



Department of Health

KATHY HOCHUL
Governor

MARY T. BASSETT, M.D., M.P.H.
Commissioner

KRISTIN M. PROUD
Acting Executive Deputy Commissioner

June 30, 2022

Todd McMillion
Director
Department of Health and Human Services
Centers for Medicare and Medicaid Services
233 North Michigan Ave, Suite 600
Chicago, IL 60601

RE: SPA #22-0053
Long Term Care Facility Services

Dear Mr. McMillion:

The State requests approval of the enclosed amendment #22-0053 to the Title XIX (Medicaid) State Plan for long term care facility services to be effective April 1, 2022 (Appendix I). This amendment is being submitted based on enacted legislation. A summary of the proposed amendment is provided 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, Part 447, Subpart C, (42 CFR §447).

A copy of the pertinent section of enacted legislation is enclosed for your information (Appendix III). Copies of the public notice of this proposed amendment, which was given in the New York State Register on March 30, 2022, is also enclosed for your information (Appendix IV). In addition, responses to the five standard funding questions are also enclosed (Appendix V).

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

Sincerely,



Amir Bassiri
Acting Medicaid Director
Office of Health Insurance Programs

Enclosures

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL
FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES**

1. TRANSMITTAL NUMBER ____ _	2. STATE ____
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3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT XIX XXI
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TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE

5. FEDERAL STATUTE/REGULATION CITATION
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6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY _____ \$ _____
b. FFY _____ \$ _____

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
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8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable)

9. SUBJECT OF AMENDMENT

10. GOVERNOR'S REVIEW (Check One)	OTHER, AS SPECIFIED:
GOVERNOR'S OFFICE REPORTED NO COMMENT	
COMMENTS OF GOVERNOR'S OFFICE ENCLOSED	
NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL	

11. SIGNATURE OF STATE AGENCY OFFICIAL 
12. TYPED NAME
13. TITLE
14. DATE SUBMITTED June 30, 2022

15. RETURN TO

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

Appendix I
2022 Title XIX State Plan
Second Quarter Amendment
Amended SPA Pages

Appendix II
2022 Title XIX State Plan
Second Quarter Amendment
Summary

SUMMARY
SPA #22-0053

This State Plan Amendment proposes to revise the State Plan for an across the board adjustment of a 5.4% Cost of Living Adjustment (COLA) to the following institutional service, Intermediate Care Facility (ICF/IID).

Appendix III
2022 Title XIX State Plan
Second Quarter Amendment
Authorizing Provisions

Part DD of Chapter 57 of the Laws of 2022

PART DD

27 Section 1. 1. Subject to available appropriations and approval of the
28 director of the budget, the commissioners of the office of mental
29 health, office for people with developmental disabilities, office of
30 addiction services and supports, office of temporary and disability
31 assistance, office of children and family services, and the state office
32 for the aging shall establish a state fiscal year 2022-23 cost of living
33 adjustment (COLA), effective April 1, 2022, for projecting for the
34 effects of inflation upon rates of payments, contracts, or any other
35 form of reimbursement for the programs and services listed in paragraphs
36 (i), (ii), (iii), (iv), (v), and (vi) of subdivision four of this
37 section. The COLA established herein shall be applied to the appropri-
38 ate portion of reimbursable costs or contract amounts. Where appropri-
39 ate, transfers to the department of health (DOH) shall be made as
40 reimbursement for the state share of medical assistance.

41 2. Notwithstanding any inconsistent provision of law, subject to the
42 approval of the director of the budget and available appropriations
43 therefore, for the period of April 1, 2022 through March 31, 2023, the
44 commissioners shall provide funding to support a five and four-tenths
45 percent (5.4%) cost of living adjustment under this section for all
46 eligible programs and services as determined pursuant to subdivision
47 four of this section.

48 3. Notwithstanding any inconsistent provision of law, and as approved
49 by the director of the budget, the 5.4 percent cost of living adjustment
50 (COLA) established herein shall be inclusive of all other cost of living
51 type increases, inflation factors, or trend factors that are newly
52 applied effective April 1, 2022. Except for the 5.4 percent cost of
53 living adjustment (COLA) established herein, for the period commencing
54 on April 1, 2022 and ending March 31, 2023 the commissioners shall not
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1 apply any other new cost of living adjustments for the purpose of estab-
2 lishing rates of payments, contracts or any other form of reimbursement.
3 The phrase "all other cost of living type increases, inflation factors,
4 or trend factors" as defined in this subdivision shall not include
5 payments made pursuant to the American Rescue Plan Act or other federal
6 relief programs related to the Coronavirus Disease 2019 (COVID-19)
7 pandemic Public Health Emergency.

8 4. Eligible programs and services. (i) Programs and services funded,
9 licensed, or certified by the office of mental health (OMH) eligible for
10 the cost of living adjustment established herein, pending federal
11 approval where applicable, include: office of mental health licensed
12 outpatient programs, pursuant to parts 587 and 599 of title 14 CRR-NY of
13 the office of mental health regulations including clinic, continuing day
14 treatment, day treatment, intensive outpatient programs and partial
15 hospitalization; outreach; crisis residence; crisis stabilization,
16 crisis/respite beds; mobile crisis, part 590 comprehensive psychiatric
17 emergency program services; crisis intervention; home based crisis
18 intervention; family care; supported single room occupancy; supported
19 housing; supported housing community services; treatment congregate;
20 supported congregate; community residence - children and youth;
21 treatment/apartment; supported apartment; community residence single
22 room occupancy; on-site rehabilitation; employment programs; recreation;
23 respite care; transportation; psychosocial club; assertive community
24 treatment; case management; care coordination, including health home
25 plus services; local government unit administration; monitoring and
26 evaluation; children and youth vocational services; single point of
27 access; school-based mental health program; family support children and

28 youth; advocacy/support services; drop in centers; recovery centers;
29 transition management services; bridge; home and community based waiver
30 services; behavioral health waiver services authorized pursuant to the
31 section 1115 MRT waiver; self-help programs; consumer service dollars;
32 conference of local mental hygiene directors; multicultural initiative;
33 ongoing integrated supported employment services; supported education;
34 mentally ill/chemical abuse (MICA) network; personalized recovery
35 oriented services; children and family treatment and support services;
36 residential treatment facilities operating pursuant to part 584 of title
37 14-NYCRR; geriatric demonstration programs; community-based mental
38 health family treatment and support; coordinated children's service
39 initiative; homeless services; and promises zone.

40 (ii) Programs and services funded, licensed, or certified by the
41 office for people with developmental disabilities (OPWDD) eligible for
42 the cost of living adjustment established herein, pending federal
43 approval where applicable, include: local/unified services; chapter 620
44 services; voluntary operated community residential services; article 16
45 clinics; day treatment services; family support services; 100% day
46 training; epilepsy services; traumatic brain injury services; hepatitis
47 B services; independent practitioner services for individuals with
48 intellectual and/or developmental disabilities; crisis services for
49 individuals with intellectual and/or developmental disabilities; family
50 care residential habilitation; supervised residential habilitation;
51 supportive residential habilitation; respite; day habilitation; prevoca-
52 tional services; supported employment; community habilitation; interme-
53 diate care facility day and residential services; specialty hospital;
54 pathways to employment; intensive behavioral services; basic home and
55 community based services (HCBS) plan support; health home services
56 provided by care coordination organizations; community transition
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1 services; family education and training; fiscal intermediary; support
2 broker; and personal resource accounts.

3 (iii) Programs and services funded, licensed, or certified by the
4 office of addiction services and supports (OASAS) eligible for the cost
5 of living adjustment established herein, pending federal approval where
6 applicable, include: medically supervised withdrawal services - residen-
7 tial; medically supervised withdrawal services - outpatient; medically
8 managed detoxification; medically monitored withdrawal; inpatient reha-
9 bilitation services; outpatient opioid treatment; residential opioid
10 treatment; KEEP units outpatient; residential opioid treatment to absti-
11 nence; problem gambling treatment; medically supervised outpatient;
12 outpatient rehabilitation; specialized services substance abuse
13 programs; home and community based waiver services pursuant to subdivi-
14 sion 9 of section 366 of the social services law; children and family
15 treatment and support services; continuum of care rental assistance case
16 management; NY/NY III post-treatment housing; NY/NY III housing for
17 persons at risk for homelessness; permanent supported housing; youth
18 clubhouse; recovery community centers; recovery community organizing
19 initiative; residential rehabilitation services for youth (RRSY); inten-
20 sive residential; community residential; supportive living; residential
21 services; job placement initiative; case management; family support
22 navigator; local government unit administration; peer engagement; voca-
23 tional rehabilitation; support services; HIV early intervention
24 services; dual diagnosis coordinator; problem gambling resource centers;
25 problem gambling prevention; prevention resource centers; primary
26 prevention services; other prevention services; and community services.

27 (iv) Programs and services funded, licensed, or certified by the
28 office of temporary and disability assistance (OTDA) eligible for the
29 cost of living adjustment established herein, pending federal approval
30 where applicable, include: nutrition outreach and education program
31 (NOEP).

32 (v) Programs and services funded, licensed, or certified by the office

33 of children and family services (OCFS) eligible for the cost of living
34 adjustment established herein, pending federal approval where applica-
35 ble, include: programs for which the office of children and family
36 services establishes maximum state aid rates pursuant to section 398-a
37 of the social services law and section 4003 of the education law; emer-
38 gency foster homes; foster family boarding homes and therapeutic foster
39 homes as defined by the regulations of the office of children and family
40 services; supervised settings as defined by subdivision twenty-two of
41 section 371 of the social services law; adoptive parents receiving
42 adoption subsidy pursuant to section 453 of the social services law; and
43 congregate and scattered supportive housing programs and supportive
44 services provided under the NY/NY III supportive housing agreement to
45 young adults leaving or having recently left foster care.

46 (vi) Programs and services funded, licensed, or certified by the state
47 office for the aging (SOFA) eligible for the cost of living adjustment
48 established herein, pending federal approval where applicable, include:
49 community services for the elderly; expanded in-home services for the
50 elderly; and supplemental nutrition assistance program.

51 5. Each local government unit or direct contract provider receiving
52 funding for the cost of living adjustment established herein shall
53 submit a written certification, in such form and at such time as each
54 commissioner shall prescribe, attesting how such funding will be or was
55 used to first promote the recruitment and retention of non-executive
56 direct care staff, non-executive direct support professionals, non-exe-
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1 cutive clinical staff, or respond to other critical non-personal service
2 costs prior to supporting any salary increases or other compensation for
3 executive level job titles.

4 6. Notwithstanding any inconsistent provision of law to the contrary,
5 agency commissioners shall be authorized to recoup funding from a local
6 governmental unit or direct contract provider for the cost of living
7 adjustment established herein determined to have been used in a manner
8 inconsistent with the appropriation, or any other provision of this
9 section. Such agency commissioners shall be authorized to employ any
10 legal mechanism to recoup such funds, including an offset of other funds
11 that are owed to such local governmental unit or direct contract provid-
12 er.

13 § 2. This act shall take effect immediately and shall be deemed to
14 have been in full force and effect on and after April 1, 2022.

Appendix IV
2022 Title XIX State Plan
Second Quarter Amendment
Public Notice

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, non-institutional and long-term care services to comply with statutory provisions. The following changes are proposed:

All Services

Effective on or after April 1, 2022, the Department of Health will adjust rates statewide to reflect a 5.4% percent Cost of Living Adjustment for the following Office of Mental Health (OMH), Office of Addiction Services and Supports (OASAS), and Office for People With Developmental Disabilities (OPWDD) State Plan Services: OMH Outpatient Services, OMH Clinic Services, OMH Rehabilitative Services, Children Family Treatment Support Services, Health Home Plus, Residential Treatment Facilities for Children and Youth, OASAS outpatient addiction services, OASAS freestanding (non-hospital) inpatient rehabilitation services, OASAS freestanding inpatient detox services, OASAS addiction treatment centers, OASAS Part 820 residential services, OASAS residential rehabilitation services for youth, Intermediate Care Facility (ICF/IDD), Day Treatment, Article 16 Clinic services, Specialty Hospital, Health Home Services Provided by Care Coordination Organizations, Independent Practitioner Services for Individual with Developmental Disabilities (IPSIDD), and OPWDD Crisis Services.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to the April 1, 2022, 5.4% percent Cost of Living Adjustment contained in the budget for State Fiscal Year 2023 is \$109.9 million.

Effective on or after April 1, 2022, Health care and mental hygiene worker bonuses will be provided to New York's essential front line health care and mental hygiene workers. These bonuses are intended to attract talented people into the profession and retain people who have been working during the COVID-19 Pandemic by rewarding them financially for their service.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for State Fiscal Year 2023 is \$1.85 billion.

Effective for dates of service on or after April 1, 2022, through March 31, 2024, all Medicaid rate-based claims will receive a 1% operating increase. Payments exempted from this increase, are as follows:

- Payments not subject to federal financial participation;
- Payments that would violate federal law including, but not limited to, hospital disproportionate share payments that would be in excess of federal statutory caps;
- Payments made by other state agencies including, but not limited to, those made pursuant to articles 16, 31 and 32 of the mental hygiene laws;
- Payments the state is obligated to make pursuant to court orders or judgments;
- Payments for which the non-federal share does not reflect any state funding; and
- At the discretion of the Commissioner of Health and the Director of the Budget, payments with regard to which it is determined that application of increases pursuant to this section would result, by operation of federal law, in a lower federal medical assistance percentage applicable to such payments.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for State Fiscal Year 2023 is \$165 million.

Effective for dates of service on or after April 1, 2022, the 1.5% uniform reduction for all non-exempt Department of Health state funds Medicaid payments will be restored.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for State Fiscal Year 2023 is \$280 million.

Non-Institutional Services

Effective on or after April 1, 2022, this proposal continues the supplemental upper payment limit payments made to general hospitals, other than major public general hospitals under non-institutional services of \$339 million annually.

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

For state fiscal year beginning April 1, 2022, through March 31, 2023, this proposal continues hospital outpatient payment adjustments that increase the operating cost components of rates of payment for hospital outpatient and emergency departments on and after April 1, 2011, for public general hospitals other than those operated by the State of New York or the State University of New York, which are located in a city with a population of over one million. The amount to be paid will be up to \$287 million annually based on criteria and methodology set by the Commissioner of Health, which the Commissioner may periodically set through a memorandum of understanding with the New York City Health and Hospitals Corporation. Such adjustments shall be paid by means of one or more estimated payments. Payments may be added to rates of payment or made as aggregate payments.

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

For state fiscal year beginning April 1, 2022, through March 31, 2023, this proposal continues payment of up to \$5.4 million in additional annual Medicaid payments to county operated free-standing clinics, not including facilities operated by the New York City Health and Hospitals Corporation, for services provided by such DTC and those provided by a county operated freestanding mental health or substance abuse DTC. Distributions shall be based on each eligible facility's proportionate share of the sum of all DTC and clinic visits for all eligible facilities receiving payments for the base year two years prior to the rate year. The proportionate share payments may be added to rates of payment or made as aggregate payments to eligible facilities.

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

Effective April 1, 2022, and each state fiscal year thereafter, this amendment proposes to revise the final payment component of the calculation to account for claim runout. The current authority to make supplemental payments for services provided by physicians, nurse practitioners and physician assistants will continue.

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

Effective on or after April 1, 2022, payments in quarter-hour units for the following harm reduction services for people who actively use drugs provided at New York State Commissioner of Health waived comprehensive harm reduction programs (community-based organizations) will be revised. The intention is to combat the opioid overdose crisis and reduce health care costs for people who use drugs. Harm reduction services improve population health and have been shown to reduce health care costs by preventing disease transmission (HIV, HBV, and HCV), injection site infections, emergency department and inpatient care from drug overdose, injury, and death. Comprehensive harm reduction programs are effective at engaging high-risk populations and serving as a bridge for entry into drug treatment and other health and social services.

Regional monthly rates will be established for New York City and the rest of the state and are based on the expected direct service costs in each region. Billable activities encompass those components of harm reduction attributable to direct client service, such as brief assessment and treatment planning, harm reduction counseling, linkage and navigation, medication management and treatment adherence counseling, psychoeducation support groups. Direct and indirect costs are budgeted as part of the rate. No funds shall be used to carry out the purchase or distribution of sterile needles or syringes for the hypodermic injection of any illegal drug.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for State Fiscal Year 2023 is \$34.6 million.

Appendix V
2022 Title XIX State Plan
Second Quarter Amendment
Responses to Standard Funding Questions

LONG-TERM SERVICES
State Plan Amendment #22-0053

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-D 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 payments, a complete listing of providers that return a portion of their payments, the amount or percentage of payments that are returned and the disposition and use of the funds once they are returned to the State (i.e., general fund, medical services account, etc.).**

Response: Providers do receive and retain the 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 through an IGT or CPE. In this case, please identify the agency to which the funds are appropriated. Please provide an estimate of total expenditure and State share amounts for each type of Medicaid payment. If any of the non-federal share is being provided using IGTs or CPEs, please fully describe the matching arrangement including when the state agency receives the transferred amounts from the local governmental entity transferring the funds. If CPEs are used, please describe the methodology used by the state to verify that the total expenditures being certified are eligible for Federal matching funds in accordance with 42 CFR 433.51(b). For any payment funded by CPEs or IGTs, please provide the following:**

- (i) a complete list of the names of entities transferring or certifying funds;
- (ii) the operational nature of the entity (state, county, city, other);
- (iii) the total amounts transferred or certified by each entity;
- (iv) clarify whether the certifying or transferring entity has general taxing authority; and,
- (v) whether the certifying or transferring entity received appropriations (identify level of appropriations).

Response: 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.

		4/1/22 – 3/31/23	
Payment Type	Non-Federal Share Funding	Non-Federal	Gross
Normal Per Diem	General Fund; Special Revenue Funds; County Contribution	\$3,267,663,998	6,535,327,996

1) **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.

- a. 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.

2) Special Revenue Funds:

- a. Health Care Reform Act (HCRA) Resource Fund: as authorized in section 92-dd of New York State Finance Law and was established in 1996, pursuant to New York State Public Health Law 2807-j. HCRA resources include health care related surcharges, assessments on hospital revenues, and a “covered lives” assessment paid by insurance carriers pursuant to chapter 820 of the laws of 2021.

- b. Health Facility Cash Assessment Program (HFCAP) Fund: HFCAP requires New York State designated providers to pay an assessment on cash operating receipts on a monthly basis. The assessment includes Article 28 Residential Health Care Facilities, Article 28 General Hospitals, Article 36 Long Term Home Health Care Programs, Article 36 Certified Home Health Agencies and Personal Care Providers that possess a Title XIX (i.e. Medicaid) contract with a Local Social Services District for the delivery of personal care services pursuant to Section 367-i of the New York State Social Services Law.

NOTE: New York's Health Care taxes are either broad based and uniform (as in all HFCAP assessments except for the Personal Care Provider Cash Assessment) or have a specific exemption known as the "D'Amato provision (Federal PHL section 105-33 4722 (c))" which allows the HCRA surcharges to exist in their current format. The single tax which has been determined by the State to be an impermissible provider tax is the HFCAP charge on Personal Care Providers. The State does not claim any Federal dollars for the surcharge collected in this manner in order to comply with all Federal provider tax rules.

3) Additional Resources for State Share Funding:

- a. 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 percent to zero over a three-year period. Beginning in State Fiscal Year 2016, counties began paying a fixed cost in perpetuity. 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. 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 ICF UPL calculation is payment-to-cost for state government and private facilities (note: there are no non-state governmental ICFs). The State is in process of completing the 2021 and 2022 ICF UPL; however, SPA does not impact this ICF UPL.

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

Response: 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.