NEW YORK
state department of
HEALTH

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

Sue Kelly
Executive Deputy Commissioner

December 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 #13-27
Non-Institutional Services

Dear Mr. Melendez:

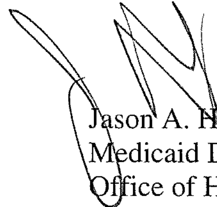
The State requests approval of the enclosed amendment #13-27 to the Title XIX (Medicaid) State Plan for non-institutional services to be effective October 1, 2013 (Appendix I). This amendment is being submitted based on section 2301 of the Affordable Care Act and in accordance with Department regulations. 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 federal legislation 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 September 25, 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: **13-27**

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 **October 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:
Section 2301 of the Affordable Care Act

7. FEDERAL BUDGET IMPACT:
a. FFY 10/01/13-09/30/14 $0
b. FFY 10/01/14-09/30/15 $0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 3.1-A: Page 11(a)
Attachment 3.1-B: Page 11(a)

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

10. SUBJECT OF AMENDMENT:
Freestanding Birth Centers
(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:

13. TYPED NAME: **Jason A. Helgerson**

14. TITLE: **Medicaid Director**
Department of Health

15. DATE SUBMITTED: December 30, 2013

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

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
11(a)

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

28. (i) Licensed or Otherwise State-Approved Freestanding Birth Centers

☒ Provided: ☒ No limitations ☐ With limitations ☐ None licensed or approved

Please describe any limitations:

28. (ii) Licensed or Otherwise State-Recognized covered professionals providing services in the Freestanding Birth Center

☒ Provided: ☒ No limitations ☐ With limitations (please describe below)
☐ Not Applicable (there are no licensed or State approved Freestanding Birth Centers)

Please describe any limitations:

Please check all that apply:
☒ (a) Practitioners furnishing mandatory services described in another benefit category and otherwise covered under the State plan (i.e., physicians and certified nurse midwives).

☐ (b) Other licensed practitioners furnishing prenatal, labor and delivery, or postpartum care in a freestanding birth center within the scope of practice under State law whose services are otherwise covered under 42 CFR 440.60 (e.g., lay midwives, certified professional midwives (CPMs), and any other type of licensed midwife). *

☐ (c) Other health care professionals licensed or otherwise recognized by the State to provide these birth attendant services (e.g., doulas, lactation consultant, etc.).*

*For (b) and (c) above, please list and identify below each type of professional who will be providing birth center services:

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE MEDICALLY NEEDY

28. (i) Licensed or Otherwise State-Approved Freestanding Birth Centers

☒ Provided: ☒ No limitations ☐ With limitations ☐ None licensed or approved

Please describe any limitations:

28. (ii) Licensed or Otherwise State-Recognized covered professionals providing services in the Freestanding Birth Center

☒ Provided: ☒ No limitations ☐ With limitations (please describe below)
☐ Not Applicable (there are no licensed or State approved Freestanding Birth Centers)

Please describe any limitations:

Please check all that apply:

☒ (a) Practitioners furnishing mandatory services described in another benefit category and otherwise covered under the State plan (i.e., physicians and certified nurse midwives).

☐ (b) Other licensed practitioners furnishing prenatal, labor and delivery, or postpartum care in a freestanding birth center within the scope of practice under State law whose services are otherwise covered under 42 CFR 440.60 (e.g., lay midwives, certified professional midwives (CPMs), and any other type of licensed midwife). *

☐ (c) Other health care professionals licensed or otherwise recognized by the State to provide these birth attendant services (e.g., doulas, lactation consultant, etc.).*

*For (b) and (c) above, please list and identify below each type of professional who will be providing birth center services:

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

SUMMARY
SPA #13-27

This State Plan Amendment pursuant to Section 2301 of the Affordable Care Act requires States to recognize freestanding birth centers, and the services rendered by certain professionals providing services in a freestanding birth center, cover the services provided by the centers and professionals as mandatory medical services.

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

of presumptive eligibility made by a hospital that elects under section 1902(a)(47)(B) to be a qualified entity for such purpose".

Applicability. 42 USC 1396a note.

(c) EFFECTIVE DATE.—The amendments made by this section take effect on January 1, 2014, and apply to services furnished on or after that date.

Subtitle D—Improvements to Medicaid Services

SEC. 2301. COVERAGE FOR FREESTANDING BIRTH CENTER SERVICES.

(a) IN GENERAL.—Section 1905 of the Social Security Act (42 U.S.C. 1396d), is amended—

(1) in subsection (a)—

(A) in paragraph (27), by striking "and" at the end;

(B) by redesignating paragraph (28) as paragraph (29); and

(C) by inserting after paragraph (27) the following new paragraph:

"(28) freestanding birth center services (as defined in subsection (l)(3)(A)) and other ambulatory services that are offered by a freestanding birth center (as defined in subsection (l)(3)(B)) and that are otherwise included in the plan; and"; and

(2) in subsection (l), by adding at the end the following new paragraph:

Definitions.

"(3)(A) The term 'freestanding birth center services' means services furnished to an individual at a freestanding birth center (as defined in subparagraph (B)) at such center.

"(B) The term 'freestanding birth center' means a health facility—

"(i) that is not a hospital;

"(ii) where childbirth is planned to occur away from the pregnant woman's residence;

"(iii) that is licensed or otherwise approved by the State to provide prenatal labor and delivery or postpartum care and other ambulatory services that are included in the plan; and

"(iv) that complies with such other requirements relating to the health and safety of individuals furnished services by the facility as the State shall establish.

Payments.

"(C) A State shall provide separate payments to providers administering prenatal labor and delivery or postpartum care in a freestanding birth center (as defined in subparagraph (B)), such as nurse midwives and other providers of services such as birth attendants recognized under State law, as determined appropriate by the Secretary. For purposes of the preceding sentence, the term 'birth attendant' means an individual who is recognized or registered by the State involved to provide health care at childbirth and who provides such care within the scope of practice under which the individual is legally authorized to perform such care under State law (or the State regulatory mechanism provided by State law), regardless of whether the individual is under the supervision of, or associated with, a physician or other health care provider. Nothing in this subparagraph shall be construed as changing State law requirements applicable to a birth attendant.".

(b) CONFORMING AMENDMENT.—Section 1902(a)(10)(A) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)), is amended in the

matter preceding clause (i) by striking "and (21)" and inserting ", (21), and (28)".

(c) EFFECTIVE DATE.—

42 USC 1396a note. Applicability.

(1) IN GENERAL.—Except as provided in paragraph (2), the amendments made by this section shall take effect on the date of the enactment of this Act and shall apply to services furnished on or after such date.

Determination.

(2) EXCEPTION IF STATE LEGISLATION REQUIRED.—In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirement imposed by the amendments made by this section, the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet this additional requirement before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

SEC. 2302. CONCURRENT CARE FOR CHILDREN.

(a) IN GENERAL.—Section 1905(o)(1) of the Social Security Act (42 U.S.C. 1396d(o)(1)) is amended—

(1) in subparagraph (A), by striking "subparagraph (B)" and inserting "subparagraphs (B) and (C)"; and

(2) by adding at the end the following new subparagraph:

"(C) A voluntary election to have payment made for hospice care for a child (as defined by the State) shall not constitute a waiver of any rights of the child to be provided with, or to have payment made under this title for, services that are related to the treatment of the child's condition for which a diagnosis of terminal illness has been made.".

(b) APPLICATION TO CHIP.—Section 2110(a)(23) of the Social Security Act (42 U.S.C. 1397jj(a)(23)) is amended by inserting "(concurrent, in the case of an individual who is a child, with care related to the treatment of the child's condition with respect to which a diagnosis of terminal illness has been made" after "hospice care".

SEC. 2303. STATE ELIGIBILITY OPTION FOR FAMILY PLANNING SERVICES.

(a) COVERAGE AS OPTIONAL CATEGORICALLY NEEDY GROUP.—

(1) IN GENERAL.—Section 1902(a)(10)(A)(ii) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(ii)), as amended by section 2001(e), is amended—

(A) in subclause (XIX), by striking "or" at the end;

(B) in subclause (XX), by adding "or" at the end; and

(C) by adding at the end the following new subclause:

"(XXI) who are described in subsection (ii) (relating to individuals who meet certain income standards);".

(2) GROUP DESCRIBED.—Section 1902 of such Act (42 U.S.C. 1396a), as amended by section 2001(d), is amended by adding at the end the following new subsection:

TITLE -10

Effective Date: 05/01/1996

Title: Part 754 - Birth Center Services

PART 754

BIRTH CENTER SERVICES

(Statutory authority: Public Health Law, Section 2803)

Sections.

754.1 Definitions
754.2 Administrative requirements
754.3 Service restrictions
754.4 Hospital transfer procedures

Volume: D
Statutory Authority: Public Health Law, Section 2803

Effective Date: 01/23/2002
Title: Section 754.1 - Definitions

Section 754.1 Definitions.

(a) **A birth center is a diagnostic and treatment center** organized to provide care to low-risk patients during pregnancy, labor and delivery who require a stay of less than 24 hours after birth. Services are provided by a physician or licensed midwife to women during a normal and an uncomplicated pregnancy, labor, birth and puerperium. Birth center services are based on a philosophy that promotes a family-centered approach to care and views pregnancy and delivery as a normal physiological process requiring limited technological and pharmacological support. The center services are designed to meet the specific needs of the population being served and promote optimum pregnancy outcomes. The licensed midwife or physician provides care for the low-risk woman during pregnancy and stays with her during labor from the time of admission to the birth center through the immediate postpartum period providing continuous physical and emotional support, evaluating progress, facilitating family interaction and assisting the woman in labor and delivery.
Nurse practitioners may provide prenatal and post partum care to birthing center patients. They may also provide supportive care during labor and delivery, but the attending provider for birth must be a physician or licensed midwife.

(b) A patient at low risk means a patient with a normal medical, surgical and obstetrical history and a normal, uncomplicated prenatal course as determined by adequate prenatal care, and prospects. for a normal uncomplicated birth. A pregnant woman, parturient or newborn shall be determined as low risk during the prenatal period, intrapartum and postpartum by the use of standardized criteria based on generally accepted standards of professional practice such as those approved by the department's Prenatal/Perinatal Advisory Council Subcommittee on Birth Centers in Guidelines for Birth Centers in New York State.

Title: Section 754.2 - Administrative requirements

754.2 Administrative requirements. When birthing center services are provided the operator shall ensure that:

(a) only those women for whom a prenatal and intrapartum history, physical examination and laboratory screening procedures have demonstrated the expectation of a normal, uncomplicated course of pregnancy and labor are admitted and cared for at the birth center;

(b) written policies, procedures and standard risk assessment criteria for determining low-risk pregnancies based upon generally accepted standards of practice are developed and implemented;

(c) written policies, procedures and protocols for the management of care are implemented in accordance with birth center philosophy;

(d) a physician or licensed midwife reviews the content of the informed consent form with each woman, and a copy is given to the woman before signing;

(e) there is a transfer agreement with a hospital(s) located within 20 minutes' transport time from the birth center to the transfer hospital for medical care of a woman or an infant when complications arise during the antepartum, intrapartum, postpartum or newborn period, written in accordance with section 400.9 of this Title;

(f) support services such as laboratory, radiology and family planning services not provided by the birth center are available by referral;

(g) the birth center services are available 24 hours a day for the admission of women, professional consultation and prompt response to inquiries;

(h) kitchen facilities are available to enable families to store and prepare food brought in for the laboring family; and

(i) the birth center takes action in accordance with the requirements of paragraph 405.21(c)(13) of this Title with respect to a voluntary acknowledgement of paternity for a child born out of wedlock.

Title: Section 754.3 - Service restrictions

754.3 Service restrictions. The operator shall ensure that:

(a) only women assessed as being low-risk by application of risk assessment criteria during pregnancy, labor, birth and puerperium are admitted and cared for at the birth center;

(b) surgical procedures are limited to those which may be performed during and after uncomplicated childbirth such as episiotomy and repair. Other surgical procedures, including forceps and vacuum extraction will not be permitted;

(c) general and regional anesthesia are not administered at the center; and (d) labor is not induced, inhibited, stimulated or augmented with pharmacological agents acting directly on the uterus during the first or second stages of labor.

Title: Section 754.4 - **<u>Hospital transfer procedures</u>**

754.4 Hospital transfer procedures. (a) There are written plans and procedures for the transfer of a woman or an infant to the obstetrical or pediatric services of the transfer hospital(s) when complications arise of an emergency nature. Such plans and procedures shall include arrangements for an ambulance service and, when appropriate, the escort of the patient to the admitting facility by a clinical staff member of the birth center.

(b) The operator, in collaboration with the transfer hospital(s) , shall develop a list of indicators necessitating transfer and a written procedure for automatic acceptance of such transfers by the transfer hospital.

(c) There shall be a system to ensure that a copy of the medical record accompanies the patient upon transfer to the hospital.

(d) There shall be an established mechanism for jointly reviewing all transfer cases by the transfer hospital(s) and the center as part of the quality assurance program specified in section 754.9 of this Part.

Appendix IV
2013 Title XIX State Plan
Third Quarter Amendment
Non-Institutional Services
Public Notice

ous State agencies including the Department of Health (DOH), the Office for People With Developmental Disabilities (OPWDD), and the Office of Mental Health (OMH). Through the CFCO, the State will expand these offerings to include personal care and CDPAP, supervision and cueing through habilitation or home-and-community support services, home maintenance, home health aide, congregate and home-delivered meals, community transportation, nutrition counseling and education, community integration training, skill building, habilitation, personal emergency response systems (PERS/EARS), adaptive technology and assistive devices called for in the person-centered care plan that substitute for human assistance and improve independence, and transitional services like one-time moving expenses, peer mentoring and other training programs aimed at ensuring an easy transition from an institutional to a community-based setting. Individuals that choose to direct their LTSS either directly or through a chosen representative who are determined to need an institutional level of care according to a comprehensive functional assessment will be eligible for the CFCO services they qualify for based on the assessment. Those who do not meet these requirements will continue to be served through waiver programs. Participants in CFCO may also access other State plan and waiver services to meet their needs.

While it is likely that community-based Medicaid services could increase under the CFCO State plan as services are now only available through waiver programs and would become available to a larger pool of individuals through the State plan, this increase is likely to be offset by increased Federal Financial Participation. CFCO services are eligible for an increased Federal Medical Assistance Percentage (FMAP) of 6%. This is expected to result in approximately $93 million to $120 million in additional Federal revenue, which may be reinvested in community based LTSS in the first year of operation to meet statutory Maintenance of Expenditure requirements.

The public is invited to review and comment on this proposed State Plan Amendment. Copies of 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 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, Bureau of Federal Relations & Provider Assessments, 99 Washington Ave. – One Commerce Plaza, Suite 1430, 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 comply with the provisions of Section 2301 of the Patient Protection and Affordable Care Act (ACA).

Non-Institutional Services

Under the Act, Section 1905 of the Social Security Act (U.S.C. 1396d) was amended to include the requirement that a State shall provide separate payments to providers, such as nurse midwives and other providers of birthing services such as birth attendants recognized under State law, when administering prenatal labor and delivery or postpartum care in a freestanding birthing center. A freestanding birthing center is a health facility that is not a hospital and is where childbirth is planned to occur away from the pregnant woman's residence. It is licensed or otherwise approved by the State to provide prenatal care and delivery or postpartum care and other ambulatory surgery services that are included in the plan.

There is no additional estimated annual change to gross Medicaid expenditures as a result of the proposed amendment since the State is already in compliance with the provisions of the recently enacted ACA using the Ambulatory Patient Group (APG) reimbursement method for payment.

The public is invited to review and comment on this proposed State Plan Amendment. Copies of 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 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, Bureau of Federal Relations & Provider Assessments, 99 Washington Ave. – One Commerce Plaza, Suite 1430, Albany, NY 12210, (518) 474-1673, (518) 473-8825 (FAX), spa_inquiries@health.state.ny.us

PUBLIC NOTICE

Nassau Health Care Corporation

Pursuant to the State Finance Law, Nassau Health Care Corporation hereby gives notice of the following:

Request for Proposals

Deferred Compensation Plan Services

The Deferred Compensation Plan for Employees of Nassau Health Care Corporation (the "Plan"), a 457(b) plan created under the laws of the State of New York and pursuant to Section 475(b) of the Internal Revenue Code, is soliciting proposals from qualified firms to provide

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

NON-INSTITUTIONAL SERVICES
State Plan Amendment #13-27

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: Based on guidance from CMS, the State will submit the current clinic UPL demonstration by December 31, 2013.

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 diagnostic and treatment and ambulatory surgery center services or hospital outpatient 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.

<u>Prior to January 1, 2014</u> States may potentially require contributions by local political subdivisions toward the non-Federal share of the States' expenditures at percentages <u>greater than</u> were required on December 31, 2009. <u>However</u>, 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 <u>anticipate potential violations and/or appropriate corrective actions</u> by the States and the Federal government.

<u>Response:</u> This SPA would [ ] / would <u>not</u> [✓] 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.**

   <u>Response:</u> This SPA does comply with the requirements of section 1902(a)(37) of the Act regarding prompt payment of claims.

<u>Tribal Assurance:</u>

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.**

<u>Response:</u> 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.