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State/Territory Name: New York

State Plan Amendment (SPA) #: 21-0054

This file contains the following documents in the order listed:

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

June 28, 2023

Amir Bassiri
Medicaid Director
Office of Health Insurance Programs
New York State Department of Health
One Commerce Plaza Rm. 1605
Albany, NY 12237

Re: New York State Plan Amendment (SPA) 21-0054

Dear Director Bassiri:

We have reviewed the proposed amendment and accompanying section 1135 waiver to add section 7.4 Medicaid Disaster Relief for the COVID-19 National Emergency to your Medicaid state plan, as submitted on April 3, 2023 under transmittal number NY-21-0054. 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 6 PM 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 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 or modifications 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 Transmittal Number 21-0054 is approved effective April 1, 2021. This SPA is in addition to all previously approved Disaster Relief SPAs and does not supersede anything approved in those SPAs.

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

Please contact Melvina Harrison at 212-616-2247 or by email at Melvina.Harrison@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.

Sincerely,

Alissa M. Deboy -S

Digitally signed by Alissa M. Deboy -S
Date: 2023.06.28 08 23:31 -04'00'

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

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: 21-0054

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
April 01, 2021

5. FEDERAL STATUTE/REGULATION CITATION
§1905(a)(4)(B), 1905(r), 1905(a)(13)(c), 1902(a), 1945

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 04/01/21-09/30/21 $ 8,201,577
b. FFY 10/01/21-09/30/22 $ 16,403,154

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
~~Attachment: 7.4 - TBD~~ Attachment 7.4 Pages 48,49,50,51,52,53,54,55,56,57,58,59

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*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

9. SUBJECT OF AMENDMENT

CFTSS
(FMAP=50%)

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:

[redacted]AGENCY OFFICIAL

Amir Bassiri

13. TITLE
Medicaid Director

14. DATE SUBMITTED
April 3, 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
April 3, 2023

17. DATE APPROVED
June 28, 2023

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
April 1, 2021

19. SIGNATURE OF APPROVING OFFICIAL
Alissa M. Deboy -S
Digitally signed by Alissa M. Deboy -S
Date: 2023.06.28 08:23:49 -04'00'

20. TYPED NAME OF APPROVING OFFICIAL
Alissa Mooney DeBoy on Behalf of Anne Marie Costello

21. TITLE OF APPROVING OFFICIAL
Deputy Director
Center for Medicaid and CHIP Services

22. REMARKS

The state authorized the following pen and ink changes:

Box 7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 7.4 Pages 48,49,50,51,52,53,54,55,56,57,58,59
Box 8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable)
N/A

Instructions on Back

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:

This provision for rate increases for Child and Family Treatment and Support Services is effective April 1, 2021 through September 30, 2022. The provision for rate increase for Article 29-I Core Health Related Services will be effective July 1, 2021 through September 30, 2022. The administrative fee for Health Homes Serving Children to conduct HCBS level of care eligibility determinations will be effective April 1, 2021, through September 30, 2022.

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

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

a. __x__ 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. _x__ 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).

c. x Tribal consultation requirements – the agency requests modification of tribal consultation timelines specified in [insert name of 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 income methodologies:

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 inconsistences 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:

3. _ The agency assures that newly added benefits or adjustments to benefits comply with all applicable statutory requirements, including the statewideness 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:

Please describe.

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): _____

Location (list published location): _____

b. Other:

Describe methodology here.

Increases to state plan payment methodologies:

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

Children and Family Treatment and Support Services (CFTSS) – PSR, CPST, Crisis, Family Peer Support Services and Youth Peer Support and Training and for Voluntary Foster Care Agencies 29I Health Facilities Core Health Services.

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

NYS DOH will increase payment for the providers that provide CFTSS, and 29-I Core Health Services, and will begin reimbursing Health Homes to conduct HCBS assessments, as referenced in the NYS DOH Spending Plan for Implementation of American Rescue Plan Act of 2021, Section 9817 and that are listed in Appendix B, or could be listed in Appendix B, of the American Rescue Plan Act, State Medicaid Director Letter, SMD#21-003 Implementation of American Rescue Plan Act of 2021 Section 9817.

These time limited funds for all claims for the identified services for dates of services between April 1, 2021, through September 30, 2022, for CFTSS and July 1, 2021, through September 30, 2022, for the 29I Health Facilities to build service capacity.
The HCBS Level of Care determination fee is based upon the annual assessment being conducted timely as outlined in the Children's Waiver.

b. Payments are increased through:

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

ii. _X___ An increase to rates as described below.

Rates are increased:

__X___ Uniformly by the following percentage: _25% on CFTSS (an additional 14% above the current 11% authorized under NY SPA 20-0036 and 25% on 29I Health Facilities Core Per Diem rates (based upon current rates).

__X___ Through a modification to published fee schedules –

Effective date (enter date of change): ___April 1, 2021_____

Location (list published location): _ Children and Family Treatment and Support Services (ny.gov)_and 29-I Health Facility (VFCA transition) (ny.gov)_____

_____ Up to the Medicare payments for equivalent services.

_____ By the following factors:

Please describe.

Payment for services delivered via telehealth:

3. _ For the duration of the emergency, the state authorizes payments for telehealth services that:

a.__ 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.

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:

__X__ Other payment changes Section F – Post-Eligibility Treatment of Income

The Health Homes (HH) HCBS assessment fee will compensate the HH for the costs associated with conduct of:

- *Evaluation and/or re-evaluation of HCBS level of care;*
- *Assessment and/or reassessment of the need for HCBS;*
- *Inclusion of all aspects of an HCBS Plan of Care in the HH's Comprehensive Care Plan.*

A one-time assessment fee of $200 annually per member within the period of April 1, 2021, through September 30, 2022. This fee will be paid in addition to the PMPM calculated above and is contingent upon the Health Home completing a timely and complete assessment A Health Home SPA will be submitted to continue this fee beyond the noted timeframe.

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

Based upon the NYS Spending Plan for Implementation of the American Rescue Plan Act of 2021, section 9817, the following supplemental payment/grants will be provided to Children and Family Treatment and Support Services (CFTSS) and 29I Volunteer Foster Care Agencies Health Center providers:

1. CFTSS Rate Adjustment
Funding: $2.3M State Funds Equivalent
Lead Agency: DOH
Expenditure Authority: State Plan Amendment
Background: Since 2019, Medicaid has applied a rate adjustment on CFTSS rates based on the articulated need of providers for implementation funding and to develop capacity to meet the needs of children, youth, and families. CFTSS providers previously had an enhanced rate that reduced gradually to meet the base rate. Providers and stakeholders are reporting capacity concerns, resulting in access issues and waitlists for CFTSS. Additionally, more children and youth are presenting for behavioral health services, including CFTSS, due to the impact of COVID-19. These clinical Medicaid services are the entry point to assist children, youth and families in early intervention and prevent the need for institutional levels of care.
Proposal:
Eligible Providers: CFTSS providers
Description: Apply the 25% rate adjustment to CFTSS rates, including "off-site" rates, retroactive to April 1, 2021
Evaluation and Reporting: DOH, in conjunction with state agency partners will monitor utilization of these services to ensure expanded access

2.Health Home Serving Children (HHSC) Rate Adjustment
Funding: $0.6M State Funds Equivalent
Lead Agency: DOH
Expenditure Authority: State Plan Amendment
Background: HHSC was implemented in 2016 to provide care management and coordination to children and youth who had two or more chronic condition or a single qualifying condition. The HHSC program serves a variety of children and youth with physical and behavioral health needs. In 2019, with the inception of the consolidated HCBS Children´s Waiver, Health Home care management services were required to meet the care coordination requirements of the 1915(c) Children´s HCBS Waiver. Accordingly, Health Home care managers were now the entity that determined HCBS eligibility by conducting an additional assessment.

The HHSC program has an acuity assessment that is necessary within the program and incorporates a one-time assessment fee when assessing for a new enrollee. This assessment cannot be used for HCBS eligibility determination. The assessment that is now required for HCBS eligibility determination is an additional assessment for which Health Homes are not separately reimbursed but is nonetheless required to ensure proper service eligibility and delivery. The HCBS assessment requires additional training and skills to conduct. The Medicaid program pays Health Home care managers to conduct HCBS eligibility determinations for adults, but not children.

Proposal:
Eligible Providers: Health Homes Servicing Children.
Description: Provide a temporary annual assessment fee of $200 to Health Homes for conducting an HCBS eligibility determination retroactive to April 1, 2021.
Evaluation and Reporting: DOH, in conjunction with state agency partners will monitor utilization of these services to ensure expanded access and will monitor the length of time it takes for a child with a potential need for HCBS to be assessed and begin receiving services.

3.Support the Transition to Article 29-I Health Facility Core Limited Health Related Services

Funding: $8.6M State Funds Equivalent
Lead Agencies: DOH, OCFS
Expenditure Authority: State Plan Amendment

Background: New York Medicaid-covered children and youth in the care of Voluntary Foster Care Agencies (VFCAs) or placed in foster homes certified by LDSS are in the process of being enrolled in MMC Plans on July 1, 2021, including Mainstream MMC plans and HIV Special Needs Plans (HIV-SNPs), unless they are otherwise excluded or exempt from mandatory MMC. As a result of the pandemic, the transition date has been significantly impacted.

Access to comprehensive, high quality health care is essential to children and youth placed in foster care. Children and youth in the foster care system have higher rates of birth defects, developmental delays, mental/behavioral health needs, and physical disabilities than children and youth from similar socio-economic backgrounds outside of the foster care system. Children and youth in foster care have a high prevalence of medical and developmental problems and utilize inpatient and outpatient mental health services at a rate 15 – 20 times higher than the general pediatric Medicaid population. The impact of the trauma these children/youth experience is profound.[4] For this reason, it is essential that there be immediate access to services upon a child or youth´s placement in foster care, and no interruption in the provision of ongoing services as a result of this transition.

All Licensed Article 29-I Health Facilities are required to provide, or make available through a contract arrangement, all Core Limited Health-Related Services. The five Core Limited Health-Related Services play a vital role in assuring all necessary services are provided in the specified time frames; children, parents and caregivers are involved in the planning and support of treatment, as applicable; information is shared appropriately among professionals involved in the child´s care; and all health-related information and documentation results in a comprehensive, person-centered treatment plan. Core Limited Health-Related Services are reimbursed with a Medicaid residual per diem rate paid to 29-I Health Facilities on a per child, per day basis to cover the costs of these services. The services include: Skill Building (provided by Licensed Behavioral Health Practitioners (LBHPs) as described in Article 29-I VFCA Health Facilities License Guidelines and any subsequent updates); Nursing Services; Medicaid Treatment Planning and Discharge Planning; Clinical Consultation and Supervision Services; and VFCA Medicaid Managed Care Liaison and Administrator services.

The per diem rates established for these services were established prior to the pandemic and do not take into account the significant impact of the pandemic on children in the care of the 29-I Health Facilities, or the additional administrative burden on the providers of the delays in the transition of this population and the 29-I services into managed care.

Proposal:
Eligible Providers: Article 29-I Health Facilities

Description: Implement a rate adjustment of 25 percent, retroactive to April 1, 2021 for Article 29-I Health Facility Core Limited Health Related Services Per Diem Rates. This temporary increase would assist providers to build capacity to meet the increasing needs of children.

Evaluation and Reporting: DOH, in conjunction with state agency partners will monitor utilization of these services.

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.