NEW YORK STATE OF OPPORTUNITY. Department of Health

ANDREW M. CUOMO
Governor

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

LISA J. PINO, M.A., J.D.
Executive Deputy Commissioner

June 29, 2021

Todd McMillion
Director
Department of Health and Human Services
Centers for Medicare and Medicaid Services
233 North Michigan Ave, Suite 600
Chicago, IL 60601

RE: SPA #21-0024
Non-Institutional Services

Dear Mr. McMillion:

The State requests approval of the enclosed amendment #21-0024 to the Title XIX (Medicaid) State Plan for non-institutional services to be effective April 1, 2021 (Appendix I). This amendment is being submitted based on proposed State regulations. A summary of the plan amendment is provided in Appendix II.

The State of New York reimburses these services through the use of rates that are consistent with and promote efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area as required by §1902(a)(30) of the Social Security Act and 42 CFR §447.204.

A copy of pertinent sections of proposed State regulations 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 March 31, 2021, 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: 21 — 0024

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
April 1, 2021

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 04/01/21-09/30/21 $ 0.00
b. FFY 10/01/21-09/30/22 $ 0.00

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

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*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

10. SUBJECT OF AMENDMENT
Clinic Safety Net Distribution Methodology Change for Non-FQHC's (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
June 29, 2021

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

Instructions on Back

Appendix I
2021 Title XIX State Plan
Second Quarter Amendment
Amended SPA Pages

New York
2(an)

Diagnostic and Treatment Centers (D&TCs) Safety Net Payment

1. For the period December 1, 2018, through March 31, 2019, and for annual state fiscal years thereafter, up to $17,350,000 of additional payments will be made to eligible Medicaid safety net diagnostic and treatment centers (D&TCs), except for Federally Qualified Health Centers (FQHCs), to sustain access to services. The amount of $17,350,000 is subject to modification by the transfers described in paragraphs (2) and (3) of this section.

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

   b. The base year data used for the period commencing on December 1, 2018 through March 31, 2019 will be the 2016 certified cost report and will be advanced one year thereafter for each subsequent period. In order to be included in the distribution calculation, a provider must timely submit a certified cost report for the base year used in the distribution calculation.

   c. New providers which do not have a full year cost or visit experience in the base year used for the distribution may qualify to be included in the distribution as follows:

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

      ii. The provider must be eligible to receive a Medicaid rate.

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

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

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

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

New York
2(an)(1)

Diagnostic and Treatment Centers (D&TCs) Safety Net Payment (continued):

d.[Each]All eligible D&TC's will [qualify for a rate add-on based on its percentage of uninsured visits to total visits according to the following tiers:]receive the same add-on which will be calculated by dividing the total D&TC Safety Net Payment available, as stated in paragraph 1 of this section, by the sum of the total number of uninsured visits and Medicaid fee-for-service visits for all eligible D&TCs reported on the base year certified cost report.

[

% of eligible uninsured visits to total visits							
Upstate				**Downstate**			
Low (at Least)	High (Less Than)	Amount	Tier	Low (at Least)	High (Less Than)	Amount	Tier
0%	5%	$0	0	0%	5%	$0	0
5%	10%	$30	1	5%	15%	$47	1
10%	15%	$40	2	15%	20%	$57	2
15%	20%	$51	3	20%	25%	$68	3
20%	25%	$63	4	25%	35%	$80	4
25% or more		$76	5	35% or more		$93	5]

]

e. Each eligible D&TC's [S]safety net payment[s] will be calculated by multiplying [each facility's]the rate add-on, calculated based on subparagraph (1)(d) of this section[, based on the tiers in paragraph (1)(d), by the number of] by the sum of each D&TC's uninsured visits and Medicaid fee-for-service visits reported on the base year certified cost report.

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

[g] f. Adjustments to rates of payment made pursuant to this section will be made quarterly as aggregate payments to eligible diagnostic and treatment centers and will not be subject to subsequent adjustment or reconciliation.

2. In the event that a provider that is included in this D&TCs Safety Net Payment section receives FQHC designation during a state fiscal year, the newly designated FQHC provider will be removed from this D&TCs Safety Net Payment section and included in section for the FQHCs Safety Net Payment as follows:

a. The effective date of the transfer will be the later of the following:

i. The first state fiscal year distribution calculation after the FQHC designated approval date; or

ii. The first state fiscal year distribution calculation after the date the Department of Health is notified of the FQHC designation.

b. The funds that were allocated to the new FQHC provider in this D&TCs Safety Net Payment section will be transferred to the FQHC Safety Net Payment section based on the prior state fiscal year calculation.

Appendix II
2021 Title XIX State Plan
Second Quarter Amendment
Summary

SUMMARY
SPA #21-0024

This State Plan Amendment proposes to revise the method of distributing the Clinic Safety Net (CSN) payments for non-FQHCs.

Appendix III
2021 Title XIX State Plan
Second Quarter Amendment
Authorizing Provisions

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

86-4.33 Clinic Safety Net Payments.

(a) Safety net distribution payments shall be made available annually on a state fiscal year basis to eligible Medicaid safety net clinics to sustain access to services.

(b) To be eligible to participate in the safety net distribution calculation, the clinic must meet the following requirements:

(1) The clinic must be a voluntary non-profit or publicly sponsored mental health clinic licensed under Article 31 of the Mental Hygiene Law, or;

(2) The clinic must be a voluntary non-profit or publicly sponsored clinic licensed under Article 28 of the Public Health Law as a Diagnostic and Treatment Center (D&TC) where comprehensive services is their principal mission and the clinic delivers a comprehensive range of health care services to the general population.

(c) Funds allocated for such distribution shall be divided into the following two groups:

(1) Diagnostic and Treatment Centers that have current Federally Qualified Health Center or Rural Health Center status from the Health Resources and Services Administration (hereinafter referred to as FQHC clinics). FQHC clinics shall receive $92,650,000, subject to federal financial participation, or $46,325,000 state share only, distributed based on the methodology described in subdivisions (i) and (k) of this section.

(2) Diagnostic and Treatment Centers that do not have current Federally Qualified Health Center or Rural Health Center status from the Health Resources and Services Administration (hereinafter referred to as non-FQHC clinics). Non-FQHC clinics shall receive $17,350,000, subject to federal financial participation, or $8,675,000 state share only, distributed based on the methodology described in subdivisions (j) and (k) of this section.

(d) The total distribution for FQHC and non-FQHC clinics shall not exceed $110,000,000, subject to federal financial participation, or $55,000,000 state share only. The FQHC and non-FQHC total distributions, as stated in subdivision (c) of this section, may be adjusted each distribution year by the transfers described in subdivision (i).

(e) For an eligible clinic to qualify for a payment from the FQHC clinic distribution, the clinic must:

(1) provide at least 5% of their total annual clinic visits to uninsured individuals;

(2) have a process in place to collect payment from third party payers;

(3) have received Federally Qualified Health Center or Rural Health Center status from the Health Resources & Services Administration (HRSA).

(f) For an eligible clinic to qualify for a payment from the non-FQHC clinic distribution, the clinic must:

(1) provide at least 3% of their total annual clinic visits to uninsured individuals;

(2) have a process in place to collect payment from third party payers;

(g) Payments made pursuant to this section shall be made as aggregate payments versus an add-on to the clinic Medicaid rate and will not be subject to adjustment or reconciliation.

(h) The base year data used for determining the FQHC and non-FQHC distributions shall be the certified cost report from the 2 years prior to the beginning of the distribution period. The Ambulatory Health Care Facility (AHCF) certified cost report shall be utilized for Article 28 clinics using the Article 28 reported comprehensive data only. The Consolidated Fiscal Report (CFR) certified cost report shall be utilized for Article 31 clinics. Clinics that have both an Article 28 and Article 31 certification, the data shall be treated separately for purposes of determining the qualifications and distribution to the clinic. To be included in the safety net distribution calculation, a clinic must timely submit a certified cost report for the base year to be used in the distribution calculation.

(i) FQHC clinics shall receive distributions based on the following method:

(1) The rate add-on (Tiers Table "Add-on Amt") applied in the development of the distribution payment for each eligible FQHC clinic shall be based on the clinic's percentage of uninsured visits to their total visits using the Tiers Table "low/high" scale:

Tiers Table

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

(2) Distributions shall be calculated by first multiplying each facility's rate add-on, based on the Tiers Table, by the sum the facility's Medicaid fee-for-service and Medicaid Managed Care visits reported in the certified cost report. Any visits in which Medicaid is not the only payer shall not be included in the Medicaid visit count.

(3) The distribution for each eligible FQHC clinic shall then be determined by multiplying the result of the calculation above by the ratio of the total funds allocated for distribution based on the tiers to the total distribution available for all eligible FQHC clinics.

(4) If a non-FQHC clinic receives FQHC designation prior to the beginning of a state fiscal year distribution calculation, the clinic will be removed from the non-FQHC distribution and included in the FQHC clinic distribution in in accordance with this paragraph.

(i) The amount of funds allocated to the clinic based on the prior state fiscal year distribution will be transferred to the FQHC clinic distribution.

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

(iii) The total value of the distribution for the FQHC clinic distribution shall be increased and the non-FQHC clinic distribution decreased in the amount of the transferred distribution.

(5) If an FQHC clinics loses its FQHC designation, the clinic shall be removed from the FQHC distribution and included in the non-FQHC distribution in accordance with this paragraph.

(i) The portion of the distribution pertaining to the Medicaid managed care visits shall no longer be paid to the clinic as of the date the FQHC clinic loses its designation. The clinic shall continue to receive a distribution based on the Medicaid fee-for-service visits.

(ii) The amount of the distribution reduction shall be calculated based on the number of days remaining in the distribution period from the date the FQHC clinic loses its designation.

(iii) The Department shall retain the portion of the distribution not paid pursuant to subparagraphs (i) and (ii) of this paragraph until the fourth quarterly aggregate payment. In the event that the clinic regains its FQHC designation during the same state fiscal year and notifies the Department prior to the payment of the fourth quarterly aggregate payment, the clinic shall receive the Medicaid managed care portion of its distribution calculated based only on the time period after which it regained its FQHC designation.

(iv) If the clinic does not regain its FQHC designation during the same state fiscal year, the portion of the distribution retained shall be redistributed to the other eligible FQHC clinics based on the proportion of their distribution to the total distribution which shall be included in the fourth quarterly aggregate payment and,

(A) The clinic shall be removed from the FQHC clinic distribution and included in the non-FQHC clinic distribution in the first state fiscal year distribution period after the FQHC designation was lost. At that time, the funds allocated to the clinic shall be transferred to the non-FQHC total distribution based on the portion of the distribution pertaining to the Medicaid fee-for-service visits.

(B) The total FQHC clinic distribution shall be decreased and the total non-FQHC distribution increased in the amount of the transferred distribution.

(j) Non-FQHC clinics shall receive distributions based on the following method:

(1) All eligible non-FQHCs will receive the same rate add-on applied in the development of the distribution. This add-on will be calculated by dividing the total distribution available for non-FQHC clinics by the sum of the total number of uninsured visits and Medicaid fee-for-service visits reported on the certified cost report for all eligible non-FQHCs.

(2) Each non-FQHC's distribution shall be calculated by multiplying the rate add-on, as determined above, by the sum of the facility's total number of uninsured visits and Medicaid fee-for-service visits reported in the certified cost report. Any visits in which Medicaid is not the only payer shall not be included in the Medicaid visit count.

(k) New clinic providers, which shall not include extension sites of clinics already eligible for distributions, that do not have a full year cost experience in the base year used may qualify to receive a distribution pursuant to this subdivision.

(1) A new clinic must meet the following criteria:

(i) The clinic must be a Medicaid Safety Net clinic, as defined in this section;

(ii) The clinic must be enrolled to receive Medicaid reimbursement in New York State and eligible to receive a clinic Medicaid reimbursement rate;

(iii) The clinic must submit a request to the Department to participate in the distribution. This request must include cost report comparable data for annualized patient visits, by payer source, which are certified by the Chief Executive Officer or a similar executive position.

(2) Distributions to new clinics, approved by the Department to participate, shall be calculated according to the methodology established in this section based on the clinic distribution in which they qualify provided that the distribution shall not exceed $100,000.

(3) In the following distribution periods for which there is a full year cost experience, such clinics shall begin receiving distributions according to the qualifying requirements and methodology established in this section.

(4) The distribution for a new clinic will be included in the total distribution amount and shall not increase the total distributions pursuant to subdivisions (c) and (d) of this section.

Appendix IV
2021 Title XIX State Plan
Second Quarter Amendment
Public Notice

greater than zero trend factors, pursuant to the provisions of Public Health Law § 2807-c(10)(c), will be applied to rates of payment for hospital inpatient and outpatient services, inpatient and adult day health care outpatient services provided by residential health care facilities pursuant to Article 28 of the Public Health Law (except for residential health care facilities or units of such facilities providing services primarily to children under 21 year of age), for certified home health agencies, long term home health care programs, AIDS home care programs, and for personal care services pursuant to section 365-a of the Social Services Law, including personal care services provided in those local social services districts, including New York City, whose rates of payment for services is established by such social services districts pursuant to a rate-setting exemption granted by the Department, and assisted living program services.

There is no additional estimated annual change to gross Medicaid expenditures as a result of this proposed amendment.

Non-Institutional Services

Effective on or after April 1, 2021, this proposal continues the supplemental upper payment limit payments made to general hospitals, other than major public general hospitals under non-institutional services of $339 million annually. There is no change to the annual gross Medicaid expenditures as a result of this proposed amendment.

For state fiscal year beginning April 1, 2021 through March 31, 2022, this proposal continues hospital outpatient payment adjustments that increase the operating cost components of rates of payment for hospital outpatient and emergency departments on and after April 1, 2011, for public general hospitals other than those operated by the State of New York or the State University of New York, which are located in a city with a population of over one million. The amount to be paid will be up to $287 million annually based on criteria and methodology set by the Commissioner of Health, which the Commissioner may periodically set through a memorandum of understanding with the New York City Health and Hospitals Corporation. Such adjustments shall be paid by means of one or more estimated payments. Payments may be added to rates of payment or made as aggregate payments.

There is no change to the annual gross Medicaid expenditures as a result of this proposed amendment.

For state fiscal year beginning April 1, 2021 through March 31, 2022, this proposal continues payment of up to $5.4 million in additional annual Medicaid payments to county operated free-standing clinics, not including facilities operated by the New York City Health and Hospitals Corporation, for services provided by such DTC and those provided by a county operated freestanding mental health or substance abuse DTC. Distributions shall be based on each eligible facility's proportionate share of the sum of all DTC and clinic visits for all eligible facilities receiving payments for the base year two years prior to the rate year. The proportionate share payments may be added to rates of payment or made as aggregate payments to eligible facilities.

There is no change to the annual gross Medicaid expenditures as a result of this proposed amendment.

Effective on or after April 1, 2021, this amendment proposes to revise the State Plan to reduce the Worker Recruitment and Retention add-on percentage by an additional 25 percent as compared to 2020/2021, for Certified Home Health Agencies (CHHA) and Hospice programs.

The estimated annual net aggregate decrease in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2021/2022 is ($1.5 million).

Effective on or after April 1, 2021 the Department will reduce coverage of certain over the counter (OTC) products. Clinically critical products such as aspirin and vitamins and minerals used for deficiencies will continue to be covered, as will less expensive OTC products that are in Preferred Drug Program (PDP) drug classes. The estimated annual net aggregate decrease in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2021/2022 is ($17.4 million).

Effective on and after April 1, 2021, this notice provides for a temporary rate adjustment with an aggregate payment amounts totaling no less than $10,001,000 annually, for Essential Community Providers (ECPs) for the periods April 1, 2021 through March 31, 2022 and April 1, 2022 through March 31, 2023. These payments will be made to the following approved providers: A.O Fox Memorial Hospital, Adirondack Medical Center, Alice Hyde Hospital Association, Auburn Memorial Hospital, Bassett Hospital of Schoharie County-Cobleskill Regional, Brooks Memorial Hospital, Canton-Potsdam Hospital, Carthage Area Hospital, Catskill Regional Hospital – Sullivan, Catskill Regional Medical Center-Hermann Div, Cayuga Medical Center-Ithaca, Champlain Valley Physicians HMC, Chenango Memorial Hospital, Claxton Hepburn Hospital, Clifton-Fine Hospital, Columbia Memorial Hospital, Community Memorial Hospital, Corning Hospital, Cortland Memorial Hospital, Cuba Memorial Hospital, Delaware Valley Hospital, Elizabethtown Community Hospital, Ellenville Community Hospital, Gouverneur Hospital, Ira Davenport Memorial Hospital, Jones Memorial Hospital, Lewis County General Hospital, Little Falls Hospital, Margaretville Memorial Hospital, Mary Imogene Bassett Hospital, Massena Memorial Hospital, Medina Memorial Hospital, Moses-Ludington Hospital, Nathan Littauer Hospital, Northern Dutchess Hospital, Noyes Memorial Hospital, O'Connor Hospital, Olean General Hospital – Main, Oneida City Hospital, Oswego Hospital, River Hospital, Samaritan Medical Center, Schuyler Hospital, Soldiers and Sailors Memorial Hospital, St. James Mercy Hospital, Tri Town Regional, Westfield Memorial Hospital, Wyoming County Community Hospital, WCA Hospital, United Memorial Medical Center, as well as St. Mary's Healthcare.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2021/2022 is $10.0 million.

Effective on and after April 1, 2021, 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 the periods April 1, 2021 through March 31, 2022 and April 1, 2022 through March 31, 2023. These payments will be made to the following:

Bassett Hospital of Schoharie County-Cobleskill Regional, Carthage Area Hospital, Catskill Regional Medical Center-Hermann, Clifton-Fine Hospital, Community Memorial Hospital, Cuba Memorial Hospital, Delaware Valley Hospital, Elizabethtown Community.

Hospital, Ellenville Regional Hospital, Gouverneur Hospital, Lewis County General Hospital, Little Falls Hospital, Margaretville Hospital, O'Connor Hospital, River Hospital, Schuyler Hospital, Soldiers and Sailors Memorial Hospital of Yates, as well as Medina Memorial Hospital.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2021/2022 is $7.5 million.

Effective on or after April 1, 2021, the State is advancing a compressive set of telehealth reforms for the purposes of strengthening and sustaining telehealth as a high-quality, cost effective, and consumer-oriented form of care delivery.

The estimated annual net aggregate decrease in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2021/2022 is ($79.0 million).

Effective on or after April 1, 2021, and each fiscal year thereafter, the State proposes to establish a 340B Reimbursement Fund for the purposes of supporting activities that expand health services to the Medicaid members, the uninsured, and low-income patients, as supported by the 340B program.

The annual gross Medicaid expenditures as a result of this proposed amendment is $102.0 million.

Effective on or after April 1, 2021, and for each State Fiscal Year thereafter, the State proposes to revise the method of distributing the funding for the Clinic Safety Net (CSN) distribution for comprehensive diagnostic and treatment centers that are other than Federally Qualified Health Centers (referred to as the non-FQHC CSN distribution).

There is no change to the annual gross Medicaid expenditures as a result of this proposed amendment.

Appendix V
2021 Title XIX State Plan
Second Quarter Amendment
Responses to Standard Funding Questions

NON-INSTITUTIONAL SERVICES
State Plan Amendment #21-0024

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 general appropriation received by the State agency that oversees medical assistance (Medicaid), which is the Department of Health.

   The source of the appropriation is the Medicaid General Fund Local Assistance Account, which is part of the Global Cap. The Global Cap is funded by General Fund and HCRA resources.

   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 officially submitted the 2021 clinic UPL calculation on 4/30/2021. The UPL demonstration includes a detail description of the methodology used to estimate the upper payment limit for each class of providers. A cost methodology is used to estimate the UPL for each class.

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.

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.