



June 29, 2023

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

RE: SPA #23-0079
Non-Institutional Services

Dear Mr. McMillion:

The State requests approval of the enclosed amendment #23-0079 to the Title XIX (Medicaid) State Plan for non-institutional services to be effective July 1, 2023 (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 28, 2023, 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,

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable)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 29, 2023

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
2023 Title XIX State Plan
Second Quarter Amendment
Amended SPA Pages

New York
4(a)(i)(9)

1905(a)(9) Clinic Services

Telehealth Services – Diagnostic and Treatment Center Offsite Rate

Effective on or after July 1, 2023, the State will allow diagnostic and treatment centers (DTCs) licensed under Article 28 of the Public Health Law to be reimbursed when there is no on-site presence at the DTC for services furnished via tele-health when neither the provider nor the Medicaid member is on-site.

Effective for services on or after July 1, 2023, reimbursement will be paid at \$75.38 per visit.

TN #23-0079

Approval Date _____

Supersedes TN # NEW

Effective Date July 1, 2023

Appendix II
2023 Title XIX State Plan
Second Quarter Amendment
Summary

SUMMARY
SPA #23-0079

This State Plan Amendment proposes to establish a fee to allow freestanding clinics, also known as diagnostic and treatment centers (DTCs), to be reimbursed when there is no on-site presence at the DTC. Effective on or after July 1, 2023, the State will reimburse DTCs for services furnished via telehealth when neither the provider nor the Medicaid member is on-site.

Appendix III
2023 Title XIX State Plan
Second Quarter Amendment
Authorizing Provisions

SSL § 367-u

§ 367-u. Payment for home telehealth services. 1. Subject to the approval of the state director of the budget, the commissioner may authorize the payment of medical assistance funds for demonstration rates or fees established for home telehealth services provided pursuant to subdivision three-c of section thirty-six hundred fourteen of the public health law.

2. Subject to federal financial participation and the approval of the director of the budget, the commissioner shall not exclude from the payment of medical assistance funds the delivery of health care services through telehealth, as defined in subdivision four of section two thousand nine hundred ninety-nine-cc of the public health law. Such services shall meet the requirements of federal law, rules and regulations for the provision of medical assistance pursuant to this title.

PHL § 2999-dd

§ 2999-dd. Telehealth delivery of services. * 1. Health care services delivered by means of telehealth shall be entitled to reimbursement under section three hundred sixty-seven-u of the social services law on the same basis, at the same rate, and to the same extent the equivalent services, as may be defined in regulations promulgated by the commissioner, are reimbursed when delivered in person; provided, however, that health care services delivered by means of telehealth shall not require reimbursement to a telehealth provider for certain costs, including but not limited to facility fees or costs reimbursed through ambulatory patient groups or other clinic reimbursement methodologies set forth in section twenty-eight hundred seven of this chapter, if such costs were not incurred in the provision of telehealth services due to neither the originating site nor the distant site occurring within a facility or other clinic setting; and further provided, however, reimbursement for additional modalities, provider categories and originating sites specified in accordance with section twenty-nine hundred ninety-nine-ee of this article, and audio-only telephone communication defined in regulations promulgated pursuant to subdivision four of section twenty-nine hundred ninety-nine-cc of this article, shall be contingent upon federal financial participation. Notwithstanding the provisions of this subdivision, for services licensed, certified or otherwise authorized pursuant to article sixteen, article thirty-one or article thirty-two of the mental hygiene law, such services provided by telehealth, as deemed appropriate by the relevant commissioner, shall be reimbursed at the applicable in person rates or

fees established by law, or otherwise established or certified by the office for people with developmental disabilities, office of mental health, or the office of addiction services and supports pursuant to article forty-three of the mental hygiene law.

* NB Effective until April 1, 2024

* 1. Health care services delivered by means of telehealth shall be entitled to reimbursement under section three hundred sixty-seven-u of the social services law; provided however, reimbursement for additional modalities, provider categories and originating sites specified in accordance with section twenty-nine hundred ninety-nine-ee of this article, and audio-only telephone communication defined in regulations promulgated pursuant to subdivision four of section twenty-nine hundred ninety-nine-cc of this article, shall be contingent upon federal financial participation.

* NB Effective April 1, 2024

2. The department of health, the office of mental health, the office of alcoholism and substance abuse services, and the office for people with developmental disabilities shall coordinate on the issuance of a single guidance document, to be updated as appropriate, that shall: (a) identify any differences in regulations or policies issued by the agencies, including with respect to reimbursement pursuant to section three hundred sixty-seven-u of the social services law; and (b) be designed to assist consumers, providers, and health plans in understanding and facilitating the appropriate use of telehealth in addressing barriers to care.

3. (a) Dental telehealth services shall adhere to the standards of appropriate patient care required in other dental health care settings, including but not limited to appropriate patient examination, taking of x-rays, and review of a patient's medical and dental history. All dental telehealth providers shall identify themselves to patients, including providing the professional's New York state license number. No dental telehealth provider shall attempt to waive liability for its telehealth services in advance of delivering such telehealth services and no dental telehealth provider shall attempt to prevent a patient from filing any complaint with any governmental agency or authority.

(b) This subdivision shall not be construed to diminish requirements for other telehealth services.

4. Nothing in this article shall be deemed to allow any person to provide any service for which a license, registration, certification or other authorization under title eight of the education law is required and which the person does not possess.

Appendix IV
2023 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 non-institutional services to comply with enacted statutory provisions. The following changes are proposed:

Non-Institutional Services

Effective on or after July 1, 2023, the Department of Health will adjust rates statewide to reflect a twenty-five percent rate increase for Day Treatment for Children services licensed by the Office of Mental Health.

The estimated net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2024 is \$3.3 million and for state fiscal year 2025 is \$4.4 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.

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 PHL 2999-DD and SSL § 367-u. The following changes are proposed:

Non-Institutional Services

Effective on or after July 1, 2023, the State proposes to establish a fee to allow freestanding clinics, also known as diagnostic and treatment centers (DTCs), to be reimbursed when there is no on-site presence at the DTC. The State will reimburse DTCs for services furnished via telehealth when neither the provider nor the Medicaid member is on-site.

The estimated net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the 2023-2024 budget is \$0.29 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 as authorized by § 2826 of New York Public Health Law. The following changes are proposed:

Non-Institutional Services

Effective on or after July 1, 2023, temporary rate adjustments have been approved for services related to providers that are undergoing closure, merger, consolidation, acquisition or restructuring themselves or other health care providers. The temporary rate adjustments have been reviewed and approved for the following Hospital:

- Mount St. Mary's Hospital with payment amounts totaling up to \$13,500,000 for the period July 1, 2023, through September 30, 2023.

The estimated net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2023-2024 is \$13.5 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.

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
2023 Title XIX State Plan
Second Quarter Amendment
Responses to Standard Funding Questions

**NON-INSTITUTIONAL SERVICES
State Plan Amendment #23-0079**

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 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 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.

Payment Type	Non-Federal Share Funding	4/1/22 – 3/31/23	
		Non-Federal	Gross
Normal Per Diem	General Fund; Special Revenue Funds; County Contribution	\$184M	\$368M

A. **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.

- 1) 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.

B. Special Revenue Funds:

- 1) 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:
 - Surcharge on net patient service revenues for specified provider types including Comprehensive Diagnostic and Treatment Centers and Ambulatory Surgery Centers.
 - The rate for commercial payors is 9.63 percent.
 - The rate for governmental payors, including Medicaid, is 7.04 percent.
 - Federal payors, including Medicare, are exempt from the surcharge.

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.

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

Entity	Annual Amount
New York City	\$4.882B
Suffolk County	\$216M
Nassau County	\$213M
Westchester County	\$199M
Erie County	\$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 clinic UPL demonstration utilizes cost-to-payment methodology to estimate the upper payment limit for each class of providers. The Medicaid payments under this State Plan Amendment will be included in the 2023 clinic 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 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.