NEW YORK STATE OF OPPORTUNITY. Department of Health

ANDREW M. CUOMO
Governor

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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 #16-0046
Non-Institutional Services

Dear Mr. Melendez:

The State requests approval of the enclosed amendment #16-0046 to the Title XIX (Medicaid) State Plan for non-institutional services to be effective July 28, 2016 (Appendix I). This amendment is being submitted based on State 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 proposed State regulations 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 July 27, 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: **16-0046**	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 28, 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 07/28/16-09/30/16 $15,938.00** **b. FFY 10/01/16-09/30/17 $70,956.00**
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: **Amendment 4.19-B: 2(ao); 2(ao)(1); 2(ao)(1.1)**	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

10. SUBJECT OF AMENDMENT:
Medicaid Safety Net Payment-FQHC
(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** **Division of Finance and Rate Setting** **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
Third Quarter Amendment
Amended SPA Pages

New York
2(ao)

Federally Qualified Health Centers (FQHCs) Safety Net Payment

1. Effective on or after July 28, 2016, and for each State Fiscal Year thereafter, additional payments of up to $127,500,000 annually will be made to eligible Medicaid safety net Federally Qualified Health Centers (FQHC) to sustain access to services.

   a. "Eligible Medicaid safety net Federally Qualified Health Centers", for purposes of this section, will mean voluntary non-profit and publicly sponsored diagnostic and treatment centers licensed under Article 28, and must meet the following criteria: deliver comprehensive range of health care services; provide at least 5% of their annual visits to uninsured individuals; have a process in place to collect payment from third party payers; received Federally Qualified Health Center or Rural Health Center status from the Health Resources & Services Administration (HRSA).

   b. The base year data used for the period commencing on July 28, 2016 through March 31, 2017 will be the 2014 certified cost report and will be advanced one year thereafter for each subsequent period.

   c. New providers with less than two full years of cost experience may qualify to be included in the distribution as follows:

      i. The provider meets the criteria in paragraph (1)(a).

      ii. The provider must be eligible to receive a Medicaid rate in New York State.

      iii. The provider must submit a request to the Department of Health to participate in the distribution. This request must include annualized patient visits, by payer source, which are certified by the Chief Executive Officer, or a similar executive position.

      iv. The effective date to be included in the distribution will be the first state fiscal year distribution calculation after the provider qualifies to be included based on the requirements in paragraphs (1)(c)(i) through (1)(c)(iii) (herein after referred to as paragraph (1)(c)) or the first state fiscal year distribution calculation after the date a request is made to the Department of Health to be included in the distribution, whichever is later.

      v. The distribution method applied to a new provider that qualifies to be included in the distribution based on paragraph (1)(c) of this section will be in accordance with the distribution method for other providers in this section. However, the annual distribution for a provider that qualifies based on paragraph (1)(c) of this section will not exceed $100,000.

      vi. The distribution for a provider that qualifies based on paragraph (1)(c) of this section will be included in the total safety net distribution amount as described in paragraph (1) of this section.

New York
2(ao)(1)

Federally Qualified Health Centers (FQHCs) Safety Net Payment

d. Each eligible FQHC will qualify for a rate add-on based on its percentage of uninsured visits according to the following tiers:

% of eligible uninsured visits to total visits							
Upstate				Downstate			
Low	High (up to)	Add-on Amt	Tier	Low	High (up to)	Add-on Amt	Tier
5%	10%	$15	1	5%	15%	$32	1
10%	15%	$25	2	15%	20%	$42	2
15%	20%	$36	3	20%	25%	$53	3
20%	25%	$48	4	25%	35%	$65	4
25%	100%	$61	5	35%	100%	$78	5

e. Safety net payments will be calculated by multiplying each facility's rate add-on by the number of Medicaid fee-for-service and Medicaid managed care visits reported in the certified base year cost report.

f. The safety net rate adjustment for each eligible FQHC that is determined based on the tier system will be scaled based on the ratio of the total funds allocated for distribution, using the tier system, to the total statewide safety net payment that is available for all eligible FQHCs.

g. The payments for this alternative payment method, which are made pursuant to this section, will be made as aggregate payments to eligible FQHC and will not be subject to subsequent adjustment or reconciliation.

2. In the event that a provider that is included in the Diagnostic and Treatment Centers (D&TCs) Safety Net Payment section receives FQHC designation the following will apply:

a. The new FQHC provider will be removed from the distribution calculated in the D&TC Safety Net Payment section and included in this section for the FQHCs Safety Net Payment.

b. The effective date of the transfer will be the first state fiscal year distribution calculation after the FQHC designated approval date or the first state fiscal year distribution calculation after the date the Department of Health is notified of the FQHC designation, whichever is later.

c. The funds allocated to the new FQHC provider in the D&TCs Safety Net Payment section will be transferred to this FQHCs Safety Net Payment section based on the prior state fiscal year calculation. The transfer of funds will be at the same time the new FQHC provider is included in this FQHCs Safety Net Payment section distribution, as stated in paragraph (2)(b), increasing the total value of the additional payment as described on paragraph (1), in this section, for the additional annual payment.

New York
2(ao)(1.1)

Federally Qualified Health Centers (FQHCs) Safety Net Payment

d. In no event will the sum of the total safety net distribution amount of the FQHCs Safety Net Payment in this section and the D&TCs Safety Net Payment section exceed $151,500,000.

3. In the event that the value of the combined total amount of the FQHCs Safety Net Payment in this section and the D&TCs Safety Net Payment section is reduced below $151,500,000, the values as described in this FQHCs Safety Net Payment section and the D&TCs Safety Net Payment section will be reduced maintaining the same proportional values.

Appendix II
2016 Title XIX State Plan
Third Quarter Amendment
Summary

SUMMARY
SPA #16-0046

This State Plan Amendment proposes to establish additional payments to Medicaid safety net Federally Qualified Health Center (FQHC) clinics to sustain access to services.

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

Effective Date:
Title: Section 86-4.33 – [Reserved] Safety Net Payments

86-4.33 Safety Net Payments.

(a) Effective on or after July 28, 2016, and for each State Fiscal Year thereafter, additional payments of up to $127,500,000 annually will be made to eligible Medicaid safety net Federally Qualified Health Centers (FQHC) and up to $24,000,000 annually will be made to eligible Medicaid safety net diagnostic and treatment centers (D&TC) except for FQHCs, to sustain access to services. In no event will the total safety net distribution amount for FQHCs and D&TCs exceed $151,500,000.

(1) (i) Providers included in subdivision (a)(3) of this section that receive the FQHC designation prior to a subsequent state fiscal year distribution calculation will be removed from the subdivision (a)(3) distribution and included in the distribution in subdivision (a)(2) of this section.

(ii) The funds allocated to the provider in the subdivision (a)(3) distribution will also be transferred based on the prior state fiscal year calculation and will be transferred at the time the provider is transferred.

(iii) The effective date of the transfer of the provider to the FQHC distribution will be the first state fiscal year distribution calculation after receiving the FQHC designation approval or the first state fiscal year distribution calculation after the date the Department of Health is notified of the FQHC designation, whichever is later.

(2) (i) "Eligible Medicaid safety net Federally Qualified Health Centers", for purposes of this section, will mean voluntary non-profit and publicly sponsored diagnostic and treatment centers licensed under Article 28, and must meet the following criteria: deliver comprehensive range of health care services; provide at least 5% of their annual visits to uninsured individuals; have a process in place to collect payment from third party payers; received Federally Qualified Health Center or Rural Health Center status from the Health Resources & Services Administration (HRSA).

(ii) Each eligible FQHC will qualify for a rate add-on based on its percentage of uninsured visits according to the following tiers:

% of eligible uninsured visits to total visits							
Upstate				Downstate			
Low	High (up to)	Add-on Amt	Tier	Low	High (up to)	Add-on Amt	Tier
5%	10%	$15	1	5%	15%	$32	1
10%	15%	$25	2	15%	20%	$42	2
15%	20%	$36	3	20%	25%	$53	3
20%	25%	$48	4	25%	35%	$65	4
25%	100%	$61	5	35%	100%	$78	5

(iii) Safety net payments will be calculated by multiplying each facility's rate add-on by the number of Medicaid fee-for-service and Medicaid Managed Care visits reported in the certified base year cost report as defined in subdivision (b) of this section.

(iv) The safety net rate adjustment for each eligible FQHC that is determined based on the tier system will be scaled based on the ratio of the total funds allocated for distribution, using the tier system, to the total statewide safety net payment that is available for all eligible FQHCs.

(3) (i) "Eligible Medicaid safety net diagnostic and treatment centers", for purposes of this section, will mean voluntary non-profit and publicly sponsored diagnostic and treatment centers licensed under Article 28 or Article 31, and must meet the following criteria: deliver comprehensive range of health care or mental health services; provide at least 5% of their annual visits to uninsured individuals; and have a process in place to collect payment from third party payers.

(ii) Each eligible D&TC will qualify for a rate add-on based on its percentage of uninsured visits according to the following tiers:

% of eligible uninsured visits to total visits							
Upstate				**Downstate**			
Low	**High (up to)**	**Add-on Amt**	**Tier**	**Low**	**High (up to)**	**Add-on Amt**	**Tier**
5%	10%	$30	1	5%	15%	$47	1
10%	15%	$40	2	15%	20%	$57	2
15%	20%	$51	3	20%	25%	$68	3
20%	25%	$63	4	25%	35%	$80	4
25%	100%	$76	5	35%	100%	$93	5

(iii) Safety net payments will be calculated by multiplying each facility's rate add-on by the number of Medicaid fee-for-service visits reported on the certified base year cost report as defined in subdivision (b) of this section.

(iv) The safety net rate adjustment for each eligible D&TC that is determined based on the tier system will be scaled based on the ratio of the total funds allocated for distribution, using the tier system, to the total statewide safety net payment that is available for all eligible D&TCs

(b) The base year data used for the period commencing on July 28, 2016 through March 31, 2017 shall be the 2014 certified cost report and will be advanced one year thereafter for each subsequent period.

(c) New providers with less than two full years of cost experience may qualify to be included in the distribution as follows:

(1) The provider meets the criteria in paragraph (a)(2)(i) or paragraph (a)(3)(i) of this section.

(2) The provider must be eligible to receive a Medicaid rate in New York State.

(3) The provider must submit a request to the Department of Health to participate in the distribution. This request must include annualized patient visits, by payer source, which are certified by the Chief Executive Officer, or a similar executive position.

(4) The effective date to be included in the distribution will be the first state fiscal year distribution calculation after the provider qualifies to be included based on the requirements in subdivision (c) of this section or the first state fiscal year distribution calculation after the date a request is made to the Department of Health to be included in the distribution, whichever is later.

(5) The distribution method applied to a new provider that qualifies to be included in the distribution calculation will be in accordance with the distribution method in which they qualify to participate in accordance with paragraph (a)(2)(i) or paragraph (a)(3)(i) of this section. However, the annual distribution for a provider that qualifies based on subdivision (c) of this

section will not exceed $100,000.

(6) The distribution for a provider that qualifies based on subdivision (c) of this section will be included in the total safety net distribution amount as described in subdivision (a) of this section.

(d) Adjustments to payments made pursuant to this section will be made as aggregate payments to eligible FQHC and D&TC and will not be subject to subsequent adjustment or reconciliation.

(e) During the July 28, 2016 through March 31, 2017 transition period, a mitigation pool may be implemented utilizing funds allocated for the 2015 distribution period under a prior method.

(f) In the event that the value of the combined total amount of the FQHC and D&TC Safety Net Payment is reduced below $151,500,000, the value of the annual distribution for the FQHC and D&TC Safety Net Payment will be reduced maintaining the same proportion of the distributions at the time of the reduction in the combined total amount.

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

(Medicaid) State Plan for institutional and long term care related to temporary rate adjustments to providers that are undergoing closure, merger, consolidation, acquisition or restructuring themselves or other health care providers. These payments are authorized by current State statutory and regulatory provisions. The following provides clarification to provisions previously noticed on May 4, 2016.

The temporary rate adjustments have been reviewed and approved, with aggregate payment amounts totaling up to 9,056,000 for the periods June 1, 2016 through July 31, 2019.

Provider	Type	YR 1	YR 2	YR 3	Total
Kaleida Health-Buffalo General Medical Center	Hospital	$2,617,302	$2,663,572	$2,719,126	$8,000,000
Good Shepherd NH	Nursing Home	935,000	130,000	-	1,065,000
		$3,552,302	$2,793,572	$2,719,126	$9,065,000

The estimated net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for State Fiscal Year 16/17 through 18/19 by provider category, is as follows: institutional $8,000,000, and long term care $1,065,000.

The public is invited to review and comment on this proposed State Plan Amendment (SPA). Copies of which will be available for public review on the Department's website at http://www.health.ny.gov/regulations/state_plans/status. In addition, approved SPA's beginning in 2011, are also available for viewing on this website.

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

For the New York City district, copies will be available at the following places:

New York County
250 Church Street
New York, New York 10018

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

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

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

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

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

PUBLIC NOTICE

Department of Health

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

The Department of Health proposes to amend the Title XIX (Medicaid) State Plan for non-institutional services to revise provisions of Comprehensive diagnostic and treatment centers Indigent Care program. The following changes are proposed:

Effective on or after July 28, 2016, and for each State Fiscal Year thereafter, the State proposes to provide additional payments of up to $151,500,000 annually to Medicaid safety net Federally Qualified Health Centers (FQHCs) and non-FQHC clinics to sustain access to services. Eligible facilities must meet the following criteria: deliver comprehensive range of health care or mental health services; provide at least 5% of their annual visits/services to uninsured individuals; and have a process in place to collect payment from third party payers. The proposed distribution methodology will qualify facilities into tiers on their percentage of uninsured visits. An Add-on amount will be established for each tier and each facility's proportion of Medicaid services will then be used to arrive at a final safety net payment. Payment made to each facility may be added to rates of payment or made as lump sum.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2016/2017 is $151,500,000.

The public is invited to review and comment on this proposed State Plan Amendment (SPA). Copies of which will be available for public review on the Department's website at http://www.health.ny.gov/regulations/state_plans/status. In addition, approved SPA's, are also available for viewing on this website.

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

For the New York City district, copies will be available at the following places:

New York County
250 Church Street
New York, New York 10018

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

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

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

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

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

PUBLIC NOTICE

Office for People With Developmental Disabilities

Announcement for Public Comment on the OPWDD 1915(c) HCBS Waiver Amendment

The NYS Office for People With Developmental Disabilities (OPWDD) hereby gives notice in order to obtain public comment on the OPWDD Comprehensive Home and Community-Based Services (1915-c HCBS) Waiver application for amendment to the Centers for Medicare and Medicaid Services (CMS). The Waiver amendment will

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

NON-INSTITUTIONAL SERVICES
State Plan Amendment #16-0046

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 Medicaid General Fund Local Assistance Account, which is part of the Global Cap. The Global Cap is funded by General Fund and HCRA resources. In addition, there have been no new provider taxes nor have the existing taxes been modified.

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 additional payments made to those providers receiving a distribution and will be paid quarterly during each period in equal installments.

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: Federally Qualified Health Centers are not included in the UPL methodology.

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 Federally Qualified Health Center services is based on the Prospective Payment System (PPS). 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: 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.