NEW YORK
state department of
HEALTH

Nirav R. Shah, M.D., M.P.H.
Commissioner

Sue Kelly
Executive Deputy Commissioner

September 30, 2013

Mr. Michael Melendez
Associate Regional Administrator
Department of Health & Human Services
Centers for Medicare & Medicaid Services
New York Regional Office
Division of Medicaid and Children's Health Operations
26 Federal Plaza - Room 37-100 North
New York, New York 10278

RE: SPA #13-52
Non-Institutional Services

Dear Mr. Melendez:

The State requests approval of the enclosed amendment #13-52 to the Title XIX (Medicaid) State Plan for non-institutional services to be effective July 1, 2013 (Appendix I). This amendment is being submitted based on State regulation. A summary of the plan amendment is provided in Appendix II.

The State of New York reimburses these services through the use of rates that are consistent with and promote efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area as required by §1902(a)(30) of the Social Security Act and 42 CFR §447.204.

Copies of pertinent sections of 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 June 26, 2013, 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 submission, please do not hesitate to contact John E. Ulberg, Jr., Medicaid Chief Financial Officer, Division of Finance and Rate Setting at (518) 474-6350.

Sincerely,

Jason A. Helgerson
Medicaid Director
Office of Health Insurance Programs

Enclosures

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: **13-52**	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, 2013**	

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION: **§1902(a) of the Social Security Act, and 42 CFR 447**	7. FEDERAL BUDGET IMPACT: **a. FFY 07/01/13-09/30/13 $0** **b. FFY 10/01/13-09/30/14 $0**
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: **Attachment 4.19-B Pages: 2(g)(2), 2(g)(3), 2(k)**	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: **Attachment 4.19-B Pages: 2(g)(2), 2(g)(3), 2(k)**

10. SUBJECT OF AMENDMENT:
July 2013 Freestanding Clinic APG Weight 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:	16. RETURN TO: **New York State Department of Health** **Bureau of Federal Relations & Provider Assessments** **99 Washington Ave – One Commerce Plaza** **Suite 1430** **Albany, NY 12210**
13. TYPED NAME: **Jason A. Helgerson**	
14. TITLE: **Medicaid Director** **Department of Health**	
15. DATE SUBMITTED: September 30, 2013	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:	18. DATE APPROVED:
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL:	20. SIGNATURE OF REGIONAL OFFICIAL:
21. TYPED NAME:	22. TITLE:

23. REMARKS:

Appendix I
2013 Title XIX State Plan
Third Quarter Amendment
Non-Institutional Services
Amended SPA Pages

New York
2(g)(2)

APG Reimbursement Methodology – Freestanding Clinics

The following links direct users to the various definitions and factors that comprise the APG reimbursement methodology, which can also be found in aggregate on the APG website at http://www.health.ny.gov/health_care/medicaid/rates/apg/index.htm. In addition, prior period information associated with these links is available upon request to the Department of Health.

Contact Information:
http://www.health.ny.gov/health_care/medicaid/rates/apg/index.htm. Click on "Contacts."

3M APG Crosswalk, version 3.3:
http://www.health.ny.gov/health_care/medicaid/rates/apg/index.htm. Click on "3M Versions and Crosswalks," then on "3M APG Crosswalk" toward bottom of page, and finally on "Accept" at bottom of page.

APG Alternative Payment Fee Schedule; updated as of 04/01/10:
http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm. Click on "Alternative Payment Fee Schedule."

APG Consolidation Logic; logic is from version of 4/1/08, updated as of 04/01/10:
http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm. Click on "Consolidation Logic" and then on "2008."

APG 3M Definitions Manual Versions; updated as of 04/01/10:
http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm. Click on "3M Versions and Crosswalk."

APG Investments by Rate Period; updated as of 04/01/10:
http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm. Click on "Investments by Rate Period."

APG Relative Weights; updated as of [04/01/13]07/01/13:
http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm. Click on "Weights, Proc Weights, and APG Fee Schedule Amounts."

Associated Ancillaries; as of 07/01/11:
http://www.health.ny.gov/health_care/medicaid/rates/apg/index.htm. Click on "Ancillary Policy."

New York
2(g)(3)

Base Rates, Freestanding Clinics; effective 12/01/09:
http://www.health.ny.gov/health_care/medicaid/rates/apg/index.htm Click on "APG Rates," and then "Freestanding Diagnostic and Treatment Center..."

Carve-outs; updated as of 04/01/10:
http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm Click on "Carve Outs."

Coding Improvement Factors (CIF); updated as of 04/01/10:
http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm Click on "CIFs by Rate Period."

If Stand Alone, Do Not Pay APGs; updated as of 04/01/10:
http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm Click on "If Stand Alone, Do Not Pay APGs."

If Stand Alone, Do Not Pay Procedures; updated as of 04/01/10:
http://www.health.state.ny.us/health_care/medicaid/rates/methodology/index.htm Click on "If Stand Alone, Do Not Pay Procedures."

Modifiers; updated as of 04/01/10:
http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm Click on "Modifiers."

Never Pay APGs; updated as of 04/01/10:
http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm Click on "Never Pay APGs."

Never Pay Procedures; updated as of [04/01/10]07/01/13:
http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm Click on "Never Pay Procedures."

No-Blend APGs; updated as of 04/01/10:
http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm Click on "No Blend APGs."

No-Blend Procedures; updated as of 04/01/10:
http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm Click on "No-Blend Procedures."

No Capital Add-on APGs: updated as of [04/01/10]07/01/13:
http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm Click on "No Capital Add-on APGs."

New York
2(k)

Reimbursement Methodology

I. The initial calculation of the APG relative weights were developed using line level charges from 2005 New York Medicaid hospital claims converted to cost using the ratio of cost to charges methodology. The line level costs were brought up to the APG level to determine the average cost of each APG.

a. The APG relative weights shall be updated [at least annually]no less frequently than every two years based on hospital claims data. These APG and weights are set as of September 1, 2009, and are effective for specified services on and after that date. A link to the list of APGs and their relative weights is available in the APG Reimbursement Methodology – [Freestanding Clinics] Reimbursement Components section.

b. The APG relative weights shall be re-weighted prospectively. The initial re-weighting will be based on Medicaid claims data for hospitals from the December 1, 2008 through September 30, 2009 period. Subsequent re-weightings will be based on Medicaid hospital claims data from the most recent twelve month period and will be based on complete and accurate line level procedure and charge data and ratio of cost to charge data.

c. The Department shall correct material errors of any given APG relative weight. Such corrections shall make use of benchmarking data consisting of payment information from other payers (including Medicare) reimbursing comparable services. Corrections to material errors in individual APG relative weights shall be made on a prospective basis.

II. The case mix index is an expression of the average paid APG weight for a given peer group after consolidation, packaging, and discounting. Case mix indices shall be calculated by running applicable freestanding D&TC and ambulatory surgery center claims data through the latest version of the APG software to determine the average final APG weight of the visits. Outlier claims or claim lines may be excluded from this calculation to assure overall accuracy of the final case mix index. Recalculations of case mix indices for periods prior to January 1, 2010 will be based on freestanding D&TC and ambulatory surgery center Medicaid data for 2007. Such revisions for the period commencing January 1, 2010 will be based on such data from the January 1, 2009 through November 15, 2009 period. Subsequent recalculations will be based on freestanding D&TC and ambulatory surgery center Medicaid claims data from the most recent twelve month period.

Appendix II
2013 Title XIX State Plan
Third Quarter Amendment
Non-Institutional Services
Summary

SUMMARY
SPA #13-52

This State Plan Amendment proposes to revise the Ambulatory Patient Group (APG) methodology for freestanding clinic and ambulatory surgery center services to reflect recalculated weights with component updates to become effective July 1, 2013. The reweighting requirement using updated Hospital Medicaid claims data is being revised from an annual requirement to a requirement of no less frequently than every two years.

Appendix III
2013 Title XIX State Plan
Third Quarter Amendment
Non-Institutional Services
Authorizing Provisions

and there is no local share for administrative costs over and above the Medicaid administrative cap.

The Medicaid managed care program utilizes existing state systems for operation (Welfare Management System, eMedNY, etc.).

The Department provides ongoing technical assistance to counties to assist in all aspects of planning, implementing and operating the local program.

Rural Area Participation:

The proposed regulations do not reflect new policy. Rather, they codify current program policies and requirements and make the regulations consistent with section 364-j of the SSL. During the development of the 1115 waiver application and the design of the managed care program, input was obtained from many interested parties.

Job Impact Statement

Nature of Impact:

The rule will have no negative impact on jobs and employment opportunities. The mandatory Medicaid managed care program authorized by Section 364-j of the Social Services Law (SSL) will expand job opportunities by encouraging managed care plans to locate and expand in New York State.

Categories and Numbers Affected:

Not applicable.

Regions of Adverse Impact:

None.

Minimizing Adverse Impact:

Not applicable.

Self-Employment Opportunities:

Not applicable.

Assessment of Public Comment

The agency received no public comment since publication of the last assessment of public comment.

NOTICE OF ADOPTION

October 2011 Ambulatory Patient Groups (APGs) Payment Methodology

I.D. No. HLT-50-11-00015-A
Filing No. 172
Filing Date: 2012-02-28
Effective Date: 2012-03-14

PURSUANT TO THE PROVISIONS OF THE State Administrative Procedure Act, NOTICE is hereby given of the following action:

Action taken: Amendment of Subpart 86-8 of Title 10 NYCRR.

Statutory authority: Public Health Law, section 2807(2-a)(e)

Subject: October 2011 Ambulatory Patient Groups (APGs) Payment Methodology.

Purpose: To refine the APG payment methodology.

Text or summary was published in the December 14, 2011 issue of the Register, I.D. No. HLT-50-11-00015-P.

Final rule as compared with last published rule: No changes.

Text of rule and any required statements and analyses may be obtained from: Katherine Ceroalo, DOH, Bureau of House Counsel, Regulatory Affairs Unit, Room 2438, ESP, Tower Building, Albany, NY 12237, (518) 473-7488, email: regsqna@health.state.ny.us

Assessment of Public Comment

The agency received no public comment.

Office of Mental Health

NOTICE OF ADOPTION

Clinic Treatment Programs

I.D. No. OMH-46-11-00006-A
Filing No. 169
Filing Date: 2012-02-27
Effective Date: 2012-03-14

PURSUANT TO THE PROVISIONS OF THE State Administrative Procedure Act, NOTICE is hereby given of the following action:

Action taken: Amendment of Part 599 of Title 14 NYCRR.

Statutory authority: Mental Hygiene Law, sections 7.09, 31.04, 43.01 and 43.02; Social Services Law, art. 33, sections 364, 364-a and 365-m

Subject: Clinic Treatment Programs.

Purpose: Amend and clarify existing regulation and enable providers to seek reimbursement for certain services using State-only dollars.

Substance of final rule: This final adoption amends Part 599 of Title 14 NYCRR which governs the licensing, operation, and Medicaid fee-for-service funding of mental health clinics. 14 NYCRR Part 599 was originally adopted as final on October 1, 2010 and resulted in major changes in the delivery and financing of mental health clinic services. When the regulation was promulgated, the Office of Mental Health understood that there would be issues that might require clarification once providers and recipients of services had experience in operating under the new regulation. This rule making was designed to address those issues and add relatively minor program modifications that have occurred since the initial regulation was promulgated. Non-substantive changes were made to the final rule to further clarify the requirements found in 14 NYCRR Part 599. A summary of all changes, including those non-substantive changes that were made since publication of the Notice of Proposed Rule Making, are found in the narrative below.

- Clarification of the distinction between ''injectable psychotropic medication administration'' and ''injectable psychotropic medication administration with monitoring and education'' and the provisions regarding reimbursement for these services;

- Clarification of the definition of ''health monitoring'', ''hospital-based clinic'', ''modifiers'', and ''psychiatric assessment'', and inclusion of definitions for ''Behavioral Health Organization'' and ''concurrent review''. The final version of this regulation also expands the definitions of ''diagnostic and treatment center'', ''hospital-based clinic'' and ''heath monitoring''. The term ''smoking status'' has been changed to ''smoking cessation'' for both adults and children, and the definition of ''health monitoring'' now includes ''substance use'' as an indicator for both adults and children - see new Subdivisions (r), (w) and (ab) of Section 599.4;

- Repeal of provisions requiring a treating clinician to determine the need for continued clinic treatment beyond 40 visits for adults and children;

-Amendment of the provisions regarding screening of clinic treatment staff by the New York Statewide Central Register of Child Abuse and Maltreatment;

- Clarification of requirements regarding required signatures on treatment plans. The final version of the regulation further clarifies that, for recipients receiving services reimbursed by Medicaid on a fee-for-service basis, the signature of the physician is required on the treatment plan. For recipients receiving services that are not reimbursed by Medicaid on a fee-for-service basis, the signature of the physician, licensed psychologist, LCSW, or other licensed individual within his/her scope of practice involved in the treatment plan is required - see Section 599.10(j)(4);

- Addition of provisions regarding reimbursement modifications for visits in excess of 30 and 50 respectively (excluding crisis visits) for fiscal years commencing on or after April 1, 2011. Note - the final version of the regulation lists other services that are excluded from the 30/50 thresholds. These services, in addition to crisis visits, include off-site visits, complex care management and any services that are counted as health services - see Section 599.13(e);

Appendix IV
2013 Title XIX State Plan
Third Quarter Amendment
Non-Institutional Services
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 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 revise provisions of the Ambulatory Patient Group (APG) reimbursement methodology on or after July 1, 2013:

The Ambulatory Patient Group (APG) reimbursement methodology is revised to include recalculated weights and component updates that will become effective on or after July 1, 2013. In addition, the requirement to reweight the APG weights used in the APG payment method is being revised from an annual requirement to a reweight of no less frequently than every two years. The estimated annual change to gross Medicaid expenditures as a result of this proposal is $0.

The public is invited to review and comment on this proposed state plan amendment, which will be available for public review on the Department's website at http://www.health.ny.gov/regulations/state_plans/status.

Copies of the proposed state plan amendment will also 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, or to review and comment, please contact: Department of Health, Bureau of Federal Relations & Provider Assessments, 99 Washington Ave. – One Commerce Plaza, Suite 810, Albany, NY 12210, (518) 474-1673, (518) 473-8825 (FAX), 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 non-institutional services to revise provisions of the Ambulatory Patient Group (APG) reimbursement methodology on or after July 1, 2013 so that the administration of a Long-Acting Reversible Contraceptive (LARC) (e.g., Inter Uterine Device-IUD) will be carved out of the APG reimbursement methodology when it is provided on the same Date of Service (DOS) as an abortion. Providers will be able to submit a separate claim using rate code 1339 when they administer a LARC during a visit in which an abortion procedure is rendered.

There is no estimated annual change to gross Medicaid expenditures as a result of the proposed amendments. However, the State will realize additional Federal Financial Participation (FFP) upon approval of the State Plan Amendment. Presently, when an IUD is provided immediately following an abortion, both the abortion and IUD insertion are billed on the same Medicaid claim and no FFP is claimed for the entire visit. Upon State Plan approval, a claim separate and distinct from the abortion procedure will be billed to Medicaid. The State will be able to claim 90% FFP for the IUD insertion.

The public is invited to review and comment on this proposed state plan amendment, which will be available for public review on the Department's website at http://www.health.ny.gov/regulations/state_plans/status.

Copies of the proposed State Plan amendment 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

Appendix V
2013 Title XIX State Plan
Third Quarter Amendment
Non-Institutional Services
Responses to Standard Funding Questions

NON-INSTITUTIONAL SERVICES
State Plan Amendment #13-52

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 this SPA. For SPAs that provide for changes to payments for clinic or outpatient hospital services or for enhanced or supplemental payments to physician or other practitioners, the questions must be answered for all payments made under the state plan for such service.

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

   Response: Providers do retain the payments made pursuant to this amendment. However, this requirement in no way prohibits the public provider, including county providers, from reimbursing the sponsoring local government for appropriate expenses incurred by the local government on behalf of the public provider. The State does not regulate the financial relationships that exist between public health care providers and their sponsoring governments, which are extremely varied and complex. Local governments may provide direct and/or indirect monetary subsidies to their public providers to cover on-going unreimbursed operational expenses and assure achievement of their mission as primary safety net providers. Examples of appropriate expenses may include payments to the local government which include reimbursement for debt service paid on a provider's behalf, reimbursement for Medicare Part B premiums paid for a provider's retirees, reimbursement for contractually required health benefit fund payments made on a provider's behalf, and payment for overhead expenses as allocated per federal Office of Management and Budget Circular A-87 regarding Cost Principles for State, Local, and Indian Tribal Governments. The existence of such transfers should in no way negate the legitimacy of these facilities' Medicaid payments or result in reduced Medicaid federal financial participation for the State. This position was further supported by CMS in review and approval of SPA 07-07C when an on-site audit of these transactions for New York City's Health and Hospitals Corporation was completed with satisfactory results.

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

   Response: Payments made to service providers under the provisions of this SPA are funded through a general appropriation received by the State agency that oversees medical assistance (Medicaid), which is the Department of Health. The source of the appropriation is the 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. **For clinic or outpatient hospital services please provide a detailed description of the methodology used by the state to estimate the upper payment limit (UPL) for each class of providers (State owned or operated,**

non-state government owned or operated, and privately owned or operated). Please provide a current (i.e., applicable to the current rate year) UPL demonstration.

Response: The State has requested an extension to submit the current 2013 clinic UPL demonstration. CMS has granted an extension to December 31, 2013 for the State to submit the clinic 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: The rate methodology included in the State Plan for freestanding and ambulatory surgery center services is based upon the Ambulatory Patient Group (APG) system with the exception of Federally Qualified Health Centers who have the option to opt into the APG system or remain on the Prospective Payment Methodology (PPS) as approved by CMS in SPA 01-03. We are unaware of any requirement under current federal law or regulation that limits individual providers' 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: This SPA 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 11-06, 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.