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

RE: SPA #17-0058
Non-Institutional Services

Dear Mr. Melendez:

The State requests approval of the enclosed amendment #17-0058 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: **17-0058**	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 $ 11,250** **b. FFY 10/01/17-09/30/18 $ 45,000**
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: **Attachment 3.1-A: Pages 2, 2(c); Attachment 3.1-B: Pages 2, 2(c); Attachment 3.1-L**	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: **Attachment 3.1-A: Pages 2, 2(c); Attachment 3.1-B: Pages 2, 2(c); Attachment 3.1-L**

10. SUBJECT OF AMENDMENT:
Women's Health Initiative
(FMAP = 90%)

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
2

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

4.a. Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.
☒ Provided: ☐ No limitations ☒ With limitations* ☐ Not provided

4.b. Early and periodic screening, diagnostic and treatment services for individuals under 21 years of age, and treatment of conditions found. (Limited to federal requirements under 1905(a) per section 1905(r) per PM 90-2.)

4.c.i. Family planning services and supplies for individuals of child-bearing age and for individuals eligible pursuant to Attachments 2.2-A and 2.2-B, if this eligibility option is elected by the State.
☒ Provided: ☒ No limitations ☐ With limitations* ☐ Not provided

4.c.ii. Family planning-related services provided under the above State Eligibility Option.
☒ Provided: ☒ No limitations ☐ With limitations*

4.c.iii. Fertility services for women ages 21 through 44
☒ Provided: ☐ No limitations ☒ With limitations*
*Limited to the provision of office visits, hysterosalpingogram services, pelvic ultrasounds, and blood testing for women in the process of ovulation enhancing drugs.

4.d.1. **Face-to-Face Counseling Services provided:**
☒ (i) By or under supervision of a physician;
☒ (ii) By any other health care professional who is legally authorized to furnish such services under State law and who is authorized to provide Medicaid coverable services other than tobacco cessation services; or
☐ (iii) Any other health care professional legally authorized to provide tobacco cessation services under State law *and* who is specifically *designated* by the Secretary in regulations. (none are designated at this time)

4.d.2. **Face-to-Face Tobacco Cessation Counseling Services for Pregnant Women**
☒ Provided: ☒ No limitations ☐ With limitations*
*Any benefit package that consists of less than four (4) counseling sessions per quit attempt, with a minimum of two (2) quit attempts per 12 month period should be explained below.
All Medicaid recipients, including pregnant women, receiving tobacco cessation counseling services can receive these services without any limitation as stated above.

Please describe any limitations: ☐

* Description provided on attachment.

New York
2(c)

6. Effective January 1, 2006, the Medicaid agency will not cover any Part D drug for full-benefit dual eligible individuals who are entitled to receive Medicare benefits under Part A or Part B.

7. The Medicaid agency provides coverage for the following excluded or otherwise restricted drugs or classes of drugs or their medical uses to all Medicaid recipients, including full benefit dual eligible beneficiaries under the Medicare Prescription Drug Benefit –Part D.

☒ **The following excluded drugs are covered:**

- ☐ (a) agents when used for anorexia, weight loss, weight gain
- ☒ (b) agents when used to promote fertility: Some – bromocriptine, clomiphene citrate, letrozole, and tamoxifen only.
- ☒ (c) agents when used for the symptomatic relief cough and colds: Some - benzonatate only
- ☒ (d) prescription vitamins and mineral products, except prenatal vitamins and fluoride: Some - select B Vitamins (niacin, pyridoxine, thiamine, cyanocobalamin); Folic Acid; Vitamin K; Vitamin D (ergocalciferol, cholecalciferol); Iron (including polysaccharide iron complex); Iodine
- ☒ (e) nonprescription drugs: Some - select allergy, asthma and sinus products; analgesics; cough and cold preparations; digestive products; insulin; feminine products; topical products, minerals and vitamin combinations
- ☐ (f) covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee

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

1. Inpatient hospital services other than those provided in an institution for mental diseases.
☑ Provided: ☐ No limitations ☑ With limitations*

2. a. Outpatient hospital services.
☑ Provided: ☐ No limitations ☑ With limitations*

b. Rural health clinic services and other ambulatory services furnished by a rural health clinic.
☑ Provided: ☐ No limitations ☑ With limitations* ☐ Not provided.

c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with section 4231 of the State Medicaid Manual (HCFA-Pub. 45-4).
☑ Provided: ☐ No limitations ☑ With limitations*

d. Ambulatory services offered by a health center receiving funds under section 329, 330, or 340 of the Public Health Service Acct to a pregnant woman or individual under 18 years of age.
☑ Provided: ☐ No limitations ☑ With limitations*

3. Other laboratory and x-ray services.
☑ Provided: ☐ No limitations ☑ With limitations*

4. a. Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.
☑ Provided: ☐ No limitations ☑ With limitations*

b. Early and periodic screening, diagnostic and treatment services for individuals under 21 years of age, and treatment of conditions found. (Limited to federal requirements under 1905(a) per section 1905(r) per PM 90-2.)
☑ Provided: ☐ No limitations ☑ With limitations* ☐ Not provided.

c.i. Family planning services and supplies for individuals of childbearing age and for individuals eligible pursuant to Attachments 2.2-A and 2.2-B, if this eligibility option is elected by the State.
☑ Provided: ☑ No limitations ☐ With limitations*

c.ii. Family planning-related services provided under the above State Eligibility Option.
☑ Provided: ☑ No limitations ☐ With limitations*

*Description provided on attachment.

c.iii. Fertility services for women ages 21 through 44
☒ Provided: ☐ No limitations ☒ With limitations*
*Limited to the provision of office visits, hysterosalpingogram services, pelvic ultrasounds, and blood testing for women in the process of ovulation enhancing drugs.

New York
2(c)

6. Effective January 1, 2006, the Medicaid agency will not cover any Part D drug for full-benefit dual eligible individuals who are entitled to receive Medicare benefits under Part A or Part B.

7. The Medicaid agency provides coverage for the following excluded or otherwise restricted drugs or classes of drugs or their medical uses to all Medicaid recipients, including full benefit dual eligible beneficiaries under the Medicare Prescription Drug Benefit–Part D.

☒ **The following excluded drugs are covered:**

- ☐ (a) agents when used for anorexia, weight loss, weight gain
- ☒ (b) agents when used to promote fertility: Some – bromocriptine, clomiphene citrate, letrozole, and tamoxifen only.
- ☒ (c) agents when used for the symptomatic relief cough and colds: Some - benzonatate only
- ☒ (d) prescription vitamins and mineral products, except prenatal vitamins and fluoride: Some - select B Vitamins (niacin, pyridoxine, thiamine, cyanocobalamin); Folic Acid; Vitamin K; Vitamin D (ergocalciferol, cholecalciferol); Iron (including polysaccharide iron complex); Iodine
- ☒ (e) nonprescription drugs: Some - select allergy, asthma and sinus products; analgesics; cough and cold preparations; digestive products; insulin; feminine products; topical products, minerals and vitamin combinations
- ☐ (f) covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee

Covered if included in the managed care contractor's benefit package or as a Medicaid FFS benefit. All orthodontia is covered as a Medicaid FFS benefit.

Remove

Other 1937 Benefit Provided:
Family Planning Services

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
No limitations

Duration Limit:
None

Scope Limit:
The offering, arranging and furnishing of those health services which enable enrollees, including minors who may be sexually active, to prevent or reduce the incidence of unwanted pregnancy. Fertility services are xxxxxxxxx limited to the provision of office visits, hysterosalpingogram services, pelvic ultrasounds, and blood testing for women in the process of ovulation enhancing drugs

Other:
Covered if included in the managed care contractor's benefit package or as a Medicaid FFS benefit.

Other 1937 Benefit Provided:
Prosthetic/Orthotic devices, Orthopedic footwear

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
No limitations

Duration Limit:
None

Scope Limit:
Prosthetic appliances or devices which replace all or part of the function of any missing part of the body. Orthotic appliances or devices used to support a weak or deformed body part or to restrict or eliminate motion in a body part.

Other:
Orthopedic footwear includes shoes and shoe modifications or additions used to correct, accommodate or prevent a physical deformity or range of motion malfunction.

Other 1937 Benefit Provided:
Personal Emergency Response Systems (PERS)

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Authorization:
Prior Authorization

Provider Qualifications:
Medicaid State Plan

Appendix II
2017 Title XIX State Plan
Third Quarter Amendment
Summary

SUMMARY
SPA #17-0058

This State Plan Amendment proposes to provide coverage of a set of services to ensure improved outcomes of women who are in the process of ovulation enhancing drugs, limited to the provision of such treatment, office visits, hysterosalpingogram services, pelvic ultrasounds, and blood testing; services shall be limited to those necessary to monitor such treatment.

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

Authorizing Provisions
SPA #17-0058

Paragraph (ee) of Subdivision 2 of Section 365-a of the Social Services Law:

(ee) Medical assistance shall include the coverage of a set of services to ensure improved outcomes of women who are in the process of ovulation enhancing drugs, limited to the provision of such treatment,office visits, hysterosalpingogram services, pelvic ultrasounds, and blood testing; services shall be limited to those necessary to monitor such treatment.

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

The Department of Health proposes to amend the Title XIX (Medicaid) State Plan for institutional services related to temporary rate adjustments to long term care 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 Temporary rate adjustments have been reviewed and approved for the CINERGY Collaborative, with aggregate payment amounts totaling up to $30,000,000 for the period July 1, 2017 through March 31, 2018.

The estimated net aggregate increase in Gross Medicaid Expenditures attributable to this initiative contained in the budget for State Fiscal Year 17/18 is as follows: Long Term Care $30,000,000.

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, 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 Chapter 550 of the laws of 2014. The following changes are proposed:

Non-Institutional Services

The amendments to public health law, insurance law and the social services law changed the definitions of telehealth modalities and practitioners entitled to receive reimbursement for provision of services via telehealth. These revisions are necessary to further align with amendments to the public health law, insurance law and social services law related to the delivery and reimbursement of health care services via telehealth. Medicaid has been covering services provided via telemedicine since 2011. These statutory amendments are intended to expand the reimbursement of health care services provided via telehealth and establish guidelines for the safe and effective delivery of such services. They will serve to eliminate barriers to care resulting from distance and practitioner shortage and will benefit NYS Medicaid enrollees by improving access to medical care and services.

The amendments will also serve to increase access to health care services by eliminating barriers to care faced by Medicaid recipients in rural communities and in areas where there is a shortage of health care practitioners. In addition, they will make it possible for telehealth providers at distant sites to collect/monitor health information and medical data from Medicaid recipients with chronic impairments and technology dependent care needs, who are located at originating sites. This amendment will be effective on or after July 1, 2017.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2017/2018 is $1.25 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, 99 Washington Ave., One Commerce Plaza, Suite 1460, 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:

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 July 1, 2017 in accordance with Section 365-a of the Social Services Law, Medical assistance shall include the coverage of a set of services to ensure improved outcomes of women who are in the process of ovulation enhancing drugs, limited to the provision of such treatment, office visits, hysterosalpingogram services, pelvic ultrasounds, and blood testing; services shall be limited to those necessary to monitor such treatment, contingent on ninety percent federal financial participation being approved for such services.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2017/2018 is $50 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 State
Division of Community Services
Notice of Public Written Comment Period

SUBJECT: Public comment period for the submission of written comments on the proposed New York State Community Services Block Grant (CSBG) Application and Plan for Federal Fiscal Years 2018 and 2019.

PURPOSE: To obtain written comments regarding New York State's proposed CSBG Application and Plan for Federal Fiscal Years 2018 and 2019.

Federal Community Services Block Grant (CSBG) funds are awarded to grantees in all counties of New York State. Community action agencies, community-based organizations, and Indian tribes or tribal organizations receive CSBG funds to provide advocacy, outreach, services and programs for economically disadvantaged persons in their local communities.

Pursuant to 42 U.S.C. § 9908, the Department of State Division of Community Services is accepting written comments on the proposed CSBG Plan for 2018 and 2019. The CSBG Plan delineates the manner in which funds will be expended and how the State will meet the federal CSBG program requirements.

Copies of the Department of State's proposed CSBG Plan may be obtained from the Department of State website at http://www.dos.ny.gov/dcs/documents.htm or by contacting:

Department of State
Division of Community Services
One Commerce Plaza
99 Washington Ave., Suite 1020
Albany, NY 12231-0001
(518) 474-5741

Persons wishing to submit written comments on the proposed CSBG Plan must submit such comments by mail to the above address or by email to dos.sm.DCS@dos.ny.gov. Written comments on the proposed CSBG Plan will be accepted until the close of business on July 28, 2017.

PUBLIC NOTICE

New York State and Local Retirement System

Pursuant to Retirement and Social Security Law, the New York State and Local Employees' Retirement System hereby gives public notice of the following:

The persons whose names and last known addresses are set forth below appear from records of the above named Retirement System to be entitled to accumulated contributions held by said retirement system whose membership terminated pursuant to Section 517-a of the Retirement and Social Security Law on or before May 31, 2017. This notice is published pursuant to Section 109 of the Retirement and Social Security Law of the State of New York. A list of the names contained in this notice is on file and open to public inspection at the office of the New York State and Local Retirement System located at the 110 State St, in the City of Albany, New York. At the expiration of six months from the date of the publication of this notice. The accumulated contributions of the persons so listed shall be deemed abandoned and shall be placed in the pension accumulation fund to be used for the purpose of said fund. Any accumulated contributions so deemed abandoned and transferred to the pension accumulation fund may be claimed by the persons who made such accumulated contributions or, in the event of his death, by his estate or such person as he shall have nominated to receive such accumulated contributions, by filing a claim with the State Comptroller in such form and in such a manner as may be prescribed by him, seeking the return of such abandoned contributions. In the event such claim is properly made the State Comptroller shall pay over to the person or persons or estate making the claim such amount of such accumulated contributions without interest.

Allen, Aaron J - Alfred Station, NY
Kruger, Lee E - Merrick, NY
Lynn, Edward J - Elkton, MD
Opie, Tina C - Binghamton, NY

PUBLIC NOTICE

New York State and Local Retirement System

Pursuant to Retirement and Social Security Law, the New York State and Local Employees' Retirement System hereby gives public notice of the following:

The persons whose names and last known addresses are set forth below appear from records of the above named Retirement System to be entitled to accumulated contributions held by said retirement system whose membership terminated pursuant to Section 613 of the Retirement and Social Security Law on or before May 31, 2017. This notice is published pursuant to Section 109 of the Retirement and Social Security Law of the State of New York. A list of the names contained in this notice is On file and open to public inspection at the office of the New York State and Local Retirement System located at the 110 State St., in the City of Albany, New York. At the expiration of six months from the date of the publication of this notice. The accumulated contributions of the persons so listed shall be deemed abandoned and shall be placed in the pension accumulation fund to be used for the purpose of said fund. Any accumulated contributions so deemed abandoned and transferred to the pension accumulation fund may be claimed by the persons who made such accumulated contributions or, in the event of his death, by his estate or such person as he shall have nominated to receive such accumulated contributions, by filing a claim with the State Comptroller in such form and in such a

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

NON-INSTITUTIONAL SERVICES
State Plan Amendment #17-0058

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 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 budget 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.

   There have been no new provider taxes and no existing taxes have 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 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: This SPA submission is to preserve our effective date, in the event the State is able to correct the delineated deficiencies and receive CMS approval of said UPL. If the State is unable to meet this expectation, this SPA will be withdrawn.

5. **Does any governmental provider receive payments that in the aggregate (normal per diem, supplemental, enhanced, other) exceed their reasonable costs of providing services? If payments exceed the cost of services, do you recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report?**

   Response: The rate methodology included in the State Plan for freestanding diagnostic and treatment and ambulatory surgery center services is based upon the Ambulatory Patient Group (APG) system with the exception of Federally Qualified Health Centers who have the option to opt into the APG system or remain on the Prospective Payment Methodology (PPS) as approved by CMS in SPA 01-03. We are unaware of any requirement under current federal law or regulation that limits individual providers' payments to their actual costs.

   The rate methodologies included in the State Plan for outpatient hospital services are either cost-based subject to ceilings or based upon the Ambulatory Patient Group (APG) system. We are unaware of any requirement under current federal law or regulation that limits individual provider's 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.