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

September 30, 2020

Ms. Nicole McKnight
Acting Associate Regional Administrator
Department of Health & Human Services
Centers for Medicare & Medicaid Services
New York Regional Office
Division of Medicaid and Children's Health Operations
26 Federal Plaza - Room 37-100 North
New York, New York 10278

RE: SPA #20-0067
Non-Institutional Services

Dear Ms. McKnight:

The State requests approval of the enclosed amendment #20-0067 to the Title XIX (Medicaid) State Plan for non-institutional services to be effective July 1, 2020 (Appendix I). This amendment is being submitted based on enacted legislation. A summary of the plan amendment is provided in Appendix II.

The State of New York reimburses these services through the use of rates that are consistent with and promote efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area as required by §1902(a)(30) of the Social Security Act and 42 CFR §447.204.

A copy of pertinent sections of enacted legislation is enclosed for your information (Appendix III). Copies of the public notice of this plan amendment, which were given in the New York State Register on April 1, 2020, and clarified on October 21, 2020 are also enclosed for your information (Appendix IV). In addition, responses to the five standard funding questions are also enclosed (Appendix V).

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,

Donna Frescatore
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

2. STATE

3. PROGRAM IDENTIFICATION: 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

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

7. FEDERAL BUDGET IMPACT
a. FFY__________ $ __________
b. FFY__________ $ __________

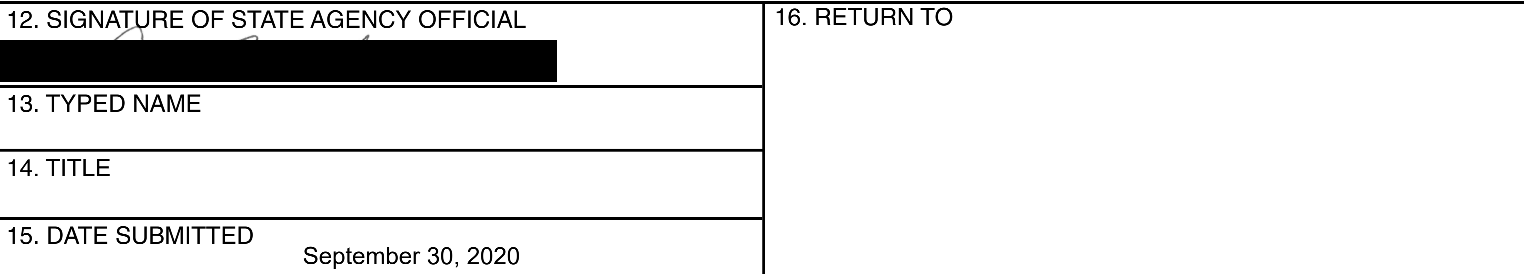
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*

10. SUBJECT OF AMENDMENT

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

13. TYPED NAME

14. TITLE

15. DATE SUBMITTED
September 30, 2020

16. RETURN TO

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

FORM CMS-179 (07/92)

Instructions on Back

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

24a.

Certified Public Expenditures
Supplemental Payment for Publicly Owned or Operated
Emergency Medical Transportation Providers

"PEMT services" means both the act of transporting an individual from any point of origin to the medical site capable of meeting the emergency medical needs of the patient, as well as emergency medical treatment provided to an individual by PEMT providers before or during the act of transportation.

a. "Advanced life support" means the assessment or treatment through the use of techniques described in the Emergency Medical Technician (EMT)-Paramedic: National Standard Curriculum or the National Emergency Medical Services (EMS) Education Standards, provided by an advanced EMT, EMT-critical care, or EMT-paramedic. These are special services designed to provide definitive prehospital emergency medical care, including but not limited to, cardiopulmonary resuscitation, cardiac monitoring, manual cardiac defibrillation, advanced airway management, intravenous therapy, administration with drugs and other medicinal preparations, and other specified techniques and procedures.

b. "Basic life support" means the assessment or treatment through the use of techniques described in the EMT-Basic National Standard Curriculum or the National EMS Education Standards. It includes emergency first aid and cardiopulmonary resuscitation procedures to maintain life without invasive techniques.

23a.

Certified Public Expenditures
Supplemental Payment for Publicly Owned or Operated
Emergency Medical Transportation Providers

"PEMT services" means both the act of transporting an individual from any point of origin to the medical site capable of meeting the emergency medical needs of the patient, as well as emergency medical treatment provided to an individual by PEMT providers before or during the act of transportation.

a. "Advanced life support" means the assessment or treatment through the use of techniques described in the Emergency Medical Technician (EMT)-Paramedic: National Standard Curriculum or the National Emergency Medical Services (EMS) Education Standards, provided by an advanced EMT, EMT-critical care, or EMT-paramedic. These are special services designed to provide definitive prehospital emergency medical care, including but not limited to, cardiopulmonary resuscitation, cardiac monitoring, manual cardiac defibrillation, advanced airway management, intravenous therapy, administration with drugs and other medicinal preparations, and other specified techniques and procedures.

b. "Basic life support" means the assessment or treatment through the use of techniques described in the EMT-Basic National Standard Curriculum or the National EMS Education Standards. It includes emergency first aid and cardiopulmonary resuscitation procedures to maintain life without invasive techniques.

Certified Public Expenditures
Supplemental Payment for Publicly Owned or Operated
Emergency Medical Transportation Providers

This program will provide supplemental payments to approved Public Emergency Medical Transportation (PEMT) entities that meet specified requirements and provide emergency medical transportation services to Medicaid beneficiaries. Participation in this program by any PEMT provider is voluntary.

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

Approved PEMT entities must submit cost reports for the previous cost and claiming period. For example, cost reports with data covering SFY 2020-21 must be submitted by September 30, 2021.

Costs will be identified using the Centers for Medicare and Medicaid Services (CMS) approved cost report. Absent the availability of a CMS approved cost report, costs will be identified and reported in such form as required by NYS DOH. 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 July 1, 2020.

A. Definitions

1. "Direct costs" means all costs that can be identified specifically with a particular final cost objective in order to meet medical transportation mandates.

2. "Indirect costs" means costs for a common or joint purpose benefitting more than one cost objective that are allocated to each benefiting objective using NYS DOH approved indirect rate or an allocation methodology. Indirect costs rate or allocation methodology must comply with OMB Circular A-87 and CMS non-institutional reimbursement policy.

3. "PEMT entity" is determined to be approved if it is a NYS DOH-certified ambulance service that is owned or operated by state, county, city, town, or village government.

B. "Shared direct costs" are direct costs that can be allocated to two or more departmental functions on the basis of shared benefits.

Supplemental Payment Methodology

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

1. The expenditures certified by the approved PEMT entity 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 PEMT entity will annually certify to NYS DOH the total costs for providing PEMT 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 requirement.

5. Computation of allowable costs and their allocation methodology must be determined in accordance with the CMS Provider Reimbursement Manual (CMS Pub. 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: 2 CFR 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.

6. Medicaid base and mileage payments to the PEMT providers for providing PEMT services are derived from the fees established for each county, for reimbursements payable by the Medicaid program.

7. For each approved PEMT provider in this supplemental program, the total uncompensated care costs 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 PEMT provider must provide PEMT services to Medicaid beneficiaries in excess of payments made from the Medicaid program and all other sources of reimbursement for such PEMT services provided to Medicaid beneficiaries. Approved PEMT providers that do not have any such uncompensated care costs will not receive a supplemental payment under this supplemental reimbursement program.

C. Cost Determination Protocols

1. An approved PEMT provider's specific allowable cost per-medical transport rate will be calculated based on the provider's audited financial data reported on the CMS-approved cost report.

   https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AmbulanceFeeSchedule/Ground-Ambulance-Services-Data-Collection-System

   The per-medical transport cost rate will be the sum of actual allowable direct and indirect costs of providing medical transport services divided by the actual number of medical transports provided for the applicable service period.

New York
6.1(d)

a. Direct costs for providing medical transport services include only the unallocated payroll costs and fringe benefits for the shifts in which personnel dedicate 100 percent of their time to providing medical transport services, medical equipment and supplies, and other costs directly related to the delivery of covered services, such as first-line supervision, materials and supplies, professional and contracted services, capital outlay, travel, and training. These costs must be in compliance with Medicaid non-institutional reimbursement policy and are directly attributable to the provision of the medical transport services.

b. Shared direct costs for emergency medical transport services, as defined by Paragraph A.5., must be allocated for salaries and benefits and capital outlay. The salaries and benefits will be allocated based on the percentage of total hours logged performing EMT activities versus other activities. The capital related costs will be allocated based on the percentage of total square footage.

c. Indirect costs are determined by applying the cognizant agency specific approved indirect cost rate to its total direct costs (Paragraph A.1.) or derived from provider's approved cost allocation plan. For approved PEMT providers that do not have a cognizant agency approved indirect cost rate or approved cost allocation plan, the costs and related basis used to determine the allocated indirect costs must be in compliance with OMB Circular A-87.

Medicare Cost Principle (42 CFR 413)

https://www.govinfo.gov/content/pkg/CFR-2010-title42-vol2/pdf/CFR-2010-title42-vol2-part413.pdf

and Medicare Provider Reimbursement Manual Part 1

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021929

and Medicare Provider Reimbursement Manual Part 2

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021935

and Medicaid non-institutional reimbursement policy.

d. The PEMT provider specific per-medical transport cost rate is calculated by dividing the total net medical transport allowable costs (Paragraphs A.1. and A.2.) of the specific provider by the total number of medical transports as reported in the transportation daily logs provided by the PEMT provider for the applicable service period.

2. Medicaid's portion of the total allowable cost for providing PEMT services by each approved PEMT provider is calculated by multiplying the total number of Medicaid FFS PEMT transports provided by the PEMT provider's specific per-medical transport cost rate (Paragraph C.1.d.) for the applicable service period.

D. Responsibilities and Reporting Requirements of the Approved PEMT Entity

An approved PEMT entity must:

1. Certify that the claimed expenditures for emergency medical transportation services made by the approved PEMT 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 approved cost report and cost identification methodology; and

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

E. NYS DOH's Responsibilities

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

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

F. Interim Supplemental Payment

1. NYS DOH will make annual interim Medicaid supplemental payments to approved PEMT 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 applicable cost reporting year. NYS DOH may make adjustments to the as-filed cost report based on the results of the most recently retrieved NY MMIS report.

2. Each approved PEMT provider 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 five months after the close of the cost and claiming 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 PEMT services to Medicaid beneficiaries from the Medicaid portion of the total PEMT allowable costs (Paragraph C.2.) reported in the as-filed cost report or 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 periods immediately prior to the effective date of this state plan in order to set a supplemental payment amount for the first year of this program.

A. Final Reconciliation

1. Providers must submit auditable documentation to NYS DOH within two years following the end of the state fiscal year 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 State fiscal year end. NYS DOH will compute the net Medicaid PEMT allowable cost using audited per-medical transport cost, and the number of Medicaid FFS PEMT transports 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 PEMT provider 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 PEMT provider has been underpaid, the PEMT 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.

Appendix II
2020 Title XIX State Plan
Third Quarter Amendment
Summary

SUMMARY
SPA #20-0067

This State Plan Amendment proposes to provide supplemental payments to approved Public Emergency Medical Transportation (PEMT) entities that meet specified requirements and provide emergency medical transportation services to Medicaid beneficiaries.

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

Authorizing Provisions

SPA 20-0067

New York State Senate - Assembly

S. 7506-B **January 22, 2020** **A. 9506--B**

https://www.nysenate.gov/legislation/bills/2019/s7506

1 § 3. The commissioner of health shall seek, pursuant to a state plan
2 amendment, authorization to establish and administer a program for the
3 federal financial participation in reimbursement for ground emergency
4 medical transportation services provided to Medicaid beneficiaries by
5 eligible transportation providers on a voluntary basis. The commissioner
6 of health may promulgate regulations, including emergency regulations,
7 in order to implement the provisions of this section.
8 1. Such program shall establish a payment methodology for supplemental
9 reimbursement that shall require the eligible transportation provider
10 file cost reports and data as required by the commissioner of health,
11 and certify that:
12 (a) in accordance with 42 C.F.R. section 433.51 or any successor regu-
13 lation, the claimed expenditures for the ground emergency medical trans-
14 portation services are eligible for federal financial participation; and
15 (b) the amount certified pursuant to paragraph (a) of this subdivision
16 when combined with amounts received from all other sources of reimburse-
17 ment from the Medicaid program does not exceed one hundred percent of
18 actual costs, as determined in accordance with the Medicaid state plan,
19 for ground emergency transportation services.
20 2. Eligible transportation providers receiving supplemental reimburse-
21 ment pursuant to this subdivision shall not receive non-comparable cost
22 reimbursement for the Medicaid costs associated with ambulance services
23 as provided in subparagraph (i) of paragraph (b) of subdivision 35 of
24 section 2807-c of the public health law and as may be further defined
25 regulations issued by the commissioner of health and shall not report
26 such costs as Medicaid reimbursable costs in the institutional cost
27 report.
28 3. For the purposes of this section, an "eligible transportation
29 provider" shall mean:
30 (a) a provider who provides ground emergency medical transportation
31 services to Medicaid beneficiaries; and
32 (b) is enrolled as a Medicaid provider for the period being claimed;
33 and
34 (c) is owned or operated by the state, a political subdivision or
35 local government, that employs or contracts with persons or entities
36 licensed to provide emergency medical services in New York state, and
37 includes private entities to the extent permissible under federal law.

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

For publication in the
October 21 edition of the
New York State Register

Public Notice
NYS 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 enacted statutory provisions. The following changes are proposed:

Non-Institutional Services

The following is a clarification to the April 1, 2020 noticed provision to pursue a Certified Public Expenditure program to maximize federal reimbursement for NEMT services incurred by municipalities. With clarification, the provision shall 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 provision 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 l

There is no additional estimated annual change to gross Medicaid expenditures as a result of this proposed amendment.

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:

New York State Department of Health
Division of Finance and Rate Setting

For publication in the
October 21 edition of the
New York State Register

99 Washington Ave – One Commerce Plaza
Suite 1432
Albany, New York 12210
spa_inquiries@health.ny.gov

- Eliminating Prescriber Prevails which applies to the Medicaid fee-for-service pharmacy program and to selected drug classes for managed care plans. Doing so would reduce inappropriate prescribing, remove barriers that limit the State's ability to manage pharmacy programs, and minimize the inappropriate influence of pharmaceutical manufacturers in the prior authorization process.

The estimated annual net aggregate decrease in gross Medicaid expenditures attributable to these initiatives contained in the budget for SFY 2020/2021 is $142 million and for SFY 2021/2022 is $428 million.

Transportation

Effective on or after April 1, 2020 and SFY thereafter, these proposals would:

- Transition the State to a single Medicaid Transportation Broker to ensure that consumers receive reliable, high quality transportation services using the mode that is appropriate for the consumer.
- Discontinue the Supplemental Ambulance Rebate Payments to emergency medical transportation (EMT) providers since updating and rationalized the ambulance fee schedule consistent with the Department of Health's Ambulance Rate Adequacy Study.
- Carve transportation out of the MLTC Benefit (excluding PACE) and into fee-for-service to create efficiencies and consistency in purchasing, arranging and managing transportation services across the Medicaid program.
- Maximize Public Transit in New York City and other urban areas to encourage the use of public transportation as an alternative to livery when appropriate for the consumer.
- Reduce Taxi/Livery Rates and promoting other modes of transportation to reflect market rates for transportation services.
- Implement an ambulance diversion - Triage, Treat and Transport (ET3) - support program to reduce avoidable hospitalizations, subject to any necessary federal approvals.
- Pursue a Certified Public Expenditure program to maximize federal reimbursement for NEMT services incurred by municipalities.
- Create a Community Paramedicine Program to expand the roles of Emergency Medical Technicians (EMTs) and Paramedics by providing medical care to patients at home to avoid unnecessary trips to the Emergency Department (ED). EMTs and Paramedics would provide additional patient health and safety services (e.g., food, medications, fall precautions) and clinical assessment and diagnostic testing in consultation with online medical control/telemedicine physicians/advanced practitioners to avoid unnecessary trips to the hospital.

The estimated annual net aggregate decrease in gross Medicaid expenditures attributable to these initiatives contained in the budget for SFY 2020-2021 is $188 million and for SFY 2021-2022 is $488 million.

Telehealth

Effective on or after April 1, 2020 and SFY thereafter, these proposals would:

- Expand Utilization of Telehealth services and reimbursement models, specifically to address behavioral health, oral health, maternity care and other high-need populations. The proposal contemplates a state-wide, hosted telehealth platform to help mitigate interoperability barriers, as well as to enhance broadband to ensure telehealth connectivity in rural areas.

The estimated annual net aggregate decrease in gross Medicaid expenditures attributable to these initiatives contained in the budget for SFY 2020-2021 is $15 million and for SFY 2021-2022 is $25.4 million.

Institutional Services

Effective on or after April 1, 2020 and SFY thereafter, these proposals would:

- Reduce the size of the voluntary hospital Indigent Care Pool by $75 million (State share);
- Eliminate the Indigent Care Pool "Transition Collar", which generates an additional $12.5 million in State share savings; and
- Eliminate the Public Hospitals Indigent Care Pool, which generates $70 million in State savings;
- Convert the value of Upper Payment Limit (UPL) payments received by public hospitals in a city with a population over a million into Medicaid reimbursement rates;
- Reduce hospital inpatient capital rate add-on by 5 percent and capital reconciliation payments by 10 percent.

The estimated annual net aggregate decrease in gross Medicaid expenditures attributable to these initiatives contained in the budget for SFY 2020-2021 is $728 million and for SFY 2021-2022 is $743 million.

Long Term Care Services

Effective on or after April 1, 2020 and SFY thereafter, these proposals would:

- Modify the current eligibility criteria for individuals to receive Personal Care Services and Consumer Directed Personal Assistance Services (CDPAS) as a Medicaid benefit, regardless of whether such services are received through fee-for-service, Mainstream Managed Care plans, or Managed Long Term Care (MLTC) plans. In order to be eligible to receive such services, an individual must be assessed to need assistance with more than two activities of daily living (ADLs) (ranging from limited assistance to total dependence).
- Institute a Home and Community Based Services lookback period of 60 months for asset transfers in determining eligibility for Medicaid for those seeking home and community based long term care services and supports as currently applies to those seeking Medicaid eligibility for nursing home care.
- Eliminate the ability of spouses living together in the community, and parents living with their child, to refuse to make their income and resources available during the determination of an applicant's eligibility for Medicaid.
- Utilize an independent clinician panel, similar to the State's Conflict Free Evaluation and Enrollment Center, to assess patients and order PCS and CDPAS under a clear set of standards and protocols.
- Implement an enhanced utilization review process by an independent assessor for any individuals who are assessed to need more than 12 hours per day on average in a given month (i.e., 360 hours per month for a 30-day month) to ensure that it remains safe for that individual to remain in the community.
- Change the frequency in which the Community Health Assessment is conducted from every six months to once annually, subject to requiring reassessments based on changes in health condition or status.
- Implement a uniform tasking tool for use by plans and Local Departments of Social Services (LDSS) to help determine service utilization, including the hours of Personal Care Services and CDPAS required each day.
- Employ the provider "choice" model to proceed with the implementation and electronic visit verification (EVV) system, as required by the Federal 21st Century Cures Act.
- Eliminate requirements that plans and LDSS educate consumers about the availability of the CDPAP program semi-annually Develop standards and protocols to determine whether consumers are self-directing and, if applicable, their designated representative is able to fulfill their obligations appropriately.
- Delay the implementation date of certain permissible Consumer First Choice Option Services (CFCO) services from January 1, 2020 to April 1, 2022.
- Incorporate additional transparency, compliance, and accountability standards to ensure that entities receiving wage parity payments are appropriately using those funds for the benefit home care aides.
- Reduce Workforce Recruitment and Retention funding for home health care workers.
- Migrate the completion of all Community Health Assessments (CHA) and reassessments to a single, statewide Independent Assessor (IA).
- Modify the minimum community spouse resource amount, which is used to determine the Medicaid eligibility of an applicant under spousal impoverishment budgeting.
- Reduce funding associated with nursing home capital reim-

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

NON-INSTITUTIONAL SERVICES
State Plan Amendment #20-0067

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. For SPAs that provide for changes to payments for clinic or outpatient hospital services or for enhanced or supplemental payments to physician or other practitioners, the questions must be answered for all payments made under the state plan for such service.

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 payments, a complete listing of providers that return a portion of their payments, 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: Governmental providers do retain the payments made pursuant to this amendment.

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 through 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 governmental 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 budget 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. Also, 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. **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.**

   Response: This is not a clinic or outpatient hospital service.

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: No governmental provider currently receives payments that in aggregate exceed their cost of providing the services. However, we are unaware of any requirement under current federal law or regulation that limits individual provider's 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.**

<u>Response:</u> 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.