



Department of Health

ANDREW M. CUOMO
Governor

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

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

Mr. Ricardo Holligan
Acting Associate Regional Administrator
Department of Health & Human Services
Centers for Medicare & Medicaid Services
New York Regional Office
Division of Medicaid and Children's Health Operations
26 Federal Plaza - Room 37-100 North
New York, New York 10278

June 28, 2019

RE: SPA #19-0022
Non-Institutional Services

Dear Mr. Holligan:

The State requests approval of the enclosed amendment #19-0022 to the Title XIX (Medicaid) State Plan for non-institutional services to be effective April 1, 2019 (Appendix I). This amendment is being submitted based on Statute. 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.

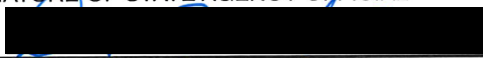
A copy of pertinent sections of Statute is enclosed for your information (Appendix III). A copy of the public notice of this plan amendment, which was given in the New York State Register on March 27, 2019, is also enclosed for your information (Appendix IV). In addition, responses to the five standard funding questions are also enclosed (Appendix V).

If you have any questions regarding this State Plan Amendment submission, please do not hesitate to contact Regina Deyette, Medicaid State Plan Coordinator, Division of Finance and Rate Setting, Office of Health Insurance Programs at (518) 473-3658.

Sincerely,

Donna Frescatore
Medicaid Director
Office of Health Insurance Programs

Enclosures

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES	1. TRANSMITTAL NUMBER <u>1 9</u> — <u>0 0</u> <u>2 2</u>	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, 2019	
5. TYPE OF PLAN MATERIAL (<i>Check One</i>) <input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT		
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (<i>Separate transmittal for each amendment</i>)		
6. FEDERAL STATUTE/REGULATION CITATION §1902(r)(5) of the Social Security Act, and 42 CFR 447	7. FEDERAL BUDGET IMPACT a. FFY <u>04/01/19-09/30/19</u> \$ <u>4,500.00</u> b. FFY <u>10/01/19-09/30/20</u> \$ <u>4,500.00</u>	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT Attachment 4.19-B: Page 2(v)	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (<i>If Applicable</i>) Attachment 4.19-B: Page 2(v)	
10. SUBJECT OF AMENDMENT 2019 Clinic UPL (FMAP=50%)		
11. GOVERNOR'S REVIEW (<i>Check One</i>) <input checked="" type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input type="checkbox"/> OTHER, AS SPECIFIED <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL		
12. SIGNATURE OF STATE AGENCY OFFICIAL 	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	
13. TYPED NAME Donna Frescatore		
14. TITLE Medicaid Director, Department of Health		
15. DATE SUBMITTED June 28, 2019		
FOR REGIONAL OFFICE USE ONLY		
17. DATE RECEIVED	18. DATE APPROVED	
PLAN APPROVED - ONE COPY ATTACHED		
19. EFFECTIVE DATE OF APPROVED MATERIAL	20. SIGNATURE OF REGIONAL OFFICIAL	
21. TYPED NAME	22. TITLE	
23. REMARKS		

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

**New York
2(v)**

Upper Payment Limit (UPL) Payments for Diagnostic and Treatment Centers (DTCs)

1. New York City Health and Hospitals Corporation (HHC) operated DTCs

Effective for the period April 1, [2018] 2019 through March 31, [2019] 2020, the Department of Health will increase medical assistance rates of payment for diagnostic and treatment center (DTC) services provided by public DTCs operated by the New York City Health and Hospitals Corporation (HHC), at the annual election of the social services district in which an eligible DTC is physically located. The amount to be paid will be \$12.6 million on an annualized basis.

Medical assistance payments will be made for patients eligible for federal financial participation under Title XIX of the federal Social Security Act based on each diagnostic and treatment center's proportionate share of the sum of all clinic visits for all facilities eligible for an adjustment for the base year two years prior to the rate year. Such proportionate share payments may be added to rates of payment or made as aggregate payments to each eligible HHC diagnostic and treatment center.

2. County Operated DTCs and mental hygiene clinics

Effective for the period April 1, [2018] 2019 through March 31, [2019] 2020, the Department of Health will increase the medical assistance rates of payment for county operated DTCs and mental hygiene clinics, excluding those facilities operated by the New York City HHC. Local social services districts may, on an annual basis, decline such increased payments within thirty days following receipt of notification. The amount to be paid will be \$5.4 million on an annualized basis.

Medical assistance payments will be made for patients eligible for federal financial participation under Title XIX of the federal Social Security Act based on each diagnostic and treatment center's proportionate share of the sum of all clinic visits for all facilities eligible for an adjustment for the base year two years prior to the rate year. Such proportionate share payments may be added to rates of payment or made as aggregate payments to each eligible county operated diagnostic and treatment center and mental hygiene clinic.

TN #19-0022

Approval Date _____

Supersedes TN #18-0029

Effective Date _____

Appendix II
2019 Title XIX State Plan
Second Quarter Amendment
Summary

SUMMARY
SPA #19-0022

This amendment proposes to authorize payment adjustments that increase the operating cost components of rates of payment for the diagnostic and treatment centers (DTC) of the New York City Health and Hospital Corporation and county operated freestanding clinics licensed under Article 31 and 32 of the NYS Mental Hygiene Law, for the period April 1, 2019 through March 31, 2020.

Appendix III
2019 Title XIX State Plan
Second Quarter Amendment
Authorizing Provisions

Part C of Chapter 58 of the laws of 2010

§ 3-a. 1. Notwithstanding any inconsistent provision of law, rule or regulation to the contrary, and subject to the availability of federal financial participation, effective for the period August 1, 2010 through March 31, 2011, and each state fiscal year thereafter, the department of health is authorized to make Medicaid payment increases for diagnostic and treatment centers (DTC) services issued pursuant to section 2807 of the public health law for public DTCs operated by the New York City Health and Hospitals Corporation, at the election of the social services district in which an eligible DTC is physically located, of up to twelve million six hundred thousand dollars on an annualized basis for DTC services pursuant to title 11 of article 5 of the social services law for patients eligible for federal financial participation under title XIX of the federal social security act based on each such DTC's proportionate share of the sum of all clinic visits for all facilities eligible for an adjustment pursuant to this section for the base year two years prior to the rate year. Such proportionate share payments may be added to rates of payment or made as aggregate payments to eligible DTCs.

2. The social services district in which an eligible public DTC is physically located shall be responsible for the payment increase for such public DTC as determined in accordance with this section for all DTC services provided by such public DTC in accordance with section 365-a of the social services law, regardless of whether another social services district or the department of health may otherwise be responsible for furnishing medical assistance to the eligible persons receiving such services.

3. Any amounts provided pursuant to this section shall be effective for purposes of determining payments for public DTCs contingent on receipt of all approvals required by federal law or regulations for federal financial participation in payments made pursuant to title XIX of the federal social security act. If federal approvals are not granted for payments based on such amounts of components thereof, payments to eligible public DTCs shall be determined without consideration of such amounts or such components. In the event of such federal disapproval, public DTCs shall refund to the state, or the state may recoup from prospective payments, any payment received pursuant to this section, including those based on a retroactive reduction in the payments. Any reduction in federal financial participation pursuant to title XIX of the federal social security act related to federal upper payment limits shall be deemed to apply first to amounts provided pursuant to this section.

4. Reimbursement by the state for payments made whether by the department of health on behalf of a social services district pursuant to section 367-b of the social services law or by a social services district directly, for a payment determined in accordance with this section for public DTC services provided in accordance with section 365-a of the social services law shall be limited to the amount of federal funds properly received or to be received on account of such expenditures. Further, payments made pursuant to this section shall be excluded from all calculations made pursuant to section 1 of part C of

chapter 58 of the laws of 2005.

5. Social services district funding of the non-federal share of any payments pursuant to this section shall be deemed to be voluntary for purposes of the increased federal medical assistance percentage provisions of the American Recovery and Reinvestment Act of 2009; provided however that, in the event the federal Centers for Medicare and Medicaid Services determines that such non-federal share payments are not voluntary payments for purposes of such Act or otherwise disallows federal financial participation in such payments, the provisions of this section shall be null and void and payments made pursuant to this section shall be recouped by the commissioner of health.

§ 3-b. 1. Notwithstanding any inconsistent provision of law, rule or regulation to the contrary, and subject to the availability of federal financial participation, effective for the period August 1, 2010 through March 31, 2011, and each state fiscal year thereafter, the department of health is authorized to make Medicaid payment increases for county operated diagnostic and treatment centers (DTC) services issued pursuant to section 2807 of the public health law and for services provided by county operated free-standing clinics licensed pursuant to articles 31 and 32 of the mental hygiene law, but not including facilities operated by the New York City Health and Hospitals Corporation, of up to five million four hundred thousand dollars on an annualized basis for such services pursuant to title 11 of article 5 of the social services law for patients eligible for federal financial participation under title XIX of the federal social security act. Local social services districts may decline such increased payments to their sponsored DTCs and free-standing clinics, provided they provide written notification to the commissioner of health, within thirty days following receipt of notification of a payment pursuant to this section. Distributions pursuant to this section shall be based on each facility's proportionate share of the sum of all DTC and clinic visits for all facilities receiving payments pursuant to this section for the base year two years prior to the rate year. Such proportionate share payments may be added to rates or payment or made as aggregate payments to eligible facilities.

2. The social services district in which an eligible public DTC is physically located shall be responsible for the payment increases for such public DTC as determined in accordance with subdivision one of this section for all DTC services provided by such public DTC in accordance with section 365-a of the social services law, regardless of whether another social services district or the department of health may otherwise be responsible for furnishing medical assistance to the eligible persons receiving such services.

3. Any amounts provided pursuant to this section shall be effective for purposes of determining payments for public DTCs contingent on receipt of all approvals required by federal law or regulations for federal financial participation in payments made pursuant to title XIX of the federal social security act. If federal approvals are not granted for payments based on such amounts of components thereof, payments to eligible public DTCs shall be determined without consideration of such amounts or such components. In the event of such federal disapproval, public DTCs shall refund to the state, or the state may recoup from prospective payments, any payment received pursuant to this section,

including those based on a retroactive reduction in the payments. Any reduction in federal financial participation pursuant to title XIX of the federal social security act related to federal upper payments limits shall be deemed to apply first to amounts provided pursuant to this section.

4. Reimbursement by the state for payments made whether by the department of health on behalf of a social services district pursuant to section 367-b of the social services law or by a social services district directly, for a payment determined in accordance with this section for public DTC services provided in accordance with section 365-a of the social services law shall be limited to the amount of federal funds properly received or to be received on account of such expenditures. Further, payments made pursuant to this section shall be excluded from all calculations made pursuant to section 1 of part C of chapter 58 of the laws of 2005.

5. Social services district funding of the non-federal share of any payments pursuant to this section shall be deemed to be voluntary for purposes of the increased federal medical assistance percentage provisions of the American Recovery and Reinvestment Act of 2009; provided however that, in the event the federal Centers for Medicare and Medicaid Services determines that such non-federal share payments are not voluntary payments for purposes of such Act or otherwise disallows federal financial participation in such payments, the provisions of this section shall be null and void and payments made pursuant to this section shall be recouped by the commissioner of health.

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

Bernard Fineson DDRO
PO Box 280507
Queens Village, NY 11428-0507

Metro NY DDRO/Bronx
2400 Halsey St.
Bronx, NY 10461

Brooklyn DDRO
888 Fountain Ave.
Bldg. 1, 2nd Floor
Brooklyn, NY 11239

Metro NY DDRO/Manhattan
25 Beaver St., 4th Floor
New York, NY 10004

Staten Island DDRO
1150 Forest Hill Rd.
Bldg. 12, Suite A
Staten Island, NY 10314-6316

Long Island DDRO
415-A Oser Ave.
Hauppauge, NY 11788

For further information and to review and comment, please contact:
Office for People With Developmental Disabilities, Division of
Person-Centered Services, Waiver Unit, 44 Holland Ave., Albany, NY
12229, Peoplefirstwaiver@opwdd.ny.gov

PUBLIC NOTICE

Department of Health

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

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

All Services

Effective on or after April 1, 2019 through March 31, 2021 all non-exempt Medicaid payments, as referenced below, will be uniformly reduced. Such reductions will be applied only if an alternative method that achieves at least \$190.2 million in Medicaid state share savings annually is not implemented.

Exemptions from the uniform reduction are as follows:

- Any reductions that would violate federal law including, but not limited to, payments required pursuant to the federal Medicare program;
- Payments pursuant to the mental hygiene law;
- Payments the state is obligated to make pursuant to court orders or judgments;
- Payments for which the non-federal share does not reflect any state funding; and
- Payments where applying the reduction would result in a lower Federal Medical Assistance Percentage as determined by the Commissioner of Health and the Director of the Budget.

The estimated annual net aggregate decrease in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2019/2020 is (\$380.4 million).

Effective on and after April 1, 2019, no greater than zero trend factors attributable to services through March 31, 2024 pursuant to the provisions of Public Health Law § 2807-c(10)(c) to rates of payment for hospital inpatient and outpatient services, inpatient and adult day health care outpatient services provided by residential health care fa-

cilities 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.

The estimated annual net aggregate decrease in gross Medicaid expenditures for state fiscal year 2019/2020 is (\$208.8 million).

Non-Institutional Services

Effective on or after April 1, 2019, the reimbursement rate for Early Intervention services furnished by licensed physical therapists (PTs), occupational therapists (OTs), and speech-language pathologists (SLPs) will increase by 5%. This increase would also apply to supplemental evaluations performed by licensed PTs, OTs and SLPs. These rates are being revised to address capacity issues that municipalities are facing statewide for these qualified professionals.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2019/20 is estimated to be \$7.2 million.

Effective on or after April 1, 2019, 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.

For state fiscal year beginning April 1, 2019 through March 31, 2020, 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.

For state fiscal year beginning April 1, 2019 through March 31, 2020, continues upon the election of the social services district in which an eligible diagnostic and treatment center (DTC) is physically located, up to \$12.6 million in additional annual Medicaid payments may be paid to public DTCs operated by the New York City Health and Hospitals Corporation. Such payments will be based on each DTC's proportionate share of the sum of all clinic visits for all facilities eligible for an adjustment 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 DTCs.

For state fiscal year beginning April 1, 2019 through March 31, 2020, continues up to \$5.4 million in additional annual Medicaid payments may be paid 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.

Capital related costs of a general hospital excluding 44% of the major movable costs and excluding staff housing costs will continue effective April 1, 2019 through March 31, 2024 and thereafter.

The estimated annual net aggregate decrease in gross Medicaid expenditures for state fiscal year 2019/2020 is (\$35.1 million).

Extends current provisions for services on April 1, 2019 through March 31, 2024 and thereafter, the reimbursable operating cost component for general hospital inpatient rates will be established with

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

NON-INSTITUTIONAL SERVICES
State Plan Amendment #19-0022

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 this SPA. 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: For the period April 1, 2019 through March 31, 2020, supplemental payments authorized in this Attachment will be paid to providers of services in an amount totaling up to \$18 million for each respective period. These payments will be made to the non-state government owned or operated provider category.

The non-federal share of these payments will be funded via an IGT payment from local governments. This transfer of funds must take place prior to the State making the payment to the eligible providers. Each applicable local government has general taxing authority. A list of the entities transferring the funds; their operational nature; and the total amounts to be transferred for this purpose will be transmitted under separate cover once the UPL is approved.

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: For the period April 1, 2019 through March 31, 2020, supplemental payments for each respective period of \$12.6 million as authorized in this SPA will be paid to eligible providers of the New York City Health and Hospital Corporation. In addition, for each respective period, \$5.4 million as authorized in this SPA will be paid to eligible county government operated Diagnostic and Treatment Centers and licensed clinics providing mental hygiene services.

- 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 is working toward final submission of the 2018 Clinic UPL. Upon submission a detailed manual of the methodology will also be submitted. The State and CMS will work together toward approval of the UPL.

- 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.