NEW YORK STATE OF OPPORTUNITY. Department of Health

KATHY HOCHUL
Governor

JAMES V. McDONALD, M.D., M.P.H.
Commissioner

JOHANNE E. MORNE, M.S.
Acting Executive Deputy Commissioner

September 29, 2023

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 #23-0075
Non-Institutional Services

Dear Mr. Scott:

The State requests approval of the enclosed amendment #23-0075 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,

[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: 23-0075

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, 2023

5. FEDERAL STATUTE/REGULATION CITATION
§1905(a)(13) Other Diagnostic, Screening, Preventative, and Rehabi

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 07/01/23-09/30/23 $ 794,578
b. FFY 10/01/23-09/30/24 $ 3,178,313

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 3.1-A Supplement Page: 3b-79, 3b-80,3b-81,3b-82,3b-83

Attachment 3.1-B Supplement Page: 3b-79, 3b-80,3b-81,3b-82,3b-83

Attachment 4.19-B Page: 3P

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*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

9. SUBJECT OF AMENDMENT
OMH Coordinated Specialty Care (CSC) program

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 29, 2023

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

Instructions on Back

Appendix I
2023 Title XIX State Plan
Third Quarter Amendment
Amended SPA Pages

New York
3b-79

1905(a)(13) Other Diagnostic, Screening, Preventative, and Rehabilitative Services

13.d Rehabilitative Services
Coordinated Specialty Care Services

Assurances:
The State assures that all rehabilitative services are provided to, or directed exclusively toward the treatment of the Medicaid-eligible individual in accordance with section 1902(a)(10)(A)(i) of the Act.

The State assures that rehabilitative services do not include and FFP is not available for any of the following in accordance with section 1905(a)(13) of the Act:

A. educational, vocational and job training services;
B. room and board;
C. habilitation services;
D. services to inmates in public institutions as defined in 42 CFR §435.1010;
E. services to individuals residing in institutions for mental diseases as described in 42 CFR §435.1010;
F. recreational and social activities; and-
G. services that must be covered elsewhere in the state Medicaid plan.

Description:
Coordinated Specialty Care (CSC) is an evidence-based practice service model recognized by the Substance Abuse and Mental Health Services Administration of the U.S. Department of Health and Human Services for the treatment of young people experiencing a first episode of psychosis (FEP). CSC services are services for adolescents and young adults with the recent onset of a psychotic disorder that are designed to reduce disability, restore functionality, and reduce acute service use.

CSC services are provided by a team of specialists who work with the beneficiary and their family to create a personalized treatment plan. CSC principles of care include shared decision-making, youth-friendly and welcoming environments, equity and inclusion, and flexible and accessible services to minimize barriers for young people who have difficulties engaging in treatment during initial psychosis symptom onset.

CSC Services are recommended by a licensed practitioner of the healing arts acting within the scope of their professional license and applicable New York State law, including licensed Physicians, Physician Assistants, Nurse Practitioners, Registered Professional Nurses, Psychologists, Licensed Clinical Social Workers (LCSW), Licensed Master Social Workers (LMSW) under the supervision of a LCSW, licensed psychologist or psychiatrist, Licensed Mental Health Counselors (LMHC), Licensed Marriage and Family Therapists (LMFT), Licensed Creative Arts Therapists (LCAT), and Psychoanalysts.

Provider Qualifications:
CSC services are provided by a multidisciplinary team of professional and paraprofessional staff under the supervision of professional staff.

New York
3b-80

1905(a)(13) Other Diagnostic, Screening, Preventative, and Rehabilitative Services

Professional staff include the following licensed, permitted, or otherwise authorized individuals acting within NYS scope of practice laws: Physicians; Psychiatrists; Physician Assistants, Nurse Practitioners; Psychiatric Nurse Practitioners; Registered Professional Nurses; Licensed Practical Nurses; Psychologists, including Psychologists who have obtained a Master's degree in Psychology while under the supervision of a Licensed Psychologist; Licensed Clinical Social Workers; Licensed Master Social Workers; Social Workers who have obtained a Master's Degree in Social Work while under the supervision of a Licensed Clinical Social Worker, Licensed Psychologist, or Psychiatrist; Licensed Mental Health Counselors; Mental Health Counselors who have obtained a Master's Degree required for licensure and are supervised by a Psychologist, Licensed Clinical Social Worker, or a Licensed Mental Health Counselor; Licensed Marriage and Family Therapists; Licensed Creative Arts Therapists; and Licensed Occupational Therapists who meet the qualifications set forth in 42 CFR § 440.110(b)(2).

Professional staff also include Psychiatric Rehabilitation Practitioners certified by the Certification Commission of the Psychiatric Rehabilitation Association; Rehabilitation Counselors who have obtained a master's degree in rehabilitation counseling or are certified by the Commission on Rehabilitation Counselor Certification; and Therapeutic Recreation Specialists who have obtained a master's degree in therapeutic recreation or are certified by the National Council for Therapeutic Recreation Certification.

Paraprofessional staff must have obtained a bachelor's degree or have attained at least 18 years of age and a high-school diploma or equivalent.

CSC services are also provided by peer specialists, who are individuals who have lived experience with mental health challenges. Peer specialists must have attained at least 18 years of age, a high-school diploma or equivalent, and possess a New York State Peer Specialist certification or provisional certification or a New York State Youth Peer Advocate credential or provisional credential. The New York State Peer Specialist certification and Youth Peer Advocate credential requires the completion of specific training and ongoing training to maintain the certificate/credential. Peer specialists are supervised by competent mental health professionals, who are defined as a professional staff above.

Staff Supervision and Training Requirements

Professional staff provide supervision to the CSC team members in the provision of CSC Services. Professional staff supervision for paraprofessional staff occurs both formally, through direct supervision and consultation, as well as informally through regular team meetings, which are a hallmark of the CSC evidence-based practice model. All CSC providers, including professionals, paraprofessionals and peer specialists, are required to complete training in the CSC model and role-specific training.

Services

CSC services will be provided based upon the assessment of an individual's mental, physical and behavioral condition and history, which will be the basis for establishing a Person-centered Treatment Plan. CSC services will also be provided to collaterals, including family, and others significant in the individual's life, for the direct benefit of the beneficiary and in accordance with the individual's Treatment Plan.

New York
3b-81

1905(a)(13) Other Diagnostic, Screening, Preventative, and Rehabilitative Services

Medically Necessary CSC Services include:

a. **Screening and Assessment Services:** Screening services are assessment services provided by professional staff to determine whether a beneficiary is experiencing first episode psychosis. Assessment services include a multi-disciplinary, continuous process of identifying an individual's strengths, barriers to achieving goals, and service needs, through the observation and evaluation of the individual's current mental, physical and behavioral health condition and history. Assessment services also include risk and safety assessments for suicide prevention and assessment of trauma and for any symptoms of post-traumatic stress disorder.

   Practitioner Qualifications: Screening and Assessment services are provided by professional staff.

b. **Person-centered Planning Services:** Person-centered Planning Services is a continuous process that engages each individual as an active partner in developing, reviewing, and modifying a course of treatment that supports the individual's progress toward recovery and accomplishing the individual's rehabilitation goals. Services also include safety planning for suicide prevention.

   Practitioner Qualifications: Person-centered Planning services are provided by professional staff or paraprofessional staff under the supervision of professional staff.

c. **Crisis Intervention Services:** Crisis Intervention Services are assessment, therapeutic, and rehabilitative services, including a safety assessment, safety planning, medication therapy, and counseling services to address acute distress and associated behaviors to ameliorate a mental health crisis.

   Practitioner Qualifications: Crisis Intervention Services are provided by professional staff or paraprofessional staff under the supervision of professional staff. Medication therapy services delivered in a crisis visit are provided by a Physician, Psychiatrist, Physician Assistant, Nurse Practitioner, or Registered Professional Nurse.

d. **Health Monitoring:** Health Monitoring is a diagnostic and therapeutic service involving the continued measurement of specific health indicators associated with increased risk of medical illness and early death. These indicators include, but are not limited to, blood pressure, body mass index (BMI), activity/ exercise level, substance use, and tobacco use.

   Practitioner Qualifications: Health Monitoring services are provided by a Psychiatrist, Physician, Nurse practitioner, Psychiatric nurse practitioner, Physician Assistant, Registered nurse or Licensed practical nurse.

e. **Medication Management Services:** Medication Management Services include a full range of medication services including supporting medication decision making using a shared decision making framework, prescribing and administering medication, evaluating the appropriateness of the individual's existing medication regimen, medication education, monitoring the effects of medication on the individual's mental and physical health, and counseling and skill development to support individuals in obtaining and self-administering medications and recognizing and coping with the side-effects of the medication(s).

1905(a)(13) Other Diagnostic, Screening, Preventative, and Rehabilitative Services

Practitioner Qualifications: Medication evaluation, prescription, administration, and education services are provided by a Physician or a Nurse Practitioner. Medication administration and education services are provided by a Physician, Nurse Practitioner, Physician Assistant, Registered Professional Nurse, or Licensed Practical Nurse. Counseling and skill development regarding medications are provided by professional or paraprofessional staff under the supervision of professional staff.

f. **Psychoeducation, including Family Psychoeducation Services:** Psychoeducation is a psychosocial education service to assist individuals and their families or other identified collaterals recognize the onset of psychiatric symptoms and prevent, manage, or reduce such symptoms.

Practitioner Qualifications: Psychoeducation services are provided by professional staff or paraprofessional staff under the supervision of professional staff.

g. **Integrated Dual Disorder Treatment:** Integrated Dual Disorder Treatment is a counseling service using an evidence-based practice model for integrating treatment of substance use disorder and mental health conditions. Services provide motivational interviewing, stage-wise interventions, cognitive-behavioral therapy, harm reduction techniques, and linkage to community support groups, to restore functionality and promote recovery for individuals with dual recovery substance use disorder and mental illness.

Practitioner Qualifications: Integrated Dual Disorder Treatment services are provided by professional staff.

h. **Individual, Group, and Family Counseling/Therapy:** Counseling/Therapy services are problem-specific and goal-oriented therapeutic services using evidence-based and evidence-informed practices, such as cognitive-behavioral therapy, for the purpose of alleviating symptoms or dysfunction associated with an individual's mental health condition, reversing or changing maladaptive patterns of behavior, encouraging personal growth and development, and supporting the individual's capacity to restore age-appropriate developmental milestones. Services include tobacco use disorder treatment services. Collateral contact is permitted as needed to address the therapeutic goals of the beneficiary.

Practitioner Qualifications: Individual, Group and/or Family Counseling/Therapy Services are provided by professional staff.

i. **Psychosocial Rehabilitation Services:** Psychosocial Rehabilitation services to develop and enhance an individual's stability and promote capacity for activities of daily living; maximize independence in self-care and wellness to maintain physical and mental health; restore or develop age-appropriate communication, social, and financial management skills; maintain housing stability; and improve familial and educational relationships. Psychosocial Rehabilitation services include skills training and relapse prevention training, which includes structured protocols, such as role-playing, for restoring or building age-appropriate skills which were lost or delayed due to the symptoms of FEP.

New York
3b-83

1905(a)(13) Other Diagnostic, Screening, Preventative, and Rehabilitative Services

Practitioner Qualifications: Psychosocial Rehabilitation Services are provided by professional staff or paraprofessional staff under the supervision of professional staff.

j. **Vocational and Educational Support Services:** Vocational and Educational Support services are psychosocial rehabilitation services to assist individuals manage the symptoms of mental illness in school or workplace settings, develop strategies to resolve issues in such settings, and maintain functional skills necessary to achieve employment or educational goals. Services do not include vocational or educational placement or job training services.

Practitioner Qualifications: Vocational and Educational Support services are provided by professional staff or paraprofessional staff under the supervision of professional staff.

k. **Peer Support Services:** Peer Support Services include person-centered goal planning, co-creating tools to support wellness, offering hope and support around the possibility of recovery, and facilitating community connections to support participants in achieving their goals and increase engagement in rehabilitative services. Services are provided in individual or group settings to promote recovery, self-advocacy, and the development of natural supports and community living skills. Services are directed toward achievement of the specific, individualized, and result-oriented goals contained in an individual's treatment plan.

Practitioner Qualifications: Peer Support Services are provided by certified, credentialed, or provisionally certified or credentialed peer support specialists under supervision as provided in this section.

l. **Community Integration and Re-integration Services:** Community Integration and Re-integration services engage and assist individuals in the restoration of social, interpersonal, and basic living skills impacted by or lost as a result of mental illness which hinder an individual's ability to live in an integrated community setting. It is an active process that includes coordination of services and supports, assisting in the transition from a hospital setting, and identification or modification of supports, to promote community tenure and manage behavioral and physical health needs. Services include the development of individualized discharge plans with the active participation of individuals and families to ensure that follow-up services are identified, in place, and occur as planned, based on the needs and preferences of participants and their families.

Practitioner Qualifications: Community Integration and Re-integration services are provided by professional staff or paraprofessional staff under supervision of professional staff.
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m. **Complex Care Management:** Complex care management services are time-limited, medically necessary interventions to restore functioning and address the symptoms of mental illness. This includes skill building to help the beneficiary to identify solutions to problems that threaten recovery and care coordination services to help beneficiaries to connect with medical or remedial services. Services will involve contacts with collaterals identified by the beneficiary for the direct benefit of the beneficiary.

Practitioners: Complex Care Management Services are provided by Professional staff and Paraprofessionals under supervision of Professional staff.

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New York
3b-83

1905(a)(13) Other Diagnostic, Screening, Preventative, and Rehabilitative Services

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Practitioner Qualifications: Peer Support Services are provided by certified, credentialed, or provisionally certified or credentialed peer support specialists under supervision as provided in this section.

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Practitioner Qualifications: Community Integration and Re-integration services are provided by professional staff or paraprofessional staff under supervision of professional staff.
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Practitioners: Complex Care Management Services are provided by Professional staff and Paraprofessionals under supervision of Professional staff.

1905(a)(13) Other diagnostic, screening, preventative, and rehabilitative services

13.d Rehabilitative Services
Coordinated Specialty Care Services

Reimbursement Methodology for Coordinated Specialty Care Services

Effective July 1, 2023, for services provided by OMH licensed providers, reimbursement for Coordinated Specialty Care (CSC) services will be made in the form of a monthly fee if the minimum number of services, as defined herein is provided. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers.

Monthly fees were calculated using provider-submitted Consolidated Fiscal Reports (CFR) for Coordinated Specialty Care services and were calculated by dividing allowable annual costs by 12 months and by provider case size. Such monthly fees are then adjusted by a factor to account for fluctuations in case load and the expected frequency of full or partial month claims based on established minimum contact thresholds.

CSC services are reimbursed either the full or half month fee based on the number of discrete contacts of at least 15 minutes in duration in which CSC services are provided. Providers will not bill more than one monthly fee, including the full or half month fee, for the same individual in the same month.

CSC services are reimbursed the full month fee for a minimum of four contacts per month, at least two of which must be with the individual. CSC services are reimbursed the half month fee for a minimum of two and fewer than four contacts per month, of which one must be with the individual. CSC services are also reimbursed the half-month fee for a minimum of two contacts per month for individuals admitted to a general hospital for the entire month, however the full monthly fee will be reimbursed in the month of the individual's admission or discharge if the provider meets the minimum of four contacts per month, of which two contacts will be provided while the individual is admitted to the hospital. Such reimbursement for individuals admitted to a general hospital is limited to five continuous months. For purposes of this provision, an inpatient admission is considered continuous if the individual is readmitted within 10 days of discharge. No more than one contact per day is counted for reimbursement purposes, except if two separate contacts are provided on the same day, including one contact with an individual and one collateral contact. Services provided using telehealth technology and services with collateral contacts are included for purposes of determining total monthly visits.

OMH Coordinated Specialty Care providers will maintain complete case records which form the basis of all claims and statistical and financial reports for at least six years from the date of service. All such records will be subject to audit for six years from the date the claim was submitted. Providers must also submit annual cost reports. The State periodically reviews case records, claims data, and provider cost reports to evaluate the adequacy and efficiency of bundled reimbursement rates.

The State also monitors the provision of CSC services to ensure that beneficiaries receive the types, quantity, and intensity of services required to meet their needs through services and provider monitoring tools including required client and program-level data reporting and annual fidelity assessment. Providers of CSC services are also required to perform patient-specific reporting to the State at routine intervals as a condition of authorization to provide CSC services.

Fees for CSC Services are available on the OMH website at:
http://www.omh.ny.gov/omhweb/medicaid_reimbursement/

Appendix II
2023 Title XIX State Plan
Third Quarter Amendment
Summary

SUMMARY
SPA #23-0075

This State Plan Amendment proposes to establish Medical Assistance coverage and rates of payment for Coordinated Specialty Care (CSC), an evidence-based practice model for the treatment of young people experiencing a first episode of psychosis (FEP).

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

SPA 23-0075

§ 7.07 Office of mental health; scope of responsibilities.

(a) The office of mental health is charged with the responsibility for assuring the development of comprehensive plans, programs, and services in the areas of research, prevention, and care, treatment, rehabilitation, education, and training of the mentally ill. Such plans, programs, and services shall be developed by the cooperation of the office, the other offices of the department where appropriate, local governments, consumers and community organizations and agencies. The office shall provide appropriate facilities and encourage the provision of facilities by local government and community organizations and agencies.

(b) The office of mental health shall advise and assist the governor in developing policies designed to meet the needs of the mentally ill and to encourage their full participation in society.

(c) The office of mental health shall have the responsibility for seeing that mentally ill persons are provided with care and treatment, that such care, treatment and rehabilitation is of high quality and effectiveness, and that the personal and civil rights of persons receiving care, treatment and rehabilitation are adequately protected.

(d) The office of mental health shall foster programs for the training and development of persons capable of providing the foregoing services.

(e) Consistent with the requirements of subdivision (b) of section 5.05 of this chapter, the office shall carry out the provisions of article thirty-one as such article pertains to regulation and quality control of services for the mentally ill.

(f) The office shall establish, and provide technical and financial support to establish two programs promoting culturally and linguistically competent mental health services. Such programs shall be operated in a collaborative manner with the Nathan S. Kline Institute for Psychiatric Research, the New York State Psychiatric Institute, academia, mental health care providers, communities interested in the mentally ill and other interested private and public sector parties. The programs, in consultation with the office's multicultural advisory committee, shall investigate and report, to the commissioner on a biannual basis recommendations as to best practices for the delivery of culturally and linguistically competent mental health services to underserved populations affected by disparities due to cultural, linguistic and systemic barriers.

(g) The office of mental health shall have the responsibility for assuring the development of plans, programs, and services in the areas of research and prevention of suicide, to reduce suicidal behavior and suicide through consultation, training, implementation of evidence-based practices, and use of suicide surveillance data. Such plans, programs,

and services shall consider the unique needs of differing demographic groups and the impact of gender, race and ethnicity, and cultural and language needs. Such plans, programs, and services shall be developed in
cooperation with other agencies and departments of the state, local governments, community organizations and entities, or other organizations and individuals. The office shall prepare and submit a written report to the governor, the speaker of the assembly, and temporary president of the senate that sets forth the progress of the office in the development of such plans, programs, and services by December first, two thousand nineteen, and biennially thereafter. In addition to delineating the progress the office has made, such report shall also include information on specific suicide prevention services and program initiatives developed and implemented to address the needs of high risk minority groups or special populations, including but not limited to latina and latino adolescents, black youth, individuals residing in rural communities, veterans, members of the lesbian, gay, bisexual and transgender community, and any other group deemed high risk
or underserved by the office.

(h) The office shall periodically review suicide prevention programs established, licensed, certified, or funded by the office to ensure that
the needs of individuals at risk of suicide are being met and make recommendations to improve such programs, which shall include but not be
limited to: (1) cultural and linguistic competency; and (2) best practices for screening and interventions aimed at addressing suicide risk factors for minority groups and other underrepresented populations.

New York State Mental Hygiene Laws §7.15

(a) The commissioner shall plan, promote, establish, develop, coordinate, evaluate, and conduct programs and services of prevention, diagnosis, examination, care, treatment, rehabilitation, training, and research for the benefit of the mentally ill. Such programs shall include but not be limited to in-patient, out-patient, partial hospitalization, day care, emergency, rehabilitative, and other appropriate treatments and services. He or she shall take all actions that are necessary, desirable, or proper to implement the purposes of this chapter and to carry out the purposes and objectives of the department within the amounts made available therefor by appropriation, grant, gift, devise, bequest, or allocation from the mental health services fund established under section ninety-seven-f of the state finance law.

(b) The activities described in subdivision (a) of this section may be undertaken in cooperation and agreement with other offices of the department and with other departments or agencies of the state, local or federal government, or with other organizations and individuals.

New York State Mental Hygiene Laws §43.01

(a) The department shall charge fees for its services to patients and residents, provided, however, that no person shall be denied services because of inability or failure to pay a fee.

(b) The commissioner may establish, at least annually, schedules of rates for inpatient services that reflect the costs of services, care, treatment, maintenance, overhead, and administration which assure maximum recovery of such costs.

In addition, the commissioner may establish, at least annually, schedules of fees for noninpatient services which need not reflect the costs of services, care, treatment, maintenance, overhead, and administration.

(c) The executive budget, as recommended, shall reflect, by individual facility, the costs of services, care, treatment, maintenance, overhead, and administration.

(d) All schedules of fees and rates which are established by the commissioner, shall be subject to the approval of the director of the division of the budget. Immediately upon their approval, copies of all schedules of fees and rates established pursuant to this section shall be forwarded to the chairman of the assembly ways and means committee and the chairman of the senate finance committee.

New York State Mental Hygiene Laws §43.02

(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
2023 Title XIX State Plan
Third Quarter Amendment
Public Notice

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 long term care services as authorized by § 2826 of the New York Public Health Law. The following changes are proposed:

Long Term Care Services

Effective on or after July 1, 2023, the Department of Health proposes to amend the Title XIX (Medicaid) State Plan for institutional services related to temporary rate adjustments to long term care providers that are undergoing closure, merger, consolidation, acquisition or restructuring themselves or other health care providers. These payments are authorized by current State statutory and regulatory provisions. The temporary rate adjustments will be reviewed and approved by the CINERGY Collaborative.

The estimated net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2023-2024 is $30 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

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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. The following changes are proposed:

Non-Institutional Services

Effective on or after July 1, 2023, this notice proposes to establish Medical Assistance coverage and rates of payment for Coordinated Specialty Care (CSC), an evidence-based practice model for the treatment of young people experiencing a first episode of psychosis (FEP). CSC services are intended to benefit adolescents and young adults with the recent onset of a psychotic disorder, helping to prevent acute service use, reduce disability, and help young people with early psychosis stay on track with their goals for school, work, and relationships.

The estimated aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2024 is $4.8 million and $6.4 million for state fiscal year 2025.

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

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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

Appendix V
2023 Title XIX State Plan
Third Quarter Amendment
Responses to Standard Funding Questions

NON-INSTITUTIONAL SERVICES
State Plan Amendment #23-0075

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.

		4/1/23 – 3/31/24	
Payment Type	**Non-Federal Share Funding**	**Non-Federal**	**Gross**
Normal Per Diem	General Fund; County Contribution	$2.4M	$4.8M

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. 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:

Entity	Annual Amount
New York City	$5.200B
Suffolk County	$226M
Nassau County	$217M
Westchester County	$204M
Erie County	$194M
Rest of State (53 Counties)	$1.187B
Total	**$7.228B**

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.