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State/Territory Name: **New York**

State Plan Amendment (SPA) #: **20-0048**

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) CMS 179 Form
- 3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850



May 12, 2021

Donna Frescatore
State Medicaid Director
New York State Department of Health
99 Washington Ave - One Commerce Plaza, Suite 1432
Albany, NY 12210

Re: New York State Plan Amendment (SPA) 20-0048

Dear Ms. Donna Frescatore:

We have reviewed the proposed amendment to add section 7.4 Medicaid Disaster Relief for the COVID-19 National Emergency to your Medicaid state plan, as submitted under transmittal number (TN) 20-0048. This amendment proposes to implement temporary policies, which are different from those policies and procedures otherwise applied under your Medicaid state plan, during the period of the Presidential and Secretarial emergency declarations related to the COVID-19 outbreak (or any renewals thereof).

On March 13, 2020, the President of the United States issued a proclamation that the COVID-19 outbreak in the United States constitutes a national emergency by the authorities vested in him by the Constitution and the laws of the United States, including sections 201 and 301 of the National Emergencies Act (50 U.S.C. 1601 *et seq.*), and consistent with section 1135 of the Social Security Act (Act). On March 13, 2020, pursuant to section 1135(b) of the Act, the Secretary of the United States Department of Health and Human Services invoked his authority to waive or modify certain requirements of titles XVIII, XIX, and XXI of the Act as a result of the consequences of the COVID-19 pandemic, to the extent necessary, as determined by the Centers for Medicare & Medicaid Services (CMS), to ensure that sufficient health care items and services are available to meet the needs of individuals enrolled in the respective programs and to ensure that health care providers that furnish such items and services in good faith, but are unable to comply with one or more of such requirements as a result of the COVID-19 pandemic, may be reimbursed for such items and services and exempted from sanctions for such noncompliance, absent any determination of fraud or abuse. This authority took effect as of 6PM Eastern Standard Time on March 15, 2020, with a retroactive effective date of March 1, 2020. The emergency period will terminate, and this state plan provision will no longer be in effect, upon termination of the public health emergency, including any extensions.

Pursuant to section 1135(b)(5) of the Act, for the period of the public health emergency, CMS is modifying the requirement at 42 C.F.R. 430.20 that the state submit SPAs related to the COVID-19 public health emergency by the final day of the quarter, to obtain a SPA effective date during the quarter, enabling SPAs submitted after the last day of the quarter to have an effective date in a previous quarter, but no earlier than the effective date of the public health emergency.

The State of New York also requested a waiver of public notice requirements applicable to the SPA submission process. Pursuant to section 1135(b)(1)(C) of the Act, CMS is waiving public notice requirements applicable to the SPA submission process. Public notice for SPAs is required under 42 C.F.R. §447.205 for changes in statewide methods and standards for setting Medicaid payment rates, 42 C.F.R. §447.57 for changes to premiums and cost sharing, and 42 C.F.R. §440.386 for changes to Alternative Benefit Plans (ABPs). Pursuant to section 1135(b)(1)(C) of the Act CMS is approving the state's request to waive these notice requirements otherwise applicable to SPA submissions.

The State of New York also requested a waiver to modify the tribal consultation timeline applicable to this SPA submission process. Pursuant to section 1135(b)(5) of the Act, CMS is also allowing states to modify the timeframes associated with tribal consultation required under section 1902(a)(73) of the Act, including shortening the number of days before submission or conducting consultation after submission of the SPA.

These waivers of the requirements related to SPA submission timelines, public notice, and tribal consultation apply only with respect to SPAs that meet the following criteria: (1) the SPA provides or increases beneficiary access to items and services related to COVID-19 (such as by waiving or eliminating cost sharing, increasing payment rates or amending ABPs to add services or providers); (2) the SPA does not restrict or limit payment or services or otherwise burden beneficiaries and providers; and (3) the SPA is temporary, with a specified sunset date that is not later than the last day of the declared COVID-19 public health emergency (or any extension thereof). We nonetheless encourage states to make all relevant information about the SPA available to the public so they are aware of the changes.

We conducted our review of your submittal according to the statutory requirements at section 1902(a) of the Act and implementing regulations. This letter is to inform you that New York's Medicaid SPA TN 20-0048 is approved effective March 1, 2020.

Enclosed is a copy of the CMS-179 summary form and the approved state plan pages.

Please contact Michael Kahnowitz at 212-616-2327 or by email at michael.kahnowitz@cms.hhs.gov if you have any questions about this approval.

We appreciate the efforts of you and your staff in responding to the needs of the residents of the State of New York and the health care community.



Alissa Mooney DeBoy
On Behalf of Anne Marie Costello,
Acting Director
Center for Medicaid and CHIP Services

Enclosures

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES	1. TRANSMITTAL NUMBER 2 0 — 0 0 4 8	2. STATE New York
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID) TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE & MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE March 1, 2020	

5. TYPE OF PLAN MATERIAL (Check One)

NEW STATE PLAN AMENDMENT TO BE CONSIDERED AS NEW PLAN AMENDMENT


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

6. FEDERAL STATUTE/REGULATION CITATION Section 1135 of SSA and Title XIX of SSA	7. FEDERAL BUDGET IMPACT a. FFY 03/01/20-09/30/20 \$ 15,181.11 * b. FFY 10/01/20-09/30/21 \$ 2,070.85
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT Attachment: 7,4 Page: 1,2,3,4,5,6,7,8,9,10,11,12,13,14,15,16, 17, 18,19, 20 *	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable) Attachment: NEW

10. SUBJECT OF AMENDMENT
COVID 19 Emergency Relief (FMAP=50%)

11. GOVERNOR'S REVIEW (Check One)

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

12. SIGNATURE OF STATE AGENCY OFFICIAL 	16. RETURN TO New York State Department of Health Division of Finance and Rate Setting 99 Washington Ave – One Commerce Plaza Suite 1432 Albany, NY 12210
13. TYPED NAME Donna Frescatore	
14. TITLE Medicaid Director, Department of Health	
15. DATE SUBMITTED August 25, 2020	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED August 25, 2020	18. DATE APPROVED May 12, 2021
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PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL March 1, 2020	20. SIGNATURE OF REGIONAL OFFICIAL Alissa M. Deboy -S <small>Digitally signed by Alissa M. Deboy Date: 2021.05.12 09:09:42 -0400</small>
21. TYPED NAME Alissa Mooney DeBoy On Behalf of Anne Marie Costello	22. TITLE Acting Director, Center for Medicaid and CHIP Services

23. REMARKS

Pen and ink change requested by New York on 04/07/21 to box 7, changing budget impact to:
 - a. FFY 03/01/20-09/30/20 \$ 31,468,188.60
 - b. FFY 10/01/20-09/30/21 \$ 52,008,809.29
 Pen and ink change requested by New York on 04/07/21 to box 8, adding page number 17, 18, 19, 20

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Section 7 – General Provisions

7.4. Medicaid Disaster Relief for the COVID-19 National Emergency

On March 13, 2020, the President of the United States issued a proclamation that the COVID-19 outbreak in the United States constitutes a national emergency by the authorities vested in him by the Constitution and the laws of the United States, including sections 201 and 301 of the National Emergencies Act (50 U.S.C. 1601 et seq.), and consistent with section 1135 of the Social Security Act (Act). On March 13, 2020, pursuant to section 1135(b) of the Act, the Secretary of the United States Department of Health and Human Services invoked his authority to waive or modify certain requirements of titles XVIII, XIX, and XXI of the Act as a result of the consequences COVID-19 pandemic, to the extent necessary, as determined by the Centers for Medicare & Medicaid Services (CMS), to ensure that sufficient health care items and services are available to meet the needs of individuals enrolled in the respective programs and to ensure that health care providers that furnish such items and services in good faith, but are unable to comply with one or more of such requirements as a result of the COVID-19 pandemic, may be reimbursed for such items and services and exempted from sanctions for such noncompliance, absent any determination of fraud or abuse. This authority took effect as of 6PM Eastern Standard Time on March 15, 2020, with a retroactive effective date of March 1, 2020. The emergency period will terminate, and waivers will no longer be available, upon termination of the public health emergency, including any extensions.

The State Medicaid agency (agency) seeks to implement the policies and procedures described below, which are different than the policies and procedures otherwise applied under the Medicaid state plan, during the period of the Presidential and Secretarial emergency declarations related to the COVID-19 outbreak (or any renewals thereof), or for any shorter period described below:

<i>Describe shorter period here. – N/A</i>
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NOTE: States may not elect a period longer than the Presidential or Secretarial emergency declaration (or any renewal thereof). States may not propose changes on this template that restrict or limit payment, services, or eligibility, or otherwise burden beneficiaries and providers.

Request for Waivers under Section 1135

The agency seeks the following under section 1135(b)(1)(C) and/or section 1135(b)(5) of the Act:

- a. SPA submission requirements – the agency requests modification of the requirement to submit the SPA by March 31, 2020, to obtain a SPA effective date during the first calendar quarter of 2020, pursuant to 42 CFR 430.20.
- b. Public notice requirements – the agency requests waiver of public notice requirements that would otherwise be applicable to this SPA submission. These requirements may include those specified in 42 CFR 440.386 (Alternative Benefit Plans), 42 CFR 447.57(c) (premiums and cost sharing), and 42 CFR 447.205 (public notice of changes in statewide methods and standards for setting payment rates).

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Supersedes TN: NEW

Approval Date: 05/12/2021
Effective Date: 03/01/2020

- c. Tribal consultation requirements – the agency requests modification of tribal consultation timelines specified in New York State Medicaid state plan, as described below:

New York will reduce the tribal consultation to zero days before submission to CMS. Tribal consultation will still be completed and mailed as per guidelines in New York’s approved state plan.

Section A – Eligibility

- 1. The agency furnishes medical assistance to the following optional groups of individuals described in section 1902(a)(10)(A)(ii) or 1902(a)(10)(c) of the Act. This may include the new optional group described at section 1902(a)(10)(A)(ii)(XXIII) and 1902(ss) of the Act providing coverage for uninsured individuals.

Include name of the optional eligibility group and applicable income and resource standard.

- 2. The agency furnishes medical assistance to the following populations of individuals described in section 1902(a)(10)(A)(ii)(XX) of the Act and 42 CFR 435.218:

- a. All individuals who are described in section 1905(a)(10)(A)(ii)(XX)

Income standard: _____

-or-

- b. Individuals described in the following categorical populations in section 1905(a) of the Act:

Income standard: _____

- 3. The agency applies less restrictive financial methodologies to individuals excepted from financial methodologies based on modified adjusted gross income (MAGI) as follows.

Less restrictive resource methodologies:

- 4. The agency considers individuals who are evacuated from the state, who leave the state for medical reasons related to the disaster or public health emergency, or who are otherwise absent from the state due to the disaster or public health emergency and who intend to return to the state, to continue to be residents of the state under 42 CFR 435.403(j)(3).

5. ____ The agency provides Medicaid coverage to the following individuals living in the state, who are non-residents:

6. ____ The agency provides for an extension of the reasonable opportunity period for non-citizens declaring to be in a satisfactory immigration status, if the non-citizen is making a good faith effort to resolve any inconsistencies or obtain any necessary documentation, or the agency is unable to complete the verification process within the 90-day reasonable opportunity period due to the disaster or public health emergency.

Section B – Enrollment

1. ____ The agency elects to allow hospitals to make presumptive eligibility determinations for the following additional state plan populations, or for populations in an approved section 1115 demonstration, in accordance with section 1902(a)(47)(B) of the Act and 42 CFR 435.1110, provided that the agency has determined that the hospital is capable of making such determinations.

Please describe the applicable eligibility groups/populations and any changes to reasonable limitations, performance standards or other factors.

2. ____ The agency designates itself as a qualified entity for purposes of making presumptive eligibility determinations described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L.

Please describe any limitations related to the populations included or the number of allowable PE periods.

3. ____ The agency designates the following entities as qualified entities for purposes of making presumptive eligibility determinations or adds additional populations as described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L. Indicate if any designated entities are permitted to make presumptive eligibility determinations only for specified populations.

Please describe the designated entities or additional populations and any limitations related to the specified populations or number of allowable PE periods.

4. ____ The agency adopts a total of ____ months (not to exceed 12 months) continuous eligibility for children under age enter age ____ (not to exceed age 19) regardless of changes in circumstances in accordance with section 1902(e)(12) of the Act and 42 CFR 435.926.
5. ____ The agency conducts redeterminations of eligibility for individuals excepted from MAGI-based financial methodologies under 42 CFR 435.603(j) once every ____ months (not to exceed 12 months) in accordance with 42 CFR 435.916(b).
6. ____ The agency uses the following simplified application(s) to support enrollment in affected areas or for affected individuals (a copy of the simplified application(s) has been submitted to CMS).
 - a. ____ The agency uses a simplified paper application.
 - b. ____ The agency uses a simplified online application.
 - c. ____ The simplified paper or online application is made available for use in call-centers or other telephone applications in affected areas.

Section C – Premiums and Cost Sharing

1. ____ The agency suspends deductibles, copayments, coinsurance, and other cost sharing charges as follows:

Please describe whether the state suspends all cost sharing or suspends only specified deductibles, copayments, coinsurance, or other cost sharing charges for specified items and services or for specified eligibility groups consistent with 42 CFR 447.52(d) or for specified income levels consistent with 42 CFR 447.52(g).

2. ____ The agency suspends enrollment fees, premiums and similar charges for:
 - a. ____ All beneficiaries
 - b. ____ The following eligibility groups or categorical populations:

Please list the applicable eligibility groups or populations.

3. ____ The agency allows waiver of payment of the enrollment fee, premiums and similar charges for undue hardship.

Please specify the standard(s) and/or criteria that the state will use to determine undue hardship.

Section D – Benefits

Benefits:

- 1. The agency adds the following optional benefits in its state plan (include service descriptions, provider qualifications, and limitations on amount, duration or scope of the benefit):

- 2. The agency makes the following adjustments to benefits currently covered in the state plan:

Due to the federal and state-declared disaster emergency, New York State has directed individuals to remain at home as much as possible to stop the spread of Novel Coronavirus 2019. In order to ensure individuals with mental health conditions are able to receive medically necessary mental health services during this time and ensure providers of such services are reimbursed for the services they are able to perform consistent with State-issued guidance, the State requests the following adjustments to benefits currently covered in the state plan:

1. For Clinic Treatment Services, authorized under the clinic and outpatient hospital services benefit, adjust requirement related to formal treatment plan review, as specified on page 2(a)(v) of the Supplements to Attachments 3.1-A and B of the Plan, as follows:

“A physician must see the patient at least once, approve the patient’s treatment plan, and periodically review the need for continued care. However, during the disaster emergency, initial treatment plans shall be developed within practicable timeframes and periodic reviews shall be postponed. Providers may work under existing, physician-approved treatment plans, provide additional services as needed to ensure continuity of care and address mental health needs related to the disaster emergency, and document such services in a progress note.

“Medically necessary Clinic Treatment Services are documented in a treatment plan which is signed by a physician and reviewed on a periodic basis. However, during the disaster emergency, initial treatment plans shall be developed within practicable timeframes and periodic reviews shall be postponed. Providers may work under existing, physician-approved treatment plans, provide additional services as needed to ensure continuity of care and address mental health needs related to the disaster emergency, and document such services in a progress note.”

2. For Partial Hospitalization Services, authorized under the clinic and outpatient hospital services benefit, adjust requirements related to clinical assessment and formal treatment plan review, as specified on page 2(a)(v)-(vi) of the Supplements to Attachments 3.1-A and B of the Plan, as follows:

“Partial Hospitalization Services are provided based upon the clinical assessment of an individual’s mental, physical and behavioral condition and history, which is the basis for establishing the individual’s diagnosis, functional deficits, and recovery goals. However, during the disaster emergency, the clinical assessment process may be modified as needed based on clinical judgment. Practitioners can complete a partial assessment based on clinical judgment when the provider may not be able to complete and document all of the elements of the assessment which

could have been provided in an office-based setting. “Medically necessary Partial Hospitalization Services are documented in a treatment plan which is signed by a physician and reviewed on a periodic basis. However, during the disaster emergency, initial treatment plans shall be developed within practicable timeframes and periodic reviews shall be postponed. Providers may work under existing, physician-approved treatment plans, provide additional services as needed to ensure continuity of care and address mental health needs related to the disaster emergency, and document such services in a progress note.”

3. For Continuing Day Treatment Services, authorized under the clinic and outpatient hospital services benefit, adjust requirements related to formal treatment plan review and assessment as specified on page 2(a)(vi)-(vii) of the Supplements to Attachments 3.1-A and B of the Plan, as follows:

“Continuing Day Treatment Services are provided based upon the clinical assessment of an individual’s mental, physical and behavioral condition and history, which is the basis for establishing the individual’s diagnosis, functional deficits, and recovery goals. However, during the disaster emergency, the clinical assessment process may be modified as needed based on clinical judgment. Practitioners can complete a partial assessment based on clinical judgment when the provider may not be able to complete and document all of the elements of the assessment which could have been provided in an office-based setting.

“Medically necessary Continuing Day Treatment Services are documented in a treatment plan which is signed by a physician and reviewed on a periodic basis. However, during the disaster emergency, initial treatment plans shall be developed within practicable timeframes and periodic reviews shall be postponed. Providers may work under existing, physician-approved treatment plans, provide additional services as needed to ensure continuity of care and address mental health needs related to the disaster emergency, and document such services in a progress note.”

4. For Day Treatment Services for Children, authorized under the clinic and outpatient hospital services benefit, adjust requirements related to formal treatment plan review specified on page 2(v) of the Supplements to Attachments 3.1-A and B of the Plan, as follows:

“A physician must see the patient at least once, approve the patient’s treatment plan, and periodically review the need for continued care. However, during the disaster emergency, initial treatment plans shall be developed within practicable timeframes and periodic reviews shall be postponed. Providers may work under existing, physician-approved treatment plans, provide additional services as needed to ensure continuity of care and address mental health needs related to the disaster emergency, and document such services in a progress note.”

5. For Personalized Recovery Oriented Services, authorized under the other rehabilitative services benefit, adjust requirements related to individualized recovery plans, as specified on pages 3b-2-3b-12.1 of the Supplements to Attachments 3.1-A and B of the Plan, as follows:

“PROS services are delivered in accordance with documented Individualized Recovery Plans which, at a minimum, must include a description of the individual's strengths, resources, including collaterals, and mental health-related barriers that interfere with functioning; a statement of the individual's recovery goals and program participation objectives; an individualized course of action to be taken, including the specific services to be provided, the expected frequency of service delivery, the expected duration of the course of service delivery, and the anticipated outcome:

criteria to determine when goals and objectives have been met: a relapse prevention plan: and a description and goals of any linkage and coordination activities with other service providers.

“For individuals receiving Intensive Rehabilitation, Ongoing Rehabilitation and Support or Clinical Treatment Services, the Individualized Recovery Plan shall identify the reasons why these services are needed, in addition to Community Rehabilitation and Support services, to achieve the individual's recovery goals. However, during the disaster emergency, individualized recovery plans shall be developed within practicable timeframes. Additionally, services may be provided under existing, approved recovery plans and additional services may be provided as needed to ensure continuity of care and address mental health needs related to the disaster emergency, which must be documented in a progress note.”

6. For Assertive Community Treatment Services, adjust minimum contact requirements specified on page 3b-1 of the Supplements to Attachments 3.1-A and B of the Plan, as follows:

“Services will be provided under the supervision of a psychiatrist by a multidisciplinary team which meets with the recipient or the recipient’s significant others a minimum of three times per month. Such contacts may occur using approved telehealth technology. Of these three contacts, at least two of the contacts must be with the Medicaid recipient. Step down services may be provided to clients found by the team to be no longer in need of full ACT team services. A client who is receiving ACT step down must receive a minimum of one contact per month. This contact may also be with a collateral for the benefit of the beneficiary.”

7. For Rehabilitative Services for residents of community-based residential programs licensed by the Office of Mental Health, adjust approved service plan requirement as specified on pages 3a-3b of the Supplements to Attachments 3.1-A and B of the Plan, as follows:

“All services must be provided pursuant to a physician’s written authorization and provided in accordance with an approved service plan, as described in 14 NYCRR 593. However, during the disaster emergency, services may be provided under existing, approved service plans and additional services may be provided as needed to ensure continuity of care and address mental health needs related to the disaster emergency, which must be documented in a progress note. In addition, services may be provided to residents and eligible for reimbursement during a period of non-residence, if the resident’s absence from the residence is due to COVID-19.”

8. For Rehabilitative Services for residents of residential addiction providers certified by the Office of Addiction Services and Supports, adjust approved service plan requirement as specified on pages 3a-37(vii) and 3b-37(vii) of the Supplements to Attachments 3.1-A and B of the Plan, as follows:

Services are subject to prior approval, must be medically necessary and must be recommended “by a licensed practitioner or physician, who is acting within the scope of his/her professional license and applicable state law ... to promote the maximum reduction of symptoms and/or restoration of an individual to his/her best age-appropriate functional level according to an individualized treatment plan.” However, during the disaster emergency, services may be provided under existing, approved treatment plans and additional services may be provided as

needed to ensure continuity of care and address addiction needs related to the disaster emergency, which must be documented in a progress note.

The following language shall be added to pages 3a-37(vii) and 3b-37(vii) of the Supplements to Attachments 3.1-A and B of the Plan: During a declared disaster emergency, Residential Addiction providers are authorized to deliver rehabilitative services to individuals in a variety of settings in the community who have been discharged from the residential setting or were not admitted due to adjustments to programs necessitated by the emergency.

9. For Rehabilitative Services delivered by Outpatient Addiction providers certified by the Office of Addiction Services and Supports, adjust approved service plan requirement as specified on pages 3a-37 (iii) and 3b-37 (iii) of the Supplements to Attachments 3.1-A and B of the Plan, as follows: “Services must be medically necessary and must be recommended by a licensed practitioner or physician, who is acting within the scope of his/her professional license and applicable state law ... to promote the maximum reduction of symptoms and/or restoration of an individual to his/her best age-appropriate functional level according to an individualized treatment plan. However, during the disaster emergency, services may be provided under existing, approved treatment plans and additional services may be provided as needed to ensure continuity of care and address addiction needs related to the disaster emergency, which must be documented in a progress note.”

10. During the Public Health Emergency, New York State seeks permission to expand medical sites to include locations that would not otherwise serve as places for laboratory services. This request includes alternate locations for specimen collection and laboratory testing, an exemption to 42 CFR 440.30(b). These temporary locations include but are not limited to the following: non-hospital buildings, parking lots, vehicles, pharmacies, community sites and patient homes. Reimbursement for COVID-19 specimen collection and COVID-19 laboratory tests are 100% of the Medicare fees. The Laboratory Fee Schedule can be found here: <https://www.emedny.org/ProviderManuals/Laboratory/index.aspx>.

Providing specimen collection and laboratory testing at these additional temporary locations will prevent the potential spread of the virus.

11. For Other Licensed Practitioner Services, as specified on page 2(xiv)(a) of the Supplements to Attachments 3.1-A and B of the Plan, adding language as follows: Pharmacists, pharmacy interns, pharmacy technicians, and pharmacies are qualified providers of COVID-19 vaccinations, specimen collection, and testing per the HHS COVID-19 PREP Act Declaration and authorizations”.

12. Suspend continuing education and in-person training requirements for providers of Crisis Intervention, Community Psychiatric Supports and Treatment, Psychosocial Rehabilitation, Family Peer Support Services, and Youth Peer Support Services, as specified on pages 3b of Attachment 3.1-A. Such trainings will be conducted remotely, whenever possible.

3. The agency assures that newly added benefits or adjustments to benefits comply with all applicable statutory requirements, including the statewide requirements found at 1902(a)(1), comparability requirements found at 1902(a)(10)(B), and free choice of provider requirements found at 1902(a)(23).
4. Application to Alternative Benefit Plans (ABP). The state adheres to all ABP provisions in 42 CFR Part 440, Subpart C. This section only applies to states that have an approved ABP(s).
- a. The agency assures that these newly added and/or adjusted benefits will be made available to individuals receiving services under ABPs.
- b. Individuals receiving services under ABPs will not receive these newly added and/or adjusted benefits, or will only receive the following subset:

Please describe

Telehealth:

5. The agency utilizes telehealth in the following manner, which may be different than outlined in the state's approved state plan:

During the emergency **all** Medicaid providers in **all** situations may use a wide variety of communication methods to deliver services remotely, to the extent it is appropriate for the care of the member, the type of service, and is within the provider's scope of practice. Varying levels of reimbursement for telephonic assessment, monitoring, and evaluation and management services provided to members are available in cases where face-to-face visits may not be recommended, and it is appropriate for the member to be evaluated and managed by telephone. Telephonic communication will be covered when provided by any qualified practitioner or service provider. All telephonic encounters documented as appropriate by the provider would be considered medically necessary for payment purposes in Medicaid FFS or Medicaid Managed Care.

This applies to all Medicaid providers and providers contracted to serve Medicaid members under Medicaid managed care plans.

Therefore, during the disaster emergency, telehealth includes telephonic, telemedicine, store and forward, and remote patient monitoring. Telemedicine is the term used in this guidance to denote two-way audiovisual communication. During the Public Health Emergency, all telehealth applications will be covered at all originating and distant sites as appropriate to properly care for the patient.

Additional telehealth reimbursement information during the emergency can be found in the Telehealth Payment section of this document.

Drug Benefit:

6. The agency makes the following adjustments to the day supply or quantity limit for covered outpatient drugs. The agency should only make this modification if its current state plan pages have limits on the amount of medication dispensed.

Please describe the change in days or quantities that are allowed for the emergency period and for which drugs.

7. Prior authorization for medications is expanded by automatic renewal without clinical review, or time/quantity extensions.

8. The agency makes the following payment adjustment to the professional dispensing fee when additional costs are incurred by the providers for delivery. States will need to supply documentation to justify the additional fees.

Please describe the manner in which professional dispensing fees are adjusted.

9. The agency makes exceptions to their published Preferred Drug List if drug shortages occur. This would include options for covering a brand name drug product that is a multi-source drug if a generic drug option is not available.

Section E – Payments*Optional benefits described in Section D:*

1. Newly added benefits described in Section D are paid using the following methodology:

- a. Published fee schedules –

Effective date (enter date of change): 5/22/2020

Location (list published location): _____

- b. Other:

Reimbursement for certain covered countermeasures against COVID-19 (COVID-19 PREP Act declaration) including administration of certain vaccines, specimen collection and COVID-19-related tests at pharmacy locations. Reimbursement for COVID-19 tests and specimen collection is 100% of the Medicare fees. Other test fees (i.e., flu, RSV) are equal

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Supersedes TN: NEW

Approval Date: 05/12/2021
Effective Date: 03/01/2020

to those on the Laboratory Fee Schedule (<https://www.emedny.org/ProviderManuals/Laboratory/index.aspx>). Reimbursement for COVID-19 vaccine administration is equal to NYS Medicaid fees for non-VFC vaccines (\$13.23). Payment will be made to the pharmacy for specimen collection, vaccine administration, or testing performed by pharmacists, pharmacy interns, or pharmacy technicians. Further information on COVID-19 specimen collection, testing, and vaccine administration at pharmacies can be found at the following link: https://www.health.ny.gov/health_care/medicaid/covid19/. In cases where vaccine administration is separately reimbursable at a fee amount, New York plans to reimburse a set fee of \$13.23 for the administration fee of the 1st COVID-19 vaccine and \$13.23 for the administration fee of the 2nd COVID vaccine. Reimbursement to a qualified facility operated by the Indian Health Service, tribal government(s), or urban Indian health program (I/T/U) will be reimbursed the same as a non-tribal FQHC. If the facility provides comprehensive clinic services above vaccine administration and all services related to administration, the facility can bill the outpatient Office of Management and Budget (OMB) rate.

Increases to state plan payment methodologies:

2. The agency increases payment rates for the following services:

ICF/IID Service.

- a. Payment increases are targeted based on the following criteria:

The ICF/IID supplemental payment is to fund ICF/IID active treatment during weekday/daytime hours not captured in the current rate setting methodology. The ICF/IID active treatment services will continue to be delivered in accordance with 42 CFR § 440.150 and with the individual’s Comprehensive Functional Assessment as defined in 42 CFR 483.440(c)(3).

- b. Payments are increased through:

- i. A supplemental payment or add-on within applicable upper payment limits:

Effective March 17, 2020, for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID) a supplemental payment will be made available to reimburse ICF/IID providers for day-time weekday service hours when the provision of active treatment outside the residence is not possible because the external treatment facility is closed or not accepting patients due to the COVID-19 public health emergency. The additional funding will be provided as a supplemental payment to ICF/IID providers. ICF/IIDs rates are based on the cost

and staffing schedule in use during a period prior to COVID. The Direct Care Staffing model in place prior to COVID is one where residents left the ICF during weekday/daytime hours to attend day services at an outside facility. Outside day facilities were mandated to be closed in the period from March 18 through early July 2020. After the end of mandatory closures, day service facilities have slowly reopened and at very limited capacities due to required safety protocols. When ICF residents cannot attend their outside day facility, the ICF must provide full staffing during the weekday/daytime hours and these hours are not funded via the ICF rate.

The supplemental payment will be available to ICF/IID providers until the earliest of:

(1) end of the public health emergency; or (2) at such a time when outside treatment facilities are permitted to safely resume operations at a capacity sufficient to provide the individual access to day services. This would capture those instances where the provider is able to operate at a limited capacity to ensure social distancing, but there is not sufficient capacity for all individuals to return to day services.

In cases where the Day Facility has a limited capacity due to social distancing requirements, only individuals who are not receiving services at the Day Facility will be eligible for the daily ICF/IID supplemental payment. Payment edits in the NY MMIS (eMedNY) will not allow same day claims for the ICF/IID supplemental payment and a service payment to the Day Facility.

Government-operated ICFs/IID are not eligible for the supplemental payments described in this section. The supplemental payment will be a regional fee as follows:

<u>Rate Setting Region</u>	<u>Week-Day Daily Fee</u>
1	\$111.02
2	\$124.89
3	\$103.39

OPWDD will continually monitor capacity at Day Facilities and local conditions related to COVID-19 cases that would impact Day Facility operations.

ii. An increase to rates as described below.

Rates are increased:

Uniformly by the following percentage: _____

Through a modification to published fee schedules –

Effective date (enter date of change): _____

Location (list published location): _____

_____ Up to the Medicare payments for equivalent services.

___X___ By the following factors:

Facilities and institutional settings (inpatient, nursing facilities) are eligible for reimbursement of the COVID-19 vaccine administration fee (\$13.23 per dose) above the facility rate, during the state of emergency.

Payment for services delivered via telehealth:

3. ___X___ For the duration of the emergency, the state authorizes payments for telehealth services that:
- a. ___X___ Are not otherwise paid under the Medicaid state plan;
 - b. _____ Differ from payments for the same services when provided face to face;
 - c. _____ Differ from current state plan provisions governing reimbursement for telehealth;

Describe telehealth payment variation.

Telephonic Reimbursement:

Reimbursement for telephonic services provided during the emergency is equal to the professional fee paid to a physician for an in-person visit.

Provider Reimbursement:

Physician/NP/PA/Midwife CPT Code 99421 = \$12.56, CPT Code 99422 = \$23.48, CPT Code 99423 = \$37.41

<https://www.emedny.org/ProviderManuals/Physician/index.aspx>

<https://www.emedny.org/ProviderManuals/NursePractitioner/index.aspx>

<https://www.emedny.org/ProviderManuals/Midwife/index.aspx>

Dentist CPT Code D9991 = \$14.

<https://www.emedny.org/ProviderManuals/Dental/index.aspx>

Clinic Rate Chart:

Rate code	Description	Upstate	Downstate
4012	FQHC OFF-SITE SERVICES (INDIV)	\$64.97	\$72.73
4015	FQHC OFF-SITE SERVICES (SBHC)*	\$64.97	\$72.73
7961	NON-FQHC OFF-SITE SERVICES (INDIV)	\$64.97	\$72.73
7962	NON-FQHC OFF-SITE SERVICES (SBHC)*	\$64.97	\$72.73
7963	TELEPHONE E & M; 5-10 MINUTES		\$12.56
7964	TELEPHONE E & M; 11-20 MINUTES		\$23.48
7965	TELEPHONE E & M; 21-30 MINUTES		\$37.41
7966	TELEPHONE E & M; 5-10 MINUTES (SBHC)*		\$12.56
7967	TELEPHONE E & M; 11-20 MINUTES (SBHC)*		\$23.48
7968	TELEPHONE E & M; 21-30 MINUTES (SBHC)*		\$37.41

Although the dollar amounts assigned to the rate codes for telephonic services are the same for each facility, dollar amounts for rate codes are not published. They are generally facility specific and a letter with the rate information is sent to the provider once a rate has been assigned. Please see examples included with the Department's response.

Store and Forward:

Reimbursement for store and forward services during the emergency period is increased from 75% to 100% of a face-to-face visit.

Remote Patient Monitoring:

Remote Patient Monitoring requires a minimum of 30 minutes of time per month. During the Public Health Emergency, the time requirement for monitoring COVID-19 positive patients has been lowered from a minimum of 30 minutes to 10 minutes per month. The fee and all other billing requirements remain the same.

During the emergency a clinic or practitioner may bill rate code "Q3014" for administrative expenses in addition to a bill for the telemedicine (audio/visual) services provided. Reimbursement for "Q3014" is \$25.76.

- d. Include payment for ancillary costs associated with the delivery of covered services via telehealth, (if applicable), as follows:
- i. Ancillary cost associated with the originating site for telehealth is incorporated into fee-for-service rates.
 - ii. Ancillary cost associated with the originating site for telehealth is separately reimbursed as an administrative cost by the state when a Medicaid service is delivered.

Other:

4. Other payment changes:

Adjustments to Outpatient Hospital, Clinic, and Other Rehabilitative Services, licensed or designated by the New York State Office of Mental Health for the treatment of mental health conditions, as follows:

1. For Partial Hospitalization Services, adjust the methodology specified on page 3k-3k(1) of Attachment 4.19-B of the Plan to change units of service contained in the state plan descriptions

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for rate codes 4351 and 4353 to reimburse providers of Partial Hospitalization Services that attempt, but are unable to deliver services under the standards set forth in the State Medicaid Plan due to the COVID-19 pandemic only and where such rate codes are used in conjunction with billing modifier code “CR” to denote instances where service delivery durations were impacted directly by the pandemic. Changes to the agency’s fee schedule rate descriptions are effective for services provided on or after March 1, 2020 and are the same for both governmental and private providers of Partial Hospitalization Services. The agency’s regional fee schedule rates for Partial Hospitalization Services remains unchanged, except as follows:

Rate Code with Modifier	Description	Long Island Region	NYC Region	Hudson River Region	Central Region	Western Region
4351-CR	Service at least 5 minutes in duration (minimum duration for rate code 4351 without modifier code is 6 hours)	Regional fees unchanged from Approved State Plan page 3k(1)				
4353-CR	Services including collateral of at least 5 minutes in duration (minimum duration for rate code 4353 without modifier code is 1 hour)	Regional fees unchanged from Approved State Plan page 3k(1)				

2. For Continuing Day Treatment Services, adjust the methodology specified on page 3(j.1)-3(j.2) of Attachment 4.19-B of the Plan to change units of service contained in the state plan descriptions for rate codes 4317 and 4325 to reimburse providers of Continuing Day Treatment Services that attempt, but are unable to deliver services under the standards set forth in the State Medicaid Plan due to the COVID-19 pandemic only and where such rate codes are used in conjunction with billing modifier code “CR” to denote instances where service delivery durations were impacted directly by the pandemic. Changes to the agency’s fee schedule rate descriptions are effective for services provided on or after March 1, 2020 and are the same for both governmental and private providers of Continuing Day Treatment Services. The agency’s regional and statewide fee schedules for Continuing Day Treatment Services remain unchanged, except as follows:

CDT Services provided by Freestanding Clinics:

Rate Code with Modifier	Description	Downstate Region	Western Region	Upstate Region
4311-CR	Sustained, attempted contact with enrolled patients (minimum duration for rate code 4311 without modifier code is 2 hours)	Regional fees unchanged from Approved State Plan page 3(j.1)		
4317-CR	Service at least 5 minutes in duration (minimum duration for rate code 4317 without modifier code is 4 hours)	Regional fees unchanged from Approved State Plan pages 3(j.1)		
4325-CR	Services including collateral of at least 5 minutes in duration (minimum duration for rate code 4325 without modifier code is a 30 minutes)	Regional fees unchanged from Approved State Plan pages 3(j.1)		

CDT Services provided by Hospitals-Based, including State-operated, outpatient providers:

Rate Code with Modifier	Description	Statewide Rate
4311-CR	Sustained, attempted contact with enrolled patients (minimum duration for rate code 4311 without modifier code is 2 hours)	Statewide fees unchanged from Approved State Plan pages 3(j.1a) and 3(j.2)
4317-CR	Service at least 5 minutes in Duration (minimum duration for rate code 4317 without modifier code is 4 hours)	Statewide fees unchanged from Approved State Plan pages 3(j.1a) and 3(j.2)
4325-CR	Services including collateral of at least 5 minutes in duration (minimum duration for rate code 4325 without modifier code is a 30 minutes)	Statewide fees unchanged from Approved State Plan pages 3(j.1a) and 3(j.2)

3. For Day Treatment Services for Children adjust the methodology specified on page 3k(2)-3k(4) of Attachment 4.19-B of the Plan to change units of service contained in the state plan descriptions for rate codes 4060 and 4066 to reimburse providers of Day Treatment Services for Children that attempt, but are unable to deliver services under the standards set forth in the State Medicaid Plan due to the COVID-19 pandemic only and where such rate codes are used in conjunction with billing modifier code "CR" to denote instances where service delivery durations were impacted directly by the pandemic. Changes to the agency's fee schedule rate descriptions are effective for services provided on or after March 1, 2020 and are the same for both governmental and private providers of Day Treatment Services for Children. The agency's regional and statewide fee schedules for Day Treatment Services remain unchanged, except as follows:

Children's Day Treatment Services provided by Freestanding Clinics and Hospital-Based outpatient providers, not including State-operated providers:

Rate Code	Description	NYC Only	Rest of State (including Long Island)
4060-CR	Service at least 5 minutes in Duration (minimum duration for rate code 4060 without modifier code is more than 5 hours)	Regional fees unchanged from Approved State Plan pages 3k(2), 3k(4)	
4061-CR	Sustained, attempted contact with enrolled patients (minimum duration for rate code 4061 without modifier code is 3 hours)	Regional fees unchanged from Approved State Plan pages 3k(2), 3k(4)	
4066-CR	Services including collateral of at least 5 minutes in duration (minimum duration for rate code 4066 without modifier code is a 30 minutes)	Regional fees unchanged from Approved State Plan pages 3k(2), 3k(4)	

Children's Day Treatment Services provided by State-Operated outpatient programs:

Rate Code	Description	Statewide
4060-CR	Service at least 5 minutes in Duration (minimum duration for rate code 4060 without modifier code is more than 5 hours)	Regional fees unchanged from Approved State Plan pages 3k(3)
4061-CR	Sustained, attempted contact with enrolled patients (minimum duration for rate code 4061 without modifier code is 3 hours)	Regional fees unchanged from Approved State Plan pages 3k(3)
4066-CR	Services including collateral of at least 5 minutes in duration (minimum duration for rate code 4066 without modifier code is a 30 minutes)	Regional fees unchanged from Approved State Plan pages 3k(3)

4. Effective March 1, 2020, for Personalized Recovery Oriented Services, adjust the methodology specified on pages 3L-2-3L-4 of Attachment 4.19-B of the Plan to change units of service to reimburse providers that attempt, but are unable to deliver services under the standards set forth in the State Medicaid Plan due to the COVID-19 pandemic only and where applicable billing codes are used in conjunction with billing modifier code "CR" to denote instances where service delivery durations were impacted directly by the pandemic, as follows:

Tier 1-CR (minimum units of service for tier 1 without crisis "CR" modifier is 2 hours per month): for the delivery of at least one service for a minimum duration of at least 5 minutes for an individual service or 15 minutes for a group service or documented attempts to contact clients, or Tier 3-CR (minimum units of service for tier 3 without crisis "CR" modifier is 28 hours per month): for the delivery of at least 4 services for a minimum duration of at least 5 minutes for an individual service or 15 minutes for a group service.

Monthly rates for tiers 1 and 3 remain unchanged from the Medicaid State Plan.

5. Effective March 1, 2020, for Assertive Community Treatment (ACT) Services, adjust the methodology specified on page 3M of Attachment 4.19-B of the Plan to change units of service to reimburse providers of ACT services the full payment for rendering services a minimum of three times per month, or one time per month for partial payment where providers are unable to deliver services under the standards set forth under the State Medicaid Plan due to the COVID-19 pandemic only and where applicable billing codes are used in conjunction with billing modifier code "CR" to denote instances where service delivery durations were impacted directly by the pandemic. For full ACT payment, at least two of the three contacts must be with the Medicaid recipient. For partial payment, contact can be with either the Medicaid recipient or a collateral for the benefit of the recipient.

For all services outlined above, the New York State Office of Mental Health will review claims submitted during the emergency period and may recoup any reimbursement in excess of historical revenues or actual cost.

6. Adjustments to Children and Family Treatment and Support Services, i.e. Other Licensed Practitioner, Crisis Intervention, Community Psychiatric Supports and Treatment, Psychosocial Rehabilitation, Family Peer Support Services, and Youth Peer Support Services, as specified on pages 3b of Attachment 3.1-A, to allow for payment of shorter durations, beginning at a minimum of 5 minutes for one billable unit, where providers are unable to deliver services under the standards set forth in the State Medicaid Plan due to the COVID-19 pandemic, as follows:

Range of Minutes	Billable Minutes	Billable Units (15 minutes per unit)
Under 5 minutes	1-4 minutes	Not billable
5-19 minutes	15 minutes	1 unit
20-34 minutes	30 minutes	2 units
35-49 minutes	45 minutes	3 units
50-64 minutes	60 minutes	4 units
65-79 minutes	75 minutes	5 units
80-94 minutes	90 minutes	6 units
95-109 minutes	105 minutes	7 units
110-124 minutes	120 minutes	8 units

Section F – Post-Eligibility Treatment of Income

1. The state elects to modify the basic personal needs allowance for institutionalized

Adjustments to Outpatient Addiction Rehabilitative Services certified or designated by the New York State Office of Addiction Services and Supports, as follows:

1. Adjustments to Outpatient Addiction Rehabilitative Services - adjust the methodology specified on pages 10(a.2)-10 (a.3) of Attachment 4.19-B of the Plan to permit providers to bill identified base rates and associated procedure codes, for the delivery of services for shorter durations due to the COVID-19 pandemic, including documented attempts to contact clients, consistent with State-issued guidance.

2. Adjustments to Opioid Treatment Services – adjust the methodology specified on pages 10(a.2)-10 (a.3) of Attachment 4.19-B of the Plan to permit services delivered by Opioid Treatment Agencies to be billed in bundled weekly payments based on the 2020 Medicare published rates for opioid use disorder (OUD) treatment services. Patients receive at least 7 days of take home medication, consistent with state-issued guidance. *Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of opioid treatment program services. The agency's fee schedule rate was set as of March 16, 2020 and is effective for services provided on or after that date. All rates are published on the OASAS website." The fee schedule is based on 2020 Medicare Published payments for a weekly bundle of services provided within an Opioid Treatment Agency, with additional fees for take home medications consistent with state guidance.*

individuals. The basic personal needs allowance is equal to one of the following amounts:

- a. The individual's total income
 - b. 300 percent of the SSI federal benefit rate
 - c. Other reasonable amount: _____
2. The state elects a new variance to the basic personal needs allowance. (Note: Election of this option is not dependent on a state electing the option described the option in F.1. above.)

The state protects amounts exceeding the basic personal needs allowance for individuals who have the following greater personal needs:

Please describe the group or groups of individuals with greater needs and the amount(s) protected for each group or groups.

Section G – Other Policies and Procedures Differing from Approved Medicaid State Plan /Additional Information

For Health Homes serving Adults, Children and Care Coordination Organization /Health Homes:

1. Waive all face-to-face requirements for Health Home Serving Adults, Health Homes Serving Children, and Care Coordination Organization/Health Homes and that CMS waive the requirements for written member consents and member signatures on plans of care and life plans; verbal consents would be documented in the member record.
2. Annual reassessment and the requirement to annually update the life plans/plan of care be waived until further notification by the DOH.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148 (Expires 03/31/2021). The time required to complete this information collection is estimated to average 1 to 2 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. Your response is required to receive a waiver under Section 1135 of the Social Security Act. All responses are public and will be made available on the CMS web site. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. ***CMS Disclosure*** Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact the Centers for Medicaid & CHIP Services at 410-786-3870.

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