NEW YORK STATE OF OPPORTUNITY. Department of Health

ANDREW M. CUOMO
Governor

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

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

SEP 2 8 2018

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

Re: SPA #18-0059
Inpatient Hospital Services

Dear Mr. Cooley:

The State requests approval of the enclosed amendment #18-0059 to the Title XIX (Medicaid) State Plan for inpatient hospital services to be effective July 1, 2018 (Appendix I). This amendment is being submitted based upon State regulations. A summary of the proposed amendment is contained in Appendix II.

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

Notice of the changes in the methods and standards for setting payment rates for general hospital inpatient services were given in the New York State Register on June 27, 2018.

A copy of the pertinent section of State regulations is enclosed for your information (Appendix III). In addition, responses to the five standard funding questions are also enclosed (Appendix V).

If you have any questions regarding this State Plan Amendment submission, please do not hesitate to contact Regina Deyette, Medicaid State Plan Coordinator, Division of Finance and Rate Setting, Office of Health Insurance Programs at (518) 473-3658.

Sincerely,

[redacted]

Donna Frescatore
Medicaid Director
Office of Health Insurance Programs

Enclosures
cc: Mr. Michael Melendez
Mr. Tom Brady

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL **FOR: HEALTH CARE FINANCING ADMINISTRATION**	1. TRANSMITTAL NUMBER: **18-0059**	2. STATE **New York**
	3. PROGRAM IDENTIFICATION: **TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)**	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE **July 1, 2018**	
5. TYPE OF PLAN MATERIAL *(Check One)*: ☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT		
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*		
6. FEDERAL STATUTE/REGULATION CITATION: **§1902(a) of the Social Security Act, and 42 CFR 447**	7. FEDERAL BUDGET IMPACT: **(in thousands)** **a. FFY 07/01/18-09/30/18 $ 560.00** **b. FFY 10/01/18-09/30/19 $ 2,240.00**	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: **Attachment 4.19-A: Page 117(i)**	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: **Attachment 4.19-A: Page 117(i)**	
10. SUBJECT OF AMENDMENT: **Inpatient Psychiatric Services Rate Adjustments (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]	16. RETURN TO: **New York State Department of Health** **Division of Finance & Rate Setting** **99 Washington Ave – One Commerce Plaza** **Suite 1432** **Albany, NY 12210**	
13. TYPED NAME: **Donna Frescatore**		
14. TITLE: **Medicaid Director** **Department of Health**		
15. DATE SUBMITTED: SEP 2 8 2018		
FOR REGIONAL OFFICE USE ONLY		
17. DATE RECEIVED:	18. DATE APPROVED:	
PLAN APPROVED – ONE COPY ATTACHED		
19. EFFECTIVE DATE OF APPROVED MATERIAL:	20. SIGNATURE OF REGIONAL OFFICIAL:	
21. TYPED NAME:	22. TITLE:	
23. REMARKS:		

FORM HCFA-179 (07-92)

Appendix I
2018 Title XIX State Plan
Third Quarter Amendment
Amended SPA Pages

772	1	Alcohol & Drug Dependence w Rehab or Rehab/Detox Therapy, SOI-1	0.8373
772	2	Alcohol & Drug Dependence w Rehab or Rehab/Detox Therapy, SOI-2	0.8373
772	3	Alcohol & Drug Dependence w Rehab or Rehab/Detox Therapy, SOI-3	0.8373
772	4	Alcohol & Drug Dependence w Rehab or Rehab/Detox Therapy, SOI-4	0.8373
773	1	Opioid Abuse & Dependence, SOI-1	1.0204
773	2	Opioid Abuse & Dependence, SOI-2	1.0204
773	3	Opioid Abuse & Dependence, SOI-3	1.0361
773	4	Opioid Abuse & Dependence, SOI-4	1.0361
774	1	Cocaine Abuse & Dependence, SOI-1	0.9807
774	2	Cocaine Abuse & Dependence, SOI-2	1.0360
774	3	Cocaine Abuse & Dependence, SOI-3	1.0513
774	4	Cocaine Abuse & Dependence, SOI-4	1.0513
775	1	Alcohol Abuse & Dependence, SOI-1	1.0196
775	2	Alcohol Abuse & Dependence, SOI-2	1.0709
775	3	Alcohol Abuse & Dependence, SOI-3	1.0709
775	4	Alcohol Abuse & Dependence, SOI-4	1.0709
776	1	Other Drug Abuse & Dependence, SOI-1	0.9363
776	2	Other Drug Abuse & Dependence, SOI-2	1.0926
776	3	Other Drug Abuse & Dependence, SOI-3	1.0926
776	4	Other Drug Abuse & Dependence, SOI-4	1.0926

iii. A rural adjustment factor of 1.2309 will be applied to the operating per diem for those hospitals designated as rural hospitals. A rural facility is a general hospital with a service area which has an average population of less than 175 persons per square mile, or a general hospital with a service area which has an average population of less than 200 persons per square mile measured as population density by zip code. For dates of service beginning on or after July 1, 2014, rural designation will be applicable to hospitals located in an upstate region, as defined in subparagraph (l) of this section, and with population densities of 225 persons or fewer per square mile as determined based on the New York State 2010 Vital Statistics table of estimated population, land area, and population density. Accordingly, there are 27 rural facilities that provide inpatient psychiatric services.

iv. An age adjustment payment factor of [1.0872] 1.3597 will be applied to the per diem operating component for adolescents ages 17 and under. For ages 18 and over, an adjustment payment factor of 1 will be applied.

Appendix II
2018 Title XIX State Plan
Third Quarter Amendment
Summary

SUMMARY
SPA #18-0059

This State Plan Amendment proposes to increase reimbursement for Article 28 hospital children's inpatient psychiatric services to better meet community children's mental health needs.

Appendix III
2018 Title XIX State Plan
Third Quarter Amendment
Authorizing Provisions

18-0059

Section 86-1.39 - Inpatient psychiatric services

86-1.39 Inpatient psychiatric services. Inpatient psychiatric services provided in general hospitals, or distinct units of general hospitals, specializing in such inpatient psychiatric services, with regard to patients admitted on and after October 20, 2010, shall be reimbursed on a per diem basis in accordance with the following, provided, however, that such rates applicable to inpatients otherwise subject to the provisions of public health law section 2807-c(1)(a-2)(i) shall be effective with regard to patients admitted on and after January 1, 2011:

(a) Such reimbursement shall be based on the All Patient Refined Diagnostic Related Group (APR-DRG) patient classification system as defined in section 86-1.15(a) of this Subpart.

(b) The operating component of the rate shall be based on a statewide price, utilizing 2005 Medicaid fee-for-service (FFS) inpatient costs adjusted for case mix and the Wage Equalization Factor (WEF) and excluding costs for Direct GME, Electroconvulsive Therapy, and capital costs.

(c) The capital cost components of rates computed pursuant to this section shall be computed on the basis of budgeted capital costs allocated to the hospital, or to the distinct unit of a hospital, in accordance with the provisions of section 86-1.25 of this Subpart divided by the hospital or distinct unit patient days and reconciled to actual total expenses.

(d) The non-operating component of the rate shall reflect 2005 Medicaid fee-for-service Direct GME costs.

(e) The statewide price shall be adjusted for each patient to reflect the following factors:

(1) a service intensity weight (SIW) associated with the case based on the grouper assigned APR-DRG, as described in subdivision (f) of this section, will be applied to the adjusted operating per diem;

(2) a rural adjustment factor of 1.2309 will be applied to the operating per diem for those hospitals designated as rural hospitals;

(i) for dates of service beginning on or after July 1, 2014, rural designation shall be applicable to hospitals located in an upstate region, as defined in subdivision (o) of this section, and with population densities of 225 persons or fewer per square mile as determined based on the New York State 2010 Vital Statistics table of estimated population, land area, and population density.

(3) an age adjustment payment factor of [1.0872] 1.3597 will be applied to the per diem operating component for adolescents ages 17 and under;

(4) a payment adjustment factor of 1.0599 will be applied to the operating component for the presence of a mental retardation diagnosis;

(5) the payment methodology shall include one co-morbidity factor per stay and if more than one co-morbidity is presented, the co-morbidity that reflects the highest payment factor shall be used to adjust the per diem operating component; and

(6) a variable payment factor will be applied to the operating per diem for each day of the stay, with the factor for days 1 through 4 established at 1.2, the factor for days 5 through 11 established at 1.0, the factor for days 12 through 22 established at 0.96 and the factor for stays longer than 22 days established at 0.92.

(7) for dates of service beginning on or after July 1, 2014, a ten percent increase will be applied for hospitals located in an upstate region as defined in subdivision (o) of this section.

(f) (1) The table of service intensity weights (SlW's) applicable to rates set pursuant to this section for each effective period is published on the New York State Department of Health website at http://www.health.ny.gov/nysdoh/hospital/drg/index.htm and reflects the cost weights assigned to each All Patient Refined (APR) diagnosis related group (DRG) patient classification category. The SIWs assigned to each DRG/APR indicates the relative cost variance of that DRG/APR classification from the average cost of all inpatients in all DRG/APRs. Such SIWs are developed using two years of Medicaid fee-for-service cost data as reported to the Statewide Planning and Research Cooperative System (SPARCS) for the years set forth in paragraph (2) of this subdivision. Costs associated with hospitals that do not have an ancillary charge structure and costs associated with statistical outliers shall be excluded from the SIW calculations.
(2) For rate periods on and after the effective date of this section the SIW shall be computed using SPARCS and reported cost data from the 2005 and 2006 calendar years, as submitted to the department by September 30, 2009.
(g) The table of co-morbidity factors applicable to the rate adjustments described in paragraph (5) of subdivision (e) of this section is published on the New York State Department of Health website at http://www.health.state.ny.us/.
(h) The first day of a patient's readmissions to the same hospital within thirty days of discharge will be treated as day four for purposes of the variable payment factor computed pursuant to paragraph (6) of subdivision (d) of this section, with subsequent days treated in a conforming manner with the provisions of such paragraph.
(i) Reimbursement for physician services shall not be included in rates set pursuant to this section and such services may be billed on a fee-for-services basis as otherwise provided by applicable provisions of law.
(j) Reimbursement for Electroconvulsive Therapy shall be established at a statewide fee of $281, as adjusted for each facility's WEF, for each treatment during a patient's stay.
(k) Reimbursement for days of alternative level of care for patients whose reimbursement is otherwise subject to this section shall be in accordance with section 86-1.22 of this Subpart.
(l) New inpatient psychiatric exempt hospitals or units established pursuant to article 28 of the public health law shall be reimbursed at the statewide price plus budgeted capital and Direct GME.
(m) For rate periods through December 31, 2014, reimbursement pursuant to this section shall include transition payments of up to twenty-five million dollars on an annualized basis, which shall be distributed in accordance with the following:
(1)(i) Fifty percent of such payments shall be allocated to facilities that experience a reduction in Medicaid operating revenue in excess of threshold percentage set forth in subparagraph (ii) of this paragraph as a result of the implementation of rates set pursuant to this section. Such payments shall be allocated proportionally, based on each eligible facility's relative Medicaid operating revenue loss in excess of the threshold, as determined by the commissioner.
(ii) The threshold percentage described in subparagraph (i) of this paragraph shall be 6.02%.
(2)(i) Fifty percent of such payments shall be allocated to facilities with regard to which it is determined by the commissioner that rates otherwise set pursuant to this section result in Medicaid revenue that is less than the facility's Medicaid costs by a threshold percentage in excess of the threshold percentage set forth in subparagraph (ii) of this paragraph. Such payments shall be allocated proportionally, based on the degree each facility Medicaid operating revenue shortfall exceeds such threshold percentage. For

those facilities without available Medicaid fee-for-service cost data, computations pursuant to this paragraph shall be based on each such facility's total operating costs as determined by the commissioner.
(ii) The threshold percentage described in subparagraph (i) of this paragraph shall be 1.20%.
(n) For rate period after October 20, 2010 through March 31, 2011, reimbursement pursuant to this paragraph may include transition payments totaling, in aggregate, up to twelve million dollars and distributed to eligible hospitals in accordance with the following, provided, however, that if less than twelve million dollars is distributed in such rate period, then additional distributions of up to such twelve million dollars may be made in accordance with the provisions of this subdivision in subsequent rate periods:
(1) Eligible hospitals shall be those general hospitals which receive approval for certificate-of-need applications submitted to the Department of Health between April 1, 2010 and March 31, 2011 for adding new behavioral health beds to their certified bed capacity as a direct result of the decertification of other general hospital behavioral health inpatient beds in the same service area, or which the Commissioner of Health, in consultation with the Commissioner of Mental Health, has determined have complied with Department of Health requests to make other significant behavioral health service delivery adjustments in direct response to such decertification.
(2) Eligible hospitals shall, as a condition of their receipt of such rate adjustments, submit to the Department of Health proposed budgets for the expenditure of such additional Medicaid payments for the purpose of providing behavioral health services and such budgets must be approved by the Department of Health, in consultation with the Office of Mental Health, prior to such rate adjustments being issued.
(3) Distributions made pursuant to this paragraph shall be made as add-ons to each eligible facility's inpatient Medicaid rate and shall be allocated proportionally, based on the proportion of each approved hospital budget to the total amount of all approved hospital budgets and such distributions shall be subsequently reconciled to ensure that actual aggregate expenditures are within available aggregate funding.
(o) For purposes of this section, downstate region of New York State shall consist of the following counties of Bronx, New York, Kings, Queens, Richmond, Nassau, Suffolk, Westchester, Rockland, Orange, Putnam and Dutchess, and the upstate region of New York state shall consist of all other New York counties.

Appendix IV
2018 Title XIX State Plan
Third Quarter Amendment
Public Notice

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, Bureau of Federal Relations and Provider Assessments, 99 Washington Ave., One Commerce Plaza, Suite 1430, Albany, NY 12210, (518) 474-1673, (518) 473-8825 (FAX), e-mail: spa_inquiries@health.state.ny.us

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 institutional services to comply with enacted statutory provisions. The following changes are proposed:

Institutional Services

Effective on or after July 1, 2018, the Department of Health will adjust rates of reimbursement for inpatient psychiatric services provided in general hospitals, or distinct units of general hospitals to reimburse hospitals for providing these services to individuals aged 17 and under to better meet community children's mental health needs. The Department of Health will increase the age adjustment factor for these services to these individuals from 1.0872 to 1.3597.

The estimated annual aggregate increase in gross Medicaid expenditures attributable to the increase of the age adjustment factor is $10,000,000. Funds for this increase are contained in the State budget beginning in state fiscal year 2018/2019.

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. In addition, approved SPA's beginning in 2011 are also available for viewing on this website.

Copies of the proposed State Plan Amendments will be on file in each local (county) social services district and available for public review.

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, e-mail: 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 institutional services at non-profit Residential Treatment Facilities for Children and Youth to comply with an OMH policy objective. The following changes are proposed:

Institutional Services

The amendment will reflect an adjustment to the minimum utilization range, used in the Residential Treatment Facility reimbursement methodology, from 93 percent to 90 percent, effective on or after July 1, 2018.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2018/2019 is $436,285, with an annualized value of $581,714.

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, e-mail: spa_inquiries@health.ny.gov

Appendix V
2018 Title XIX State Plan
Third Quarter Amendment
Responses to Standard Funding Questions

APPENDIX V
HOSPITAL SERVICES
State Plan Amendment #18-0059

CMS Standard Funding Questions (NIRT Standard Funding Questions)

The following questions are being asked and should be answered in relation to all payments made to all providers under Attachment 4.19-A of the state plan.

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

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

2. Section 1902(a)(2) provides that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan. Please describe how the state share of each type of Medicaid payment (normal per diem, supplemental, enhanced, other) is funded. Please describe whether the state share is from

appropriations from the legislature to the Medicaid agency, through intergovernmental transfer agreements (IGTs), certified public expenditures (CPEs), provider taxes, or any other mechanism used by the state to provide state share. Note that, if the appropriation is not to the Medicaid agency, the source of the state share would necessarily be derived through either an IGT or CPE. In this case, please identify the agency to which the funds are appropriated. Please provide an estimate of total expenditure and State share amounts for each type of Medicaid payment. If any of the non-federal share is being provided using IGTs or CPEs, please fully describe the matching arrangement including when the state agency receives the transferred amounts from the local government entity transferring the funds. If CPEs are used, please describe the methodology used by the state to verify that the total expenditures being certified are eligible for Federal matching funds in accordance with 42 CFR 433.51(b). For any payment funded by CPEs or IGTs, please provide the following:

(i) a complete list of the names of entities transferring or certifying funds;

(ii) the operational nature of the entity (state, county, city, other);

(iii) the total amounts transferred or certified by each entity;

(iv) clarify whether the certifying or transferring entity has general taxing authority; and,

(v) whether the certifying or transferring entity received appropriations (identify level of appropriations).

Response: Payments made to service providers under the provisions of this SPA are funded through a general appropriation received by the State agency that oversees medical assistance (Medicaid), which is the Department of Health. The source of the appropriation is the Local Assistance Account under the General Fund/Aid to Localities.

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

Response: The payments authorized for this provision are not supplemental or enhanced payments.

4. Please provide a detailed description of the methodology used by the state to estimate the upper payment limit (UPL) for each class of providers (State owned or operated, non-state government owned or operated, and privately owned or operated). Please provide a current (i.e. applicable to the current rate year) UPL demonstration. Under regulations at 42 CFR 447.272, States are prohibited from setting payment rates for Medicaid inpatient services that exceed a reasonable estimate of the amount that would be paid under Medicare payment principals.

Response: The State will submit the 2018 clinic UPL demonstration by March 31, 2019.

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

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

ACA Assurances:

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

MOE Period.

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

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

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

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

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

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

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

Tribal Assurance:

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

IHCIA Section 2107(e)(I) of the Act was also amended to apply these requirements to the Children's Health Insurance Program CHIP. Consultation is required concerning Medicaid and CHIP matters having a direct impact on Indian health programs and Urban Indian organizations.
a) Please describe the process the State uses to seek advice on a regular ongoing basis from federally recognized tribes Indian Health Programs and Urban Indian Organizations on matters related to Medicaid and CHIP programs and for consultation on State Plan Amendments waiver proposals waiver extensions waiver amendments waiver renewals and proposals for demonstration projects prior to submission to CMS.
b) Please include information about the frequency inclusiveness and process for seeking such advice.
c) Please describe the consultation process that occurred specifically for the development and submission of this State Plan Amendment when it occurred and who was involved.

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