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

September 30, 2019

Ms. Nicole McKnight
Acting 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 #19-0049
Non-Institutional Services

Dear Ms. McKnight:

The State requests approval of the enclosed amendment #19-0049 to the Title XIX (Medicaid) State Plan for non-institutional services to be effective July 1, 2019 (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.

A copy of pertinent sections of enacted legislation is 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 19, 2019 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 Regina Deyette, Medicaid State Plan Coordinator, Division of Finance and Rate Setting, Office of Health Insurance Programs at (518) 473-3658.

Sincerely,

[redacted]

Donna Frescatore
Medicaid Director
Office of Health Insurance Programs

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

# TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

**FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES**

1. TRANSMITTAL NUMBER: 19 — 0049

2. STATE: New York

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)
TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2019

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
a. FFY 07/1/19-9/30/19 $ 240.75
b. FFY 10/1/19-9/30/20 $ 963.00

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment: 4.19-B Pages: 1(e)(2), 1(e)(2.1), 1(i)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment: 4.19-B Pages: 1(e)(2), 1(e)(2.1), 1(i)

10. SUBJECT OF AMENDMENT
JULY 2019 APG UPDATES - HOSPITAL OUTPATIENT
(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
[redacted]

13. TYPED NAME
Donna Frescatore

14. TITLE
Medicaid Director, Department of Health

15. DATE SUBMITTED
September 30, 2019

16. RETURN TO
New York State Department of Health
Division of Finance and Rate Setting
99 Washington Ave – One Commerce Plaza
Suite 1432
Albany, NY 12210

**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED

18. DATE APPROVED

**PLAN APPROVED - ONE COPY ATTACHED**

19. EFFECTIVE DATE OF APPROVED MATERIAL

20. SIGNATURE OF REGIONAL OFFICIAL

21. TYPED NAME

22. TITLE

23. REMARKS

**Appendix I**
**2019 Title XIX State Plan**
**Third Quarter Amendment**
**Amended SPA Pages**

**New York**
**1(e)(2)**

## APG Reimbursement Methodology – Hospital Outpatient

The following links direct users to the various definitions and factors that comprise the APG reimbursement methodology, which can also be found in aggregate on the APG website at http://www.health.ny.gov/health_care/medicaid/rates/apg/index.htm. In addition, prior period information associated with these links is available upon request to the Department of Health.

**Contact Information:**
http://www.health.ny.gov/health_care/medicaid/rates/apg/index.htm Click on "Contacts."

**3M APG Crosswalk, version 3.14; updated as of [01/01/19 and 04/01/19] 07/01/19 and 10/01/19:**
http://www.health.ny.gov/health_care/medicaid/rates/crosswalk/index.htm
http://dashboard.emedny.org/CrossWalk/html/cwAgreement.html Click on "Accept" at bottom of page to gain access.

**APG Alternative Payment Fee Schedule; updated as of 01/01/11:**
http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm Click on "Alternative Payment Fee Schedule."

**APG Consolidation Logic; logic is from the version of 4/01/08, updated as of 01/01/19:**
http://www.health.ny.gov/health_care/medicaid/rates/bundling/ Click on "2019"

**APG 3M Definitions Manual Versions; updated as of [01/01/19 and 04/01/18] 07/01/19 and 10/01/19:**
http://www.health.ny.gov/health_care/medicaid/rates/crosswalk/index.htm

**APG Investments by Rate Period; updated as of 01/01/11:**
http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm Click on "Investments by Rate Period."

**APG Relative Weights; updated as of [01/01/19] 07/01/19:**
http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm Click on "Weights, Proc Weights, and APG Fee Schedule Amounts" file.

**Associated Ancillaries; updated as of 07/01/15:**
http://www.health.ny.gov/health_care/medicaid/rates/apg/index.htm Click on "Ancillary Policy."

**New York**
**1(e)(2.1)**

**Carve-outs; updated as of 10/01/12:**
http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm Click on "Carve Outs."

**Coding Improvement Factors (CIF); updated as of 07/01/12:**
http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm Click on "CIFs by Rate Period."

**If Stand Alone, Do Not Pay APGs; updated as of 01/01/15:**
http://www.health.state.ny.us/health_care/medicaid/rates/methodology/index.htm Click on "If Stand Alone, Do Not Pay APGs."

**If Stand Alone, Do Not Pay Procedures; updated as of 01/01/19:**
http://www.health.state.ny.us/health_care/medicaid/rates/methodology/index.htm Click on "If Stand Alone, Do Not Pay Procedures."

**Modifiers; updated as of 07/01/18:**
http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm Click on "Modifiers."

**Never Pay APGs; updated as of 01/01/19:**
http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm Click on "Never Pay APGs."

**Never Pay Procedures; updated as of [07/01/18] 07/01/19:**
http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm Click on "Never Pay Procedures."

**No-Blend APGs; updated as of 04/01/10:**
http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm Click on "No Blend APGs."

**No-Blend Procedures; updated as of 01/01/11:**
http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm Click on "No Blend Procedures."

**New York**
**1(i)**

## Reimbursement Methodology – Hospital Outpatient

I. The criteria for using a procedure-based weight or the relative weight in the methodology is as follows: If a procedure-based weight is available for a particular procedure code, then the procedure-based weight is used. If a procedure-based weight is not available for a particular procedure code, then the relative weight (i.e., "APG weight") is used.

II. The initial calculation of the APG relative weights were developed using line level charges from 2005 New York Medicaid claims converted to cost using the ratio of cost to charges methodology. The line level costs were brought up to the APG level to determine the average cost of each APG.

a. The APG relative weights will be updated no less frequently than every [seven] eight years. These APG and weights are set as of December 1, 2008, and are effective for specified services on and after that date. A link to the list of APGs and their relative weights is available in the APG Reimbursement Methodology – Reimbursement Components section.

b. The APG relative weights will be reweighted prospectively. The initial reweighting will be based on Medicaid claims data from the December 1, 2008 through September 30, 2009 period. Subsequent reweighting's will be based on Medicaid claims data from the most recent twelve-month period and will be based on complete and accurate line level procedure and charge data and ratio of cost to charge data.

c. The Department will correct material errors of any given APG relative weight. Such corrections will make use of benchmarking data consisting of payment information from other payers (including Medicare) reimbursing comparable services. Corrections to material errors in individual APG relative weights will be made on a prospective basis.

III. Case mix index is an expression of the average paid APG weight for a given peer group after consolidation, packaging, and discounting. Case mix indices will be calculated by running applicable claims data through the latest version of the APG software to determine the average final APG weight of the visits. Outlier claims or claim lines may be excluded from this calculation to assure overall accuracy of the final case mix. The initial calculation of case mix indices for periods prior to January 1, 2010, will be based on Medicaid data from the December 1, 2008, through April 30, 2009 period. The January 1, 2010, calculation of case-mix indices will be based on Medicaid data for the period December 1, 2008, through September 30, 2009. Subsequent calculations will be based on Medicaid claims data from the most recent twelve-month period.

# Appendix II
# 2019 Title XIX State Plan
# Third Quarter Amendment
# Summary

**SUMMARY**
**SPA #19-0049**

This State Plan Amendment proposes to revise the Ambulatory Patient Group (APG) methodology for hospital-based clinic and ambulatory surgery services, including emergency room services, to reflect the recalculated weights with component updates to become effective July 1, 2019. The reweighting requirement using updated Medicaid claims data is being revised from no less frequently than every seven years to no less frequently than every eight years.

**Appendix III**
**2019 Title XIX State Plan**
**Third Quarter Amendment**
**Authorizing Provisions**

19-0049

PHL §2807(2-a)(e):

(e) (i) notwithstanding any inconsistent provisions of this subdivision, the commissioner shall promulgate regulations establishing, subject to the approval of the state director of the budget, methodologies for determining rates of payment for the services described in this subdivision. Such regulations shall reflect utilization of the ambulatory patient group (APG) methodology, in which patients are grouped based on their diagnosis, the intensity of the services provided and the medical procedures performed, and with each APG assigned a weight reflecting the projected utilization of resources. Such regulations shall provide for the development of one or more base rates and the multiplication of such base rates by the assigned weight for each APG to establish the appropriate payment level for each such APG. Such regulations may also utilize bundling, packaging and discounting mechanisms.

If the commissioner determines that the use of the APG methodology is not, or is not yet, appropriate or practical for specified services, the commissioner may utilize existing payment methodologies for such services or may promulgate regulations, and may promulgate emergency regulations, establishing alternative payment methodologies for such services.

(ii) Notwithstanding this subdivision and any other contrary provision of law, the commissioner may incorporate within the payment methodology described in subparagraph (i) of this paragraph payment for services provided by facilities pursuant to licensure under the mental hygiene law, provided, however, that such APG payment methodology may be phased into effect in accordance with a schedule or schedules as jointly determined by the commissioner, the commissioner of mental health, the commissioner of alcoholism and substance abuse services, and the commissioner of mental retardation and developmental disabilities.

(iii) Regulations issued pursuant to this paragraph may incorporate quality related measures limiting or excluding reimbursement related to potentially preventable conditions and complications; provided however, such quality related measures shall not include any preventable conditions and complications not identified for Medicare nonpayment or limited payment.

**Appendix IV**
**2019 Title XIX State Plan**
**Third Quarter Amendment**
**Public Notice**

# MISCELLANEOUS NOTICES/HEARINGS

## Notice of Abandoned Property Received by the State Comptroller

Pursuant to provisions of the Abandoned Property Law and related laws, the Office of the State Comptroller receives unclaimed monies and other property deemed abandoned. A list of the names and last known addresses of the entitled owners of this abandoned property is maintained by the office in accordance with Section 1401 of the Abandoned Property Law. Interested parties may inquire if they appear on the Abandoned Property Listing by contacting the Office of Unclaimed Funds, Monday through Friday from 8:00 a.m. to 4:30 p.m., at:

1-800-221-9311
or visit our web site at:
www.osc.state.ny.us

Claims for abandoned property must be filed with the New York State Comptroller's Office of Unclaimed Funds as provided in Section 1406 of the Abandoned Property Law. For further information contact: Office of the State Comptroller, Office of Unclaimed Funds, 110 State St., Albany, NY 12236.

## PUBLIC NOTICE

### Department of Agriculture and Markets

Pursuant to Agriculture and Markets Law § 284-a, Notice is hereby given that the Department of Agriculture and Markets has designated the "Southern Tier Craft Beverage Trail" to be described as:

"Beginning at the intersection of NY 369 and the Exit 3 WB off-ramp from NY 7 in the town of Port Crane and continuing north on NY 369 for 5.8 miles, continuing west on NY 79 for 2.6 miles to the intersection with NY 12, continuing north on NY 12 for 1.9 miles to the intersection with County Route 1 (Cloverdale Rd.), continuing northwest on County Route 1 for 1.3 miles, continuing northwest on County Route 140 (Cloverdale Rd.) for 3.1 miles to the intersection with County Route 133 (South St.), continuing south on County Route 133 for 0.3 miles to the intersection with NY 79, continuing west on NY 79 for 18.4 miles through the village of Whitney Point to the intersection with NY 38 in the hamlet of Richford, continuing south on NY 38 for 17.9 miles to the intersection with NY 96, continuing south on NY 96 for 2.2 miles to the intersection with NY 434 in the village of Owego, continuing east on NY 434 for 7.3 miles to the intersection with NY 962J in the hamlet of Apalachin, continuing north on NY 962J for 0.4 miles to the intersection with NY 17C, continuing east on NY 17C for 13.2 miles through the village of Endicott, hamlet of Endwell, and village of Johnson City to the intersection with US 11 (Court St.) in the city of Binghamton, continuing south on US 11 for 0.2 miles to end at the junction with Washington St."

*For further information, please contact*: Anne St. Cyr, Agricultural Development, Department of Agriculture and Markets, 10B Airline Dr., Albany, NY 12235, (518) 485-9974, (518) 457-2716 (Fax)

## 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. The following changes are proposed:

Non-Institutional

Effective on or after July 1, 2019, the Ambulatory Patient Group (APG) reimbursement methodology is revised to include recalculated weight and component updates.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2019/2020 is $1.9 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, Bureau of Federal Relations & Provider Assessments, 99 Washington Ave., One Commerce Plaza, Suite 1430, Albany, NY 12210, (518) 474-1673, (518) 473-8825 (FAX), spa_inquiries@health.state.ny.us

## PUBLIC NOTICE

### Department of Health

Pursuant to 42 CFR Section 447.205, the Office of Mental Health (OMH), Office of Alcoholism and Substance Abuse Services (OASAS), and the Department of Health (DOH) hereby gives public notice of the following:

OMH, OASAS, and DOH 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, 2019, existing providers participating in the Certified Community Behavioral Health Clinic (CCBHC) demonstration will continue delivering and being reimbursed for comprehensive behavioral health services beyond the Federal demonstration period.

CCBHCs provide a comprehensive range of ambulatory mental health and substance use disorder services to individuals throughout New York State, including:

- Crisis mental health services including 24-hour mobile crisis teams, emergency crisis intervention and crisis stabilization
- Outpatient mental health and substance use services with ancillary withdrawal
- Screening, assessment and diagnosis including risk management
- Primary care screening and monitoring
- Case management
- Psychiatric rehabilitation services
- Peer support, counseling services, and family support services
- Services for members of the armed services and veterans

This amendment will allow New York State to maintain the CCBHC program model by ensuring all services in the program model are covered benefits in the State Plan. To facilitate this, the State proposes to amend the Title XIX State Plan to allow for coverage of outpatient rehabilitative mental health services delivered to individuals in a site-based clinic, home or community setting as appropriate to their individual needs.

This Amendment will also seek approval of a reimbursement methodology that allows the CCBHC providers to utilize a Prospective Payment System (PPS), which is a provider specific cost-based service rate developed in accordance with Federal standards contained in the Protecting Access to Medicare Act of 2014 (H.R. 4302) for reimbursement for a range of identified state plan services. The Office of Mental Health and the Office of Alcoholism and Substance Abuse Services will submit a 1915(b)(4) Waiver simultaneous with the state plan submission to allow for Selective Contracting with the existing 13 CCBHCs.

CCBHC providers are listed below by region:

Central New York: Helio Health (Syracuse Brick House, Inc.) – Onondaga County

Finger Lakes: University of Rochester, Strong Memorial Hospital – Monroe County

Long Island: Central Nassau Guidance & Counseling Services – Nassau County

Mid-Hudson: Achieve (Bikur Cholim Inc.) – Rockland County

North Country: Citizens Advocates Inc, North Star Behavioral

Health Services – Franklin County

NYC: New Horizon Counseling Center – Queens County

Samaritan Daytop Village – Bronx County

Services for the UnderServed, Inc (S:US) – Kings County

Promesa – Bronx County

VIP Community Services – Bronx County

Western New York:

Best Self (Lake Shore Behavioral Health, Inc.) – Erie County

Spectrum Human Services – Erie County

Endeavor (Mid-Erie Mental Health Services, Inc.) – Erie County

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

The public is invited to review and comment on this proposed State Plan Amendment, 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. Individuals without Internet access may view the State Plan Amendments at any local (county) social services district.

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

New York County

250 Church Street
New York, New York 10018

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

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

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

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

*For further information and to review and comment, please contact*: Department of Health, Bureau of Federal Relations & Provider Assessments, 99 Washington Ave., One Commerce Plaza, Suite 1432, Albany, NY 12210, (518) 474-1673, (518) 473-8825 (FAX), spa_inquiries@health.state.ny.us

## PUBLIC NOTICE

### Department of Health

The New York State Department of Health (DOH) is submitting requests to the Federal Centers for Medicare and Medicaid Services (CMS) to amend the 1915(c) Children's Waiver (#NY.4125.R05.03) Home and Community Based Services (HCBS) coverage as follows:

Effective July 1, 2019

- All Children's 1915(c) waiver participants will be required to receive at least one HCBS service per month.
- Family Peer Support Services will be removed from the waiver. The service is available as a State Plan service SPA-19-003, which has already been approved by CMS effective July 1, 2019.
- Language in performance measures will be modified to clarify that Care Managers will meet regularly with waiver participants in a manner and frequency that is consistent with the participant's Health Home acuity level.

Effective October 1, 2019

Language will be incorporated to reference the Medicaid Managed Care delivery system throughout the application and concurrent operation with the 1115 waiver amendment already submitted to CMS and expected to be approved no later than July 1, 2019.

Effective January 1, 2020

- Youth Peer Supports and Crisis Intervention will be removed from the Children's waiver and be made available as a State Plan service.

*For further information and to review and comment, please contact*: Department of Health, Office of Health Insurance Programs, 99 Washington Ave., One Commerce Plaza, Suite 720, Albany, NY 12210, BH.Transition@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 State Fiscal Year 2019/20 Budget statutory provisions included in Public Health Law § 2826.

Non-Institutional Services:

Effective on and after July 1, 2019, this notice provides for a temporary rate adjustment with an aggregate payment totaling no less than $7.5 million annually for Critical Access Hospitals (CAHs), for

# Appendix V
# 2019 Title XIX State Plan
# Third Quarter Amendment
# Responses to Standard Funding Questions

**NON-INSTITUTIONAL SERVICES**
**State Plan Amendment #19-0049**

## 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 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:** The State submitted the 2019 Hospital OP UPL demonstration on April 17, 2019, and will await feedback based on CMS review.

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 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:** The 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 17-0065, 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.