NEW YORK STATE | Department of Health

KATHY HOCHUL
Governor

JAMES V. McDONALD, MD, MPH
Commissioner

JOHANNE E. MORNE, MS
Executive Deputy Commissioner

December 31, 2024

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 #24-0041
Non-Institutional Services

Dear Director McMillion:

The State requests approval of the enclosed amendment #24-0041 to the Title XIX (Medicaid) State Plan for non-institutional services to be effective October 1, 2024 (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). Copies of the public notices of this plan amendment, which were given in the *New York State Register* on March 27, 2024, and subsequently clarified on December 31, 2024, are 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]
Michael Ogborn
Deputy 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: 24 — 0041

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
October 1, 2024

5. FEDERAL STATUTE/REGULATION CITATION
§ 1905(a)(4)(B) EPSDT Services

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 10/01/24-09/30/25 $ 1,225,000
b. FFY 10/01/25-09/30/26 $ (400,000)

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.19-B Page: 1(a)(iii)(2)

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 4.19-B Page: 1(a)(iii)(2)

9. SUBJECT OF AMENDMENT

Early Intervention 5pct Rate Increase and 20pct Rate Reduction for Services Delivered via Telehealth

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
Michael Ogborn

13. TITLE
Deputy Medicaid Director

14. DATE SUBMITTED
December 31, 2024

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

FORM CMS-179 (09/24)

Instructions on Back

Appendix I
2024 Title XIX State Plan
Fourth Quarter Amendment
Amended SPA Pages

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: New York

1905(a)(4)(B) Early and Periodic Screening, Diagnostic, and Treatment services

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE

EPSDT provided as EPSDT Early Intervention (EI) Services

Early and periodic screening, diagnostic and treatment services (EPSDT) for individuals under 21 years of age, and treatment of conditions found.

EPSDT EI services are delivered by Department of Health-approved early intervention service providers in each county of the State or the City of New York and include the following Medicaid services as described in Item 6.d(i) of Section 3.1-A and 3.1-B of the Medicaid State Plan.

1) Screening Services, 2) Evaluation Services, 3) Audiology Services, 4) Nursing Services, 5) Nutrition Services, 6) Occupational Therapy Services, 7) Physical Therapy Services, 8) Psychological Services, 9) Social Work Services, 10) Special Instruction/Developmental, Services, 11) Speech-Language Pathology Services, 12) Medical Equipment and Appliances, 13) Vision Services, 14) Applied Behavioral Analysis Services, 15) Transportation Services.

Fees established by the Department of Health and in effect on July 1, 2018, will be used to pay for EPSDT EI services furnished on or after July 1, 2018. The fees are available on the Department of Health's website at the following links:

EPSDT EI Services (other than DME and transportation):
www.health.ny.gov/community/infants_children/early_intervention/service_rates.htm

Fees established by the Department of Health and in effect on July 1, 2023, will be used to pay for EPSDT EI transportation services furnished on or after July 1, 2023. The fees are available on the Department of Health's website at the following links:

EPSDT EI transportation services:
www.health.ny.gov/community/infants_children/early_intervention/service_rates.htm

Medical equipment and appliances are reimbursed in accordance with the methodology in place for Durable Medical Equipment on page 6(a)(viii) of the State Plan.

Effective October 1, 2024, and applicable to services on and after October 1, 2024, rates for EPSDT Early Intervention services will be increased by 5%.

Effective January 1, 2025, rates for EPSDT EI services delivered via telehealth pursuant to an approved Individualized Family Service Plan (IFSP) for basic and extended home and community services will be reduced by the following percentages by Region:

NYC, Westchester, Poughkeepsie, Long Island	(22%)
Rest of State	(10%)

Appendix II
2024 Title XIX State Plan
Fourth Quarter Amendment
Summary

SUMMARY
SPA #24-0041

This State Plan Amendment proposes to increase the reimbursement rates for EPSDT early intervention (EI) services and decrease rates for EI services delivered via telehealth. This rate increase is needed to address provider capacity issues that municipalities are facing statewide.

Appendix III
2024 Title XIX State Plan
Fourth Quarter Amendment
Authorizing Provisions

SPA 24-0041

10 NYCRR 69-4.30

Title: Section 69-4.30 - Computation of rates for early intervention services provided to infants and children ages birth to three years old and their families or caregivers

Effective Date

02/14/2024

69-4.30 Computation of rates for early intervention services provided to infants and children ages birth to three years old and their families or caregivers.

(a) The commissioner shall annually determine the rates for approved early intervention services and evaluations provided to eligible children, subject to the approval of the director of the budget. For payments made pursuant to this section for early intervention services to Medicaid patients, reimbursement shall be based upon a uniform payment schedule with discrete prices as set forth in subdivision (d) of this section. To be eligible to receive reimbursement pursuant to this section, providers must be approved to provide early intervention services pursuant to Article 25 of the Public Health Law.

(b) For purposes of this section, a billable visit shall mean a face to face contact for the provision of authorized early intervention services between a provider of early intervention services and the individual(s) receiving such services, except for service coordination as described in subdivision (c)(3) of this section. Duration shall mean the time spent by a provider of early intervention services providing direct care or client contact. Activities such as case recording, training and conferences, supervisory conferences, team meetings and administrative work are not separately billable activities.

(c) Reimbursement shall be available at prices established pursuant to this section for the following early intervention program services:

(1) Screening as defined in section 69-4.1(an) of this Subpart and performed in accordance with section 69-4.8 of this Subpart. A provider shall submit one claim for a screening regardless of the number of visits required to perform and complete a screening. The Early Intervention Official shall approve any screenings provided to a child beyond the initial

screening conducted in accordance with section 69-4.8 of this Subpart. Reimbursement shall not be provided for screenings performed after a child has been found eligible for early intervention services.

(2) Multidisciplinary evaluation as defined in section 69-4.1(o) of this Subpart and performed in accordance with section 69-4.8 of this Subpart. Reimbursable evaluations shall include multidisciplinary evaluations and supplemental evaluations. A provider shall submit one claim for an evaluation (multidisciplinary or supplemental) regardless of the number of visits required to perform and complete the evaluation.

(i) A multidisciplinary evaluation shall include a developmental assessment, a review of pertinent records and a parent interview as specified in section 69-4.8(e)(3)(ii) of this Subpart, and may include a family-directed assessment.

(a) A developmental assessment shall mean procedures conducted by qualified personnel with sufficient expertise in early childhood development who are trained in the use of professionally acceptable methods and procedures to evaluate each of the developmental domains: physical development, cognitive development, communication development, social or emotional development and adaptive development.

(b) A family-directed assessment shall mean a voluntary, family-directed assessment conducted by qualified personnel who are trained in the use of professionally acceptable methods and procedures to assist the family in identifying their concerns, priorities and resources related to the development of the child.

(ii) Supplemental evaluations shall include supplemental physician or non-physician evaluations and shall be provided upon the recommendation of the IFSP based on input from the team conducting the multidisciplinary evaluation and agreement of the child's parent. Supplemental evaluations provided must be required by and performed in accordance with the child's IFSP as specified in section 69-4.8(l) of this Subpart.

(a) Supplemental physician evaluation shall mean an evaluation by a physician licensed pursuant to article 131 of the Education Law for the purpose of providing specific medical information regarding physical or mental conditions that may impact on the growth and development of the child and completing the required evaluation of the child's physical development as specified in section 69-4.8(f)(3)(i) of this Subpart, or assessing specific needs in one or more of the

developmental domains in accordance with section 69-4.8(f) of this Subpart.

(b) Supplemental non-physician evaluation shall mean an additional evaluation for assessing the child's specific needs in one or more of the developmental domains in accordance with section 69-4.8 of this Subpart. Information obtained from this evaluation shall provide direction as to the specific early intervention services that may be required for the child for the IFSP team to determine whether the current team can address the concerns with the addition of another functional outcome or if additional services or specific interventions are required to meet the needs of the child. Supplemental non-physician evaluations may be conducted only by qualified personnel as defined in section 69-4.1(al) of this Subpart.

(*c*) A non-physician supplemental audiological evaluation may be performed for infants who have failed newborn hearing screening.

(iii)(a) One multidisciplinary evaluation may be reimbursed within a 12-month period without prior approval of the Early Intervention Official to develop and implement the initial IFSP. The Early Intervention Official shall assess the need for and, if appropriate, approve and notify the department of any additional multidisciplinary or supplemental evaluations provided to a child within a twelve-month period. If additional multidisciplinary or supplemental evaluations are necessary, such notice shall be provided on a monthly basis in a format provided by the department. Additional multidisciplinary or supplemental evaluations provided subsequent to the child's initial IFSP must be required by and performed in accordance with the IFSP as specified in section 69-4.8(l) of this Subpart.

(b) Certain evaluation and assessment procedures may be repeated if deemed necessary and appropriate by the Early Intervention Official in conjunction with the required annual evaluation of the child's IFSP or more frequently in accordance with section 69-4.8(k) of this Subpart. If additional evaluation or assessment procedures are necessary, the Early Intervention Official shall approve up to one more multidisciplinary evaluation and two supplemental evaluations prior to the next annual IFSP. Such additional evaluations must be required by and performed in accordance with the child's IFSP as specified in section 69-4.8(l) of this Subpart. Any additional evaluations within that period shall be based on the indicators specified in section 69-4.8(k) and shall first be approved by the Early Intervention Official and

the Commissioner of Health of the New York State Department of Health; in assessing the need for such additional evaluations, the Early Intervention Official and the Commissioner of Health shall ensure that such additional evaluations are required by and performed in accordance with the child's IFSP.

(3) Service coordination as defined in section 69-4.1(m)(2)(xii) of this Subpart. Service coordination shall be provided by appropriate qualified personnel, delivered in accordance with the child's IFSP, and billed in 15 minute units that reflect the time spent providing services in accordance with sections 69-4.6 and 69-4.7 of this Subpart, or billed under a capitation or other rate methodology as may be established by the Commissioner subject to the approval of the Director of the Budget and as specified in prior written notice provided by the Commissioner to Early Intervention Officials. Such written notice shall specify that any newly established rate methodology shall apply only to initial IFSPs and IFSP amendments made on or after the effective date of such written notice by the Commissioner. The rate methodology may be established on a per month, per week, and/or service component basis for providing service coordination services. When units of time are billed, the first unit shall reflect the initial five to fifteen minutes of service provided and each unit thereafter shall reflect up to an additional fifteen minutes of service provided. Except for child/family interviews to make assessments and plans, contacts for service coordination need not be face-to-face encounters; they may include contacts with service providers or a child's parent, caregiver, daycare worker or other similar collateral contacts, in fulfillment of the child's IFSP.

(4) Assistive technology as defined in section 69-4.1(m)(2)(ii) of this Subpart;

(5) Home and community-based individual/collateral visit. This shall mean the provision by appropriate qualified personnel of early intervention services to an eligible child and/or collateral services that are provided in the context of the parent/caregiver-child dyad to help the child reach their outcomes, as articulated in the child's IFSP. Home and community-based visits take place at the child's home or other natural setting in which children under three years of age are typically found (including day care centers, other than those located at the same premises as the early intervention provider, and family day care homes). Reimbursable home and community-based individual/collateral visits shall include basic and extended visits.

(i) A basic visit is a minimum of 30 minutes and less than one hour in duration. Up to three (3) such visits provided by appropriate qualified personnel within different disciplines per day may be billed for each eligible child as specified in an approved IFSP without prior approval of the Early Intervention Official.

(ii) An extended visit is one hour or more in duration. Up to three (3) such visits provided by appropriate qualified personnel within different disciplines per day may be billed for each eligible child as specified in an approved IFSP without prior approval of the Early Intervention Official.

(iii) Notwithstanding subparagraphs (i) and (ii) of this paragraph, no more than three (3) basic and extended visits combined per day may be billed for each eligible child as specified in an approved IFSP without prior approval of the Early Intervention Official.

(iv) A provider shall not bill for a basic and extended visit provided on the same day by appropriate qualified personnel within the same discipline without prior approval of the Early Intervention Official.

(6) Office/facility-based individual/collateral visit. This shall mean the provision by appropriate qualified personnel of early intervention services to an eligible child and/or collateral services that are provided in the context of the parent/caregiver-child dyad to help the child reach his or her outcomes, as articulated in the child’s IFSP. Office/facility-based visits take place at an approved early intervention provider's site (including day care centers located at the same premises as the early intervention provider). A basic office/facility-based visit is a minimum of 30 minutes and less than one hour in duration. Up to one (1) visit per discipline and no more than three (3) office/facility-based visits per day may be billed for each eligible child as specified in an approved IFSP without prior approval of the Early Intervention Official.

(7) Parent-child group visit. This shall mean the provision of early intervention services in a group composed of parent(s) or other designated caregivers and eligible children, and a minimum of one appropriate professional qualified to provide early intervention services at an early intervention provider's site or a community-based site (e.g. day care center or family day care). Up to one (1) visit per day may be billed for each eligible child as specified in an approved

IFSP without prior approval of the Early Intervention Official.

(8) Group early intervention service visit. This shall mean the provision of physical therapy, occupational therapy, speech-language therapy, applied behavior analysis, or special instruction early intervention services by appropriate qualified personnel to eligible children in a group at an approved early intervention provider's site or at a day care facility duly licensed in New York State.

(i) Up to 120 minutes of group early intervention services per day may be billed for each eligible child as specified in an approved IFSP without prior approval of the Early Intervention Official. Any additional group sessions in the same day shall be approved by the Early Intervention Official.

(ii) A group early intervention service session shall be a minimum of 60 minutes and a maximum of 120 minutes in length and in accordance with the child’s IFSP.

(iii) Groups shall consist of two to ten eligible children. Use of a one-to-one aide should be based on clinical appropriateness.

(iv) Groups shall be provided by, at a minimum, one approved and appropriately qualified early intervention provider and one assistant.

(v) Groups shall consist of children with similar IFSP outcomes and include appropriate therapeutic approaches.

(vi) Children participating in a group early intervention service shall not also receive individual services (including push-in/pull-out services) while the group is in session.

(vii) Session notes shall be provided for each child as an individual, not for the group as a whole, and shall include, at a minimum:

(*a*) eligible child’s name;

(*b*) specific type of service provided;

(*c*) individual or group service;

(*d*) group size if applicable;

(*e*) setting in which the group service was rendered;

(*f*) date and time the service was rendered, including start and end times;

(*g*) brief description of the student’s progress made by receiving the service during the session;

(*h*) name, title, signature, and credentials of the person furnishing the service; and

(*i*) signature and credentials of supervising clinician as appropriate, dated within 45 days of the date of service.

(9) Family/caregiver support group visit. This shall mean the provision of early intervention services by appropriate qualified personnel to a group of parents or other designated caregivers (such as foster parents, day care staff) and/or siblings of eligible children for the purposes of:

(i) enhancing their capacity to care for and/or enhance the development of the eligible child; and/or

(ii) provide support, education, and guidance to such individuals relative to the child's unique developmental needs. Up to two (2) visits per day may be billed for each eligible child as specified in an approved IFSP without prior approval of the Early Intervention Official (for example, one (1) for parents or other designated caregivers and one (1) for sibling(s) in a given day).

(10) ABA services. ABA services shall be billed as either basic or extended visits, as described in subdivision (c) paragraph (5) of this section, up to and in accordance with the hours of service as specified the child's IFSP.

(11) The Early Intervention Official shall approve and notify the department of any visits provided in addition to those described in paragraphs (5) through (11) of this subdivision as may be required by and provided in accordance with the child's IFSP. If such additional visits are necessary, such notice shall be provided on a monthly basis on forms provided by the department.

(d) The prices established pursuant to this section shall provide full reimbursement for the following:

(1) physician services, nursing services, therapist services, technician services, nutrition services, psychosocial services, service coordination, and other related professional and paraprofessional expenses directly incurred by the approved provider;

(2) space occupancy, except as provided in subdivision (f) of this section, and plant overhead costs;

(3) all supplies directly related to the provision of early intervention services, except as provided in subdivision (g) of this section; and

(4) administrative, personnel, business office, data processing, recordkeeping, housekeeping, and other related provider overhead expenses.

(e) The price for each service shall be adjusted for regional differences in wage levels to reflect differences in labor costs for personnel providing direct care and support staff and shall include consideration of absentee data and child to professional to paraprofessional ratios.

(f) Assistive Technology Devices - Reimbursement for approved assistive technology devices shall be at reasonable and customary charges approved by the Commissioner or her designee.

Statutory Authority

Public Health Law Section 2559-b

Volume
VOLUME A-1a (Title 10)

Appendix IV
2024 Title XIX State Plan
Fourth Quarter Amendment
Public Notice

MISCELLANEOUS
NOTICES/HEARINGS

Notice of Abandoned Property Received by the State Comptroller

Pursuant to provisions of the Abandoned Property Law and related laws, the Office of the State Comptroller receives unclaimed monies and other property deemed abandoned. A list of the names and last known addresses of the entitled owners of this abandoned property is maintained by the office in accordance with Section 1401 of the Abandoned Property Law. Interested parties may inquire if they appear on the Abandoned Property Listing by contacting the Office of Unclaimed Funds, Monday through Friday from 8:00 a.m. to 4:30 p.m., at:

1-800-221-9311
or visit our web site at:
www.osc.state.ny.us

Claims for abandoned property must be filed with the New York State Comptroller's Office of Unclaimed Funds as provided in Section 1406 of the Abandoned Property Law. For further information contact: Office of the State Comptroller, Office of Unclaimed Funds, 110 State St., Albany, NY 12236.

PUBLIC NOTICE
Department of Civil Service

Pursuant to the Open Meetings Law, the New York State Civil Service Commission hereby gives public notice of the following:

Please take notice that the regular monthly meeting of the State Civil Service Commission for April 2024 will be conducted on April 17 and April 18 commencing at 10:00 a.m. This meeting will be conducted at NYS Media Services Center, Suite 146, South Concourse, Empire State Plaza, Albany, NY with live coverage available at: https://www.cs.ny.gov/commission/

For further information, contact: Office of Commission Operations, Department of Civil Service, Empire State Plaza, Agency Bldg. 1, Albany, NY 12239 (518) 473-6598

PUBLIC NOTICE
Office of General Services

Pursuant to section 30-a of the Public Lands Law, the Office of General Services hereby gives notice to the following:

Notice is hereby given that the Department of Environmental Conservation has determined that:

Address: .21 acres of land, Plank Road

Berlin, NY

Rensselaer County

.21 ± acres of land, known as a portion of the Cowee State Forest, is surplus and no longer useful or necessary for state program purposes and has abandoned the property to the Commissioner of General Services for sale or other disposition as Unappropriated State land.

For further information, please contact: Frank Pallante, Office of General Services, Legal Services, 36th Fl., Corning Tower, Empire State Plaza, Albany, NY 12242, (518) 474-8831

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 the 2024-2025 proposed executive budget. The following changes are proposed:

All Services

Effective on or after April 1, 2024, the Department of Health will adjust rates statewide to reflect a 1.5% 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, Comprehensive Psychiatric Emergency Program, including Extended Observation Beds, Children Family Treatment Support Services, Health Home Plus, Psychiatric 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, Independent Practitioner Services for Individual with Developmental Disabilities (IPSIDD), and OPWDD Crisis Services.

The estimated net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2024-2025 is $25.1 million.

Non-Institutional Services

Effective on or after April 1, 2024, noticed provision for a rate change regarding Emergency Medical Services will be revised. All such Emergency Medical Services will be paid established fees for ambulance services providing treatment in place (TIP) without transport, a base fee without a mileage charge. This change will reduce unnecessary Emergency Department (ED) trips, thus relieving ED wait times, improving overall ED and EMS care and reducing Medicaid costs.

The estimated net aggregate decrease in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2024-2025 is ($1.2 million).

Effective on or after April 1, 2024, the reimbursement rate for Early Intervention services will increase by 5%. These rates are being increased to address capacity issues that municipalities are facing statewide.

The estimated net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2024-2025 is $12 million.

Effective on or after April 1, 2024, rates of payment for Early and Periodic Screening Diagnosis and Treatment (EPSDT) related to behavioral health services provided by Health Facilities licensed under Article 29-I of the Public Health Law to individuals under age 21 years, will be increased to account for enhanced programmatic requirements related to delivery of care in Qualified Residential Treatment Facilities.

The estimated net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2024-2025 is $18 million.

Effective on April 1, 2024, conflicts of interest between Consumer Directed Personal Assistance Program (CDPAP) CDPAP Fiscal Intermediaries (FIs) and Licensed Home Care Service Agencies (LHCSAs) will be eliminated.

Effective on October 1, 2024, consumer self-direction will be required in the CDPAP program, and proposed regulation authority relating to quality-of-care standards and labor protections for the CDPAP and Personal Care programs shall take effect.

Effective on or after January 1, 2025, FI procurement will be repealed and replaced with an authorization process.

Effective on or after April 1, 2025, conflicts of interest between CDPAP Fis, Managed Long-term Care Plans (MLTCs), and Health Maintenance Organizations will be eliminated.

The estimated net aggregate decrease in gross Medicaid expenditures attributable to these initiatives contained in the budget for state fiscal year 2025 is ($200 million) and for state fiscal year 2026 is ($400 million).

Long Term Care Services

Effective on or after April 1, 2024, the case mix adjustment from the operating component of the rates for skilled nursing facilities shall remain unchanged from the July 2023 rates during the development and until full implementation of a new case mix methodology in accordance with Federal acuity data.

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

Effective on or after April 1, 2024 and each SFY thereafter, the Department proposes to reduce funding associated with residential health care facilities' capital reimbursement by 10 percent.

The estimated net aggregate decrease in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2024-2025 is ($57 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. 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 Long Term Care Services as authorized by § 2826 of New York Public Health Law. The following changes are proposed:

Long Term Care Service

Effective on or after April 1, 2024, the Department of Health proposes to amend the Title XIX (Medicaid) State Plan for long term care services related to 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.

The estimated net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2024-2025 is $30 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. 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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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 statutory provisions. The following changes are proposed:

Non-Institutional Services

Effective on or after April 1, 2024, this amendment proposes to revise the payment eligibility criteria, for Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs), that are eligible for the Alternative Payment Methodology (APM) which provides for an additional payment annually to preserve and improve beneficiary

MISCELLANEOUS
NOTICES/HEARINGS

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1-800-221-9311
or visit our web site at:
www.osc.state.ny.us

Claims for abandoned property must be filed with the New York State Comptroller's Office of Unclaimed Funds as provided in Section 1406 of the Abandoned Property Law. For further information contact: Office of the State Comptroller, Office of Unclaimed Funds, 110 State St., Albany, NY 12236.

PUBLIC NOTICE
Department of Civil Service

PURSUANT to the Open Meetings Law, the New York State Civil Service Commission hereby gives public notice of the following:

Please take notice that the regular monthly meeting of the State Civil Service Commission for January 2025 will be conducted on January 15 and January 16 commencing at 10:00 a.m. This meeting will be conducted at NYS Media Services Center, Suite 146, South Concourse, Empire State Plaza, Albany, NY with live coverage available at https://www.cs.ny.gov/commission/.

For further information, contact: Office of Commission Operations, Department of Civil Service, Empire State Plaza, Agency Bldg. 1, Albany, NY 12239, (518) 473-6598

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 Part HH of Chapter 57 of the Laws of 2024. The following changes are proposed:

Non-Institutional Services

Effective on or after January 1, 2025, the Consumer Directed Personal Assistance Program (CDPAP) will begin transitioning to a single statewide fiscal intermediary (FI). The administrative reimbursement for CDPAP will transition from a three-tiered per Member per Month (PMPM) rate structure to a rate established through the Single FI contracting process.

The estimated net aggregate decrease in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2025 is ($28 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. 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 the 2024-2025 enacted budget. The following changes are proposed:

Non-Institutional Services

The following is a clarification to the March 27, 2024, noticed provision to increase provider rates for early intervention services. With clarification, this provision now includes a decrease to provider rates for early intervention services delivered via telehealth.

The estimated net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2024-2025 is now $2.9 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. 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 the federal statutory requirements in Section 5121 of the Consolidated Appropriations Act, 2023 (CAA, 2023) (P.L. 117-328). The following changes are proposed:

Non-Institutional Services

Effective on or after January 1, 2025, State Medicaid programs are federally required to have a plan in place and, in accordance with such plan, provide any screenings and diagnostic services which meet reasonable standards of medical and dental practice, as determined by the state, or as otherwise indicated as medically necessary, in accordance with the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) requirements, including a behavioral health screening or diagnostic service, for an eligible individual who is within 30 days of their scheduled date of release from a public carceral setting following adjudication.

Effective on or after January 1, 2025, State Medicaid programs are also federally required to have a plan in place and, in accordance with such plan, provide Targeted Case Management (TCM) services in the 30 days prior to release, and for at least 30 days following release, including referrals to appropriate care and services available in the geographic region of the home or residence of the eligible juvenile.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative is $1.5 million for screenings and diagnostic services, and $3 million for TCM services.

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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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 PHL 2999-D and SSL § 367-u. The following changes are proposed:

Non-Institutional Services

Effective on or after January 1, 2025, The Department of Health will reimburse Federally Qualified Health Centers and Rural Health Clinics a separate payment in lieu of the Prospective Payment System rate for non-visit services, such as eConsults and remote patient monitoring.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative is $86,000.

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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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

Appendix V
2024 Title XIX State Plan
Fourth Quarter Amendment
Responses to Standard Funding Questions

NON-INSTITUTIONAL SERVICES
State Plan Amendment #24-0041

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 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.

		4/1/24 – 3/31/25	
Payment Type	**Non-Federal Share Funding**	**Non-Federal**	**Gross**
Normal Per Diem	General Fund; County Contribution	$139M	$277M

A. **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.

1) 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.

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

Entity	Annual Amount
New York City	$5.210B
Suffolk County	$243M
Nassau County	$231M
Westchester County	$215M
Erie County	$205M
Rest of State (53 Counties)	$1.260B
Total	**$7.364B**

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.