

## **Table of Contents**

**State/Territory Name: New York**

**State Plan Amendment (SPA) #: 21-0073**

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) Summary Form (with 179-like data)
- 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



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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) 21-0073

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 March 30, 2023 under transmittal number NY-21-0073. 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 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 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 state's Medicaid SPA Transmittal Number 21-0073 is approved effective October 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.

Page 3 - Amir Bassiri

Please contact Melvina Harrison at 212-616-2247 or by email at [Melvina.Harrison@cms.hhs.gov](mailto: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 25:07 -04'00'

Alissa Mooney DeBoy  
On Behalf of Anne Marie Costello, Deputy 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 <u>2</u> <u>1</u> — <u>0</u> <u>0</u> <u>7</u> <u>3</u>	2. STATE <u>NY</u>
3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT <input checked="" type="radio"/> XIX <input type="radio"/> XXI	

TO: CENTER DIRECTOR  
CENTERS FOR MEDICAID & CHIP SERVICES  
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE  
**October 1, 2021**

5. FEDERAL STATUTE/REGULATION CITATION  
**§ 1905(a)(13), 1905(a)(8)**

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)  
a. FFY 10/01/21-09/30/22 \$ 64,181,274  
b. FFY 10/01/22-09/30/23 \$ 10,000,000

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT  
~~Attachment: TBD~~ **Attachment 7.4 Pages:  
60,61,62,63,64,65,66,67,68,69,70,71,72,73**

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable)  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

9. SUBJECT OF AMENDMENT

**Private Duty Nursing, OASAS HCBS and Rehab, OMH ACT, PROs and Rehab**

10. 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. TYPED NAME  
**Amir Bassiri**

13. TITLE  
**Medicaid Director**

14. DATE SUBMITTED  
**March 30, 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  
**March 30, 2023**

17. DATE APPROVED  
**June 28, 2023**

**PLAN APPROVED - ONE COPY ATTACHED**

18. EFFECTIVE DATE OF APPROVED MATERIAL  
**October 01, 2021**

19. SIGNATURE OF APPROVING OFFICIAL  
**Alissa M. Deboy -S**  
Digitally signed by Alissa M. Deboy -S  
Date: 2023.06.28  
08:25:25 -0400

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 authorizes the following pen and ink changes:**  
  
**Box 7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT  
Attachment 7.4 Pages: 60,61,62,63,64,65,66,67,68,69,70,71,72,73**  
  
**Box 8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable)  
N/A**

**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:

*SPA effective date is October 1, 2021*

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).

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- 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:

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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.*

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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).
- \_\_\_\_\_ The agency uses a simplified paper application.
  - \_\_\_\_\_ The agency uses a simplified online application.
  - \_\_\_\_\_ 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:
- \_\_\_\_\_ All beneficiaries
  - \_\_\_\_\_ The following eligibility groups or categorical populations:

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*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.   X   The agency makes the following adjustments to benefits currently covered in the state plan:

***OASAS Residential Reintegration***

Effective November 1, 2021, the Office of Addiction Services and Supports (OASAS) is adding the third element of OASAS Residential Reintegration to its FFS Medicaid benefit. The other two elements of the service, Residential Stabilization and Residential Rehabilitation, are already approved in FFS by CMS (SPA 16-0004). All three residential service elements must be recommended by a physician or other licensed practitioner of the healing arts.

For purposes of the section below, a Qualified Health Professional (QHP) is defined as any of the professionals listed in this paragraph, who are in good standing with the appropriate licensing or certifying authority, with a minimum of one year of experience or satisfactory completion of a training program in the treatment of addiction: (1) a credentialed alcoholism and substance abuse counselor (CASAC) who has a current valid credential issued by the OASAS, or a comparable credential, certificate or license from another recognized certifying body as determined by OASAS; (2) a counselor certified by and currently registered as such with the National Board for Certified Counselors; (3) a rehabilitation counselor certified by the Commission of Rehabilitation Counselor Certification; (4) a therapeutic recreation therapist certified by the National Council on Therapeutic Recreation or the American Therapeutic Recreation Association; or a person who holds a baccalaureate degree in a field allied to therapeutic recreation and, either before or after 7 receiving such degree, has five years of full-

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time, paid work experience in an activities program in a health care setting; (5) a professional licensed and currently registered as such by the New York State Education Department to include: (i) a physician who has received a doctor of medicine (M.D.) or doctor of osteopathy (D.O.) degree; (ii) a physician[']s assistant (PA); (iii) a certified nurse practitioner (NP); (iv) a registered nurse (RN); (v) a psychologist; (vi) an occupational therapist; (vii) a social worker (LMSW; LCSW), including an individual with a Limited Permit Licensed Master Social Worker (LP-LMSW) only if such person has a permit which designates the OASAS-certified program as the employer and is under the general supervision of a LMSW or a LCSW; and (viii) a mental health practitioner including: a licensed mental health counselor (LMHC), a marriage and family therapist (LMFT), a creative arts therapist (LCAT), and licensed psychoanalyst; and any mental health practitioner with a Limited Permit. A certified peer is not a QHP, but must be supervised by a QHP. To pursue certification as a Recovery Peer Advocate, an individual must meet the following minimum requirements: hold a high school diploma or have their GED and pass the International Certification and Reciprocity Consortium (IC-RC) exam; complete 46 hours of required training (advocacy, mentoring and education, recovery and wellness, and ethical responsibility); complete at least 500 hours of related volunteer or work experience; and complete at least 25 hours of supervision by qualified supervisory staff. The peer certification is active for two years and then needs to be renewed. The applicant needs 28 hours of recovery specific training (continuing education) in order to renew.

The Medicaid coverable services in Residential Reintegration (with the allowable practitioner types in parentheses) includes the following:

- individual or group counseling (any QHP, typically a CASAC, LCSW, or LMHC)
- psychosocial rehabilitation, including in adult life/living skills, addressing symptoms that interfere with employment, the management of urges, cravings, or lapses, emotional regulation, and skills in accessing services to support social needs (any QHP, but can also be a certified peer (if supervised by a QHP))
- 
- therapeutic recreation (recreation therapist, CASAC, licensed staff)
- peer supports (certified peer (if supervised by a QHP))
- medication management support (RN, LPN - an RN may also train certified counseling staff to observe self-medication)
- care coordination (any QHP, typically a CASAC)
- discharge planning (any QHP, typically a CASAC)

3.   X   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.   X   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.   X   The agency assures that these newly added and/or adjusted benefits will be made available to individuals receiving services under ABPs.

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- 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 – **Home and Community-Based Services Eligible (Rehab Services - Addiction)**

Residential Reintegration Service

Effective, November 1, 2021, the OASAS residential reintegration service is added to the already approved elements of the service, stabilization and reintegration, including temporary rate enhancements ending on June 30, 2022 for all three elements (see Section E for stabilization and rehabilitation fee changes), with fees for reintegration as follows:

Service Type			11/1/2021-6/30/2022 Fee		Post 6/30/2022	
			Upstate	Downstate	Upstate	Downstate
Residential Reintegration			\$173.13	\$202.55	\$115.42	\$135.03

Effective date (enter date of change): 11/1/2021

Location (list published location): Table above and on OASAS website (upon approval)

b.  Other:

**Home and Community-Based Services Eligible (Rehab Services - Addiction)**  
*The third element of the residential program, reintegration services, had not previously been reimbursed under the FFS NYS Medicaid program. OASAS has calculated fees, in conjunction with the NYS Department of Health and their actuary, for the reintegration element of the service. The calculated fees are based on a hypothetical model program; utilizing reasonable and appropriate Medicaid-eligibility assumptions for staffing, administration, fringe, and non-personal service, and excluding room and board as non-allowable under Medicaid reimbursement for residential programs. This is the same methodology used for the stabilization and rehabilitation fees that were previously approved by CMS in SPA 16-0004. The calculated fees for reintegration have been verified as efficient and economical by OASAS using actual cost data for the service element (excluding room and board), which has been operated since 2016 as an OASAS-certified, non-Medicaid program.*  
*Reintegration programs will receive 150% of the calculated fees for the period November 1, 2021 through June 30, 2022. The initial reintegration fees are to be set 50% higher than the level of the ongoing fees (beginning July 1, 2022), on a time-limited basis, in order to cover the cost of programs gearing up to meet Medicaid billing and record keeping requirements, as well as to encourage lower intensity residential programs to recruit and train staff and make other investments necessary to meet the regulatory*

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*requirements associated with a Medicaid-eligible level of care. On July 1, 2022, the reintegration service will move down to 100% of the calculated fees.*

*Increases to state plan payment methodologies:*

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

**NYS Department of Health (DOH) Private Duty Nursing:** Effective November 1, 2021, Private duty nursing provided to fee-for-service individuals who have aged out of the medically fragile children’s reimbursement program. Fees will be increased as described in a., b.i., and b.ii. below.

**NYS Office of Mental Health (OMH) Assertive Community Treatment (ACT)** – as described in b.ii. below.

**OMH Rehabilitation Services in Community Residences** – as described in b.ii. below.

**OMH Personalized Recovery Oriented Services (PROS)** – as described in b.ii. below.

**OASAS Residential Rehabilitation Services and Off-site Addiction Rehab Services** – as described in b.ii. below.

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

**DOH Private Duty Nursing** - Individuals are 23 and older, receiving private duty nursing services.

OMH ACT, PROS, and Rehab Services in Community Residences – All services under these headings, with increases as described in b.ii. below.

OASAS HCBS and Rehab programs – The Stabilization and Rehabilitation elements of the OASAS Residential Rehabilitation service, as well as (in-community) off-site outpatient addiction rehab services.

- b. Payments are increased through:

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

**Private Duty Nursing:** This is an add-on payment for providers who are enrolled in the program, are willing to be listed in a web-based database available to the public, and who provide services to medically fragile adults.

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- ii.  An increase to rates as described below.

Rates are increased:

Uniformly by the following percentage: 75

**Private Duty Nursing**

Through a modification to published fee schedules –

Effective date (enter date of change): \_\_\_\_\_

Location (list published location):

**Private Duty Nursing:** Additional information (for providers) can be found here: [https://health.ny.gov/health\\_care/medicaid/redesign/pdn\\_children/providers/regional\\_fees.htm](https://health.ny.gov/health_care/medicaid/redesign/pdn_children/providers/regional_fees.htm) and [https://health.ny.gov/health\\_care/medicaid/redesign/pdn\\_children/providers/directory\\_benefits.htm](https://health.ny.gov/health_care/medicaid/redesign/pdn_children/providers/directory_benefits.htm) (Note: this page has been updated for 2022 while this SPA is applicable to 2021-2023)

**ACT, PROs, and Rehab Services in Community Residences** –are described below and can be found at: [https://omh.ny.gov/omhweb/medicaid\\_reimbursement/](https://omh.ny.gov/omhweb/medicaid_reimbursement/)

Up to the Medicare payments for equivalent services.

By the following factors:

**Home and Community-Based Services:**

OMH increases payment for providers of services referenced in New York’s American Rescue Plan Act Home and Community Based Services Enhanced Funding Spending Plan. Providers are Social Security Act Section 1905(a)(13) Rehabilitative Services providers 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.

The time-limited rate increases described in this section will be used to expand, enhance or strengthen mental health rehabilitative services programs through workforce recruitment and retention strategies and other implementation or expansion activities, consistent with New York’s American Rescue Plan Act Home and Community Based Services Enhanced Funding Spending Plan. Rate increases will not extend beyond March 31, 2024, except where approved by CMS.

- 1. For all Assertive Community Treatment services, effective for dates of service from October 7, 2021, through March 31, 2022, rates are increased 18.9%.

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- 2. For Assertive Community Treatment services for children/youth, effective for dates of service from October 7, 2021, through June 30, 2022, rates are increased an additional 50%.
- 3. For Personalized Recovery Oriented Services, effective for dates of service from October 14, 2021, through March 31, 2022, rates are increased 35.4%.
- 4. For Rehabilitation Services in Community Residences, effective for dates of service from October 1, 2021, through March 31, 2022, rates are increased 29.7%.

*Please describe.* **OASAS Residential Rehabilitation Services and Off-site (In-Community) Outpatient Addiction Rehab - (Rehab Services - Addiction)**

*Freestanding outpatient addiction services will receive a time-limited ten percent increase to existing CMS-approved fees, in SPA 16-0004, for the period November 1, 2021, through June 30, 2022. On July 1, 2022, these fees will return to levels previously approved by CMS. All fees, both existing and proposed, are shown in the tables below and will be posted on the OASAS website upon approval by CMS.*

*Outpatient addiction services, when provided in the community (outside of a brick-and-mortar setting), will receive an additional in-community increase for the same period (November 1, 2021, through June 30, 2022). The in-community fee enhancement will apply only to Ambulatory Patient Group (APG) fees and will not apply to the Opioid Treatment Program weekly bundle fees. As part of an effort towards fee rationalization, all freestanding outpatient addiction services will share the same in-community APG fees based on an additional ten percent for in-community outpatient addiction day rehabilitation, as shown in the applicable fee table below. All three services will revert to identical rationalized (i.e., using the same Ambulatory Patient Group conversion factors) in-community APG fees on July 1, 2022.*

*Residential addiction services will receive a time-limited ten percent fee enhancement for the period November 1, 2021, through June 30, 2022 for the stabilization and rehabilitation elements of the service. On July 1, 2022, the stabilization and rehabilitation fees will return to the levels found in SPA 16-0004.*

*The fee regions for both outpatient addiction services and residential addiction services are as follows:*

*Downstate – The counties of Bronx, Kings, New York, Queens, Richmond, Nassau, Suffolk, Westchester, Rockland, Orange, Putnam, and Dutchess.*

*Upstate – All other counties in the State.*

**Freestanding outpatient addiction services fees**

TN:   21-0073    
Supersedes TN:   NEW  

Approval Date:   June 28, 2023    
Effective Date:   October 1, 2021

Service Type	Pre 11/1/2021 Fee SPA 16-0004		11/1/21-6/30/2022 Fee		Post 6/30/2022 Fee SPA 16-0004	
	Upstate	Downstate	Upstate	Downstate	Upstate	Downstate
Outpatient Addiction Rehab (reimbursed using APGs)	\$150.11	\$175.64	\$165.12	\$193.20	\$150.11	\$175.64
Outpatient Addiction Day Rehab (APGs)	\$150.52	\$176.12	\$165.57	\$193.73	\$150.52	\$176.12
Opioid Treatment Program (APGs)	\$138.31	\$161.82	\$152.14	\$178.00	\$138.31	\$161.82
OTP Weekly Bundle (Methadone Full Bundle)	\$178.80	\$209.19	\$196.68	\$230.11	\$178.80	\$209.19
OTP Weekly Bundle (Methadone Take-Home Only)	\$35.28	\$35.28	\$38.81	\$38.81	\$35.28	\$35.28
OTP Weekly Bundle (Buprenorphine Full Bundle)	\$222.73	\$260.59	\$245.00	\$286.65	\$222.73	\$260.59
OTP Weekly Bundle (Buprenorphine Take-Home Only)	\$86.26	\$86.26	\$94.89	\$94.89	\$86.26	\$86.26

**Freestanding outpatient addiction services fees (off-site)**

Service Type	11/1/2021-6/30/2022 Fee		post 6/30/2022 Fee	
	Upstate	Downstate	Upstate	Downstate
Outpatient Addiction Rehab (APGs)	\$182.13	\$213.11	\$150.52	\$176.12
Outpatient Addiction Day Rehab (APGs)	\$182.13	\$213.11	\$150.52	\$176.12
Opioid Treatment Program (APGs)	\$182.13	\$213.11	\$150.52	\$176.12

**Residential addiction services (stabilization and rehabilitation)**

Service Type	Pre 11/1/2021		11/1/2021-6/30/2022 Fee		Post 6/30/2022 Fee	
	Upstate	Downstate	Upstate	Downstate	Upstate	Downstate
Residential Stabilization	\$151.53	\$165.27	\$166.68	\$181.80	\$151.53	\$165.27
Residential Rehabilitation	\$142.01	\$163.56	\$156.21	\$179.92	\$142.01	\$163.56

TN:   21-0073    
 Supersedes TN:   NEW  

Approval Date:   June 28, 2023    
 Effective Date:   October 1, 2021

*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:*

- 4.  Other payment changes:

*Please describe.*

**Section F – Post-Eligibility Treatment of Income**

- 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.)

TN: 21-0073  
 Supersedes TN: NEW

Approval Date: June 28, 2023  
 Effective Date: October 1, 2021

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**

**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.

TN: 21-0073  
Supersedes TN: NEW

Approval Date: June 28, 2023  
Effective Date: October 1, 2021