ATTACHMENT G

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

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 #21-0006
Non-Institutional Services

Dear Ms. McKnight:

The State requests approval of the enclosed amendment #21-0006 to the Title XIX (Medicaid) State Plan for non-institutional services to be effective January 22, 2021 (Appendix I). This amendment is being submitted based on enacted legislation and State regulations. 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.

Copies of pertinent sections of enacted legislation and State regulations are 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 December 30, 2020 is 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

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: 21 — 0006

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 $ 70,524.21
b. FFY 10/01/21-09/30/22 $ 101,565.02

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT

Attachment 3.1-A Supp: Page 3(d)(A)(i)
Attachment 3.1-B Supp: Page 3(d)(A)(i)
Attachment 4.19-B: Pages 6.1(a), 6.1(b), 6.1(c), 6.1(d), 6.1(e), 6.1(f)

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*

NEW

10. SUBJECT OF AMENDMENT

Supplemental reimbursement for publicly owned, emergency ambulance providers (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
Donna Frescatore

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

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

New York
3(d)(A)(i)

4. "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.

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

New York
3(d)(A)(i)

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New York
6.1(a)

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

This program will provide supplemental payments to Medicaid enrolled 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 spanning July 1 to June 30, unless another time period is approved by CMS and the state. Participating providers will have six months following the completion of a cost reporting period to submit reports. For example, cost reports with data covering the 2020-21 reporting period from July 1, 2020 to June 30, 2021 must be submitted by December 31, 2021. Subsequent years will align with this timeline. 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 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 April 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 Medicaid enrolled NYS DOH-certified ambulance service that is owned or operated by state, county, city, town, or village government.

New York
6.1(b)

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 requirements.

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 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 transport billing records 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

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 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 prior cost reporting year.

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 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 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 adjusted by NYS DOH (Paragraph F.1.).

4. Cost reports may be utilized from the period 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. 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.

G. 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 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
Fourth Quarter Amendment
Summary

SUMMARY
SPA #21-0006

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

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.

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

Authorizing Provisions

SPA 21-0006

New York State Senate - Assembly

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

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

§ 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.

DRAFT Regulations: SPA 21-0006

Pursuant to the authority vested in the Commissioner of Health by section three of Part LL of Chapter 56 of the Laws of 2020, paragraph (1) of subdivision (l) of Section 86-1.15 of Title 10 (Health) of the Official Compilation of Codes, Rules and Regulations of the State of New York is amended to be effective on or after October 1, 2020, to read as follows:

(1) Medicaid costs associated with ambulance services operated by a facility and reported as inpatient costs in the institutional cost report. Effective October 1, 2020, these costs shall exclude ground emergency transportation services costs that are being reimbursed pursuant to Chapter 56 of the Laws of 2020; and

REGULATORY IMPACT STATEMENT

Statutory Authority:

The statutory authority for this regulation is contained in Chapter 56 of the Laws of 2020 and authorizes the Commissioner to promulgate regulations, including emergency regulations, regarding a supplemental Medicaid reimbursement payment for ground emergency medical transportation services. This supplemental payment is in lieu of an ambulance non-comparable add-on in the hospital acute inpatient reimbursement rate. Rate regulations are set forth in Subpart 86-1 of Title 10 (Health) of the Official Compilation of Codes, Rules, and Regulations of the State of New York (NYCRR).

Legislative Objectives:

The legislative objective is to provide the ability to participate in the supplemental payment for ground emergency medical transportation services but eliminate any potential duplicate Medicaid reimbursement.

Needs and Benefits:

Based on the requirements of Chapter 56 of the Laws of 2020, eligible ground emergency transportation providers will be provided the ability to participate in a supplemental payment in lieu of receiving reimbursement through a hospital. Article 28 hospitals currently receive reimbursement through their acute hospital inpatient rate for ambulance services provided by the ground emergency medical transportation providers. For ground emergency transportation providers that meet the requirements of this chapter and receive the supplemental payment, the hospitals through which they were reimbursed will not be eligible to also receive the ambulance add-on in the acute hospital inpatient rate.

COSTS:

Costs to Private Regulated Parties:

There will be no additional costs to private regulated parties.

Costs to State Government:

There is no cost to State Government for this proposed regulation.

Costs of Local Government:

There is no cost to Local Government for this proposed regulation.

Costs to the Department of Health:

There will be no additional costs to the Department of Health as a result of this proposed regulation.

Local Government Mandates:

The proposed regulation does not impose any new programs, services, duties or responsibilities upon any county, city, town, village, school district, fire district or other special district.

Paperwork:

No additional paperwork is required of providers.

Duplication:

This regulation does not duplicate any existing federal, state or local government regulation.

Alternatives:

There is no alternative as an alternative would provide a duplicate payment to hospitals.

Federal Standards:

The proposed regulation does not exceed any minimum standards of the federal government for the same or similar subject areas.

Compliance Schedule:

The Department of Health will be implementing the ground emergency transportation services supplemental program effective on or after October 1, 2020 which requires the potential duplicate payment be removed as of the same date.

Contact Person: Katherine Ceroalo
New York State Department of Health
Bureau of Program Counsel, Regulatory Affairs Unit
Corning Tower Building, Rm. 2438
Empire State Plaza
Albany, New York 12237
(518) 473-7488
(518) 473-2019 (FAX)
REGSQNA@health.ny.gov

STATEMENT IN LIEU OF

REGULATORY FLEXIBILITY ANALYSIS

No regulatory flexibility analysis is required pursuant to section 202(b)(3)(a) of the State Administrative Procedure Act. The proposed regulations do not impose an adverse economic impact on small businesses or local governments, and they do not impose reporting, record keeping or other compliance requirements on small businesses or local governments.

STATEMENT IN LIEU OF

RURAL AREA FLEXIBILITY ANALYSIS

No rural flexibility analysis is required pursuant to section 202-bb(4)(a) of the State Administrative Procedure Act. The proposed regulations do not impose an adverse impact on facilities in rural areas, and they do not impose reporting, record keeping or other compliance requirements on facilities in rural areas.

JOB IMPACT STATEMENT

A Job Impact Statement is not required pursuant to Section 201-a(2)(a) of the State Administrative Procedure Act. The proposed rule will not have a substantial adverse impact on jobs or employment opportunities, nor does it have adverse implications for job opportunities.

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

NON-INSTITUTIONAL SERVICES
State Plan Amendment #21-0006

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.**

Response: Tribal consultation was performed in accordance with the State's tribal consultation policy as approved in SPA 17-0065, and documentation ofsuch 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.