DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-25-26
Baltimore, Maryland 21244-1850

State Demonstrations Group

May 30, 2024

Amir Bassiri
Medicaid Director, Deputy Commissioner
New York Department of Health
Empire State Plaza, Corning Tower, Room 1466
Albany, NY 12237

Dear Director Bassiri:

New York submitted a draft Designated State Health Programs (DSHP) Claiming Protocol on March 18, 2024, in accordance with the special terms and conditions (STC), specifically, STC 11.4. The Centers for Medicare & Medicaid Services (CMS) is approving the protocol for the approved DSHP programs, as an attachment to the STC for New York's section 1115 demonstration project entitled, "Medicaid Redesign Team" (MRT) (Project No. 11-W-00114/2), effective through March 31, 2027. A copy of the approved attachment is enclosed and will be incorporated into the STCs as Attachment O. Attachment O will be updated, upon CMS review and approval of the remaining, submitted DSHP requests.

This approval is conditioned upon compliance with the previously approved STC, which set forth in detail the nature, character, and extent of anticipated federal involvement in the project. In addition, as stipulated in the STC, the state must continue conducting monitoring and evaluation of all DSHP-funded initiatives.

We look forward to our continued partnership on the MRT section 1115 demonstration. If you have any questions, please contact your CMS project officer, Jonathan Morancy. Jonathan can be reached by email at Jonathan.Morancy@cms.hhs.gov.

Sincerely,

Angela D. Garner
Director
Division of System Reform Demonstrations

cc: Melvina Harrison, State Monitoring Lead, Medicaid and CHIP Operations Group

Enclosure

ATTACHMENT O
DSHP Claiming Protocol

To support the goals of improving health outcomes and promoting health equity, the state may claim federal Financial Participation (FFP) for the following state programs subject to the annual limits and restrictions described in the Standard Terms and Conditions (STCs) Section #11 of New York's Medicaid Redesign Team (MRT) Demonstration 11-W-00114/2 through March 31, 2027. This attachment contains the protocol for such determination of cost.

Federal regulation 2 C.F.R. Part 200, Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards requires federal grants be provided net of any applicable credits. The state is required to offset all revenues received relating to eligible expenditures identified under this attachment.

All sources of non-federal funding must be compliant with section 1903 (w) of the Act and applicable regulations. In addition, all sources of the non-federal share of funding are subject to CMS approval.

CMS may review the sources of the non-federal share of funding for the demonstration. The state agrees that all funding sources deemed unacceptable by CMS shall be addressed within the timeframes set by CMS. Any amendments that impact the program's financial status shall require the state to provide information to CMS about all sources of the non- federal share of funding. For purposes of expenditures claimed under this protocol, the state cannot utilize provider-related donations as a source of the non-federal share.

In accordance with Section XI STC 11.2(c)(iii) DSHP expenditures submitted to CMS will not include payment for:

- **a.** Bricks and mortar;
- **b.** Shelters, vaccines, and medications for animals;
- **c.** Coverage/services specifically for individuals who are not lawfully present or are undocumented.
- **d.** Revolving capital funds; and
- **e.** Non-specific projects for which CMS lacks sufficient information to ascertain the nature and character of the project and whether it is consistent with these STCs.

Below are descriptions of each DSHP program approved under Project Number 11-W-00114/2.

I. Claiming and Accounting Systems

eMedNY:

Chapter 639 of the Laws of the State of New York, 1976, mandated that a statewide Medicaid Management Information System (MMIS) be designed, developed, and implemented. New York State's MMIS, called eMedNY, is a computerized system for claims processing which also provides information upon which management decisions can be made. The system allows New York Medicaid providers to submit claims and receive payments for Medicaid-covered services provided to eligible clients. eMedNY offers several innovative technical and architectural features, facilitating the adjudication and payment of claims and providing extensive support and convenience for its users.

Statewide Financial System (SFS):

SFS is the State's accounting system, the 'book-of-record' for New York State. Each agency enters vouchers into SFS. The Office of the State Comptroller (OSC) reviews, approves, and then processes the payments. The OSC process includes budget checks against appropriations/segregations to ensure appropriate authority for the expenditures has been provided by the NYS Division of the Budget through a certificate of approval process that is built into SFS.

DOH receives claims/vouchers and pays for such receipts through the SFS payment system. Such payment ties back to the specific budget appropriation for such a program.

II. DSHP Program Details

A. Vital Access Providers Assurance Program (VAPAP)

State Agency: Department of Health

Program Codes: **N/A**

Funding Sources: **State General Fund**

Brief Description:

The VAPAP program provides State-only support for facilities in severe financial distress to enable these facilities to maintain operations and provision of vital services while they implement longer-term solutions to achieve sustainable health care service delivery.

Additional information can be found here:

- For Hospitals: https://www.health.ny.gov/facilities/hospital/vapap/
- For Nursing Homes: https://www.health.ny.gov/facilities/nursing/vapap/

Eligible Populations:

N/A

Eligible Providers:

The eligibility requirements for financial assistance under VAPAP are expansive, as this is a discretionary State funding program. All requests for VAPAP financial assistance are filed through the submission of a VAPAP application (refer to link below in application process section of this narrative). Because VAPAP is a discretionary program, eligibility for a VAPAP award does not ensure that an eligible distressed provider will receive funding under the VAPAP program or receive the amount of funding that it has requested. The State conducts reviews of the VAPAP applications and determines awards based on factors including a facility's financial condition and other aspects of facility sustainability.

Eligible facilities include:

- A public hospital, which shall mean a general hospital operated by a county, municipality, or a public benefit corporation.
- A federally designated critical access hospital.
- A federally designated sole community hospital.
- A general hospital that is a safety net hospital which shall mean a hospital in which; (1) at least thirty percent of its inpatient discharges made up of Medicaid eligible individuals, uninsured individuals or Medicaid dually eligible individuals and with at least thirty-five percent of its outpatient visits made up of Medicaid eligible individuals, uninsured individuals or Medicaid dually-eligible individuals; or (2) such hospital serves at least thirty percent of the residents of a county or a multi-county area who are Medicaid eligible individuals, uninsured individuals or Medicaid dually-eligible individuals; or (3) such hospital that, in the discretion of the commissioner, serves a significant population of Medicaid eligible individuals, uninsured individuals or Medicaid dually-eligible individuals.
- An Article 28 residential health care facility, with less than 15 days of cash equivalents on hand or negative operating margins within the last two complete calendar years, and is not currently the subject of known investigation or enforcement action by CMS, the Department of Justice, HHS-OIG, the Office of the Attorney General or the Office of the Medicaid Inspector General.

Claiming Process:

Payments are made by either the NYS Medicaid Claiming System (eMedNY) or the Statewide Financial System (SFS).

eMedNY Claiming Process:

eMedNY provides the Department of Health (DOH) with the capability to reimburse Medicaid providers with a Lump Sum Payment. The term Lump Sum signifies a supplemental payment, which differs from claim-based payments, because supplemental ones do not originate from a Medicaid provider entering a claim in the eMedNY system. Rather, supplemental payments are developed by the Department of Health and entered in eMedNY to be processed and paid. Consequently, the provider's weekly Medicaid check is comprised of both its claims and lump sums.

Lump sum payments can only go to Medicaid-enrolled service providers or Medicaid-enrolled Managed Care Plans. Furthermore, lump sum payments must exhibit funding that is a combination of Federal, State, and Locally capped shares.

Since lump sum payments are not subject to eMedNY's extensive claim edits, appropriate checks & balances have been put in place to ensure accuracy and integrity. Payment upload packages must contain all the necessary documents required to upload payments, these include payment request forms, Division of Budget and OHIP authorizations, and Federal authorization (if the payment utilizes Federal funding).

To ensure each payment is uploaded and charged correctly, and the provider receives the appropriate amount, lump sum payments processed through eMedNY require the following information:

- General Ledger (GL) Code - General Ledger Codes exist for each Federal grant program. These codes are used to determine how the payments will be Federally funded. They are also used to determine how the payments will be recorded on the Statewide Financial System (SFS) and how they will be reported to the Centers for Medicare and Medicaid Services (CMS).

- Provider ID - When a provider enrolls in the Medicaid Program, they are assigned an 8-digit MMIS ID. This 8-digit MMIS ID corresponding to the provider(s) is required with all payment requests.

- Reason Code (RSN) - OHIP has created "Reason Codes" corresponding to the most common payment types. The RSN codes are used to map the lump sum payment to the correct State appropriation.

- Payment Amount - Every provider listed in the lump sum payment request needs a payment amount. The total payment amount should align with the approved Division of the Budget (DOB) letter.

- County Code – Represents the County fiscally responsible for the Local Share of each payment, this code ensures the appropriate county is charged.

Statewide Financial System (SFS)/Claiming Process:

The VAPAP program was established through legislative action (§2826 of NYS Public Health Law) with reimbursement to distressed providers determined by DOH. Program funding is provided annually through an appropriation established in the NYS aid to localities budget legislation. Provider cash flows and financial documents are submitted regularly depending on the severity of financial distress and reviewed for appropriateness by DOH staff prior to payment. Electronic payment is made through the Statewide Financial System (SFS).

State law requires claiming information be maintained for a period of not less than seven years. Program staff maintain the Annual State Aid Application and the Quarterly Expenditure Reports. The DOH audit unit has been tasked with performing audits of the Local Health Department claims (external audits). The Department's internal audit unit is tasked with performing necessary process reviews (internal audits).

The Statewide Financial System is the State of New York's accounting system whereby the DOH enters vouchers into this system for payment. The Office of State Comptroller (OSC) reviews, approves, and then processes such payments. The OSC process includes budget checks against appropriations/segregations to ensure appropriate authority for the expenditures has been provided by the NYS Division of the Budget (DOB) through a journal process that is built into SFS.

DOH uses the SFS to process contracts and vouchers for the review, approval, and payment by OSC. When the State transitioned into SFS, DOH established unique program codes within SFS for all its programs to track disbursements. The VAPAP program is uniquely defined in SFS with the following Chart of Accounts coding:

	Department	*Program*	*Fund*	*Account*	*CF 1*	*Bud Ref*
VAPAP	3450000	xxxx	10000	60303	XXXXX	2024-25

The SFS system budget tracks the transaction to ensure sufficient funds are available within the segregation/appropriation authority established through an approval process with DOB and OSC. Such a mechanism also serves as a budget tool to track expenditures and provide a history of such expenditures by program that can be used for audit purposes.

B. Health Care Workforce Bonus (HWB) Program

State Agency: Department of Health (DOH)
Office for People with Developmental Disabilities (OPWDD)
Office of Mental Health (OMH)
Office of Addiction Services and Supports (OASAS)

Program Codes: 28353 & 28623

Funding Sources: General Fund

Brief Description:

In accordance with section 367-w of the Social Services Law, this initiative recognizes certain frontline healthcare workers and authorizes bonus payments. For an employee to qualify for a bonus payment they must meet the following requirements:

1. Work for a qualified employer as defined in SOS §367-w(2)(b) and (c);
2. Work in one of the eligible titles listed in SOS §367-w(2)(a)(i)-(iii);
3. Receive an annual base salary of $125,000 or less (excluding any bonus or overtime pay paid by the employer);
4. Be employed by a qualified employer at all times during the "vesting period" as defined in SOS §367-w(2)(d) (vesting periods defined in the chart below):

Vesting Period	Submission Start Date	Submission End Date
One (10/1/21 - 3/31/22)	August 3, 2022	September 2, 2022
Two (4/1/22 - 9/30/22)	October 1, 2022	November 30, 2022
Three (10/1/22 - 3/31/23)	April 1, 2023	May 1, 2023
Four (4/1/23 - 9/30/23)	October 1, 2023	October 31, 2023
Five (10/1/23 -3/31/24)	April 1, 2024	May 1, 2024

5. Must not be excluded or suspended from participation in the Medicaid program; and
6. Must have worked the required minimum number of hours (at least 20 hours per week) during the vesting period to be eligible for the bonus.

Eligible Population:

Qualified employers (description below) will pay bonus amounts to qualified employees (list below) based on the number of hours worked during the vesting period as defined below:

- Qualified employees who work at least 20 hours but no more than 30 hours per week are eligible for a bonus of $500;
- Qualified employees who work at least 30 hours but no more than 35 hours per week are eligible for a bonus of $1,000; and
- Qualified employees who work at least 35 hours per week are eligible for a bonus of $1,500.

A qualified employee is eligible for up to two vesting periods per employer. The maximum any employee may receive is $3,000.

Eligible titles are as follows:
Frontline Direct Care Health and Mental Hygiene Workers
Activity/Creative Arts Therapist
Admitting Clerk
Admitting Clerk Cashier
Advanced Emergency Medical Technician
Assistant Program or Assistant Site Director
Behavior Intervention Specialist 1
Behavior Intervention Specialist 2
Building Attendant
Building Service Aide
Building Service Worker
Cardiovascular Technologists and Technician
Case Manager
Certified First Responders
Certified Recovery Peer Advocate
Clerks
Clinical Coordinator
Clinical Laboratory Technologists and Technician
Counseling Aide/Assistant – Alcoholism and Substance
Counselor
Counselor – Alcoholism and Substance Abuse (CASAC)
Counselor – Rehabilitation
Crisis Prevention Specialist
Critical Care Clerk
Custodian
Dental Assistants
Dental Hygienists
Developmental Disabilities Specialist QIDP-Direct Care
Developmental Disabilities Specialist/Habilitation
Diagnostic Medical Sonographers
Dietary Aide
Dietary Worker
Dietetic Technician
Dietician/Nutritionist
Dining Aide

Dining Assistant
Discharge Control Clerk
Early Recognition Specialist
Emergency Medical Technician
Emergency Services Clerk
Environmental Service Aide/Tech
Environmental Services Worker
Exercise Physiologists
Floor Maintenance Worker
Food & Nutrition Aide
Food Prep/Service Worker
Front Desk Clerk
Housekeeping Worker and Maid
Intake/Screening
Intensive Case Manager
Intensive Case Manager/Coordinator
Job Coach/Employment Specialist
Lead Intake Specialist
Licensed Mental Health Counselor
Licensed Mental Health Counselor (OASAS)
Licensed Mental Health Counselor (OCFS)
Licensed Practical and Licensed Vocational Nurse
Licensed Practical Nurse
Licensed Psychoanalyst
Magnetic Resonance Imaging Technologist
Maintenance/Physical Plant workers
Manager
Marriage and Family Counselor/Therapist
Medical Assistants
Medical Fellow
Medical Resident
Mental Hygiene
Mental Hygiene Worker
Nuclear Medicine Technologist
Nurse Anesthetist
Nurse Midwives
Nurse Practitioner
Nurse Practitioner/Nursing Supervisor
Nurses
Nurse's Aide/Medical Aide
Nursing Assistants
Occupational Therapist
Occupational Therapy Aide
Occupational Therapy Assistant
Operating Room Clerk
Ophthalmic Medical Technician

Orderlies
Orthotist
Other Clinical Staff/Assistants
Other Direct Care Staff
Paramedic
Peace Officer
Peer Professional-Non-CRPA (OASAS Only)
Peer Specialist
Pharmacist
Pharmacy Technician
Phlebotomist
Physical Therapist
Physical Therapy Aides
Physical Therapy Assistant
Physician Assistant
Program or Site Director
Prosthetist
Psychiatric Aide
Psychologist (Licensed)
Psychologist (Master's Level)/Behavioral Specialist
Psychology Worker/Other Behavioral Worker
Radiation Therapist
Radiologic Technologist
Recreational Therapist
Registered Nurse
Registration Clerk
Residence/Site Worker
Residential Treatment Facility (RTF)
Respiratory Therapist
Sanitation Worker
Security Guard
Senior Counselor
Service Worker
Social Worker-Licensed (LMSW, LCSW)
Social Worker-Master's Level (MSW)
Specialist QIDP-Clinical
Speech Therapist
Speech-Language Pathologist
Supervisor
Support Services Worker
Surgical Technologist
Technologists and Technicians
Therapists
Therapy Assistant/Activity Assistant
Transition Coordinator
Unit Assistant

Unit Associate
Unit Clerk
Unit Coordinator
Unit Receptionist
Unit Secretary
Ward Clerk

Eligible Providers:

Qualified employers include certain providers with at least one employee, and that bill for services under the Medicaid state plan or a home or community-based services (HCBS) waiver, providers that have a provider agreement to bill for Medicaid services provided or arranged through a managed care organization or a managed long term care plan, and certain educational institutions and other funded programs. These include certain providers, facilities, pharmacies, and school-based health centers licensed under the state Public Health Law, Mental Hygiene Law, and Education Law, as well as certain programs funded by the Office of Mental Health (OMH), Office for the Aging, Office of Addiction Services and Supports (OASAS), and the Office for People with Developmental Disabilities (OPWDD).

Statewide Financial System (SFS) Claiming Process:

The Department of Health (DOH), Office for People with Developmental Disabilities (OPWDD), Office of Mental Health (OMH), and Office of Addiction Services and Supports (OASAS) enters vouchers into the SFS system for payment. The Office of State Comptroller (OSC) reviews, approves, and then processes such payments. The OSC process includes budget checks against appropriations and segregations to ensure appropriate authority for the expenditures has been provided by the NYS Division of the Budget through a journal process that is built into SFS.

The agencies use the SFS to process contracts and vouchers for the review, approval, and payment by the State Comptroller. When the State transitioned into SFS, the agencies established unique codes within SFS for all its programs to track disbursements. For the HWB SFS payments the State takes the following steps:

Step 1. Claims for reimbursement are submitted by the eligible employers for eligible employees during the 30-day submission period after each prescribed vesting period.

Step 2 An agency contract manager reviews the information and enters the claim into the SFS system. Upon approval, payments are disbursed through the SFS system. For all qualified providers, the agency keeps the State standard voucher, expenditure reports, narrative expenditure report, and the submitted claim.

Step 3 The following Chart of Accounts is used to code reimbursement claims for this program:

Departments: DOH: 3450405, OMH: 3650000, OPWDD: 3660000, OASAS - 3670000

Program Codes: 28353 & 28623

Fund: 10000

Budget Reference: Dependent on claim period

Step 4 The SFS system budget tracks the transaction to ensure sufficient funds are available within the segregation/appropriation authority established through an approval process with the NYS Division of the Budget and the Office of State Comptroller. Such a mechanism also serves as a budget tool to track expenditures and provide a history of such expenditures by program that can be used for audit purposes.

Step 5 DSHP expenditures for this program will constitute the voucher payments and advances described and paid through this process.

NOTE: The HWB claims do not get processed for FFP.

eMedNY Claiming Process:

eMedNY provides the Department of Health (DOH) the capability to reimburse Medicaid providers with a Lump Sum Payment. The term Lump Sum signifies a supplemental payment, which differs from claim-based payments, because supplemental ones do not originate from a Medicaid provider entering a claim in the eMedNY system. Rather, supplemental payments are developed by the Department of Health and entered in eMedNY to be processed and paid. Consequently, the provider's weekly Medicaid check is comprised of both its claims and lump sums.

Lump sum payments can only go to Medicaid-enrolled service providers or Medicaid-enrolled Managed Care Plans. Furthermore, lump sum payments must exhibit funding that is a combination of Federal, State, and Locally capped shares.

Since lump sum payments are not subject to eMedNY's extensive claim edits, appropriate checks & balances have been put in place to ensure accuracy and integrity. Payment upload packages must contain all the necessary documents required to upload payments, these include payment request forms, Division of Budget and OHIP authorizations, and Federal authorization (if the payment utilizes Federal funding).

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also used to determine how the payments will be recorded on the Statewide Financial System (SFS) and how they will be reported to the Centers for Medicare and Medicaid Services (CMS).

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