NEW YORK STATE OF OPPORTUNITY. Department of Health

ANDREW M. CUOMO
Governor

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

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

SEP 2 9 2016

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 #16-0020
Non-Institutional Services

Dear Mr. Melendez:

The State requests approval of the enclosed amendment #16-0020 to the Title XIX (Medicaid) State Plan for non-institutional services to be effective July 1, 2016 (Appendix I). This amendment is being submitted based on enacted legislation. 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 proposed State statute 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 March 9, 2016, 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 John E. Ulberg, Jr., Medicaid Chief Financial Officer, Division of Finance and Rate Setting, Office of Health Insurance Programs 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: **16-0020**	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, 2016**	

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

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

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

6. FEDERAL STATUTE/REGULATION CITATION: **§1902(a) of the Social Security Act, and 42 CFR 447**	7. FEDERAL BUDGET IMPACT: **(in thousands)** **a. FFY 07/01/16-09/30/16 $ 1,500** **b. FFY 10/01/16-06/30/17 $ 6,000**
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: **Attachment 4.19-B: Pages 10-1E, 10-1F, 10-1G, 17(s), 17(s)(i), 17(u)**	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: **Attachment 4.19-B: Pages 10-1E, 10-1F, 10-1G, 17(s), 17(s)(i), 17(u)**

10. SUBJECT OF AMENDMENT:
School Supportive Health - Preschool
(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 1460** **Albany, NY 12210**
13. TYPED NAME: **Jason A. Helgerson**	
14. TITLE: **Medicaid Director** **Department of Health**	
15. DATE SUBMITTED: SEP 2 9 2016	

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
2016 Title XIX State Plan
Second Quarter Amendment
Amended SPA Pages

[Rehabilitative Services
(continued)

Preschool Supportive Health Services

Physical Therapy Services

The fee covers services provided during a calendar month. A minimum of two services must be provided within the month in order to claim reimbursement. The monthly fee is made up of 1) direct costs, personal service costs and other than personal service costs associated with the direct provision of service, 2) indirect costs, a percent of those costs incurred as part of operations, and 3) evaluation costs, one twelfth of the annual cost of conducting an evaluation. The sum of the three components was multiplied by the average monthly frequency to obtain the monthly fee.

Occupational Therapy Services

The fee covers services provided during a calendar month. A minimum of two services must be provided within the month in order to claim reimbursement. The monthly fee is made up of 1) direct costs, personal service costs and other than personal service costs associated with the direct provision of service, 2) indirect costs, a percent of those costs incurred as part of operations, and 3) evaluation costs, one twelfth of the annual cost of conducting an evaluation. The sum of the three components was multiplied by the average monthly frequency to obtain the monthly fee.

Speech Pathology Services

The fee covers services provided during a calendar month. A minimum of two services must be provided within the month in order to claim reimbursement. The monthly fee is made up of 1) direct costs, personal service costs and other than personal service costs associated]

[Rehabilitative Services
(continued)

With the direct provision of service, 2) indirect costs, a percent of those costs incurred as part of operations, and 3) evaluation costs, one twelfth of the annual cost of conducting an evaluation. The sum of the three components was multiplied by the average monthly frequency to obtain the monthly fee.

Nursing Services

The fee covers services provided during a calendar month. A minimum of two services must be provided within the month in order to claim reimbursement. The monthly fee is made up of 1) direct costs, personal service costs and other than personal service costs associated with the direct provision of service, and 2) indirect costs, a percent of those costs incurred as part of operations. The sum of the two components was multiplied by the average monthly frequency to obtain the monthly fee.

Psychological Counseling Services

The fee covers services provided during a calendar month. A minimum of two services must be provided within the month in order to claim reimbursement. The monthly fee is made up of 1) direct costs, personal service costs and other personal service costs associated with the direct provision of service, and 2) indirect costs, a percent of those costs incurred as part of operations. The sum of the two components was multiplied by the average monthly frequency to obtain the monthly fee.]

[Rehabilitative Services
(continued)

Psychological Evaluations

The fee is fee-for-service and is made up of 1) directs costs, personal service costs and other than personal service costs associated with the direct provision of service, and 2) indirect costs, a percent of those costs incurred as part of operations. The sum of the two components is the evaluation fee.

Transportation Services

The transportation fee is fee-for-service and is made up of 1) direct costs, personal service costs and other than personal service costs associated with the direct provision of service and 2) indirect costs, a percent of those costs incurred as part of operations. The sum of the two components is the fee.

Audiological Evaluations

The fee is fee-for-service and is made up of 1) direct costs, personal service costs and other than personal service costs associated with the direct provision of service, and 2) indirect costs, a percent of those costs incurred as part of operations. The sum of the two components is the evaluation fee.

Medical Evaluations

The medical evaluation fee and specialized medical evaluation fee are fee-for-service and are made up of 1) direct costs, personal service costs and other than personal service costs associated with the direct provision of service, and 2) indirect costs, a percent of those costs incurred as part of operations. The sum of the two components is the evaluation fee. The specialized medical evaluation fee is reimbursable only when the service is provided by a physician specialist subsequent to and upon the written recommendation of the provider of a medical evaluation.]

New York
17(s)

3. **Time Study:** A time study that incorporates CMS-approved methodology is used to determine the percentage of time that medical service personnel spend on direct medical services, general and administrative time and all other activities to account for 100 percent of time to assure that there is no duplicate claiming. The time study methodology for counties will include all clinicians that are employees of a county and will utilize a time log approach that accounts for 100 percent of time for each county employed clinician. This methodology will generate a Direct Medical Service time study percentage that will be applied to the appropriate direct costs to determine the Direct Medical Service costs.

   The direct medical service percentages will be calculated using the average from the three quarterly time studies which will occur during the quarters of October to December, January to March, and April to June. *For example*, for cost reporting period July 1, 2012 through June 30, 2013, the RMTS quarters would be October 2012 to December 2012, January 2013 to March 2013 and April 2013 to June 2013.

Direct Medical Service TS Percentage

a. Fee-For-Service TS Percentage
   i. Direct Medical Service Cost Pool: Apply the Direct Medical Service percentage from the Time Study (Activity Code 4.b.). The direct medical service costs and time study results must be aligned to assure appropriate cost allocation.

b. General Administrative Percentage Allocation
   i. Direct Medical Service All Other Cost Pool: Apply the General Administrative time applicable to the Direct Medical Services percentage from the Random Moment Time Study (Activity Code 10). The direct medical services costs and time study results must be aligned to assure appropriate cost allocation.

The formula below details the Direct Medical Percentage (Activity Code 4.b) with the applicable portion of General Administration (Activity Code 10) reallocated to it. The same calculation is completed for the Direct Medical Service Therapy and Direct Medical Service All Other cost pools.

A = All Codes
D = IEP Direct Medical Services (Activity Code 4.b)
R = Redistributed Activities (Activity Code 10)
U = Unallowable (Activity Code 11)

$$\textit{Direct Medical Service Percentage} = \frac{D+\left(\frac{D}{A-R-U} * R\right)}{A}$$

4. **IEP Medicaid Eligibility Ratio:** A county-specific IEP Ratio will be established for each participating county. When applied, this IEP Ratio will discount the Direct Medical cost pool by the percentage of IEP Medicaid students. The IEP ratio will be based on child count reporting of students with a direct medical service in an IEP during the school year [required for Individuals with Disabilities Education Act (IDEA) on the first Wednesday in October of the Fiscal Year] for which the report is completed. *For example,* for the cost reporting period covering July 1, 2012 through June 30,

2013, the IEP Ratio will be based on the student [count] of students with an IEP at any time during the July 1, 2013 through June 30, 2013 school year [from October 3, 2012].

[The names and birthdates of students with an IEP with a direct medical service will be identified from the Student Count Report as of the first Wednesday in October and matched against the Medicaid eligibility file to determine the percentage of those that are eligible for Medicaid.] The numerator will be the number of Medicaid eligible IEP students in the LEA for whom at least one claim was processed through the MMIS for the year for which the report is completed. [with a direct medical service, as outlined in their IEP.] The denominator will be the total number of students in the LEA with an IEP with a direct medical service as outlined in their IEP at any time during the school year reporting period. Direct medical services are those services billable under the PSSHS program.

The IEP Medicaid Eligibility Ratio will be calculated on an annual basis using student counts, as described above, and MMIS data [as of the first Wednesday of October] for the fiscal year for which the cost report is completed.

5. **Total Medicaid Reimbursable Cost:** The results of the previous steps will be a total Medicaid reimbursable cost for each county for Direct Medical Services.

E. Special Transportation Services Payment Methodology

Effective for dates of service on or after October 1, 2011, providers will be paid on a cost basis. Providers will be reimbursed interim rates for PSSHS Special Transportation services as specified the *Special Transportation* paragraph of the EPSDT section of this Attachment. Federal matching funds will be available for interim rates paid by the State. On an annual basis a cost reconciliation and cost settlement will be processed for all over and under payments.

The State requires providers billing the Medicaid program to keep a log of one-way trips. The State conducts audits of PSSHSP providers through the Office of the Medicaid Inspector General, including special transportation services. Audit protocols developed include review of documentation of Medicaid services other than transportation delivered to the student on the day he or she received special transportation services.

Special transportation is allowed to or from a Medicaid covered direct IEP service which may be provided at school or other location as specified in the IEP. Transportation may be claimed as a Medicaid service when the following conditions are met:

- Special transportation is specifically listed in the IEP as a required service;
- The child required special transportation in a vehicle that has been modified as documented in the IEP;
- A Medicaid IEP medical service (other than transportation) is provided on the day that special transportation is billed; and
- The service billed represents a one-way trip.

New York
17(u)

The annual PSSHS Cost Report includes a certification of funds statement to be completed, certifying the provider's actual, incurred costs/expenditures. All filed annual PSSHS Cost Reports are subject to a desk review by the DOH or its designee.

H. Cost Reconciliation Process

Once all interim claims (CPT/HCPCS claims) are paid, the state will calculate the final reconciliation and settlement. There will be separate settlements for every Medicaid provider. The cost reconciliation process will be completed after the reporting period covered by the annual PSSHSP Cost Report. The total CMS-approved, Medicaid allowable scope of costs based on CMS-approved cost allocation methodology procedures is compared to the provider's Medicaid interim payments for school health services delivered during the reporting period as documented in the MMIS and CMS-64 form, resulting in cost reconciliation.

For the purposes of cost reconciliation, the State may not modify the CMS-approved scope of costs, the CMS-approved cost allocation methodology procedures, or its CMS-approved time study for cost-reporting purposes. CMS approval will be sought prior to any modification to the scope of cost, cost allocation methodology procedures, or time study for cost-reporting purposes.

I. Cost Settlement Process

For services delivered for a period covering July 1st through June 30th, the annual PSSHSP Cost Report is due on or before December 31st of the same year. The final reconciliation will occur prior to the 24th month following the end of the fiscal period to ensure all claims are paid through MMIS for the dates of service in the reporting period.

As part of the final cost reconciliation and cost settlement DOH will conduct an analysis of the Medicaid payments to ensure compliance with the requirements for efficiency and economy as outlined in the Social Security Act section 1902(a)(30)(A) and LEAs found to be out of compliance may be subjected to a corrective action plan.

If interim claiming payments exceed the actual, certified costs of the provider for PSSHSP services to Medicaid clients, an amount equal to the overpayment will be returned. Overpayments will be recouped within one year from the date that the overpayment was discovered.

If actual, certified costs of a provider for PSSHSP services exceed the interim claiming, the Department of Health (DOH) and the providers will share in the retention of the incremental payment. The final settlement will be an accounting adjustment that is made off-line for each provider. The State will report the final settlement that is paid to each provider in the CMS-64 form for the quarter corresponding to the date of payment.

J. Sunset Date

Effective for dates of service on or after October 1, 2011 through June 30, [2016] 2017; the State will be able to process cost reconciliations and cost settlements on all cost reports completed for the fiscal years covering dates of service through June 30, [2016] 2017.

Appendix II
2016 Title XIX State Plan
Second Quarter Amendment
Summary

SUMMARY
SPA #16-0020

This State Plan Amendment proposes to revise IEP eligibility ratio formula per CMS request and extend sunset date to June 30, 2017.

Appendix III
2016 Title XIX State Plan
Second Quarter Amendment
Authorizing Provisions

SPA 16-0020

S.2809-B/A-4009.B - Part H

§ 6. Section 368-d of the social services law is amended by adding three new subdivisions 4, 5 and 6 to read as follows:

4. The commissioner of health is authorized to contract with one or more entities to conduct a study to determine actual direct and indirect costs incurred by public school districts and state operated/state supported schools which operate pursuant to article eighty-five, eighty-seven or eighty-eight of the education law for medical care, services and supplies, including related special education services and special transportation, furnished to children with handicapping conditions.

5. Notwithstanding any inconsistent provision of sections one hundred twelve and one hundred sixty-three of the state finance law, or section one hundred forty-two of the economic development law, or any other law, the commissioner of health is authorized to enter into a contract or contracts under subdivision four of this section without a competitive bid or request for proposal process, provided, however, that:

(a) The department of health shall post on its website, for a period of no less than thirty days:

(i) A description of the proposed services to be provided pursuant to the contract or contracts;

(ii) The criteria for selection of a contractor or contractors;

(iii) The period of time during which a prospective contractor may seek selection, which shall be no less than thirty days after such information is first posted on the website; and

(iv) The manner by which a prospective contractor may seek such selection, which may include submission by electronic means;

(b) All reasonable and responsive submissions that are received from prospective contractors in timely fashion shall be reviewed by the commissioner of health; and

(c) The commissioner of health shall select such contractor or contractors that, in his or her discretion, are best suited to serve the purposes of this section.

6. The commissioner shall evaluate the results of the study conducted pursuant to subdivision four of this section to determine, after identification of actual direct and indirect costs incurred by public school districts and state operated/state supported schools, whether it is advisable to claim federal reimbursement for expenditures under this section as certified public expenditures. In the event such claims are submitted, if federal reimbursement received for certified public expenditures on behalf of medical assistance recipients whose assistance and care are the responsibility of a social services district in a city with a population of over two million, results in a decrease in the state share of annual expenditures pursuant to this section for such recipients, then to the extent that the amount of any such decrease when combined with any decrease in the state share of annual expenditures described in subdivision five of section three hundred sixty-eight-e of this title exceeds fifty million dollars, the excess amount shall be transferred to such city. Any such excess amount transferred shall not be considered a revenue received by such social services district in determining the district's actual medical assistance expenditures for purposes of paragraph (b) of section one of part C of chapter fifty-eight of the laws of two thousand five.

§ 7. Section 368-e of the social services law is amended by adding three new subdivisions 3, 4 and 5 to read as follows:

3. The commissioner of health is authorized to contract with one or more entities to conduct a study to determine actual direct and indirect costs incurred by counties for medical care, services and supplies, including related special education services and special transportation, furnished to pre-school children with handicapping conditions.

4. Notwithstanding any inconsistent provision of sections one hundred twelve and one hundred sixty-three of the state finance law, or section one hundred forty-two of the economic development law, or any other law, the commissioner of health is authorized to enter into a contract or contracts under subdivision three of this section without a competitive bid or request for proposal process, provided, however, that:

(a) The department of health shall post on its website, for a period of no less than thirty days:

(i) A description of the proposed services to be provided pursuant to the contract or contracts;

(ii) The criteria for selection of a contractor or contractors;

(iii) The period of time during which a prospective contractor may seek selection, which shall be no less than thirty days after such information is first posted on the website; and

(iv) The manner by which a prospective contractor may seek such selection, which may include submission by electronic means;

(b) All reasonable and responsive submissions that are received from prospective contractors in timely fashion shall be reviewed by the commissioner of health; and

(c) The commissioner of health shall select such contractor or contractors that, in his or her discretion, are best suited to serve the purposes of this section.

5. The commissioner shall evaluate the results of the study conducted pursuant to subdivision three of this section to determine, after identification of actual direct and indirect costs incurred by counties for medical care, services, and supplies furnished to pre-school children with handicapping conditions, whether it is advisable to claim federal reimbursement for expenditures under this section as certified public expenditures. In the event such claims are submitted, if federal reimbursement received for certified public expenditures on behalf of medical assistance recipients whose assistance and care are the responsibility of a social services district in a city with a population of over two million, results in a decrease in the state share of annual expenditures pursuant to this section for such recipients, then to the extent that the amount of any such decrease when combined with any decrease in the state share of annual expenditures described in subdivision six of section three hundred sixty-eight-d of this title exceeds fifty million dollars, the excess amount shall be transferred to such city. Any such excess amount transferred shall not be considered a revenue received by such social services district in determining the district's actual medical assistance expenditures for purposes of paragraph (b) of section one of part C of chapter fifty-eight of the laws of two thousand five.

NEW YORK STATE SCHOOL SUPPORTIVE HEALTH SERVICES PROGRAM
COMPLIANCE AGREEMENT

I. PREAMBLE

New York State agrees to implement a Compliance and Integrity Program ("Program") to prevent fraud, abuse, and false billing to Medicaid in its School and Pre-school Supportive Health Services Programs (collectively, the "SSHSP"). The Program shall be maintained so as to ensure that the New York State Medicaid program, the New York State Education Department, local school districts, including the City of New York, and its relevant employees are in compliance with all laws and regulations applicable to this program and with the terms of the Agreement set forth below.

II. TERMS AND CONDITIONS

1. The period of future compliance obligations assumed by New York State under this Agreement shall be three (3) years from the date of signature of this Agreement. All reports and notifications required under this Agreement shall be sent to the Associate Regional Administrator, Division of Medicaid and Children's Health, 26 Federal Plaza, Room 37-100, New York, N.Y. 10278 (Telephone: 212-616-2428), or to another official as designated by the Centers for Medicare and Medicaid Services ("CMS").

2. The State agrees to implement the following measures within ninety (90) days of the date of execution of this Agreement, unless otherwise specified below:

A. Compliance Officer and Committee

i. A Compliance Officer shall be chosen by the New York State Commissioner of Health. The Compliance Officer shall be responsible for compliance operations, including the review of State and local school district policies and procedures to assure compliance with CMS rules, regulations and guidelines governing federal claims for SSHSP under the Medicaid program,

and shall assure the development and oversight of training programs for State and local school district staff on Medicaid rules, regulations and guidelines. The Compliance Officer shall monitor and report on the ongoing payment reviews and annual audits conducted by the Office of the Medicaid Inspector General ("OMIG") staff and shall oversee any Department internal audit staff assigned to this function. The payment review protocol and sampling methodology shall be subject to review and approval by CMS. The Compliance Officer shall submit and certify comprehensive annual (or more frequent, if circumstances require) reports to CMS on the status of compliance by the State and local school districts.

ii. The Compliance Officer shall chair a Compliance Committee that shall oversee and monitor the Program. In addition to the Compliance Officer, the members of the Compliance Committee shall include, at a minimum, the New York State Department of Health ("DOH") Deputy Commissioner, Office of Health Insurance Programs; the New York State Department of Health Chief Financial Officer; Deputy Commissioner, New York State Education Department, or their respective designees.

iii. The Compliance Officer shall report the names, addresses, and phone numbers of him/herself and the members of the Compliance Committee in the annual reports and at any time there is a change in the Compliance Officer or members of the Compliance Committee.

B. Audit Requirements

i. OMIG audit staff shall conduct ongoing payment reviews and audits of the SSHSP's compliance with all applicable federal laws and regulations regarding claims for federal Medicaid participation. Such audits shall be performed in accordance with State regulations governing such audits, and internal controls shall be implemented in accordance with State internal control requirements. The State shall provide CMS with certified copies of its payment reviews and audit reports.

ii. OMIG payment reviews shall include reviews of the following services: physical therapy; occupational therapy; speech pathology; audiological evaluations; evaluations for all available services; nursing services; psychological services; transportation; medical evaluations; targeted case management services; initial individual education plan ("IEP"); triennial evaluations; annual IEP; requested or interim IEP; and ongoing service coordination.

iii. The OMIG shall implement separate payment audits for SSHSP claims from the New York City Department of Education ("NYCDOE") and the City of New York, and from school districts in the Rest of the State ("ROS"). The results of these audits will be provided to CMS.

a. NYC Reviews. To be reimbursed for each service type for which claiming had been suspended by the State during the course of the federal SSHSP review, NYCDOE or the City of New York, as applicable, must first submit a corrective action plan ("CAP") for that service for DOH's approval. After each CAP has been approved, new claims for that service type for a period selected by OMIG will be pended. The claims will be reviewed for accuracy and proper documentation, either in their entirety or by use of a sample, and paid as appropriate. If OMIG's review establishes that claims for a service type demonstrate an unacceptably high error rate, OMIG will require additional corrective action. In such case, OMIG will either suspend or pend claims for that service type pending correction of the errors.

The OMIG will perform an annual post-payment audit of NYCDOE and City of New York claims using standard OMIG random sampling audit protocols. Such reviews will begin in January 2010.

b. ROS Reviews. The OMIG will perform post payment audits of Medicaid claims for individual local school district and county providers using random samples of paid claims. Audit findings will be extrapolated to that provider's universe of claims pursuant to standard OMIG random sampling audit protocols. The audits will begin in January 2010. ROS providers receiving gross Medicaid payments of $1 million dollars or more will be audited annually. A random sample of 25 providers receiving between $250,000 and $1 million in gross Medicaid payments will be audited annually, and a random sample of 10 providers receiving gross Medicaid payments of less than $250,000 will be audited annually.

c. Areas of Concern Requiring an Action Plan. If an area of concern is identified during any of these NYC or ROS post-payment reviews, the OMIG, at its discretion, will apply an 1141 edit to either "Pend" or "Deny" any claims processed by eMedNY for that provider or for a service type. The OMIG will require corrective action before lifting a "Pend" or "Deny" 1141 edit status.

d. The State shall annually perform these NYC and ROS audits for the length of this Agreement in compliance with CMS rules, regulations and guidelines governing federal

claims for SSHSP. If other reviews conducted by the State reveal situations that might constitute or indicate noncompliance with federal requirements, the results of such reviews shall be provided to the Compliance Officer.

C. Independent Audits

Within one year of execution of this Agreement, the State shall retain an independent accounting firm, subject to review and approval of the scope of work by CMS and in accordance with competitive bidding requirements under State Finance Law, to perform a comprehensive audit at least annually of the SSHSP's internal controls to ensure compliance with federal requirements, including the certifications made on Medicaid expenditures via the CMS-64 in the Medicaid Budget and Expenditure Control System (MBES) for SSHSP claims. The independent audit shall include a statistically valid sample of claims to test the effectiveness of internal controls implemented by the State to assure compliance with federal requirements. A certified copy of the independent audit findings and recommendations shall be submitted to the State and CMS upon completion. Within 60 days of receipt of the audit report, the State shall submit to CMS a corrective action plan, subject to CMS review and approval, to address the audit findings and recommendations.

D. Annual Written Reports

i. The State shall annually provide CMS with a certified copy of all written reports or findings of its internal audits on the SSHSP. The State will also annually provide CMS with a certified report of the corrective actions, if any, that the State has undertaken as a result of any deficiencies that were discovered by its own internal audit, or by other audits or payment reviews. The annual report shall be due one year after execution of this Agreement and for each of the two years thereafter. This report on the State's corrective actions shall include a certification by the Compliance Officer that all deficiencies found have been addressed to ensure the State's compliance with all requirements of federal law, regulation, and this Agreement. CMS may request additional corrective action if it believes that the State's actions are not adequate to ensure compliance with federal requirements.

ii. All audit work papers or other supporting documents for audits or reviews of federal compliance shall be made available to CMS or HHS upon request.

iii. Any material violations discovered during any audits or reviews shall be reported immediately to CMS and remedied within sixty (60) days of identification by the State. The State shall report its findings concerning the material violation, its actions to correct such material violation, and any further steps the State plans to take to address such material violation and prevent it from recurring in the future. A material violation is one that has a significant, adverse impact on proper claiming for federal participation in the Medicaid program.

E. New York State SSHSP Compliance Policy

Within ninety (90) days of the execution of this Agreement, the State shall implement written policies regarding its commitment to ensure compliance with all laws and regulations related to the receipt of federal Medicaid participation in the SSHSP. These policies shall be adopted by the DOH and the New York State Education Department and shall be distributed to all local school district providers. The policies shall be included as part of annual training and shall be included as part of the annual report to CMS. Such policies shall be updated to reflect any changes in State or federal policy or practices.

F. Training

The State shall institute and maintain a training program designed to ensure that the State Medicaid program, the State Education Department, local school districts and relevant employees are aware of all applicable laws and regulations and standards of conduct for federal participation in the Medicaid program and that each entity and individual is expected to follow and the consequences both to the individual, the State and local school districts that will ensue from any violation of such requirements. "Relevant employees" of a school district or a county are those employees who provide SSHSP services to students, who prepare or submit Medicaid claims under the SSHSP, the school business official or county fiscal designee who oversees the Medicaid claiming process, and the school district's special education program director. For purposes of this section, a "relevant employee" shall also mean a non-employee or independent contractor who is a provider of SSHSP services to students. Each relevant employee shall receive at least one hour of initial training that shall include a discussion of the contents of this Compliance Agreement and the written compliance policies. Each relevant employee shall receive additional training of at least one hour on an annual basis. A schedule and topic outline of the training shall be included in the

annual report submitted to CMS. Relevant employees shall be required to certify in writing that they have participated in the training. Such certifications must be maintained for three years from the date of training and shall be made available to CMS upon request.

G. Confidential Disclosure Program

The State and local school districts shall establish a confidential disclosure mechanism enabling employees to disclose anonymously any practices or billing procedures, deemed by the employee to be inappropriate, to the State's Compliance Officer. The State shall make the confidential disclosure mechanism known to each employee as part of his or her training. The State and local school district shall, as part of the confidential disclosure program, require the internal review of any such credible disclosure and ensure that proper follow-up is conducted. The State shall include in its annual compliance report to CMS a summary of communications concerning inappropriate billings or any other inappropriate conduct under the confidential disclosure program, and the results of any internal review and follow-up of such disclosures.

H. State Plan and SSHSP Reimbursement Methodology

i. The State shall agree to terminate the existing Medicaid State plan reimbursement methodology and the non-Federal share financing associated with all SSHSP-related claims, effective with the beginning of the 2009 School Year. The State shall submit to CMS a Medicaid State Plan amendment ("SPA") effective July 1, 2009 that proposes to implement a SSHSP reimbursement methodology and source of non-Federal share financing consistent with Federal requirements. Effective July 1, 2009, Federal matching funds will only be available for SSHSP under the terms of the revised SPA, which must receive CMS approval.

ii. Compliance with the provisions of this section does not relieve the State of its responsibility to comply with changes in federal laws and regulations, and to ensure that claims for federal funding are consistent with all applicable requirements.

I. Implementation Plan

Within 90 days, the State shall submit an Implementation Plan, subject to review and approval by CMS, which describes and certifies to the actions required in the Terms and Conditions of this Agreement. The Implementation Plan shall include:

i. the name, address, phone number and title of the Compliance Officer and the members of the Compliance Committee, and a position description for the Compliance Officer, including the Officer's non-compliance responsibilities;

ii. the program for payment audits, agency internal audits, and other audits or reviews to be conducted by the OMIG or DOH internal audit staffs;

iii. the implementation plan for retaining an independent accounting firm to conduct an annual comprehensive audit of SSHSP;

iv. a description of the training programs required by section II.2.F. of this Agreement;

v. a description of the steps to be taken by the State to address termination of the existing Medicaid State plan reimbursement methodology and actions to be taken to assure that the State's SSHSP reimbursement methodology and source of non-Federal share financing is consistent with Federal requirements.

J. Certifications

The certification of State reports required by this Agreement shall include a certification by the Compliance Officer that the State is in compliance with all of the requirements of this Agreement to the best of his or her knowledge, and that the Compliance Officer has reviewed the required reports and has made reasonable inquiry regarding its content and believes that, upon such inquiry, the information is accurate and truthful.

III. CMS INSPECTION, AUDIT AND REVIEW RIGHTS

In addition to any other right that CMS has pursuant to 45 C.F.R. §92.42(e) or any other authority, the Department of Health and Human Services, CMS, or their duly authorized representatives may examine and copy the State's books, records, and other documents and supporting materials for the purpose of verifying and evaluating: (a) the State's compliance with the terms of this Agreement; (b) the State's conduct in its dealing with the United States Government, or any agencies or agents thereof; and (c) the State's compliance with any federal requirements. The documentation described above shall be made available by the State at all reasonable times for inspection, audit and/or reproduction. Furthermore, for purposes of this provision, CMS or its authorized representatives may, upon five business days advance notice to the Compliance Officer, interview any State employee at the employee's place of business during normal business hours or

at such other place and time as may be mutually agreed upon between the employee and CMS. Employees may elect to be interviewed with or without a representative of the State present.

IV. DOCUMENT AND RECORD RETENTION

In addition to the document retention requirements contained in 45 C.F.R. §92.42(b), or in the terms of the pertinent Medicaid grant award, cooperative agreement, or contract, the State shall maintain for inspection all documents and records relating to reimbursement for SSHSP for a period of not less than six (6) years following the execution of this Agreement.

V. BREACH AND DEFAULT PROVISIONS

1. Stipulated Payment for Failure to Comply with Certain Obligations

A. In the event that CMS believes the State has breached one or more of its obligations under this Agreement, CMS shall notify the Compliance Officer of the alleged breach by certified mail, specifying the nature and extent of the alleged breach. The State will have thirty (30) days from receipt of the notice: (a) to cure said breach; or (b) otherwise satisfy the government that (1) it is in full compliance with this Agreement or (2) the breach cannot be reasonably cured within 30 days, but that the State has taken action to cure the breach and is pursuing such action with diligence.

B. If at the end of the thirty day period described above, CMS determines that the State continues to be in breach of one or more of its obligations under this Agreement, CMS shall, in writing and by certified mail, declare the State to be in default and initiate proceedings to undertake a contractual remedy as described herein.

C. The State and CMS agree that failure to comply with Sections II.2.A-J as set forth in this Agreement shall lead to the imposition of stipulated monetary payment in the amount of $2,500 per day for each day the State fails to establish and implement its obligations under this Agreement.

2. Timely Written Requests for Extensions

The State may, in advance of the due date, submit a timely written request for an extension of time to perform any act or file any notification or report required by this Agreement. Notwithstanding any other provision of section V of this Agreement, if CMS grants the timely written request with respect to an act, notification, or report, Stipulated Payment for failure to

perform the act or file the notification or report shall not begin to accrue until one day after the State fails to meet the revised deadline set by CMS. Notwithstanding any other provision in such section, if CMS denies such a timely written request, Stipulated Payment for failure to perform the act or file the notification or report shall not begin to accrue until three business days after the State receives CMS's written denial of such request or the original due date, whichever is later. A "timely written request" is defined as a request in writing received by CMS at least five business days prior to the date by which any act is due to be performed or any notification or report is due to be filed.

3. Contractual Remedy Action

A. Upon a finding that the State has failed to comply with any of the obligations described in this Agreement and after determining that Stipulated Payment is appropriate, CMS shall notify the State of: (a) the State's failure to comply; and (b) CMS's exercise of its contractual right to impose the stipulated monetary payment in the amount of $2,500 for each day the State fails to establish and implement its obligations under this Agreement. This action shall not be subject to appeal per this Agreement. Any such stipulated monetary payment shall be deducted by CMS from future grant awards, including but not limited to Medicaid grant awards, to the State of New York.

B. Nothing in this Agreement shall preclude CMS from taking a disallowance action in accordance with 42 CFR §430.42 for any overpayment claimed by the State as part of the SSHSP. CMS may defer and/or disallow any and all claims submitted on the CMS-64 subsequent to the inception of this agreement, and will recover all identified overpayments. Nothing in this Agreement shall be interpreted as precluding the State's right to challenge any such action through any and all legal means.

VI. APPROPRIATED FUNDS

The obligations of the State of New York under this agreement shall not constitute a debt of the State within the meaning of any provisions of the New York State Constitution or any New York statute and may only be undertaken by the State of New York using funds that have been appropriated for such purpose or otherwise lawfully available as set forth in Section 41 of the State Finance Law. Nothing in this paragraph limits or voids CMS's remedies under section V., above.

VII. COSTS RELATED TO COMPLIANCE PLANS

In addition to the obligations assumed by the State under this Agreement and as described above, if CMS determines that an independent audit or review is needed to determine whether, or the extent to which, the State is complying with its obligation under this Agreement, the State agrees to pay for the reasonable cost of any such audit or review by CMS or another independent entity. Nothing in this Agreement shall be interpreted as precluding the State's right to challenge through any and all legal means any CMS determination under this section.

VIII. MODIFICATION

The State and CMS agree that any modification to this Agreement shall not be effective until a written amendment is signed by the signatories to this agreement or by institutional representatives duly authorized to execute such amendment.

IX. INTEGRATION CLAUSE

This Agreement and the Settlement Agreement entered into by CMS, the State, the NYCDOE, the City of New York, the Relator, and the U.S. Department of Justice ("the parties") embody the entire agreement and understanding of the parties with respect to the subject matter contained herein. There are no restrictions, promises, representations, warranties, covenants, or undertakings other than those expressly set forth or referred to in this Agreement. This Agreement, together with the Settlement Agreement between the State and the U.S. Department of Justice, supersedes any and all prior agreements and understandings between the parties with respect to this subject matter, except for the terms and conditions of individual grant awards and contracts.

CENTERS FOR MEDICARE & MEDICAID SERVICES

DATED: July 17, 2009 BY: Charlene Frizzera

Charlene Frizzera
Acting Administrator
Centers for Medicare & Medicaid Services

STATE OF NEW YORK

DATED: July 17 2009 BY: _____

Gregor N. Macmillan

Director, Bureau of Health Insurance Programs

Division of Legal Affairs

New York State Department of Health

DATED: _____ BY: _____

Erin M. O'Grady-Parent

Acting Counsel

New York State Department of Education

DATED: _____ BY: _____

James G. Sheehan

New York State Medicaid Inspector General

STATE OF NEW YORK

DATED: _____ BY: _____

Gregor N. Macmillan
Director, Bureau of Health Insurance Programs
Division of Legal Affairs
New York State Department of Health

DATED: 7/17/09 BY: Erin M. O'Grady-Parent

Erin M. O'Grady-Parent
Acting Counsel
New York State Department of Education

DATED: _____ BY: _____

James G. Sheehan
New York State Medicaid Inspector General

STATE OF NEW YORK

DATED: _____ BY: _____

Gregor N. Macmillan
Director, Bureau of Health Insurance Programs
Division of Legal Affairs
New York State Department of Health

DATED: _____ BY: _____

Erin M. O'Grady-Parent
Acting Counsel
New York State Department of Education

DATED: 7/20/09 BY: _____

James G. Sheehan
New York State Medicaid Inspector General

Appendix IV
2016 Title XIX State Plan
Second Quarter Amendment
Public Notice

250 Church Street
New York, New York 10018

Queens County, Queens Center
3220 Northern Boulevard
Long Island City, New York 11101

Kings County, Fulton Center
114 Willoughby Street
Brooklyn, New York 11201

Bronx County, Tremont Center
1916 Monterey Avenue
Bronx, New York 10457

Richmond County, Richmond Center
95 Central Avenue, St. George
Staten Island, New York 10301

Richmond County, Richmond Center
95 Central Avenue, St. George
Staten Island, New York 10301

For further information and to review and comment, please contact: Department of Health, Division of Finance and Rate Setting, 99 Washington Ave. – One Commerce Plaza, Suite 1460, Albany, NY 12210 or e-mail: spa_inquiries@health.ny.gov

PUBLIC NOTICE
Department of Health

Pursuant to 42 CFR Section 447.205, the Department of Health hereby gives public notice of the following:

The Department of Health proposes to amend the Title XIX (Medicaid) State Plan for non-institutional services to comply with enacted statutory provisions. The following changes are proposed:

Effective on or after April 1, 2016 the Department of Health proposes to extend the sunset date from June 30, 2016 to June 30, 2017 and revise a component of the formula used in calculating certified public expenditures (CPEs) for school-age and preschool school supportive health services.

School Supportive Health Services (SSHS) are provided to Medicaid-eligible students with disabilities in school districts and counties. SSHS are authorized under § 1903(c) of the Social Security Act and include: physical therapy, occupational therapy, speech therapy, psychological evaluations, psychological counseling, skilled nursing services, medical evaluations, medical specialist evaluations, audiological evaluations, and special transportation services.

The formula to determine the individualized education program ratio, a component of the reimbursement calculations under the existing CPE reimbursement methodology, will be adjusted to ensure that CPE reimbursement more closely aligns with Medicaid interim claiming.

There is no additional estimated annual change to gross Medicaid expenditures as a result of the clarifying proposed amendments.

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, Division of Finance and Rate Setting, 99 Washington Ave. – One Commerce Plaza, Suite 1460, Albany, NY 12210 or e-mail: spa_inquiries@health.ny.gov

PUBLIC NOTICE
Madison County

Madison County has issued a Final Request For Proposals (RFP) dated February 4, 2016 to request comments from companies that are interested in developing a facility in the County's Agriculture and Renewable Energy (ARE) Park located in the Town of Lincoln at the County's landfill site on Buyea Road that will use non-recyclable plastic material and tires from Madison County and elsewhere to produce oil products. Interested companies should request a copy of the Final RFP from Kipp Hicks, Director, Madison County IDA. Comments received on the Draft RFP have been considered and incorporated into this Final RFP where appropriate. Proposals must be submitted in hard copy to the Madison County Purchasing Officer, Ms. Nicole Schafer-Farino, on or before 3:00 p.m. on April 1, 2016 (County Office Building, North Court Street, P.O. Box 635, Wampsville, New York 13163).

Contact Person: Kipp Hicks, Director, Madison County IDA, (315) 697-9817, Fax (315) 697-8169, e-mail: director@madisoncountyida.com

PUBLIC NOTICE
Department of State
F-2016-0135 (DA)
Date of Issuance – March 9, 2016

The New York State Department of State (DOS) is required by Federal regulations to provide timely public notice for the activities described below, which are subject to the consistency provisions of the Federal Coastal Zone Management Act of 1972, as amended.

The Agency has determined that the proposed activity complies with and will be conducted in a manner consistent to the maximum extent practicable with the approved New York State Coastal Management Program. The Agency's consistency determination and accompanying public information and data are available for inspection at the New York State Department of State offices located at One Commerce Plaza, 99 Washington Avenue, in Albany, New York.

In F-2016-0135 Amtrak is proposing the Positive Train Control Project at the Rhinecliff train station in Dutchess County, NY. Amtrak proposes to install two antennas on an existing 70 foot tower currently existing on the train station.

Any interested parties and/or agencies desiring to express their views concerning any of the above proposed activities may do so by filing their comments, in writing, no later than 4:30 p.m., 15-days from the date of publication of this notice, or, March 24, 2016.

Comments should be addressed to the New York State Department of State, Office of Planning and Development, One Commerce Plaza, 99 Washington Avenue, Albany, New York 12231. Telephone (518) 474-6000; Fax (518) 473-2464. cr@dos.ny.gov

Appendix V
2016 Title XIX State Plan
Second Quarter Amendment
Responses to Standard Funding Questions

APPENDIX V
HOSPITAL SERVICES
State Plan Amendment #16-0020

CMS Standard Funding Questions (NIRT Standard Funding Questions)

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

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

   Response: Providers do retain the payments made pursuant to this amendment. However, this requirement in no way prohibits the public provider, including county providers, from reimbursing the sponsoring local government for appropriate expenses incurred by the local government on behalf of the public provider. The State does not regulate the financial relationships that exist between public health care providers and their sponsoring governments, which are extremely varied and complex. Local governments may provide direct and/or indirect monetary subsidies to their public providers to cover on-going unreimbursed operational expenses and assure achievement of their mission as primary safety net providers. Examples of appropriate expenses may include payments to the local government which include reimbursement for debt service paid on a provider's behalf, reimbursement for Medicare Part B premiums paid for a provider's retirees, reimbursement for contractually required health benefit fund payments made on a provider's behalf, and payment for overhead expenses as allocated per federal Office of Management and Budget Circular 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 an IGT or CPE. In this case, please identify the agency to which the funds are appropriated. Please provide an estimate of total expenditure and State share amounts for each type of Medicaid payment. If any of the non-federal share is being provided using IGTs or CPEs, please fully describe the matching arrangement including when the state agency receives the transferred amounts from the local government entity transferring the funds. If CPEs are used, please describe the methodology used by the state to verify that the total expenditures being certified are eligible for Federal matching funds in accordance with 42 CFR 433.51(b). For any payment funded by CPEs or IGTs, please provide the following:**
    - **(i) a complete list of the names of entities transferring or certifying funds;**
    - **(ii) the operational nature of the entity (state, county, city, other);**
    - **(iii) the total amounts transferred or certified by each entity;**
    - **(iv) clarify whether the certifying or transferring entity has general taxing authority; and,**
    - **(v) whether the certifying or transferring entity received appropriations (identify level of appropriations).**

Response: Payments made to service providers under the provisions of this SPA are funded through a budget appropriation received by the State agency that oversees medical assistance (Medicaid), which is the Department of Health.

The federal and non-federal shares associated with the provisions of this SPA are funded from appropriations by the State Legislature to two separate State agencies, the State Education Department (SED) and the State Department of Health (SDOH). The SED non-federal share appropriation authority is transferred or sub-allocated from the SED to the SDOH (the single state Medicaid agency) which enables the SDOH to draw general funds dollars directly to fund the non-federal share of payments for SSHS. This transfer authority for the federal share is already resident in the SDOH budget; transferring budget authorization from SED to DOH enables the SDOH to make the 100% computable payment.

Specific to the certified public expenditure (CPE) methodology, the State and CMS review the cost report final calculations for each participating

Preschool/School Supportive Health Services (P/SSHS) provider to verify the eligibility of the reported expenditures for Federal matching funds.

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

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

4. **Please provide a detailed description of the methodology used by the state to estimate the upper payment limit (UPL) for each class of providers (State owned or operated, non-state government owned or operated, and privately owned or operated). Please provide a current (i.e. applicable to the current rate year) UPL demonstration. Under regulations at 42 CFR 4447.272, 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: Question is not applicable as P/SSHS are not clinic or outpatient hospital services.

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 preschool supportive health services is cost-based subject to ceilings. Rates of payment for services are currently based upon the 2010 Medicare fee schedule, except for rates for special transportation services, which are based on a cost study. Effective on or after September 1, 2013, on an annual basis, a district-specific cost reconciliation and cost settlement for all over and under payments will be processed. 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 State does comply with the requirements of section 1902(a)(37) of the Act regarding prompt payment of claims.

Tribal Assurance:

Section 1902(a)(73) of the Social Security Act the Act requires a State in which one or more Indian Health Programs or Urban Indian Organizations furnish health care services to establish a process for the State Medicaid agency to seek advice on a regular ongoing basis from designees of Indian

health programs whether operated by the Indian Health Service HIS Tribes or Tribal organizations under the Indian Self Determination and Education Assistance Act ISDEAA or Urban Indian Organizations under the Indian Health Care Improvement Act.

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

a) **Please describe the process the State uses to seek advice on a regular ongoing basis from federally recognized tribes Indian Health Programs and Urban Indian Organizations on matters related to Medicaid and CHIP programs and for consultation on State Plan Amendments waiver proposals waiver extensions waiver amendments waiver renewals and proposals for demonstration projects prior to submission to CMS.**

b) **Please include information about the frequency inclusiveness and process for seeking such advice.**

c) **Please describe the consultation process that occurred specifically for the development and submission of this State Plan Amendment when it occurred and who was involved.**

Response: The provision concerning tribal consultations does not apply to this SPA since Indian Health Programs in New York State do not provide school supportive health services and, therefore, receive no Medicaid payments for such services.