NEW YORK STATE OF OPPORTUNITY. | Department of Health

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

September 30, 2019

Ms. Nicole McKnight
Acting Associate Regional Administrator
Department of Health & Human Services
Centers for Medicare & Medicaid Services
New York Regional Office
Division of Medicaid and Children's Health Operations
26 Federal Plaza - Room 37-100 North
New York, New York 10278

RE: SPA #19-0047
Non-Institutional Services

Dear Ms. McKnight:

The State requests approval of the enclosed amendment #19-0047 to the Title XIX (Medicaid) State Plan for non-institutional services to be effective September 14, 2019 (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 and promote 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 19, 2019, 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]

Donna Frescatore
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: 19 — 0047

2. STATE: New York

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)
TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
September 14, 2019

5. TYPE OF PLAN MATERIAL *(Check One)*

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate transmittal for each amendment)*

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

7. FEDERAL BUDGET IMPACT
a. FFY 07/01/19-09/30/19 $ 515.20
b. FFY 10/01/19-09/30/20 $ 54,898.55

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT

Attachment 3.1-A Pages: 3b-39, 3b-39(i), 3b-39(ii), 3b-39(iii), 3b-39(iv), 3b-39(v), 3b-39(vi), 3b-39(vii), 3b-39(viii)
Attachment 3.1-B Pages: 3b-39, 3b-39(i), 3b-39(ii), 3b-39(iii), 3b-39(iv), 3b-39(v), 3b-39(vi), 3b-39(vii), 3b-39(viii)

Attachment 4.19-B: 3N, 3N(1)

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*

10. SUBJECT OF AMENDMENT

Certified Community Behavioral Health Clinic (CCBHC)
(FMAP=50%)

11. 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

12. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

13. TYPED NAME
Donna Frescatore

14. TITLE
Medicaid Director, Department of Health

15. DATE SUBMITTED
September 30, 2019

16. 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 REGIONAL OFFICE USE ONLY

17. DATE RECEIVED

18. DATE APPROVED

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL

20. SIGNATURE OF REGIONAL OFFICIAL

21. TYPED NAME

22. TITLE

23. REMARKS

Appendix I
2019 Title XIX State Plan
Third Quarter Amendment
Amended SPA Pages

13d. Rehabilitative Services

Other Diagnostic, Screening, Preventive, and Rehabilitative Services - Rehabilitative Services

1905(a)(13); 42 CFR 440.130(d)

Outpatient Mental Health Services:

The State provides coverage for Outpatient Mental Health Services as defined at 42 CFR 440.130(d) and in this section. The State assures that rehabilitative services do not include and Federal Financial Participation is not available for any of the following in accordance with section 1905(a)(13) of the Act.

a. educational, vocational and job training services;
b. room and board;
c. habilitation services;
d. services to inmates in public institutions as defined in 42 CFR §435.1010;
e. services to individuals residing in institutions for mental diseases as described in 42 CFR §435.1010;
f. recreational and social activities; and
g. services that must be covered elsewhere in the state Medicaid plan.

Outpatient Mental Health Services are recommended by a licensed practitioner of the healing arts acting within the scope of his/her professional license and applicable New York State law, including physicians, physician assistants, nurse practitioners, registered nurses, psychologists, licensed clinical social workers (LCSW), licensed master social workers (LMSW) under the supervision of a LCSW, licensed psychologist or psychiatrist, licensed mental health counselors (LMHC), licensed marriage and family therapists (LMFT), licensed psychoanalysts, licensed creative arts therapists (LCAT), and licensed occupational therapists (OT).

Outpatient Mental Health Services are person-centered, recovery-oriented rehabilitative services designed to help individuals achieve recovery from mental health conditions by treating the symptoms of those conditions and restoring skills which have been lost due to the onset of mental illness and which are necessary for individuals to manage and cope with the symptoms and behaviors associated with mental health conditions and function successfully in the community. Medically necessary Outpatient Mental Health Services are those which are necessary to promote the maximum reduction of symptoms and/or restoration of an individual to their best age-appropriate functional level and are provided according to an individualized treatment plan.

Services to the beneficiary's family and significant others are for the direct benefit of the beneficiary, in accordance with the beneficiary's needs and treatment goals identified in the beneficiary's treatment plan, and for the purpose of assisting in the beneficiary's recovery.

New York
3b-39(i)

Provider Qualifications:

Outpatient Mental Health Services as described herein are provided by professionals and paraprofessionals qualified by credentials, training, and/or experience to provide direct services related to the treatment of mental illness and substance use disorders employed by or under contract with provider agencies licensed or authorized by the New York State Office of Mental Health, as follows:

1. Professional Staff include:

a. Physician: An individual who is currently licensed or possesses a permit to practice medicine issued by the New York State Education Department;
b. Psychiatrist: An individual who is currently licensed or possesses a permit to practice medicine issued by the New York State Education Department and who is either a diplomate of the American Board of Psychiatry and Neurology or is eligible to be certified by such Board or is certified by the American Osteopathic Board of Neurology and Psychiatry or is eligible to be certified by such Board;
c. Physician assistant: An individual who is currently licensed or possesses a permit to practice as a physician assistant issued by the New York State Education Department;
d. Nurse practitioner: An individual who is currently certified or possesses a permit to practice as a nurse practitioner issued by the New York State Education Department;
e. Psychiatric nurse practitioner: An individual who is currently certified or possesses a permit to practice as a nurse practitioner with an approved specialty area of psychiatry issued by the New York State Education Department;
f. Registered nurse: An individual who is currently licensed or possesses a permit to practice as a registered professional nurse issued by the New York State Education Department;
g. Licensed Practical Nurse: An individual who is currently licensed or possesses a permit to practice as a licensed practical nurse issued by the New York State Education Department;
h. Psychologist: An individual who is currently licensed or possesses a permit to practice as a psychologist issued by the New York State Education Department;
i. Social worker: An individual who is either currently licensed or possesses a permit to practice as a licensed master social worker (LMSW) or as a licensed clinical social worker (LCSW) issued by the New York State Education Department;
j. Mental health counselor: An individual who is currently licensed or possesses a permit to practice as a mental health counselor issued by the New York State Education Department;
k. Marriage and family therapist: An individual who is currently licensed or possesses a permit to practice as a marriage and family therapist issued by the New York State Education Department;
l. Psychoanalyst: An individual who is currently licensed or possesses a permit to practice as a psychoanalyst issued by the New York State Education Department;
m. Creative arts therapist: An individual who is currently licensed or possesses a permit to practice as a creative arts therapist issued by the New York State Education Department;

New York
3b-39(ii)

n. Certified psychiatric rehabilitation practitioner: An individual who is certified by the Psychiatric Rehabilitation Association as a psychiatric rehabilitation practitioner working within the adult mental health system. The certified psychiatric rehabilitation practitioner credential is exam and work experienced-based. In order to obtain certification, practitioners must have completed up to 45 hours of training and up to 4,000 hours of relevant work experience, depending on academic preparation and other certification, if any, and pass the Psychiatric Rehabilitation Association Examination;

o. Certified rehabilitation counselor: An individual certified by the Commission on Rehabilitation Counselor Certification as a rehabilitation counselor. The certified rehabilitation counselor credential is exam and training-based. In order to obtain certification, counselors must be a student within 12 months of graduation or graduate of a master's level rehabilitation counseling or clinical rehabilitation counseling program, have completed a 600-hour internship in rehabilitation counseling, and pass the Certified Rehabilitation Counselor exam. In addition to passing the Certified Rehabilitation Counselor exam, Graduates of master's or doctoral programs in other related fields of study must have completed coursework required by the Commission of Rehabilitation Counselor Certification and either a 600-hour internship or 12 months of supervised or 24 months of acceptable work experience; and

p. Occupational Therapist: An individual who is currently licensed or possesses a permit to practice as an occupational therapist issued by the New York State Education Department and meets the qualifications set forth in 42 CFR § 440.110(b)(2).

2. Paraprofessional staff are qualified by formal or informal training and professional and/or personal experience in a mental health field or treatment setting. Paraprofessional staff, including certified peer specialists, credentialed family peer advocates, and credentialed youth peer advocates, will be supervised by Professional staff. Professional staff, as defined herein are competent mental health professionals in compliance with CMS requirements for peer-delivered services. Paraprofessional staff will be at least 18 years of age and have a bachelor's degree, which may be substituted for a high school diploma or equivalent and 1-3 years of relevant experience working with individuals with serious mental illness or substance use disorders. Certified peer specialists, credentialed family peer advocates, and credentialed youth peer advocates will be at least 18 years of age and certified or provisionally certified by New York State Office of Mental Health (OMH) based on the following criteria:

Certified Peer Specialists will:

1. Possess a certification as a Certified Peer Specialist from an OMH-approved Certified Peer Specialist certification program;
2. Identify as being actively in recovery from a mental health condition or major life disruption and self-disclose one's mental health recovery journey;
3. Have completed 2000 hours of peer specialist experience under the supervision of a qualified supervisor; and
4. Completed 10 continuing education hours of peer specialist specific training annually.

New York
3b-39(iii)

Certified Peer Specialists will be provisionally certified if they meet all of the criteria above except (3) and are actively working toward obtaining 2000 hours of peer specialist experience under the supervision of a qualified supervisor.

Credentialed Family Peer Advocates (FPA) will:

1. Possess a Family Peer Advocate credential from an OMH-approved Family Peer Advocate credentialing program;
2. Demonstrate 'lived experience' as a parent or primary caregiver who has navigated multiple child serving systems on behalf of their child(ren) with social, emotional, developmental, health and/or behavioral healthcare needs;
3. Have completed Level One and Level Two of the Family Peer Advocate Core Training/Parent Empowerment Program training or another training approved by the Office of Mental Health;
4. Have completed 1000 hours of experience providing peer support services under the supervision of a qualified supervisor;
5. Submit three letters of reference attesting to proficiency in and suitability for the role of a Family Peer Advocate (FPA) including one from the FPA's supervisor;
6. Complete 20 hours of continuing education and renew their FPA credential every two years; and
7. Agree to practice according to the Professional Family Peer Advocate Code of Ethics.

Credentialed Family Peer Advocates will be provisionally credentialed for a period not to exceed 18 months if they have demonstrated lived experience as described in (2), above, completed Level One of the Family Peer Advocate Core Training/Parent Empowerment Program Training; submit two letters of reference as described in (5), above, and agree to practice according to the Professional Family Peer Advocate Code of Ethics.

Credentialed Youth Peer Advocate will:

1. Possess a valid Youth Peer Advocate Provisional Credential from an OMH-approved Youth Peer Advocate credentialing program;
2. Demonstrate "lived experience" as a person with first-hand experience with social, emotional, medical, developmental, substance use, and/or behavioral challenges in juvenile justice, special education, and/or foster care settings who is able to assist in supporting young people attain resiliency/recovery and wellness;
3. Have completed the Youth Peer Advocate Training Level Two (online and in-person) or another training approved by the Office of Mental Health;
4. Have completed 600 hours of experience providing peer support services under the supervision of a qualified supervisor;
5. Complete 20 hours of continuing education annually to renew their credential; and
6. Agree to practice according to the Youth Peer Advocate Code of Ethics.

New York
3b-39(iv)

Credentialed Youth Peer Advocate will be provisionally credentialed for a period not to exceed 18 months if they meet the following criteria:

1. Self-identify as a person with first-hand experience with social, emotional, medical, developmental, substance use, and/or behavioral challenges in juvenile justice, special education, and/or foster care settings who is able to assist in supporting young people attain resiliency/recovery and wellness;
2. Complete the Youth Peer Advocate Training Level One; and
3. Complete the Youth Peer Advocate application which includes: Two Letters of Recommendation; Signed Youth Peer Advocate Code of Ethics; Statement of Lived Experience; Resume; and Proof of age.

Service Descriptions:

Outpatient Mental Health Services include assessments/screening; treatment planning; counseling/therapy; medication treatment; psychiatric consultation; testing services; health monitoring; Screening, Brief Intervention and Referral to Treatment (SBIRT); care coordination; peer/family peer recovery support; crisis intervention; and psychosocial rehabilitation services. Except as otherwise noted, all services are for both children and adults.

All Outpatient Mental Health Services are delivered on an individual or group basis in a wide variety of settings including provider offices, in the community, or in the individual's place of residence, consistent with guidance issued by the New York State Office of Mental Health. The setting in which the service is provided is determined by the individual's needs and goals identified in the individual's treatment plan. Where indicated below, the individual's collateral supports, such as identified family members or significant others, may participate in services as necessary, for the benefit of the Medicaid beneficiary.

Outpatient Mental Health Services include:

- **Assessments/Screenings** – Including initial, immediate needs, risk, psychiatric, and functional/rehabilitative assessments, and health screenings and health physicals, for the purpose of gathering or updating information concerning the individual's mental and physical health history and status, including determination of substance use, in order to determine the appropriate diagnosis, assess the individual's functional limitations, and inform the treatment planning process. Health screenings and health physicals assess the need for and referral to additional physical health services. Assessments may include interactions between the professional and an individual's collateral supports to obtain necessary information for the benefit of the treatment planning for the individual.

New York
3b-39(v)

Outpatient Mental Health Services include: (continued)

Practitioners: Assessment/screenings, except psychiatric assessments, health screenings and health physicals are provided by Professional staff. Functional/rehabilitative assessments are provided by Professional staff and Paraprofessional staff under the supervision of Professional staff. Psychiatric assessments are provided by a Physician, Psychiatrist, Psychiatric nurse practitioner, or Physician's Assistant. Health screenings and health physicals are provided by a Physician, Psychiatrist, Physician's assistant, Nurse practitioner, Registered nurse or Licensed Practical Nurse.

- **Treatment Planning** – A collaborative person-centered process directed by the individual in collaboration with the individual's family or other collaterals, as appropriate and approved by the individual and a licensed clinician, resulting in the development of treatment and rehabilitative goals, needs, preferences, capacities and desired outcomes for the provision of Outpatient Mental Health Services.

  Practitioners: Treatment Planning services are provided by Professional staff and Paraprofessional staff under the supervision of Professional staff.

- **Counseling/Therapy** – Individual, group, and family counseling/therapy services are therapeutic counseling services for the purpose of alleviating symptoms or dysfunction associated with an individual's mental health condition or emotional disturbance, reversing or changing maladaptive patterns of behavior, encouraging personal growth and development, and supporting the individual's capacity to restore age-appropriate developmental milestones. Services include tobacco use disorder treatment services. Collateral contact is permitted as needed to address the therapeutic goals of the beneficiary.

  Practitioners: Counseling/Therapy Services are provided by Professional Staff and Paraprofessional staff under the supervision of Professional staff.

- **Medication Treatment –** Medication Treatment is a therapeutic and rehabilitative service to treat the symptoms of an individual's mental illness and/or substance use disorder, including the following components which may be provided by the following professionals:

  - Prescribing medications, monitoring the effects of medications, evaluating target symptom response to medications, and ordering and reviewing diagnostic studies, provided by a Psychiatrist, Physician, Nurse practitioner, Psychiatric Nurse Practitioner, or Physician's assistant;

- Preparing, administering and monitoring the injection of intramuscular medications, provided by a Psychiatrist, Physician, Nurse practitioner, Psychiatric Nurse Practitioner, Physician's assistant, Registered professional nurse or Licensed practical nurse; and
- Medication skills training and psychoeducation on medication use and effects, provided by Professional staff.

- **Psychiatric Consultation** – Psychiatric Consultation services are diagnostic and therapeutic services including face-to-face evaluation of a beneficiary who is not currently enrolled in the practitioner's program when the service is provided, and such consultation is required for purposes of diagnosis, integration of treatment and continuity of care. Consultation services may be provided through telehealth technology.

  Practitioners: Psychiatric Consultation services are provided by a Physician, Psychiatrist, Nurse practitioner, Psychiatric nurse practitioner, or Physician's assistant.

- **Testing Services, including developmental and psychological testing** - Developmental testing services are diagnostic services including the administration, interpretation, and reporting of screening and assessment instruments for children and adolescents to assist in the determination of the child's developmental level for the purpose of facilitating the mental health diagnosis and treatment planning processes. Psychological Testing Services are diagnostic services in which practitioners employ standard assessment methods and instruments to inform the assessment and treatment planning processes.

  Practitioners: Developmental Testing Services are provided by Professional staff. Psychological Testing Services are provided by a Psychologist, Psychiatrist, or Physician.

- **Health Monitoring** - Health Monitoring is a diagnostic and therapeutic service involving the continued measurement of specific health indicators associated with increased risk of medical illness and early death. For adults these indicators include, but are not limited to, blood pressure, body mass index (BMI), substance use, and tobacco use. For children these indicators include, but are not limited to, BMI, activity/exercise level, substance use, and smoking status.

  Practitioners: Health Monitoring services are provided by a Psychiatrist, Physician, Nurse practitioner, Psychiatric nurse practitioner, Physician's assistant, Registered nurse or Licensed practical nurse.

New York
3b-39(vii)

- **Screening, Brief Intervention and Referral to Treatment (SBIRT) services** – SBIRT are evidence-based assessment, counseling, and referral services which provide: (i) screening to identify individuals exhibiting or who are at risk of substance use-related problems; (ii) early intervention, including counseling and skills restoration services to modify risky consumption patterns and behaviors; and (iii) referral to appropriate services for individuals who need more extensive, specialized treatment to address such substance consumption patterns and behaviors.

  Practitioners: SBIRT services are provided by Professional staff and Paraprofessional staff under the supervision of Professional staff.

- **Care Coordination -** Care coordination services include service planning and referral and linkage to medically necessary Medicaid physical and/or behavioral health services or other necessary social support services to address the individual's needs and avoid more restrictive levels of treatment.

  Practitioners: Care coordination services are provided by Professional staff or Paraprofessional under the supervision of professional staff.

- **Peer/Family Peer Recovery Support Services** – Peer Recovery Support Services for adults and children/youth include age-appropriate psychoeducation, counseling, person-centered goal planning, modeling effective coping skills, and facilitating community connections to reduce symptomology and restore functionality. Services for children/youth also include family peer support services as set forth in item 13d of the Supplement to the Attachment 3.1-A (or B) of the Plan. Services are provided in individual or group settings to promote recovery, self-advocacy, and the development of natural supports and community living skills. Individuals and/or family members actively participate in decision-making and the delivery of services. Services are directed toward achievement of the specific, individualized, and result-oriented goals contained in an individual's treatment plan developed under the supervision of a competent mental health professional.

  Practitioners: Services for adults are provided by Certified Peer Specialists under supervision as described in this section. Services for children/youth are provided by Credentialed Family Peer Advocates and Credentialed Youth Peer Advocates under supervision as described in this section.

New York
3b-39(viii)

- **Crisis Intervention Services, including crisis response, crisis planning, and crisis stabilization services** – Crisis intervention services are provided to address and remediate acute distress and rehabilitate individuals who are experiencing or who are at risk of experiencing acute mental health crises and to avoid the need for emergency or inpatient psychiatric hospital services, as follows:
  - Crisis response services: Include services to safely and respectfully de-escalate situations of acute distress or agitation which require immediate attention.
  - Crisis planning services: Include rehabilitative skills training services to assist individuals to effectively avoid or respond to mental health crises by identifying triggers that risk their remaining in the community or that result in functional impairments. Services assist the individual and/or family members, or other collaterals as necessary for the benefit of the beneficiary, with identifying a potential psychiatric or personal crisis, developing a crisis management or safety plan, and/or as appropriate, seeking other supports to restore stability and functioning.
  - Crisis Stabilization Services: Stabilization services are transitional, rehabilitative, and supportive services that include symptom management and skills training to stabilize an individual after a crisis response in order to reduce the need for urgent care services or a higher level of care.

  Practitioners: Crisis intervention services are provided by Professional staff and Paraprofessional staff under supervision as provided in this section.

- **Psychosocial Rehabilitation Services** – Psychosocial Rehabilitation Services are designed to assist individuals restore their highest possible functional level and may include other collateral supports beyond the individual or family/caregiver, as necessary, to address the therapeutic goals of the beneficiary. Services include:
  - Psychoeducation and rehabilitative counseling to assist individuals to identify meaningful life role goals and barriers to their realization through a person-centered exploration of the individual's desired goals and objectives, experiences, supports, and motivation to achieve recovery;
  - Essential skill restoration and rehabilitative skill-building to assist individuals to regain the skills necessary for living successfully in the community and attain specific life role goals; and
  - Recovery planning services designed to engage and assist individuals in managing their illness and reduce the risk of hospitalization or relapse, loss of housing, or involvement with the criminal justice system due to lost functionality or uncontrolled symptomology.

  Practitioners: Psychosocial Rehabilitation Services are provided by Professional staff and Paraprofessionals under supervision of Professional staff.

13d. Rehabilitative Services

Other Diagnostic, Screening, Preventive, and Rehabilitative Services - Rehabilitative Services

1905(a)(13); 42 CFR 440.130(d)

Outpatient Mental Health Services:

The State provides coverage for Outpatient Mental Health Services as defined at 42 CFR 440.130(d) and in this section. The State assures that rehabilitative services do not include and Federal Financial Participation is not available for any of the following in accordance with section 1905(a)(13) of the Act.

a. educational, vocational and job training services;
b. room and board;
c. habilitation services;
d. services to inmates in public institutions as defined in 42 CFR §435.1010;
e. services to individuals residing in institutions for mental diseases as described in 42 CFR §435.1010;
f. recreational and social activities; and
g. services that must be covered elsewhere in the state Medicaid plan.

Outpatient Mental Health Services are recommended by a licensed practitioner of the healing arts acting within the scope of his/her professional license and applicable New York State law, including physicians, physician assistants, nurse practitioners, registered nurses, psychologists, licensed clinical social workers (LCSW), licensed master social workers (LMSW) under the supervision of a LCSW, licensed psychologist or psychiatrist, licensed mental health counselors (LMHC), licensed marriage and family therapists (LMFT), licensed psychoanalysts, licensed creative arts therapists (LCAT), and licensed occupational therapists (OT).

Outpatient Mental Health Services are person-centered, recovery-oriented rehabilitative services designed to help individuals achieve recovery from mental health conditions by treating the symptoms of those conditions and restoring skills which have been lost due to the onset of mental illness and which are necessary for individuals to manage and cope with the symptoms and behaviors associated with mental health conditions and function successfully in the community. Medically necessary Outpatient Mental Health Services are those which are necessary to promote the maximum reduction of symptoms and/or restoration of an individual to their best age-appropriate functional level and are provided according to an individualized treatment plan.

Services to the beneficiary's family and significant others are for the direct benefit of the beneficiary, in accordance with the beneficiary's needs and treatment goals identified in the beneficiary's treatment plan, and for the purpose of assisting in the beneficiary's recovery.

New York
3b-39(i)

Provider Qualifications:

Outpatient Mental Health Services as described herein are provided by professionals and paraprofessionals qualified by credentials, training, and/or experience to provide direct services related to the treatment of mental illness and substance use disorders employed by or under contract with provider agencies licensed or authorized by the New York State Office of Mental Health, as follows:

1. Professional Staff include:

a. Physician: An individual who is currently licensed or possesses a permit to practice medicine issued by the New York State Education Department;
b. Psychiatrist: An individual who is currently licensed or possesses a permit to practice medicine issued by the New York State Education Department and who is either a diplomate of the American Board of Psychiatry and Neurology or is eligible to be certified by such Board or is certified by the American Osteopathic Board of Neurology and Psychiatry or is eligible to be certified by such Board;
c. Physician assistant: An individual who is currently licensed or possesses a permit to practice as a physician assistant issued by the New York State Education Department;
d. Nurse practitioner: An individual who is currently certified or possesses a permit to practice as a nurse practitioner issued by the New York State Education Department;
e. Psychiatric nurse practitioner: An individual who is currently certified or possesses a permit to practice as a nurse practitioner with an approved specialty area of psychiatry issued by the New York State Education Department;
f. Registered nurse: An individual who is currently licensed or possesses a permit to practice as a registered professional nurse issued by the New York State Education Department;
g. Licensed Practical Nurse: An individual who is currently licensed or possesses a permit to practice as a licensed practical nurse issued by the New York State Education Department;
h. Psychologist: An individual who is currently licensed or possesses a permit to practice as a psychologist issued by the New York State Education Department;
i. Social worker: An individual who is either currently licensed or possesses a permit to practice as a licensed master social worker (LMSW) or as a licensed clinical social worker (LCSW) issued by the New York State Education Department;
j. Mental health counselor: An individual who is currently licensed or possesses a permit to practice as a mental health counselor issued by the New York State Education Department;
k. Marriage and family therapist: An individual who is currently licensed or possesses a permit to practice as a marriage and family therapist issued by the New York State Education Department;
l. Psychoanalyst: An individual who is currently licensed or possesses a permit to practice as a psychoanalyst issued by the New York State Education Department;
m. Creative arts therapist: An individual who is currently licensed or possesses a permit to practice as a creative arts therapist issued by the New York State Education Department;

New York
3b-39(ii)

n. Certified psychiatric rehabilitation practitioner: An individual who is certified by the Psychiatric Rehabilitation Association as a psychiatric rehabilitation practitioner working within the adult mental health system. The certified psychiatric rehabilitation practitioner credential is exam and work experienced-based. In order to obtain certification, practitioners must have completed up to 45 hours of training and up to 4,000 hours of relevant work experience, depending on academic preparation and other certification, if any, and pass the Psychiatric Rehabilitation Association Examination;

o. Certified rehabilitation counselor: An individual certified by the Commission on Rehabilitation Counselor Certification as a rehabilitation counselor. The certified rehabilitation counselor credential is exam and training-based. In order to obtain certification, counselors must be a student within 12 months of graduation or graduate of a master's level rehabilitation counseling or clinical rehabilitation counseling program, have completed a 600-hour internship in rehabilitation counseling, and pass the Certified Rehabilitation Counselor exam. In addition to passing the Certified Rehabilitation Counselor exam, Graduates of master's or doctoral programs in other related fields of study must have completed coursework required by the Commission of Rehabilitation Counselor Certification and either a 600-hour internship or 12 months of supervised or 24 months of acceptable work experience; and

p. Occupational Therapist: An individual who is currently licensed or possesses a permit to practice as an occupational therapist issued by the New York State Education Department and meets the qualifications set forth in 42 CFR § 440.110(b)(2).

2. Paraprofessional staff are qualified by formal or informal training and professional and/or personal experience in a mental health field or treatment setting. Paraprofessional staff, including certified peer specialists, credentialed family peer advocates, and credentialed youth peer advocates, will be supervised by Professional staff. Professional staff, as defined herein are competent mental health professionals in compliance with CMS requirements for peer-delivered services. Paraprofessional staff will be at least 18 years of age and have a bachelor's degree, which may be substituted for a high school diploma or equivalent and 1-3 years of relevant experience working with individuals with serious mental illness or substance use disorders. Certified peer specialists, credentialed family peer advocates, and credentialed youth peer advocates will be at least 18 years of age and certified or provisionally certified by New York State Office of Mental Health (OMH) based on the following criteria:

Certified Peer Specialists will:

1. Possess a certification as a Certified Peer Specialist from an OMH-approved Certified Peer Specialist certification program;
2. Identify as being actively in recovery from a mental health condition or major life disruption and self-disclose one's mental health recovery journey;
3. Have completed 2000 hours of peer specialist experience under the supervision of a qualified supervisor; and
4. Completed 10 continuing education hours of peer specialist specific training annually.

New York
3b-39(iii)

Certified Peer Specialists will be provisionally certified if they meet all of the criteria above except (3) and are actively working toward obtaining 2000 hours of peer specialist experience under the supervision of a qualified supervisor.

Credentialed Family Peer Advocates (FPA) will:

1. Possess a Family Peer Advocate credential from an OMH-approved Family Peer Advocate credentialing program;
2. Demonstrate 'lived experience' as a parent or primary caregiver who has navigated multiple child serving systems on behalf of their child(ren) with social, emotional, developmental, health and/or behavioral healthcare needs;
3. Have completed Level One and Level Two of the Family Peer Advocate Core Training/Parent Empowerment Program training or another training approved by the Office of Mental Health;
4. Have completed 1000 hours of experience providing peer support services under the supervision of a qualified supervisor;
5. Submit three letters of reference attesting to proficiency in and suitability for the role of a Family Peer Advocate (FPA) including one from the FPA's supervisor;
6. Complete 20 hours of continuing education and renew their FPA credential every two years; and
7. Agree to practice according to the Professional Family Peer Advocate Code of Ethics.

Credentialed Family Peer Advocates will be provisionally credentialed for a period not to exceed 18 months if they have demonstrated lived experience as described in (2), above, completed Level One of the Family Peer Advocate Core Training/Parent Empowerment Program Training; submit two letters of reference as described in (5), above, and agree to practice according to the Professional Family Peer Advocate Code of Ethics.

Credentialed Youth Peer Advocate will:

1. Possess a valid Youth Peer Advocate Provisional Credential from an OMH-approved Youth Peer Advocate credentialing program;
2. Demonstrate "lived experience" as a person with first-hand experience with social, emotional, medical, developmental, substance use, and/or behavioral challenges in juvenile justice, special education, and/or foster care settings who is able to assist in supporting young people attain resiliency/recovery and wellness;
3. Have completed the Youth Peer Advocate Training Level Two (online and in-person) or another training approved by the Office of Mental Health;
4. Have completed 600 hours of experience providing peer support services under the supervision of a qualified supervisor;
5. Complete 20 hours of continuing education annually to renew their credential; and
6. Agree to practice according to the Youth Peer Advocate Code of Ethics.

New York
3b-39(iv)

Credentialed Youth Peer Advocate will be provisionally credentialed for a period not to exceed 18 months if they meet the following criteria:

1. Self-identify as a person with first-hand experience with social, emotional, medical, developmental, substance use, and/or behavioral challenges in juvenile justice, special education, and/or foster care settings who is able to assist in supporting young people attain resiliency/recovery and wellness;
2. Complete the Youth Peer Advocate Training Level One; and
3. Complete the Youth Peer Advocate application which includes: Two Letters of Recommendation; Signed Youth Peer Advocate Code of Ethics; Statement of Lived Experience; Resume; and Proof of age.

Service Descriptions:

Outpatient Mental Health Services include assessments/screening; treatment planning; counseling/therapy; medication treatment; psychiatric consultation; testing services; health monitoring; Screening, Brief Intervention and Referral to Treatment (SBIRT); care coordination; peer/family peer recovery support; crisis intervention; and psychosocial rehabilitation services. Except as otherwise noted, all services are for both children and adults.

All Outpatient Mental Health Services are delivered on an individual or group basis in a wide variety of settings including provider offices, in the community, or in the individual's place of residence, consistent with guidance issued by the New York State Office of Mental Health. The setting in which the service is provided is determined by the individual's needs and goals identified in the individual's treatment plan. Where indicated below, the individual's collateral supports, such as identified family members or significant others, may participate in services as necessary, for the benefit of the Medicaid beneficiary.

Outpatient Mental Health Services include:

- **Assessments/Screenings** – Including initial, immediate needs, risk, psychiatric, and functional/rehabilitative assessments, and health screenings and health physicals, for the purpose of gathering or updating information concerning the individual's mental and physical health history and status, including determination of substance use, in order to determine the appropriate diagnosis, assess the individual's functional limitations, and inform the treatment planning process. Health screenings and health physicals assess the need for and referral to additional physical health services. Assessments may include interactions between the professional and an individual's collateral supports to obtain necessary information for the benefit of the treatment planning for the individual.

New York
3b-39(v)

Outpatient Mental Health Services include: (continued)

Practitioners: Assessment/screenings, except psychiatric assessments, health screenings and health physicals are provided by Professional staff. Functional/rehabilitative assessments are provided by Professional staff and Paraprofessional staff under the supervision of Professional staff. Psychiatric assessments are provided by a Physician, Psychiatrist, Psychiatric nurse practitioner, or Physician's Assistant. Health screenings and health physicals are provided by a Physician, Psychiatrist, Physician's assistant, Nurse practitioner, Registered nurse or Licensed Practical Nurse.

- **Treatment Planning** – A collaborative person-centered process directed by the individual in collaboration with the individual's family or other collaterals, as appropriate and approved by the individual and a licensed clinician, resulting in the development of treatment and rehabilitative goals, needs, preferences, capacities and desired outcomes for the provision of Outpatient Mental Health Services.

  Practitioners: Treatment Planning services are provided by Professional staff and Paraprofessional staff under the supervision of Professional staff.

- **Counseling/Therapy** – Individual, group, and family counseling/therapy services are therapeutic counseling services for the purpose of alleviating symptoms or dysfunction associated with an individual's mental health condition or emotional disturbance, reversing or changing maladaptive patterns of behavior, encouraging personal growth and development, and supporting the individual's capacity to restore age-appropriate developmental milestones. Services include tobacco use disorder treatment services. Collateral contact is permitted as needed to address the therapeutic goals of the beneficiary.

  Practitioners: Counseling/Therapy Services are provided by Professional Staff and Paraprofessional staff under the supervision of Professional staff.

- **Medication Treatment** – Medication Treatment is a therapeutic and rehabilitative service to treat the symptoms of an individual's mental illness and/or substance use disorder, including the following components which may be provided by the following professionals:

  - Prescribing medications, monitoring the effects of medications, evaluating target symptom response to medications, and ordering and reviewing diagnostic studies, provided by a Psychiatrist, Physician, Nurse practitioner, Psychiatric Nurse Practitioner, or Physician's assistant;

- Preparing, administering and monitoring the injection of intramuscular medications, provided by a Psychiatrist, Physician, Nurse practitioner, Psychiatric Nurse Practitioner, Physician's assistant, Registered professional nurse or Licensed practical nurse; and
- Medication skills training and psychoeducation on medication use and effects, provided by Professional staff.

- **Psychiatric Consultation** – Psychiatric Consultation services are diagnostic and therapeutic services including face-to-face evaluation of a beneficiary who is not currently enrolled in the practitioner's program when the service is provided, and such consultation is required for purposes of diagnosis, integration of treatment and continuity of care. Consultation services may be provided through telehealth technology.

  Practitioners: Psychiatric Consultation services are provided by a Physician, Psychiatrist, Nurse practitioner, Psychiatric nurse practitioner, or Physician's assistant.

- **Testing Services, including developmental and psychological testing** - Developmental testing services are diagnostic services including the administration, interpretation, and reporting of screening and assessment instruments for children and adolescents to assist in the determination of the child's developmental level for the purpose of facilitating the mental health diagnosis and treatment planning processes. Psychological Testing Services are diagnostic services in which practitioners employ standard assessment methods and instruments to inform the assessment and treatment planning processes.

  Practitioners: Developmental Testing Services are provided by Professional staff. Psychological Testing Services are provided by a Psychologist, Psychiatrist, or Physician.

- **Health Monitoring** - Health Monitoring is a diagnostic and therapeutic service involving the continued measurement of specific health indicators associated with increased risk of medical illness and early death. For adults these indicators include, but are not limited to, blood pressure, body mass index (BMI), substance use, and tobacco use. For children these indicators include, but are not limited to, BMI, activity/exercise level, substance use, and smoking status.

  Practitioners: Health Monitoring services are provided by a Psychiatrist, Physician, Nurse practitioner, Psychiatric nurse practitioner, Physician's assistant, Registered nurse or Licensed practical nurse.

New York
3b-39(vii)

- **Screening, Brief Intervention and Referral to Treatment (SBIRT) services** – SBIRT are evidence-based assessment, counseling, and referral services which provide: (i) screening to identify individuals exhibiting or who are at risk of substance use-related problems; (ii) early intervention, including counseling and skills restoration services to modify risky consumption patterns and behaviors; and (iii) referral to appropriate services for individuals who need more extensive, specialized treatment to address such substance consumption patterns and behaviors.

  Practitioners: SBIRT services are provided by Professional staff and Paraprofessional staff under the supervision of Professional staff.

- **Care Coordination** - Care coordination services include service planning and referral and linkage to medically necessary Medicaid physical and/or behavioral health services or other necessary social support services to address the individual's needs and avoid more restrictive levels of treatment.

  Practitioners: Care coordination services are provided by Professional staff or Paraprofessional under the supervision of professional staff.

- **Peer/Family Peer Recovery Support Services** – Peer Recovery Support Services for adults and children/youth include age-appropriate psychoeducation, counseling, person-centered goal planning, modeling effective coping skills, and facilitating community connections to reduce symptomology and restore functionality. Services for children/youth also include family peer support services as set forth in item 13d of the Supplement to the Attachment 3.1-A (or B) of the Plan. Services are provided in individual or group settings to promote recovery, self-advocacy, and the development of natural supports and community living skills. Individuals and/or family members actively participate in decision-making and the delivery of services. Services are directed toward achievement of the specific, individualized, and result-oriented goals contained in an individual's treatment plan developed under the supervision of a competent mental health professional.

  Practitioners: Services for adults are provided by Certified Peer Specialists under supervision as described in this section. Services for children/youth are provided by Credentialed Family Peer Advocates and Credentialed Youth Peer Advocates under supervision as described in this section.

New York
3b-39(viii)

- **Crisis Intervention Services, including crisis response, crisis planning, and crisis stabilization services** – Crisis intervention services are provided to address and remediate acute distress and rehabilitate individuals who are experiencing or who are at risk of experiencing acute mental health crises and to avoid the need for emergency or inpatient psychiatric hospital services, as follows:
  - Crisis response services: Include services to safely and respectfully de-escalate situations of acute distress or agitation which require immediate attention.
  - Crisis planning services: Include rehabilitative skills training services to assist individuals to effectively avoid or respond to mental health crises by identifying triggers that risk their remaining in the community or that result in functional impairments. Services assist the individual and/or family members, or other collaterals as necessary for the benefit of the beneficiary, with identifying a potential psychiatric or personal crisis, developing a crisis management or safety plan, and/or as appropriate, seeking other supports to restore stability and functioning.
  - Crisis Stabilization Services: Stabilization services are transitional, rehabilitative, and supportive services that include symptom management and skills training to stabilize an individual after a crisis response in order to reduce the need for urgent care services or a higher level of care.

  Practitioners: Crisis intervention services are provided by Professional staff and Paraprofessional staff under supervision as provided in this section.

- **Psychosocial Rehabilitation Services** – Psychosocial Rehabilitation Services are designed to assist individuals restore their highest possible functional level and may include other collateral supports beyond the individual or family/caregiver, as necessary, to address the therapeutic goals of the beneficiary. Services include:
  - Psychoeducation and rehabilitative counseling to assist individuals to identify meaningful life role goals and barriers to their realization through a person-centered exploration of the individual's desired goals and objectives, experiences, supports, and motivation to achieve recovery;
  - Essential skill restoration and rehabilitative skill-building to assist individuals to regain the skills necessary for living successfully in the community and attain specific life role goals; and
  - Recovery planning services designed to engage and assist individuals in managing their illness and reduce the risk of hospitalization or relapse, loss of housing, or involvement with the criminal justice system due to lost functionality or uncontrolled symptomology.

  Practitioners: Psychosocial Rehabilitation Services are provided by Professional staff and Paraprofessionals under supervision of Professional staff.

New York
3N

Rehabilitative Services: Outpatient Behavioral Health Services Provided by Certified Community Behavioral Health Centers

Effective September 14, 2019, the New York State Office of Mental Health establishes provider-specific, cost-based rates for Outpatient Behavioral Health Services provided by Certified Community Behavioral Health Centers (CCBHC). All rates are subject to approval by the New York State Division of the Budget. The approved rates for CCBHCs are available at the following State website:

https://omh.ny.gov/omhweb/medicaid_reimbursement/

Plan services provided by CCBHCs and reimbursed pursuant to this methodology are as follows:

- Outpatient Addiction Rehabilitative Services and Outpatient Mental Health Services described in Section 13d of the Supplement to Attachments 3.1-A and B of the Plan
- Targeted Case Management Services for Target Groups D, D1, D2 and H described in Supplement 1 to Attachment 3.1-A

Rates for such services provided by CCBHCs are consistent with the prospective payment system methodology required pursuant to Section 223 of the Protecting Access to Medicare Act of 2014, which established the CCBHC demonstration program and mandated use of the prospective payment system (PPS).

Provider-specific rates will be a fixed, daily amount for all services provided on any given day by a CCBHC directly or through a formal relationship with a Designated Collaborating Organization (DCO). A DCO is an entity that is not under the direct supervision of the CCBHC but is engaged in a formal relationship with the CCBHC to provide CCBHC services. Payment for services provided by a DCO are included within the scope of the CCBHC's PPS rate, and DCO visits will be treated as CCBHC visits for purposes of the PPS rate.

Rates willl be calculated based upon cost and visit data supplied annually by each CCBHC on the CMS/OMB- approved CCBHC Cost Report (OMB # 0398-1148/CNS – 10398(#43)), updated to the applicable rate year utilizing the Medicare Economic Index (MEI). Services and costs related to services provided by DCOs will be included in the rate computation. The PPS rate will be calculated in accordance with the following formula:

(Total annual allowable CCBHC costs * MEI) / Total number of CCBHC annual daily visits

Allowable costs are those necessary to support the provision of CCBHC services and comply with 45 CFR § 75: Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards and 42 CFR § 413: Principles of Reasonable Cost Reimbursement, as well as Medicare principles of reasonable cost reimbursement contained in the Medicare Provider Reimbursement Manual. Reimbursement for dispensed medication will be covered under the Medicaid pharmacy benefit and will not be included in allowable CCBHC costs.

New York
3N(1)

Rehabilitative Services: Outpatient Behavioral Health Services Provided by Certified Community Behavioral Health Centers (continued)

Units of Service – A unit of service for services provided by CCBHCs will be a daily visit. The daily visit will consist of all services provided to the consumer on a single day whether provided by the CCBHC or a DCO and will be limited to one (1) daily CCBHC visit per beneficiary per day. A CCBHC or DCO must provide at least one service to the beneficiary to qualify for reimbursement. Contact with collaterals alone will not qualify for reimbursement unless an additional service as described herein is also provided to the beneficiary that day.

Appendix II
2019 Title XIX State Plan
Third Quarter Amendment
Summary

SUMMARY
SPA #19-0047

This amendment proposes to revise the State Plan to authorize the addition of Outpatient Mental Health Rehabilitation Services to include coverage for psychiatric rehabilitation, crisis, counseling, assessment, medication management, care coordination and mental health peer support services delivered on an individual or group basis in a wide variety of settings, including provider offices, in the community, or in the individual's place of residence and authorize reimbursement for a range of identified State Plan services pursuant to the established Perspective Payment System consistent with Section 223 of Protecting Access to Medicare Act (Pub. L. 113-93).

Appendix III
2019 Title XIX State Plan
Third Quarter Amendment
Authorizing Provisions

McKinney's Consolidated Laws of New York Annotated
Social Services Law (Refs & Annos)
Chapter 55. Of the Consolidated Laws
Article 5. Assistance and Care
Title 11. Medical Assistance for Needy Persons (Refs & Annos)

McKinney's Social Services Law § 365-l

§ 365-l. Health homes

Effective: April 12, 2018
Currentness

1. Notwithstanding any law, rule or regulation to the contrary, the commissioner of health is authorized, in consultation with the commissioners of the office of mental health, office of alcoholism and substance abuse services, and office for people with developmental disabilities, to (a) establish, in accordance with applicable federal law and regulations, standards for the provision of health home services to Medicaid enrollees with chronic conditions, (b) establish payment methodologies for health home services based on factors including but not limited to the complexity of the conditions providers will be managing, the anticipated amount of patient contact needed to manage such conditions, and the health care cost savings realized by provision of health home services, (c) establish the criteria under which a Medicaid enrollee will be designated as being an eligible individual with chronic conditions for purposes of this program, (d) assign any Medicaid enrollee designated as an eligible individual with chronic conditions to a provider of health home services.

2. In addition to payments made for health home services pursuant to subdivision one of this section, the commissioner is authorized to pay additional amounts to providers of health home services that meet process or outcome standards specified by the commissioner. Such additional amounts may be paid with state funds only if federal financial participation for such payments is unavailable.

2-a. Up to fifteen million dollars in state funding may be used to fund health home infrastructure development. Such funds shall be used to develop enhanced systems to support Health Home operations including assignments, workflow, and transmission of data. Funding will also be disbursed pursuant to a formula established by the commissioner to be designated health homes. Such formula may consider prior access to similar funding opportunities, geographic and demographic factors, including the population served, and prevalence of qualifying conditions, connectivity to providers, and other criteria as established by the commissioner.

2-b. The commissioner is authorized to make lump sum payments or adjust rates of payment to providers up to a gross amount of five million dollars, to establish coordination between the health homes and the criminal justice system and for the integration of information of health homes with state and local correctional facilities, to the extent permitted by law. Such rate adjustments may be made to health homes participating in a criminal justice pilot program with the purpose of enrolling incarcerated individuals with serious mental illness, two or more chronic conditions, including substance abuse disorders, or HIV/AIDS, into such health home. Health homes receiving funds under this subdivision shall be required to document and demonstrate the effective use of funds distributed herein.

2-c. The commissioner is authorized to make grants up to a gross amount of one million dollars for certified application counselors and assistors to facilitate the enrollment of persons in high risk populations, including but not limited to persons with mental health and/or substance abuse conditions that have been recently discharged or are pending release from state and local correctional facilities. Funds allocated for certified application counselors and assistors shall be expended through a request for proposal process.

2-d. The commissioner shall establish reasonable targets for health home participation by enrollees of special needs managed care plans designated pursuant to subdivision four of section three hundred sixty-five-m of this title and by high-risk enrollees of other Medicaid managed care plans operating pursuant to section three hundred sixty-four-j of this title, and shall encourage both the managed care providers and the health homes to work collaboratively with each other to achieve such targets. The commissioner may assess penalties under this subdivision in instances of failure to meet the participation targets established pursuant to this subdivision, where the department has determined that such failure reflected the absence of a good faith and reasonable effort to achieve the participation targets, except that managed care providers shall not be penalized for the failure of a health home to work collaboratively toward meeting the participation targets and a health home shall not be penalized for the failure of a managed care provider to work collaboratively toward meeting the participation targets.

3. Until such time as the commissioner obtains necessary waivers and/or approvals of the federal social security act, Medicaid enrollees assigned to providers of health home services will be allowed to opt out of such services. In addition, upon enrollment, an enrollee shall be offered an option of at least two providers of health home services, to the extent practicable.

4. Payments authorized pursuant to this section will be made with state funds only, to the extent that such funds are appropriated therefore, until such time as federal financial participation in the costs of such services is available.

5. The commissioner is authorized to submit amendments to the state plan for medical assistance and/or submit one or more applications for waivers of the federal social security act, to obtain federal financial participation in the costs of health home services provided pursuant to this section, and as provided in subdivision three of this section.

6. Notwithstanding any limitations imposed by section three hundred sixty-four-l of this title on entities participating in demonstration projects established pursuant to such section, the commissioner is authorized to allow such entities which meet the requirements of this section to provide health home services.

7. Notwithstanding any law, rule, or regulation to the contrary, the commissioners of the department of health, the office of mental health, the office for people with developmental disabilities, and the office of alcoholism and substance abuse services are authorized to jointly establish a single set of operating and reporting requirements and a single set of construction and survey requirements for entities that:

(a) can demonstrate experience in the delivery of health, and mental health and/or alcohol and substance abuse services and/or services to persons with developmental disabilities, and the capacity to offer integrated delivery of such services in each location approved by the commissioner; and

(b) meet the standards established pursuant to subdivision one of this section for providing and receiving payment for health home services; provided, however, that an entity meeting the standards established pursuant to subdivision one of this section shall not be required to be an integrated service provider pursuant to this subdivision.

In establishing a single set of operating and reporting requirements and a single set of construction and survey requirements for entities described in this subdivision, the commissioners of the department of health, the office of mental health, the office for people with developmental disabilities, and the office of alcoholism and substance abuse services are authorized to waive any regulatory requirements as are necessary to avoid duplication of requirements and to allow the integrated delivery of services in a rational and efficient manner.

8. (a) The commissioner of health is authorized to contract with one or more entities to assist the state in implementing the provisions of this section. Such entity or entities shall be the same entity or entities chosen to assist in the implementation of the multipayor patient centered medical home program pursuant to section twenty-nine hundred fifty-nine-a of the public health law. Responsibilities of the contractor shall include but not be limited to: developing recommendations with respect to program policy, reimbursement, system requirements, reporting requirements, evaluation protocols, and provider and patient enrollment; providing technical assistance to potential medical home and health home providers; data collection; data sharing; program evaluation, and preparation of reports.

(b) Notwithstanding any inconsistent provision of sections one hundred twelve and one hundred sixty-three of the state finance law, or section one hundred forty-two of the economic development law, or any other law, the commissioner of health is authorized to enter into a contract or contracts under paragraph (a) of this subdivision without a competitive bid or request for proposal process, provided, however, that:

(i) The department of health shall post on its website, for a period of no less than thirty days:

(1) A description of the proposed services to be provided pursuant to the contract or contracts;

(2) The criteria for selection of a contractor or contractors;

(3) The period of time during which a prospective contractor may seek selection, which shall be no less than thirty days after such information is first posted on the website; and

(4) The manner by which a prospective contractor may seek such selection, which may include submission by electronic means;

(ii) All reasonable and responsive submissions that are received from prospective contractors in timely fashion shall be reviewed by the commissioner of health; and

(iii) The commissioner of health shall select such contractor or contractors that, in his or her discretion, are best suited to serve the purposes of this section.

9. The contract entered into by the commissioner of health prior to January first, two thousand thirteen pursuant to subdivision eight of this section may be amended or modified without the need for a competitive bid or request for proposal process, and without regard to the provisions of sections one hundred twelve and one hundred sixty-three of the state finance law, section one hundred forty-two of the economic development law, or any other provision of law, excepting the responsible vendor requirements of the state finance law, including, but not limited to, sections one hundred sixty-three and one hundred thirty-nine-

k of the state finance law, to allow the purchase of additional personnel and services, subject to available funding, for the limited purpose of assisting the department of health with implementing the Balancing Incentive Program, the Fully Integrated Duals Advantage Program, the Vital Access Provider Program, the Medicaid waiver amendment associated with the public hospital transformation, the addition of behavioral health services as a managed care plan benefit, the delivery system reform incentive payment plan, activities to facilitate the transition of vulnerable populations to managed care and/or any workgroups required to be established by the chapter of the laws of two thousand thirteen that added this subdivision. The department is authorized to extend such contract for a period of one year, without a competitive bid or request for proposal process, upon determination that the existing contractor is qualified to continue to provide such services; provided, however, that the department of health shall submit a request for applications for such contract during the time period specified in this subdivision and may terminate the contract identified herein prior to expiration of the extension authorized by this subdivision.

Credits

(Added L.2011, c. 59, pt. H, § 37, eff. March 31, 2011, deemed eff. April 1, 2011. Amended L.2013, c. 56, pt. A, §§ 6, 23, eff. March 28, 2013, deemed eff. April 1, 2013; L.2014, c. 60, pt. C, § 35, eff. March 31, 2014, deemed eff. April 1, 2014; L.2015, c. 57, pt. B, § 25, eff. April 13, 2015, deemed eff. April 1, 2015; L.2016, c. 59, pt. B, §§ 17, 28, eff. April 13, 2016, deemed eff. April 1, 2016; L.2017, c. 57, pt. S, § 1, eff. April 20, 2017; L.2018, c. 57, pt. C, § 2, eff. April 12, 2018.)

McKinney's Social Services Law § 365-l, NY SOC SERV § 365-l
Current through L.2019, chapter 144. Some statute sections may be more current, see credits for details.

End of Document

"(I) Data relating to changes in the number of uninsured individuals.

"(II) Data relating to the amount and sources of hospitals' uncompensated care costs, including the amount of such costs that are the result of providing unreimbursed or under-reimbursed services, charity care, or bad debt.

"(III) Data identifying hospitals with high levels of uncompensated care that also provide access to essential community services for low-income, uninsured, and vulnerable populations, such as graduate medical education, and the continuum of primary through quarternary care, including the provision of trauma care and public health services.

"(IV) State-specific analyses regarding the relationship between the most recent State DSH allotment and the projected State DSH allotment for the succeeding year and the data reported under subclauses (I), (II), and (III) for the State.

"(iii) DATA.—Notwithstanding any other provision of law, the Secretary regularly shall provide MACPAC with the most recent State reports and most recent independent certified audits submitted under section 1923(j), cost reports submitted under title XVIII, and such other data as MACPAC may request for purposes of conducting the reviews and preparing and submitting the annual reports required under this subparagraph.

"(iv) SUBMISSION DEADLINES.—The first report required under this subparagraph shall be submitted to Congress not later than February 1, 2016. Subsequent reports shall be submitted as part of, or with, each annual report required under paragraph (1)(C) during the period of fiscal years 2017 through 2024.".

SEC. 222. REALIGNMENT OF THE MEDICARE SEQUESTER FOR FISCAL YEAR 2024.

Paragraph (6) (relating to implementing direct spending reductions) of section 251A of the Balanced Budget and Emergency Deficit Control Act of 1985 (2 U.S.C. 901a) is amended by adding at the end the following new subparagraph:

"(D) Notwithstanding the 2 percent limit specified in subparagraph (A) for payments for the Medicare programs specified in section 256(d), the sequestration order of the President under such subparagraph for fiscal year 2024 shall be applied to such payments so that— Applicability.

"(i) with respect to the first 6 months in which such order is effective for such fiscal year, the payment reduction shall be 4.0 percent; and

"(ii) with respect to the second 6 months in which such order is so effective for such fiscal year, the payment reduction shall be 0.0 percent.".

SEC. 223. DEMONSTRATION PROGRAMS TO IMPROVE COMMUNITY MENTAL HEALTH SERVICES. 42 USC 1396a note.

(a) CRITERIA FOR CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINICS TO PARTICIPATE IN DEMONSTRATION PROGRAMS.—

Deadline.

(1) PUBLICATION.—Not later than September 1, 2015, the Secretary shall publish criteria for a clinic to be certified by a State as a certified community behavioral health clinic for purposes of participating in a demonstration program conducted under subsection (d).

(2) REQUIREMENTS.—The criteria published under this subsection shall include criteria with respect to the following:

(A) STAFFING.—Staffing requirements, including criteria that staff have diverse disciplinary backgrounds, have necessary State-required license and accreditation, and are culturally and linguistically trained to serve the needs of the clinic's patient population.

(B) AVAILABILITY AND ACCESSIBILITY OF SERVICES.—Availability and accessibility of services, including crisis management services that are available and accessible 24 hours a day, the use of a sliding scale for payment, and no rejection for services or limiting of services on the basis of a patient's ability to pay or a place of residence.

(C) CARE COORDINATION.—Care coordination, including requirements to coordinate care across settings and providers to ensure seamless transitions for patients across the full spectrum of health services including acute, chronic, and behavioral health needs. Care coordination requirements shall include partnerships or formal contracts with the following:

(i) Federally-qualified health centers (and as applicable, rural health clinics) to provide Federally-qualified health center services (and as applicable, rural health clinic services) to the extent such services are not provided directly through the certified community behavioral health clinic.

(ii) Inpatient psychiatric facilities and substance use detoxification, post-detoxification step-down services, and residential programs.

(iii) Other community or regional services, supports, and providers, including schools, child welfare agencies, juvenile and criminal justice agencies and facilities, Indian Health Service youth regional treatment centers, State licensed and nationally accredited child placing agencies for therapeutic foster care service, and other social and human services.

(iv) Department of Veterans Affairs medical centers, independent outpatient clinics, drop-in centers, and other facilities of the Department as defined in section 1801 of title 38, United States Code.

(v) Inpatient acute care hospitals and hospital outpatient clinics.

(D) SCOPE OF SERVICES.—Provision (in a manner reflecting person-centered care) of the following services which, if not available directly through the certified community behavioral health clinic, are provided or referred through formal relationships with other providers:

(i) Crisis mental health services, including 24-hour mobile crisis teams, emergency crisis intervention services, and crisis stabilization.

(ii) Screening, assessment, and diagnosis, including risk assessment.

(iii) Patient-centered treatment planning or similar processes, including risk assessment and crisis planning.

(iv) Outpatient mental health and substance use services.

(v) Outpatient clinic primary care screening and monitoring of key health indicators and health risk.

(vi) Targeted case management.

(vii) Psychiatric rehabilitation services.

(viii) Peer support and counselor services and family supports.

(ix) Intensive, community-based mental health care for members of the armed forces and veterans, particularly those members and veterans located in rural areas, provided the care is consistent with minimum clinical mental health guidelines promulgated by the Veterans Health Administration including clinical guidelines contained in the Uniform Mental Health Services Handbook of such Administration.

(E) QUALITY AND OTHER REPORTING.—Reporting of encounter data, clinical outcomes data, quality data, and such other data as the Secretary requires.

(F) ORGANIZATIONAL AUTHORITY.—Criteria that a clinic be a non-profit or part of a local government behavioral health authority or operated under the authority of the Indian Health Service, an Indian tribe or tribal organization pursuant to a contract, grant, cooperative agreement or compact with the Indian Health Services pursuant to the Indian Self-Determination Act (25 U.S.C. 450 et seq.) or an urban Indian organization pursuant to a grant or contract with the Indian Health Service under title V of the Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.).

(b) GUIDANCE ON DEVELOPMENT OF PROSPECTIVE PAYMENT SYSTEM FOR TESTING UNDER DEMONSTRATION PROGRAMS.—

(1) IN GENERAL.—Not later than September 1, 2015, the Secretary, through the Administrator of the Centers for Medicare & Medicaid Services, shall issue guidance for the establishment of a prospective payment system that shall only apply to medical assistance for mental health services furnished by a certified community behavioral health clinic participating in a demonstration program under subsection (d). Deadline. Applicability.

(2) REQUIREMENTS.—The guidance issued by the Secretary under paragraph (1) shall provide that—

(A) no payment shall be made for inpatient care, residential treatment, room and board expenses, or any other non-ambulatory services, as determined by the Secretary; and

(B) no payment shall be made to satellite facilities of certified community behavioral health clinics if such facilities are established after the date of enactment of this Act.

(c) PLANNING GRANTS.—

(1) IN GENERAL.—Not later than January 1, 2016, the Secretary shall award planning grants to States for the purpose of developing proposals to participate in time-limited demonstration programs described in subsection (d). Deadline.

(2) USE OF FUNDS.—A State awarded a planning grant under this subsection shall—

(A) solicit input with respect to the development of such a demonstration program from patients, providers, and other stakeholders;

Certification.

(B) certify clinics as certified community behavioral health clinics for purposes of participating in a demonstration program conducted under subsection (d); and

(C) establish a prospective payment system for mental health services furnished by a certified community behavioral health clinic participating in a demonstration program under subsection (d) in accordance with the guidance issued under subsection (b).

(d) DEMONSTRATION PROGRAMS.—

Deadline.

(1) IN GENERAL.—Not later than September 1, 2017, the Secretary shall select States to participate in demonstration programs that are developed through planning grants awarded under subsection (c), meet the requirements of this subsection, and represent a diverse selection of geographic areas, including rural and underserved areas.

(2) APPLICATION REQUIREMENTS.—

(A) IN GENERAL.—The Secretary shall solicit applications to participate in demonstration programs under this subsection solely from States awarded planning grants under subsection (c).

(B) REQUIRED INFORMATION.—An application for a demonstration program under this subsection shall include the following:

(i) The target Medicaid population to be served under the demonstration program.

(ii) A list of participating certified community behavioral health clinics.

(iii) Verification that the State has certified a participating clinic as a certified community behavioral health clinic in accordance with the requirements of subsection (b).

(iv) A description of the scope of the mental health services available under the State Medicaid program that will be paid for under the prospective payment system tested in the demonstration program.

(v) Verification that the State has agreed to pay for such services at the rate established under the prospective payment system.

(vi) Such other information as the Secretary may require relating to the demonstration program including with respect to determining the soundness of the proposed prospective payment system.

(3) NUMBER AND LENGTH OF DEMONSTRATION PROGRAMS.—Not more than 8 States shall be selected for 2-year demonstration programs under this subsection.

(4) REQUIREMENTS FOR SELECTING DEMONSTRATION PROGRAMS.—

(A) IN GENERAL.—The Secretary shall give preference to selecting demonstration programs where participating certified community behavioral health clinics—

(i) provide the most complete scope of services described in subsection (a)(2)(D) to individuals eligible

for medical assistance under the State Medicaid program;

(ii) will improve availability of, access to, and participation in, services described in subsection (a)(2)(D) to individuals eligible for medical assistance under the State Medicaid program;

(iii) will improve availability of, access to, and participation in assisted outpatient mental health treatment in the State; or

(iv) demonstrate the potential to expand available mental health services in a demonstration area and increase the quality of such services without increasing net Federal spending.

(5) PAYMENT FOR MEDICAL ASSISTANCE FOR MENTAL HEALTH SERVICES PROVIDED BY CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINICS.—

(A) IN GENERAL.—The Secretary shall pay a State participating in a demonstration program under this subsection the Federal matching percentage specified in subparagraph (B) for amounts expended by the State to provide medical assistance for mental health services described in the demonstration program application in accordance with paragraph (2)(B)(iv) that are provided by certified community behavioral health clinics to individuals who are enrolled in the State Medicaid program. Payments to States made under this paragraph shall be considered to have been under, and are subject to the requirements of, section 1903 of the Social Security Act (42 U.S.C. 1396b).

(B) FEDERAL MATCHING PERCENTAGE.—The Federal matching percentage specified in this subparagraph is with respect to medical assistance described in subparagraph (A) that is furnished—

(i) to a newly eligible individual described in paragraph (2) of section 1905(y) of the Social Security Act (42 U.S.C. 1396d(y)), the matching rate applicable under paragraph (1) of that section; and

(ii) to an individual who is not a newly eligible individual (as so described) but who is eligible for medical assistance under the State Medicaid program, the enhanced FMAP applicable to the State.

(C) LIMITATIONS.—

(i) IN GENERAL.—Payments shall be made under this paragraph to a State only for mental health services—

(I) that are described in the demonstration program application in accordance with paragraph (2)(iv);

(II) for which payment is available under the State Medicaid program; and

(III) that are provided to an individual who is eligible for medical assistance under the State Medicaid program.

(ii) PROHIBITED PAYMENTS.—No payment shall be made under this paragraph—

(I) for inpatient care, residential treatment, room and board expenses, or any other non-

ambulatory services, as determined by the Secretary; or

(II) with respect to payments made to satellite facilities of certified community behavioral health clinics if such facilities are established after the date of enactment of this Act.

(6) WAIVER OF STATEWIDENESS REQUIREMENT.—The Secretary shall waive section 1902(a)(1) of the Social Security Act (42 U.S.C. 1396a(a)(1)) (relating to statewideness) as may be necessary to conduct demonstration programs in accordance with the requirements of this subsection.

(7) ANNUAL REPORTS.—

(A) IN GENERAL.—Not later than 1 year after the date on which the first State is selected for a demonstration program under this subsection, and annually thereafter, the Secretary shall submit to Congress an annual report on the use of funds provided under all demonstration programs conducted under this subsection. Each such report shall include—

(i) an assessment of access to community-based mental health services under the Medicaid program in the area or areas of a State targeted by a demonstration program compared to other areas of the State;

(ii) an assessment of the quality and scope of services provided by certified community behavioral health clinics compared to community-based mental health services provided in States not participating in a demonstration program under this subsection and in areas of a demonstration State that are not participating in the demonstration program; and

(iii) an assessment of the impact of the demonstration programs on the Federal and State costs of the full range of mental health services (including inpatient, emergency and ambulatory services).

(B) RECOMMENDATIONS.—Not later than December 31, 2021, the Secretary shall submit to Congress recommendations concerning whether the demonstration programs under this section should be continued, expanded, modified, or terminated.

(e) DEFINITIONS.—In this section:

(1) FEDERALLY-QUALIFIED HEALTH CENTER SERVICES; FEDERALLY-QUALIFIED HEALTH CENTER; RURAL HEALTH CLINIC SERVICES; RURAL HEALTH CLINIC.—The terms "Federally-qualified health center services", "Federally-qualified health center", "rural health clinic services", and "rural health clinic" have the meanings given those terms in section 1905(l) of the Social Security Act (42 U.S.C. 1396d(l)).

(2) ENHANCED FMAP.—The term "enhanced FMAP" has the meaning given that term in section 2105(b) of the Social Security Act (42 U.S.C. 1397dd(b)) but without regard to the second and third sentences of that section.

(3) SECRETARY.—The term "Secretary" means the Secretary of Health and Human Services.

(4) STATE.—The term "State" has the meaning given such term for purposes of title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).

(f) FUNDING.—

(1) IN GENERAL.—Out of any funds in the Treasury not otherwise appropriated, there is appropriated to the Secretary—

(A) for purposes of carrying out subsections (a), (b), and (d)(7), $2,000,000 for fiscal year 2014; and

(B) for purposes of awarding planning grants under subsection (c), $25,000,000 for fiscal year 2016.

(2) AVAILABILITY.—Funds appropriated under paragraph (1) shall remain available until expended.

SEC. 224. ASSISTED OUTPATIENT TREATMENT GRANT PROGRAM FOR INDIVIDUALS WITH SERIOUS MENTAL ILLNESS. 42 USC 290aa note.

(a) IN GENERAL.—The Secretary shall establish a 4-year pilot program to award not more than 50 grants each year to eligible entities for assisted outpatient treatment programs for individuals with serious mental illness.

(b) CONSULTATION.—The Secretary shall carry out this section in consultation with the Director of the National Institute of Mental Health, the Attorney General of the United States, the Administrator of the Administration for Community Living, and the Administrator of the Substance Abuse and Mental Health Services Administration.

(c) SELECTING AMONG APPLICANTS.—The Secretary—

(1) may only award grants under this section to applicants that have not previously implemented an assisted outpatient treatment program; and

(2) shall evaluate applicants based on their potential to reduce hospitalization, homelessness, incarceration, and interaction with the criminal justice system while improving the health and social outcomes of the patient.

(d) USE OF GRANT.—An assisted outpatient treatment program funded with a grant awarded under this section shall include—

(1) evaluating the medical and social needs of the patients who are participating in the program;

(2) preparing and executing treatment plans for such patients that—

(A) include criteria for completion of court-ordered treatment; and

(B) provide for monitoring of the patient's compliance with the treatment plan, including compliance with medication and other treatment regimens;

(3) providing for such patients case management services that support the treatment plan;

(4) ensuring appropriate referrals to medical and social service providers;

(5) evaluating the process for implementing the program to ensure consistency with the patient's needs and State law; and

(6) measuring treatment outcomes, including health and social outcomes such as rates of incarceration, health care utilization, and homelessness.

(e) REPORT.—Not later than the end of each of fiscal years 2016, 2017, and 2018, the Secretary shall submit a report to the appropriate congressional committees on the grant program under this section. Each such report shall include an evaluation of the following: Evaluation.

Appendix IV
2019 Title XIX State Plan
Third 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 Agriculture and Markets

Pursuant to Agriculture and Markets Law § 284-a, Notice is hereby given that the Department of Agriculture and Markets has designated the "Southern Tier Craft Beverage Trail" to be described as:

"Beginning at the intersection of NY 369 and the Exit 3 WB off-ramp from NY 7 in the town of Port Crane and continuing north on NY 369 for 5.8 miles, continuing west on NY 79 for 2.6 miles to the intersection with NY 12, continuing north on NY 12 for 1.9 miles to the intersection with County Route 1 (Cloverdale Rd.), continuing northwest on County Route 1 for 1.3 miles, continuing northwest on County Route 140 (Cloverdale Rd.) for 3.1 miles to the intersection with County Route 133 (South St.), continuing south on County Route 133 for 0.3 miles to the intersection with NY 79, continuing west on NY 79 for 18.4 miles through the village of Whitney Point to the intersection with NY 38 in the hamlet of Richford, continuing south on NY 38 for 17.9 miles to the intersection with NY 96, continuing south on NY 96 for 2.2 miles to the intersection with NY 434 in the village of Owego, continuing east on NY 434 for 7.3 miles to the intersection with NY 962J in the hamlet of Apalachin, continuing north on NY 962J for 0.4 miles to the intersection with NY 17C, continuing east on NY 17C for 13.2 miles through the village of Endicott, hamlet of Endwell, and village of Johnson City to the intersection with US 11 (Court St.) in the city of Binghamton, continuing south on US 11 for 0.2 miles to end at the junction with Washington St."

For further information, please contact: Anne St. Cyr, Agricultural Development, Department of Agriculture and Markets, 10B Airline Dr., Albany, NY 12235, (518) 485-9974, (518) 457-2716 (Fax)

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 revise provisions of the Ambulatory Patient Group (APG) reimbursement methodology. The following changes are proposed:

Non-Institutional

Effective on or after July 1, 2019, the Ambulatory Patient Group (APG) reimbursement methodology is revised to include recalculated weight and component updates.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2019/2020 is $1.9 million.

The public is invited to review and comment on this proposed State Plan Amendment. Copies of which will be available for public review on the Department's website at http://www.health.ny.gov/regulations/state_plans/status

Copies of the proposed State Plan Amendments will be on file in each local (county) social services district and available for public review.

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

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

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

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

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

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

For further information and to review and comment, please contact: Department of Health, Bureau of Federal Relations & Provider Assessments, 99 Washington Ave., One Commerce Plaza, Suite 1430, Albany, NY 12210, (518) 474-1673, (518) 473-8825 (FAX), spa_inquiries@health.state.ny.us

PUBLIC NOTICE

Department of Health

Pursuant to 42 CFR Section 447.205, the Office of Mental Health (OMH), Office of Alcoholism and Substance Abuse Services (OASAS), and the Department of Health (DOH) hereby gives public notice of the following:

OMH, OASAS, and DOH 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, 2019, existing providers participating in the Certified Community Behavioral Health Clinic (CCBHC) demonstration will continue delivering and being reimbursed for comprehensive behavioral health services beyond the Federal demonstration period.

CCBHCs provide a comprehensive range of ambulatory mental health and substance use disorder services to individuals throughout New York State, including:

•eCrisis mental health services including 24-hour mobile crisise teams, emergency crisis intervention and crisis stabilization

•eOutpatient mental health and substance use services with ancillary withdrawal

•eScreening, assessment and diagnosis including risk managemente

•ePrimary care screening and monitoringe

•eCase managemente

•ePsychiatric rehabilitation servicese

•ePeer support, counseling services, and family support servicese

•eServices for members of the armed services and veteranse

This amendment will allow New York State to maintain the CCBHCe program model by ensuring all services in the program model are covered benefits in the State Plan. To facilitate this, the State proposes to amend the Title XIX State Plan to allow for coverage of outpatient rehabilitative mental health services delivered to individuals in a site-based clinic, home or community setting as appropriate to their individual needs.

This Amendment will also seek approval of a reimbursement methodology that allows the CCBHC providers to utilize a Prospective Payment System (PPS), which is a provider specific cost-based service rate developed in accordance with Federal standards contained in the Protecting Access to Medicare Act of 2014 (H.R. 4302) for reimbursement for a range of identified state plan services. The Office of Mental Health and the Office of Alcoholism and Substance Abuse Services will submit a 1915(b)(4) Waiver simultaneous with the state plan submission to allow for Selective Contracting with the existing 13 CCBHCs.

CCBHC providers are listed below by region:

Central New York: Helio Health (Syracuse Brick House, Inc.) – Onondaga County

Finger Lakes: University of Rochester, Strong Memorial Hospital – Monroe County

Long Island: Central Nassau Guidance & Counseling Services – Nassau County

Mid-Hudson: Achieve (Bikur Cholim Inc.) – Rockland County

North Country: Citizens Advocates Inc, North Star Behavioral Health Services – Franklin County

NYC: New Horizon Counseling Center – Queens County

Samaritan Daytop Village – Bronx County

Services for the UnderServed, Inc (S:US) – Kings County

Promesa – Bronx County

VIP Community Services – Bronx County

Western New York:

Best Self (Lake Shore Behavioral Health, Inc.) – Erie County;

Spectrum Human Services – Erie County

Endeavor (Mid-Erie Mental Health Services, Inc.) – Erie County

There is no additional estimated annual change to gross Medicaid expenditures as a result of the clarifying proposed amendments.

The public is invited to review and comment on thisproposed 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, Bureau of Federal Relations & Provider Assessments, 99 Washington Ave., One Commerce Plaza, Suite 1432, Albany, NY 12210, (518) 474-1673, (518) 473-8825 (FAX), spa_inquiries@health.state.ny.us

PUBLIC NOTICE

Department of Health

The New York State Department of Health (DOH) is submitting requests to the Federal Centers for Medicare and Medicaid Services (CMS) to amend the 1915(c) Children's Waiver (#NY.4125.R05.03) Home and Community Based Services (HCBS) coverage as follows:

Effective July 1, 2019

•eAll Children's 1915(c) waiver participants will be required toe receive at least one HCBS service per month.

•eFamily Peer Support Services will be removed from the waiver.e The service is available as a State Plan service SPA-19-003, which has already been approved by CMS effective July 1, 2019.

•eLanguage in performance measures will be modified to clarifye that Care Managers will meet regularly with waiver participants in a manner and frequency that is consistent with the participant's Health Home acuity level.

Effective October 1, 2019

Language will be incorporated to reference the Medicaid Managed Care delivery system throughout the application and concurrent operation with the 1115 waiver amendment already submitted to CMS and expected to be approved no later than July 1, 2019.

Effective January 1, 2020

• Youth Peer Supports and Crisis Intervention will be removed frome the Children's waiver and be made available as a State Plan service.

For further information and to review and comment, please contact: Department of Health, Office of Health Insurance Programs, 99 Washington Ave., One Commerce Plaza, Suite 720, Albany, NY 12210, BH.Transition@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 State Fiscal Year 2019/20 Budget statutory provisions included in Public Health Law § 2826.

Non-Institutional Services:

Effective on and after July 1, 2019, this notice provides for a temporary rate adjustment with an aggregate payment totaling no less than $7.5 million annually for Critical Access Hospitals (CAHs), for

Appendix V
2019 Title XIX State Plan
Third Quarter Amendment
Responses to Standard Funding Questions

NON-INSTITUTIONAL SERVICES
State Plan Amendment #19-0047

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. For SPAs that provide for changes to payments for clinic or outpatient hospital services or for enhanced or supplemental payments to physician or other practitioners, the questions must be answered for all payments made under the state plan for such service.

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 payments, a complete listing of providers that return a portion of their payments, 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 retain the payments made pursuant to this amendment. However, this requirement in no way prohibits the public provider, including county providers, from reimbursing the sponsoring local government for appropriate expenses incurred by the local government on behalf of the public provider. The State does not regulate the financial relationships that exist between public health care providers and their sponsoring governments, which are extremely varied and complex. Local governments may provide direct and/or indirect monetary subsidies to their public providers to cover on-going unreimbursed operational expenses and assure achievement of their mission as primary safety net providers. Examples of appropriate expenses may include payments to the local government which include reimbursement for debt service paid on a provider's behalf, reimbursement for Medicare Part B premiums paid for a provider's retirees, reimbursement for contractually required health benefit fund payments made on a provider's behalf, and payment for overhead expenses as allocated per federal Office of Management and Budget Circular 2 CFR 200 regarding Cost Principles for State, Local, and Indian Tribal Governments. The existence of such transfers should in no way negate the legitimacy of these facilities' Medicaid payments or result in reduced Medicaid federal financial participation for the State. This position was further supported by CMS in review and approval of SPA 07-07C when an on-site audit of these transactions for New York City's Health and Hospitals Corporation was completed with satisfactory results.

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 through 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 governmental 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: Payments made to service providers under the provisions of this SPA are funded through a general appropriation received by the State agency that oversees medical assistance (Medicaid), which is the Department of Health.

   The source of the appropriation is the Medicaid General Fund Local Assistance Account, which is part of the Global Cap. The Global Cap is funded by General Fund and HCRA resources. There have been no new provider taxes and no existing taxes have been modified.

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 payments authorized for this provision are not supplemental or enhanced 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.**

   Response: These services are covered as rehabilitation services and are, therefore, not held to UPL requirements.

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: The rate methodology included in the State Plan for services provided by CCBHCs is a provider-specific and cost-based prospective payment methodology as required by Section 223 of the Protecting Access to Medicare Act of 2014, pursuant to which New York State initially authorized such services as a demonstration program. We are unaware of any requirement under current federal law or regulation that limits individual providers' payments to their actual costs.

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 does comply 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.