NEW YORK STATE OF OPPORTUNITY. Department of Health

KATHY HOCHUL
Governor

MARY T. BASSETT, M.D., M.P.H.
Commissioner

KRISTIN M. PROUD
Acting Executive Deputy Commissioner

June 30, 2022

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 #22-0044
Non-Institutional Services

Dear Mr. McMillion:

The State requests approval of the enclosed amendment #22-0044 to the Title XIX (Medicaid) State Plan for non-institutional services to be effective April 1, 2022 (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 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 March 30, 2022, 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]

Amir Bassiri
Acting 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: 22 — 0044

2. STATE: NY

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

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
April 1, 2022

5. FEDERAL STATUTE/REGULATION CITATION
§ 1902(a)(43) & §1905(r) of the Social Security Act and 42 CFR 447

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 04/01/22-09/30/22 $ 18,253,570
b. FFY 10/01/22-09/30/23 $ 16,147,096

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.19-B: Page 1(a)(iii)(3)

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 4.19-B: Page 1(a)(iii)(3)

9. SUBJECT OF AMENDMENT
Applied Behavior Analysis Fee Adjustment

10. 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:

11. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

12. TYPED NAME
Amir Bassiri

13. TITLE
Acting Medicaid Director

14. DATE SUBMITTED
June 30, 2022

15. 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 CMS USE ONLY

16. DATE RECEIVED

17. DATE APPROVED

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL

19. SIGNATURE OF APPROVING OFFICIAL

20. TYPED NAME OF APPROVING OFFICIAL

21. TITLE OF APPROVING OFFICIAL

22. REMARKS

Appendix I
2022 Title XIX State Plan
Second Quarter Amendment
Amended SPA Pages

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: New York

Section 1905(a)(6): Medical Care, Or Any Other Type of Remedial Care

Applied Behavior Analysis

Effective for services on or after [October 1, 2019] April 1, 2022, rates established by the Commissioner of Health and approved by the Director of the Budget will reflect Applied Behavior Analysis (ABA) costs on a per hour basis when medically necessary ABA services have taken place.

Rates for the assessment and delivery of ABA services will be the amount billed by the provider not to exceed [$29.00] $76.31 per hour. Services less than 60 minutes are not eligible for reimbursement.

Appendix II
2022 Title XIX State Plan
Second Quarter Amendment
Summary

SUMMARY
SPA #22-0044

This State Plan Amendment proposes to increase Medicaid reimbursement for the assessment and delivery of medically necessary ABA services to Medicaid members. The current rate of reimbursement is $29.00 per hour. An increase to $76.31 per hour is proposed to incentivize ABA providers to enroll and participate in the Medicaid program resulting in increased access to ABA services for Medicaid members.

Appendix III
2022 Title XIX State Plan
Second Quarter Amendment
Authorizing Provisions

SPA 22-0044

Social Services Law

§ 365-a. Character and adequacy of assistance. The amount, nature and manner of providing medical assistance for needy persons shall be determined by the public welfare official with the advice of a physician and in accordance with the local medical plan, this title, and the regulations of the department.

1. "Benchmark coverage" shall mean payment of part or all of the cost of medically necessary medical, dental, and remedial care, services, and supplies described in subdivision two of this section, and to the extent not included therein, any essential benefits as defined in 42 U.S.C. 18022(b), with the exception of institutional long term care services; such care, services and supplies shall be provided consistent with the managed care program described in section three hundred sixty-four-j of this title.

2. "Standard coverage" shall mean payment of part or all of the cost of medically necessary medical, dental and remedial care, services and supplies, as authorized in this title or the regulations of the department, which are necessary to prevent, diagnose, correct or cure conditions in the person that cause acute suffering, endanger life, result in illness or infirmity, interfere with such person's capacity for normal activity, or threaten some significant handicap and which are furnished an eligible person in accordance with this title and the regulations of the department. Such care, services and supplies shall include the following medical care, services and supplies, together with such medical care, services and supplies provided for in subdivisions three, four and five of this section, and such medical care, services and supplies as are authorized in the regulations of the department:

(a) services of qualified physicians, dentists, nurses, and private duty nursing services shall be further subject to the provisions of section three hundred sixty-seven-o of this chapter, optometrists, and other related professional personnel;

(b) care, treatment, maintenance and nursing services in hospitals, nursing homes that qualify as providers in the medicare program pursuant to title XVIII of the federal social security act, infirmaries or other eligible medical institutions, and health-related care and services in intermediate care facilities, while operated in compliance with applicable provisions of this chapter, the public health law, the mental hygiene law and other laws, including any provision thereof requiring an operating certificate or license, or where such facilities are not conveniently accessible, in hospitals located without the state; provided, however, that care, treatment, maintenance and nursing services in nursing homes or in intermediate care facilities, including those operated by the state department of mental hygiene or any other state department or agency, shall, for persons who are receiving or who are eligible for medical assistance under provisions of subparagraph four of paragraph (a) of subdivision one of section three hundred sixty-six of this chapter, be limited to such periods of time as may be determined necessary in accordance with a utilization review procedure established by the state commissioner of health providing for a review of medical necessity, in the case of skilled nursing care, every thirty days for the first ninety days and every ninety days thereafter, and in the case of care in an intermediate care facility, at least every six months, or more frequently if indicated at the time of the last review, consistent with federal utilization review requirements; provided,

further, that in-patient care, services and supplies in a general hospital shall not exceed such standards as the commissioner of health shall promulgate but in no case greater than twenty days per spell of illness during which all or any part of the cost of such care, services and supplies are claimed as an item of medical assistance, unless it shall have been determined in accordance with procedures and criteria established by such commissioner that a further identifiable period of in-patient general hospital care is required for particular patients to preserve life or to prevent substantial risks of continuing disability; provided further, that in-patient care, services and supplies in a general hospital shall, in the case of a person admitted to such a facility on a Friday or Saturday, be deemed to include only those in-patient days beginning with and following the Sunday after such date of admission, unless such care, services and supplies are furnished for an actual medical emergency or pre-operative care for surgery as provided in paragraph (d) of subdivision five of this section, or are furnished because of the necessity of emergency or urgent surgery for the alleviation of severe pain or the necessity for immediate diagnosis or treatment of conditions which threaten disability or death if not promptly diagnosed or treated; provided, however, in-patient days of a general hospital admission beginning on a Friday or a Saturday shall be included commencing with the day of admission in a general hospital which the commissioner or his designee has found to be rendering and which continues to render full service on a seven day a week basis which determination shall be made after taking into consideration such factors as the routine availability of operating room services, diagnostic services and consultants, laboratory services, radiological services, pharmacy services, staff patterns consistent with full services and such other factors as the commissioner or his designee deems necessary and appropriate; provided, further, that in-patient care, services and supplies in a general hospital shall not include care, services and supplies furnished to patients for certain uncomplicated procedures which may be performed on an out-patient basis in accordance with regulations of the commissioner of health, unless the person or body designated by such commissioner determines that the medical condition of the individual patient requires that the procedure be performed on an in-patient basis;

(c) out-patient hospital or clinic services in facilities operated in compliance with applicable provisions of this chapter, the public health law, the mental hygiene law and other laws, including any provisions thereof requiring an operating certificate or license, including facilities authorized by the appropriate licensing authority to provide integrated mental health services, and/or alcoholism and substance abuse services, and/or physical health services, and/or services to persons with developmental disabilities, when such services are provided at a single location or service site, or where such facilities are not conveniently accessible, in any hospital located within the state and care and services in a day treatment program operated by the department of mental hygiene or by a voluntary agency under an agreement with such department in that part of a public institution operated and approved pursuant to law as an intermediate care facility for persons with developmental disabilities; and provided, that the commissioners of health, mental health, alcoholism and substance abuse services and the office for people with developmental disabilities may issue regulations, including emergency regulations promulgated prior to October first, two thousand fifteen that are required to facilitate the establishment of integrated services clinics. Any such regulations promulgated under this

paragraph shall be described in the annual report required pursuant to section forty-five-c of part A of chapter fifty-six of the laws of two thousand thirteen;

(d) home health services provided in a recipient's home and prescribed by a physician including services of a nurse provided on a part-time or intermittent basis rendered by an approved home health agency or if no such agency is available, by a registered nurse, licensed to practice in this state, acting under the written orders of a physician and home health aide service by an individual or shared aide provided by an approved home health agency when such services are determined to be cost effective and appropriate to meet the recipient's needs for assistance subject to the provisions of section three hundred sixty-seven-j and section three hundred sixty-seven-o of this title;

(e) (i) personal care services, including personal emergency response services, shared aide and an individual aide, subject to the provisions of subparagraphs (ii), (iii), and (iv) of this paragraph, furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease, as determined to meet the recipient's needs for assistance when cost effective and appropriate, and when prescribed by a physician, in accordance with the recipient's plan of treatment and provided by individuals who are qualified to provide such services, who are supervised by a registered nurse and who are not members of the recipient's family, and furnished in the recipient's home or other location;

(ii) the commissioner is authorized to adopt standards, pursuant to emergency regulation, for the provision and management of services available under this paragraph for individuals whose need for such services exceeds a specified level to be determined by the commissioner;

(iii) the commissioner shall provide assistance to persons receiving services under this paragraph who are transitioning to receiving care from a managed long term care plan certified pursuant to section forty-four hundred three-f of the public health law, consistent with subdivision thirty-one of section three hundred sixty-four-j of this title;

(iv) personal care services available pursuant to this paragraph shall not exceed eight hours per week for individuals whose needs are limited to nutritional and environmental support functions;

(f) preventive, prophylactic and other routine dental care, services and supplies;

(g) sickroom supplies, eyeglasses, prosthetic appliances and dental prosthetic appliances furnished in accordance with the regulations of the department; provided further that: (i) the commissioner of health is authorized to implement a preferred diabetic supply program wherein the department of health will receive enhanced rebates from preferred manufacturers of glucometers and test strips, and may subject non-preferred manufacturers' glucometers and test strips to prior authorization under section two hundred seventy-three of the public health law; (ii) enteral formula therapy and nutritional supplements are limited to coverage only for nasogastric, jejunostomy, or gastrostomy tube feeding, for treatment of an inborn metabolic disorder, or to address growth and development problems in children, or, subject to standards established by the commissioner, for persons with a diagnosis of HIV infection, AIDS or HIV-related illness or other diseases and conditions; (iii) prescription footwear and inserts are limited to coverage only when used as an integral part of a lower limb orthotic appliance, as part of a diabetic treatment plan, or to address growth

and development problems in children; (iv) compression and support stockings are limited to coverage only for pregnancy or treatment of venous stasis ulcers; and (v) the commissioner of health is authorized to implement an incontinence supply utilization management program to reduce costs without limiting access through the existing provider network, including but not limited to single or multiple source contracts or, a preferred incontinence supply program wherein the department of health will receive enhanced rebates from preferred manufacturers of incontinence supplies, and may subject non-preferred manufacturers' incontinence supplies to prior approval pursuant to regulations of the department, provided any necessary approvals under federal law have been obtained to receive federal financial participation in the costs of incontinence supplies provided pursuant to this subparagraph;

(g-1) drugs provided on an in-patient basis, those drugs contained on the list established by regulation of the commissioner of health pursuant to subdivision four of this section, and those drugs which may not be dispensed without a prescription as required by section sixty-eight hundred ten of the education law and which the commissioner of health shall determine to be reimbursable based upon such factors as the availability of such drugs or alternatives at low cost if purchased by a medicaid recipient, or the essential nature of such drugs as described by such commissioner in regulations, provided, however, that such drugs, exclusive of long-term maintenance drugs, shall be dispensed in quantities no greater than a thirty day supply or one hundred doses, whichever is greater; provided further that the commissioner of health is authorized to require prior authorization for any refill of a prescription when more than a ten day supply of the previously dispensed amount should remain were the product used as normally indicated, or in the case of a controlled substance, as defined in section thirty-three hundred two of the public health law, when more than a seven day supply of the previously dispensed amount should remain were the product used as normally indicated; provided further that the commissioner of health is authorized to require prior authorization of prescriptions of opioid analgesics in excess of four prescriptions in a thirty-day period in accordance with section two hundred seventy-three of the public health law; medical assistance shall not include any drug provided on other than an in-patient basis for which a recipient is charged or a claim is made in the case of a prescription drug, in excess of the maximum reimbursable amounts to be established by department regulations in accordance with standards established by the secretary of the United States department of health and human services, or, in the case of a drug not requiring a prescription, in excess of the maximum reimbursable amount established by the commissioner of health pursuant to paragraph (a) of subdivision four of this section;

(h) speech therapy, and when provided at the direction of a physician or nurse practitioner, physical therapy including related rehabilitative services and occupational therapy; provided, however, that speech therapy and occupational therapy each shall be limited to coverage of twenty visits per year; physical therapy shall be limited to coverage of forty visits per year; such limitation shall not apply to persons with developmental disabilities or, notwithstanding any other provision of law to the contrary, to persons with traumatic brain injury;

(i) laboratory and x-ray services; and

(j) transportation when essential and appropriate to obtain medical care, services and supplies otherwise available under the medical assistance program in accordance with this section, upon prior

authorization, except when required in order to obtain emergency care, and when not otherwise available to the recipient free of charge or through a transportation program implemented pursuant to section three hundred sixty-five-h of this title and approved by the commissioner of health for which federal financial participation is claimed as an administrative cost;

* (k) care and services furnished by an entity offering a comprehensive health services plan, including an entity that has received a certificate of authority pursuant to sections forty-four hundred three, forty-four hundred three-a or forty-four hundred eight-a of the public health law (as added by chapter six hundred thirty-nine of the laws of nineteen hundred ninety-six) or a health maintenance organization authorized under article forty-three of the insurance law, to eligible individuals residing in the geographic area served by such entity, when such services are furnished in accordance with an agreement approved by the department which meets the requirements of federal law and regulations.

* NB Effective until December 31, 2024

* (k) care and services furnished by an entity offering a comprehensive health services plan to eligible individuals residing in the geographic area served by such entity, when such services are furnished in accordance with an agreement approved by the department which meets the requirements of federal law and regulations.

* NB Effective December 31, 2024

(l) care and services of podiatrists which care and services shall only be provided upon referral by a physician, nurse practitioner or certified nurse midwife in accordance with the program of early and periodic screening and diagnosis established pursuant to subdivision three of this section or to persons eligible for benefits under title XVIII of the federal social security act as qualified medicare beneficiaries in accordance with federal requirements therefor and private duty nurses which care and services shall only be provided in accordance with regulations of the department of health; provided, however, that private duty nursing services shall not be restricted when such services are more appropriate and cost-effective than nursing services provided by a home health agency pursuant to section three hundred sixty-seven-l;

(m) hospice services provided by a hospice certified pursuant to article forty of the public health law, to the extent that federal financial participation is available, and, notwithstanding federal financial participation and any provision of law or regulation to the contrary, for hospice services provided pursuant to the hospice supplemental financial assistance program for persons with special needs as provided for in article forty of the public health law.

* (n) care and services of audiologists provided in accordance with regulations of the department of health.

* NB There are two ù (n)'s

* (n) care, treatment, maintenance and rehabilitation services that would otherwise qualify for reimbursement pursuant to this chapter to persons suffering from alcoholism in alcoholism facilities or chemical dependence, as such term is defined in section 1.03 of the mental hygiene law, in inpatient chemical dependence facilities, services, or programs operated in compliance with applicable provisions of this chapter and the mental hygiene law, and certified by the office of alcoholism and substance abuse services, provided however that such services shall be limited to such periods of time as may be determined necessary in accordance with a utilization review procedure established

by the commissioner of the office of alcoholism and substance abuse services and provided further, that this paragraph shall not apply to any hospital or part of a hospital as defined in section two thousand eight hundred one of the public health law.

* NB There are two ù (n)'s

* (o) care and services furnished by a managed long term care plan or approved managed long term care demonstration pursuant to the provisions of section forty-four hundred three-f of the public health law to eligible individuals residing in the geographic area served by such entity, when such services are furnished in accordance with an agreement with the department of health and meet the applicable requirements of federal law and regulation.

* NB Repealed December 31, 2024

(p) targeted case management services provided to children who

(i) are eighteen years of age or under; and

(ii) either

(1) are physically disabled, according to the federal supplemental security income program criteria, including but not limited to a person who is multiply disabled; or

(2) have a developmental disability, as defined in subdivision twenty-two of section 1.03 of the mental hygiene law and demonstrate complex health needs as defined in paragraph c of subdivision seven of section three hundred sixty-six of this title; or

(3) have a mental illness, as defined in subdivision twenty of section 1.03 of the mental hygiene law and demonstrate complex health or mental health care needs as defined in paragraph d of subdivision nine of section three hundred sixty-six of this title; and

(iii) require the level of care provided by an intermediate care facility for the developmentally disabled, a nursing facility, a hospital or any other institution; and

(iv) are capable of being cared for in the community if provided with case management services and/or other services provided under this title; and

(v) are capable of being cared for in the community at less cost than in the appropriate institutional setting; and

(vi) are not receiving services under section three hundred sixty-seven-c of this title and for whom services provided under section three hundred sixty-seven-a of this title are not available or sufficient to support the children's care in the community.

(q) diabetes self-management training services for persons diagnosed with diabetes when such services are ordered by a physician, registered physician assistant, registered nurse practitioner, or licensed midwife and provided by a licensed, registered, or certified health care professional, as determined by the commissioner of health, who is certified as a diabetes educator by the National Certification Board for Diabetes Educators, or a successor national certification board, or provided by such a professional who is affiliated with a program certified by the American Diabetes Association, the American Association of Diabetes Educators, the Indian Health Services, or any other national accreditation organization approved by the federal centers for medicare and medicaid services; provided, however, that the provisions of this paragraph shall not take effect unless all necessary approvals under federal law and regulation have been obtained to receive federal financial participation in the costs of health care services provided pursuant to this paragraph. Nothing in this paragraph shall be construed to modify any licensure, certification or scope of practice provision under title eight of the education law.

(r) asthma self-management training services for persons diagnosed with asthma when such services are ordered by a physician, registered physician's assistant, registered nurse practitioner, or licensed midwife and provided by a licensed, registered, or certified health care professional, as determined by the commissioner of health, who is certified as an asthma educator by the National Asthma Educator Certification Board, or a successor national certification board; provided, however, that the provisions of this paragraph shall not take effect unless all necessary approvals under federal law and regulation have been obtained to receive federal financial participation in the costs of health care services provided pursuant to this paragraph. Nothing in this paragraph shall be construed to modify any licensure, certification or scope of practice provision under title eight of the education law.

(s) smoking cessation counseling services; provided, however, that the provisions of this paragraph shall not take effect unless all necessary approvals under federal law and regulation have been obtained to receive federal financial participation in the costs of such services.

(t) cardiac rehabilitation services when ordered by the attending physician and provided in a hospital-based or free-standing clinic in an area set aside for cardiac rehabilitation, or in a physician's office; provided, however, that the provisions of this paragraph relating to cardiac rehabilitation services shall not take effect unless all necessary approvals under federal law and regulation have been obtained to receive federal financial participation in the costs of such services.

(u) screening, brief intervention, and referral to treatment of individuals at risk for substance abuse including referral to the appropriate level of intervention and treatment in a community setting; provided, however, that the provisions of this paragraph relating to screening, brief intervention, and referral to treatment services shall not take effect unless all necessary approvals under federal law and regulation have been obtained to receive federal financial participation in such costs.

(v) administration of vaccinations in a pharmacy by a certified pharmacist within his or her scope of practice.

(w) podiatry services for individuals with a diagnosis of diabetes mellitus; provided, however, that the provisions of this paragraph shall not take effect unless all necessary approvals under federal law and regulation have been obtained to receive federal financial participation in the costs of health care services provided pursuant to this paragraph.

(x) lactation counseling services for pregnant and postpartum women when such services are ordered by a physician, registered physician assistant, registered nurse practitioner, or licensed midwife and provided by a certified lactation consultant, as determined by the commissioner of health; provided, however, that the provisions of this paragraph shall not take effect unless all necessary approvals under federal law and regulation have been obtained to receive federal financial participation in the costs of health care services provided pursuant to this paragraph. Nothing in this paragraph shall be construed to modify any licensure, certification or scope of practice provision under title eight of the education law.

(y) harm reduction counseling and services to reduce or minimize the adverse health consequences associated with drug use, provided by a qualified drug treatment program or community-based organization, as determined by the commissioner of health; provided, however, that the

provisions of this paragraph shall not take effect unless all necessary approvals under federal law and regulation have been obtained to receive federal financial participation in the costs of health care services provided pursuant to this paragraph. Nothing in this paragraph shall be construed to modify any licensure, certification or scope of practice provision under title eight of the education law.

(z) hepatitis C wrap-around services to promote care coordination and integration when ordered by a physician, registered physician assistant, registered nurse practitioner, or licensed midwife, and provided by a qualified professional, as determined by the commissioner of health. Such services may include client outreach, identification and recruitment, hepatitis C education and counseling, coordination of care and adherence to treatment, assistance in obtaining appropriate entitlement services, peer support and other supportive services; provided, however, that the provisions of this paragraph shall not take effect unless all necessary approvals under federal law and regulation have been obtained to receive federal financial participation in the costs of health care services provided pursuant to this paragraph. Nothing in this paragraph shall be construed to modify any licensure, certification or scope of practice provision under title eight of the education law.

** (aa) care and services furnished by a developmental disability individual support and care coordination organization (DISCO) that has received a certificate of authority pursuant to section forty-four hundred three-g of the public health law to eligible individuals residing in the geographic area served by such entity, when such services are furnished in accordance with an agreement approved by the department of health which meets the requirements of federal law and regulations.

* NB Repealed September 30, 2023

(bb) Subject to the availability of federal financial participation, services and supports authorized by the federal regulations governing the Home and Community-Based Attendant Services and Supports State Plan Option (Community First Choice) pursuant to 42 U.S.C. § 1396n(k).

(cc) care and services for surgical first assistant services provided by a registered nurse first assistant provided that: (i) the registered nurse first assistant is certified in operating room nursing; (ii) the services are within the scope of practice of a non-physician surgical first assistant; and (iii) the terms and conditions of the policy or contract otherwise provide for the coverage of the services. Nothing in this paragraph shall be construed to prevent the medical management or utilization review of the services; prevent a policy or contract from requiring that services are to be provided through a network of participating providers who meet certain requirements for participation, including provider credentialing; or prohibit an insurer from providing a global or capitated payment or electing to directly reimburse a non-physician surgical first assistant for the services, as otherwise permitted by law.

(dd) pasteurized donor human milk (PDHM), which may include fortifiers as medically indicated, for inpatient use, for which a licensed medical practitioner has issued an order for an infant who is medically or physically unable to receive maternal breast milk or participate in breast feeding or whose mother is medically or physically unable to produce maternal breast milk at all or in sufficient quantities or participate in breast feeding despite optimal lactation support. Such infant shall: (i) have a documented birth weight of less than one thousand five hundred grams; or (ii) have a congenital or acquired

condition that places the infant at a high risk for development of necrotizing enterocolitis; or (iii) have a congenital or acquired condition that may benefit from the use of donor breast milk as determined by the commissioner of health or his or her designee.

(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. In the event that ninety percent federal financial participation for such services is not available, the state share of appropriations related to these services shall be used for a grant program intended to accomplish the purpose of this section.

* (ff) evidence-based prevention and support services recognized by the federal Centers for Disease Control (CDC), provided by a community-based organization, and designed to prevent individuals at risk of developing diabetes from developing Type 2 diabetes.

* NB Effective July 1, 2019

3. Any inconsistent provisions of this section notwithstanding, medical assistance shall include:

(a) early and periodic screening and diagnosis of eligible persons under six years of age and, in accordance with federal law and regulations, early and periodic screening and diagnosis of eligible persons under twenty-one years of age to ascertain physical and mental disabilities; and

(b) care and treatment of disabilities and conditions discovered by such screening and diagnosis including such care, services and supplies as the commissioner shall by regulation require to the extent necessary to conform to applicable federal law and regulations.

(c) screening, diagnosis, care and treatment of disabilities and conditions discovered by such screening and diagnosis of eligible persons ages three to twenty-one, inclusive, including such care, services and supplies as the commissioner shall by regulation require to the extent necessary to conform to applicable federal law and regulations, provided that such screening, diagnosis, care and treatment shall include the provision of evaluations and related services rendered pursuant to article eighty-nine of the education law and regulations of the commissioner of education by persons qualified to provide such services thereunder.

* (d) family planning services and supplies for eligible persons of childbearing age, including children under twenty-one years of age who can be considered sexually active, who desire such services and supplies, in accordance with the requirements of federal law and regulations and the regulations of the department. No person shall be compelled or coerced to accept such services or supplies.

* NB Effective until January 1, 2020

* (d) family planning services and twelve months of supplies for eligible persons of childbearing age, including children under twenty-one years of age who can be considered sexually active, who desire such services and supplies, in accordance with the requirements of federal law and regulations and the regulations of the department. Coverage of prescription contraceptives shall include a twelve-month supply that may be dispensed at one time or up to twelve times within one year from the date of the prescription. No person shall be compelled or coerced to accept such services or supplies.

* NB Effective January 1, 2020

4. Any inconsistent provision of law notwithstanding, medical

assistance shall not include, unless required by federal law and regulation as a condition of qualifying for federal financial participation in the medicaid program, the following items of care, services and supplies:

(a) drugs which may be dispensed without a prescription as required by section sixty-eight hundred ten of the education law; provided, however, that the state commissioner of health may by regulation specify certain of such drugs which may be reimbursed as an item of medical assistance in accordance with the price schedule established by such commissioner. Notwithstanding any other provision of law, additions to the list of drugs reimbursable under this paragraph may be filed as regulations by the commissioner of health without prior notice and comment;

(a-1) (i) a brand name drug for which a multi-source therapeutically and generically equivalent drug, as determined by the federal food and drug administration, is available, unless previously authorized by the department of health. The commissioner of health is authorized to exempt, for good cause shown, any brand name drug from the restrictions imposed by this subparagraph;

(ii) notwithstanding the provisions of subparagraph (i) of this paragraph, the commissioner is authorized to deny reimbursement for a generic equivalent, including a generic equivalent that is on the preferred drug list or the clinical drug review program, when the net cost of the brand name drug, after consideration of all rebates, is less than the cost of the generic equivalent, unless prior authorization is obtained under section two hundred seventy-three of the public health law;

(a-2) drugs which may not be dispensed without a prescription as required by section sixty-eight hundred ten of the education law, and which are non preferred drugs pursuant to section two hundred seventy-two of the public health law, or the clinical drug review program under section two hundred seventy-four of the public health law, unless prior authorization is granted or not required;

(b) care and services of chiropractors and supplies related to the practice of chiropractic;

(c) care and services of an optometrist for using drugs in excess of the maximum reimbursable amounts for optometric care and services established by the commissioner and approved by the director of the budget;

(d) any medical care, services or supplies furnished outside the state, except, when prior authorized in accordance with department regulations or for care, services and supplies furnished: as a result of a medical emergency; because the recipient's health would have been endangered if he or she had been required to travel to the state; because the care, services or supplies were more readily available in the other state; or because it is the general practice for persons residing in the locality wherein the recipient resides to use medical providers in the other state;

(e) drugs, procedures and supplies for the treatment of erectile dysfunction when provided to, or prescribed for use by, a person who is required to register as a sex offender pursuant to article six-C of the correction law, provided that any denial of coverage pursuant to this paragraph shall provide the patient with the means of obtaining additional information concerning both the denial and the means of challenging such denial; or

(f) drugs for the treatment of sexual or erectile dysfunction, unless such drugs are used to treat a condition, other than sexual or erectile dysfunction, for which the drugs have been approved by the federal food

and drug administration.

(g) for eligible persons who are also beneficiaries under part D of title XVIII of the federal social security act, drugs which are denominated as "covered part D drugs" under section 1860D-2(e) of such act.

(h) opioids prescribed in violation of the treatment plan standards of subdivision eight of section thirty-three hundred thirty-one of the public health law or treatment plan standards as otherwise required by the commissioner.

5. (a) Medical assistance shall include surgical benefits for emergency or urgent surgery for the alleviation of severe pain, for immediate diagnosis or treatment of conditions which threaten disability or death if not promptly diagnosed or treated.

(b) Medical assistance shall include surgical benefits for certain surgical procedures which meet standards for surgical intervention, as established by the state commissioner of health on the basis of medically indicated risk factors, and medically necessary surgery where delay in surgical intervention would substantially increase the medical risk associated with such surgical intervention.

(c) Medical assistance shall include surgical benefits for other deferrable surgical procedures specified by the state commissioner of health, based on the likelihood that deferral of such procedures for six months or more may jeopardize life or essential function, or cause severe pain; provided, however, such deferrable surgical procedures shall be included in the case of in-patient surgery only when a second written opinion is obtained from a physician, or as otherwise prescribed, in accordance with regulations established by the state commissioner of health, that such surgery should not be deferred.

(d) Medical assistance shall include a maximum of one patient day of pre-operative hospital care for surgery authorized by paragraphs (b) or (c) of this subdivision; provided, however, that with respect to specific surgical procedures which the state commissioner of health has identified as requiring more than one patient day of pre-operative care, medical assistance shall include such longer maximum period of pre-operative care as such commissioner has identified as necessary.

(e) Medical assistance shall not include any in-patient surgical procedures or any care, services or supplies related to such surgery other than those authorized by this subdivision.

6. Any inconsistent provision of law notwithstanding, medical assistance shall also include payment for medical care, services or supplies furnished to eligible pregnant women pursuant to paragraph (o) of subdivision four of section three hundred sixty-six and subdivision six of section three hundred sixty-four-i of this title, to the extent that and for so long as federal financial participation is available therefor; provided, however, that nothing in this section shall be deemed to affect payment for such medical care, services or supplies if federal financial participation is not available for such care, services and supplies solely by reason of the immigration status of the otherwise eligible pregnant woman.

7. Medical assistance shall also include disproportionate share payments to general hospitals under the public health law.

8. When a non-governmental entity is authorized by the department pursuant to contract or subcontract to make prior authorization or prior approval determinations that may be required for any item of medical assistance, a recipient may challenge any action taken or failure to act in connection with a prior authorization or prior approval determination as if such determination were made by a government entity, and shall be

entitled to the same medical assistance benefits and standards and to the same notice and procedural due process rights, including a right to a fair hearing and aid continuing pursuant to section twenty-two of this chapter, as if the prior authorization or prior approval determination were made by a government entity, without regard to expiration of the prior service authorization.

9. (a) Notwithstanding any inconsistent provision of law, any utilization controls on occupational therapy or physical therapy, including but not limited to, prior approval of services, utilization thresholds or other limitations imposed on such therapy services in relation to a chronic condition in clinics certified under article twenty-eight of the public health law or article sixteen of the mental hygiene law shall be: (i) developed by the department of health in concurrence with the office of mental retardation and developmental disabilities; and (ii) in accord with nationally recognized professional standards. In the event that nationally recognized professional standards do not exist, such thresholds shall be based upon the reasonably recognized professional standards of those with a specific expertise in treating individuals served by clinics certified under article twenty-eight of the public health law or article sixteen of the mental hygiene law.

(b) Prior approval by the department of health of a physical therapy evaluation or an occupational therapy evaluation by a qualified practitioner practicing within the scope of such practitioner's licensure shall not be required. The department may require prior approval for treatment as recommended by such an evaluation. In the event that prior approval is required, and the department fails to make a determination within eight days of presentation of a treatment request for physical or occupational therapy services, the department shall automatically approve four therapy visits. In the case of any denial of a prior approval request for physical therapy or occupational therapy, the department shall provide a reasonable opportunity for the qualified practitioner to provide his or her assessment of the beneficiary's physical and functional status as documented in a treatment plan with reasonable and obtainable goals. If, upon completion of such four therapy visits, the department has not yet rendered a determination on the request for physical or occupational therapy services, the department shall automatically approve an additional four therapy visits. Subsequent automatic approvals shall be issued in the same manner until such time as the department issues a determination, but in no event shall such approvals exceed the number of services or the period of time recommended by the evaluation. If the qualified practitioner provides documentation that is in accord with reasonably recognized professional standards, the recommended treatment plan shall be final, and the prior approval request shall be approved.

Appendix IV
2022 Title XIX State Plan
Second Quarter Amendment
Public Notice

Effective on or after April 1, 2022, this notice proposes to establish Medical Assistance coverage and rates of payment for crisis intervention services to stabilize and treat mental health and substance use disorder conditions, provided by mobile crisis teams and residential crisis settings for adults, as well as crisis stabilization centers for adults and children.

More specifically, crisis intervention services provided by multidisciplinary mobile crisis teams in accordance with Section 9813 of the American Rescue Plan Act provide an array of crisis intervention services, including telephonic triage for both adults and children, mobile crisis response, and mobile or telephonic follow-up services, in a variety of settings in the community.

Crisis intervention services provided in crisis stabilization centers will provide urgently needed immediate evaluation, treatment, and support services, including coordination with other mental health and substance use services, for children and adults experiencing or at risk of a mental health or substance use disorder crisis.

Crisis intervention services will also be provided in residential crisis settings, which are short-term, voluntary, non-IMD, sub-acute settings, and address a spectrum of acuity levels in which an individual may present in a mental health or substance use disorder crisis. Services stabilize crisis symptoms and restore functionality to enable transition back to the community and to prevent or reduce future psychiatric crises.

The estimated annual net aggregate increase in gross Medicaid expenditures related to this State Plan Amendment for State Fiscal Year 2023 is $16M and for State Fiscal Year 2024 is $44.5 million.

Effective on or after April 1, 2022, 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.

Effective on or after April 1, 2022, the State proposes to enter into outcomes-based contract arrangements with drug manufacturers for drugs provided to Medicaid beneficiaries through supplemental rebate agreements.

The estimated annual net aggregate decrease in gross Medicaid expenditures attributable to this initiative contained in the budget for State Fiscal Year 2023 is ($5 million).

Effective on or after April 1, 2022, this notice proposes to enhance (increase) state established reimbursement rates as follows:

Contingent upon CMS approval of the Spending Plan submitted by the state, established rates will be enhanced for state-plan approved private duty nursing (PDN) services for members 23 years of age and older by an additional 30 percent for the medically fragile training and experience and 45 percent for the private duty nursing directory starting April 1, 2022.

The estimated annual net aggregate increase in gross Medicaid expenditures as a result of the proposed amendments for PDN services for State Fiscal Year 2023 is $38.9 million.

Effective on or after April 1, 2022, pursuant to the Centers for Medicare and Medicaid Services, Medicaid coverage must include routine patient costs for items and services furnished in connection with participation by beneficiaries in qualifying clinical trials. The Department will submit a State Plan Amendment for Medicaid to formalize federal approval of existing coverage in accordance with the requirements. Routine patient costs and qualifying clinical trials are defined in Section 1905(a)30 and Section 1905(gg) of the Social Security Act (the Act), respectively. This includes clinical trials in any clinical phase of development that is conducted in relation to the prevention, detection, or treatment of any serious or life-threatening disease or condition and is described in any of clauses (i)-(iii) of section 1905(gg) of the Act. Routine patient costs do not include any investigational item or service that is the subject of the qualifying clinical trial and is not otherwise covered outside of the clinical trial under the state plan, waiver, or demonstration project.

There is no estimated annual change to gross Medicaid expenditures as a result of this proposed amendment, since these benefits are already covered under long-standing NYS Medicaid policy.

Effective on or after April 1, 2022, pursuant to the Centers for Medicare and Medicaid Services, Alternative Benefit Plans (ABP) coverage must include routine patient costs for items and services furnished in connection with participation by beneficiaries in qualifying clinical trials. The Department will submit a State Plan Amendment for ABP to formalize federal approval of existing coverage in accordance with the requirements. Routine patient costs and qualifying clinical trials are defined in Section 1905(a)30 and Section 1905(gg) of the Social Security Act (the Act), respectively. This includes clinical trials in any clinical phase of development that is conducted in relation to the prevention, detection, or treatment of any serious or life-threatening disease or condition and is described in any of clauses (i)-(iii) of section 1905(gg) of the Act. Routine patient costs do not include any investigational item or service that is the subject of the qualifying clinical trial and is not otherwise covered outside of the clinical trial under the state plan, waiver, or demonstration project.

There is no estimated annual change to gross Medicaid expenditures as a result of this proposed amendment, since these benefits are already covered under long-standing NYS Medicaid policy.

Effective April 1, 2022, the Medicaid Program is proposing to incentivize ABA provider enrollment and participation by increasing Medicaid reimbursement amounts, aligning fees with those paid by the Child Health Plus program. "Applied behavior analysis" or "ABA" is the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior. ABA services are provided to individuals who have a diagnosis of autism spectrum or related disorder. As of August 1, 2021, Medicaid began accepting enrollment of Licensed Behavior Analysts as independent practitioners to provide ABA to Medicaid members under age 21 with a diagnosis of Autism Spectrum Disorder or Rhett's Syndrome. However, Medicaid Managed Care Plans (MMC) and ABA providers indicated that the Medicaid reimbursement rate is below rates paid by CHP and commercial plans. Subsequently, very few ABA providers have been willing to enroll as Medicaid managed care and/or fee-for-service providers.

The estimated annual net aggregate increase in gross Medicaid expenditures as a result of the proposed amendment for State Fiscal Year 2023 is $73.2 million.

Effective on or after April 1, 2022, this proposal to amend the State Plan to align with Subdivision 2 of section 365-a of the social services law, that authorizes clinical social workers, licensed pursuant to Article 154 of the Education law, to bill Medicaid directly for their services within their scope of practice, effective April 1, 2022.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for State Fiscal Year 2023 is $24.2 million.

Effective on or after April 1, 2022, this proposal to amend the State Plan to align with Subdivision 2 of section 365-a of the social services law, that authorizes licensed mental health counselors and marriage and family therapists, licensed pursuant to Article 163 of the Education law, to bill Medicaid directly for their services within their scope of practice, effective April 1, 2022.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for State Fiscal Year 2023 is $4.2 million.

Effective on or after July 1, 2022, Medicaid reimbursement rates for non-facility physician services will be updated to 70% of current Medicare rates. This update will apply to Evaluation & Management (E&M) and Medicine procedure codes. Most Medicaid physician reimbursement rates have not been updated since 2009 and New York Medicaid is currently reimbursing physicians, on average, at 45% of Medicare for E&M codes and 58% of Medicare for Medicine codes. Updating the Medicaid physician fee schedule is intended to increase the use of primary care and preventative services and reduced utilization of costlier downstream care.

Appendix V
2022 Title XIX State Plan
Second Quarter Amendment
Responses to Standard Funding Questions

NON-INSTITUTIONAL SERVICES
State Plan Amendment #22-0044

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.

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 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 receive and retain the total Medicaid expenditures claimed by the State and the State does not require any provider to return any portion of such payments to the State, local government entities, or any other intermediary organization.

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 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 government 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: The Non-Federal share Medicaid provider payment is funded by a combination of the following funds/funding sources through enacted appropriations authority to the Department of Health (DOH) for the New York State Medicaid program.

		4/1/22 – 3/31/23	
Payment Type	**Non-Federal Share Funding**	**Non-Federal**	**Gross**
Normal Per Diem	General Fund; Special Revenue Funds; County Contribution	$251,040,721	$502,081,442

1) General Fund: Revenue resources for the State's General Fund includes taxes (e.g., income, sales, etc.), and miscellaneous fees (including audit recoveries). Medicaid expenditures from the State's General Fund are authorized from Department of Health Medicaid.

a. New York State Audit Recoveries: The Department of Health collaborates with the Office of the Medical Inspector General (OMIG) and the Office of the Attorney General (AG) in recovering improperly expended Medicaid funds. OMIG conducts and coordinates the investigation, detection, audit, and review of Medicaid providers and recipients to ensure they are complying with all applicable laws and regulation. OMIG recovers any improper payments through cash collections and voided claim recoveries. Cash collections are deposited into the State's General Fund to offset Medicaid costs.

   In addition to cash collections, OMIG finds inappropriately billed claims within provider claims. To correct an error, OMIG and DOH process the current accurate claim, and reduce this claim by the inappropriate claim value to recoup the previous overclaim and decrease state spending.

2) Special Revenue Funds:

a. Health Care Reform Act (HCRA) Resource Fund: as authorized in section 92-dd of New York State Finance Law and was established in 1996, pursuant to New York State Public Health Law 2807-j. HCRA resources include health care related surcharges, assessments on hospital revenues, and a "covered

lives" assessment paid by insurance carriers pursuant to chapter 820 of the laws of 2021.

b. Health Facility Cash Assessment Program (HFCAP) Fund: HFCAP requires New York State designated providers to pay an assessment on cash operating receipts on a monthly basis. The assessment includes Article 28 Residential Health Care Facilities, Article 28 General Hospitals, Article 36 Long Term Home Health Care Programs, Article 36 Certified Home Health Agencies and Personal Care Providers that possess a Title XIX (i.e. Medicaid) contract with a Local Social Services District for the delivery of personal care services pursuant to Section 367-i of the New York State Social Services Law.

NOTE: New York's Health Care taxes are either broad based and uniform (as in all HFCAP assessments except for the Personal Care Provider Cash Assessment) or have a specific exemption known as the "D'Amato provision (Federal PHL section 105-33 4722 (c)" which allows the HCRA surcharges to exist in their current format. The single tax which has been determined by the State to be an impermissible provider tax is the HFCAP charge on Personal Care Providers. The State does not claim any Federal dollars for the surcharge collected in this manner in order to comply with all Federal provider tax rules.

3) Additional Resources for State Share Funding:

a. County Contribution: In State Fiscal Year 2006, through enacted State legislation (Part C of Chapter 58 of the laws of 2005), New York State "capped" the amount localities contributed to the non-Federal share of providers claims. This was designed to relieve pressure on county property taxes and the NYC budget by limiting local contributions having New York State absorb all local program costs above this fixed statutory inflation rate (3% at the time).

However, in State Fiscal Year 2013 New York State provided additional relief to Localities by reducing local contributions annual growth from three precent to zero over a three-year period. Beginning in State Fiscal Year 2016, counties began paying a fixed cost in perpetuity. By eliminating the growth in localities Medicaid costs, the State has statutorily capped total Statewide County Medicaid expenditures at 2015 levels. All additional county Medicaid costs are funded by the State through State funding as described above. DOH provides annual letters to counties providing weekly contributions. Contributions are deposited directly into State escrow account and used to offset 'total' State share Medicaid funding.

NOTE: The Local Contribution is not tied to a specific claim or service category and instead is a capped amount based on 2015 county spending levels as stated above.

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 Medicaid payments under this State Plan Amendment are not supplemental 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. Under regulations at 42 CFR 447.272, States are prohibited from setting payment rates for Medicaid inpatient services that exceed a reasonable estimate of the amount that would be paid under Medicare payment principals.**

   Response: The Medicaid payments authorized under this State Plan Amendment do not impact the UPL demonstrations.

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: Providers do not receive payments that in the aggregate exceed their reasonable costs of providing services. If any providers received payments that in the aggregate exceeded their reasonable costs of providing services, the State would recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report.

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**

- **<u>Ends on:</u> 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.**

<u>Response:</u> 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.**

   <u>Prior to January 1, 2014</u> States may potentially require contributions by local political subdivisions toward the non-Federal share of the States' expenditures at percentages <u>greater than</u> were required on December 31, 2009. <u>However</u>, 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 <u>anticipate potential violations and/or appropriate corrective actions</u> by the States and the Federal government.

   <u>Response:</u> This SPA would [ ] / would <u>not</u> [✓] 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.**

   <u>Response:</u> The State complies with the requirements of section 1902(a)(37) of the Act regarding prompt payment of claims.

<u>Tribal Assurance:</u>

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.