



Department of Health

KATHY HOCHUL
Governor

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

KRISTIN M. PROUD
Acting Executive Deputy Commissioner

June 30, 2022

James G. Scott, Director
Division of Program Operations
Centers for Medicare & Medicaid Services
601 E. 12th St., Room 355
Kansas City, Missouri 64106

RE: SPA #22-0073
Non-Institutional Services

Dear Mr. Scott:

The State requests approval of the enclosed amendment #22-0073 to the Title XIX (Medicaid) State Plan for non-institutional services to be effective April 1, 2022 (Appendix I). This amendment is being submitted based on proposed legislation. A summary of the plan amendment is provided in Appendix II.

The State of New York reimburses these services through the use of rates that are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area as required by § 1902(a)(30) of the Social Security Act and 42 CFR § 447.204.

A copy of pertinent sections of proposed 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 March 30, 2022, 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,

Amir Bassiri
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 OF THE SOCIAL SECURITY ACT

XIX

XXI

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE

5. FEDERAL STATUTE/REGULATION CITATION

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)

a. FFY _____ \$ _____

b. FFY _____ \$ _____

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable)

9. SUBJECT OF AMENDMENT

10. GOVERNOR'S REVIEW (Check One)

GOVERNOR'S OFFICE REPORTED NO COMMENT
COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

OTHER, AS SPECIFIED:

11. SIGNATURE OF STATE AGENCY OFFICIAL



15. RETURN TO

12. TYPED NAME

13. TITLE

14. DATE SUBMITTED June 30, 2022

FOR CMS USE ONLY

16. DATE RECEIVED

17. DATE APPROVED

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL

19. SIGNATURE OF APPROVING OFFICIAL

20. TYPED NAME OF APPROVING OFFICIAL

21. TITLE OF APPROVING OFFICIAL

22. REMARKS

Appendix I
2022 Title XIX State Plan
Second Quarter Amendment
Amended SPA Pages

[Records](#) / [Submission Packages - Your State](#)

NY - Submission Package - NY2022MS0006O - (NY-22-0073) - Health Homes

[Summary](#) [Reviewable Units](#) [Correspondence Log](#) [News](#) [Related Actions](#)

CMS-10434 OMB 0938-1188

Package Information

Package ID	NY2022MS0006O	Submission Type	Official
Program Name	NYS CCO/HHs Serving Individuals with I/DD	State	NY
SPA ID	NY-22-0073	Region	New York, NY
Version Number	1	Package Status	Submitted
Submitted By	Jennifer Yungandreas	Submission Date	6/30/2022
		Regulatory Clock	83 days remain
		Review Status	Review 1

Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | NY2022MS00060 | NY-22-0073 | NYS CCO/HHs Serving Individuals with I/DD

Package Header

Package ID	NY2022MS00060	SPA ID	NY-22-0073
Submission Type	Official	Initial Submission Date	6/30/2022
Approval Date	N/A	Effective Date	N/A
Superseded SPA ID	N/A		

Reviewable Unit Instructions

State Information

State/Territory Name: New York

Medicaid Agency Name: Department of Health

Submission Component

- State Plan Amendment
- Medicaid
- CHIP

Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | NY2022MS00060 | NY-22-0073 | NYS CCO/HHs Serving Individuals with I/DD

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Approval Date	N/A	Effective Date	N/A
Superseded SPA ID	N/A		

Reviewable Unit Instructions

SPA ID and Effective Date

SPA ID NY-22-0073

Reviewable Unit	Proposed Effective Date	Superseded SPA ID
Health Homes Intro	4/1/2022	22-0016
Health Homes Payment Methodologies	4/1/2022	22-0016

Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | NY2022MS00060 | NY-22-0073 | NYS CCO/HHs Serving Individuals with I/DD

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Reviewable Unit Instructions

Executive Summary

Summary Description Including Goals and Objectives This State Plan Amendment proposes to adjust rates statewide to reflect a 5.4 percent Cost Of Living Adjustment for Care Coordination Organization/Health Homes for individuals with intellectual and developmental disabilities

Federal Budget Impact and Statute/Regulation Citation



Federal Budget Impact

	Federal Fiscal Year	Amount
First	2022	\$5858560
Second	2023	\$11717121

Federal Statute / Regulation Citation

§1902(a) of the Social Security Act and 42 CFR 447

Supporting documentation of budget impact is uploaded (optional).

Name	Date Created	
Fiscal Calculations (22-0073) (5-18-22)	5/18/2022 2:51 PM EDT	
Authorizing Provisions (22-0073) (6-2-22)	6/2/2022 2:46 PM EDT	

Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | NY2022MS00060 | NY-22-0073 | NYS CCO/HHs Serving Individuals with I/DD

Package Header

Package ID	NY2022MS00060	SPA ID	NY-22-0073
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Approval Date	N/A	Effective Date	N/A
Superseded SPA ID	N/A		

Reviewable Unit Instructions

Governor's Office Review

- No comment
- Comments received
- No response within 45 days
- Other

Submission - Medicaid State Plan

MEDICAID | Medicaid State Plan | Health Homes | NY2022MS00060 | NY-22-0073 | NYS CCO/HHs Serving Individuals with I/DD

CMS-10434 OMB 0938-1188

The submission includes the following:

- Administration
- Eligibility
- Benefits and Payments
- Health Homes Program

Do not use "Create New Health Homes Program" to amend an existing Health Homes program. Instead, use "Amend existing Health Homes program," below.

- Create new Health Homes program
- Amend existing Health Homes program
- Terminate existing Health Homes program

NYS CCO/HHs Serving Individuals with I/DD

Health Homes SPA - Reviewable Units

Only select Reviewable Units to include in the package which you intend to change.

*

<input type="checkbox"/>	Reviewable Unit Name	Included in Another Source Type Submission Package
<input type="checkbox"/>	Health Homes Intro	APPROVED
<input type="checkbox"/>	Health Homes Geographic Limitations	APPROVED
<input type="checkbox"/>	Health Homes Population and Enrollment Criteria	APPROVED
<input type="checkbox"/>	Health Homes Providers	APPROVED
<input type="checkbox"/>	Health Homes Service Delivery Systems	APPROVED
<input type="checkbox"/>	Health Homes Payment Methodologies	APPROVED
<input type="checkbox"/>	Health Homes Services	APPROVED
<input type="checkbox"/>	Health Homes Monitoring, Quality Measurement and Evaluation	APPROVED

1 - 8 of 8

Submission - Public Notice/Process

MEDICAID | Medicaid State Plan | Health Homes | NY2022MS00060 | NY-22-0073 | NYS CCO/HHs Serving Individuals with I/DD

Package Header

Package ID	NY2022MS00060	SPA ID	NY-22-0073
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Approval Date	N/A	Effective Date	N/A
Superseded SPA ID	N/A		


Reviewable Unit Instructions

Name of Health Homes Program

NYS CCO/HHs Serving Individuals with I/DD

Public notice was provided due to proposed changes in methods and standards for setting payment rates for services, pursuant to 42 CFR 447.205.

Upload copies of public notices and other documents used

Name	Date Created	
NYS Register -COLA (3-30-22)	5/18/2022 2:56 PM EDT	

Submission - Tribal Input

MEDICAID | Medicaid State Plan | Health Homes | NY2022MS00060 | NY-22-0073 | NYS CCO/HHs Serving Individuals with I/DD

Package Header

Package ID	NY2022MS00060	SPA ID	NY-22-0073
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Superseded SPA ID	N/A		

Reviewable Unit Instructions

Name of Health Homes Program:

NYS CCO/HHs Serving Individuals with I/DD

One or more Indian Health Programs or Urban Indian Organizations furnish health care services in this state

- Yes
- No

This state plan amendment is likely to have a direct effect on Indians, Indian Health Programs or Urban Indian Organizations, as described in the state consultation plan.

- Yes
- No

The state has solicited advice from Indian Health Programs and/or Urban Indian Organizations, as required by section 1902(a)(73) of the Social Security Act, and in accordance with the state consultation plan, prior to submission of this SPA.

Complete the following information regarding any solicitation of advice and/or tribal consultation conducted with respect to this submission:

Solicitation of advice and/or Tribal consultation was conducted in the following manner:

All Indian Health Programs

Date of solicitation/consultation:	Method of solicitation/consultation:
6/8/2022	Paper mailing/electronic mailing


All Urban Indian Organizations

States are not required to consult with Indian tribal governments, but if such consultation was conducted voluntarily, provide information about such consultation below:

All Indian Tribes

Date of consultation:	Method of consultation:
6/8/2022	Paper mailing/electronic mailing

The state must upload copies of documents that support the solicitation of advice in accordance with statutory requirements, including any notices sent to Indian Health Programs and/or Urban Indian Organizations, as well as attendee lists if face-to-face meetings were held. Also upload documents with comments received from Indian Health Programs or Urban Indian Organizations and the state's responses to any issues raised. Alternatively indicate the key issues and summarize any comments received below and describe how the state incorporated them into the design of its program.

Name	Date Created	
Tribal Consultation for 22-0073 (Summary) (6-8-22)	6/30/2022 8:17 PM EDT	

Indicate the key issues raised (optional)

- Access
- Quality
- Cost
- Payment methodology
- Eligibility

- Benefits
- Service delivery
- Other issue

Submission - Other Comment

MEDICAID | Medicaid State Plan | Health Homes | NY2022MS00060 | NY-22-0073 | NYS CCO/HHs Serving Individuals with I/DD

Package Header

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Approval Date	N/A	Effective Date	N/A
Superseded SPA ID	N/A		

Reviewable Unit Instructions

SAMHSA Consultation

Name of Health Homes Program

NYS CCO/HHs Serving Individuals with I/DD

The State provides assurance that it has consulted and coordinated with the Substance Abuse and Mental Health Services Administration (SAMHSA) in addressing issues regarding the prevention and treatment of mental illness and substance abuse among eligible individuals with chronic conditions.

Date of consultation
4/1/2022

Health Homes Intro

MEDICAID | Medicaid State Plan | Health Homes | NY2022MS0006O | NY-22-0073 | NYS CCO/HHs Serving Individuals with I/DD

Package Header

Package ID	NY2022MS0006O	SPA ID	NY-22-0073
Submission Type	Official	Initial Submission Date	6/30/2022
Approval Date	N/A	Effective Date	4/1/2022
Superseded SPA ID	22-0016		
	User-Entered		

Reviewable Unit Instructions

Program Authority

1945 of the Social Security Act

The state elects to implement the Health Homes state plan option under Section 1945 of the Social Security Act.

Name of Health Homes Program

NYS CCO/HHs Serving Individuals with I/DD

Executive Summary

Provide an executive summary of this Health Homes program including the goals and objectives of the program, the population, providers, services and service delivery model used

The Department of Health proposes to amend the Title XIX (Medicaid) State Plan Amendment for non-institutional services to comply with enacted statutory provisions for Care Coordination Organization/Health Home (CCO/HH). Pursuant to the enacted 2022-23 NYS Budget this State Plan Amendment proposes to adjust CCO/Health Home rates statewide to reflect a 5.4 percent cost of living adjustment outlined in proposed legislation S. 8007-C A. 9007—C, Article VII Part DD

The New York State Department of Health (DOH), in collaboration with the New York State Office for People With Developmental Disabilities (OPWDD), is seeking a new Health Home State Plan, effective July 1, 2018, to create and authorize Health Home care management for individuals with intellectual and/or developmental disabilities (I/DD). The goal of establishing Health Homes to serve the I/DD population is to provide a strong, stable, person-centered approach to holistic service planning and coordination required to ensure the delivery of quality care that is integrated and supports the needs of individuals with I/DD chronic conditions. The Health Home program authorized under this State Plan shall be known as the NYS Care Coordination Organizations/Health Homes (CCO/HHs) Serving Individuals with Intellectual and Developmental Disabilities (I/DD) Program (NYS CCO/HHs Serving I/DD) and Health Homes authorized under this State Plan shall be known as Care Coordination Organizations/Health Homes (CCO/HHs). As described in more detail, this SPA will establish requirements for the NYS CCO/HHs Serving I/DD Program, including establishing eligible I/DD Health Home chronic conditions; transitioning Medicaid Service Coordination (MSC) and Plan of Care Support Services (PCSS) to Health Homes; establishing per member per month rates for Health Homes designated to serve members with I/DD; defining CCO/HHs core requirements, including Health Information Technology (HIT) requirements; establishing the processes for referring Medicaid members to CCO/HHs; and defining the requirements for providers to be eligible to be designated as CCO/HHs. The State Plan authorizes the statewide enrollment of individuals with eligible Developmental Disability conditions in designated CCO/HHs.

General Assurances

- The state provides assurance that eligible individuals will be given a free choice of Health Homes providers.
- The states provides assurance that it will not prevent individuals who are dually eligible for Medicare and Medicaid from receiving Health Homes services.
- The state provides assurance that hospitals participating under the state plan or a waiver of such plan will be instructed to establish procedures for referring eligible individuals with chronic conditions who seek or need treatment in a hospital emergency department to designated Health Homes providers.
- The state provides assurance that FMAP for Health Homes services shall be 90% for the first eight fiscal quarters from the effective date of the SPA. After the first eight quarters, expenditures will be claimed at the regular matching rate.
- The state provides assurance that it will have the systems in place so that only one 8-quarter period of enhanced FMAP for each health homes enrollee will be claimed.
- The state provides assurance that there will be no duplication of services and payment for similar services provided under other Medicaid authorities.

Health Homes Payment Methodologies

MEDICAID | Medicaid State Plan | Health Homes | NY2022MS00060 | NY-22-0073 | NYS CCO/HHs Serving Individuals with I/DD

Package Header

Package ID	NY2022MS00060	SPA ID	NY-22-0073
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Superseded SPA ID	22-0016		
	User-Entered		

Reviewable Unit Instructions

Payment Methodology

The State's Health Homes payment methodology will contain the following features

- Fee for Service
 - Individual Rates Per Service
 - Per Member, Per Month Rates
 - Fee for Service Rates based on
 - Severity of each individual's chronic conditions
 - Capabilities of the team of health care professionals, designated provider, or health team
 - Other
- Comprehensive Methodology Included in the Plan
- Incentive Payment Reimbursement

Describe below
see text box below regarding rates.

Describe any variations in payment based on provider qualifications, individual care needs, or the intensity of the services provided see text below

- PCCM (description included in Service Delivery section)
- Risk Based Managed Care (description included in Service Delivery section)
- Alternative models of payment, other than Fee for Service or PMPM payments (describe below)

Health Homes Payment Methodologies

MEDICAID | Medicaid State Plan | Health Homes | NY2022MS00060 | NY-22-0073 | NYS CCO/HHs Serving Individuals with I/DD

Package Header

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	User-Entered		

Reviewable Unit Instructions

Agency Rates

Describe the rates used

- FFS Rates included in plan
- Comprehensive methodology included in plan
- The agency rates are set as of the following date and are effective for services provided on or after that date

Effective Date

4/1/2022

Website where rates are displayed

https://health.ny.gov/health_care/medicaid/program/medicaid_health_homes/idd/index.htm

Health Homes Payment Methodologies

MEDICAID | Medicaid State Plan | Health Homes | NY2022MS00060 | NY-22-0073 | NYS CCO/HHs Serving Individuals with I/DD

Package Header

Package ID	NY2022MS00060	SPA ID	NY-22-0073
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Approval Date	N/A	Effective Date	4/1/2022
Superseded SPA ID	22-0016		
	User-Entered		

Reviewable Unit Instructions

Rate Development

Provide a comprehensive description in the SPA of the manner in which rates were set

1. In the SPA please provide the cost data and assumptions that were used to develop each of the rates;
2. Please identify the reimbursable unit(s) of service;
3. Please describe the minimum level of activities that the state agency requires for providers to receive payment per the defined unit;
4. Please describe the state's standards and process required for service documentation, and;
5. Please describe in the SPA the procedures for reviewing and rebasing the rates, including:
 - the frequency with which the state will review the rates, and
 - the factors that will be reviewed by the state in order to understand if the rates are economic and efficient and sufficient to ensure quality services.

Comprehensive Description Provide a comprehensive description of the rate-setting policies the State will use to establish Health Homes provider reimbursement fee for service or PMPM rates. Explain how the methodology is consistent with the goals of efficiency, economy and quality of care within your description please explain the reimbursable unit(s) of service, the cost assumptions and other relevant factors used to determine the payment amounts, the minimum level of activities that the State agency requires for providers to receive payment per the defined unit, and the State's standards and process required for service documentation.

Care Coordination Organization/Health Home (CCO/HH) Program Improvements and Efficiencies
Effective July 1, 2020, certain rate setting provisions in the approved 2020-2021 New York State Budget are being changed to reflect historical utilization and efficiencies related to the transition to CCO/HHs.

Care Management Fee

CCO/HH providers that meet State and federal standards will be paid a per member per month care management fee that is based on region, assessment data, residential status and other functional indicators. A unit of service will be defined as a billable unit per service month. To be reimbursed for a billable unit of service per month, CCO/HH providers must, at a minimum, provide active care management by providing at least one of the core health home services per month. Once an individual has been assigned a care manager and is enrolled in the CCO/HHs program, the active care management per member per month (PMPM) may be billed. Care managers must maintain the CCO/HHs consent forms and document all services provided to the member in the member's life plan. Upon enrollment in the program, Care Managers will attest in the State system the individual's consent to enroll in Health Homes. The CCO will maintain the consent form electronically within the individual's record in the Care Coordination system.

As described in the attachment CCO/HH Rate Setting Methodology, the care management PMPM will include four rate tiers. The rate tier of an individual is determined by region, the intensity of care coordination required to serve the individual and the residential/living setting of the individual. For enrollees who are new to the OPWDD service delivery system, there will be a separate tiered CCO/HH care management PMPM that may be billed for the first month of enrollment in CCO/HH for individuals who have never received a Medicaid-funded long-term service. The separate tiered rate includes costs related to preparing an initial life plan; an initial Medicaid application, if needed; and gathering documentation and records to support the I/DD diagnosis, that such I/DD condition results in substantial handicap and the individual's ability to function normally in society and level of care determination. The PMPM rate tiers are calculated based on total costs relating to the care manager (salary, fringe benefits, non-personal services, capital and administration costs) and, for each tier, caseload assumptions. The State will periodically review the CCO/HH payments in conjunction with Department of Labor salary data to ensure that the Health Home rates are sufficient to ensure quality services. In addition, based on operating experience, the State will make adjustments, as appropriate, to the PMPM.

Medicaid Service Coordinators (MSC) and Plan of Care Support Services (PCSS)

CCO/HH MSC and PCSS agencies that provide care management to individuals with developmental disabilities under the State Plan that convert to a CCO/HH or become part of a CCO/HHs will be paid the care management PMPMs described above.

All payment policies have been developed to assure that there is no duplication of payment for CCO/HH services.

Health Homes Payment Methodologies

MEDICAID | Medicaid State Plan | Health Homes | NY2022MS00060 | NY-22-0073 | NYS CCO/HHs Serving Individuals with I/DD

Package Header

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	User-Entered		

Reviewable Unit Instructions

Assurances

- The State provides assurance that it will ensure non-duplication of payment for services similar to Health Homes services that are offered/covered under a different statutory authority, such as 1915(c) waivers or targeted case management.
 - Describe below how non-duplication of payment will be achieved** All rates are published on the DOH website. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers. All of the above payment policies have been developed to assure that there is no duplication of payment for health home services.
- The state has developed payment methodologies and rates that are consistent with section 1902(a)(30)(A).
- The State provides assurance that all governmental and private providers are reimbursed according to the same rate schedule, unless otherwise described above.
- The State provides assurance that it shall reimburse providers directly, except when there are employment or contractual arrangements consistent with section 1902(a)(32).

Optional Supporting Material Upload

Name	Date Created	
SFQ (22-0073) (6-29-22)	6/30/2022 8:15 PM EDT	

PRA Disclosure Statement: Centers for Medicare & Medicaid Services (CMS) collects this mandatory information in accordance with (42 U.S.C. 1396a) and (42 CFR 430.12); which sets forth the authority for the submittal and collection of state plans and plan amendment information in a format defined by CMS for the purpose of improving the state application and federal review processes, improve federal program management of Medicaid programs and Children's Health Insurance Program, and to standardize Medicaid program data which covers basic requirements, and individualized content that reflects the characteristics of the particular state's program. The information will be used to monitor and analyze performance metrics related to the Medicaid and Children's Health Insurance Program in efforts to boost program integrity efforts, improve performance and accountability across the programs. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1188. The time required to complete this information collection is estimated to range from 1 hour to 80 hours per response (see below), including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

This view was generated on 7/7/2022 8:46 PM EDT

Appendix II
2022 Title XIX State Plan
Second Quarter Amendment
Summary

SUMMARY
SPA #22-0073

This State Plan Amendment proposes to adjust rates statewide to reflect a 5.4% Cost Of Living Adjustment for Care Coordination Organization/Health Homes for individuals with intellectual and developmental disabilities.

Appendix III
2022 Title XIX State Plan
Second Quarter Amendment
Authorizing Provisions

Part DD of Chapter 57 of the Laws of 2022

26

PART DD

27 Section 1. 1. Subject to available appropriations and approval of the
28 director of the budget, the commissioners of the office of mental
29 health, office for people with developmental disabilities, office of
30 addiction services and supports, office of temporary and disability
31 assistance, office of children and family services, and the state office
32 for the aging shall establish a state fiscal year 2022-23 cost of living
33 adjustment (COLA), effective April 1, 2022, for projecting for the
34 effects of inflation upon rates of payments, contracts, or any other
35 form of reimbursement for the programs and services listed in paragraphs
36 (i), (ii), (iii), (iv), (v), and (vi) of subdivision four of this
37 section. The COLA established herein shall be applied to the appropri-
38 ate portion of reimbursable costs or contract amounts. Where appropri-
39 ate, transfers to the department of health (DOH) shall be made as
40 reimbursement for the state share of medical assistance.

41 2. Notwithstanding any inconsistent provision of law, subject to the
42 approval of the director of the budget and available appropriations
43 therefore, for the period of April 1, 2022 through March 31, 2023, the
44 commissioners shall provide funding to support a five and four-tenths
45 percent (5.4%) cost of living adjustment under this section for all
46 eligible programs and services as determined pursuant to subdivision
47 four of this section.

48 3. Notwithstanding any inconsistent provision of law, and as approved
49 by the director of the budget, the 5.4 percent cost of living adjustment
50 (COLA) established herein shall be inclusive of all other cost of living
51 type increases, inflation factors, or trend factors that are newly
52 applied effective April 1, 2022. Except for the 5.4 percent cost of
53 living adjustment (COLA) established herein, for the period commencing
54 on April 1, 2022 and ending March 31, 2023 the commissioners shall not
S. 8007--C 59 A. 9007--C

1 apply any other new cost of living adjustments for the purpose of estab-
2 lishing rates of payments, contracts or any other form of reimbursement.
3 The phrase "all other cost of living type increases, inflation factors,
4 or trend factors" as defined in this subdivision shall not include
5 payments made pursuant to the American Rescue Plan Act or other federal
6 relief programs related to the Coronavirus Disease 2019 (COVID-19)
7 pandemic Public Health Emergency.

8 4. Eligible programs and services. (i) Programs and services funded,
9 licensed, or certified by the office of mental health (OMH) eligible for
10 the cost of living adjustment established herein, pending federal
11 approval where applicable, include: office of mental health licensed
12 outpatient programs, pursuant to parts 587 and 599 of title 14 CRR-NY of
13 the office of mental health regulations including clinic, continuing day
14 treatment, day treatment, intensive outpatient programs and partial
15 hospitalization; outreach; crisis residence; crisis stabilization,
16 crisis/respite beds; mobile crisis, part 590 comprehensive psychiatric
17 emergency program services; crisis intervention; home based crisis
18 intervention; family care; supported single room occupancy; supported
19 housing; supported housing community services; treatment congregate;
20 supported congregate; community residence - children and youth;
21 treatment/apartment; supported apartment; community residence single
22 room occupancy; on-site rehabilitation; employment programs; recreation;
23 respite care; transportation; psychosocial club; assertive community
24 treatment; case management; care coordination, including health home

25 plus services; local government unit administration; monitoring and
26 evaluation; children and youth vocational services; single point of
27 access; school-based mental health program; family support children and
28 youth; advocacy/support services; drop in centers; recovery centers;
29 transition management services; bridge; home and community based waiver
30 services; behavioral health waiver services authorized pursuant to the
31 section 1115 MRT waiver; self-help programs; consumer service dollars;
32 conference of local mental hygiene directors; multicultural initiative;
33 ongoing integrated supported employment services; supported education;
34 mentally ill/chemical abuse (MICA) network; personalized recovery
35 oriented services; children and family treatment and support services;
36 residential treatment facilities operating pursuant to part 584 of title
37 14-NYCRR; geriatric demonstration programs; community-based mental
38 health family treatment and support; coordinated children's service
39 initiative; homeless services; and promises zone.

40 (ii) Programs and services funded, licensed, or certified by the
41 office for people with developmental disabilities (OPWDD) eligible for
42 the cost of living adjustment established herein, pending federal
43 approval where applicable, include: local/unified services; chapter 620
44 services; voluntary operated community residential services; article 16
45 clinics; day treatment services; family support services; 100% day
46 training; epilepsy services; traumatic brain injury services; hepatitis
47 B services; independent practitioner services for individuals with
48 intellectual and/or developmental disabilities; crisis services for
49 individuals with intellectual and/or developmental disabilities; family
50 care residential habilitation; supervised residential habilitation;
51 supportive residential habilitation; respite; day habilitation; prevoca-
52 tional services; supported employment; community habilitation; interme-
53 diate care facility day and residential services; specialty hospital;
54 pathways to employment; intensive behavioral services; basic home and
55 community based services (HCBS) plan support; health home services
56 provided by care coordination organizations; community transition
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1 services; family education and training; fiscal intermediary; support
2 broker; and personal resource accounts.

3 (iii) Programs and services funded, licensed, or certified by the
4 office of addiction services and supports (OASAS) eligible for the cost
5 of living adjustment established herein, pending federal approval where
6 applicable, include: medically supervised withdrawal services - residen-
7 tial; medically supervised withdrawal services - outpatient; medically
8 managed detoxification; medically monitored withdrawal; inpatient reha-
9 bilitation services; outpatient opioid treatment; residential opioid
10 treatment; KEEP units outpatient; residential opioid treatment to absti-
11 nence; problem gambling treatment; medically supervised outpatient;
12 outpatient rehabilitation; specialized services substance abuse
13 programs; home and community based waiver services pursuant to subdivi-
14 sion 9 of section 366 of the social services law; children and family
15 treatment and support services; continuum of care rental assistance case
16 management; NY/NY III post-treatment housing; NY/NY III housing for
17 persons at risk for homelessness; permanent supported housing; youth
18 clubhouse; recovery community centers; recovery community organizing
19 initiative; residential rehabilitation services for youth (RRSY); inten-
20 sive residential; community residential; supportive living; residential
21 services; job placement initiative; case management; family support
22 navigator; local government unit administration; peer engagement; voca-
23 tional rehabilitation; support services; HIV early intervention
24 services; dual diagnosis coordinator; problem gambling resource centers;
25 problem gambling prevention; prevention resource centers; primary
26 prevention services; other prevention services; and community services.

27 (iv) Programs and services funded, licensed, or certified by the
28 office of temporary and disability assistance (OTDA) eligible for the

29 cost of living adjustment established herein, pending federal approval
30 where applicable, include: nutrition outreach and education program
31 (NOEP).

32 (v) Programs and services funded, licensed, or certified by the office
33 of children and family services (OCFS) eligible for the cost of living
34 adjustment established herein, pending federal approval where applica-
35 ble, include: programs for which the office of children and family
36 services establishes maximum state aid rates pursuant to section 398-a
37 of the social services law and section 4003 of the education law; emer-
38 gency foster homes; foster family boarding homes and therapeutic foster
39 homes as defined by the regulations of the office of children and family
40 services; supervised settings as defined by subdivision twenty-two of
41 section 371 of the social services law; adoptive parents receiving
42 adoption subsidy pursuant to section 453 of the social services law; and
43 congregate and scattered supportive housing programs and supportive
44 services provided under the NY/NY III supportive housing agreement to
45 young adults leaving or having recently left foster care.

46 (vi) Programs and services funded, licensed, or certified by the state
47 office for the aging (SOFA) eligible for the cost of living adjustment
48 established herein, pending federal approval where applicable, include:
49 community services for the elderly; expanded in-home services for the
50 elderly; and supplemental nutrition assistance program.

51 5. Each local government unit or direct contract provider receiving
52 funding for the cost of living adjustment established herein shall
53 submit a written certification, in such form and at such time as each
54 commissioner shall prescribe, attesting how such funding will be or was
55 used to first promote the recruitment and retention of non-executive
56 direct care staff, non-executive direct support professionals, non-exe-
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1 cutive clinical staff, or respond to other critical non-personal service
2 costs prior to supporting any salary increases or other compensation for
3 executive level job titles.

4 6. Notwithstanding any inconsistent provision of law to the contrary,
5 agency commissioners shall be authorized to recoup funding from a local
6 governmental unit or direct contract provider for the cost of living
7 adjustment established herein determined to have been used in a manner
8 inconsistent with the appropriation, or any other provision of this
9 section. Such agency commissioners shall be authorized to employ any
10 legal mechanism to recoup such funds, including an offset of other funds
11 that are owed to such local governmental unit or direct contract provid-
12 er.

13 § 2. This act shall take effect immediately and shall be deemed to
14 have been in full force and effect on and after April 1, 2022.

Appendix IV
2022 Title XIX State Plan
Second Quarter Amendment
Public Notice

PUBLIC NOTICE

Department of Health

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

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

All Services

Effective on or after April 1, 2022, the Department of Health will adjust rates statewide to reflect a 5.4% percent Cost of Living Adjustment for the following Office of Mental Health (OMH), Office of Addiction Services and Supports (OASAS), and Office for People With Developmental Disabilities (OPWDD) State Plan Services: OMH Outpatient Services, OMH Clinic Services, OMH Rehabilitative Services, Children Family Treatment Support Services, Health Home Plus, Residential Treatment Facilities for Children and Youth, OASAS outpatient addiction services, OASAS freestanding (non-hospital) inpatient rehabilitation services, OASAS freestanding inpatient detox services, OASAS addiction treatment centers, OASAS Part 820 residential services, OASAS residential rehabilitation services for youth, Intermediate Care Facility (ICF/IDD), Day Treatment, Article 16 Clinic services, Specialty Hospital, Health Home Services Provided by Care Coordination Organizations, Independent Practitioner Services for Individual with Developmental Disabilities (IPSIDD), and OPWDD Crisis Services.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to the April 1, 2022, 5.4% percent Cost of Living Adjustment contained in the budget for State Fiscal Year 2023 is \$109.9 million.

Effective on or after April 1, 2022, Health care and mental hygiene worker bonuses will be provided to New York's essential front line health care and mental hygiene workers. These bonuses are intended to attract talented people into the profession and retain people who have been working during the COVID-19 Pandemic by rewarding them financially for their service.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for State Fiscal Year 2023 is \$1.85 billion.

Effective for dates of service on or after April 1, 2022, through March 31, 2024, all Medicaid rate-based claims will receive a 1% operating increase. Payments exempted from this increase, are as follows:

- Payments not subject to federal financial participation;
- Payments that would violate federal law including, but not limited to, hospital disproportionate share payments that would be in excess of federal statutory caps;
- Payments made by other state agencies including, but not limited to, those made pursuant to articles 16, 31 and 32 of the mental hygiene laws;
- Payments the state is obligated to make pursuant to court orders or judgments;
- Payments for which the non-federal share does not reflect any state funding; and
- At the discretion of the Commissioner of Health and the Director of the Budget, payments with regard to which it is determined that application of increases pursuant to this section would result, by operation of federal law, in a lower federal medical assistance percentage applicable to such payments.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for State Fiscal Year 2023 is \$165 million.

Effective for dates of service on or after April 1, 2022, the 1.5% uniform reduction for all non-exempt Department of Health state funds Medicaid payments will be restored.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for State Fiscal Year 2023 is \$280 million.

Non-Institutional Services

Effective on or after April 1, 2022, this proposal continues the supplemental upper payment limit payments made to general hospitals, other than major public general hospitals under non-institutional services of \$339 million annually.

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

For state fiscal year beginning April 1, 2022, through March 31, 2023, this proposal continues hospital outpatient payment adjustments that increase the operating cost components of rates of payment for hospital outpatient and emergency departments on and after April 1, 2011, for public general hospitals other than those operated by the State of New York or the State University of New York, which are located in a city with a population of over one million. The amount to be paid will be up to \$287 million annually based on criteria and methodology set by the Commissioner of Health, which the Commissioner may periodically set through a memorandum of understanding with the New York City Health and Hospitals Corporation. Such adjustments shall be paid by means of one or more estimated payments. Payments may be added to rates of payment or made as aggregate payments.

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

For state fiscal year beginning April 1, 2022, through March 31, 2023, this proposal continues payment of up to \$5.4 million in additional annual Medicaid payments to county operated free-standing clinics, not including facilities operated by the New York City Health and Hospitals Corporation, for services provided by such DTC and those provided by a county operated freestanding mental health or substance abuse DTC. Distributions shall be based on each eligible facility's proportionate share of the sum of all DTC and clinic visits for all eligible facilities receiving payments for the base year two years prior to the rate year. The proportionate share payments may be added to rates of payment or made as aggregate payments to eligible facilities.

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

Effective April 1, 2022, and each state fiscal year thereafter, this amendment proposes to revise the final payment component of the calculation to account for claim runout. The current authority to make supplemental payments for services provided by physicians, nurse practitioners and physician assistants will continue.

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

Effective on or after April 1, 2022, payments in quarter-hour units for the following harm reduction services for people who actively use drugs provided at New York State Commissioner of Health waived comprehensive harm reduction programs (community-based organizations) will be revised. The intention is to combat the opioid overdose crisis and reduce health care costs for people who use drugs. Harm reduction services improve population health and have been shown to reduce health care costs by preventing disease transmission (HIV, HBV, and HCV), injection site infections, emergency department and inpatient care from drug overdose, injury, and death. Comprehensive harm reduction programs are effective at engaging high-risk populations and serving as a bridge for entry into drug treatment and other health and social services.

Regional monthly rates will be established for New York City and the rest of the state and are based on the expected direct service costs in each region. Billable activities encompass those components of harm reduction attributable to direct client service, such as brief assessment and treatment planning, harm reduction counseling, linkage and navigation, medication management and treatment adherence counseling, psychoeducation support groups. Direct and indirect costs are budgeted as part of the rate. No funds shall be used to carry out the purchase or distribution of sterile needles or syringes for the hypodermic injection of any illegal drug.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for State Fiscal Year 2023 is \$34.6 million.

Appendix V
2022 Title XIX State Plan
Second Quarter Amendment
Responses to Standard Funding Questions

**NON-INSTITUTIONAL SERVICES
State Plan Amendment #22-0073**

CMS Standard Funding Questions

The following questions are being asked and should be answered in relation to all payments made to all providers reimbursed pursuant to a methodology described in Attachment 4.19-B of the state plan.

- 1. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by States for services under the approved State plan. Do providers receive and retain the total Medicaid expenditures claimed by the State (includes normal per diem, supplemental, enhanced payments, other) or is any portion of the payments returned to the State, local governmental entity, or any other intermediary organization? If providers are required to return any portion of payments, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the amount or percentage of payments that are returned and the disposition and use of the funds once they are returned to the State (i.e., general fund, medical services account, etc.)**

Response: Providers do receive and retain the total Medicaid expenditures claimed by the State and the State does not require any provider to return any portion of such payments to the State, local government entities, or any other intermediary organization.

- 2. Section 1902(a)(2) provides that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan. Please describe how the state share of each type of Medicaid payment (normal per diem, supplemental, enhanced, other) is funded. Please describe whether the state share is from appropriations from the legislature to the Medicaid agency, through intergovernmental transfer agreements (IGTs), certified public expenditures (CPEs), provider taxes, or any other mechanism used by the state to provide state share. Note that, if the appropriation is not to the Medicaid agency, the source of the state share would necessarily be derived through either an IGT or CPE. In this case, please identify the agency to which the funds are appropriated. Please provide an estimate of total expenditure and State share amounts for each type of Medicaid payment. If any of the non-federal share is being provided using IGTs or CPEs, please fully describe the matching arrangement including when the state agency receives the transferred amounts from the local government entity transferring the funds. If CPEs are used, please describe the methodology used by the state to verify that the total expenditures being certified are eligible for Federal matching funds in accordance with 42 CFR**

433.51(b). For any payment funded by CPEs or IGTs, please provide the following:

- (i) a complete list of the names of entities transferring or certifying funds;
- (ii) the operational nature of the entity (state, county, city, other);
- (iii) the total amounts transferred or certified by each entity;
- (iv) clarify whether the certifying or transferring entity has general taxing authority; and,
- (v) whether the certifying or transferring entity received appropriations (identify level of appropriations).

Response: The Non-Federal share Medicaid provider payment is funded by a combination of the following funds/funding sources through enacted appropriations authority to the Department of Health (DOH) for the New York State Medicaid program.

		4/1/22 – 3/31/23	
Payment Type	Non-Federal Share Funding	Non-Federal	Gross
Normal Per Diem	General Fund; Special Revenue Funds; County Contribution	\$3,267,663,998	\$6,535,327,996

1) General Fund: Revenue resources for the State's General Fund includes taxes (e.g., income, sales, etc.), and miscellaneous fees (including audit recoveries). Medicaid expenditures from the State's General Fund are authorized from Department of Health Medicaid.

- a. New York State Audit Recoveries: The Department of Health collaborates with the Office of the Medical Inspector General (OMIG) and the Office of the Attorney General (AG) in recovering improperly expended Medicaid funds. OMIG conducts and coordinates the investigation, detection, audit, and review of Medicaid providers and recipients to ensure they are complying with all applicable laws and regulation. OMIG recovers any improper payments through cash collections and voided claim recoveries. Cash collections are deposited into the State's General Fund to offset Medicaid costs.

In addition to cash collections, OMIG finds inappropriately billed claims within provider claims. To correct an error, OMIG and DOH process the current accurate claim, and reduce this claim by the inappropriate claim value to recoup the previous overclaim and decrease state spending.

2) Special Revenue Funds:

- a. Health Care Reform Act (HCRA) Resource Fund: as authorized in section 92-dd of New York State Finance Law and was established in 1996, pursuant to New York State Public Health Law 2807-j. HCRA resources include health care related surcharges, assessments on hospital revenues, and a "covered

lives" assessment paid by insurance carriers pursuant to chapter 820 of the laws of 2021.

- b. Health Facility Cash Assessment Program (HFCAP) Fund: HFCAP requires New York State designated providers to pay an assessment on cash operating receipts on a monthly basis. The assessment includes Article 28 Residential Health Care Facilities, Article 28 General Hospitals, Article 36 Long Term Home Health Care Programs, Article 36 Certified Home Health Agencies and Personal Care Providers that possess a Title XIX (i.e. Medicaid) contract with a Local Social Services District for the delivery of personal care services pursuant to Section 367-i of the New York State Social Services Law.

NOTE: New York's Health Care taxes are either broad based and uniform (as in all HFCAP assessments except for the Personal Care Provider Cash Assessment) or have a specific exemption known as the "D'Amato provision (Federal PHL section 105-33 4722 (c))" which allows the HCRA surcharges to exist in their current format. The single tax which has been determined by the State to be an impermissible provider tax is the HFCAP charge on Personal Care Providers. The State does not claim any Federal dollars for the surcharge collected in this manner in order to comply with all Federal provider tax rules.

3) Additional Resources for State Share Funding:

- a. County Contribution: In State Fiscal Year 2006, through enacted State legislation (Part C of Chapter 58 of the laws of 2005), New York State "capped" the amount localities contributed to the non-Federal share of providers claims. This was designed to relieve pressure on county property taxes and the NYC budget by limiting local contributions having New York State absorb all local program costs above this fixed statutory inflation rate (3% at the time).

However, in State Fiscal Year 2013 New York State provided additional relief to Localities by reducing local contributions annual growth from three percent to zero over a three-year period. Beginning in State Fiscal Year 2016, counties began paying a fixed cost in perpetuity. By eliminating the growth in localities Medicaid costs, the State has statutorily capped total Statewide County Medicaid expenditures at 2015 levels. All additional county Medicaid costs are funded by the State through State funding as described above. DOH provides annual letters to counties providing weekly contributions. Contributions are deposited directly into State escrow account and used to offset 'total' State share Medicaid funding.

NOTE: The Local Contribution is not tied to a specific claim or service category and instead is a capped amount based on 2015 county spending levels as stated above.

3. **Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan. If supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to each provider type.**

Response: The Medicaid payments under this State Plan Amendment are not supplemental payments.

4. **For clinic or outpatient hospital services please provide a detailed description of the methodology used by the state to estimate the upper payment limit (UPL) for each class of providers (state owned or operated, non-state government owned or operated, and privately owned or operated). Please provide a current (i.e., applicable to the current rate year) UPL demonstration. Under regulations at 42 CFR 447.272, States are prohibited from setting payment rates for Medicaid inpatient services that exceed a reasonable estimate of the amount that would be paid under Medicare payment principals.**

Response: The Medicaid payments authorized under this State Plan Amendment do not impact the UPL demonstrations.

5. **Does any governmental provider receive payments that in the aggregate (normal per diem, supplemental, enhanced, other) exceed their reasonable costs of providing services? If payments exceed the cost of services, do you recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report?**

Response: Providers do not receive payments that in the aggregate exceed their reasonable costs of providing services. If any providers received payments that in the aggregate exceeded their reasonable costs of providing services, the State would recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report.

ACA Assurances:

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

MOE Period.

- **Begins on: March 10, 2010, and**

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

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

2. **Section 1905(y) and (z) of the Act provides for increased FMAPs for expenditures made on or after January 1, 2014 for individuals determined eligible under section 1902(a)(10)(A)(i)(VIII) of the Act. Under section 1905(cc) of the Act, the increased FMAP under sections 1905(y) and (z) would not be available for States that require local political subdivisions to contribute amounts toward the non-Federal share of the State's expenditures at a greater percentage than would have been required on December 31, 2009.**

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

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

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

Response: The State complies with the requirements of section 1902(a)(37) of the Act regarding prompt payment of claims.

Tribal Assurance:

Section 1902(a)(73) of the Social Security Act the Act requires a State in which one or more Indian Health Programs or Urban Indian Organizations furnish health care services to establish a process for the State Medicaid agency to seek advice on a regular ongoing basis from designees of Indian health programs whether operated by the Indian Health Service HIS Tribes or Tribal organizations under the Indian Self Determination and Education Assistance Act ISDEAA or Urban Indian Organizations under the Indian Health Care Improvement Act.

IHCIA Section 2107(e)(I) of the Act was also amended to apply these requirements to the Children's Health Insurance Program CHIP. Consultation is required concerning Medicaid and CHIP matters having a direct impact on Indian health programs and Urban Indian organizations.

- a) Please describe the process the State uses to seek advice on a regular ongoing basis from federally recognized tribes Indian Health Programs and Urban Indian Organizations on matters related to Medicaid and CHIP programs and for consultation on State Plan Amendments waiver proposals waiver extensions waiver amendments waiver renewals and proposals for demonstration projects prior to submission to CMS.**
- b) Please include information about the frequency inclusiveness and process for seeking such advice.**
- c) Please describe the consultation process that occurred specifically for the development and submission of this State Plan Amendment when it occurred and who was involved.**

Response: Tribal consultation was performed in accordance with the State's tribal consultation policy as approved in SPA 17-0065, and documentation of such is included with this submission. To date, no feedback has been received from any tribal representative in response to the proposed change in this SPA.