff of the Crisis Stabilization Center who are participating in the treatment of the Recipient consistent with 45 C.F.R. Parts 160 and 164 and 42 CFR Part 2.
(c) All Recipients from the Crisis Stabilization Center must have a case record which, at a minimum, includes a presentation note which indicates:
(1)a brief description of the presenting problem, critical needs and overall conditions;

(2) a brief description of the care and treatment required to address the Recipient's needs safely and effectively during the initial period after screening and assessment; and
(3) a brief description of the Crisis Stabilization Center's attempts to contact collaterals.
(d) Case records for Recipients shall include:
(1) Recipient identifying information and available substance use, psychiatric, medical and relevant social history, including the Recipient's residential situation and the details of the circumstances leading to the Recipient's presentation at the Center , and the name of the person or persons who have referred or brought the Recipient to the Center , if any. In the case of Recipients brought to the Center by law enforcement, the officer(s) should be interviewed and identified in the case record;
(2) diagnosis if applicable;
(3) assessment of the Recipient's treatment needs based upon substance use, psychiatric, physical, social and functional evaluations;
(4) individual service plan;
(5) reports of all substance use-related, mental and physical diagnostic exams, assessments, tests, and consultations;
(6)progress notes which relate to goals and objectives of treatment and document services provided.
(7)notes which relate to special circumstances and clinically relevant incidents;
(8) dated and signed orders for all medications;
(9) discharge plan, including demonstrated linkages to referrals to other programs and services;
(10) consents as appropriate pursuant to this Part; and
(11) documentation of attempts to contact Collaterals.

Part 600.13 Premises

(a) A Crisis Stabilization Center shall maintain premises that are adequate and appropriate for the safe and effective operation of a Crisis Stabilization Center in accordance with the following:
(1)the Center shall be maintained in a good state of repair and sanitation;
(2) the Center's space shall be both adequate and appropriate for the comfort and convenience of those waiting for and receiving services;
(3)the Center's space shall be constructed using trauma informed principles;
(4)the Center shall have sufficient, appropriate and comfortable furnishings maintained in good condition and appropriate equipment and material for the population served;
(5) the Center's space shall be sufficient to provide safety, and to allow for a reasonable degree of privacy consistent with the effective delivery of services;
(6)the Center's space shall include examination rooms;
(7) the Center's space shall be both adequate and appropriate for the maintenance of privacy for interviews between staff members and Recipients served;
(8) the premises shall be reasonably maintained to ensure access to services by all Recipients;
(9)the Center shall provide and ensure accessibility for persons with disabilities to program and bathroom facilities, including showers;
(10) the Center shall provide appropriate access to telephone, internet, and food for all Recipients;
(11)the Center shall ensure access to laundry facilities;
(12) the Center shall provide for controlled access to and maintenance of medications and supplies in accordance with all applicable Federal and State laws and regulations;
(13) the Center shall provide for controlled access to and maintenance of records;

(14) the Center shall provide sufficient separation and supervision of various treatment populations, including adults and children, to ensure the safety of the population receiving crisis stabilization services;
(15) the Center shall provide a separate entrance and triage area for law enforcement drop-offs; and
(16) where minors under the age of 18 are receiving services in the Center, they shall not be commingled with adults in areas of the space where the adults are receiving services, nor shall they receive services in groups which include adults.
(i) In extraordinary circumstances, such commingling may be permitted upon written approval of the office, on a situational and time-limited basis.
(b)Observation chairs shall be located in the Crisis Stabilization Center as approved by a plan submitted to the Office.
(c) Crisis Stabilization Centers shall ensure life safety on the premises by possession of a certificate of occupancy in accordance with the Building Code of New York State and the Property Maintenance Code of New York State (19 NYCRR Chapter XXXIII, Subchapter A, Parts 1221 and 1226) or comparable local codes.
(d)Facilities shall comply with all local zoning and building laws, regulations and ordinances.
(e)Heating, lighting and ventilation shall be adequate for the comfort and well-being of the Recipients and the employees.
(f)Copies of all local inspection reports, and other relevant inspection reports, shall be maintained and available upon request.

Part 600.14 Statistical records and reports

(a) Statistical information shall be prepared and maintained as may be necessary for the effective operation of the Crisis Stabilization Center including but not limited to quality measures and monitoring of outcomes and as may be required by the Office.
(b) Statistical information shall be reported to the Office in a manner and within time limits specified by the Office.
(c)Statistical reporting shall be the responsibility of an individual whose name and title shall be made known to the Office.

Appendix IV
2022 Title XIX State Plan
Second Quarter Amendment
Public Notice

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 on or after April 1, 2022, the Department of Health will adjust rates statewide to reflect a 5.4% percent Cost of Living Adjustment for the following Office of Mental Health (OMH), Office of Addiction Services and Supports (OASAS), and Office for People With Developmental Disabilities (OPWDD) State Plan Services: OMH Outpatient Services, OMH Clinic Services, OMH Rehabilitative Services, Children Family Treatment Support Services, Health Home Plus, Residential Treatment Facilities for Children and Youth, OASAS outpatient addiction services, OASAS freestanding (non-hospital) inpatient rehabilitation services, OASAS freestanding inpatient detox services, OASAS addiction treatment centers, OASAS Part 820 residential services, OASAS residential rehabilitation services for youth, Intermediate Care Facility (ICF/IDD), Day Treatment, Article 16 Clinic services, Specialty Hospital, Health Home Services Provided by Care Coordination Organizations, Independent Practitioner Services for Individual with Developmental Disabilities (IPSIDD), and OPWDD Crisis Services.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to the April 1, 2022, 5.4% percent Cost of Living Adjustment contained in the budget for State Fiscal Year 2023 is $109.9 million.

Effective on or after April 1, 2022, Health care and mental hygiene worker bonuses will be provided to New York's essential front line health care and mental hygiene workers. These bonuses are intended to attract talented people into the profession and retain people who have been working during the COVID-19 Pandemic by rewarding them financially for their service.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for State Fiscal Year 2023 is $1.85 billion.

Effective for dates of service on or after April 1, 2022, through March 31, 2024, all Medicaid rate-based claims will receive a 1% operating increase. Payments exempted from this increase, are as follows:

- Payments not subject to federal financial participation;
- Payments that would violate federal law including, but not limited to, hospital disproportionate share payments that would be in excess of federal statutory caps;
- Payments made by other state agencies including, but not limited to, those made pursuant to articles 16, 31 and 32 of the mental hygiene laws;
- Payments the state is obligated to make pursuant to court orders or judgments;
- Payments for which the non-federal share does not reflect any state funding; and
- At the discretion of the Commissioner of Health and the Director of the Budget, payments with regard to which it is determined that application of increases pursuant to this section would result, by operation of federal law, in a lower federal medical assistance percentage applicable to such payments.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for State Fiscal Year 2023 is $165 million.

Effective for dates of service on or after April 1, 2022, the 1.5% uniform reduction for all non-exempt Department of Health state funds Medicaid payments will be restored.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for State Fiscal Year 2023 is $280 million.

Non-Institutional Services

Effective on or after April 1, 2022, this proposal continues the supplemental upper payment limit payments made to general hospitals, other than major public general hospitals under non-institutional services of $339 million annually.

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

For state fiscal year beginning April 1, 2022, through March 31, 2023, this proposal continues hospital outpatient payment adjustments that increase the operating cost components of rates of payment for hospital outpatient and emergency departments on and after April 1, 2011, for public general hospitals other than those operated by the State of New York or the State University of New York, which are located in a city with a population of over one million. The amount to be paid will be up to $287 million annually based on criteria and methodology set by the Commissioner of Health, which the Commissioner may periodically set through a memorandum of understanding with the New York City Health and Hospitals Corporation. Such adjustments shall be paid by means of one or more estimated payments. Payments may be added to rates of payment or made as aggregate payments.

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

For state fiscal year beginning April 1, 2022, through March 31, 2023, this proposal continues payment of up to $5.4 million in additional annual Medicaid payments to county operated free-standing clinics, not including facilities operated by the New York City Health and Hospitals Corporation, for services provided by such DTC and those provided by a county operated freestanding mental health or substance abuse DTC. Distributions shall be based on each eligible facility's proportionate share of the sum of all DTC and clinic visits for all eligible facilities receiving payments for the base year two years prior to the rate year. The proportionate share payments may be added to rates of payment or made as aggregate payments to eligible facilities.

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

Effective April 1, 2022, and each state fiscal year thereafter, this amendment proposes to revise the final payment component of the calculation to account for claim runout. The current authority to make supplemental payments for services provided by physicians, nurse practitioners and physician assistants will continue.

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

Effective on or after April 1, 2022, payments in quarter-hour units for the following harm reduction services for people who actively use drugs provided at New York State Commissioner of Health waivered comprehensive harm reduction programs (community-based organizations) will be revised. The intention is to combat the opioid overdose crisis and reduce health care costs for people who use drugs. Harm reduction services improve population health and have been shown to reduce health care costs by preventing disease transmission (HIV, HBV, and HCV), injection site infections, emergency department and inpatient care from drug overdose, injury, and death. Comprehensive harm reduction programs are effective at engaging high-risk populations and serving as a bridge for entry into drug treatment and other health and social services.

Regional monthly rates will be established for New York City and the rest of the state and are based on the expected direct service costs in each region. Billable activities encompass those components of harm reduction attributable to direct client service, such as brief assessment and treatment planning, harm reduction counseling, linkage and navigation, medication management and treatment adherence counseling, psychoeducation support groups. Direct and indirect costs are budgeted as part of the rate. No funds shall be used to carry out the purchase or distribution of sterile needles or syringes for the hypodermic injection of any illegal drug.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for State Fiscal Year 2023 is $34.6 million.

Effective on or after April 1, 2022, this notice proposes to establish Medical Assistance coverage and rates of payment for crisis intervention services to stabilize and treat mental health and substance use disorder conditions, provided by mobile crisis teams and residential crisis settings for adults, as well as crisis stabilization centers for adults and children.

More specifcally , crisis intervention services provided by multidisciplinary mobile crisis teams in accordance with Section 9813 of the American Rescue Plan Act provide an array of crisis intervention services, including telephonic triage for both adults and children, mobile crisis response, and mobile or telephonic follow-up services, in a variety of settings in the community.

Crisis intervention services provided in crisis stabilization centers will provide urgently needed immediate evaluation, treatment, and support services, including coordination with other mental health and substance use services, for children and adults experiencing or at risk of a mental health or substance use disorder crisis.

Crisis intervention services will also be provided in residential crisis settings, which are short-term, voluntary, non-IMD, sub-acute settings, and address a spectrum of acuity levels in which an individual may present in a mental health or substance use disorder crisis. Services stabilize crisis symptoms and restore functionality to enable transition back to the community and to prevent or reduce future psychiatric crises.

The estimated annual net aggregate increase in gross Medicaid expenditures related to this State Plan Amendment for State Fiscal Year 2023 is $16M and for State Fiscal Year 2024 is $44.5 million.

Effective on or after April 1, 2022, and for each State Fiscal Year thereafter, the State proposes to revise the method of distributing the funding for the Clinic Safety Net (CSN) distribution for comprehensive diagnostic and treatment centers that are other than Federally Qualif ed Health Centers (referred to as the non-FQHC CSN distribution).

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

Effective on or after April 1, 2022, the State proposes to enter into outcomes-based contract arrangements with drug manufacturers for drugs provided to Medicaid benefciaries through supplemental rebate agreements.

The estimated annual net aggregate decrease in gross Medicaid expenditures attributable to this initiative contained in the budget for State Fiscal Year 2023 is ($5 million).

Effective on or after April 1, 2022, this notice proposes to enhance (increase) state established reimbursement rates as follows:

Contingent upon CMS approval of the Spending Plan submitted by the state, established rates will be enhanced for state-plan approved private duty nursing (PDN) services for members 23 years of age and older by an additional 30 percent for the medically fragile training and experience and 45 percent for the private duty nursing directory starting April 1, 2022.

The estimated annual net aggregate increase in gross Medicaid expenditures as a result of the proposed amendments for PDN services for State Fiscal Year 2023 is $38.9 million.

Effective on or after April 1, 2022, pursuant to the Centers for Medicare and Medicaid Services, Medicaid coverage must include routine patient costs for items and services furnished in connection with participation by benef ciaries in qualifying clinical trials. The Department will submit a State Plan Amendment for Medicaid to formalize federal approval of existing coverage in accordance with the requirements. Routine patient costs and qualifying clinical trials are def ned in Section 1905(a)30 and Section 1905(gg) of the Social Security Act (the Act), respectively. This includes clinical trials in any clinical phase of development that is conducted in relation to the prevention, detection, or treatment of any serious or life-threatening disease or condition and is described in any of clauses (i)-(iii) of section 1905(gg) of the Act. Routine patient costs do not include any investigational item or service that is the subject of the qualifying clinical trial and is not otherwise covered outside of the clinical trial under the state plan, waiver, or demonstration project.

There is no estimated annual change to gross Medicaid expenditures as a result of this proposed amendment, since these benef ts are already covered under long-standing NYS Medicaid policy.

Effective on or after April 1, 2022, pursuant to the Centers for Medicare and Medicaid Services, Alternative Benef t Plans (ABP) coverage must include routine patient costs for items and services furnished in connection with participation by benefciaries in qualifying clinical trials. The Department will submit a State Plan Amendment for ABP to formalize federal approval of existing coverage in accordance with the requirements. Routine patient costs and qualifying clinical trials are def ned in Section 1905(a)30 and Section 1905(gg) of the Social Security Act (the Act), respectively. This includes clinical trials in any clinical phase of development that is conducted in relation to the prevention, detection, or treatment of any serious or life-threatening disease or condition and is described in any of clauses (i)-(iii) of section 1905(gg) of the Act. Routine patient costs do not include any investigational item or service that is the subject of the qualifying clinical trial and is not otherwise covered outside of the clinical trial under the state plan, waiver, or demonstration project.

There is no estimated annual change to gross Medicaid expenditures as a result of this proposed amendment, since these benef ts are already covered under long-standing NYS Medicaid policy.

Effective April 1, 2022, the Medicaid Program is proposing to incentivize ABA provider enrollment and participation by increasing Medicaid reimbursement amounts, aligning fees with those paid by the Child Health Plus program. "Applied behavior analysis'' or "ABA" is the design, implementation, and evaluation of environmental modif cations, using behavioral stimuli and consequences, to produce socially signif cant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior. ABA services are provided to individuals who have a diagnosis of autism spectrum or related disorder. As of August 1, 2021, Medicaid began accepting enrollment of Licensed Behavior Analysts as independent practitioners to provide ABA to Medicaid members under age 21 with a diagnosis of Autism Spectrum Disorder or Rhett's Syndrome. However, Medicaid Managed Care Plans (MMC) and ABA providers indicated that the Medicaid reimbursement rate is below rates paid by CHP and commercial plans. Subsequently, very few ABA providers have been willing to enroll as Medicaid managed care and/or fee-for-service providers.

The estimated annual net aggregate increase in gross Medicaid expenditures as a result of the proposed amendment for State Fiscal Year 2023 is $73.2 million.

Effective on or after April 1, 2022, this proposal to amend the State Plan to align with Subdivision 2 of section 365-a of the social services law, that authorizes clinical social workers, licensed pursuant to Article 154 of the Education law, to bill Medicaid directly for their services within their scope of practice, effective April 1, 2022.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for State Fiscal Year 2023 is $24.2 million.

Effective on or after April 1, 2022, this proposal to amend the State Plan to align with Subdivision 2 of section 365-a of the social services law, that authorizes licensed mental health counselors and marriage and family therapists, licensed pursuant to Article 163 of the Education law, to bill Medicaid directly for their services within their scope of practice, effective April 1, 2022.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for State Fiscal Year 2023 is $4.2 million.

Effective on or after July 1, 2022, Medicaid reimbursement rates for non-facility physician services will be updated to 70% of current Medicare rates. This update will apply to Evaluation & Management (E&M) and Medicine procedure codes. Most Medicaid physician reimbursement rates have not been updated since 2009 and New York Medicaid is currently reimbursing physicians, on average, at 45% of Medicare for E&M codes and 58% of Medicare for Medicine codes. Updating the Medicaid physician fee schedule is intended to increase the use of primary care and preventative services and reduced utilization of costlier downstream care.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fscal year 2022/2023 is $9.8 million.

Effective on or after April 1, 2022, the Medicaid fee-for-service Schedule will be adjusted to increase the reimbursement rate for midwifery services such that midwives will be reimbursed at 95% of the physician fee-for-service schedule.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this action contained in the budget for state fscal year 2022/2023 is $2.8 million.

Effective on or after April 1, 2022, this notice proposes to enhance (increase) state established reimbursement rates as follows:

Contingent upon approval of the Fiscal Year 2023 State Budget, established rates will be enhanced for the top twenty (20) state-plan approved orthotics and prosthetics (O & P) for Fee-for Service (FFS) and managed care members from the current Medicaid rate to 80% of the Medicare reimbursement rate.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fscal year 2023 is $8 million.

Institutional Services

Effective on or after April 1, 2022, this proposal continues the supplemental upper payment limit payments made to general hospitals, other than major public general hospitals under institutional services of $339 million annually.

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

For state f scal year beginning April 1, 2022 through March 31, 2023, this proposal continues adjustments for hospital inpatient services provided on and after April 1, 2012, to public general hospitals, other than those operated by the State of New York or the State University of New York, located in a city with a population of over one million and receiving reimbursement of up to $1.08 billion annually based on criteria and methodology set by the Commissioner of Health, which the Commissioner may periodically set through a memorandum of understanding with the New York City Health and Hospitals Corporation. Such adjustments shall be paid by means of one or more estimated payments. Payments to eligible public general hospitals may be added to rates of payment or made as aggregate payments.

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

For state f scal year beginning April 1, 2022, through March 31, 2023, this proposal continues supplemental payments to State government owned hospitals. These payments will not exceed the upper payment limit for inpatient services provided by state government-owned hospitals when aggregated with other Medicaid payments.

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

Effective on or after April 1, 2022, this proposal would extend the requirement to rebase and update the Service Intensity Weights (SIWs) for the acute Diagnostic Related Group (DRG) hospital rates no less frequently than every four years from July 1, 2022, to on or after January 1, 2024. It also revises the requirement for the base year used for rebasing. The new base year may be more than four years prior to the frst applicable rate period that utilizes such new base year.

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

Effective on or after April 1, 2022, additional medical assistance, known as, Intergovernmental Transfer (IGT) payments, for inpatient hospital services may be made to public general hospitals operated by the State of New York or the State University of New York, or by a county which shall not include a city with a population over one million, and those public general hospitals located in the counties of Westchester, Erie, or Nassau, up to one hundred percent (100%) of each such public hospital's medical assistance, and uninsured patient losses after all other medical assistance, including disproportionate share hospital (DSH) payments to such public general hospitals. Payments will be made by means of one or more estimated distributions initially based on the latest DSH audit results, which shall later be reconciled to such payment year's actual DSH audit uncompensated care costs. Payments may be added to rates of payment or made as aggregate payments. Such payments will continue April 1, 2022, through March 31, 2025.

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

Effective on and after April 1, 2022, through March 31, 2024, this notice provides for funding to distressed hospitals.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for State Fiscal Year 2023 is $200 million.

Effective for days of service on or after April 1, 2022, The Department of Health will adjust inpatient psychiatric fee-for-service per diem rates of reimbursement for distinct exempt units specializing in inpatient psychiatric services, in Article 28 hospitals, by increasing the case mix neutral psychiatric statewide per diem base price to produce a full annual net aggregate increase in gross Medicaid expenditures of $55 million. This State Plan Amendment is necessary to more adequately reimburse hospitals for providing these services and to better meet the community's mental health needs.

Long Term Care Services

Effective on or after April 1, 2022, this proposal continues additional payments to non-state government operated public residential health care facilities, including public residential health care facilities located in Nassau, Westchester, and Erie Counties, but excluding public residential health care facilities operated by a town or city within a county, in aggregate amounts of up to $500 million. The amount allocated to each eligible public RHCF will be in accordance with the previously approved methodology, provided, however that patient days shall be utilized for such computation ref ecting actual reported data. Payments to eligible RHCF's may be added to rates of payment or made as aggregate payments.

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

Effective on and after April 1, 2022, this notice provides for $30 million annually in temporary rate adjustments to long term care providers that are undergoing closure, merger, consolidation, acquisition or restructuring themselves or other health care providers. These payments are authorized by current State statutory and regulatory provisions. The temporary rate adjustments will be reviewed and approved by the CINERGY Collaborative.

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

Effective on and after April 1, 2022, through March 31, 2024, this notice provides for temporary rate adjustments to long term care providers that are undergoing closure, merger, consolidation, acquisition or restructuring themselves or other health care providers. These payments are authorized by current State statutory and regulatory provisions.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for State Fiscal Year 2023 is $200 million.

Eligibility

Effective January 1, 2023, the Medicaid program will eliminate the resource test for aged, blind and disabled applicants and recipients and raise the income eligibility level to 138% of the federal poverty level for aged, blind, disabled and other medically needy applicants and recipients.

The estimated net aggregate increase in gross Medicaid expenditures as a result of the proposed amendment for State Fiscal Year 2023 is $10 million.

The public is invited to review and comment on this proposed State Plan Amendment, a copy of which will be available for public review on the Department's website at http://www.health.ny.gov/regulations/state_plans/status. In addition, approved SPA's beginning in 2011 are also available for viewing on this website.

Copies of the proposed State Plan Amendments will be on f le in

each local (county) social services district and available for public review.

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

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

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

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

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

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

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

PUBLIC NOTICE

Department of State
Notice of Review of Request for
Brownfeld Opportunity Area
Conformance Determination
Project: Alvista Rise
Location: 147-25 94th Avenue
Jamaica Brownfeld Opportunity Area
City of New York, Queens County

In accordance with General Municipal Law, Article 18 - C, Section 970-r, the Secretary of State designated the Jamaica Brownf eld Opportunity Area, in the Bronx, on April 15, 2015. The designation of the Jamaica Brownfeld Opportunity Area was supported by a Nomination or a comprehensive planning tool that identif es strategies to revitalize the area which is affected by one or more known or suspected brownfeld sites.

Pursuant to New York State Tax Law, Article 1, Section 21, the eligible taxpayer(s) of a project site located in a designated Brownfeld Opportunity Area may apply for an increase in the allowable tangible property tax credit component of the brownf eld redevelopment tax credit if the Secretary of State determines that the project conforms to the goals and priorities established in the Nomination for a designated Brownfeld Opportunity Area.

On October 5, 2021, J2 Owner LLC submitted a request for the Secretary of State to determine whether the project Alvista Rise, located at 147-25 94th Avenue, Queens, NY, which will be located within the designated Jamaica Brownfeld Opportunity Area, conform to the goals and priorities identif ed in the Nomination that was prepared for the designated Jamaica Brownfeld Opportunity Area.

The public is permitted and encouraged to review and provide comments on the request for conformance. For this purpose, the full application for a conformance determination is available online at: https://dos.ny.gov/system/f les/documents/2022/03/application_147-25_94th-avenue_jamaica.pdf

Comments must be submitted no later than April 30th, 2022, either by mail to: Kevin Garrett, Department of State, Offce of Planning and Development, 123 William St., #20-163, New York, NY 10038, or by email to: kevin.garrett@dos.ny.gov

PUBLIC NOTICE

Department of State
Notice of Review of Request for
Brownfeld Opportunity Area
Conformance Determination
Project: The Arches
Location: Port Morris Harlem Riverfront
Brownfeld Opportunity Area
City of New York, Bronx County

In accordance with General Municipal Law, Article 18 - C, Section 970-r, the Secretary of State designated the Port Morris Harlem Riverfront Brownf eld Opportunity Area, in the Bronx, on April 9, 2015. The designation of the Port Morris Harlem Riverfront Brownfeld Opportunity Area was supported by a Nomination or a comprehensive planning tool that identif es strategies to revitalize the area which is affected by one or more known or suspected brownfeld sites.

Pursuant to New York State Tax Law, Article 1, Section 21, the eligible taxpayer(s) of a project site located in a designated Brownfeld Opportunity Area may apply for an increase in the allowable tangible property tax credit component of the brownf eld redevelopment tax credit if the Secretary of State determines that the project conforms to the goals and priorities established in the Nomination for a designated Brownfeld Opportunity Area.

On July 30, 2021, Deegan 135 Realty LLC submitted a request for the Secretary of State to determine whether The Arches Project, which will be located within the designated Port Morris Harlem Riverfront Brownf eld Opportunity Area, conform to the goals and priorities identifed in the Nomination that was prepared for the designated Port Morris Harlem Riverfront Brownfeld Opportunity Area.

The public is permitted and encouraged to review and provide comments on the request for conformance. For this purpose, the full application for a conformance determination is available online at: https://dos.ny.gov/system/f les/documents/2022/03/2021-07-30-f nalboa-conformance-application-with-attachments-for-deegan-135-realty-llc.pdf

Comments must be submitted no later than March 30th, 2022, either by mail to: Kevin Garrett, Department of State, Off ce of Planning and Development, 123 William St., #20-163, New York, NY 10038, or by email to: kevin.garrett@dos.ny.gov

PUBLIC NOTICE

Department of State
F-2022-0058, F-2022-0130 through F-2022-0140
Date of Issuance – March 30, 2022

The New York State Department of State (DOS) is required by Federal regulations to provide timely public notice for the activities described below, which are subject to the consistency provisions of the Federal Coastal Zone Management Act (CZMA) of 1972, as amended.

The applicant has certifed that the proposed activities comply with and will be conducted in a manner consistent with the federally approved New York State Coastal Management Program (NYSCMP). The applicant's consistency certifcation and accompanying public information and data are available for inspection at the New York State Department of State off ces located at One Commerce Plaza, 99 Washington Avenue, in Albany, New York.

In F-2022-0058, F-2022-0130, F-2022-0131, F-2022-0132, F-2022-0133, F-2022-0134, F-2022-0135, F-2022-0136, F-2022-0137, F-2022-0138, F-2022-0139, and F-2022-0140, the consultant, Andrew Baird at First Coastal Corp., is proposing a living shoreline along twelve contiguous properties. The shoreline design will contain the following parts: a 12' wide emergent rock sill ranging from 40' to 65' long consisting of approx. 110 cubic yards of stone per property to be placed 58 feet seaward of the rock core dune; 94 cubic yards of clean sand fll landward of rock sill per property; 750 square feet of spartina planting 12″ O.C. per property; a rock-core dune of 45 cubic yards of toe stone and fll stone per property for 6 of the homes; additional 18″

Appendix V
2022 Title XIX State Plan
Second Quarter Amendment
Responses to Standard Funding Questions

NON-INSTITUTIONAL SERVICES
State Plan Amendment #22-0026

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.

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 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 receive and retain the total Medicaid expenditures claimed by the State and the State does not require any provider to return any portion of such payments to the State, local government entities, or any other intermediary organization.

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 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 government 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: The Non-Federal share Medicaid provider payment is funded by a combination of the following funds/funding sources through enacted appropriations authority to the Department of Health (DOH) for the New York State Medicaid program.

		4/1/22 – 3/31/23	
Payment Type	**Non-Federal Share Funding**	**Non-Federal**	**Gross**
Normal Per Diem	General Fund; Special Revenue Funds; County Contribution	$251,040,721	$502,081,442

1) **General Fund:** Revenue resources for the State's General Fund includes taxes (e.g., income, sales, etc.), and miscellaneous fees (including audit recoveries). Medicaid expenditures from the State's General Fund are authorized from Department of Health Medicaid.

   a. New York State Audit Recoveries: The Department of Health collaborates with the Office of the Medical Inspector General (OMIG) and the Office of the Attorney General (AG) in recovering improperly expended Medicaid funds. OMIG conducts and coordinates the investigation, detection, audit, and review of Medicaid providers and recipients to ensure they are complying with all applicable laws and regulation. OMIG recovers any improper payments through cash collections and voided claim recoveries. Cash collections are deposited into the State's General Fund to offset Medicaid costs.

      In addition to cash collections, OMIG finds inappropriately billed claims within provider claims. To correct an error, OMIG and DOH process the current accurate claim, and reduce this claim by the inappropriate claim value to recoup the previous overclaim and decrease state spending.

2) **Special Revenue Funds:**

   a. Health Care Reform Act (HCRA) Resource Fund: as authorized in section 92-dd of New York State Finance Law and was established in 1996, pursuant to New York State Public Health Law 2807-j. HCRA resources include health care related surcharges, assessments on hospital revenues, and a "covered

lives" assessment paid by insurance carriers pursuant to chapter 820 of the laws of 2021.

b. Health Facility Cash Assessment Program (HFCAP) Fund: HFCAP requires New York State designated providers to pay an assessment on cash operating receipts on a monthly basis. The assessment includes Article 28 Residential Health Care Facilities, Article 28 General Hospitals, Article 36 Long Term Home Health Care Programs, Article 36 Certified Home Health Agencies and Personal Care Providers that possess a Title XIX (i.e. Medicaid) contract with a Local Social Services District for the delivery of personal care services pursuant to Section 367-i of the New York State Social Services Law.

   NOTE: New York's Health Care taxes are either broad based and uniform (as in all HFCAP assessments except for the Personal Care Provider Cash Assessment) or have a specific exemption known as the "D'Amato provision (Federal PHL section 105-33 4722 (c)" which allows the HCRA surcharges to exist in their current format. The single tax which has been determined by the State to be an impermissible provider tax is the HFCAP charge on Personal Care Providers. The State does not claim any Federal dollars for the surcharge collected in this manner in order to comply with all Federal provider tax rules.

3) Additional Resources for State Share Funding:

a. County Contribution: In State Fiscal Year 2006, through enacted State legislation (Part C of Chapter 58 of the laws of 2005), New York State "capped" the amount localities contributed to the non-Federal share of providers claims. This was designed to relieve pressure on county property taxes and the NYC budget by limiting local contributions having New York State absorb all local program costs above this fixed statutory inflation rate (3% at the time).

   However, in State Fiscal Year 2013 New York State provided additional relief to Localities by reducing local contributions annual growth from three precent to zero over a three-year period. Beginning in State Fiscal Year 2016, counties began paying a fixed cost in perpetuity. By eliminating the growth in localities Medicaid costs, the State has statutorily capped total Statewide County Medicaid expenditures at 2015 levels. All additional county Medicaid costs are funded by the State through State funding as described above. DOH provides annual letters to counties providing weekly contributions. Contributions are deposited directly into State escrow account and used to offset 'total' State share Medicaid funding.

   NOTE: The Local Contribution is not tied to a specific claim or service category and instead is a capped amount based on 2015 county spending levels as stated above.

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 Medicaid payments under this State Plan Amendment are not supplemental 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. Under regulations at 42 CFR 447.272, States are prohibited from setting payment rates for Medicaid inpatient services that exceed a reasonable estimate of the amount that would be paid under Medicare payment principals.**

   Response: The Medicaid payments authorized under this State Plan Amendment do not impact the UPL demonstrations.

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: Providers do not receive payments that in the aggregate exceed their reasonable costs of providing services. If any providers received payments that in the aggregate exceeded their reasonable costs of providing services, the State would recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report.

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 complies 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.