NEW YORK STATE OF OPPORTUNITY. Department of Health

KATHY HOCHUL
Governor

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

KRISTIN M. PROUD
Acting Executive Deputy Commissioner

September 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 #22-0080
Non-Institutional Services

Dear Mr. Scott:

The State requests approval of the enclosed amendment #22-0080 to the Title XIX (Medicaid) State Plan for non-institutional services to be effective July 1, 2022 (Appendix I). This amendment is being submitted based on enacted legislation. A summary of the plan amendment is provided in Appendix II.

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

A copy of pertinent sections of enacted legislation is enclosed for your information (Appendix III). A copy of the public notice of this plan amendment, which was given in the New York State Register on June 29, 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,

[redacted]

Amir Bassiri
Medicaid Director
Office of Health Insurance Programs

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 22-0080

2. STATE: NY

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
July 1, 2022

5. FEDERAL STATUTE/REGULATION CITATION
§ 1905(a)(30) Other Medical Care

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 07/01/22-09/30/22 $ 2,934,095
b. FFY 10/01/22-09/30/23 $ 11,736,380

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 3.1-A Supplement: Pages 3(d)(B)
Attachment 3.1-B Supplement: Pages 3(d)(B)

Attachment 4.19-B: Page 5(b)

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 4.19-B: Page 5(b)

9. SUBJECT OF AMENDMENT
Comprehensive Psychiatric Emergency Program (CPEP) Rate Increase

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
[redacted]

12. TYPED NAME
Amir Bassiri

13. TITLE
Medicaid Director

14. DATE SUBMITTED
September 30, 2022

15. RETURN TO
New York State Department of Health
Division of Finance and Rate Setting
99 Washington Ave – One Commerce Plaza
Suite 1432
Albany, NY 12210

FOR 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
Third Quarter Amendment
Amended SPA Pages

New York
3(d)(B)

1905(a)(30) Other Medical Care

24.e. Emergency hospital services.

Comprehensive Psychiatric Emergency Program (CPEP) Services are Emergency Hospital Services necessary to prevent the death or serious impairment of the health of a beneficiary. Comprehensive Psychiatric Emergency Program Services are provided by hospitals licensed under Article 28 of the Public Health Law and Article 31 of the Mental Hygiene Law and are delivered in accordance with 42 C.F.R. § 440.170(e). CPEP Services are provided 24 hours per day, seven days per week and include crisis intervention, crisis outreach, and extended observation bed services in hospital emergency departments. Crisis Outreach Services are also provided outside the emergency department.

Crisis intervention services are provided in full emergency visits or as triage and referral services. Full emergency visits provide assessment and comprehensive psychiatric treatment to stabilize and treat a psychiatric emergency. Triage and referral services provide assessment, treatment and discharge planning, and referral and linkage to appropriate sub-acute services.

Crisis Outreach Services include assessment, therapeutic communication, coordination with identified supports, psychiatric consultation, safety planning, referral, linkage, peer services, and mobile crisis services.

Extended observation beds are located in or adjacent to the emergency room of a Comprehensive Psychiatric Emergency Program designed to provide, for a period up to 72 hours, a safe environment for an individual who, in the opinion of the examining physicians, requires extensive evaluation, assessment, or stabilization of the person's acute psychiatric symptoms.

Limitations on amount, duration and scope of CPEP services are as follows:

1. Beneficiaries will be limited to one CPEP Crisis intervention service per calendar day.

2. Beneficiaries will be limited to one Crisis Outreach Service and one Crisis Intervention Service per calendar day.

New York
3(d)(B)

1905(a)(30) Other Medical Care

23e. Comprehensive Psychiatric Emergency Program (CPEP) Services are Emergency Hospital Services necessary to prevent the death or serious impairment of the health of a beneficiary. Comprehensive Psychiatric Emergency Program Services are provided by hospitals licensed under Article 28 of the Public Health Law and Article 31 of the Mental Hygiene Law and are delivered in accordance with 42 C.F.R. § 440.170(e). CPEP Services are provided 24 hours per day, seven days per week and include crisis intervention, crisis outreach, and extended observation bed services in hospital emergency departments. Crisis Outreach Services are also provided outside the emergency department

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Extended observation beds are located in or adjacent to the emergency room of a Comprehensive Psychiatric Emergency Program designed to provide, for a period up to 72 hours, a safe environment for an individual who, in the opinion of the examining physicians, requires extensive evaluation, assessment, or stabilization of the person's acute psychiatric symptoms.

Limitations on amount, duration and scope of CPEP services are as follows:

1. Beneficiaries will be limited to one Crisis Intervention Service in one calendar day.

2. Beneficiaries will be limited to one Crisis Outreach Service and one Crisis Intervention Service in one calendar day.

New York
5(b)

1905(a)(30) Other medical care

Comprehensive Psychiatric Emergency Program (CPEP)

Reimbursement:

Comprehensive Psychiatric Emergency Program (CPEP) services are reimbursed on a daily basis. A CPEP provider may receive reimbursement for one Triage and Referral visit or one Full Emergency visit service in one calendar day. A provider may be reimbursed for one Crisis Outreach Service and either one Triage and Referral visit or one Full Emergency Visit per individual, per one calendar day.

Extended Observation Bed services (EOB) will be reimbursed on a daily basis subject to the following conditions:

- Reimbursement is available only for the calendar day after the calendar day in which the Full or Triage and Referral visit is completed.
- The EOB rate may only be claimed when a person has been present in the CPEP for more than 24 hours.
- If the individual is admitted to a psychiatric inpatient unit from an EOB, the stay will be reimbursed under the inpatient psychiatric inpatient unit methodology, beginning on the first day of admission to the EOB.

Effective July 1, 2022, statewide fees for Comprehensive Psychiatric Emergency Program Services are as follows:

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

Eyeglasses and Other Visual Services

Fee schedule developed by Department of Health and approved by Division of the Budget.

Hearing Aid Supplies and Services

Fee schedule developed by Department of Health and approved by Division of the Budget.

Prosthetic and Orthotic Appliances

Payments are limited to the lower of the usual and customary charge to the general public or fee schedule developed by Department of Health and approved by the Division of the Budget.

~~**Comprehensive Psychiatric Emergency Programs**~~

~~Flat fee developed by OMH and approved by the Division of the Budget.~~

Appendix II
2022 Title XIX State Plan
Third Quarter Amendment
Summary

SUMMARY
SPA #22-0080

This State Plan Amendment proposes to add programmatic and fiscal detail to the State Plan and increase Comprehensive Psychiatric Emergency Program (CPEP) reimbursement rates, including triage and referral visit, full emergency visit, and extended observation bed services.

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

SPA 22-0080

42 CFR § 440.170 - Any other medical care or remedial care recognized under State law and specified by the Secretary.

(e) *Emergency hospital services.* "Emergency hospital services" means services that -

(1) Are necessary to prevent the death or serious impairment of the health of a beneficiary; and

(2) Because of the threat to the life or health of the beneficiary necessitate the use of the most accessible hospital available that is equipped to furnish the services, even if the hospital does not currently meet -

(i) The conditions for participation under Medicare; or

(ii) The definitions of inpatient or outpatient hospital services under §§ 440.10 and 440.20.

Mental Hygiene (MHY) CHAPTER 27, TITLE B, ARTICLE 7

§ 7.09 Powers of the office and commissioner; how exercised.

(a) The commissioner shall exercise all powers vested in the office. He may delegate any function, power, or duty assigned to him or to the office of mental health to a director of a facility operated by such office or to any other officer or employee of such office, unless otherwise provided by law. He may enter into agreements with the executive director of the justice center for the protection of people with special needs or the other commissioners of the department in order to ensure that programs and services are provided for all of the mentally disabled.

(b) The commissioner may adopt regulations necessary and proper to implement any matter under his jurisdiction. Proposed rules and regulations shall be submitted at least sixty days prior to action thereon to the mental health services council for its advice, in accordance with section 7.05 of this chapter, unless the commissioner finds that the public health, safety or general welfare requires that such submission be dispensed with.

Mental Hygiene (MHY) CHAPTER 27, TITLE E, ARTICLE 31

§ 31.04 Regulatory powers of the commissioner.

(a) The commissioner shall have the power to adopt regulations to effectuate the provisions and purposes of this article, including, but not limited to, the following:

1. establishing classes of operating certificates based upon such factors as physical plant, program, and staff.

2. setting standards of quality and adequacy of facilities, equipment, personnel, services, records, and programs for the rendition of services for the mentally disabled pursuant to an operating certificate.

3. specifying a definite period for which the operating certificate will be in effect for each class.

* 4. establishing procedures for the issuance, amendment, and renewal of operating certificates, including temporary operating certificates, and for the suspension or revocation of operating certificates. Such procedures shall specify that no application for the issuance or renewal of an operating certificate for a hospital, which is operated as part of a hospital as defined in article twenty-eight of the public health law, shall be effective until such hospital is granted approval to admit patients in emergencies for immediate observation, care and treatment in accordance with section 9.39 or 9.40 of this chapter, provided that the commissioner shall waive this requirement for two year periods upon his determination that (i) there is no need for additional beds for emergency psychiatric admissions in the local geographic area, (ii) the hospital lacks the physical capacity to reasonably accommodate such emergency admissions without extensive structural changes, (iii) the hospital does not and reasonably could not provide the scope of services necessary to assure adequate and appropriate psychiatric care and treatment for patients in emergency situations, or (iv) the hospital has agreed to accept referrals of involuntary psychiatric patients under an emergency admissions system which has been approved by the commissioner.

Provided, however, nothing in this paragraph shall be interpreted to require a hospital without an onsite emergency room to accept patients in need of emergency observation, care and treatment.

* NB Effective until July 1, 2024

* 4. establishing procedures for the issuance, amendment, and renewal of operating certificates, including temporary operating certificates, and for the suspension or revocation of operating certificates. Such procedures shall specify that no application for the issuance or renewal of an operating certificate for a hospital, which is operated as part of a hospital as defined in article twenty-eight of the public health law, shall be effective until such hospital is granted approval to admit patients in emergencies for immediate observation, care and treatment in accordance with section 9.39 of this chapter, provided that the commissioner shall waive this requirement for two year periods upon his determination that (i) there is no need for additional beds for emergency psychiatric admissions in the local geographic area, (ii) the hospital lacks the physical capacity to reasonably accommodate such emergency admissions without extensive structural changes, (iii) the hospital does not and reasonably could not provide the scope of services necessary to assure adequate and appropriate psychiatric care and treatment for patients in emergency situations, or (iv) the hospital has agreed to accept referrals of involuntary psychiatric patients under an emergency admissions system which has been approved by the commissioner.
Provided, however, nothing in this paragraph shall be interpreted to require a hospital without an onsite emergency room to accept patients in need of emergency observation, care and treatment.

* NB Effective July 1, 2024

5. setting for the operation of certified family care homes standards governing adequacy of the building and equipment, fire protection, safety, sanitation, food service, programs for the rendition of service, recreation and religious participation, medical services, personnel, insurance, record keeping procedures and statistical records as well as

appropriate standards governing or precluding ownership of more than one
such home.

6. establishing criteria for use by staff of department facilities, social services officials and directors of local governmental units for determining the appropriateness of referring patients to family care homes, other community residences and residential care centers for adults.

7. establishing criteria for determining the public need for family care homes, other community residences and residential care centers for adults in each geographical area of the state.

8. establishing a schedule of fees for the purpose of processing applications for the issuance of operating certificates. All fees pursuant to this section shall be payable to the office for deposit into the general fund.

Mental Hygiene (MHY) CHAPTER 27, TITLE E, ARTICLE 31
**** § 31.27 Comprehensive psychiatric emergency programs.**

(a) As used in this section:

(1) "Commissioner" means the commissioner of mental health.

(2) "Crisis intervention services" means services provided in an emergency room located within a general hospital, which shall include but not be limited to: psychiatric and medical evaluations and assessments; prescription or adjustment of medication, counseling, and other stabilization or treatment services intended to reduce symptoms of mental illness when appropriate.

(3) "Crisis outreach services" means psychiatric emergency services provided outside an emergency room setting including evaluation, assessment and stabilization services; crisis reduction services; referral services; and other psychiatric emergency services.

(5) "Extended observation bed" means an inpatient bed which is in or adjacent to an emergency room located within a general hospital or satellite facility approved by the commissioner, designed to provide a safe environment for an individual who, in the opinion of the examining physician, requires extensive evaluation, assessment, or stabilization of the person's acute psychiatric symptoms, except that, if the commissioner determines that the program can provide for the privacy and safety of all patients receiving services in a hospital, he or she may approve the location of one or more such beds within another unit of the hospital.

(6) "General hospital" shall be defined as in article twenty-eight of the public health law.

(9) "Psychiatric emergency services" means services designed to stabilize and, when possible, reduce acute psychiatric symptoms of an individual who appears to be mentally ill and in crisis.

(10) "Triage and referral services" means services designed to provide preliminary diagnosis, assessment and evaluation of individuals served by a comprehensive psychiatric emergency program in order to direct such person to those services which appropriately address their needs.

(11) "Voluntary agency" shall be defined as in section 41.03 of this chapter.

(12) "Satellite facility" means a medical facility providing psychiatric emergency services that is managed and operated by a general hospital who holds a valid operating certificate for a comprehensive psychiatric emergency program and is located away from the central campus of the general hospital.

(b) (1) The commissioner may license the operation of comprehensive psychiatric emergency programs by general hospitals which are operated by state or local governments or voluntary agencies. The provision of such services in general hospitals may be located either within the

state or, with the approval of the commissioner and the director of the budget and to the extent consistent with state and federal law, in a contiguous state. The commissioner is further authorized to enter into interstate agreements for the purpose of facilitating the development of programs which provide services in another state. A comprehensive psychiatric emergency program shall serve as a primary psychiatric emergency service provider within a defined catchment area for persons in need of psychiatric emergency services including persons who require immediate observation, care and treatment in accordance with section 9.40 of this chapter. Each comprehensive psychiatric emergency program shall provide or contract to provide psychiatric emergency services twenty-four hours per day, seven days per week, including but not limited to: crisis intervention services, crisis outreach services, extended observation beds, and triage and referral services.

(2) The commissioner of mental health shall require that each comprehensive psychiatric emergency program submit a plan. The plan must be approved by the commissioner prior to the issuance of an operating certificate pursuant to this article. Each plan shall include: (i) a description of the program's catchment area; (ii) a description of the program's psychiatric emergency services, including but not limited to crisis intervention services, crisis outreach services, extended observation beds, and triage and referral services, whether or not provided directly or through agreement with other providers of services; (iii) agreements or affiliations with hospitals, as defined in section 1.03 of this chapter, to receive and admit persons who require inpatient psychiatric services; (iv) agreements or affiliations with general hospitals to receive and admit persons who have been referred by the comprehensive psychiatric emergency program and who require medical or surgical care which cannot be provided by the comprehensive psychiatric emergency program; (v) a description of local resources available to the program to prevent unnecessary hospitalizations of persons, which shall include agreements with local mental health, health, substance abuse, alcoholism or alcohol abuse, developmental disabilities, or social services agencies to provide appropriate services; (vi) a description of the program's linkages with local police agencies, emergency medical services, ambulance services, and other transportation agencies; (vii) a

description of local resources available to the program to provide appropriate community mental health services upon release or discharge, which shall include case management services and agreements with state or local mental health and other human service providers; (viii) written criteria and guidelines for the development of appropriate discharge planning for persons in need of post emergency treatment or services; (ix) a statement indicating that the program has been included in an approved local services plan developed pursuant to article forty-one of this chapter for each local government located within the program's catchment area; and (x) any other information or agreements required by the commissioner.

(c) Each comprehensive psychiatric emergency program shall have at least one physician, who is a member of the psychiatric staff of the program, on duty and available at all times, provided, however, the commissioner may promulgate regulations to permit the issuance of a waiver of this requirement when the volume of service of a program does not require such level of staff coverage.

(d) The commissioner shall promulgate regulations to establish a maximum number and location of extended observation beds which may be provided in a program, including provisions to maximize the privacy and safety of all patients receiving services in the hospital in which such extended observation beds are located.

(e) The commissioner may prevent new presentations and admissions from entering a comprehensive psychiatric emergency program when the commissioner concludes that the ability of the program to deliver quality services would be jeopardized. Before reaching such a conclusion, the commissioner shall consider the effect presenting new presentations and admissions may have on other hospital emergency rooms which provide psychiatric emergency services, and the commissioner shall review the continued necessity for such prevention at least once every twenty-four hours.

(f) The commissioner and the commissioner of health shall enter into a cooperative agreement to govern the operation of comprehensive

psychiatric emergency programs including visitation, inspection and supervision of such programs, enforcement of the conditions of operating certificates issued by the office of mental health and the department of health, and the protection of the confidentiality of clinical information regarding patients at such programs.

(g) The office of mental health, the department of social services and the department of health shall establish a uniform system by which general hospitals which operate comprehensive psychiatric emergency programs shall report the cost of operating such programs.

(h) Notwithstanding any other provision of law, nothing in this section shall be interpreted to create an entitlement for any individual to receive psychiatric emergency services in a comprehensive psychiatric emergency program.

Mental Hygiene (MHY) CHAPTER 27, TITLE E, ARTICLE 43

§ 43.02 Rates or methods of payment for services at facilities subject to licensure or certification by the office of mental health, the office for people with developmental disabilities or the office of alcoholism and substance abuse services.

(a) Notwithstanding any inconsistent provision of law, payment made by government agencies pursuant to title eleven of article five of the social services law for services provided by any facility licensed by the office of mental health pursuant to article thirty-one of this chapter or certified by the office of alcoholism and substance abuse services pursuant to this chapter to provide inpatient chemical dependence services, as defined in section 1.03 of this chapter, shall be at rates or fees certified by the commissioner of the respective office and approved by the director of the division of the budget, provided, however, the commissioner of mental health shall annually certify such rates or fees which may vary for distinct geographical areas of the state and, provided, further, that rates or fees for service for inpatient psychiatric services or inpatient chemical dependence services, at hospitals otherwise licensed pursuant to article twenty-eight of the public health law shall be established in accordance

with section two thousand eight hundred seven of the public health law and, provided, further, that rates or fees for services provided by any facility or program licensed, operated or approved by the office for people with developmental disabilities, shall be certified by the commissioner of health; provided, however, that such methodologies shall be subject to approval by the office for people with developmental disabilities and shall take into account the policies and goals of such office.

(b) Operators of facilities licensed by the office of mental health pursuant to article thirty-one of this chapter, licensed by the office for people with developmental disabilities pursuant to article sixteen of this chapter or certified by the office of alcoholism and substance abuse services pursuant to this chapter to provide inpatient chemical dependence services shall provide to the commissioner of the respective office such financial, statistical and program information as the commissioner may determine to be necessary. The commissioner of the appropriate office shall have the power to conduct on-site audits of books and records of such facilities.

(c) The commissioner of the office of mental health, the commissioner of the office for people with developmental disabilities and the commissioner of the office of alcoholism and substance abuse services shall adopt rules and regulations to effectuate the provisions of this section. Such rules and regulations shall include, but not be limited to, provisions relating to:

(i) the establishment of a uniform statewide system of reports and audits relating to the quality of care provided, facility utilization and costs of providing services; such a uniform statewide system may provide for appropriate variation in the application of the system to different classes or subclasses of facilities licensed by the office of mental health pursuant to article thirty-one of this chapter or licensed or operated by the office for people with developmental disabilities pursuant to article sixteen of this chapter, or certified by the office of alcoholism and substance abuse services pursuant to this chapter to provide inpatient chemical dependence services; and

(ii) methodologies used in the establishment of the schedules of rates or fees pursuant to this section provided, however, that the commissioner of health shall adopt rules and regulations including methodologies developed by him or her for services provided by any facility or program licensed, operated or approved by the office for people with developmental disabilities; provided, however, that such rules and regulations shall be subject to the approval of the office for people with developmental disabilities and shall take into account the policies and goals of such office.

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

(Medicaid) State Plan for non-institutional services to revise provisions of the Ambulatory Patient Group (APG) reimbursement methodology. The following changes are proposed:

Non-Institutional Services

Effective on or after July 1, 2022, the Ambulatory Patient Group (APG) reimbursement methodology is revised to include recalculated weight and component updates in order to maintain consistent reimbursement for APG payments. Also, rates of reimbursement are being established for Licensed Mental Health Counselors and Licensed Marriage and Family Therapists in hospital outpatient departments and freestanding clinics.

The estimated annual change to gross Medicaid expenditures as a result of this proposed amendment is $3,603,802.

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 comply with enacted statutory provisions. The following changes are proposed:

Non-Institutional Services

Effective on or after July 1, 2022, the "Behavioral Health Utilization Controls" will be removed and the payment reduction for OPWDD Article 16 Clinics will no longer be applied.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2022/2023 is $368,218.

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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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 statutory provisions. The following changes are proposed:

Non-Institutional Services

Effective for dates of service on or after July 1, 2022, the Department of Health will increase Comprehensive Psychiatric Emergency Program (CPEP) reimbursement including fees paid for full emergency visits, triage and referral visits and extended observation bed services. This investment will result in a full annual projected increase in gross Medicaid expenditures of $20,000,000. This State Plan Amendment is necessary to adequately reimburse CPEP programs for providing these services and better meet the community's mental health needs.

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:

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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

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

Non-Institutional Services

Effective on or after July 1, 2022, the Department of Health will adjust rates statewide to reflect a five percent increase for the following Office of Mental Health services: Continuing Day Treatment (CDT), Day Treatment for Children and Partial Hospitalization (PH).

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to the July 1, 2022, five percent increase for the Continuing Day Treatment (CDT), Day Treatment for Children and Partial Hospitalization (PH) services is $1.3 million. The amount is contained in the budget for State Fiscal Year 2023.

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 comply with enacted statutory provisions. The following changes are proposed:

Non-Institutional Services

Beginning October 1, 2022, the minimum wage for a home care aide shall be increased by $2.00 and beginning October 1, 2023, the minimum wage shall be increased by an additional $1.00.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2022-23 is $20.7 million.

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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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 for coverage and reimbursement for Medicaid services. The following changes are proposed:

Non-Institutional Services

Effective on or after July 1, 2022, the Medicaid State Plan will be amended to authorize payment for Psychologist services provided to children/youth by agencies designated under the Child and Family Treatment and Support Services designation process.

There is no estimated annual change to gross Medicaid expenditures as a result of this 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 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

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

NON-INSTITUTIONAL SERVICES
State Plan Amendment #22-0080

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 100 percent of 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 (normal per diem and supplemental) 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; County Contribution	$27M	$54M

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) Additional Resources for Non-Federal Share Funding:

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 precent to zero over a three-year period. Beginning in State Fiscal Year 2016, counties began paying a fixed cost in perpetuity as follows:

County	Annual Amount
New York City	$4.882B
Suffolk	$216M
Nassau	$213M
Westchester	$199M
Erie	$185M
Rest of State (53 Counties)	$979M
Total	**$6.835B**

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 outpatient UPL demonstration utilizes a cost-to-payment methodology to estimate the upper payment limit for each class of providers. The State is in the process of completing the 2022 outpatient UPL as well as the Procedural Manual which describes the methodology for eligible providers and will be submitting both documents to CMS. The Medicaid payments under this State Plan Amendment will be included in the 2022 outpatient UPL when it is submitted to CMS.

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 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.