NEW YORK STATE OF OPPORTUNITY. Department of Health

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New York HCBS eFMAP Adult Day Health Care Provider Attestation

The American Rescue Plan Act (ARPA) was signed into law on March 11, 2021. Section 9817 provided qualifying states with a temporary 10 percentage point increase to the federal medical assistance percentage (FMAP) for certain Medicaid expenditures for Home and Community-Based Services (HCBS). This affords states the ability to invest or reinvest these funds in a variety of ways that expand and enhance investments in Medicaid-covered HCBS, address COVID-related needs, and build HCBS capacity.

As part of New York State's enhanced FMAP for HCBS efforts, the Department of Health (DOH) has chosen to invest in Adult Day Health Care Programs (ADHCs) and AIDS Adult Day Health Centers (AIDS ADHCs), which were closed during the height of the pandemic, to strengthen, enhance, and expand the availability of approved HCBS services. This component of the initiative is to support ADHCs and AIDS ADHCs which have reopened in order to sustain safety and institute effective infection control measures, support community integration and access, support transportation costs and provide workforce development funds for recruitment and retention of qualified staff. Funding to eligible programs will be based on operating certificate listed capacity. **Please be aware that all funding will follow the published State Plan Amendment (SPA) #23-0020, approved by CMS June 21st, 2023.**

Eligible providers will be responsible for using their awards to strengthen, enhance, and expand the availability of approved HCBS services. **To be eligible for these awards, providers will be responsible for submitting the attestation form on or before February 16, 2024.** Providers that do not submit this attestation form by **February 16, 2024,** will not be eligible for funding. Providers that are not open and providing services before August 1, 2023, will not be eligible for supplemental payments. Providers must also be open **and** providing services at the time which payments are distributed.

Providers will also be required to submit site surveys to the State **within 5 business days after completing the attestation** and quarterly beginning February 1, 2024 to retain their awards and maintain eligibility for future HCBS enhanced FMAP funding opportunities.
Additionally, sites that fail to expend funds, or expend funds on non-approved uses, will be ineligible for future awards and/or subject to recoupment of their award.

Section 1: Instructions

1. You must submit attestation responses by **February 16, 2024.** A reminder notice will be sent to the email address on file.
2. Failure to submit the attestation and questionnaire by the deadline will result in exclusion from payment.
3. All providers must submit a copy of this attestation to NYSDOH through the method set forth in Section 7 of this document and must maintain a copy of this attestation.
4. Please note that electronic signatures will be the legal equivalent of a handwritten signature. Individuals that have sufficient authority to bind the provider may sign this application. This includes, for example:

   Owner
   Chief Executive Officer
   Chief Operating Officer
   President/Officer
   Chairperson
   Chief Financial Officer
   Governing Board

Section 2: Authorized Signatory

Identify the individual who is authorized to sign this attestation. This individual must be authorized to make legal commitments on behalf of the providers.

Name:	
Position:	
Email Address:	
Phone Number:	

Section 3: Site Information

Please provide the following information:

ADHC or AADHC:	
MMIS ID(s):	
NPI(s):	
Facility ID:	
Location Code:	
Spot Capacity:	

Section 4: Member Information

Please provide the following information:

Is your site contracted with Managed Care Organization(s). If yes, please indicate which:	
Number of members with Managed Care:	
Does your site serve individuals with FFS:	
Number of members with FFS:	
Does your site serve individuals with Private Pay:	
Number of members with Private Pay:	

Section 5: Activities and Budget:

Please select the programs and/or strategies that your program site will develop from the list below. Additional detail on these strategies is available in the Adult Day Health Center and AIDS Adult Day Health Center Guidance for Providers document. Please select at least one.

Workforce:

☐ Workforce retention strategies

☐ Development, implementation and promotion of training programs for staff

☐ Recruit and retain a racially, ethnically diverse and culturally competent workforce

Service Support:

☐ Supplement Community Integration activities

☐ Transportation subsidy fund

Emergency Preparedness:

☐ Emergency preparedness efforts such as personal protective equipment (PPE)

Section 6: Spending Narrative

Please describe how you plan to use your award to implement the choices you selected above and how you will assure sustainability of implementation beyond the use of these funds. You should describe your plan for each category selected above, including details such as known expenses, timeline for implementation, etc. Please remember that you must use your awards for investments at the sites and program in which you are qualified for funding. To fulfill this requirement, you must complete the **NYSDOH ARPA ADHC Spending Template** and submit to NYSDOH through the method provided as well as maintain a copy along with this attestation.

Section 7: Attestation

I am the named authorized signatory identified above, and I attest that I have read the directions and guidance pertaining to the New York HCBS eFMAP Adult Day Health Center/AIDS Adult Day Health Center Reopening Initiative, including the instructions for this survey, and understand the requirements for eligibility for funding under this payment program.

I have the requisite authority to complete this attestation in accordance with the directions that I have read. All information provided in response to this survey is true, accurate, and complete and I have taken reasonable steps to verify the accuracy thereof. I understand that funds under this program are only available for categories of expenses to strengthen, enhance, and expand the availability of approved HCBS services expressly identified and described by the Department herein and in related provider guidance, and the provider must use this award to develop at least one such program or strategy. I also understand that such funds may not be used to supplant any existing or planned expenses, including any portion of any settlement obligations or other liabilities owed by the provider, or any related person or entity, prior to July 31, 2023.

Further, I understand that payment under this program will be from federal and/or state public funds and that any false claims or non-approved use of such funds are strictly prohibited and **will result in becoming disqualified for any further funds under this program and may result in civil or criminal fines and/or prosecution under applicable federal and state laws.** All funding will be used in compliance with the HCBS eFMAP requirements outlined in section 9817 of the American Rescue Act Plan, as well as state regulations and policy.

In addition, I understand that as a condition of receiving and retaining these funds I agree and attest that the provider shall maintain compliance with all applicable state and federal wage and labor laws, and shall not engage in any unlawful conduct with respect to the employment of its employees, including any practices that are impermissible under any federal or state law.

Furthermore, I understand that no payments made under this program shall be used for any capital investment.

I agree, and it is my intent, to electronically sign this document by typing in my signature, or providing a handwritten signature below. By submitting this e-document to the New York State

Department of Health in this way, I understand that my e-signing and submitting is the legal equivalent of having placed my handwritten signature and affirmation on the submitted document, and am affirming to the truth of the information contained therein.

Under penalty of perjury, I hereby certify that the information provided on this form is true and accurate.

Authorized signatory signature: