NEW YORK STATE OF OPPORTUNITY. 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

Todd McMillion
Director
Department of Health and Human Services
Centers for Medicare and Medicaid Services
233 North Michigan Ave, Suite 600
Chicago, IL 60601

RE: SPA #22-0035
Non-Institutional Services

Dear Mr. McMillion:

The State requests approval of the enclosed amendment #22-0035 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 proposed State Regulations. 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 proposed State Regulations 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,

[redacted]

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: 22-0035

2. STATE: NY

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
April 1, 2022

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

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 04/01/22-09/30/22 $ 0
b. FFY 10/01/22-09/30/23 $ 0

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.19-B: Pages 2(an), 2(an)(1), 2(an)(1.1)

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 4.19-B: Pages 2(an), 2(an)(1), 2(an)(1.1)

9. SUBJECT OF AMENDMENT
Non-FQHC Clinic Safety Net Distribution Methodology Change

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
[redacted]

12. TYPED NAME
Amir Bassiri

13. TITLE
Acting Medicaid Director

14. DATE SUBMITTED
June 30, 2022

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

FOR 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

Instructions on Back

SPA 22-0035

Attachment A

Annotated Pages

Annotated Pages: 2(an)(1)

New York
2(an)(1)

[Diagnostic and Treatment Centers (D&TCs) Safety Net Payment (continued):

d. Each eligible D&TC will qualify for a rate add-on based on its percentage of uninsured visits to total visits according to the following tiers:

% of eligible uninsured visits to total visits							
Upstate				**Downstate**			
Low (at Least)	High (Less Than)	Amount	Tier	Low (at Least)	High (Less Than)	Amount	Tier
0%	5%	$0	0	0%	5%	$0	0
5%	10%	$30	1	5%	15%	$47	1
10%	15%	$40	2	15%	20%	$57	2
15%	20%	$51	3	20%	25%	$68	3
20%	25%	$63	4	25%	35%	$80	4
25% or more		$76	5	35% or more		$93	5

e. Safety net payments will be calculated by multiplying each facility's rate add-on, based on the tiers in paragraph (1)(d), by the number of Medicaid fee-for-service visits reported on the base year certified cost report.

f. The safety net rate adjustment for each eligible D&TC that is determined based on the tier system will be scaled based on the ratio of the total funds allocated for distribution, using the tier system, to the total statewide safety net payment that is available for all eligible D&TCs.

g. Adjustments to rates of payment made pursuant to this section will be made quarterly as aggregate payments to eligible diagnostic and treatment centers and will not be subject to subsequent adjustment or reconciliation.

2. In the event that a provider that is included in this D&TCs Safety Net Payment section receives FQHC designation during a state fiscal year, the newly designated FQHC provider will be removed from this D&TCs Safety Net Payment section and included in section for the FQHCs Safety Net Payment as follows:

a. The effective date of the transfer will be the later of the following:

i. The first state fiscal year distribution calculation after the FQHC designated approval date; or

ii. The first state fiscal year distribution calculation after the date the Department of Health is notified of the FQHC designation.

b. The funds that were allocated to the new FQHC provider in this D&TCs Safety Net Payment section will be transferred to the FQHC Safety Net Payment section based on the prior state fiscal year calculation.]

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

New York
2(an)

1905(a)(9) Clinic Services

Diagnostic and Treatment Centers (D&TCs) Safety Net Payment

1. For the period December 1, 2018, through March 31, 2019, and for annual state fiscal years thereafter, up to $17,350,000 of additional payments will be made to eligible Medicaid safety net diagnostic and treatment centers (D&TCs), except for Federally Qualified Health Centers (FQHCs), to sustain access to services. The amount of $17,350,000 is subject to modification by the transfers described in paragraphs (2) and (3) of this section.

   a. "Eligible Medicaid safety net diagnostic and treatment centers", for purposes of this section, will mean voluntary non-profit and publicly sponsored diagnostic and treatment centers licensed under Article 28 or Article 31, and must meet the following criteria: deliver comprehensive range of health care or mental health services; provide at least 5% of their annual visits to uninsured individuals and, for distribution periods beginning on and after April 1, 2022, provide at least 3% of their annual visits to uninsured individuals; and have a process in place to collect payment from third party payers.

   b. The base year data used for the period commencing on December 1, 2018 through March 31, 2019 will be the 2016 certified cost report and will be advanced one year thereafter for each subsequent period. In order to be included in the distribution calculation, a provider must timely submit a certified cost report for the base year used in the distribution calculation.

   c. New providers which do not have a full year cost or visit experience in the base year used for the distribution may qualify to be included in the distribution as follows:

      i. The provider meets the criteria in paragraph (1)(a).

      ii. The provider must be eligible to receive a Medicaid rate.

      iii. The provider must submit a request to the Department of Health to participate in the distribution. This request must include annualized patient visits, by payer source, which are certified by the Chief Executive Officer, or a similar executive position.

      iv. The effective date to be included in the distribution will be the first state fiscal year distribution calculation after the provider qualifies to be included based on the requirements in paragraphs (1)(c)(i) through (1)(c)(iii) (herein after referred to as paragraph (1)(c)) or the first state fiscal year distribution calculation after the date a request is made to the Department of Health to be included in the distribution, whichever is later.

      v. The distribution method applied to a new provider that qualifies to be included in the distribution based on paragraph (1)(c) of this section will be in accordance with the distribution method for other providers in this section. However, the annual distribution for a provider that qualifies based on paragraph (1)(c) of this section will not exceed $100,000.

      vi. The distribution for a provider that qualifies based on paragraph (1)(c) of this section will be included in the total safety net distribution amount as described in paragraph (1) of this section.

New York
2(an)(1)

1905(a)(9): Clinic Services

Diagnostic and Treatment Centers (D&TCs) Safety Net Payment (continued):

d. (i) Each eligible D&TC will qualify for a rate add-on based on its percentage of uninsured visits to total visits according to the following tiers:

% of eligible uninsured visits to total visits							
Upstate				**Downstate**			
Low (at Least)	High (Less Than)	Amount	Tier	Low (at Least)	High (Less Than)	Amount	Tier
0%	5%	$0	0	0%	5%	$0	0
5%	10%	$30	1	5%	15%	$47	1
10%	15%	$40	2	15%	20%	$57	2
15%	20%	$51	3	20%	25%	$68	3
20%	25%	$63	4	25%	35%	$80	4
25% or more		$76	5	35% or more		$93	5

(ii) For the distribution periods beginning on and after April 1, 2022, the tiers will not apply and all eligible D&TC's will receive a uniform add-on which will be calculated by dividing the total D&TC Safety Net Payment available, as stated in paragraph 1 of this section, by the sum of the total number of uninsured visits and Medicaid fee-for-service visits for all eligible D&TCs reported on the base year certified cost report. Any visit which Medicaid is not the only payer will not be included in the calculation.

e. (i) For the distribution periods prior to April 1, 2022, safety net payments will be calculated by multiplying each facility's rate add-on, based on the tiers in paragraph (1)(d)(i) of this section, by the number of Medicaid fee-for-service visits reported on the base year certified cost report.

(ii) For the distribution periods beginning on and after April 1, 2022, each eligible D&TC's safety net payment will be calculated by multiplying the uniform rate add-on, calculated based on paragraph (1)(d)(ii) of this section, by the sum of each D&TC's uninsured visits and Medicaid fee-for-service visits reported on the base year certified cost report. The uninsured and Medicaid fee-for-service visits used in the facility's distribution calculation will be the same visits utilized in the uniform rate add-on calculation described in paragraph (1)(d)(ii) of this section.

f. The safety net rate adjustment for each eligible D&TC that is determined based on the tier system in paragraph (1)(d)(i) of this section will be scaled based on the ratio of the total funds allocated for distribution, using the tier system, to the total statewide safety net payment that is available for all eligible D&TCs. The safety net rate adjustment for each eligible D&TC that is determined based on the uniform rate add-on in paragraph (1)(d)(ii) of this section will no longer require the rate adjustment be scaled.

g. Adjustments to rates of payment made pursuant to this section will be made quarterly as aggregate payments to eligible diagnostic and treatment centers and will not be subject to subsequent adjustment or reconciliation.

New York
2(an)(1.1)

1905(a)(9) Clinic Services

Diagnostic and Treatment Centers (D&TCs) Safety Net Payment (continued):

2. In the event that a provider that is included in this D&TCs Safety Net Payment section receives FQHC designation during a state fiscal year, the newly designated FQHC provider will be removed from this D&TCs Safety Net Payment section and included in section for the FQHCs Safety Net Payment as follows:

a. The effective date of the transfer will be the later of the following:

i. The first state fiscal year distribution calculation after the FQHC designated approval date; or

ii. The first state fiscal year distribution calculation after the date the Department of Health is notified of the FQHC designation.

b. The funds that were allocated to the new FQHC provider in this D&TCs Safety Net Payment section will be transferred to the FQHC Safety Net Payment section based on the prior state fiscal year calculation.

i. The transfer of funds will be at the same time the new FQHC provider is included in the FQHC Safety Net Payment section distribution.

ii. Due to the transfer of the newly designated FQHC's funds to the FQHCs Safety Net Payment section, the total value of the additional payment, as described in paragraph (1) of this section for the additional annual payment, will decrease.

c. In no event will the sum of the total safety net distribution amount of the FQHCs Safety Net Payment in this section and the D&TCs Safety Net Payment section exceed $151,500,000 for the period July 28, 2016, through March 31, 2017, and $110,000,000 for the annual state fiscal periods thereafter.

3. In the event that a provider that is included in the FQHCs Safety Net Payment section loses its FQHC designation, the FQHCs Safety Net Payment distribution to the provider calculated for the state fiscal year during which the provider lost its FQHC designation will be transferred to this section as follows:

a. The provider will be removed from the distribution calculated in the FQHC Safety Net Payment section and included in this section for the D&TC Safety Net Payment.

b. The effective date of the transfer will be the first state fiscal year distribution calculation after the date the provider lost their FQHC designation.

c. The funds allocated to the provider in the FQHC Safety Net Payment section will be transferred to this D&TC Safety Net Payment section based on the portion of the distribution pertaining to the Medicaid fee-for-service visits applied to the tier add-on payment. The transfer of funds will be at the same time the provider is included in this D&TC Safety Net Payment section distribution, as stated in paragraph (3)(b) of this section, increasing the total value of the additional payment as described on paragraph (1) of this section.

Appendix II
2022 Title XIX State Plan
Second Quarter Amendment
Summary

SUMMARY
SPA #22-0035

This State Plan Amendment proposes to revise the method of distributing the Clinic Safety Net (CSN) payments for non-FQHCs.

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

Effective Date:
Title: Section 86-4.33 – [Reserved] Clinic Safety Net Payments

86-4.33 Clinic Safety Net Payments.

(a) Effective beginning April 1, 2022, Safety net distribution payments shall be made available annually on a state fiscal year basis to eligible Medicaid safety net clinics to sustain access to services.

(b) To be eligible to participate in the safety net distribution calculation, the clinic must meet the following requirements:

(1) The clinic must be a voluntary non-profit or publicly sponsored mental health clinic licensed under Article 31 of the Mental Hygiene Law, or;

(2) The clinic must be a voluntary non-profit or publicly sponsored clinic licensed under Article 28 of the Public Health Law as a Diagnostic and Treatment Center (D&TC) where comprehensive services is their principal mission and the clinic delivers a comprehensive range of health care services to the general population.

(c) Funds allocated for such distribution shall be divided into the following two groups:

(1) Diagnostic and Treatment Centers that have current Federally Qualified Health Center or Rural Health Center status from the Health Resources and Services Administration (hereinafter referred to as FQHC clinics). FQHC clinics shall receive $92,650,000, subject to federal financial participation, or $46,325,000 state share only, distributed based on the methodology described in subdivisions (i) and (k) of this section.

(2) Diagnostic and Treatment Centers that do not have current Federally Qualified Health Center or Rural Health Center status from the Health Resources and Services Administration (hereinafter referred to as non-FQHC clinics). Non-FQHC clinics shall receive $17,350,000, subject to federal financial participation, or $8,675,000 state share only, distributed based on the methodology described in subdivisions (j) and (k) of this section.

(d) The total distribution for FQHC and non-FQHC clinics shall not exceed $110,000,000, subject to federal financial participation, or $55,000,000 state share only. The FQHC and non-FQHC total distributions, as stated in subdivision (c) of this section, may be adjusted each distribution year by the transfers described in subdivision (i).

(e) For an eligible clinic to qualify for a payment from the FQHC clinic distribution, the clinic must:

(1) provide at least 5% of their total annual clinic visits to uninsured individuals;

(2) have a process in place to collect payment from third party payers;

(3) have received Federally Qualified Health Center or Rural Health Center status from the Health Resources & Services Administration (HRSA).

(f) For an eligible clinic to qualify for a payment from the non-FQHC clinic distribution, the clinic must:

(1) provide at least 3% of their total annual clinic visits to uninsured individuals;

(2) have a process in place to collect payment from third party payers;

(g) Payments made pursuant to this section shall be made as aggregate payments versus an add-on to the clinic Medicaid rate and will not be subject to adjustment or reconciliation.

(h) The base year data used for determining the FQHC and non-FQHC distributions shall be the certified cost report from the 2 years prior to the beginning of the distribution period. The Ambulatory Health Care Facility (AHCF) certified cost report shall be utilized for Article 28 clinics using the Article 28 reported comprehensive data only. The Consolidated Fiscal Report (CFR) certified cost report shall be utilized for Article 31 clinics. Clinics that have both an Article 28 and Article 31 certification, the data shall be treated separately for purposes of determining the qualifications and distribution to the clinic. To be included in the safety net distribution calculation, a clinic must timely submit a certified cost report for the base year to be used in the distribution calculation.

(i) FQHC clinics shall receive distributions based on the following method:

(1) The rate add-on (Tiers Table “Add-on Amt”) applied in the development of the distribution payment for each eligible FQHC clinic shall be based on the clinic’s percentage of uninsured visits to their total visits using the Tiers Table “low/high” scale:

Tiers Table

% of eligible uninsured visits to total visits							
Upstate				**Downstate**			
Low	**High (up to)**	**Add-on Amt**	**Tier**	**Low**	**High (up to)**	**Add-on Amt**	**Tier**
5%	10%	$15	1	5%	15%	$32	1
10%	15%	$25	2	15%	20%	$42	2
15%	20%	$36	3	20%	25%	$53	3
20%	25%	$48	4	25%	35%	$65	4
25%	100%	$61	5	35%	100%	$78	5

(2) Distributions shall be calculated by first multiplying each facility's rate add-on, based on the Tiers Table, by the sum the facility's Medicaid fee-for-service and Medicaid Managed Care visits reported in the certified cost report. Any visits in which Medicaid is not the only payer shall not be included in the Medicaid visit count.

(3) The distribution for each eligible FQHC clinic shall then be determined by multiplying the result of the calculation above by the ratio of the total funds allocated for distribution based on the tiers to the total distribution available for all eligible FQHC clinics.

(4) If a non-FQHC clinic receives FQHC designation prior to the beginning of a state fiscal year distribution calculation, the clinic will be removed from the non-FQHC distribution and included in the FQHC clinic distribution in in accordance with this paragraph.

(i) The amount of funds allocated to the clinic based on the prior state fiscal year distribution will be transferred to the FQHC clinic distribution.

(ii) The effective date of the transfer shall be the first state fiscal year distribution calculation after receiving the FQHC designation approval or the first state fiscal year distribution calculation after the date the Department is notified of the FQHC designation, whichever is later.

(iii) The total value of the distribution for the FQHC clinic distribution shall be increased and the non-FQHC clinic distribution decreased in the amount of the transferred distribution.

(5) If an FQHC clinics loses its FQHC designation, the clinic shall be removed from the FQHC distribution and included in the non-FQHC distribution in accordance with this paragraph.

(i) The portion of the distribution pertaining to the Medicaid managed care visits shall no longer be paid to the clinic as of the date the FQHC clinic loses its designation. The clinic shall continue to receive a distribution based on the Medicaid fee-for-service visits.

(ii) The amount of the distribution reduction shall be calculated based on the number of days remaining in the distribution period from the date the FQHC clinic loses its designation.

(iii) The Department shall retain the portion of the distribution not paid pursuant to subparagraphs (i) and (ii) of this paragraph until the fourth quarterly aggregate payment. In the event that the clinic regains its FQHC designation during the same state fiscal year and notifies the Department prior to the payment of the fourth quarterly aggregate payment, the clinic shall receive the Medicaid managed care portion of its distribution calculated based only on the time period after which it regained its FQHC designation.

(iv) If the clinic does not regain its FQHC designation during the same state fiscal year, the portion of the distribution retained shall be redistributed to the other eligible FQHC clinics based on the proportion of their distribution to the total distribution which shall be included in the fourth quarterly aggregate payment and,

(A) The clinic shall be removed from the FQHC clinic distribution and included in the non-FQHC clinic distribution in the first state fiscal year distribution period after the FQHC designation was lost. At that time, the funds allocated to the clinic shall be transferred to the non-FQHC total distribution based on the portion of the distribution pertaining to the Medicaid fee-for-service visits.

(B) The total FQHC clinic distribution shall be decreased and the total non-FQHC distribution increased in the amount of the transferred distribution.

(j) Non-FQHC clinics shall receive distributions based on the following method:

(1) All eligible non-FQHCs will receive a uniform rate add-on. This add-on will be calculated by dividing the total distribution available for non-FQHC clinics by the sum of the total number of uninsured visits and Medicaid fee-for-service visits reported on the certified cost report for all

eligible non-FQHCs clinics. Any visit in which Medicaid is not the only payer shall not be included in the Medicaid visit count.

(2) Each non-FQHC's distribution shall be calculated by multiplying the uniform rate add-on, as determined above, by the sum of the facility's total number of uninsured visits and Medicaid fee-for-service visits reported in the certified cost report. The uninsured and Medicaid fee-for-service visits used in the facility's distribution calculation will be the same visits utilized in the uniform rate add-on calculation stated above.

(k) New clinic providers, which shall not include extension sites of clinics already eligible for distributions, that do not have a full year cost experience in the base year used may qualify to receive a distribution pursuant to this subdivision.

(1) A new clinic must meet the following criteria:

(i) The clinic must be a Medicaid Safety Net clinic, as defined in this section;

(ii) The clinic must be enrolled to receive Medicaid reimbursement in New York State and eligible to receive a clinic Medicaid reimbursement rate;

(iii) The clinic must submit a request to the Department to participate in the distribution. This request must include cost report comparable data for annualized patient visits, by payer source, which are certified by the Chief Executive Officer or a similar executive position.

(2) Distributions to new clinics, approved by the Department to participate, shall be calculated according to the methodology established in this section based on the clinic distribution in which they qualify provided that the distribution shall not exceed $100,000.

(3) In the following distribution periods for which there is a full year cost experience, such clinics shall begin receiving distributions according to the qualifying requirements and methodology established in this section.

(4) The distribution for a new clinic will be included in the total distribution amount and shall not increase the total distributions pursuant to subdivisions (c) and (d) of this section.

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

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 specifically, 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 Qualified 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 beneficiaries 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 beneficiaries 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 defined 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 benefits 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 Benefit Plans (ABP) coverage must include routine patient costs for items and services furnished in connection with participation by beneficiaries 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 defined 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 benefits 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 modifications, using behavioral stimuli and consequences, to produce socially significant 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.

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

NON-INSTITUTIONAL SERVICES
State Plan Amendment #22-0035

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**
Supplemental	General Fund; Special Revenue Funds	$8,675,000	$17,350,000

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. **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 authorized under this State Plan Amendment are supplemental payments and total $17,350,000 for State Fiscal Year 2022-23.

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.