NEW YORK STATE OF OPPORTUNITY. Department of Health

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

LISA J. PINO, M.A., J.D.
Executive Deputy Commissioner

December 30, 2020

National Institutional Reimbursement Team
Attention: Mark Cooley
CMS, CMCS
7500 Security Boulevard, M/S S3-14-28
Baltimore, MD 21244-1850

Re: SPA #21-0009
Inpatient Hospital Services

Dear Mr. Cooley:

The State requests approval of the enclosed amendment #21-0009 to the Title XIX (Medicaid) State Plan for inpatient hospital services to be effective January 22, 2021 (Appendix I). This amendment is being submitted based upon enacted legislation. A summary of the proposed amendment is contained in Appendix II.

This amendment is submitted pursuant to §1902(a) of the Social Security Act (42 USC 1396a(a)) and Title 42 of the Code of Federal Regulations (CFR), Part 447, Subpart C.

Notice of the changes in the methods and standards for setting payment rates for general hospital inpatient services were given in the New York State Register on December 30, 2020.

A copy of pertinent sections of enacted legislation is enclosed for your information (Appendix III). In addition, responses to the five standard funding questions and the standard access questions are also enclosed (Appendix V and VI, respectively).

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, Office of Health Insurance Programs at (518) 473-3658.

Sincerely,

[redacted]

Donna Frescatore
Medicaid Director
Office of Health Insurance Programs

Enclosures
cc: Todd McMillion

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

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 21 — 0009

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
January 22, 2021

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
§ 1902(a) of the Social Security Act and 42 CFR 447

7. FEDERAL BUDGET IMPACT
a. FFY 01/22/21-09/30/21 $ (10,328.83)
b. FFY 10/01/21-09/30/22 $ (14,875.00)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.19-A Page: 104

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 4.19-A Page: 104

10. SUBJECT OF AMENDMENT
Ambulance Non-Comparable Add-on Revision (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
December 30, 2020

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

Instructions on Back

Appendix I
2020 Title XIX State Plan
Fourth Quarter Amendment
Amended SPA Pages

6. *Graduate medical education (GME).*

   a. *Direct GME (DGME) costs* will mean the reimbursable salaries, fringe benefits, non-salary costs and allocated overhead teaching costs for residents, fellows, and supervising physicians trended for inflation to the rate year by the applicable provisions of this section. Only the costs reported for Interns and Residents Services Salary and Fringes, Interns and Residents Services Other Program Costs, and Supervising Physician Teaching will be included in the direct GME cost development.

   b. *Indirect GME (IME) costs* will mean an estimate of the costs associated with additional ancillary intensiveness of medical care, more aggressive treatment regimens, and increased availability of state-of-the-art testing technologies resulting from the training of residents and fellows.

7. *High-cost outlier costs* for payment purposes will mean 100 percent of the hospital's total billed patient charges, as approved by IPRO, that have been converted to cost using the hospital's most recent charge convertor for that same service period, as defined in this Section, that exceed the DRG specific high-cost thresholds calculated pursuant to the Outlier Rates of Payment Section.

8. *Alternate level of care (ALC) services* will mean those services provided by a hospital to a patient for whom it has been determined that inpatient hospital services are not medically necessary, but that post-hospital extended care services are medically necessary, consistent with utilization review standards, and are being provided by the hospital and are not otherwise available.

9. *Exempt hospitals and units* will mean those hospitals and units that are paid per diem rates of payment pursuant to the provisions of the Exempt Units and Hospitals Section, rather than receiving per discharge case-based rates of payment.

10. *The wage equalization factor (WEF)* will mean the mechanism to equalize hospital salary and fringe benefit costs to account for the differences in the price of labor among hospitals and groups of hospitals.

11. *Statewide Base Price* will mean the numeric value calculated pursuant to the Statewide Base Price Section, which will be used to calculate DRG case-based payments per discharge as defined in paragraph (2) of this Section.

12. *Non-comparable costs* will mean those base year costs, as defined in this Section, that are excluded from the statewide base price calculation and applied to the case-based rate of payment as an add-on payment. The following will be considered non-comparable costs:

    a. Medicaid costs associated with ambulance services operated by a facility that are not reimbursed through a supplemental payment program and reported as inpatient costs in the Institutional Cost Report (ICR); and

Appendix II
2020 Title XIX State Plan
Fourth Quarter Amendment
Summary

SUMMARY
SPA #21-0009

This State Plan Amendment proposes to restrict hospitals that are eligible to receive a non-comparable ambulance add-on in their acute inpatient rate to providers that are not receiving a supplemental payment for these costs.

Appendix III
2020 Title XIX State Plan
Fourth Quarter Amendment
Authorizing Provisions

SPA 21-0009

Non-Comparable Ambulance Reimbursement
Article VII Language Bill
Chapter 56 of the Laws of 2020, S7506-B/A9506-B, Part LL, § 3

§ 3. The commissioner of health shall seek, pursuant to a state plan amendment, authorization to establish and administer a program for the federal financial participation in reimbursement for ground emergency medical transportation services provided to Medicaid beneficiaries by eligible transportation providers on a voluntary basis. The commissioner of health may promulgate regulations, including emergency regulations, in order to implement the provisions of this section.

1. Such program shall establish a payment methodology for supplemental reimbursement that shall require the eligible transportation provider file cost reports and data as required by the commissioner of health, and certify that:

(a) in accordance with 42 C.F.R. section 433.51 or any successor regulation, the claimed expenditures for the ground emergency medical transportation services are eligible for federal financial participation; and

(b) the amount certified pursuant to paragraph (a) of this subdivision when combined with amounts received from all other sources of reimbursement from the Medicaid program does not exceed one hundred percent of actual costs, as determined in accordance with the Medicaid state plan, for ground emergency transportation services.

2. Eligible transportation providers receiving supplemental reimbursement pursuant to this subdivision shall not receive non-comparable cost reimbursement for the Medicaid costs associated with ambulance services as provided in subparagraph (i) of paragraph (b) of subdivision 35 of section 2807-c of the public health law and as may be further defined regulations issued by the commissioner of health and shall not report such costs as Medicaid reimbursable costs in the institutional cost report.

3. For the purposes of this section, an "eligible transportation provider" shall mean:

(a) a provider who provides ground emergency medical transportation services to Medicaid beneficiaries; and

(b) is enrolled as a Medicaid provider for the period being claimed; and

(c) is owned or operated by the state, a political subdivision or local government, that employs or contracts with persons or entities licensed to provide emergency medical services in New York state, and includes private entities to the extent permissible under federal law.

Appendix IV
2020 Title XIX State Plan
Fourth Quarter Amendment
Public Notice

Richmond County, Richmond Center
95 Central Avenue, St. George
Staten Island, New York 10301

For further information and to review and comment, please contact: Department of Health, Division of Finance and Rate Setting, 99 Washington Ave., One Commerce Plaza, Suite 1432, Albany, NY 12210, spa_inquiries@health.ny.gov

PUBLIC NOTICE
Department of Health

Pursuant to 42 CFR Section 447.205, the Department of Health hereby gives public notice of the following:

The Department of Health proposes to amend the Title XIX (Medicaid) State Plan for non-institutional services to comply with S.7506-B & A.9506-B, Part LL, § 3. The following changes are proposed:

Effective on or after January 22, 2021, and subject to Federal financial participation, a supplemental reimbursement program for publicly owned or operated Medicaid enrolled ground emergency medical transportation (ambulance) providers would be established or transitioned from one approved under emergency State Plan Amendment authority. Medicaid enrolled 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. This proposed amendment is intended to help bridge that fiscal gap. Providers 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.

The additional estimated annual change to gross Medicaid expenditures as a result of this proposed amendment is estimated to be $175M. This proposed amendment presents a potential savings to local governments, counties; cities; towns; or villages, which own or operate ground emergency medical transportation (ambulance) services, and which voluntarily choose to participate.

The public is invited to review and comment on this proposed State Plan Amendment, a copy of which will be available for public review on the Department's website at http://www.health.ny.gov/regulations/state_plans/status. Individuals without Internet access may view the State Plan Amendments at any local (county) social services district.

For the New York City district, copies will be available at the following places:

New York County
250 Church Street
New York, New York 10018

Queens County, Queens Center
3220 Northern Boulevard
Long Island City, New York 11101

Kings County, Fulton Center
114 Willoughby Street
Brooklyn, New York 11201

Bronx County, Tremont Center
1916 Monterey Avenue
Bronx, New York 10457

Richmond County, Richmond Center
95 Central Avenue, St. George
Staten Island, New York 10301

For further information and to review and comment, please contact: Department of Health, Division of Finance and Rate Setting, 99 Washington Ave., One Commerce Plaza, Suite 1432, Albany, NY 12210, spa_inquiries@health.ny.gov

PUBLIC NOTICE
Department of State
Program Change

STATEWIDE — Pursuant to 15 CFR 923, the New York State Department of State (DOS) hereby gives notice that the National Oceanic and Atmospheric Administration's Office for Coastal Management (OCM) concurred on December 8, 2020 on the incorporation of the Village of Alexandria Bay and Town of Alexandria Local Waterfront Revitalization Program (LWRP) into New York State's Coastal Management Program as a Program Change. As of December 8, 2020, the enforceable policies identified in the Table of Approved Changes below shall be applicable in reviewing federal actions pursuant to the federal consistency requirements of the Coastal Zone Management Act (CZMA) and its implementing regulations found at 15 CFR part 930. DOS requested OCM's concurrence on this action on October 14, 2020, in a previous notice in the New York State Register, which further described the content of the action.

The Village of Alexandria Bay and Town of Alexandria LWRP was prepared in partnership with DOS and in accordance with the New York State Waterfront Revitalization of Coastal Areas and Inland Waterways Act and the New York State Coastal Management Program. The LWRP is a long-term management program for the waterfront resources of the Village and Town along the St. Lawrence River and Otter Creek and is based on the policies of the New York State Coastal Management Program. The Village of Alexandria Bay and Town of Alexandria LWRP provides a detailed inventory and analysis of natural, historic and cultural resources in the Local Waterfront Revitalization Area in the Village and Town, describes existing land and water uses, harbor management, and important economic activities, presents issues and opportunities for future development, and contains enforceable polices to be used for CZMA consistency review purposes.

Pursuant to the New York State Coastal Management Program and Article 42 of the New York State Executive Law, the Village of Alexandria Bay and Town of Alexandria LWRP was adopted by resolution by the Village of Alexandria Bay Board of Trustees on May 8, 2018 and by the Town of Alexandria Town Board on September 19, 2018 and approved by the New York State Secretary of State on January 6, 2020.

OCM's concurrence includes the following list of changes and qualifications:

Table of Approved Changes

Legal citation	Title of policy, section, or other descriptor	Is the change new, revised, or deleted	Date effective in state	Enforceable policy	Enforceable mechanism citation
Not applicable	Village of Alexandria Bay and Town of Alexandria Joint Local Waterfront Revitalization Program (LWRP)	Revised	01/06/2020	Yes (Section III only)	Executive Law, Article 42

Qualifications

As with previous approval of NY CMP LWRPs, the enforceable provisions of Section III are only the stated policies and sub-policies. The enforceable policies do not include the explanatory text that accompanies each policy. While the explanatory text may be advisory as to how activities can show consistency with the LWRP policies, the State may not use the explanatory text as a basis for issuing an objection under its CZMA authority. Please also note that for the review of federal actions pursuant to the CZMA, the requirements of the statute and implementing regulations at 15 CFR part 930 are controlling over any conflicting interpretation of the discussion of the CZMA federal consistency requirements within the Village of Alexandria Bay and Town of Alexandria LWRP.

As a standard qualification applying to all program changes, states

Appendix V
2020 Title XIX State Plan
Fourth Quarter Amendment
Responses to Standard Funding Questions

HOSPITAL SERVICES
State Plan Amendment #21-0009

CMS Standard Funding Questions (NIRT Standard Funding Questions)

The following questions are being asked and should be answered in relation to all payments made to all providers under Attachment 4.19-A 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 do retain the payments made pursuant to this amendment. However, this requirement in no way prohibits the public provider, including county providers, from reimbursing the sponsoring local government for appropriate expenses incurred by the local government on behalf of the public provider. The State does not regulate the financial relationships that exist between public health care providers and their sponsoring governments, which are extremely varied and complex. Local governments may provide direct and/or indirect monetary subsidies to their public providers to cover on-going unreimbursed operational expenses and assure achievement of their mission as primary safety net providers. Examples of appropriate expenses may include payments to the local government which include reimbursement for debt service paid on a provider's behalf, reimbursement for Medicare Part B premiums paid for a provider's retirees, reimbursement for contractually required health benefit fund payments made on a provider's behalf, and payment for overhead expenses as allocated per federal Office of Management and Budget Circular 2 CFR 200 regarding Cost Principles for State, Local, and Indian Tribal Governments. The existence of such transfers should in no way negate the legitimacy of these facilities' Medicaid payments or result in reduced Medicaid federal financial participation for the State. This position was further supported by CMS in review and approval of SPA 07-07C when an on-site audit of these transactions for New York City's Health and Hospitals Corporation was completed with satisfactory results.

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: Payments made to service providers under the provisions of this SPA are funded through a general appropriation received by the State agency that oversees medical assistance (Medicaid), which is the Department of Health.

The source of the appropriation is the Medicaid General Fund Local Assistance Account, which is part of the Global Cap. The Global Cap is funded by General Fund and HCRA resources.

There have been no new provider taxes and no existing taxes have been modified.

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 payments authorized for this provision are not supplemental or enhanced payments.

4. **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 state and CMS are working toward completing and approval of current year UPL.

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: The rate methodology included in the approved State Plan for institutional services is prospective payment methodology. We are unaware of any requirement under current federal law or regulation that limits individual provider payments to their actual costs.

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 does comply 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.

Appendix VI
2020 Title XIX State Plan
Fourth Quarter Amendment
Responses to Standard Access Questions

APPENDIX VI
INPATIENT SERVICES
State Plan Amendment 21-0009

CMS Standard Access Questions

The following questions have been asked by CMS and are answered by the State in relation to all payments made to all providers under Attachment 4.19-A of the state plan.

1. **Specifically, how did the State determine that the Medicaid provider payments that will result from the change in this amendment are sufficient to comply with the requirements of 1902(a)(30)?**

   Response: This amendment seeks to restrict hospitals that are eligible to receive the non-comparable ambulance add-on component of the hospital inpatient payments made under the State's Institutional State Plan section 4.19-A to providers not receiving reimbursement under a supplemental payment program for these costs, effective for dates of service beginning January 22, 2021 and thereafter. While this may result in a reduction in reimbursement through the inpatient rates for some hospitals, it will only affect providers who are eligible for alternate reimbursement under a supplemental payment program (State Plan Amendment #21-0006) and will not result in a loss of revenue for those providers.

2. **How does the State intend to monitor the impact of the new rates and implement a remedy should rates be insufficient to guarantee required access levels?**

   Response: The State has various ways to ensure that access levels in the Medicaid program are retained and is currently not aware of any access issues. Certain classes of providers must notify and receive approval from the Department's Office of Primary Care and Health Systems Management in order to discontinue services. This office monitors and considers such requests in the context of access as they approve/deny changes in services. Finally, providers cannot discriminate based on source of payment.

   For providers that are not subject to an approval process, the State will continue to monitor provider complaint hotlines to identify geographic areas of concern and/or service type needs. If Medicaid beneficiaries begin to encounter access issues, the Department would expect to see a marked increase in complaints. These complaints will be identified and analyzed in light of the changes proposed in this State Plan Amendment.

   Finally, the State ensures that there is sufficient provider capacity for Medicaid Managed Care plans as part of its process to approve managed care rates and plans. Should access to services be compromised, the State would be alerted and would take appropriate action to ensure retention of access to such services.

3. **How were providers, advocates and beneficiaries engaged in the discussion around rate modifications? What were their concerns and how did the State address these concerns?**

   Response: This change was enacted by the State Legislature as part of the negotiation of the 2020-21 Budget. The impact of this change was weighed in the context of the overall Budget in the State. The legislative process provides opportunities for all stakeholders to lobby their concerns, objections, or support for various legislative initiatives. In addition, NY published notice in the state register of the proposed policy and did not receive any comments.

4. **What action(s) does the State plan to implement after the rate change takes place to counter any decrease to access if the rate decrease is found to prevent sufficient access to care?**

   Response: Should any essential community provider experience Medicaid or other revenue issues that would prevent access to needed community services, per usual practice, the State would meet with them to explore the situation and discuss possible solutions, if necessary.

5. **Is the State modifying anything else in the State Plan which will counterbalance any impact on access that may be caused by the decrease in rates (e.g. increasing scope of services that other provider types may provide or providing care in other settings)?**

   Response: The State continues to implement Medicaid reform initiatives to better align reimbursement and to ensure access to quality of care in the appropriate setting. To counterbalance any impact that may be caused by restricting the hospitals eligible for this add-on as part of this amendment, the State has submitted State Plan Amendment #21-0006 in support of a supplemental payment program for transportation services.