NEW YORK STATE OF OPPORTUNITY. Department of Health

KATHY HOCHUL
Governor

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

MEGAN E. BALDWIN
Acting Executive Deputy Commissioner

March 31, 2023

James G. Scott, Director
Division of Program Operations
Centers for Medicare & Medicaid Services
601 E. 12th St., Room 355
Kansas City, Missouri 64106

RE: SPA #20-0069A

Dear Mr. Scott:

In consultation with CMS, the State has split NY-20-0069 into two separate SPAs as follows:

- SPA 20-0069 relates to COVID only NF rates; and
- SPA 20-0069A relates to Transportation;

The State is resubmitting and requests approval of the enclosed amendment to as part of the ongoing global pandemic, COVID19. This amendment is being split and resubmitted as requested by CMS.

If you have any questions regarding this State Plan Amendment submission, please do not hesitate to contact Regina Deyette, Medicaid State Plan Coordinator, Division of Finance and Rate Setting at (518) 473-3658.

Sincerely,

[redacted]

Amir Bassiri
Medicaid Director
Office of Health Insurance Programs

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 20 — 0069

2. STATE: New York

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)
TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
March 1, 2020

5. TYPE OF PLAN MATERIAL *(Check One)*

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ■ AMENDMENT

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

6. FEDERAL STATUTE/REGULATION CITATION
Section 1135 of SSA and Title XIX of SSA

7. FEDERAL BUDGET IMPACT
a. FFY 03/01/20 09/30/20 $ $44,071.61
b. FFY 10/01/20 09/30/21 $ $122,103.07

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT

Attachment: 7.4 Page:21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*

Attachment: NEW

10. SUBJECT OF AMENDMENT

COVID 19 Emergency Relief
(FMAP=50%)

11. GOVERNOR'S REVIEW *(Check One)*

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

12. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

13. TYPED NAME
Donna Frescatore

14. TITLE
Medicaid Director, Department of Health

15. DATE SUBMITTED
May 11, 2021

16. RETURN TO
New York State Department of Health
Division of Finance and Rate Setting
99 Washington Ave – One Commerce Plaza
Suite 1432
Albany, NY 12210

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED

18. DATE APPROVED

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL

20. SIGNATURE OF REGIONAL OFFICIAL

21. TYPED NAME

22. TITLE

23. REMARKS

Pen and Ink Authorizations

NY-20-0069-A

The State authorizes the following pen and ink changes:

Box 1 Transmittal Number

20-0069-A

Box 4 Proposed Effective Date

April 1, 2020

Box 7 Federal Budget Impact

a. FFY 04/01/20 – 09/30/20 $ 49,429,376.00
b. FFY 10/01/20 – 09/30/21 $ 54,866,607.00

Box 8 Page Number of the Plan Section or Attachment

State/Territory: __New York__

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:

Effective April 1, 2020

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. ____ 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:

Increases to state plan payment methodologies:

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

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

b. Payments are increased through:

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

1) Publicly owned or operated ground emergency medical transportation (ambulance) providers are currently reimbursed on a fee-for-service basis, but at a rate that is far less than the actual cost of providing these services. The current national emergency has exacerbated this fiscal gap, by increasing the operating costs of publicly owned or operated ground emergency medical transportation (ambulance) providers, while simultaneously increasing the public need for the vital services that they provide. This proposed amendment is intended to help bridge this fiscal gap.

Only Medicaid enrolled, publicly owned or operated ground emergency medical transportation (ambulance) providers will be eligible to participate in these programs. Any private emergency medical transportation providers that may have contracted with governmental entities to provide this service are not eligible to participate.

Effective April 1, 2020, and throughout the duration of the declared national emergency; subject to Federal financial participation, a supplemental reimbursement program for publicly owned or operated ground emergency medical transportation (ambulance) providers would be established.

Concurrent with the adoption of this amendment, any publicly owned or operated ground emergency medical transportation (ambulance) providers, which are also participating in the inpatient supplemental reimbursement program, will no longer be reimbursed through the inpatient rates as a non-comparable add-on to the acute per discharge rate. This will eliminate the risk of overpayments to providers.

This program will provide supplemental payments to New York State Department of Health (NYS DOH) certified publicly owned or operated ambulance services that meet specified requirements and provide emergency medical transportation services to Medicaid beneficiaries. Participation in this program by any publicly owned or operated ambulance services is voluntary. A publicly owned or operated ambulance service is one that is owned or operated by a county, city, town, or village.

Supplemental payments provided by this program are available only for allowable costs that are in excess of other Medicaid revenue that the approved publicly owned or operated ambulance services receive for emergency medical transportation services to Medicaid approved recipients. Approved publicly owned or operated ambulance services must provide certification to the New York State Department of Health (NYS DOH) of: (a) a certification for the total expenditure of funds, and (b) a certification of federal financial participation (FFP) eligibility for the amount claimed.

Approved publicly owned or operated ambulance services must submit cost reports for the previous cost approved by CMS and the state. Participating providers will have six months following the completion of a cost reporting period to submit reports. Only one (1) extension of time shall be granted to a provider for a cost reporting year and no extension of time shall exceed (60) days.

Costs will be identified using a cost report in a format prescribed by the DOH and presented to CMS for review. NYS DOH will review all cost report submissions. Payments will not be disbursed as increases to current reimbursement rates for specific services.

Costs covered will include the following applicable Medicaid emergency services: Basic Life Support Ambulance Service, and Advanced Life Support Ambulance Service. All services must be provided by NYS DOH-certified and publicly owned or operated ambulance services.

This supplemental payment program will be in effect beginning April 1, 2020 under SPA #20-0069A and will transition to SPA #21-0006 upon the effective date of this SPA.

Supplemental Payment Methodology

Supplemental payments provided by this program to an approved publicly owned or operated ambulance services will consist of FFP for Medicaid emergency medical transportation costs based on the difference between the prevailing Medicaid reimbursement amount and the providers' actual and allowable costs for providing ambulance services to approved Medicaid beneficiaries. The supplemental payment methodology is as follows:

1. The expenditures certified by the approved publicly owned or operated ambulance services to NYS DOH will represent the payment approved for FFP. Allowable certified public expenditures will determine the amount of FFP claimed.

2. In no instance will the amount certified pursuant to Paragraph D.1, when combined with the amount received for emergency medical transportation services pursuant to any other provision of this State Plan or any Medicaid waiver granted by CMS, exceed 100 percent of the allowable costs for such emergency medical transportation services.

3. Pursuant to Paragraph D.1, the approved publicly owned or operated ambulance service will annually certify to NYS DOH the total costs for providing ambulance services for Medicaid beneficiaries, offset by the received Medicaid payments for the same cost and claiming period. The supplemental Medicaid reimbursement received pursuant to this segment of the State Plan will be distributed in one annual lump-sum payment after submission of such annual certification.

4. For the subject year, the emergency medical transportation service costs that are certified pursuant to Paragraph D.1 will be computed in a manner consistent with Medicaid cost principles regarding allowable costs and will only include costs that satisfy applicable Medicaid requirements. Consistent with CMCS Informational Bulletin, August 17, 2022, Applicable Federal Cost Principles for GEMT, only relevant costs associated with the personnel, vehicle, and equipment used to transport a beneficiary to a facility for treatment will be included for the supplemental payment. Costs associated with other emergency response personnel, vehicles, and equipment that are not involved in the provision of a Medicaid-covered service, such as police and their vehicles and equipment, should not be included in GEMT cost identification and allocation. Costs such as fire and rescue personnel and equipment are generally

not directly related to Medicaid covered services and will not be considered when calculating the supplemental payment.

5. The publicly owned or operated ambulance services shall submit a certified annual cost report to the Department. The certified annual cost report shall clearly identify the total direct costs of providing ambulance services, all ambulance service volume, Medicaid ambulance service volume, and total Medicaid payments received for Medicaid ambulance services.

   For personnel calculations, the publicly owned or operated ambulances will use the Computer Aided Dispatch (CAD) System to identify the direct personnel costs of providing ambulance services. Only direct costs associated with the emergency ambulance personnel involved in the transport should be included. The CAD system must be able to be queried by trip type to isolate emergency ambulance trips. CAD will be used to 1) sum all "time on duty" across all ambulance units per year for the participating publicly owned or operated ambulance service and 2) sum all "time on task" across all ambulance units per year for the participating publicly owned or operated ambulance service. Time on task begins at the moment an emergency ambulance is dispatched to an emergency medical services incident and ends at the moment that the ambulance returns to service; having transferred care of the patient to the hospital (or other medical destination) thereby making the ambulance available for the next emergency medical response. A "time on task" proportion will be calculated as the time on task for the year divided by the time on duty for the year. Ambulance personnel costs for the year are multiplied by the time on task proportion to determine the portion of salary and personnel costs considered to be direct, on task, costs.

   The sum of annual direct personnel costs will be added to other direct Medical Transportation Services (MTS) non-personnel costs (vehicles and equipment), and divided across all ambulance service volume to determine direct costs per ambulance service.

   This cost per ambulance service will be multiplied by total number of Medicaid ambulance services, gleaned from billing data, to calculate the total Medicaid ambulance service cost. Ambulance Medicaid payments shall be subtracted from the estimated total Medicaid ambulance service cost. The supplemental payment shall be the Federal Financial Participation (FFP) amount of the difference between the Medicaid ambulance service cost and the actual Medicaid payments made.

   Note: Costs such as fire and rescue personnel and equipment are generally not directly related to Medicaid covered services and will not be considered in the methodology.

6. Computation of allowable costs and their allocation methodology must be determined in accordance with the CMS Provider Reimbursement Manual (CMSPub. 15-1)

   https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-

Manuals-Items/CMS021929

CMS non-institutional reimbursement policies, and OMB Circular A-87, codified at: 2CFR Part 225,

https://www.govinfo.gov/content/pkg/CFR-2012-title2-vol1/pdf/CFR-2012-title2-vol1-part225.pdf

which establish principles and standards for determining allowable costs and the methodology for allocating and apportioning those expenses to the Medicaid program, except as expressly modified below.

7. Medicaid base payments to the publicly owned or operated ambulance services for providing ambulance services are derived from the fees established for each county, for reimbursements payable by the Medicaid program.

8. For each approved publicly owned or operated ambulance service in this supplemental program, the total supplemental payment available for reimbursement will be no greater than the shortfall resulting from the allowable costs calculated using the Cost Determination Protocols (Section C.). Each approved provider must provide ambulance services to Medicaid beneficiaries in excess of payments made from the Medicaid program and all other sources of reimbursement for such ambulance services provided to Medicaid beneficiaries. Approved providers that do not have any such excess costs will not receive a supplemental payment under this supplemental reimbursement program.

A. Cost Determination Protocols

1. An approved publicly owned or operated ambulance service's specific allowable cost per-ambulance service rate will be calculated based on the provider's audited financial data reported on the CMS cost report.

The per-ambulance service cost rate will be the sum of actual allowable direct costs of providing medical transport services divided by the actual number of ambulance services provided for the applicable service period as reported in billing records provided for the applicable service period. Consistent with CMS Informational Bulletin: Applicable Cost Principles for GEMT, only those direct costs associated with the provision of emergency ambulance transportation should be used.

2. Medicaid's portion of the total allowable cost for providing ambulance services by each approved publicly owned or operated ambulance service is calculated by multiplying the total number of Medicaid FFS ambulance services provided by the provider's specific per-ambulance service cost rate for the applicable service period.

B. Responsibilities and Reporting Requirements of the Approved publicly owned or operated ambulance service

An approved publicly owned or operated ambulance service must:

1. Certify that the claimed expenditures for emergency ambulance services made by the approved entity are approved for FFP;

2. Provide evidence supporting the certification as specified by NYS DOH;

3. Submit data as specified by NYS DOH to determine the appropriate amounts to claim as qualifying expenditures for FFP through the CMS cost report and cost identification methodology; and

4. Keep, maintain, and have readily retrievable any records required by NYS DOH or CMS.

C. NYS DOH's Responsibilities

1. NYS DOH will submit claims for FFP for the expenditures for services that are allowable expenditures under federal law.

2. NYS DOH will, on an annual basis, submit to the federal government CMS cost report in order to provide assurances that FFP will include only those expenditures that are allowable under federal law.

D. Interim Supplemental Payment

1. NYS DOH will make annual interim Medicaid supplemental payments to approved providers. The interim supplemental payments for each provider are based on the provider's completed annual cost report in the format prescribed by NYS DOH and approved by CMS for the prior cost reporting year.

2. Each approved publicly owned or operated ambulance service must compute the annual cost in accordance with the Cost Determination Protocols (Section C.)and must submit the completed annual as-filed cost report to NYS DOH no later than six months after the close of the interim reporting period.

3. The interim supplemental payment is calculated by subtracting the total Medicaid base payments (Paragraph B.6.) and other payments, such as Medicaid co- payments, received by the providers for ambulance services to Medicaid beneficiaries from the Medicaid portion of the total allowable costs (Paragraph C.2.) reported in the as-filed cost report or the as-filed cost report adjusted by NYS DOH (Paragraph F.1.).

4. Cost reports may be utilized from the period immediately prior to the effectivedate of this state plan in order to set a supplemental payment amount for the first year

of this program. Going forward, each annual cost report will be used to calculate a final reconciliation (described in paragraph G) as well as an interim supplemental payment for the subsequent reporting period.

E. Final Reconciliation

1. Providers must submit auditable documentation to NYS DOH within two years following the end of the July to June reporting period in which payments have been

received. NYS DOH will perform a final reconciliation where it will settle the provider's annual cost report as audited, three years following the July to June reporting period end. NYS DOH will compute the net Medicaid allowable cost using audited per-ambulance service cost, and the number of Medicaid FFS ambulance services data from the updated NY MMIS reports. Actual net Medicaid allowable cost will be compared to the total base and interim supplemental payments and settlement payments made, and any other source of reimbursement received by the provider for the period.

2. If at the end of the final reconciliation it is determined that the publicly owned or operated ambulance service has been overpaid, the provider will return the overpayment to NYS DOH, and NYS DOH will return the overpayment to the federal government pursuant to 42 CFR 433.316

   https://www.govinfo.gov/content/pkg/CFR-2012-title42-vol4/pdf/CFR-2012-title42- vol4-sec433-316.pdf

   If at the end of the final reconciliation it is determined that the publicly owned or operated ambulance service has been underpaid, the provider will receive a final supplemental payment in the amount of the underpayment.

3. All cost report information for which Medicaid payments are calculated and reconciled are subject to CMS review and must be furnished upon request.

ii. ___ An increase to rates as described below.

Rates are increased:

____ Uniformly by the following percentage:

____ Through a modification to published fee schedules –

Effective date (enter date of change): _____

Location (list published location): _____

_____ Up to the Medicare payments for equivalent services.

____ By the following factors:

State/Territory: __New York__

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:

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.)

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

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.

SUMMARY
SPA #20-0069-A

This State Plan Amendment is a temporary amendment in response to COVID-19 Emergency Relief.

NON-INSTITUTIONAL SERVICES
State Plan Amendment #20-0069A

CMS Standard Funding Questions

The following questions are being asked and should be answered in relation to all payments made to all providers reimbursed pursuant to a methodology described in Attachment 4.19-B of the state plan.

1. **Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by States for services under the approved State plan. Do providers receive and retain the total Medicaid expenditures claimed by the State (includes normal per diem, supplemental, enhanced payments, other) or is any portion of the payments returned to the State, local governmental entity, or any other intermediary organization? If providers are required to return any portion of payments, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the amount or percentage of payments that are returned and the disposition and use of the funds once they are returned to the State (i.e., general fund, medical services account, etc.)**

   Response: Providers receive and retain 100 percent of total Medicaid expenditures claimed by the State and the State does not require any provider to return any portion of such payments to the State, local government entities, or any other intermediary organization.

2. **Section 1902(a)(2) provides that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan. Please describe how the state share of each type of Medicaid payment (normal per diem, supplemental, enhanced, other) is funded. Please describe whether the state share is from appropriations from the legislature to the Medicaid agency, through intergovernmental transfer agreements (IGTs), certified public expenditures (CPEs), provider taxes, or any other mechanism used by the state to provide state share. Note that, if the appropriation is not to the Medicaid agency, the source of the state share would necessarily be derived through either an IGT or CPE. In this case, please identify the agency to which the funds are appropriated. Please provide an estimate of total expenditure and State share amounts for each type of Medicaid payment. If any of the non-federal share is being provided using IGTs or CPEs, please fully describe the matching arrangement including when the state agency receives the transferred amounts from the local government entity transferring the funds. If CPEs are used, please describe the methodology used by the state to verify that the total expenditures being certified are eligible for Federal matching funds in accordance with 42 CFR 433.51(b). For any payment funded by CPEs or IGTs, please provide the following:**
   - **(i) a complete list of the names of entities transferring or certifying funds;**
   - **(ii) the operational nature of the entity (state, county, city, other);**

(iii) the total amounts transferred or certified by each entity;
(iv) clarify whether the certifying or transferring entity has general taxing authority: and,
(v) whether the certifying or transferring entity received appropriations (identify level of appropriations).

Response: The Non-Federal share Medicaid provider payment is funded by a combination of the following funds/funding sources through enacted appropriations authority to the Department of Health (DOH) for the New York State Medicaid program.

		4/1/20 – 4/20/21	
Payment Type	**Non-Federal Share Funding**	**Non-Federal**	**Gross**
Supplemental	General Fund	$104M	$209M

A. **General Fund:** Revenue resources for the State's General Fund includes taxes (e.g., income, sales, etc.), and miscellaneous fees (including audit recoveries). Medicaid expenditures from the State's General Fund are authorized from Department of Health Medicaid.

1) New York State Audit Recoveries: The Department of Health collaborates with the Office of the Medical Inspector General (OMIG) and the Office of the Attorney General (AG) in recovering improperly expended Medicaid funds. OMIG conducts and coordinates the investigation, detection, audit, and review of Medicaid providers and recipients to ensure they are complying with all applicable laws and regulation. OMIG recovers any improper payments through cash collections and voided claim recoveries. Cash collections are deposited into the State's General Fund to offset Medicaid costs.

In addition to cash collections, OMIG finds inappropriately billed claims within provider claims. To correct an error, OMIG and DOH process the current accurate claim, and reduce this claim by the inappropriate claim value to recoup the previous overclaim and decrease state spending.

3. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan. If supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to each provider type.

Response: The Medicaid payments authorized under this State Plan Amendment are supplemental payments and total $209 million for 4/1/20-4/20/21.

	Private	**State Government**	**Non-State Government**	**4/1/20-4/20/21 Total**
Supplemental	$0M	$104.3M	$104.3M	$208.6M

4. **For clinic or outpatient hospital services please provide a detailed description of the methodology used by the state to estimate the upper payment limit (UPL) for each class of providers (state owned or operated, non-state government owned or operated, and privately owned or operated). Please provide a current (i.e., applicable to the current rate year) UPL demonstration. Under regulations at 42 CFR 447.272, States are prohibited from setting payment rates for Medicaid inpatient services that exceed a reasonable estimate of the amount that would be paid under Medicare payment principals.**

   Response: The Medicaid payments authorized under this State Plan Amendment do not impact the UPL demonstrations.

5. **Does any governmental provider receive payments that in the aggregate (normal per diem, supplemental, enhanced, other) exceed their reasonable costs of providing services? If payments exceed the cost of services, do you recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report?**

   Response: Providers do not receive payments that in the aggregate exceed their reasonable costs of providing services. If any providers received payments that in the aggregate exceeded their reasonable costs of providing services, the State would recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report.

ACA Assurances:

1. **Maintenance of Effort (MOE). Under section 1902(gg) of the Social Security Act (the Act), as amended by the Affordable Care Act, as a condition of receiving any Federal payments under the Medicaid program during the MOE period indicated below, the State shall not have in effect any eligibility standards, methodologies, or procedures in its Medicaid program which are more restrictive than such eligibility provisions as in effect in its Medicaid program on March 10, 2010.**

   MOE Period.
   - **Begins on: March 10, 2010, and**
   - **Ends on: The date the Secretary of the Federal Department of Health and Human Services determines an Exchange established by a State under the provisions of section 1311 of the Affordable Care Act is fully operational.**

   Response: This SPA complies with the conditions of the MOE provision of section 1902(gg) of the Act for continued funding under the Medicaid program.

2. **Section 1905(y) and (z) of the Act provides for increased FMAPs for expenditures made on or after January 1, 2014 for individuals determined eligible under section 1902(a)(10)(A)(i)(VIII) of the Act. Under section 1905(cc) of the Act, the increased FMAP under sections 1905(y) and (z) would not be available for States that require local political subdivisions to contribute amounts toward the**

non-Federal share of the State's expenditures at a greater percentage than would have been required on December 31, 2009.

Prior to January 1, 2014 States may potentially require contributions by local political subdivisions toward the non-Federal share of the States' expenditures at percentages greater than were required on December 31, 2009. However, because of the provisions of section 1905(cc) of the Act, it is important to determine and document/flag any SPAs/State plans which have such greater percentages prior to the January 1, 2014 date in order to anticipate potential violations and/or appropriate corrective actions by the States and the Federal government.

Response: This SPA would [ ] / would not [✓] violate these provisions, if they remained in effect on or after January 1, 2014.

3. **Please indicate whether the State is currently in conformance with the requirements of section 1902(a)(37) of the Act regarding prompt payment of claims.**

   Response: The State complies with the requirements of section 1902(a)(37) of the Act regarding prompt payment of claims.

Tribal Assurance:

Section 1902(a)(73) of the Social Security Act the Act requires a State in which one or more Indian Health Programs or Urban Indian Organizations furnish health care services to establish a process for the State Medicaid agency to seek advice on a regular ongoing basis from designees of Indian health programs whether operated by the Indian Health Service HIS Tribes or Tribal organizations under the Indian Self Determination and Education Assistance Act ISDEAA or Urban Indian Organizations under the Indian Health Care Improvement Act.

IHCIA Section 2107(e)(I) of the Act was also amended to apply these requirements to the Children's Health Insurance Program CHIP. Consultation is required concerning Medicaid and CHIP matters having a direct impact on Indian health programs and Urban Indian organizations.

a) **Please describe the process the State uses to seek advice on a regular ongoing basis from federally recognized tribes Indian Health Programs and Urban Indian Organizations on matters related to Medicaid and CHIP programs and for consultation on State Plan Amendments waiver proposals waiver extensions waiver amendments waiver renewals and proposals for demonstration projects prior to submission to CMS.**
b) **Please include information about the frequency inclusiveness and process for seeking such advice.**
c) **Please describe the consultation process that occurred specifically for the development and submission of this State Plan Amendment when it occurred and who was involved.**

Response: Tribal consultation was performed in accordance with the State's tribal consultation policy as approved in SPA 17-0065, and documentation of such is included with this submission. To date, no feedback has been received from any tribal representative in response to the proposed change in this SPA.