



Department of Health

ANDREW M. CUOMO
Governor

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

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

June 30, 2020

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 #20-0036
Non-Institutional Services

Dear Ms. McKnight:

The State requests approval of the enclosed amendment #20-0036 to the Title XIX (Medicaid) State Plan for non-institutional services to be effective April 2, 2020 (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 April 1, 2020 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,



Donna Frescatore
Medicaid Director
Office of Health Insurance Programs

Enclosures

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL
FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES**

1. TRANSMITTAL NUMBER <u>2 0 — 0 0 3 6</u>	2. STATE New York
3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID) TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
4. PROPOSED EFFECTIVE DATE April 2, 2020	

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

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(r)(5) of the Social Security Act, and 42 CFR 447	7. FEDERAL BUDGET IMPACT a. FFY <u>04/02/20-09/30/20</u> \$ <u>850,000.00</u> b. FFY <u>10/01/20-09/30/21</u> \$ <u>1,700,000.00</u>
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT Attachment: 4.19-B Page(s): 1(a)(i), 1(a)(iii)	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (<i>If Applicable</i>) Attachment: 4.19-B Page(s): 1(a)(i), 1(a)(iii)

10. SUBJECT OF AMENDMENT
Children and Family Treatment and Support Services (CFTSS)
(FMAP=50%)

11. GOVERNOR'S REVIEW (*Check One*)

- GOVERNOR'S OFFICE REPORTED NO COMMENT OTHER, AS SPECIFIED
 COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
 NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

12. SIGNATURE OF STATE AGENCY OFFICIAL 	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
13. TYPED NAME Donna Frescatore	
14. TITLE Medicaid Director, Department of Health	
15. DATE SUBMITTED June 30, 2020	

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
2020 Title XIX State Plan
Second Quarter Amendment
Amended SPA Pages

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: New York

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

Non-Physician Licensed Behavioral Health Practitioner Services (EPSDT only)

Reimbursement for EPSDT NP-LBHP as outlined in Item 6.d(i). per Attachment 3.1-A, are paid based upon Medicaid rates established by the State of New York.

Except as otherwise noted in the State Plan, the State-developed rates are the same for both governmental and private providers. The provider agency’s rates were set as of January 1, 2019 for Other Licensed Practitioner, Community Psychiatric Support and Treatment, and Psychosocial Rehabilitation Supports, and are effective for these services provided on or after that date.

Provider agency’s rates were set as of July 1, 2019 for Family Peer Support Services and are effective for these services provided on or after that date. Additionally, the agency’s rates were set as of January 1, 2020 for Crisis Intervention and Youth Peer Supports and Training are effective for these services provided on or after that date.

As of April 2, 2020 the rates will be updated to reflect changes in reimbursements for the following services:

- Other Licensed Practitioner
- Community Psychiatric Support and Treatment
- Psychosocial Rehabilitation Supports
- Family Peer Support Services
- Crisis Intervention
- Youth Peer Supports and Training

All rates are published on the Department of Health website:

https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/proposed_spa.htm

[Crisis Intervention Rates]

[https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/docs/2019-12-19_child-family_rate_summary.pdf]

[Family Peer Supports Services and Youth Peer Supports Rates]

[https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/docs/fpss_bh_kids_ffs_rates.pdf]

[Other Licensed Practitioner, Community Psychiatric Support and Treatment, and Psychosocial Rehabilitation Supports Rates]

[https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/docs/bh_kids_ffs_rates.pdf]

TN # #20-0036

Approval Date _____

Supersedes TN # 20-0001

Effective Date April 2, 2020

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: New York

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

Rehabilitative Services (EPSDT only)

Reimbursement for EPSDT Rehabilitative Services as outlined in item 13.d per Attachment 3.1-A, are paid based upon Medicaid rates established by the State of New York.

Except as otherwise noted in the State Plan, the State-developed rates are the same for both governmental and private providers. The provider agency’s rates were set as of January 1, 2019 for Other Licensed Practitioner, Community Psychiatric Support and Treatment, and Psychosocial Rehabilitation Supports, and are effective for these services provided on or after that date.

Provider agency’s rates were set as of July 1, 2019 for Family Peer Support Services and are effective for these services provided on or after that date. Additionally, the agency’s rates were set as of January 1, 2020 for Crisis Intervention and Youth Peer Supports and Training and are effective for these services provided on or after that date.

As of April 2, 2020 the rates will be updated to reflect changes in reimbursements for the following services:

- Other Licensed Practitioner
- Community Psychiatric Support and Treatment
- Psychosocial Rehabilitation Supports
- Family Peer Support Services
- Crisis Intervention
- Youth Peer Supports and Training

All rates are published on the Department of Health website:

https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/proposed_spa.htm

[Crisis Intervention Rates]

https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/docs/2019-12-19_child-family_rate_summary.pdf

[Family Peer Supports Services and Youth Peer Supports Rates]

https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/docs/fpssbh_kids_ffs_rates.pdf

The rate development methodology will primarily be composed of provider cost modeling, through New York provider compensation studies and cost data. Rates from similar State Medicaid programs may be considered, as well. The following list outlines the major components of the cost model to be used in rate development.

- Staffing assumptions and staff wages.
- Employee-related expenses — benefits, employer taxes (e.g., Federal Insurance Contributions Act (FICA), unemployment, and workers compensation).
- Program-related expenses (e.g., supplies).
- Provider overhead expenses.
- Program billable units.

The rates will be developed as the ratio of total annual modeled provider costs to the estimated annual billable units.

TN # #20-0036

Approval Date _____

Supersedes TN # 20-0001

Effective Date April 2, 2020

Appendix II
2020 Title XIX State Plan
Second Quarter Amendment
Summary

SUMMARY
SPA #20-0036

This State Plan Amendment proposes to continue additional 11% enhanced transition rate to the following Children and Family Treatment and Support Services (CFTSS) as follows:

- Other Licensed Practitioner (OLP), Community Psychiatric Support and Treatment (CPST) and Psychosocial Rehabilitation (PSR), April 1, 2020 through March 31, 2022.
- Family Peer Support Service (FPSS) July 1, 2020 through March 31, 2022.
- Crisis Intervention (CI) and Youth Peer Supports (YPS) January 1, 2021 – March 31, 2022

All of the above will return to Base Rate effective April 1, 2022 and forward.

Appendix III
2020 Title XIX State Plan
Second Quarter Amendment
Authorizing Provisions

New York Codes, Rules and Regulations

18 CRR-NY
505.38
NY-CRR

OFFICIAL COMPILATION OF CODES, RULES AND REGULATIONS OF THE STATE OF NEW YORK
TITLE 18. DEPARTMENT OF SOCIAL SERVICES
CHAPTER II. REGULATIONS OF THE DEPARTMENT OF SOCIAL SERVICES
SUBCHAPTER E. MEDICAL CARE
ARTICLE 3. POLICIES AND STANDARDS GOVERNING PROVISION OF MEDICAL AND DENTAL CARE
PART 505. MEDICAL CARE

18 CRR-NY 505.38
18 CRR-NY 505.38

505.38 Children's behavioral health and health services.

(a) Purpose.

This section promotes the expansion of health and behavioral health services for children/youth under 21 years of age. The New York State Department of Health (DOH), the New York State Office of Mental Health (OMH), the New York State Office of Alcoholism and Substance Abuse Services (OASAS), and the New York State Office of Children and Family Services (OCFS) (the State agencies) shall designate licensed, certified or approved providers to deliver specifically defined services under the Medicaid program.

(b) Services.

The following services shall be available to children and youth who are eligible for Medicaid, when provided in accordance with the provisions of this section.

(1) Crisis intervention (CI). CI services are provided to a child/youth under age 21, and his/her family/caregiver who is experiencing a psychiatric or substance use (behavioral health) crisis, and are designed to:

- (i) interrupt and/or ameliorate the crisis experience;
- (ii) include an assessment that is culturally and linguistically sensitive;
- (iii) result in immediate crisis resolution and de-escalation;
- (iv) develop a crisisplan.

(2) Other licensed practitioner.

(i) A non-physician licensed behavioral health practitioner (NP-LBHP) is an individual who is licensed and acting within his or her lawful scope of practice under Title VIII of the Education Law and in any setting permissible under State law.

(ii) Individual staff qualifications:

(a) NP-LBHPs include the following practitioners; each is permitted to practice independently within his or her scope of practice:

- (1) licensed psychoanalysts;

(2) licensed clinical social workers (LCSWs);

(3) licensed marriage and family therapists; and

(4) licensed mental health counselors;

(b) NP-LBHPs also include licensed master social workers (LMSWs) under the supervision of licensed clinical social workers (LCSWs), licensed psychologists, or psychiatrists.

(3) Community psychiatric support and treatment (CPST). CPST services are goal-directed supports and solution-focused interventions intended to achieve identified goals or objectives as set forth in the child's/youth's individualized treatment plan. CPST is designed to provide community-based services to children or youth and their families or caregivers who may have difficulty engaging in formal office settings, but can benefit from community based rehabilitative services. CPST allows for delivery of services within **a variety** of permissible settings including community locations where the child/youth lives, works,

attends school, engages in services (e.g., provider office sites), and/or socializes. This includes the implementation of evidence based practices with approval by the State agencies.

(4) Psychosocial rehabilitation (PSR). PSR services are provided to children or youth and their families or caregivers to implement interventions outlined in the individualized treatment plan to compensate for or eliminate functional deficits and interpersonal and/or environmental barriers associated with a child/youth's behavioral health needs. The intent of PSR is to restore, rehabilitate, and support a child/youth's functional level as much as possible and as necessary for the integration of the child/youth as an active and productive member of their community and family with minimal ongoing professional interventions. Activities included must be task oriented and intended to achieve the identified goals or objectives as set forth in the child/youth's individualized treatment plan.

(5) Family peer support (FPS). FPS services are an array of formal and informal services and supports provided to families caring for/raising a child/youth who is experiencing social, emotional, developmental, medical, substance use, and/or behavioral challenges in their home, school, placement, and/or community. FPS services provide a structured, strength-based relationship between a credentialed family peer with relevant lived experience as determined appropriate by the State agencies as defined in subdivision (a) of this section and the parent/family member/caregiver for the benefit of the child/youth. Activities must be task oriented and intended to achieve the identified goals or objectives as set forth in the child/youth's individualized treatment plan.

(6) Youth peer support and training (YPST). YPST services are youth formal and informal services and supports provided to youth who are experiencing social, emotional, medical, developmental, substance use, and/or behavioral challenges in their home, school, placement, and/or community centered services. These services provide the training and support necessary by a credentialed youth peer with relevant lived experience as determined appropriate by the State agencies as defined in subdivision

(a) of this section to ensure engagement and active participation of the youth in the treatment planning process and with the ongoing implementation and reinforcement of skills learned throughout the treatment processes. YPST activities must be intended to develop and achieve the identified goals and/or objectives as set forth in the youth's individualized treatment plan. YPST services delivered are based on the individualized treatment plan developed by the licensed practitioner working with the youth.

(a) Provider qualifications.

(1) Any child serving agency or agency with children's behavioral health and health experience must have the necessary licensure, certification, designation, or approval from DOH, OMH, OASAS, or OCFS to provide the services authorized by this section.

(2) Any licensed practitioner providing behavioral health or health services authorized under this section must work in a child serving agency or agency with children's behavioral health and health experience, as described in paragraph (1) of this subdivision.

(3) Crisis intervention practitioners must work in a child serving agency, or agency with children's behavioral health and health experience, that obtains or possesses a current license or authorization to provide crisis and/or crisis treatment services, consistent with the requirements of paragraph (1) of this subdivision.

(4) Any organization seeking to provide any service authorized by this regulation and to serve the general population needing mental health services must be licensed or authorized to do so by OMH in addition to obtaining the licensure, certification, designation, or approval described in paragraph (1) of this subdivision.

(5) Any organization seeking to provide any service authorized by this regulation and to serve the general population needing substance use disorder services must be certified, designated or authorized to do so by OASAS in addition to obtaining the licensure, certification, designation, or approval described in paragraph (1) of this subdivision.

(b) Designation of providers.

(1) As a prerequisite to providing any of the services authorized by this section, a provider must receive a designation from DOH, OMH, OASAS, or OCFS. Being designated to provide services authorized by this section is not a substitute for possessing any required State licensure, certification, authorization or credential, and any such designation may be conditioned upon obtaining or modifying a required licensure, certification, authorization or credential.

(2) To be eligible for designation, a provider must submit an application on a form required by the State agencies and must

(i) be enrolled in the Medicaid program prior to commencing service delivery;

(ii) be a qualified provider as described in subdivision (c) of this section and maintain its license, certification or approval with that State agency;

(iii) be in good standing according to the standards of each agency by which it is licensed, certified or approved;

(iv) be a fiscally viable agency;

(v) meet developed criteria as outlined in the provider designation application guidance and form, including adequate explanation of how the provider meets such criteria; and

(vi) adhere to the standards of care described in the *Children's Health and Behavioral Health Services Transformation Medicaid State Plan Provider Manual for Children's BH Early and Periodic Screening and Diagnostic Testing (EPSDT)*

Services which have been incorporated by reference in this Part and have been filed in the office of the Secretary of State of the State of New York, the publication so filed being the document entitled: *Children's Health and Behavioral Health Services Transformation Medicaid State Plan Provider Manual for Children's BH Early and Periodic Screening and Diagnostic Testing (EPSDT) Services*, published in December, 2016, and any subsequent updates. This document incorporated by reference may be examined at the office of the Department of State, 99 Washington Ave., Albany, NY 12231 or obtained from the Department of Health, 99 Washington Ave., Albany, NY 12231.

(3) A provider designated to provide services authorized by this section will be assigned a lead State agency (DOH, OASAS, OCFS or OMH), based on the primary population served, location, and indicated line of business on the provider application, which will be responsible, in collaboration with the other State agencies, for monitoring and oversight of the provider.

(4) If a provider is designated to provide community support and treatment services, it may seek approval of the lead State agency and DOH to utilize, in the provision of services, specified evidence-based techniques drawn from cognitive-behavioral therapy and/or other evidence based psychotherapeutic interventions.

(5) Nothing contained herein shall authorize a provider to provide medical services, except as otherwise authorized by law.

(c) Rescinding a designation.

(1) A provider who fails to comply with laws, regulations and policies may have its designation rescinded by the lead State agency, which will consult with the other State agencies before taking such action. The provider has 14 business days to appeal the action to the lead State agency. The lead State agency shall respond with a final decision within 14 business days of appeal.

(2) A provider whose designation was rescinded may apply for redesignation pursuant to subdivision (d) of this section. The provider must show that it corrected the problems that led to the rescission. An on-site and/or desk evaluation may be conducted by the lead State agency prior to approving the redesignation request.

(d) Reimbursement.

Reimbursement for children's behavioral health and health services must be in accordance with the rates established by the department and approved by the Director of the Division of Budget.

18 CRR-NY 505.38
Current through July 15, 2019

END OF DOCUMENT
Works

2018 Thomson Reuters. No claim to original U.S. Government's.

Appendix IV
2020 Title XIX State Plan
Second 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 Health

The Department of Health proposes to amend the Title XIX (Medicaid) State Plan for inpatient, long term care, and non-institutional services to comply with recently proposed statutory provisions. The following significant changes are proposed:

All Services

Effective for dates of service April 1, 2020 through March 31, 2021, and each state fiscal year thereafter, all non-exempt Department of Health state funds Medicaid payments will be uniformly reduced by \$2.5 billion. Such reductions will be applied only to the extent that alternative methods that achieve Medicaid state share savings annually are not implemented. Medicaid payments that will be exempted from the uniform reduction include:

1. Payments whereby federal law precludes such reduction, including:
 - Federally Qualified Health Center services;
 - Indian Health Services and services provided to Native Americans;
 - Supplemental Medical Insurance – Part A and Part B;
 - State Contribution for Prescription Drug Benefit (aka Medicare Part D payments);
 - Any local share cap payment required by the Federal Medical Assistance Percentage (FMAP) increase legislation;
 - Services provided to American citizen repatriates; and
 - Hospice Services.
2. Payments funded exclusively with federal and/or local funds include, but are not limited to, the following:
 - Upper payment limit payments to non-state owned or operated governmental providers certified under Article 28 of the NYS Public Health Law;
 - Certified public expenditure payments to the NYC Health and Hospital Corporation;
 - Certain disproportionate share payments to non-state operated or owned governmental hospitals;

- Certain managed care payments pursuant to section 3-d of Part B of the Chapter 58 of the Laws of 2010; and
 - Services provided to inmates of local correctional facilities.
3. Other Payments that are not subject to the reduction include:
 - Payments pursuant to Article 32, Article 31 and Article 16 of the Mental Hygiene Law;
 - Required payments related to the School Supportive Health Services Program and Preschool Supportive Health Services Program;
 - Early Intervention;
 - Payments for services provided by Other State Agencies including Office of Children and Family Services, State Education Department, and the Department of Corrections and Community Supervision.
 - Vital Access Providers and Vital Access Provider Assurance Program;
 - Physician Administered Drugs;
 - Court orders and judgments; and
 - Family Planning services.

Copies of the proposed state plan amendments will be on file in each local (county) social services district and available for public review.

PUBLIC NOTICE Department of Health

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

The Department of Health proposes to amend the Title XIX (Medicaid) State Plan for institutional, non-institutional or long term care services to comply with proposed Medicaid Redesign Team II (MRT) initiatives. The following changes are proposed:

All Services

Effective for dates of service April 1, 2020 through March 31, 2021, and each State Fiscal Year (SFY) thereafter, all non-exempt Department of Health state funds Medicaid payments will be uniformly reduced by 1.875 percent. Medicaid payments that will be exempted from the uniform reduction include:

- Payments whereby federal law precludes such reduction, including:
 - Federally Qualified Health Center services;
 - Indian Health Services and services provided to Native Americans;
 - Supplemental Medical Insurance – Part A and Part B;
 - State Contribution for Prescription Drug Benefit (aka Medicare Part D payments);
 - Any local share cap payment required by the Federal Medical Assistance Percentage (FMAP) increase legislation;
 - Services provided to American citizen repatriates; and
 - Hospice Services.
- Payments funded exclusively with federal and/or local funds include, but are not limited to, the following:
 - Upper payment limit payments to non-state owned or operated governmental providers certified under Article 28 of the NYS Public Health Law;
 - Certified public expenditure payments to the NYC Health and Hospitals Corporation;
 - Certain disproportionate share payments to non-state oper-

ated or owned governmental hospitals;

- Certain managed care payments pursuant to section 3-d of Part B of the Chapter 58 of the Laws of 2010; and
- Services provided to inmates of local correctional facilities.
- Other Payments that are not subject to the reduction include:
 - Payments pursuant to Article 32, Article 31 and Article 16 of the Mental Hygiene Law;
 - Required payments related to the School Supportive Health Services Program and Preschool Supportive Health Services Program;
 - Early Intervention;
 - Payments for services provided by Other State Agencies including Office of Children and Family Services, State Education Department, and the Department of Corrections and Community Supervision;
 - Vital Access Providers and Vital Access Provider Assurance Program;
 - Physician Administered Drugs;
 - Children and Family Treatment and Support Services (CFTSS);
 - Court orders and judgments; and
 - Family Planning services.

The estimated annual net aggregate decrease in gross Medicaid expenditures attributable to this initiative contained in the budget for SFY 2020-21 is (\$438 million).

Non-Institutional Services

Care Management

Effective on or after April 1, 2020 and SFY thereafter, these proposals will:

- **Implement Health Home Improvement, Efficiency, Consolidation and Standardization:** These efficiencies include eliminating outreach payments, reducing unnecessary documentation, revising the criteria for admission, and re-evaluating the benchmarks for stepping patients down to lower levels of care management or graduation from a Health Home. Finally, placing the most seriously mentally ill clients in care management arrangements with appropriate caseload sizes – overseen by the Office of Mental Health – while moving lower acuity members into less intensive care management arrangements will both improve program quality and achieve efficiencies.
- **Promote Further Adoption of Patient-Centered Medical Homes (PCMH):** Continues incentive payments at current levels for lower cost, higher value PCMH programs while incorporating a tiered quality component into the incentive payments to align with other State initiatives such as the Prevention Agenda.
- **Comprehensive Prevention and Management of Chronic Disease:** Advances the use of evidence-based prevention strategies to manage highly prevalent chronic diseases, including diabetes, hypertension, asthma, smoking, osteoarthritis, chronic kidney disease, HIV/AIDS, and sickle cell disease. Specifically, the proposal will: (1) promote the use of evidence-based, self-care education, and prevention strategies; (2) implement an awareness campaign to educate Medicaid Managed Care (MMC) Plans, providers, and Medicaid members on the various resources and programs that are available; (3) educate the provider community relative to adherence to established evidence-based practice guidelines; (4) optimize services that are already covered by Medicaid, including expanding who can provide services; (5) optimize pharmacist services and leverage the frequency of patient visits to the pharmacy by expanding Collaborative Drug Therapy Management (CDTM) to the community setting, enable pharmacists to administer point-of-care testing for designated CLIA-waived tests and to initiate prescriptions for certain medications; (6) focus on chronic condition management within Patient-Centered Medical Homes (PCMHs) and Health Homes; initially, focus treatment and care management resources on adults with diabetes and hypertension, and children with asthma.
- **Children's Preventive Care and Care Transitions:** Promotes behavioral health integration in pediatrics by continuing ongoing pilot work focused on pregnancy and early childhood (e.g., preschool screening and universal, light-touch home visits) and leverages participation in CMMI's Integrated Care for Kids (InCK) model of

integration of medical and behavioral health care, using resources already available in the community. In addition, this proposal improves care transitions for children with chronic medical and behavioral conditions, with a special focus on children with sickle cell disease (SCD) moving from pediatric to adult care settings.

- **Children and Family Treatment and Support Services (CFTSS) - Restores specialized transition rates for CFTSS.**
 - **Invest in Medically Fragile Children:** Invests Medicaid resources to improve access to private duty nursing (PDN) for medically fragile children in order to prevent hospitalization and emergency visits, by leveraging additional utilization of telehealth, commercial insurance coverage for PDN, further PDN network development and enhanced rates. Specifically, the proposal would increase fee-for-service PDN rates over a three year period to benchmark to the current Medicaid Managed Care rates; create a PDN Network whereby PDN providers would receive a negotiated enhanced rate of payment for PDN services.
 - **Preventive Dentistry:** Promotes evidence-based preventative dentistry using fluoride varnish and silver diamine fluoride. Specifically, the proposal increases the application of fluoride varnish by primary care providers, including Registered Nurses, which will decrease early childhood decay and associated restorative costs. In addition, the proposal expands Medicaid dental coverage to include silver diamine fluoride which stops tooth decay and prevents additional oral complications.
 - **Emergency Room Avoidance and Cost Reductions:** this proposal reduces unnecessary Emergency Department (ED) utilization and/or cost by redesigning care pathways for high ED utilizing patients and transitions navigation to community services by: allowing sharing of individualized patient treatment plans for chronic conditions (through Qualified Entity (QEs)); expanding access to Urgent Care Centers by increasing co-location with Emergency Rooms; requiring Urgent Care Centers to accept Medicaid; and exploring a lower ED triage fee for non-emergency conditions.
 - **Addressing Barriers to Opioid Care:** Implements a series of Opioid related interventions to address certain barriers to care for Medicaid members, including but not limited to, better bundled payments that support opiate treatment through the adjustment of Ambulatory Patient Groups (APG) payments to eliminate unnecessary volume incentive and to promote more appropriate access including take home medication, when clinically appropriate; reduced Medicaid Coverage Limits for Rehabilitation Services as pathway to nonpharmacologic treatment alternative for pain management, and increased utilization of the Opioid Medical Maintenance (OMM) Model.
 - **Promote Maternal Health to Reduce Maternal Mortality:** Focuses on optimizing the health of individuals of reproductive age, including discussions on comprehensive family planning and patient centered primary and preventive care. The proposal aims to improve access to quality prenatal care, free from implicit bias, and ensuring postpartum home visits are available to all individuals who agree have a home visit after giving birth, by working with Medicaid Managed Care plans to identify and address the barriers to achieving these goals. The proposal also includes ensuring all pregnant individuals have access to childbirth education and supports the participation of birthing centers in the Perinatal Quality Collaborative.
- The estimated annual net aggregate decrease in gross Medicaid expenditures attributable to these initiatives contained in the budget for SFY 2020-2021 is \$86 million and for SFY 2021-2022 is \$140 million.

Pharmacy

Effective on or after April 1, 2020 and SFY thereafter, these proposals would:

- **Reduce Drug Cap Growth by Enhancing Purchasing Power to Lower Drug Costs** by providing the ability to negotiate supplemental rebates for new blockbuster drugs and gene therapies that do not yet have utilization; and the authority to negotiate value-based agreements with manufacturers.
- **Reducing coverage of certain OTC products and increasing copayments** (with exceptions for the most vulnerable populations).

Appendix V
2020 Title XIX State Plan
Second Quarter Amendment
Responses to Standard Funding Questions

**NON-INSTITUTIONAL SERVICES
State Plan Amendment #20-0036**

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: The services we are proposing are for EPSDT only; they are not hospital or clinic services and not calculated for the UPL. This question does not apply.

- 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: No. Governmental providers will receive payments based on a uniform fee schedule which is the same for both governmental and private providers. These payments will not exceed their costs to provide these services.

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.