



Department of Health

KATHY HOCHUL
Governor

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

KRISTIN M. PROUD
Acting Executive Deputy Commissioner

September 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 #22-0076
Non-Institutional Services

Dear Mr. McMillion:

The State requests approval of the enclosed amendment #22-0076 to the Title XIX (Medicaid) State Plan for non-institutional services to be effective July 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 June 29, 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
Medicaid Director
Office of Health Insurance Programs

Enclosures

**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 _____ \$ _____
b. FFY _____ \$ _____

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable)

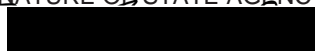
9. SUBJECT OF AMENDMENT

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



15. RETURN TO

12. TYPED NAME

//

13. TITLE

14. DATE SUBMITTED

September 30, 2022

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
Third Quarter Amendment
Amended SPA Pages

New York
2(w) (ii)

1905(a)(9) Clinic Services

Beginning state fiscal year 2014-2015, and each subsequent state fiscal year thereafter, the utilization look-back period ~~shall~~ will be the period used in the preceding state fiscal year advanced by twelve months.

For the period April 1, 2011, through March 31, 2012, OPWDD ~~may~~ will waive the reimbursement rate reductions described here, provided, however, that the waiver will be subject to retroactive revocation upon a determination by OPWDD, in consultation with the Department of Health, that the clinic has not complied with the terms of such waiver. Such terms are:

- (i) In order to receive a waiver, a clinic must submit to OPWDD a request for a waiver and a utilization reduction plan. OPWDD's decision on the waiver will be based on whether the clinic's utilization reduction plan shows a reduction in the clinic's planned state fiscal year 2011-2012 Medicaid visits by an amount equal to the paid visits in excess of the utilization thresholds and whether the clinic is operating in conformance with all applicable statutes, rules and regulations. For purposes of this section, a clinic's planned state fiscal year 2011-2012 visits cannot exceed its paid Medicaid visits in calendar year 2010.
- (ii) OPWDD will compare the actual paid and planned visits between April 1, 2011, and March 31, 2012, for each clinic granted a waiver. If a clinic fails to achieve the reduction in utilization in accordance with its utilization reduction plan, OPWDD will revoke the waiver and reduce the clinic's reimbursement rates for state fiscal year 2011-12 as computed in accordance with the provisions of this section, provided, however, that such reduction computation will incorporate and reflect any utilization reduction that the clinic did achieve while operating under the waiver.

Effective 07/01/2022, the Behavioral Health Utilization Controls will be sunset for Article 16 clinics licensed by OPWDD.

Appendix II
2022 Title XIX State Plan
Third Quarter Amendment
Summary

SUMMARY
SPA #22-0076

This State Plan Amendment proposes to remove the "Behavioral Health Utilization Controls" payment reductions for OPWDD Article 16 Clinics per the enacted 2023 Budget.

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

SPA 22-0076

Part TT of Chapter 57 of the Laws of 2022

PART TT

6 Section 1. Section 26 of part H of chapter 59 of the laws
of 2011,

7 amending the public health law and other laws, relating to
targeted

8 Medicaid reimbursement rate reductions, is amended to read as
follows:

9 § 26. Notwithstanding any provision of law to the contrary
and subject

10 to the availability of federal financial participation, for
periods on

11 and after April 1, 2011, clinics certified pursuant to
[~~articles 16,~~

12 article 31 or 32 of the mental hygiene law shall be subject to
targeted

13 Medicaid reimbursement rate reductions in accordance with the
provisions

14 of this section. Such reductions shall be based on utilization
thresh-

15 olds which may be established either as provider-specific or
patient-

16 specific thresholds. Provider-specific thresholds shall be
based on

17 average patient utilization for a given provider in comparison
to a peer

18 based standard to be determined for each service. The
commissioners of

19 the office of mental health[~~, the office for persons with
developmental~~

20 ~~disabilities,~~] and the office of [~~alcoholism and
substance abuse~~

21 addiction services and supports, in consultation with the
commissioner

22 of health, are authorized to waive utilization thresholds for
patients

23 of clinics certified pursuant to article [~~16,~~] 31[~~,~~] or 32 of
the mental

24 hygiene law who are enrolled in specific treatment programs or
otherwise

25 meet criteria as may be specified by such commissioners. When
applying

26 a provider-specific threshold, rates will be reduced on a
prospective

27 basis based on the amount any provider is over the determined
threshold

28 level. Patient-specific thresholds will be based on annual
thresholds

29 determined for each service over which the per visit payment
for each

30 visit in excess of the standard during a twelve month period
shall be

31 reduced by a pre-determined amount. The thresholds, peer based
standards
32 and the payment reductions shall be determined by the
department of
33 health, with the approval of the division of the budget, and
in consul-
34 tation with the office of mental health[~~, the office for~~
~~people with~~
35 ~~developmental disabilities~~] and the office of [~~alcoholism and~~
~~substance~~
36 ~~abuse~~] addiction services and supports, and any such
resulting rates
37 shall be subject to certification by the appropriate
commissioners
38 pursuant to subdivision (a) of section 43.02 of the mental
hygiene law.
39 The base period used to establish the thresholds shall be
the 2009
40 calendar year. The total annualized reduction in payments shall
be not
41 more than \$10,900,000 for Article 31 clinics[~~, not more than~~
~~\$2,400,000~~
42 ~~for Article 16 clinics,~~] and not more than \$13,250,000 for
Article 32
43 clinics. The commissioner of health may promulgate regulations
to imple-
44 ment the provisions of this section.
45 § 2. This act shall take effect immediately.
46 § 2. Severability clause. If any clause, sentence, paragraph,
subdivi-
47 sion, section or part of this act shall be adjudged by any
court of
48 competent jurisdiction to be invalid, such judgment shall not
affect,
49 impair, or invalidate the remainder thereof, but shall be
confined in
50 its operation to the clause, sentence, paragraph, subdivision,
section
51 or part thereof directly involved in the controversy in which
such judg-
52 ment shall have been rendered. It is hereby declared to be the
intent of
53 the legislature that this act would have been enacted
even if such
54 invalid provisions had not been included herein.

**Appendix IV
2022 Title XIX State Plan
Third Quarter Amendment
Public Notice**

(Medicaid) State Plan for non-institutional services to revise provisions of the Ambulatory Patient Group (APG) reimbursement methodology. The following changes are proposed:

Non-Institutional Services

Effective on or after July 1, 2022, the Ambulatory Patient Group (APG) reimbursement methodology is revised to include recalculated weight and component updates in order to maintain consistent reimbursement for APG payments. Also, rates of reimbursement are being established for Licensed Mental Health Counselors and Licensed Marriage and Family Therapists in hospital outpatient departments and freestanding clinics.

The estimated annual change to gross Medicaid expenditures as a result of this proposed amendment is \$3,603,802.

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

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

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

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

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

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

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

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

PUBLIC NOTICE
Department of Health

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

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

Non-Institutional Services

Effective on or after July 1, 2022, the "Behavioral Health Utilization Controls" will be removed and the payment reduction for OPWDD Article 16 Clinics will no longer be applied.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2022/2023 is \$368,218.

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

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

PUBLIC NOTICE
Department of Health

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

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

Non-Institutional Services

Effective for dates of service on or after July 1, 2022, the Department of Health will increase Comprehensive Psychiatric Emergency Program (CPEP) reimbursement including fees paid for full emergency visits, triage and referral visits and extended observation bed services. This investment will result in a full annual projected increase in gross Medicaid expenditures of \$20,000,000. This State Plan Amendment is necessary to adequately reimburse CPEP programs for providing these services and better meet the community's mental health needs.

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

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

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Bronx County, Tremont Center
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Bronx, New York 10457
Richmond County, Richmond Center

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

NON-INSTITUTIONAL SERVICES
State Plan Amendment #22-0076

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 receive and retain 100 percent of 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 (normal per diem and supplemental) 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.

Payment Type	Non-Federal Share Funding	4/1/22 – 3/31/23	
		Non-Federal	Gross
Normal Per Diem	General Fund; County Contribution	\$28M	\$55M

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) Additional Resources for Non-Federal Share Funding:

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 percent to zero over a three-year period. Beginning in State Fiscal Year 2016, counties began paying a fixed cost in perpetuity as follows:

County	Annual Amount
New York City	\$4.882B
Suffolk	\$216M
Nassau	\$213M
Westchester	\$199M
Erie	\$185M
Rest of State (53 Counties)	\$979M
Total	\$6.835B

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 clinic UPL demonstration utilizes cost-to-payment methodology to estimate the upper payment limit for each class of providers. The State is in the process of completing the 2022 clinic UPL as well as the Procedural Manual which describes the methodology for eligible providers and will be submitting both documents to CMS. The Medicaid payments under this State Plan Amendment will be included in the 2022 clinic UPL when it is submitted to CMS.

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.