NEW YORK STATE OF OPPORTUNITY. Department of Health

KATHY HOCHUL
Governor

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

JOHANNE E. MORNE, M.S.
Acting Executive Deputy Commissioner

September 29, 2023

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

RE: SPA #23-0005
Non-Institutional Services

Dear Mr. Scott:

The State requests approval of the enclosed amendment #23-0005 to the Title XIX (Medicaid) State Plan for non-institutional services to be effective August 1, 2023 (Appendix I). This amendment is being submitted based on Section 1902(a)(70) of the Social Security Act, New York State Social Services Law Section 365-h(4)(b), and 18 NYCRR Section 505.10. 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 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 the pertinent section of New York State Social Services Law and implementing State regulation are 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 February 22, 2023, 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]

Amir Bassiri
Medicaid Director
Office of Health Insurance Programs

Enclosures

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

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 23-0005

2. STATE: NY

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

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
August 1, 2023

5. FEDERAL STATUTE/REGULATION CITATION
§ 1905(a)(30) Other Medical Care

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 08/01/23-09/30/23 $ (4,250,000)
b. FFY 10/01/23-09/30/24 $ (17,000,000)

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 3.1-D Pages: 1, 2, 3, 3.1
Attachment 3.1-A Supplemental Page: 3(d)
Attachment 3.1-B Supplemental Page: 3(d)

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 3.1-D Pages: 1, 2, 3
Attachment 3.1-A Supplemental Page: 3(d)
Attachment 3.1-B Supplemental Page: 3(d)

9. SUBJECT OF AMENDMENT
Medicaid Transportation Broker Model

10. 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:

11. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

12. TYPED NAME
Amir Bassiri

13. TITLE
Medicaid Director

14. DATE SUBMITTED
September 29, 2023

15. 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 CMS USE ONLY

16. DATE RECEIVED

17. DATE APPROVED

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL

19. SIGNATURE OF APPROVING OFFICIAL

20. TYPED NAME OF APPROVING OFFICIAL

21. TITLE OF APPROVING OFFICIAL

22. REMARKS

Instructions on Back

SPA 23-0005

Attachment A

Annotated Pages

Annotated Attachment 3.1-D Page: 3

v. Payment for reimbursement of the MA recipient's use of a personal vehicle will be made at the Internal Revenue Service's established rate for *Medical Mileage*. Payment of reimbursement for use of a personal vehicle of a volunteer driver or family memeber of a MA recipient will be made at the Internal Revenue Service's established rate for *Standard Mileage.*

b. Payment for transportation is only available for transportation to and from providers of necessary medical care and services which can be paid for under the MA program. MA payment for transportation will not be made if the care or services are not covered under the MA program.

c. MA payment to vendors of transportation services is limited to situations where an MA recipient is actually being transported in the vehicle.

d. MA payment will not generally be made for transportation which is ordinarily made available to other persons in the community without charge. If federal financial participation is available for the costs of such transportation, the MA program is permitted to pay for the transportation.

e. Vendors of transportation services must provide pertinent cost data to a social services district upon request or risk termination from participation in the MA program.

Finally, the provisions require social services districts to notify applicants for and recipients of MA of the procedures for obtaining prior authorization of transportation services.

C. Transportation Management

The following table depicts, for each county, whether the county department of social services or State manages the transportation program.

Managed by Local Department of Social Services		Managed by Department of Health Under Contract	
Allegany	Monroe	Albany	Queens
Cattaraugus	Nassau	Bronx	Rensselaer
Chautauqua	Niagara	Broome	Richmond
Chemung	Ontario	Cayuga	Rockland
Chenango	Orleans	Columbia	Saratoga
Clinton	Oswego	Delaware	Schenectady
Cortland	Otsego	Dutchess	Schoharie
Erie	Schuyler	Essex	Sullivan
Franklin	Seneca	Fulton	Ulster
Genesee	St. Lawrence	Greene	Warren
Hamilton	Steuben	Kings	Washington
Herkimer	Suffolk	Montgomery	Westchester
Jefferson	Tioga	New York	
Lewis	Tompkins	Oneida	
Livingston	Wayne	Onondaga	
Madison	Wyoming	Orange	
Suffolk	Yates	Putnam	

Appendix I
2023 Title XIX State Plan
Second Quarter Amendment
Amended SPA Pages

New York
3(d)

1905(a)(30) Other Medical Care

24a. Prior approval is required for non-emergent transportation, including the services and subsistence of the attendant. Requests can be made by recipients or their family members; or medical practitioners acting on behalf of a recipient.

Transportation providers are assigned to requests for non-emergency transportation services based upon first, a recipient's choice of available participating vendors in the prior authorization official's network at the most cost effective, medically appropriate level of transportation; then, if the recipient indicates no preference, the ordering practitioner's choice among available participating vendors in the prior authorization official's network at the most cost effective, medically appropriate level of transportation; and finally, if no choice is made by the ordering practitioner, the request is given via rotation among the most cost effective, medically ~~available and~~ appropriate mode of transportation providers in the prior authorization official's network.

~~1. To assure comparability and statewideness, each county's local department of social services manages transportation services on behalf of recipient's assigned to the county~~
~~2. The Commissioner of Health is authorized to assume the responsibility of managing transportation services from any local social services district. If the Commissioner elects to assume this responsibility, the Commissioner may choose to contract with a transportation manager or managers to manage transportation services in any local social services district.~~

~~3.~~ Prior approval is also required for arrangement of or reimbursement for ancillary expenses associated with transportation to Medicaid covered services. Recipient, family member, or volunteer reimbursement is made as an administrative expense of the Medicaid Program. This applies to any personal vehicle mileage reimbursement, lodging, airfare, or other expense borne on behalf of the Medicaid recipient by a non-direct vendor.

24d. Prior approval is required for skilled nursing facility services except when admitted directly from a hospital, another skilled nursing facility or from a health facility.

Medicaid payments will not be authorized for skilled nursing facilities which are not certified or have not applied for certification to participate in Medicare.

26. Personal Care Services means some or total assistance with personal hygiene, dressing and feeding and nutritional and environmental support functions. Prior approval is required for all personal care services. The authorization period and amount of personal care services authorized depends upon patient need, as indicated in the patient's assessment.

Electronic Visit Verification System: NY will comply with the Electronic Visit Verification System (EVV) requirements for personal care services (PCS) by January 1, 2021.

New York
3(d)

1905(a)(30) Other Medical Care

24a. Prior approval is required for non-emergent transportation, including the services and subsistence of the attendant. Requests can be made by recipients or their family members; or medical practitioners acting on behalf of a recipient.

Transportation providers are assigned to requests for non-emergency transportation services based upon first, a recipient's choice of available participating vendors in the prior authorization official's network at the most cost effective, medically appropriate level of transportation; then, if the recipient indicates no preference, the ordering practitioner's choice among available participating vendors in the prior authorization official's network at the most cost effective, medically appropriate level of transportation; and finally, if no choice is made by the ordering practitioner, the request is given via rotation among the most cost effective, medically ~~available and~~ appropriate mode of transportation providers in the prior authorization official's network.

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Electronic Visit Verification System: NY will comply with the Electronic Visit Verification System (EVV) requirements for personal care services (PCS) by January 1, 2021.

New York
1
Provisions for Providing
Medical Assistance Transportation

1905(a)(30) Other Medical Care

The following provisions set forth the Department's policy concerning transportation services provided to Medical Assistance (MA) recipients for the purpose of obtaining necessary medical care and services which can be paid for under the MA program. These provisions set forth the standards which the Department will use in determining when the MA program will pay for transportation and describes the prior authorization process for obtaining payment.

The MA program covers all modes of transportation, including, but not limited to: emergency ambulance and non-emergency modes of transportation. Transportation is provided by service providers at Department-established or approved fee schedules set at levels where the Department can successfully assure the availability of medically necessary transportation to services covered by the MA program.

A. Prior Authorization

Prior authorization means a prior authorization official's determination that payment for a specific mode of transportation is essential in order for an MA recipient to obtain necessary medical care and services and that the prior authorization official accepts conditional liability for payment of the recipient's transportation costs.

Prior authorization official means the Department, the transportation manager or the transportation broker, or such other entity under contract with, or specifically permitted by, the Department of Health, as applicable.

1. Prior authorization is required for the following:

   a. all transportation to obtain medical care and services, except emergency ambulance transportation or Medicare approved transportation by ambulance service provided to an MA-eligible person who is also eligible for Medicare Part B payments.

   b. transportation expenses of an attendant for the MA recipient.

   c. ancillary expenses associated with transportation to Medicaid covered services.

The provisions set forth the standards to be used in evaluating prior authorization requests and provides the prior authorization official ~~(i.e., the Department or its contracted agents, the county department of social services or their designated agents)~~ with the authority to approve or deny reimbursement to MA recipients for the use of private vehicles (personal cars) or mass transportation which the recipient uses for the usual activities of daily living. A prior authorization official ~~may~~ will approve reimbursement for the use of personal cars or mass transportation, however, if, in the opinion of the prior authorization official, circumstances so warrant. A prior authorization official ~~may~~ will also approve reimbursement for the use of some other mode of transportation, such as ambulance, wheelchair or stretcher van, or taxi/livery, as required by the MA recipient.

2. Criteria to be used by the prior authorization official in making prior authorization determinations are:

   a. the MA recipient has access to necessary medical care or services by use of a private vehicle or by means of mass transportation which is used by the recipient for the usual activities of daily living;

   b. the frequency of visits or treatments within a short period of time whereby the recipient would suffer financial hardship if required to make payment for the transportation;

   c. the nature and severity of the MA recipient's illness which necessitates transportation by a mode other than that ordinarily used by the MA recipient (such as an acute event wherein an otherwise ambulatory recipient becomes physically disabled);

1905(a)(30) Other Medical Care

d. the geographic locations of the MA recipient and the provider of medical care and services;

e. the medical care and services available within the common medical marketing area of the MA recipient's community;

f. the need to continue a regimen of medical care or service with a specific provider; and,

g. any other circumstances which are unique to a particular MA recipient and which the prior authorization official determines have an effect on the need for payment of transportation services.

The decision to require the MA recipient to travel using a personal vehicle, public transit, or taxi is made by the prior authorization official based upon the prior authorization official's knowledge of the recipient's ability to travel by personal vehicle ~~ownership~~ and the local public transit routes. When a more specialized mode of transportation is required, such as wheelchair or stretcher van, or ambulance, the prior authorization official will make a decision on the proper mode of transport after consideration of information obtained from a medical practitioner, supervisors, the Department, program guidance materials, and any other source available, that will help the official to make a reasoned decision.

~~B. Payment~~

~~1. Criteria to be used when establishing payment for medical assistance transportation:~~

~~a. Social services districts, except those where the Commissioner of Health has assumed the management of transportation services, have the authority to establish payment rates with vendors of transportation services which will ensure the efficient provision of appropriate transportation for MA recipients in order for the recipients to obtain necessary medical care or services. Social services districts may establish such rates in a number of ways, which may include negotiation with the vendors. However, no established rate will be reimbursed unless that rate has been approved by the Department as the Department established rate.~~

~~i. The State defines "department established rate" as the rate for any given mode of transportation which the department has determined will ensure the efficient provision of appropriate transportation to MA recipients in order for the recipients to obtain necessary medical care and services.~~

~~ii. The department may will either establish rate schedules at which transportation services can be assured or delegate such authority to the social services districts prior authorization official. Delegation of authority exists only in episodic circumstances in which immediate transportation is needed at a cost not considered in the established fee schedule. In order to ensure access to needed medical care and service, the social services districts prior authorization official will approve a rate to satisfy the immediate need.~~

~~iii. Plans, rate schedules or amendments may will not be implemented without departmental approval.~~

~~iv. Social services districts have no authority to establish a fee schedule without the Department's involvement; there is no incongruity between the Department's and social services district's fee schedules.~~

1905(a)(30) Other Medical Care

B. Payment

1. Criteria to be used when establishing payment for medical assistance transportation:

a. Payment for transportation expenses will be made only when transportation expenses have been prior authorized except for emergency ambulance transportation or Medicare approved transportation by an ambulance service provided to an MA recipient who is also eligible for Medicare Part B payments or in other instances determined by the department, such as during a declared state of emergency.

b. Payment for transportation expenses will be made only to the vendor of transportation services, to the MA recipient or to an individual providing transportation services on behalf of the MA recipient.

c. Payment will be made only for the least expensive available mode of transportation suitable to the MA recipient's needs, as determined by the prior authorization official.

d. Except for fees and value-based payments established by a transportation management broker set forth in a service agreement, payment to vendors for transportation services must not exceed the lower of the Department established fee, the locally prevailing fee, or the fee charged to the public, by the most direct route for the mode of transportation used; provided however, payment will be made in excess of the locally prevailing fee or the fee charged to the public when Federal financial participation in the MA payment for transportation services is available and such payment is necessary to assure the transportation service.

e. Payment to vendors will made only where an MA recipient is actually being transported in the vehicle.

f. In order to receive payment for services provided to an MA recipient, a vendor must be lawfully authorized to provide transportation services on the date the services are rendered. A vendor of transportation services is lawfully authorized to provide such services.

g. Payment is available for transportation services provided in order for the recipient to receive an MA covered service if the recipient receives such service (other than transportation services) at school or off of the school premises and both the covered service and transportation service are included in the recipient's individualized education plan. Payment is available for transportation services provided in order for the recipient, or the recipient's family member or significant other to receive an MA covered service if both the covered service and transportation service are included in the recipient's interim or final individualized family services plan. For purposes of this section, a significant other is a person who substitutes for the recipient's family, interacts regularly with the recipient, and affects directly the recipient's developmental status. Reimbursement for such services must be made in accordance with the provider agreement.

New York
3.1

1905(a)(30) Other Medical Care

h. Payment to a provider of ambulette services will only be made for services documented in contemporaneous records that must include:

i. the recipient's name and MA identification number;

ii. the origination of the trip;

iii. the destination of the trip;

iv. the date and time of service; and

v. the name of the driver transporting the recipient.

i. Payment will not be made for transportation services when:

i. the transportation services are ordinarily made available to other persons in the community without charge; however, payment will be made under such circumstances when Federal financial participation in the MA payment for transportation services is available:

ii. the transportation services are provided by a medical facility and the costs are included in the facility's MA rate;

iii. a vendor is not actually transporting an MA recipient;

iv. the MA recipient has access to and can make use of transportation, such as a private vehicle or mass transportation, which the recipient ordinarily uses for the usual activities of daily living unless prior authorization has been granted by the prior authorization official.

2. Medical transportation plans and fee schedules.

a. The Department will establish fee schedules at which transportation services can be assured; provided, however, such fees will not apply to non-emergency transportation services provided by a vendor in accordance with a service agreement with a transportation management broker. The transportation management broker, as the prior authorization official, has the authority to establish payment rates with vendors of transportation services which will ensure the efficient provision of appropriate transportation for MA recipients in order for the recipients to obtain necessary care or services The prior authorization official will establish rates in a number of ways, including negotiation with the vendors. However, no established rate will be reimbursed unless that rate has been approved by the Department as the Department established rate.

1905(a)(30) Other Medical Care

b. The Department or transportation management broker, as applicable, must adhere to the following requirements

i. in establishing fees with vendors of transportation services:

One of the following must be selected:

1) a flat fee for all transportation services provided;

A. a base fee for all transportation services provided, plus a mileage charge;

B. a flat fee for transportation services within specified areas; or

C. a mileage fee based on distance.

2) A reduced fee will be established for any of the following:

A. transportation of additional persons;

B. transportation of persons traveling to and from day treatment or continuing treatment programs; and

C. transportation of persons for purposes of obtaining regularly recurring medical care and services.

3) An additional fee will be established for any of the following:

A. other transportation costs, limited to the costs of meals, lodging and transportation attendants;

B. bridge and road tolls; and

C. value-based payments.

C. Transportation Management

Under State law, the Commissioner has elected to assume responsibility of managing transportation services and chose to contract with a transportation management broker to provide cost effective nonemergency transportation to Medicaid beneficiaries. As the prior authorization official, the transportation management broker is required to notify applicants for and recipients of MA of the procedures for obtaining prior

Appendix II
2023 Title XIX State Plan
Second Quarter Amendment
Summary

SUMMARY
SPA #23-0005

This State Plan Amendment proposes to transition the New York State Medicaid non-emergency medical transportation (NEMT) program from an administrative- services only model to a risk-based broker model authorized pursuant to Section 1902(a)(70) of the Social Security Act.

Appendix III
2023 Title XIX State Plan
Second Quarter Amendment
Authorizing Provisions

SPA 23-0005

§ 365-h. Provision and reimbursement of transportation costs. 1. The local social services official and, subject to the provisions of subdivision four of this section, the commissioner of health shall have responsibility for prior authorizing transportation of eligible persons and for limiting the provision of such transportation to those recipients and circumstances where such transportation is essential, medically necessary and appropriate to obtain medical care, services or supplies otherwise available under this title.

2. In exercising this responsibility, the local social services official and, as appropriate, the commissioner of health shall:

(a) make appropriate and economical use of transportation resources available in the district in meeting the anticipated demand for transportation within the district, including, but not limited to: transportation generally available free-of-charge to the general public or specific segments of the general public, public transportation, promotion of group rides, county vehicles, coordinated transportation, and direct purchase of services; and

(b) maintain quality assurance mechanisms in order to ensure that (i) only such transportation as is essential, medically necessary and appropriate to obtain medical care, services or supplies otherwise available under this title is provided; (ii) no expenditures for taxi or livery transportation are made when public transportation or lower cost transportation is reasonably available to eligible persons; and (iii) transportation services are provided in a safe, timely, and reliable manner by providers that comply with state and local regulatory requirements and meet consumer satisfaction criteria approved by the commissioner of health.

3. In the event that coordination or other such cost savings measures are implemented, the commissioner shall assure compliance with applicable standards governing the safety and quality of transportation of the population served.

4. (a) The commissioner of health is authorized to assume responsibility from a local social services official for the provision and reimbursement of transportation costs under this section. If the commissioner elects to assume such responsibility, the commissioner shall notify the local social services official in writing as to the election, the date upon which the election shall be effective and such information as to transition of responsibilities as the commissioner deems prudent. The commissioner is authorized to contract with a transportation manager or managers to manage transportation services in any local social services district, other than transportation services provided or arranged for enrollees of managed long term care plans issued certificates of authority under section forty-four hundred three-f of the public health law. Any transportation manager or managers selected by the commissioner to manage transportation services shall have proven experience in coordinating transportation services in a geographic and demographic area similar to the area in New York state

within which the contractor would manage the provision of services under
this section. Such a contract or contracts may include responsibility for: review, approval and processing of transportation orders; management of the appropriate level of transportation based on documented patient medical need; and development of new technologies leading to efficient transportation services. If the commissioner elects
to assume such responsibility from a local social services district, the
commissioner shall examine and, if appropriate, adopt quality assurance measures that may include, but are not limited to, global positioning tracking system reporting requirements and service verification mechanisms. Any and all reimbursement rates developed by transportation managers under this subdivision shall be subject to the review and approval of the commissioner.

(b)(i) Subject to federal financial participation, for periods on and after April first, two thousand twenty-one, in order to more cost-effectively provide non-emergency transportation to Medicaid beneficiaries who need access to medical care and services, the commissioner is authorized to contract with one or more transportation management brokers to manage such transportation on a statewide or regional basis, as determined by the commissioner, in accordance with the federal social security act as follows:

(A) The transportation management broker or brokers shall be selected through a competitive bidding process based on an evaluation of the broker's experience, performance, references, resources, qualifications and costs; provided, however, that the department's selection process shall be memorialized in a procurement record as defined in section one hundred sixty-three of the state finance law;

(B) The transportation management broker or brokers shall have oversight procedures to monitor Medicaid beneficiary access and complaints and ensure that enrolled Medicaid transportation providers are licensed, qualified, competent and courteous.

(C) The transportation management broker or brokers shall be subject to regular auditing and oversight by the department in order to ensure the quality of the transportation services provided and adequacy of Medicaid beneficiary access to medical care and services.

(D) The transportation management broker or brokers shall comply with requirements related to prohibitions on referrals and conflicts of interest required by the federal social security act.

(ii) The transportation management broker or brokers may be paid a per member per month capitated fee or a combination of capitation and fixed cost reimbursement and the contract shall include, but not be limited to, responsibility for:

(A) establishing a network of high-quality Medicaid enrolled providers; provided, however, that in developing such network the transportation management broker shall evaluate the qualifications of current Medicaid transportation providers on a priority basis for participation in its network, and leverage reputable transportation

providers with a proven record of serving Medicaid beneficiaries with high-quality services;

(B) continuing outreach to Medicaid enrolled providers to assess and resolve service quality issues;

(C) developing mandatory corrective actions for any Medicaid enrolled provider that falls under quality performance standards;

(D) establishing a prior approval process which shall include verifying Medicaid eligibility and reviewing, approving and processing transportation orders;

(E) managing the appropriate level of transportation based on documented patient medical need to ensure that Medicaid beneficiaries are using the most medically appropriate mode of transportation, including public transportation, which shall be maximized statewide, including in rural areas; provided that when determining the appropriate
level of transportation, the transportation management broker shall ensure that patients have reasonable and timely access to medically appropriate transportation services;

(F) implementing technologies to effectuate efficient transportation services, such as GPS, to improve match to mode of transportation;

(G) establishing fees to reimburse enrolled Medicaid transportation providers;

(H) adjudicating and paying claims submitted by enrolled Medicaid transportation providers;

(I) reporting on performance encompassing all aspects of the transportation program, including but not limited to Medicaid beneficiary complaints including the length of time to make a compliant,
wait times related to the receipt of services by a recipient, and tracking medical justifications to modes of transportation provided;

(J) collaborating with Medicaid beneficiaries and consumer groups to identify and resolve issues to increase consumer satisfaction;

(K) auditing cancellation data on a quarterly basis to ensure accuracy;

(L) coordinating medical benefits and transportation with Medicaid managed care organizations, including development of value based payments for transportation services; and

(M) such contracts shall include penalties for incorrect denials, unresolved complaint rates, unfulfilled trips, and any other criteria determined by the commissioner and specified in the competitive bidding process.

(iii) A transportation management broker with which the commissioner contracts shall file with the commissioner a bond issued by an insurer authorized to write fidelity and surety insurance in this state, in an

amount and form to be determined by the commissioner. The purpose of the surety bond shall be to provide the sole source of recourse to providers of Medicaid transportation services, other than the transportation management broker, that cannot receive payment for services properly provided if the transportation management broker becomes insolvent. To the extent permitted by law, the surety bond shall provide that any funds that remain after such provider liabilities are satisfied shall be paid to that state.

(iv) A transportation management broker with which the commissioner contracts shall provide to Medicaid enrolled providers annually a conspicuous written disclosure that states the following: "The New York State Department of Health has contracted with this transportation management broker to arrange non-emergency transportation for Medicaid beneficiaries who need access to medical care and services and is paying the transportation management broker a per member per month capitated fee or a combination of capitation and fixed cost reimbursement. This transportation management broker is not licensed by the New York State Department of Financial Services as an insurer and is not subject to its supervision as an insurer. This transportation management broker is not protected by New York security funds and there will not be any right to recover against the department of health, department of financial services, or this state in the event of the transportation management broker's insolvency.

(v) To the extent practicable, the competitive bidding and contracting process maybe completed by April first, two thousand twenty-one; provided, however, such contract may be effective at some date after April first, two thousand twenty-one, if the process takes longer to complete.

(vi) Responsibility for transportation services provided or arranged for enrollees of managed long term care plans issued certificates of authority under section forty-four hundred three-f of the public health law, not including a program designated as a Program of All-Inclusive Care for the Elderly (PACE) as authorized by Federal Public law 1053-33, subtitle I of title IV of the Balanced Budget Act of 1997, and, at the commissioner's discretion, other plans that integrate benefits for dually eligible Medicare and Medicaid beneficiaries based on a demonstration by the plan that inclusion of transportation within the benefit package will result in cost efficiencies and quality improvement, shall be transferred to a transportation management broker that has a contract with the commissioner in accordance with this paragraph. Providers of adult day health care may elect to, but shall not be required to, use the services of the transportation management broker.

5. Notwithstanding any contrary provision of law, and subject to federal financial participation, the commissioner of health shall make adjustments to payments under this section, for the purposes of providing increased access to Medicaid non-emergency transportation in

rural communities. Up to two million dollars shall be available for such
purposes.

6. (a) The commissioner of health shall require transportation providers enrolled in the Medicaid program and specified by the commissioner pursuant to regulation, to report the costs incurred in providing transportation services to Medicaid beneficiaries pursuant to this section; provided, however, this requirement shall only apply if there is no transportation management broker contract authorized in subdivision four of this section. The commissioner shall specify the frequency and format of such reports and determine the type and amount of information required to be submitted, including supporting documentation, provided that such reports shall be no more frequent than
quarterly. The commissioner shall give all transportation providers no less than ninety calendar days' notice before such reports are due.

(b) If the commissioner determines that the cost report submitted by a Medicaid transportation provider is inaccurate or incomplete, the commissioner shall notify such provider in writing and advise the provider of the correction or additional information that the provider must submit. The provider shall submit the corrected or additional information within thirty calendar days from the date the provider receives the notice.

(c) The commissioner shall grant a provider an additional thirty calendar days to submit the original cost report, or corrected or additional information required pursuant to paragraph (b) of this subdivision only when the provider submits a written request to the commissioner for an extension prior to the due date and establishes to the satisfaction of the commissioner that the provider cannot submit the
cost report or corrected or additional information by the due date for reasons beyond the provider's control.

* NB Repealed 16 years after the contract entered into pursuant to this section 365-h is executed

* § 365-h. Provision and reimbursement of transportation costs. 1. The local social services official shall have responsibility for prior authorizing transportation of eligible persons and for limiting the provision of such transportation to those recipients and circumstances where such transportation is essential, medically necessary and appropriate to obtain medical care, services or supplies otherwise available under this title.

2. In exercising this responsibility, the local social services official shall:

(a) make appropriate and economical use of transportation resources available in the district in meeting the anticipated demand for transportation within the district, including, but not limited to: transportation generally available free-of-charge to the general public or specific segments of the general public, public transportation, promotion of group rides, county vehicles, coordinated transportation, and direct purchase of services; and

(b) maintain quality assurance mechanisms in order to ensure that (i) only such transportation as is essential, medically necessary and appropriate to obtain medical care, services or supplies otherwise available under this title is provided and (ii) no expenditures for taxi
or livery transportation are made when public transportation or lower cost transportation is reasonably available to eligible persons.

3. In the event that coordination or other such cost savings measures are implemented, the commissioner shall assure compliance with applicable standards governing the safety and quality of transportation of the population served.

* NB Effective 16 years after the contract entered into pursuant to this section 365-h has been executed

18 NYCRR 505.10 Transportation for medical care and services. (a) Scope and purpose. This section describes the department's policy concerning payment for transportation services provided to Medical Assistance (MA) recipients, the standards to be used in determining when the MA program will pay for transportation, and the prior authorization process required for obtaining such payment. Generally, payment will be made only upon prior authorization for transportation services provided to an eligible MA recipient. Prior authorization will be granted by the prior authorization official only when payment for transportation expenses is essential in order for an eligible MA recipient to obtain necessary medical care and services which may be paid for under the MA program.

(b) Definitions. (1) Ambulance means a motor vehicle, aircraft, boat or other form of transportation designed and equipped to provide emergency medical services during transit.

(2) Ambulance service means any entity, as defined in section 3001 of the Public Health Law, which is engaged in the provision of emergency medical services and the transportation of sick, disabled or injured persons by motor vehicle, aircraft, boat or other form of transportation to or from facilities providing hospital services and which is currently certified or registered by the Department of Health as an ambulance service.

(3) Ambulette or paratransit vehicle means a special-purpose vehicle, designed and equipped to provide nonemergency transport, that has wheelchair-carrying capacity, stretcher-carrying capacity, or the ability to carry disabled individuals.

(4) Ambulette service means an individual, partnership, association, corporation, or any other legal entity which transports disabled individuals by ambulette to or from facilities which provide medical care. An ambulette service provides disabled individuals with personal assistance as defined in this subdivision.

(5) Common medical marketing area means the geographic area from which a community customarily obtains its medical care and services.

(6) Community means either the State, a portion of the State, a city or a particular classification of the population, such as all persons 65 years of age and older.

(7) Conditional liability means that the prior authorization official is responsible for making payment only for transportation services which are provided to MA-eligible individuals in accordance with the requirements of this Title.

(8) Day treatment program or continuing treatment program means a planned combination of diagnostic, treatment and rehabilitative services certified by the Office for People with Developmental Disabilities or the Office of Mental Health.

(9) Department established fee means the fee for any given mode of transportation which the department has determined will ensure the efficient provision of appropriate transportation to MA recipients in order for the recipients to obtain necessary medical care or services.

(10) Emergency ambulance transportation means the provision of ambulance transportation for the purpose of obtaining hospital services for an MA recipient who suffers from severe, life-threatening or potentially disabling conditions which require the provision of emergency medical services while the recipient is being transported.

(11) Emergency medical services means the provision of initial urgent medical care including, but not limited to, the treatment of trauma, burns, and respiratory, circulatory and obstetrical emergencies.

(12) Emergency triage, treat and transport (ET3) model means an innovative payment and service delivery model established by the United States Department of Health and Human Services to lower costs and improve quality of care to Medicare beneficiaries by requiring ambulance service suppliers selected by the Center for Medicare and Medicaid Innovation (CMMI), or successor agency or office, to partner with qualified health care practitioners to deliver treatment in place and/or transport to alternative destination sites, such as primary care physician offices or urgent care clinics.

(13) Locally prevailing fee means a fee for a given mode of transportation which is established by a transit or transportation authority or commission empowered to establish fees for public transportation, a municipality, or a third-party payor, and which is charged to all persons using that mode of transportation in a given community.

(14) Nonemergency ambulance transportation means the provision of ambulance transportation for the purpose of obtaining necessary medical care or services to an MA recipient whose medical condition requires transportation by an ambulance service.

(15) New York State Medicaid payment system means an automated system, such as eMedNY, used to process Medicaid fee-for-service claims submitted by Medicaid enrolled providers for services provided to Medicaid beneficiaries.

(16) Ordering practitioner means the MA recipient's attending physician or other medical practitioner who has not been excluded from enrollment in the MA program and who is requesting transportation on behalf of the MA recipient in order that the MA recipient may obtain medical care or services which are covered under the MA program. The ordering practitioner is responsible for initially determining when a specific mode of transportation to a particular medical care or service is medically necessary.

(17) Personal assistance means the provision of physical assistance by a provider of transportation services to an MA recipient for the purpose of assuring safe access to and from the recipient's place of residence, vehicle and MA covered health service provider's place of business. Personal assistance is the rendering of physical assistance to the recipient in walking, climbing or descending stairs, ramps, curbs or other obstacles; opening or closing doors; accessing a vehicle; and the moving of wheelchairs or other items of medical equipment and the removal of obstacles as necessary to assure the safe movement of the recipient. In providing personal assistance, the provider or the provider's employee will physically assist the recipient which shall include touching, or, if the recipient prefers not to be touched, guiding the recipient in such close proximity that the provider of services will be able to prevent any potential injury due to a sudden loss of steadiness or balance. A recipient

who can walk to and from a vehicle, his or her home, and a place of medical services without such assistance is deemed not to require personal assistance.

(18) Prior authorization means a prior authorization official's determination that payment for a specific mode of transportation is essential in order for an MA recipient to obtain necessary medical care and services and that the prior authorization official accepts conditional liability for payment of the recipient's transportation costs.

(19) Prior authorization official means the department, the transportation manager or the transportation management broker, or such other entity under contract with, or specifically permitted by, the Department of Health, as applicable.

(20) Service Agreement means an agreement between a vendor and a transportation management broker that includes, but is not limited to, vendor service standards and fees to be established and paid by the transportation management broker for the provision of non-emergency transportation services to MA recipients.

(21) Transportation attendant means any individual authorized by the prior authorization official to assist the MA recipient in receiving safe transportation.

(22) Transportation expenses means:

(i) the costs of transportation services; and

(ii) the costs of outside meals and lodging incurred when going to and returning from a provider of medical care and services when distance and travel time require these costs.

(23) Transportation management broker or brokers means the entity or entities with which the commissioner contracts to cost-effectively administer non-emergency transportation services to MA recipients in accordance with Social Services Law section 365-h(4)(b).

(24) Transportation manager or managers means the entity or entities with which the commissioner contracts to manage transportation services provided to MA recipients in accordance with Social Services Law section 365-h(4)(a).

(25) Transportation services means:

(i) transportation by ambulance, ambulette or paratransit vehicle, taxicab/livery, transportation network company/high-volume for-hire services vehicle (TNC), common carrier or other means appropriate to the MA recipient's medical condition; and

(ii) a transportation attendant to accompany the MA recipient, if necessary. Such services may include the transportation attendant's transportation, meals, lodging and salary; however, no salary will be paid to a transportation attendant who is a member of the MA recipient's family.

(26) Undue financial hardship means transportation expenses which the MA recipient cannot be expected to meet from monthly income or from available resources. Such transportation expenses may include those of a recurring nature or major one-time costs.

(27) Value-based payment means an additional fee for certain transportation services determined by the department that may be paid to vendors that achieve certain quality and/or efficiency targets established by the department or a transportation management broker.

(28) Vendor means a lawfully authorized provider of transportation services who is enrolled in the MA program pursuant to Part 504 of this Title and authorized to receive payment for transportation services directly from the New York State Medicaid payment system or pursuant to a service agreement with a transportation management broker, as applicable.

The term vendor does not mean an MA recipient or other individual who transports an MA recipient by means of a private vehicle.

(c) Ambulette and nonemergency ambulance transportation. (1) Who may order. Only those practitioners, facilities or programs listed in paragraphs (d)(7) and (8) of this section may order or submit an order on behalf of a practitioner for ambulette or nonemergency ambulance transportation services. All requests for ambulette and nonemergency ambulance transportation must include a written form verifying MA transportation abilities as specified by the department.

(2) Criteria for ordering ambulette transportation. Ambulette transportation may be ordered if any one of the following conditions exist:

(i) The recipient needs to be transported in a recumbent position and the ambulette service ordered has stretcher-carrying capacity;

(ii) The recipient is wheelchair bound and is unable to use a taxi, livery service, bus or private vehicle;

(iii) The recipient has a disabling physical condition which requires the use of a walker, crutches, or other mobility assistive equipment, and is unable to use a taxi, livery service, bus or private vehicle;

(iv) The recipient has a disabling physical condition other than one described in subparagraph (iii) of this paragraph or a disabling mental condition, either of which requires the personal assistance provided by an ambulette service, and the ordering practitioner certifies, in a manner approved by the department, that the recipient cannot be transported by a taxi, livery service, bus or private vehicle and requires transportation by ambulette service; or

(v) An otherwise ambulatory recipient receives radiation therapy, chemotherapy, dialysis treatment, or other ongoing needs for chronic care treatment, which results in a disabling physical condition after treatment and renders the recipient unable to access transportation by taxi, livery service, TNC, bus or private vehicle.

(3) Criteria for ordering nonemergency ambulance transportation. Nonemergency ambulance transportation may be ordered when the recipient is in need of medical treatment or medical monitoring while being transported to a provider of medical services which can only be administered by a NYS certified emergency medical technician (or higher level of certification), who is an employee or volunteer member of an ambulance service.

(4) Recordkeeping. The ordering practitioner must note in the recipient's patient record the condition which justifies the practitioner's ordering of ambulette or nonemergency ambulance services and maintain a copy of the completed form required by paragraph (1) of this subdivision.

(5) Audit and claim review. An ordering practitioner, or a facility or program submitting an order on the practitioner's behalf, which does not comply with this subdivision may be subjected to monetary claims and/or program sanctions as provided in section 504.8(a) of this Title.

(d) Prior authorization. (l) Generally, prior authorization must be obtained before transportation expenses are incurred. Prior authorization is not required for emergency ambulance transportation or Medicare approved transportation by an ambulance service provided to an MA recipient who is also eligible for Medicare Part B payments. If transportation services are provided in accordance with paragraph (e)(7) of this section, the

individualized education program or interim or final individualized family services plan of an MA recipient will qualify as the prior authorization required by this subdivision.

(2) Requests for prior authorization may be made by the MA recipient, his or her representative, or an ordering practitioner.

(3) The recipient, his or her representative, or ordering practitioner must make the request in the manner required by the prior authorization official and the department.

(4) In instances when the MA recipient's condition requires transportation by a method other than the least expensive method available in the geographic area, the MA recipient's ordering practitioner must complete and submit to the prior authorization official a written form verifying MA transportation abilities as specified by the department and published by the prior authorization official.

(5) In instances when the MA recipient's condition requires MA covered specialized medical care or services that are not available within the MA recipient's common medical marketing area, the MA recipient's ordering practitioner must complete and submit to the prior authorization official a written form for transportation outside the common medical marketing area as specified by the department and published by the prior authorization official. If additional information is necessary, the prior authorization official may also require the submission of a letter of medical necessity from the ordering practitioner before making a determination to approve or deny transportation.

(6) Ordering practitioners shall complete and submit all required forms and letters at no cost to the MA recipient, the department, or the prior authorization official.

(7) A request for prior authorization for nonemergency ambulance transportation must be supported by the written order of an ordering practitioner who is the MA recipient's attending physician, physician's assistant or nurse practitioner.

(8) A request for prior authorization for transportation by ambulette or paratransit vehicle must be supported by the written order of an ordering practitioner who is the MA recipient's attending physician, physician's assistant, nurse practitioner, dentist, optometrist, podiatrist or other type of medical practitioner approved by the department.

(9) A diagnostic and treatment center, hospital, nursing home, intermediate care facility, long-term home health care program, or home and community-based services waiver program, or managed care program may submit an order for ambulette or nonemergency ambulance transportation services on behalf of the ordering practitioner.

(10) Each prior authorization official must inform recipients of MA of the need for prior authorization in order for transportation expenses to be paid under the MA program and of the procedures for obtaining such prior authorization.

(11) The prior authorization official may approve or deny a request for prior authorization or require the ordering practitioner to submit additional information before the request is approved or denied.

(12) The prior authorization official must use the following criteria in determining whether to authorize payment of transportation expenses in accordance with this subdivision:

(i) when the MA recipient can be transported to necessary medical care or services by use of private vehicle or by means of mass transportation which are use by the MA recipient for the usual activities of daily living, prior authorization for payment for ambulette, TNC, taxi or livery services may be denied;

(ii) when the MA recipient needs multiple visits or treatments within a short period of time and the MA recipient would suffer undue financial hardship if required to make payment for the transportation to such visits or treatments, prior authorization for payment for such transportation expenses may be approved for a means of transportation ordinarily used by the MA recipient for the usual activities of daily living;

(iii) when the nature and severity of the MA recipient's illness necessitates a mode of transportation other than that ordinarily used by the MA recipient, prior authorization for such a mode of transportation may be approved;

(iv) when the geographic locations of the MA recipient and the provider of medical care and services are such that the usual mode of transportation is inappropriate, prior authorization for another mode of transportation may be approved;

(v) when the distance to be traveled necessitates a large transportation expense and undue financial hardship to the MA recipient, prior authorization for payment for the MA recipient's usual mode of transportation may be approved;

(vi) when the medical care and services needed are available within the common medical marketing area of the MA recipient's community, prior authorization for payment of transportation expenses to such medical care and services outside the common medical marketing area may be denied;

(vii) when the need to continue a regimen of medical care or service with a specific provider necessitates travel which is outside the MA recipient's common medical marketing area, notwithstanding the fact that the medical care or service is available within the common medical marketing area, prior authorization for payment of transportation expenses to such medical care and services outside the common medical marketing area may be approved; and

(viii) when there are any other circumstances which are unique to the MA recipient and which the prior authorization official determines have an effect on the need for payment of transportation expenses, prior authorization for payment for such transportation expenses may be aproved.

(e) Payment. (1) Payment for transportation expenses will be made only when transportation expenses have been prior authorized except for emergency ambulance transportation or Medicare approved transportation by an ambulance service provided to an MA recipient who is also eligible for Medicare Part B payments or in other instances determined by the department, such as during a declared state of emergency.

(2) Payment for transportation expenses will be made only to the vendor of transportation services, to the MA recipient or to an individual providing transportation services on behalf of the MA recipient.

(3) Payment will be made only for the least expensive available mode of transportation suitable to the MA recipient's needs, as determined by the prior authorization official.

(4) Except for fees and value-based payments established by a transportation management broker set forth in a service agreement, payment to vendors for transportation services must not exceed the lower of the department established fee, the locally prevailing fee, or the fee charged to the public, by the most direct route for the mode of transportation used; provided owever, payment may be made in excess of the locally prevailing fee or the fee charged to the public when Federal financial participation in the MA payment for transportation services is available and such payment is necessary to assure the transportation service.

(5) Payment to vendors will made only where an MA recipient is actually being transported in the vehicle.

(6) In order to receive payment for services provided to an MA recipient, a vendor must be lawfully authorized to provide transportation services on the date the services are rendered. A vendor of transportation services is lawfully authorized to provide such services if it meets the following standards:

(i) Ambulance services must be certified by the Department of Health and comply with all requirements of that department;

(ii) Ambulette services must be authorized by the Department of Transportation. Ambulette drivers must be qualified under Article 19-A of the Vehicle and Traffic Law. Ambulette services and their drivers must comply with all requirements of the Department of Transportation and the Department of Motor Vehicles or have a statement in writing from the appropriate department or departments verifying that the ambulette services or their drivers are exempt from such requirements;

(iii) taxicab or livery services must comply with all requirements of the local municipality concerning the operation of taxicab or livery service in that municipality and with all requirements of the Department of Motor Vehicles and TNCs must be licensed pursuant to Article 44-B of the Vehicle and Traffic Law or Subchapter 59D or Chapter 59 of Title 35 of the Rules of the City of New York; and

(iv) Vendors which provide transportation to day treatment or continuing treatment programs must be authorized by the Department of Transportation. Drivers for such vendors must be qualified under Article 19-A of the Vehicle and Traffic Law. Such vendors and their drivers must comply with all requirements of the Department of Transportation and the Department of Motor Vehicles or have a statement in writing from the appropriate department or departments verifying that the vendors or their drivers are exempt from such requirements.

(7) Payment is available for transportation services provided in order for the recipient to receive an MA covered service if the recipient receives such service (other than transportation services) at school or off of the school premises and both the covered service and transportation service are included in the recipient's individualized education plan. Payment is available for transportation services provided in order for the recipient, or the recipient's family member or significant other to receive an MA covered service if both the covered service and transportation service are included in the recipient's interim or final individualized family services plan. For purposes of this section, a significant other is a person who substitutes for the recipient's family, interacts regularly with the recipient, and affects directly the recipient's developmental status. Reimbursement for such services must be made in accordance with the provider agreement.

(8) Payment to a provider of ambulette services will only be made for services documented in contemporaneous records in accordance with section 504.3 of this Title. Documentation must include:

(i) the recipient's name and MA identification number;

(ii) the origination of the trip;

(iii) the destination of the trip;

(iv) the date and time of service; and

(v) the name of the driver transporting the recipient.

(9) Payment will not be made for transportation services when:

(i) the transportation services are ordinarily made available to other persons in the community without charge; however, payment may be made under such circumstances when Federal financial participation in the MA payment for transportation services is available;

(ii) the transportation services are provided by a medical facility and the costs are included in the facility's MA rate;

(iii) a vendor is not actually transporting an MA recipient;

(iv) the MA recipient has access to and can make use of transportation, such as a private vehicle or mass transportation, which the recipient ordinarily uses for the usual activities of daily living unless prior authorization has been granted by the prior authorization official.

(f) Medical transportation plans and fee schedules. The department shall establish fee schedules at which transportation services can be assured; provided, however, such fees shall not apply to non-emergency transportation services provided by a vendor in accordance with a service agreement with a transportation management broker. In addition, the following shall apply:

(1) Upon request, a vendor of transportation services must submit pertinent cost data, which is available to the vendor, to the department or the transportation management broker. The department may not require a certified cost document if providing such certification will result in additional expense to the vendor. Failure to comply with the requirements of this paragraph may result in the vendor's termination from participation in the MA program, either directly or through a transportation management broker.

(2) The department or transportation management broker, as applicable, must adhere to the following requirements in establishing fees with vendors of transportation services:

(i) The department must select at least one of the following:

(a) a flat fee for all transportation services provided;

(b) a base fee for all transportation services provided, plus a mileage charge;

(c) a flat fee for transportation services within specified areas; or

(d) a mileage fee based on distance.

(ii) The department may establish with vendors a reduced fee for any of the following:

(a) transportation of additional persons;

(b) transportation of persons traveling to and from day treatment or continuing treatment programs; and

(c) transportation of persons for purposes of obtaining regularly recurring medical care and services.

(iii) The department may establish an additional fee for any of the following:

(a) other transportation costs, limited to the costs of meals, lodging and transportation attendants;

(b) bridge and road tolls; and

(c) value-based payments.

(g) On or after October 1, 2020 and subject to federal financial participation, MA payments will be made to ambulance service vendors that participate in an ET3 model as follows:

(1) In order to participate in this model for MA payment purposes, an ambulance service vendor shall submit:

(i) a copy of its ET3 application as submitted to CMMI;

(ii) a copy of the approval letter from CMMI; and

(iii) any other documentation deemed necessary by the department to confirm Medicare ET3 payments are being made to the vendor.

(2) The department established fees for services provided under an ET3 model, which may include value-based payments, shall be for:

(i) transport to an alternative non-hospital destination, a base fee plus a mileage charge; and

(ii) treatment in place without transport, a base fee without a mileage charge.

(3) Ambulance service vendors receiving MA payments in accordance with this subdivision shall submit to the department copies of all reports provided to CMMI during the course of the Medicare demonstration.

(4) Medicaid payments under the ET3 model will continue only for the duration of the Medicare demonstration approved by CMMI and will be terminated when either the demonstration period expires or upon termination of Medicare participation by CMMI at any time for any reason.

Appendix IV
2023 Title XIX State Plan
Second Quarter Amendment
Public Notice

MISCELLANEOUS NOTICES/HEARINGS

Notice of Abandoned Property Received by the State Comptroller

Pursuant to provisions of the Abandoned Property Law and related laws, the Office of the State Comptroller receives unclaimed monies and other property deemed abandoned. A list of the names and last known addresses of the entitled owners of this abandoned property is maintained by the office in accordance with Section 1401 of the Abandoned Property Law. Interested parties may inquire if they appear on the Abandoned Property Listing by contacting the Office of Unclaimed Funds, Monday through Friday from 8:00 a.m. to 4:30 p.m., at:

1-800-221-9311
or visit our web site at:
www.osc.state.ny.us

Claims for abandoned property must be filed with the New York State Comptroller's Office of Unclaimed Funds as provided in Section 1406 of the Abandoned Property Law. For further information contact: Office of the State Comptroller, Office of Unclaimed Funds, 110 State St., Albany, NY 12236.

PUBLIC NOTICE
Department of Civil Service

PURSUANT to the Open Meetings Law, the New York State Civil Service Commission hereby gives public notice of the following:

Please take notice that the regular monthly meeting of the State Civil Service Commission for March 2023 will be conducted on March 8 and March 9 commencing at 10:00 a.m. This meeting will be conducted at NYS Media Services Center, Suite 146, South Concourse, Empire State Plaza, Albany, NY with live coverage available at https://www.cs.ny.gov/commission/

For further information, contact: Office of Commission Operations, Department of Civil Service, Empire State Plaza, Agency Bldg. One, Albany, NY 12239, (518) 473-6598

PUBLIC NOTICE
Division of Criminal Justice Services
Juvenile Justice Advisory Group

Pursuant to Public Officer Law § 104, the Division of Criminal Justice Services gives notice of a meeting of the New York State Juvenile Justice Advisory Group:

Date: March 9, 2023

Time: 10:00 a.m. - 1:00 p.m.

Place: Empire State Development Corp.
633 Third Ave., 37th Fl.
Conference Rm. 36A
New York, NY 10007

Video Conference with:

Division of Criminal Justice Services
80 S. Swan St., 1st Fl., Rm. 348
Albany, NY 12210

For further information, contact: Thomas R. Andriola, Chief of Policy and Implementation Office of Youth Justice, Division of Criminal Justices Services, 80 S. Swan St., 8th Fl., Albany, NY 12210, (518) 320-6926, Thomas.Andriola@dcjs.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 in accordance with New York State Social Service Law Section 365-h(4)(b), as authorized by the federal Social Security Act Section 1902(a)(70) and 42 CFR Section 440.170(a)(4). The following changes are proposed:

Non-Institutional Services

Effective on or after May 1, 2023, based on a competitive procurement, non-emergency medical transportation will be transitioned by the State from the current Medicaid Transportation managers to one or more Medicaid Transportation Broker(s) to ensure that Medicaid eligible individuals receive reliable, high quality non-emergency medical transportation (NEMT) services using the mode that is appropriate for each individual. The Medicaid Transportation Broker will contract directly with transportation providers to develop an adequate network, ensure compliance with transportation network driver and vehicle requirements and negotiate fee-for-service transportation provider reimbursement. The State will reimburse the Medicaid Transportation Broker in two ways: (1) monthly through an administrative fee on a per member per month basis for each Medicaid eligible individual whose transportation is being managed by the Medicaid Transportation Broker and (2) annually through a risk-sharing arrangement pursuant to a gain sharing agreement in which the Medicaid Transportation Broker agrees to share with the State net income gains over specified limits. The State will not share in net losses.

The estimated net aggregate decrease in gross Medicaid expenditures attributable to this initiative contained in the budget for State fiscal year 2023/2024 is ($34 million).

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 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 14 NYCRR Part 857, 14 NYCRR 818, 14 NYCRR 820, 14 NYCRR 822 and 14 NYCRR 825, which authorize Medicaid reimbursement for standalone problem gambling disorder treatment. Currently, problem gambling treatment is authorized when it is secondary to treatment for substance use disorder. The following changes are proposed:

Non-Institutional Services

Effective on or after March 1, 2023, the Department of Health will amend the Medicaid State plan to include coverage and reimbursement for problem gambling treatment provided to individuals receiving services from the Office of Addiction Services and Supports (OASAS) certified services, pursuant to 14 NYCRR Part 818 Chemical Dependence Inpatient Services, 14 NYCRR Part 820 Residential Addiction Rehabilitation Services, 14 NYCRR Part 822 Outpatient Addiction Rehabilitation Services, and 14 NYCRR Part 825 Integrated Outpatient Addiction Rehabilitation Services, with the OASAS gambling designation, when services are for problem gambling only. The OASAS gambling designation is not required when treatment is provided for individuals whose problem gambling disorder is secondary to their substance use disorder.

The estimated net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for State fiscal year 2022/2023 is $3,750 and the net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for State fiscal year 2023/2024 is $45,000.

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

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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 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 in accordance with Chapter 53 of the Laws of 2022 and Subdivision 5 of section 365-m of the social services law. The following changes are proposed:

Non-Institutional Services

Effective on or after March 1, 2023, the Department of Health will adjust rates for Office of Addiction Services and Supports (OASAS) State Plan Service NYCRR Title 14 Part 820 Residential Services. The stabilization element of the service in the downstate region will receive a parity adjustment with respect to the upstate region. Stabilization will also receive a 15.0% rate increase and rehabilitation will receive a 4.5% rate increase.

The estimated net aggregate increase in gross Medicaid expenditures attributable to this change $1,746 for State Fiscal Year 2023 and $20,956 for State Fiscal Year 2024.

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

Appendix V
2023 Title XIX State Plan
Second Quarter Amendment
Responses to Standard Funding Questions

NON-INSTITUTIONAL SERVICES
State Plan Amendment #23-0005

CMS Standard Funding Questions

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

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

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

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

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

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

		4/1/23 – 3/31/24	
Payment Type	**Non-Federal Share Funding**	**Non-Federal**	**Gross**
Transportation	General Fund; County Contribution	$495M	$989M

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

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

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

B. Additional Resources for Non-Federal Share Funding:

County Contribution: In State Fiscal Year 2006, through enacted State legislation (Part C of Chapter 58 of the laws of 2005), New York State "capped" the amount localities contributed to the non-Federal share of providers claims. This was designed to relieve pressure on county property taxes and the NYC budget by limiting local contributions having New York State absorb all local program costs above this fixed statutory inflation rate (3% at the time).

However, in State Fiscal Year 2013 New York State provided additional relief to Localities by reducing local contributions annual growth from three precent to zero over a three-year period. Beginning in State Fiscal Year 2016, counties began paying a fixed cost in perpetuity as follows:

Entity	Annual Amount
New York City	$5.200B
Suffolk County	$226M
Nassau County	$217M
Westchester County	$204M
Erie County	$194M
Rest of State (53 Counties)	$1.187B
Total	**$7.228B**

By eliminating the growth in localities Medicaid costs, the State has statutorily capped total Statewide County Medicaid expenditures at 2015 levels. All additional county Medicaid costs are funded by the State through State funding as described above. DOH provides annual letters to counties providing weekly contributions. Contributions are deposited directly into State escrow account and used to offset 'total' State share Medicaid funding.

NOTE: The Local Contribution is not tied to a specific claim or service category and instead is a capped amount based on 2015 county spending levels as stated above.

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

   Response: The Medicaid payments under this State Plan Amendment are not supplemental 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. Under regulations at 42 CFR 447.272, States are prohibited from setting payment rates for Medicaid inpatient services that exceed a reasonable estimate of the amount that would be paid under Medicare payment principals.**

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

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

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

ACA Assurances:

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

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

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

2. **Section 1905(y) and (z) of the Act provides for increased FMAPs for expenditures made on or after January 1, 2014 for individuals determined eligible under section 1902(a)(10)(A)(i)(VIII) of the Act. Under section 1905(cc) of the Act, the increased FMAP under sections 1905(y) and (z) would not be available for States that require local political subdivisions to contribute amounts toward the non-Federal share of the State's expenditures at a greater percentage than would have been required on December 31, 2009.**

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

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

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

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

Tribal Assurance:

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

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

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

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