



KATHY HOCHUL
Governor

Department
of Health

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

KRISTIN M. PROUD
Acting Executive Deputy Commissioner

December 30, 2021

Todd McMillion
Director
Department of Health and Human Services
Centers for Medicare and Medicaid Services
233 North Michigan Ave, Suite 600
Chicago, IL 60601

RE: SPA #21-0066
Non-Institutional Services

Dear Mr. McMillon:

The State requests approval of the enclosed amendment #21-0066 to the Title XIX (Medicaid) State Plan for non-institutional services to be effective November 1, 2021 (Appendix I). This amendment is being submitted based on the Federal stimulus funding under the American Rescue Act to aid providers in the recovery of the COVID emergency. 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 the Federal stimulus funding under the American Rescue Act to aid providers in the recovery of the COVID emergency 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 October 27, 2021, 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,

Brett R. Friedman
Acting Medicaid Director
Office of Health Insurance Programs

Enclosures

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

1. TRANSMITTAL NUMBER _____	2. STATE _____
3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
4. PROPOSED EFFECTIVE DATE _____	

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

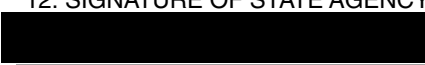
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (*Separate transmittal for each amendment*)

6. FEDERAL STATUTE/REGULATION CITATION	7. FEDERAL BUDGET IMPACT a. FFY _____ \$ _____ b. FFY _____ \$ _____
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (<i>If Applicable</i>)

10. SUBJECT OF AMENDMENT

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
13. TYPED NAME Brett R. Friedman	
14. TITLE	
15. DATE SUBMITTED December 30, 2021	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED	18. DATE APPROVED
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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
2021 Title XIX State Plan
Fourth Quarter Amendment
Amended SPA Pages

New York
4(a)(i)(3.1)

Services Provided To Adults

For purposes of this section, for the period beginning November 1, 2021 through March 31, 2022, rates of payment for continuous nursing services for adults provided by a certified home health agency, or by registered nurses or licensed practical nurses who are independent providers, will be established to ensure the availability of such services, and will be established at a rate that is sixty percent higher than the provider's current rate for private duty nursing services. A certified home health agency that receives such rates for continuous nursing services for adults will use such enhanced rates to increase payments to registered nurses and licensed practical nurses who provide these services. All government and non-government owned or operated providers are eligible for this adjustment pursuant to the same uniformly applied methodology.

TN #21-0066

Approval Date _____

Supersedes TN NEW

Effective Date November 1, 2021

**New York
5(a)**

The Commissioner will increase the rates of payment for all eligible providers in an amount up to an aggregate of \$16,000,000 annually for the periods June 1, 2006 through March 31, 2007, April 1, 2007 through March 31, 2008, and April 1, 2008 through March 31, 2009.

Rates will be adjusted in the form of a uniform percentage add-on as calculated by the Department, based upon the proportion of total allocated dollars, to the total Medicaid expenditures for covered home care services provided in local social services districts that do not include a city with a population over one million. All government and non-government owned or operated providers are eligible for this adjustment pursuant to the same uniformly applied methodology.

Services Provided to Medically Fragile Children

For purposes of this section, for the period beginning October 1, 2020 and thereafter, a medically fragile child will mean a child, up to twenty-three years of age, who is at risk of hospitalization or institutionalization for reasons that include but are not limited to the following: children who are technologically-dependent for life or health-sustaining functions; require complex medication regimen or medical interventions to maintain or improve their health status; or are in need of ongoing assessment or intervention to prevent serious deterioration of their health status or medical complications that place their life, health or development at risk. These children are capable of being cared for at home if provided with appropriate home care services including but not limited to continuous nursing services.

For the period January 1, 2007 and thereafter, rates of payment for continuous nursing services for medically fragile children will be established to ensure the availability of such services or programs and will be established at a rate that is thirty percent higher than the provider's current rate for private duty nursing services. Providers that receive such rates for continuous nursing services for medically fragile children must use these enhanced rates to increase payments to registered nurses or licensed practical nurses who provide these services to medically fragile children. All government and non-government owned or operated providers are eligible for this adjustment pursuant to the same uniformly applied methodology.

For the period beginning October 1, 2020, providers who enroll in the medically fragile children private duty nursing provider directory will receive an enhanced rate as indicated in the chart below:

2020 rate = 10/1/20 base rate + 15 percent
2021 rate = 2021 base rate + 30 percent
2022 rate = 2022 base rate + 45 percent

[Nursing Services (Limited)]

The Commissioner of Health, subject to the approval of the Director of the Budget, establishes reimbursement rates for certain nursing services provided to eligible residents by a certified operator of an adult home or enriched housing program that has been issued a limited license by the Department. A limited license may be issued to the certified operator of an adult home or enriched housing program and allows such operator to directly provide certain]

TN #21-0066 **Approval Date** _____

Supersedes TN #20-0060 **Effective Date** November 1, 2021

**New York
5(a.1)**

Services Provided to Adults

For the period November 1, 2021 through March 31, 2022, rates of payment for continuous nursing services for adults will be established to ensure the availability of such services or programs and will be established at a rate that is sixty percent higher than the provider's current rate for private duty nursing services. Providers that receive such rate for continuous nursing service for adults must use these enhanced rates to increase payments to registered nurses, or licensed practical nurses who provide these services to adults. All government and non-government owned or operated providers are eligible for this adjustment pursuant to the same uniformly applied methodology.

For the period beginning November 1, 2021, providers will receive an enhanced rate as indicated in the chart below:

2021 rate = 2021 base rate + 60 percent

2022 rate = 2022 base rate + 60 percent

Nursing Services (Limited)

The Commissioner of Health, subject to the approval of the Director of the Budget, establishes reimbursement rates for certain nursing services provided to eligible residents by a certified operator of an adult home or enriched housing program that has been issued a limited license by the Department. A limited license may be issued to the certified operator of an adult home or enriched housing program and allows such operator to directly provide certain

TN #21-0066

Supersedes TN NEW

Approval Date _____

Effective Date November 1, 2021

Appendix II
2021 Title XIX State Plan
Fourth Quarter Amendment
Summary

SUMMARY
SPA #21-0066

This State Plan Amendment proposes to increase the Private Duty Nursing fee-for-service reimbursement for nursing services provided to adults and for individuals transitioning out of the Medically Fragile Children's program, for a period of 5 months until March 31, 2022. This will decrease the disparity that occurred 2020 and 2021 when fees for medically fragile children were increased. Also, increased fee-for-service reimbursement and access to providers shall decrease the risk of unnecessary hospitalizations and institutionalization of the adult population.

Appendix III
2021 Title XIX State Plan
Fourth Quarter Amendment
Authorizing Provisions

SPA 21-0066 Authorizing Provision

The American Rescue Plan Act (ARPA) was signed into law on March 11, 2021. Section 9817 of ARPA provides a 10 percent increase in Federal Medical Assistance Percentage (FMAP) to state Medicaid programs from April 1, 2021 to March 30, 2022 to supplement existing state expenditures on home and community-based services (HCBS). As detailed in State Medicaid Direct Letter #21-003, issued by the Centers for Medicare & Medicaid Services (CMS) on May 13, 2021 (the SMDL), CMS affords states the ability to invest or reinvest these funds in a variety of ways that expand and enhance investments in Medicaid-covered HCBS, address COVID-related needs, and build HCBS capacity. While these enhanced funds are generated until April 1, 2022, states may expend these funds any time before March 31, 2024.

Adult Private Duty Nursing

Background: New York Medicaid Fee-for-Service (FFS) enrolled adults (23 years and older) covered under the Private Duty Nursing (PDN) program were left in a disparate situation after the 2020 and 2021 increase of fees for nursing care of Medically Fragile Children (MFC), those below the age of 23, under MRT II. Because of the higher reimbursement fees for children's cases, providers shifted away from the care of adults.

Access to comprehensive, consistent, high-quality nursing care is essential to compromised adults. Families, advocacy groups, and providers have expressed concerns and raised lack of coverage issues since the enactment of the enhanced fees for children. Without the appropriate care and consistent coverage, in the long-term, many of these comprised adults may require institutionalization.

Proposal:

Eligible Providers: Licensed Home Care Services Agencies (LHCSA) and independently enrolled registered nurses (RN) and licensed practical nurses (LPN).

Description: Implement a fee adjustment of sixty (60) percent, from November 1, 2021 until March 31, 2022 for providers of PDN to FFS enrolled adults. This temporary increase would assist providers to build capacity to meet the increasing needs of adults by beginning to bring parity to the reimbursement fees for adults and will also serve as a protection for those young adults aging out of the higher fees under the MFC program.

SPA 21-0066

EC. 9817. <<NOTE: 42 USC 1396d note.>> ADDITIONAL SUPPORT FOR
MEDICAID HOME AND COMMUNITY-BASED
SERVICES DURING THE COVID-19 EMERGENCY.

(a) Increased FMAP.--

(1) In general.--Notwithstanding section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)) or section 1905(ff), in the case of a State that meets the HCBS program requirements under subsection (b), the Federal medical assistance percentage determined for the State under section 1905(b) of such Act (or, if applicable, under section 1905(ff)) and, if applicable, increased under subsection (y), (z), (aa), or (ii) of section 1905 of such Act (42 U.S.C. 1396d), section 1915(k) of such Act (42 U.S.C. 1396n(k)), or section 6008(a) of the Families First Coronavirus Response Act (Public Law 116-127), shall be increased by 10 percentage points with respect to expenditures of the State under the State Medicaid program for home and community-based services (as defined in paragraph (2)(B)) that are provided during the HCBS program improvement period (as defined in paragraph (2)(A)). In no case may the application of the previous sentence result in the Federal medical assistance percentage determined for a State being more than 95 percent with respect to such expenditures. Any payment <<NOTE: Territories.>> made to Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, or American Samoa for expenditures on medical assistance that are subject to the Federal medical assistance percentage increase specified under the first sentence of this paragraph shall not be taken into account for purposes of applying payment limits under subsections (f) and (g) of section 1108 of the Social Security Act (42 U.S.C. 1308).

(2) Definitions.--In this section:

(A) <<NOTE: Time period.>> HCBS program improvement period.--The term ``HCBS program improvement period'' means, with respect to a State, the period--

- (i) beginning on April 1, 2021; and
- (ii) ending on March 31, 2022.

(B) Home and community-based services.--The term ``home and community-based services'' means any of the following:

[[Page 135 STAT. 217]]

(i) Home health care services authorized under paragraph (7) of section 1905(a) of the Social Security Act (42 U.S.C. 1396d(a)).

(ii) Personal care services authorized under paragraph (24) of such section.

(iii) PACE services authorized under paragraph (26) of such section.

(iv) Home and community-based services authorized under subsections (b), (c), (i), (j), and (k) of section 1915 of such Act (42 U.S.C. 1396n), such services authorized under a waiver under section 1115 of such Act (42 U.S.C. 1315), and such services through coverage authorized under section 1937 of such Act (42 U.S.C. 1396u-7).

(v) Case management services authorized under section 1905(a)(19) of the Social Security Act (42 U.S.C. 1396d(a)(19)) and section 1915(g) of such

Act (42 U.S.C. 1396n(g)).

(vi) Rehabilitative services, including those related to behavioral health, described in section 1905(a)(13) of such Act (42 U.S.C. 1396d(a)(13)).

(vii) Such other services specified by the Secretary of Health and Human Services.

(C) Eligible individual.--The term ``eligible individual'' means an individual who is eligible for and enrolled for medical assistance under a State Medicaid program and includes an individual who becomes eligible for medical assistance under a State Medicaid program when removed from a waiting list.

(D) Medicaid program.--The term ``Medicaid program'' means, with respect to a State, the State program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) (including any waiver or demonstration under such title or under section 1115 of such Act (42 U.S.C. 1315) relating to such title).

(E) 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.).

(b) State Requirements for FMAP Increase.--As conditions for receipt of the increase under subsection (a) to the Federal medical assistance percentage determined for a State, the State shall meet each of the following requirements (referred to in subsection (a) as the HCBS program requirements):

(1) <<NOTE: Effective date.>> Supplement, not supplant.--The State shall use the Federal funds attributable to the increase under subsection (a) to supplement, and not supplant, the level of State funds expended for home and community-based services for eligible individuals through programs in effect as of April 1, 2021.

(2) Required implementation of certain activities.--The State shall implement, or supplement the implementation of, one or more activities to enhance, expand, or strengthen home and community-based services under the State Medicaid program.

**Appendix IV
2021 Title XIX State Plan
Fourth Quarter Amendment
Public Notice**

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

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

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

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

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

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

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

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

PUBLIC NOTICE

Department of Health

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

The Department of Health proposes to amend the Title XIX (Medicaid) State Plan for non-institutional Services to permit remote delivery of services. The following changes are proposed:

Non-Institutional Services

Effective on and after November 1, 2021, the Office for People With Developmental Disabilities’ (OPWDD) will allow reimbursement for the remote delivery of Crisis Services for Individuals with Intellectual and/or Developmental Disabilities (CSIDD). The State will allow reimbursement for the remote delivery of CSIDD through telephonic or other technology in accordance with State, Federal, and Health Insurance Portability and Accountability Act (HIPAA) requirements. Other technology means any two-way, real-time communication technology that meets HIPAA requirements.

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

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

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

PUBLIC NOTICE

Department of Health

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

The Department of Health proposes to amend the Title XIX (Medicaid) State Plan for non-institutional services to comply with enacted federal statutory provisions of Section 9817 of the American Rescue Plan Act of 2021 (ARP) which, subject to approval of the state’s initial spending plan and narrative (Spending Plan) by the Centers for Medicare and Medicaid Services (CMS), provides a ten percent increase in Federal Medical Assistance Percentage (FMAP) to state Medicaid programs from April 1, 2021 to March 31, 2022 to supplement existing state expenditures on home and community-based services (HCBS). The following changes are proposed:

Non-Institutional Services

Contingent upon CMS approval of the Spending Plan submitted by the state, effective on or after November 1, 2021, this notice proposes to enhance (increase) state established reimbursement rates as follows:

State established rates will be enhanced for state-plan approved private duty nursing (PDN) services for members 23 years of age and older by an additional 60 percent for the period November 1, 2021 through March 31, 2022.

The estimated annual net aggregate increase in gross Medicaid expenditures as a result of the proposed amendments for PDN services is \$13,100,000.

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

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

PUBLIC NOTICE

Department of Health

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

The Department of Health proposes to amend the Title XIX (Medicaid) State Plan for non-institutional services to enhance and increase access to Home and Community Based Services (HCBS) in accordance with the federal statutory provisions of Section 9817 of the American Rescue Plan Act of 2021 (ARP) which, subject to approval of the State's initial spending plan and narrative (Spending Plan) by the Centers for Medicare and Medicaid Services (CMS), provides a ten percent increase in Federal Medical Assistance Percentage (FMAP) to state Medicaid programs from April 1, 2021 to March 31, 2022 to supplement existing state expenditures on HCBS. The following changes are proposed:

Non-Institutional Services

Contingent upon CMS approval of the Spending Plan submitted by the State, effective on or after November 1, 2021, this notice proposes to increase recovery oriented residential offerings by incorporating the residential reintegration services into the Medicaid benefit package and provide for an enhanced rate for a period of November 1, 2021 to March 31, 2024. To allow for full disbursement of funds available April 1, 2021 – March 31, 2022, the initial rate will be increased by 50% for November 1, 2021 until December 31, 2021. Rates will then be reduced 50% percent effective January 1, 2022. This enhancement will enhance and expand the HCBS system and sustain promising and effective programs and services for individuals in recovery from a substance use disorder under the Medicaid program, including, but not limited to, strengthening the response to the COVID-19 Public Health Emergency, increasing services for individuals in early recovery to assist with reintegrating into their community and allowing providers to supplement the implementation of residential rehabilitation reintegration services to address increases in overdose rates and substance use disorder treatment and recovery service needs of Medicaid beneficiaries receiving HCBS during the COVID-19 PHE.

The estimated annual net aggregate increase in gross Medicaid expenditures as a result of this proposed increase for Residential Rehabilitation Integration Services is \$23,668,639.05.

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

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12210, spa_inquiries@health.ny.gov

PUBLIC NOTICE

Department of Health

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

The Department of Health proposes to amend the Title XIX (Medicaid) State Plan for non-institutional services to enhance and increase access to Home and Community Based Services (HCBS) in accordance with the federal statutory provisions of Section 9817 of the American Rescue Plan Act of 2021 (ARP) which, subject to approval of the State's initial spending plan and narrative (Spending Plan) by the Centers for Medicare and Medicaid Services (CMS), provides a ten percent increase in Federal Medical Assistance Percentage (FMAP) to state Medicaid programs from April 1, 2021 to March 31, 2022 to supplement existing state expenditures on HCBS. The following changes are proposed:

Non-Institutional Services

Contingent upon CMS approval of the Spending Plan submitted by the State, effective on or after November 1, 2021, this notice proposes to increase reimbursement rates, as follows:

1) Residential Addiction Rehabilitation Services. To allow for the full disbursement of funds available April 1, 2021 – March 31, 2022, rates for state-plan approved residential addiction rehabilitation services provided in 820 stabilization and reintegration services will be increased by ten percent, for the period November 1, 2021 – December 31, 2021. Rates will then be reduced 10 percent effective January 1, 2022. This enhancement will allow providers to supplement the implementation of one or more activities to enhance, expand or strengthen HCBS under the Medicaid program, including strengthening the response to the COVID-19 Public Health Emergency, assisting providers in meeting the challenges of serving the highest need individuals including but not limited to, those suffering from opioid addiction, dually diagnosed individuals or individuals with multiple comorbidities.

The estimated annual net aggregate increase in gross Medicaid expenditures as a result of the proposed increase for Residential Rehabilitation Addiction Services is \$41,420,118.34.

2) Outpatient Addiction Rehabilitation Services. Rates for state-plan approved Outpatient Addiction Rehabilitation Services provided to individuals in the community will be temporarily increased by an additional 10 percent for the period November 1, 2021 – December 31, 2021. This enhancement will allow providers to increase patient engagement and access to services for those who are unwilling or unable to otherwise engage in care.

The estimated annual net aggregate increase in gross Medicaid expenditures as a result of this proposed increase for Outpatient Addiction Rehabilitation Services is \$11,834,319.53.

3) Rates for state-plan approved Addiction Services increased by an additional 10 percent for the period November 1, 2021 – December 31, 2021. This enhancement will allow providers to increase recruitment and retention of experienced and dedicated direct care and other staff through measures including, but not limited to, targeted loan forgiveness, tuition reimbursement, hiring and signing bonuses, longevity payments, continuing education assistance, shift differential pay and retirement contributions.

The estimated annual net aggregate increase in gross Medicaid expenditures as a result of this proposed increase for Addiction Rehabilitation Services is \$21,301,775.15.

The public is invited to review and comment on this proposed State

Appendix V
2021 Title XIX State Plan
Fourth Quarter Amendment
Responses to Standard Funding Questions

NON-INSTITUTIONAL SERVICES
State Plan Amendment #21-0066

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.

Payments made to service providers under the provisions of this SPA are funded through an appropriation within the Medicaid General Fund Local Assistance Account, which is part of the State's Medicaid Global Cap.

There have been no new provider taxes and no existing taxes have been modified associated with this SPA.

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: Private Duty Nursing payments are not subject 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: There are various state agencies that perform audits each year to determine the appropriateness of Medicaid payments. In the event that inappropriate payments are determined, recoupments would be initiated and the Federal share would be returned to CMS within the associated quarterly expenditure report.

ACA Assurances:

- 1. Maintenance of Effort (MOE). Under section 1902(gg) of the Social Security Act (the Act), as amended by the Affordable Care Act, as a condition of receiving any Federal payments under the Medicaid program during the MOE period indicated below, the State shall not have in effect any eligibility standards, methodologies, or procedures in its Medicaid program which are more restrictive than such eligibility provisions as in effect in its Medicaid program on March 10, 2010.**

MOE Period.

- **Begins on: March 10, 2010, and**
- **Ends on: The date the Secretary of the Federal Department of Health and Human Services determines an Exchange established by a State under the provisions of section 1311 of the Affordable Care Act is fully operational.**

Response: This SPA complies with the conditions of the MOE provision of section 1902(gg) of the Act for continued funding under the Medicaid program.

- 2. Section 1905(y) and (z) of the Act provides for increased FMAPs for expenditures made on or after January 1, 2014 for individuals determined eligible under section 1902(a)(10)(A)(i)(VIII) of the Act. Under section 1905(cc) of the Act, the increased FMAP under sections 1905(y) and (z) would not be available for States that require local political subdivisions to**

contribute amounts toward the non-Federal share of the State's expenditures at a greater percentage than would have been required on December 31, 2009.

Prior to January 1, 2014 States may potentially require contributions by local political subdivisions toward the non-Federal share of the States' expenditures at percentages **greater than** were required on December 31, 2009. **However**, because of the provisions of section 1905(cc) of the Act, it is important to determine and document/flag any SPAs/State plans which have such greater percentages prior to the January 1, 2014 date in order to **anticipate potential violations and/or appropriate corrective actions** by the States and the Federal government.

Response: This SPA would [] / would not [✓] violate these provisions, if they remained in effect on or after January 1, 2014.

- 3. Please indicate whether the State is currently in conformance with the requirements of section 1902(a)(37) of the Act regarding prompt payment of claims.**

Response: The State 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.