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

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

SEP 26 2017

RE: SPA #17-0028
Non-Institutional Services

Dear Mr. Melendez:

The State requests approval of the enclosed amendment #17-0032 to the Title XIX (Medicaid) State Plan for non-institutional services to be effective July 1, 2017 (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 enacted legislation are enclosed for your information (Appendix III). A copy of the public notice of this plan amendment, which was given in the New York State Register on June 28, 2017, 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: **17-0028**	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, 2017**	

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 07/01/17-09/30/17 $ 2,000.00** **b. FFY 10/01/17-09/30/18 $ 8,000.00**
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: **Attachment 4.19-B: Page 17(u)**	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: **Attachment 4.19-B: Page 17(u)**

10. SUBJECT OF AMENDMENT:
Extend ROS county CPE sunset date to 2022
(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 & Rate Setting** **99 Washington Ave – One Commerce Plaza** **Suite 1432** **Albany, NY 12210**
13. TYPED NAME: **Jason A. Helgerson**	
14. TITLE: **Medicaid Director** **Department of Health**	
15. DATE SUBMITTED: SEP 26 2017	

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
2017 Title XIX State Plan
Third Quarter Amendment
Amended SPA Pages

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, 2022 [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, 2022 [2017].

Appendix II
2017 Title XIX State Plan
Third Quarter Amendment
Summary

SUMMARY
SPA #17-0028

This State Plan Amendment proposes to revise the sunset date for Preschool Supportive Health Services Program Certified Public Expenditure reimbursement methodology.

Appendix III
2017 Title XIX State Plan
Third Quarter Amendment
Authorizing Provisions

SPA 17-0028

Sections 368-D and 368-E of the Social Services Law:

§ 368-d. Reimbursement to 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.

1. The department of health shall review claims for expenditures made by or on behalf of local 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 which are furnished to children with handicapping conditions or such children suspected of having handicapping conditions, as such children are defined in the education law. If approved by the department, payment for such medical care, services and supplies which would otherwise qualify for reimbursement under this title and which are furnished in accordance with this title and the regulations of the department to such children, shall be made in accordance with the department's approved medical assistance fee schedules by payment to such local public school district, and state operated/state supported schools which operate pursuant to article eighty-five, eighty-seven or eighty-eight of the education law, which furnished the care, services or supplies either directly or by contract.

2. Claims for payment under this section shall be made in such form and manner, at such times, and for such periods as the department may require.

3. The provisions of this section shall be of no force and effect unless all necessary approvals under federal law and regulation have been obtained to receive federal financial participation in the costs of health care services provided pursuant to this section.

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.

(d) Upon selection of a contractor or contractors, the department of health shall provide written notification of such selection and a summary of the criteria employed in such selection to the chair of the senate finance committee and the chair of the assembly ways and means committee.

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, 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 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 one hundred fifty million dollars for the period April 1, 2011 through March 31, 2013, or exceeds one hundred million dollars in state fiscal years 2013-14 and 2014-15, the excess amount shall be transferred to such public school districts in amounts proportional to their percentage contribution to the statewide savings; an amount equal to thirteen and five hundredths percent of any decrease in the state share of annual expenditures pursuant to this section for such recipients in state fiscal year 2015-16 and any fiscal year thereafter shall be transferred to such public school districts in amounts proportional to their percentage contribution to the statewide savings. Any amount transferred pursuant to this section 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.

§ 368-e. Reimbursement to counties for pre-school children with handicapping conditions. 1. The department of health shall review claims for expenditures made by counties and the city of New York for medical care, services and supplies which are furnished to preschool children with handicapping conditions or such preschool children suspected of having handicapping conditions, as such children are defined in the education law. If approved by the department, payment for such medical care, services and supplies which would otherwise qualify for reimbursement under this title and which are furnished in accordance with this title and the regulations of the department to such children, shall be made in accordance with the department's approved medical assistance fee schedules by payment to such county or city which furnished the care, services or supplies either directly or by contract. Notwithstanding any provisions of law, rule or regulation to the contrary, any clinic or diagnostic and treatment center licensed under article twenty-eight of the public health law, which as determined by the state education department, in conjunction with the department of

health, has a less than arms length relationship with the provider approved under section forty-four hundred ten of the education law shall, subject to the approval of the department and based on standards developed by the department, be authorized to directly submit such claims for medical assistance, services or supplies so furnished for any period beginning on or after July first, nineteen hundred ninety-seven. The actual full cost of the individualized education program (IEP) related services incurred by the clinic shall be reported on the New York State Consolidated Fiscal Report in the education law section forty-four hundred ten program cost center in which the student is placed and the associated medical assistance revenue shall be reported in the same manner.

2. Claims for payment under this section shall be made in such form and manner, at such times, and for such periods as the department may require.

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.

(d) Upon selection of a contractor or contractors, the department of health shall provide written notification of such selection and a summary of the criteria employed in such selection to the chair of the senate finance committee and the chair of the assembly ways and means committee.

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, 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 one hundred fifty million dollars for the period April 1, 2011 through March 31, 2013, or exceeds one hundred million dollars in state fiscal years 2013-14 and 2014-15, the excess amount shall be transferred to such counties in amounts proportional to their percentage contribution to the statewide savings; an amount equal to thirteen and five hundredths percent of any decrease in the state share of annual expenditures pursuant to this section for such recipients in state fiscal year 2015-16 and any fiscal year thereafter shall be transferred to such counties in amounts proportional to their percentage contribution to the statewide savings. Any amount transferred pursuant to this section 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.

The provisions of this section shall be of no force and effect unless all necessary approvals under federal law and regulation have been obtained to receive federal financial participation in the costs of health care services provided pursuant to this section.

Appendix VI
2017 Title XIX State Plan
Third Quarter Amendment
Responses to Standard Access Questions

Appendix IV
2017 Title XIX State Plan
Third Quarter Amendment
Public Notice

exemption qualifications of 575.8(a)(4). Individual cultivar assessments are available upon request. Therefore, a person may legally possess, sell, import, purchase, transport, or introduce the following plant cultivars and no labeling requirements apply:

Prohibited Species

Common Name	Scientific Name	Cultivar Name	Trademark Name	Accession Number	Patent	Status
Japanese Barberry	Berberis thunbergii	'Aurea'				Conditionally Exempt
Japanese Barberry	Berberis thunbergii	'UCONNBTCP4N'	Crimson Cutie		PPAF	Conditionally Exempt
Japanese Barberry	Berberis thunbergii	'UCONNBTB113'	Lemon Cutie		PPAF	Conditionally Exempt
Japanese Barberry	Berberis thunbergii	'UCONNBTB048'	Lemon Glow		PPAF	Conditionally Exempt

Regulated Species

Common Name	Scientific Name	Cultivar Name	Trademark Name	Accession Number	Patent	Status
Chinese Silvergrass	Miscanthus sinensis	'NCMS1'	My Fair Maiden	H2008 093 004	PPAF	Conditionally Exempt
Chinese Silvergrass	Miscanthus sinensis	'Tift M77'	Scout		PPAF	Conditionally Exempt
Winter Creeper	Euonymus fortunei	'Kewensis'				Conditionally Exempt
Winter Creeper	Euonymus fortunei	'Vanilla Frost'				Conditionally Exempt

Conditionally Exempt – Cultivars exempt from Part 575 Prohibited and Regulated requirements, subject to periodic re-evaluation.

Questions should be directed to: Department of Environmental Conservation, Lands and Forests, Invasive Species Coordination Unit, Dave Adams at (518) 402-9425, or isinfo@dec.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 the Ambulatory Patient Group (APG) reimbursement methodology on and after July 1, 2017. The following changes are proposed:

The Ambulatory Patient Group (APG) reimbursement methodology is revised to include recalculated weight and component updates that will become effective on and after July 1, 2017.

The estimated annual net aggregate decrease in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2017/2018 is ($3.84) million.

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, Office of Health Insurance Programs, 99 Washington Ave., One Commerce Plaza, Suite 1432, Albany, NY 12210, (518) 408-6657, spa_inquiries@health.state.ny.us

PUBLIC NOTICE

Department of Health

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

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

Non-Institutional Services

Effective on or after July 1, 2017 in accordance with Sections 368-d and 368-e of the Social Services Law, the Department of Health proposes to a) increase interim encounter-based fee rates and b) to utilize certified public expenditures (CPEs) reimbursement methodology through June 30, 2020.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative for state fiscal year 2017/2018 is $250 million.

The public is invited to review and comment on this proposed State Plan Amendment, a copy 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 1432, Albany, NY 12210, 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:

Appendix V
2017 Title XIX State Plan
Third Quarter Amendment
Responses to Standard Funding Questions

NON-INSTITUTIONAL SERVICES
State Plan Amendment #17-0028

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 the state plan. 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 2 CFR 200 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 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. **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: 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: 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.