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

June 29, 2021

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

RE: SPA #21-0032
Non-Institutional Services

Dear Mr. Scott:

The State requests approval of the enclosed amendment #21-0032 to the Title XIX (Medicaid) State Plan for non-institutional services to be effective April 1, 2021 (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). A copy of the public notice of this plan amendment, which was given in the New York State Register on March 31, 2021, is also enclosed for your information (Appendix IV). 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

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 — 0032

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
April 1, 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
Public Health Law § 2999-cc(6) and Social Services Law § 367-u(2)

7. FEDERAL BUDGET IMPACT
a. FFY 04/01/21-09/30/21 $ (6,517.50)
b. FFY 10/01/21-09/30/22 $ (16,087.50)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT

Attachment: 3.1-A Supp Page 2(a)(ii)(d)
3.1-B Supp Page 2(a)(ii)(d)
4.19-B Page 4(a)(i)(6)

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*

Attachment: 3.1-A Supp Page 2(a)(ii)(d)
3.1-B Supp Page 2(a)(ii)(d)
4.19-B Page 4(a)(i)(6)

10. SUBJECT OF AMENDMENT
Telehealth Expansion of Store and Forward Coverage (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
June 29, 2021

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

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED

18. DATE APPROVED

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL

20. SIGNATURE OF REGIONAL OFFICIAL

21. TYPED NAME

22. TITLE

23. REMARKS

Instructions on Back

Appendix I
2021 Title XIX State Plan
Second Quarter Amendment
Amended SPA Pages

New York
2(a)(ii)(c)

Telehealth Services – Store and Forward

Effective on or after April 1, 2018, the Commissioner of Health is authorized to establish fees to reimburse the cost of telehealth store and forward technology.

Telehealth store and forward technology is the asynchronous, secure electronic transmission of a patient's health information in the form of patient-specific digital images, including medical records and/or pre-recorded videos from a provider at an originating site to a consulting provider at a distant site.

Effective on or after April 1, 2021, store and forward technology will include reimbursement for interprofessional consultations. The purpose of providing interprofessional consultations via telehealth is to assist the originating site provider in the management of patients whose medical needs are outside of the originating provider's expertise and/or scope of practice.

Reimbursement for telehealth store and forward services, including interprofessional consultations, is to be provided for Medicaid patients [with conditions or clinical circumstances] where the provision of telehealth services can appropriately reduce the need for on-site or in-office visits.

All services delivered via telehealth store and forward technology must be performed on dedicated secure transmission linkages that meet the minimum federal and state requirements, including but not limited to 45 CFR, Parts 160 and 164 (HIPAA Security Rules). All existing confidentiality requirements that apply to written medical records will apply to services delivered by store and forward technology, including the actual transmission of health care data and any other electronic information/records.

New York
2(a)(ii)(c)

Telehealth Services – Store and Forward

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All services delivered via telehealth store and forward technology must be performed on dedicated secure transmission linkages that meet the minimum federal and state requirements, including but not limited to 45 CFR, Parts 160 and 164 (HIPAA Security Rules). All existing confidentiality requirements that apply to written medical records will apply to services delivered by store and forward technology, including the actual transmission of health care data and any other electronic information/records.

New York
4(a)(i)(6)

Telehealth Services – Store and Forward

The Commissioner of Health is authorized to establish fees, approved by the Director of the Budget, to reimburse the cost of consultations provided via telehealth store and forward technology.

Telehealth store and forward technology involves the asynchronous, secure electronic transmission of a patient's health information in the form of patient-specific digital images, including medical records and/or pre-recorded videos from a provider at an originating site to a consulting provider at a distant site without the patient present. Reimbursement for telehealth store and forward services, including interprofessional consultations, is to be provided for Medicaid patients with conditions or clinical circumstances where the provision of telehealth services can appropriately reduce the need for on-site or in-office visits.

Reimbursement will be made to the consulting provider. Telehealth store and forward technology is reimbursed at [75]100% of the applicable fee for the evaluation and management code that applies. Provider fee schedules can be found at

https://www.emedny.org/ProviderManuals/index.aspx

Appendix II
2021 Title XIX State Plan
Second Quarter Amendment
Summary

SUMMARY
SPA #21-0032

This State Plan Amendment proposes to revise the State Plan to expand coverage of store and forward services for the purposes of strengthening and sustaining telehealth as a high-quality, cost effective, and consumer-oriented form of care delivery.

Appendix III
2021 Title XIX State Plan
Second Quarter Amendment
Authorizing Provisions

SPA 21-0032

The authorizing provisions for this SPA are Public Health Law § 2999-cc(6) and Social Services Law § 367-u(2).

N.Y. Public Health Law § 2999-cc

§ 2999-cc. Definitions. As used in this article, the following terms shall have the following meanings:

1. "Distant site" means a site at which a telehealth provider is located while delivering health care services by means of telehealth. Any site within the United States or United States' territories is eligible to be a distant site for delivery and payment purposes.

2. "Telehealth provider" means:

(a) a physician licensed pursuant to article one hundred thirty-one of the education law;

(b) a physician assistant licensed pursuant to article one hundred thirty-one-B of the education law;

(c) a dentist licensed pursuant to article one hundred thirty-three of the education law;

(d) a nurse practitioner licensed pursuant to article one hundred thirty-nine of the education law;

(e) a registered professional nurse licensed pursuant to article one hundred thirty-nine of the education law only when such nurse is receiving patient-specific health information or medical data at a distant site by means of remote patient monitoring;

(f) a podiatrist licensed pursuant to article one hundred forty-one of the education law;

(g) an optometrist licensed pursuant to article one hundred forty-three of the education law;

(h) a psychologist licensed pursuant to article one hundred fifty-three of the education law;

(i) a social worker licensed pursuant to article one hundred fifty-four of the education law;

(j) a speech language pathologist or audiologist licensed pursuant to article one hundred fifty-nine of the education law;

(k) a midwife licensed pursuant to article one hundred forty of the education law;

(l) a physical therapist licensed pursuant to article one hundred thirty-six of the education law;

(m) an occupational therapist licensed pursuant to article one hundred fifty-six of the education law;

(n) a person who is certified as a diabetes educator by the National Certification Board for Diabetes Educators, or a successor national certification board, or provided by such a professional who is affiliated with a program certified by the American Diabetes Association, the American Association of Diabetes Educators, the Indian Health Services, or any other national accreditation organization approved by the federal centers for medicare and medicaid services;

(o) a person who is certified as an asthma educator by the National Asthma Educator Certification Board, or a successor national certification board;

(p) a person who is certified as a genetic counselor by the American Board of Genetic Counseling, or a successor national certification board;

(q) a hospital as defined in article twenty-eight of this chapter, including residential health care facilities serving special needs populations;

(r) a home care services agency as defined in article thirty-six of this chapter;

(s) a hospice as defined in article forty of this chapter;

(t) credentialed alcoholism and substance abuse counselors credentialed by the office of addiction services and supports or by a credentialing entity approved by such office pursuant to section 19.07 of the mental hygiene law;

(u) providers authorized to provide services and service coordination under the early intervention program pursuant to article twenty-five of this chapter;

(v) clinics licensed or certified under article sixteen of the mental hygiene law and certified and non-certified day and residential programs funded or operated by the office for people with developmental disabilities;

(w) a care manager employed by or under contract to a health home program, patient centered medical home, office for people with developmental disabilities Care Coordination Organization (CCO), hospice or a voluntary foster care agency certified by the office of children and family services certified and licensed pursuant to article twenty-nine-i of this chapter;

(x) certified peer recovery advocate services providers certified by the commissioner of addiction services and supports pursuant to section 19.18-b of the mental hygiene law, peer providers credentialed by the commissioner of addiction services and supports and peers certified or credentialed by the office of mental health; and

(y) any other provider as determined by the commissioner pursuant to regulation or, in consultation with the commissioner, by the commissioner of the office of mental health, the commissioner of the office of addiction services and supports, or the commissioner of the office for people with developmental disabilities pursuant to regulation.

3. "Originating site" means a site at which a patient is located at the time health care services are delivered to him or her by means of telehealth.

4. "Telehealth" means the use of electronic information and communication technologies by telehealth providers to deliver health care services, which shall include the assessment, diagnosis, consultation, treatment, education, care management and/or self-management of a patient. Telehealth shall not include delivery of health care services by means of facsimile machines, or electronic messaging alone, though use of these technologies is not precluded if used in conjunction with telemedicine, store and forward technology, or remote patient monitoring. For purposes of this section, telehealth shall be limited to telemedicine, store and forward technology, remote patient monitoring and audio-only telephone communication, except that with respect to the medical assistance program established under section three hundred sixty-six of the social services law, and the child health insurance plan under title one-A of article twenty-five of this chapter, telehealth shall include audio-only telephone communication only to the extent defined in regulations as may be promulgated by the commissioner. This subdivision shall not preclude the delivery of health care services by means of "home telehealth" as used in section thirty-six hundred fourteen of this chapter.

5. "Telemedicine" means the use of synchronous, two-way electronic audio visual communications to deliver clinical health care services, which shall include the assessment, diagnosis, and treatment of a patient, while such patient is at the originating site and a telehealth provider is at a distant site.

6. "Store and forward technology" means the asynchronous, electronic transmission of a patient's health information in the form of patient-specific digital images and/or pre-recorded videos from a provider at an originating site to a telehealth provider at a distant site.

7. "Remote patient monitoring" means the use of synchronous or asynchronous electronic information and communication technologies to collect personal health information and medical data from a patient at an originating site that is transmitted to a telehealth provider at a distant site for use in the treatment and management of medical conditions that require frequent monitoring. Such technologies may include additional interaction triggered by previous transmissions, such as interactive queries conducted through communication technologies or by telephone. Such conditions shall include, but not be limited to, congestive heart failure, diabetes, chronic obstructive pulmonary disease, wound care, polypharmacy, mental or behavioral problems, and technology-dependent care such as continuous oxygen, ventilator care, total parenteral nutrition or enteral feeding. Remote patient monitoring shall be ordered by a physician licensed pursuant to article one hundred thirty-one of the education law, a nurse practitioner licensed pursuant to article one hundred thirty-nine of the education law, or a midwife licensed pursuant to article one hundred forty of the education law, with which the patient has a substantial and ongoing relationship.

N.Y. Social Services Law § 367-u

§ 367-u. Payment for home telehealth services. 1. Subject to the approval of the state director of the budget, the commissioner may authorize the payment of medical assistance funds for

demonstration rates or fees established for home telehealth services provided pursuant to subdivision three-c of section thirty-six hundred fourteen of the public health law.

2. Subject to federal financial participation and the approval of the director of the budget, the commissioner shall not exclude from the payment of medical assistance funds the delivery of health care services through telehealth, as defined in subdivision four of section two thousand nine hundred ninety-nine-cc of the public health law. Such services shall meet the requirements of federal law, rules and regulations for the provision of medical assistance pursuant to this title.

Appendix IV
2021 Title XIX State Plan
Second Quarter Amendment
Public Notice

greater than zero trend factors, pursuant to the provisions of Public Health Law § 2807-c(10)(c), will be applied to rates of payment for hospital inpatient and outpatient services, inpatient and adult day health care outpatient services provided by residential health care facilities pursuant to Article 28 of the Public Health Law (except for residential health care facilities or units of such facilities providing services primarily to children under 21 year of age), for certified home health agencies, long term home health care programs, AIDS home care programs, and for personal care services pursuant to section 365-a of the Social Services Law, including personal care services provided in those local social services districts, including New York City, whose rates of payment for services is established by such social services districts pursuant to a rate-setting exemption granted by the Department, and assisted living program services.

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

Non-Institutional Services

Effective on or after April 1, 2021, this proposal continues the supplemental upper payment limit payments made to general hospitals, other than major public general hospitals under non-institutional services of $339 million annually. There is no change to the annual gross Medicaid expenditures as a result of this proposed amendment.

For state fiscal year beginning April 1, 2021 through March 31, 2022, this proposal continues hospital outpatient payment adjustments that increase the operating cost components of rates of payment for hospital outpatient and emergency departments on and after April 1, 2011, for public general hospitals other than those operated by the State of New York or the State University of New York, which are located in a city with a population of over one million. The amount to be paid will be up to $287 million annually based on criteria and methodology set by the Commissioner of Health, which the Commissioner may periodically set through a memorandum of understanding with the New York City Health and Hospitals Corporation. Such adjustments shall be paid by means of one or more estimated payments. Payments may be added to rates of payment or made as aggregate payments.

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

For state fiscal year beginning April 1, 2021 through March 31, 2022, this proposal continues payment of up to $5.4 million in additional annual Medicaid payments to county operated free-standing clinics, not including facilities operated by the New York City Health and Hospitals Corporation, for services provided by such DTC and those provided by a county operated freestanding mental health or substance abuse DTC. Distributions shall be based on each eligible facility's proportionate share of the sum of all DTC and clinic visits for all eligible facilities receiving payments for the base year two years prior to the rate year. The proportionate share payments may be added to rates of payment or made as aggregate payments to eligible facilities.

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

Effective on or after April 1, 2021, this amendment proposes to revise the State Plan to reduce the Worker Recruitment and Retention add-on percentage by an additional 25 percent as compared to 2020/2021, for Certified Home Health Agencies (CHHA) and Hospice programs.

The estimated annual net aggregate decrease in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2021/2022 is ($1.5 million).

Effective on or after April 1, 2021 the Department will reduce coverage of certain over the counter (OTC) products. Clinically critical products such as aspirin and vitamins and minerals used for deficiencies will continue to be covered, as will less expensive OTC products that are in Preferred Drug Program (PDP) drug classes. The estimated annual net aggregate decrease in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2021/2022 is ($17.4 million).

Effective on and after April 1, 2021, this notice provides for a temporary rate adjustment with an aggregate payment amounts totaling no less than $10,001,000 annually, for Essential Community Providers (ECPs) for the periods April 1, 2021 through March 31, 2022 and April 1, 2022 through March 31, 2023. These payments will be made to the following approved providers: A.O Fox Memorial Hospital, Adirondack Medical Center, Alice Hyde Hospital Association, Auburn Memorial Hospital, Bassett Hospital of Schoharie County-Cobleskill Regional, Brooks Memorial Hospital, Canton-Potsdam Hospital, Carthage Area Hospital, Catskill Regional Hospital – Sullivan, Catskill Regional Medical Center-Hermann Div, Cayuga Medical Center-Ithaca, Champlain Valley Physicians HMC, Chenango Memorial Hospital, Claxton Hepburn Hospital, Clifton-Fine Hospital, Columbia Memorial Hospital, Community Memorial Hospital, Corning Hospital, Cortland Memorial Hospital, Cuba Memorial Hospital, Delaware Valley Hospital, Elizabethtown Community Hospital, Ellenville Community Hospital, Gouverneur Hospital, Ira Davenport Memorial Hospital, Jones Memorial Hospital, Lewis County General Hospital, Little Falls Hospital, Margaretville Memorial Hospital, Mary Imogene Bassett Hospital, Massena Memorial Hospital, Medina Memorial Hospital, Moses-Ludington Hospital, Nathan Littauer Hospital, Northern Dutchess Hospital, Noyes Memorial Hospital, O'Connor Hospital, Olean General Hospital – Main, Oneida City Hospital, Oswego Hospital, River Hospital, Samaritan Medical Center, Schuyler Hospital, Soldiers and Sailors Memorial Hospital, St. James Mercy Hospital, Tri Town Regional, Westfield Memorial Hospital, Wyoming County Community Hospital, WCA Hospital, United Memorial Medical Center, as well as St. Mary's Healthcare.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2021/2022 is $10.0 million.

Effective on and after April 1, 2021, this notice provides for a temporary rate adjustment with an aggregate payment totaling no less than $7.5 million annually for Critical Access Hospitals (CAHs), for the periods April 1, 2021 through March 31, 2022 and April 1, 2022 through March 31, 2023. These payments will be made to the following:

Bassett Hospital of Schoharie County-Cobleskill Regional, Carthage Area Hospital, Catskill Regional Medical Center-Hermann, Clifton-Fine Hospital, Community Memorial Hospital, Cuba Memorial Hospital, Delaware Valley Hospital, Elizabethtown Community.

Hospital, Ellenville Regional Hospital, Gouverneur Hospital, Lewis County General Hospital, Little Falls Hospital, Margaretville Hospital, O'Connor Hospital, River Hospital, Schuyler Hospital, Soldiers and Sailors Memorial Hospital of Yates, as well as Medina Memorial Hospital.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2021/2022 is $7.5 million.

Effective on or after April 1, 2021, the State is advancing a compressive set of telehealth reforms for the purposes of strengthening and sustaining telehealth as a high-quality, cost effective, and consumer-oriented form of care delivery.

The estimated annual net aggregate decrease in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2021/2022 is ($79.0 million).

Effective on or after April 1, 2021, and each fiscal year thereafter, the State proposes to establish a 340B Reimbursement Fund for the purposes of supporting activities that expand health services to the Medicaid members, the uninsured, and low-income patients, as supported by the 340B program.

The annual gross Medicaid expenditures as a result of this proposed amendment is $102.0 million.

Effective on or after April 1, 2021, and for each State Fiscal Year thereafter, the State proposes to revise the method of distributing the funding for the Clinic Safety Net (CSN) distribution for comprehensive diagnostic and treatment centers that are other than Federally Qualified Health Centers (referred to as the non-FQHC CSN distribution).

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

Appendix V
2021 Title XIX State Plan
Second Quarter Amendment
Responses to Standard Funding Questions

NON-INSTITUTIONAL SERVICES
State Plan Amendment #21-0032

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: 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 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 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.

   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 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: There are various State and Federal agencies that perform audits each year to determine the appropriateness of Medicaid payments. In the event that inappropriate payments are determined, recoupments would be initiated, and the Federal share would be returned to CMS within the associated quarterly expenditure report.

ACA Assurances:

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

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

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

2. **Section 1905(y) and (z) of the Act provides for increased FMAPs for expenditures made on or after January 1, 2014 for individuals determined eligible under section 1902(a)(10)(A)(i)(VIII) of the Act. Under section 1905(cc) of the Act, the increased FMAP under sections 1905(y) and (z)**

would not be available for States that require local political subdivisions to contribute amounts toward the non-Federal share of the State's expenditures at a greater percentage than would have been required on December 31, 2009.

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

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

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

   Response: The State 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
2021 Title XIX State Plan
Second Quarter Amendment
Responses to Standard Access Questions

APPENDIX VI
NON-INSTITUTIONAL SERVICES
State Plan Amendment # 21-0032

CMS Standard Access Questions - Clinic

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-B 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: Providers are required to meet licensure and certification requirements to ensure providers are qualified to deliver services to Medicaid patients. These requirements as well as other methods and procedures the state has to assure efficiency, economy and quality of care are not impacted in anyway by the amendment. Secondly, this amendment increases reimbursement for telehealth store and forward technology from 75% reimbursement of an in person visit to 100% reimbursement. Telehealth expansion is expected to provide savings through an increase in access to services and improved outcomes.

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. Utilization of telehealth modalities to deliver services will increase access in provider shortage areas. The State monitors and considers requests in the context of access as they approve/deny changes in services. Additionally, 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. Telehealth modalities will also expand access to providers within the Managed Care plans. The State does expect to see a reduction in transportation services as a result of telehealth. Should sufficient access to services, including transportation 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: Telehealth work groups, surveys, and Medicaid Redesign proposals are used as reference in telehealth reform. The Governor also created a diverse 16-member commission to consult with the State on telehealth recommendations. In addition, NY published notice in the state register of the proposed policy and did not receive any comment.

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: Telehealth reform should increase access to providers by eliminating geographical barriers throughout the state. This State Plan Amendment will not reduce existing rates paid to providers. Savings will be achieved through a reduction in transportation and Emergency Department visits, as well as improved outcomes. 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 has undertaken a massive reform initiative to better align reimbursement with care. When fully implemented, the initiative will invest over $600 million in the State's ambulatory care system (outpatient, ambulatory surgery, emergency department, clinic and physicians) to incentivize care in the most appropriate setting. The State has also increased its physician reimbursement schedule to resemble Medicare payments for similar services, thus ensuring continued access for Medicaid beneficiaries. While some of these initiatives are outside the scope of the State Plan, they represent some of the measures the State is taking to ensure quality care for the State's most vulnerable population. Rates will not be reduced as part of this State Plan Amendment. Additionally, telehealth reforms are expected to increase access to needed services, particularly for those living in rural areas.