NEW YORK STATE OF OPPORTUNITY. Department of Health

ANDREW M. CUOMO
Governor

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

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

June 29, 2021

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

RE: SPA #21-0022
Non-Institutional Services

Dear Mr. McMillion:

The State requests approval of the enclosed amendment #21-0022 to the Title XIX (Medicaid) State Plan for non-institutional services to be effective April 1, 2021 (Appendix I). This amendment is being submitted based on enacted legislation. A summary of the plan amendment is provided in Appendix II.

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

A copy of pertinent sections of enacted legislation is enclosed for your information (Appendix III). A copy of the public notice of this plan amendment, which was given in the New York State Register on March 31, 2021 is also enclosed for your information (Appendix IV). In addition, responses to the five standard funding questions are also enclosed (Appendix).

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

Sincerely,

[redacted]

Donna Frescatore
Medicaid Director
Office of Health Insurance Programs

Enclosures

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

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 21 — 0022

2. STATE: New York

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

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

4. PROPOSED EFFECTIVE DATE
April 1, 2021

5. TYPE OF PLAN MATERIAL *(Check One)*

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION
§ 1902(a) of the Social Security Act and 42 CFR 447

7. FEDERAL BUDGET IMPACT
a. FFY 04/01/21-09/30/21 $ 1,875.50
b. FFY 10/01/21-09/30/22 $ 3,751.00

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.19-B: Pages 1(q)(ii), 1(q)(iii),1(q)(iv), 1(q)(iv)(1), 1(q)(iv)(2), 1(q)(iv)(3)

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

10. SUBJECT OF AMENDMENT
Critical Access Hospital (CAH)-OP
(FMAP=50%)

11. GOVERNOR'S REVIEW *(Check One)*

☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED

12. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

13. TYPED NAME
Donna Frescatore

14. TITLE
Medicaid Director, Department of Health

15. DATE SUBMITTED
June 29, 2021

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

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED

18. DATE APPROVED

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL

20. SIGNATURE OF REGIONAL OFFICIAL

21. TYPED NAME

22. TITLE

23. REMARKS

Instructions on Back

SPA 21-0022

Attachment A

Replacement Pages: 1(q)(ii), 1(q)(iii), 1(q)(iv), 1(q)(iv)(1), 1(q)(iv)(2)

New York
1(q)(ii)

[Hospital-Based Outpatient Services – Critical Access Hospitals (CAHs):

Provider Name	Gross Medicaid Rate Adjustment	Rate Period Effective
Bassett Hospital of Schoharie County-Cobleskill Regional Hospital	$372,500	07/01/2019 – 3/31/2020
	$372,500	04/01/2020 – 03/31/2021
Carthage Area Hospital	$325,000	11/01/2014 – 03/31/2015
	$520,000	10/01/2015 - 03/31/2016
	$520,000	04/01/2016 - 03/31/2017
	$532,500	08/01/2017 – 03/31/2018
	$532,500	04/01/2018 – 03/31/2019
	$532,500	07/01/2019 – 03/31/2020
	$532,500	04/01/2020 – 03/31/2021
Catskill Regional Medical Center – Hermann Division	$275,000	02/01/2014 – 03/31/2014
	$240,000	11/01/2014 – 03/31/2015
	$327,500	10/01/2015 – 03/31/2016
	$327,500	04/01/2016 - 03/31/2017
	$310,000	08/01/2017 – 03/31/2018
	$310,000	04/01/2018 – 03/31/2019
	$310,000	07/01/2019 – 03/31/2020
	$310,000	04/01/2020 – 03/31/2021
Clifton-Fine Hospital	$350,000	02/01/2014 – 03/31/2014
	$325,000	11/01/2014 – 03/31/2015
	$520,000	10/01/2015 – 03/31/2016
	$520,000	04/01/2016 – 03/31/2017
	$532,500	08/01/2017 – 03/31/2018
	$532,500	04/01/2018 – 03/31/2019
	$532,500	07/01/2019 – 03/31/2020
	$532,500	04/01/2020 – 03/31/2021
Community Memorial Hospital	$240,000	11/01/2014 – 03/31/2015
	$384,000	10/01/2015 – 03/31/2016
	$384,000	04/01/2016 – 03/31/2017
	$372,500	08/01/2017 – 03/31/2018
	$372,500	04/01/2018 – 03/31/2019
	$372,500	07/01/2019 – 03/31/2020
	$372,500	04/01/2020 – 03/31/2021

]

New York
1(q)(iii)

[Hospital-Based Outpatient Services – Critical Access Hospitals (CAHs) (continued):

Provider Name	Gross Medicaid Rate Adjustment	Rate Period Effective
Cuba Memorial Hospital	$315,000	02/01/2014 – 03/31/2014
	$445,000	11/01/2014 – 03/31/2015
	$550,000	10/01/2015 – 03/31/2016
	$550,000	04/01/2016 – 03/31/2017
	$532,500	08/01/2017 – 03/31/2018
	$532,500	04/01/2018 – 03/31/2019
	$532,500	07/01/2019 – 03/31/2020
	$532,500	04/01/2020 – 03/31/2021
Delaware Valley Hospital	$246,000	02/01/2014 – 03/31/2014
	$240,000	11/01/2014 – 03/31/2015
	$327,500	10/01/2015 – 03/31/2016
	$327,500	04/01/2016 – 03/31/2017
	$310,000	08/01/2017 – 03/31/2018
	$310,000	04/01/2018 – 03/31/2019
	$310,000	07/01/2019 – 03/31/2020
	$310,000	04/01/2020 – 03/31/2021
Elizabethtown Community Hospital	$410,000	02/01/2014 – 03/31/2014
	$240,000	11/01/2014 – 03/31/2015
	$327,500	10/01/2015 – 03/31/2016
	$327,500	04/01/2016 – 03/31/2017
	$310,000	08/01/2017 – 03/31/2018
	$310,000	04/01/2018 – 03/31/2019
	$310,000	07/01/2019 – 03/31/2020
	$310,000	04/01/2020 – 03/31/2021
Ellenville Regional Hospital	$384,800	02/01/2014 – 03/31/2014
	$240,000	11/01/2014 – 03/31/2015
	$327,500	10/01/2015 – 03/31/2016
	$327,500	04/01/2016 – 03/31/2017
	$310,000	08/01/2017 – 03/31/2018
	$310,000	04/01/2018 – 03/31/2019
	$310,000	07/01/2019 – 03/31/2020
	$310,000	04/01/2020 – 03/31/2021

]

New York
1(q)(iv)

[Hospital-Based Outpatient Services – Critical Access Hospitals (CAHs) (continued):

Provider Name	Gross Medicaid Rate Adjustment	Rate Period Effective
Gouverneur Hospital, Inc.	$300,000	02/01/2014 – 03/31/2014
	$240,000	11/01/2014 – 03/31/2015
	$327,500	10/01/2015 – 03/31/2016
	$327,500	04/01/2016 – 03/31/2017
	$372,500	08/01/2017 – 03/31/2018
	$372,500	04/01/2018 – 03/31/2019
	$372,500	07/01/2019 – 03/31/2020
	$372,500	04/01/2020 – 03/31/2021
Lewis County General Hospital	$370,000	02/01/2014 – 03/31/2014
	$325,000	11/01/2014 – 03/31/2015
	$520,000	10/01/2015 – 03/31/2016
	$520,000	04/01/2016 – 03/31/2017
	$532,500	08/01/2017 – 03/31/2018
	$532,500	04/01/2018 – 03/31/2019
	$532,500	07/01/2019 – 03/31/2020
	$532,500	04/01/2020 – 03/31/2021
Little Falls Hospital	$342,000	02/01/2014 – 03/31/2014
	$240,000	11/01/2014 – 03/31/2015
	$327,500	10/01/2015 – 03/31/2016
	$327,500	04/01/2016 – 03/31/2017
	$372,500	08/01/2017 – 03/31/2018
	$372,500	04/01/2018 – 03/31/2019
	$372,500	07/01/2019 – 03/31/2020
	$372,500	04/01/2020 – 03/31/2021
Margaretville Memorial Hospital	$128,600	02/01/2014 – 03/31/2014
	$325,000	11/01/2014 – 03/31/2015
	$520,000	10/01/2015 – 03/31/2016
	$520,000	04/01/2016 – 03/31/2017
	$532,500	08/01/2017 – 03/31/2018
	$532,500	04/01/2018 – 03/31/2019
	$532,500	07/01/2019 – 03/31/2020
	$532,500	04/01/2020 – 03/31/2021

]

New York
1(q)(iv)(1)

[Hospital-Based Outpatient Services – Critical Access Hospitals (CAHs) (continued):

Provider Name	Gross Medicaid Rate Adjustment	Rate Period Effective
Medina Memorial Hospital	$480,000	10/01/2015 – 03/31/2016
	$480,000	04/01/2016 – 03/31/2017
	$432,000	08/01/2017 – 03/31/2018
	$432,000	04/01/2018 – 03/31/2019
	$432,000	07/01/2019 – 03/31/2020
	$432,000	04/01/2020 – 03/31/2021
Moses Ludington Hospital	$359,800	02/01/2014 – 03/31/2014
	$325,000	11/01/2014 – 03/31/2015
	$390,000	10/01/2015 – 03/31/2016
	$390,000	04/01/2016 – 03/31/2017
	$372,500	08/01/2017 – 03/31/2018
	$372,500	04/01/2018 – 03/31/2019
O'Connor Hospital	$363,800	02/01/2014 – 03/31/2014
	$240,000	11/01/2014 – 03/31/2015
	$327,500	10/01/2015 – 03/31/2016
	$327,500	04/01/2016 – 03/31/2017
	$310,000	08/01/2017 – 03/31/2018
	$310,000	04/01/2018 – 03/31/2019
	$310,000	07/01/2019 – 03/31/2020
	$310,000	04/01/2020 – 03/31/2021
River Hospital	$482,000	02/01/2014 – 03/31/2014
	$445,000	11/01/2014 – 03/31/2015
	$550,000	10/01/2015 – 03/31/2016
	$550,000	04/01/2016 – 03/31/2017
	$532,500	08/01/2017 – 03/31/2018
	$532,500	04/01/2018 – 03/31/2019
	$532,500	07/01/2019 – 03/31/2020
	$532,500	04/01/2020 – 03/31/2021
Schuyler Hospital	$453,000	02/01/2014 – 03/31/2014
	$240,000	11/01/2014 – 03/31/2015
	$384,000	10/01/2015 – 03/31/2016
	$384,000	04/01/2016 – 03/31/2017
	$462,500	08/01/2017 – 03/31/2018
	$462,500	04/01/2018 – 03/31/2019
	$462,500	07/01/2019 – 03/31/2020
	$462,500	04/01/2020 – 03/31/2021

]

New York
1(q)(iv)(2)

[Hospital-Based Outpatient Services – Critical Access Hospitals (CAHs) (continued):

Provider Name	Gross Medicaid Rate Adjustment	Rate Period Effective
Soldiers & Sailors Memorial Hospital	$220,000	02/01/2014 – 03/31/2014
	$325,000	11/01/2014 – 03/31/2015
	$390,000	10/01/2015 – 03/31/2016
	$390,000	04/01/2016 – 03/31/2017
	$372,500	08/01/2017 – 03/31/2018
	$372,500	04/01/2018 – 03/31/2019
	$372,500	07/01/2019 – 03/31/2020
	$372,500	04/01/2020 – 03/31/2021

]

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

New York
1(q)(ii)

Hospital-Based Outpatient Services – Critical Access Hospitals (CAHs):

Provider Name	Gross Medicaid Rate Adjustment	Rate Period Effective
Bassett Hospital of Schoharie County-Cobleskill Regional Hospital	$372,500	07/01/2019 – 3/31/2020
	$372,500	04/01/2020 – 03/31/2021
	$372,500	04/01/2021 – 03/31/2022
	$372,500	04/01/2022 – 03/31/2023
Carthage Area Hospital	$325,000	11/01/2014 – 03/31/2015
	$520,000	10/01/2015 - 03/31/2016
	$520,000	04/01/2016 - 03/31/2017
	$532,500	08/01/2017 – 03/31/2018
	$532,500	04/01/2018 – 03/31/2019
	$532,500	07/01/2019 – 03/31/2020
	$532,500	04/01/2020 – 03/31/2021
	$532,500	04/01/2021 – 03/31/2022
	$532,500	04/01/2022 – 03/31/2023
Catskill Regional Medical Center – Hermann Division	$275,000	02/01/2014 – 03/31/2014
	$240,000	11/01/2014 – 03/31/2015
	$327,500	10/01/2015 – 03/31/2016
	$327,500	04/01/2016 - 03/31/2017
	$310,000	08/01/2017 – 03/31/2018
	$310,000	04/01/2018 – 03/31/2019
	$310,000	07/01/2019 – 03/31/2020
	$310,000	04/01/2020 – 03/31/2021
	$310,000	04/01/2021 – 03/31/2022
	$310,000	04/01/2022 – 03/31/2023
Clifton-Fine Hospital	$350,000	02/01/2014 – 03/31/2014
	$325,000	11/01/2014 – 03/31/2015
	$520,000	10/01/2015 – 03/31/2016
	$520,000	04/01/2016 – 03/31/2017
	$532,500	08/01/2017 – 03/31/2018
	$532,500	04/01/2018 – 03/31/2019
	$532,500	07/01/2019 – 03/31/2020
	$532,500	04/01/2020 – 03/31/2021
	$532,500	04/01/2021 – 03/31/2022
	$532,500	04/01/2022 – 03/31/2023

New York
1(q)(iii)

Hospital-Based Outpatient Services – Critical Access Hospitals (CAHs) (continued):

Provider Name	Gross Medicaid Rate Adjustment	Rate Period Effective
Community Memorial Hospital	$240,000	11/01/2014 – 03/31/2015
	$384,000	10/01/2015 – 03/31/2016
	$384,000	04/01/2016 – 03/31/2017
	$372,500	08/01/2017 – 03/31/2018
	$372,500	04/01/2018 – 03/31/2019
	$372,500	07/01/2019 – 03/31/2020
	$372,500	04/01/2020 – 03/31/2021
	$372,500	04/01/2021 – 03/31/2022
	$372,500	04/01/2022 – 03/31/2023
Cuba Memorial Hospital	$315,000	02/01/2014 – 03/31/2014
	$445,000	11/01/2014 – 03/31/2015
	$550,000	10/01/2015 – 03/31/2016
	$550,000	04/01/2016 – 03/31/2017
	$532,500	08/01/2017 – 03/31/2018
	$532,500	04/01/2018 – 03/31/2019
	$532,500	07/01/2019 – 03/31/2020
	$532,500	04/01/2020 – 03/31/2021
	$532,500	04/01/2021 – 03/31/2022
	$532,500	04/01/2022 – 03/31/2023
Delaware Valley Hospital	$246,000	02/01/2014 – 03/31/2014
	$240,000	11/01/2014 – 03/31/2015
	$327,500	10/01/2015 – 03/31/2016
	$327,500	04/01/2016 – 03/31/2017
	$310,000	08/01/2017 – 03/31/2018
	$310,000	04/01/2018 – 03/31/2019
	$310,000	07/01/2019 – 03/31/2020
	$310,000	04/01/2020 – 03/31/2021
	$310,000	04/01/2021 – 03/31/2022
	$310,000	04/01/2022 – 03/31/2023

New York
1(q)(iv)

Hospital-Based Outpatient Services – Critical Access Hospitals (CAHs) (continued):

Provider Name	Gross Medicaid Rate Adjustment	Rate Period Effective
Elizabethtown Community Hospital	$410,000	02/01/2014 – 03/31/2014
	$240,000	11/01/2014 – 03/31/2015
	$327,500	10/01/2015 – 03/31/2016
	$327,500	04/01/2016 – 03/31/2017
	$310,000	08/01/2017 – 03/31/2018
	$310,000	04/01/2018 – 03/31/2019
	$310,000	07/01/2019 – 03/31/2020
	$310,000	04/01/2020 – 03/31/2021
	$310,000	04/01/2021 - 03/31/2022
	$310,000	04/01/2022 – 03/31/2023
Ellenville Regional Hospital	$384,800	02/01/2014 – 03/31/2014
	$240,000	11/01/2014 – 03/31/2015
	$327,500	10/01/2015 – 03/31/2016
	$327,500	04/01/2016 – 03/31/2017
	$310,000	08/01/2017 – 03/31/2018
	$310,000	04/01/2018 – 03/31/2019
	$310,000	07/01/2019 – 03/31/2020
	$310,000	04/01/2020 – 03/31/2021
	$310,000	04/01/2021 - 03/31/2022
	$310,000	04/01/2022 – 03/31/2023
Gouverneur Hospital, Inc.	$300,000	02/01/2014 – 03/31/2014
	$240,000	11/01/2014 – 03/31/2015
	$327,500	10/01/2015 – 03/31/2016
	$327,500	04/01/2016 – 03/31/2017
	$372,500	08/01/2017 – 03/31/2018
	$372,500	04/01/2018 – 03/31/2019
	$372,500	07/01/2019 – 03/31/2020
	$372,500	04/01/2020 – 03/31/2021
	$372,500	04/01/2021 - 03/31/2022
	$372,500	04/01/2022 – 03/31/2023

New York
1(q)(iv)(1)

Hospital-Based Outpatient Services – Critical Access Hospitals (CAHs) (continued):

Provider Name	Gross Medicaid Rate Adjustment	Rate Period Effective
Lewis County General Hospital	$370,000	02/01/2014 – 03/31/2014
	$325,000	11/01/2014 – 03/31/2015
	$520,000	10/01/2015 – 03/31/2016
	$520,000	04/01/2016 – 03/31/2017
	$532,500	08/01/2017 – 03/31/2018
	$532,500	04/01/2018 – 03/31/2019
	$532,500	07/01/2019 – 03/31/2020
	$532,500	04/01/2020 – 03/31/2021
	$532,500	04/01/2021 – 03/31/2022
	$532,500	04/01/2022 – 03/31/2023
Little Falls Hospital	$342,000	02/01/2014 – 03/31/2014
	$240,000	11/01/2014 – 03/31/2015
	$327,500	10/01/2015 – 03/31/2016
	$327,500	04/01/2016 – 03/31/2017
	$372,500	08/01/2017 – 03/31/2018
	$372,500	04/01/2018 – 03/31/2019
	$372,500	07/01/2019 – 03/31/2020
	$372,500	04/01/2020 – 03/31/2021
	$372,500	04/01/2021 – 03/31/2022
	$372,500	04/01/2022 – 03/31/2023
Margaretville Memorial Hospital	$128,600	02/01/2014 – 03/31/2014
	$325,000	11/01/2014 – 03/31/2015
	$520,000	10/01/2015 – 03/31/2016
	$520,000	04/01/2016 – 03/31/2017
	$532,500	08/01/2017 – 03/31/2018
	$532,500	04/01/2018 – 03/31/2019
	$532,500	07/01/2019 – 03/31/2020
	$532,500	04/01/2020 – 03/31/2021
	$532,500	04/01/2021 – 03/31/2022
	$532,500	04/01/2022 – 03/31/2023

New York
1(q)(iv)(2)

Hospital-Based Outpatient Services – Critical Access Hospitals (CAHs) (continued):

Provider Name	Gross Medicaid Rate Adjustment	Rate Period Effective
Medina Memorial Hospital	$480,000	10/01/2015 – 03/31/2016
	$480,000	04/01/2016 – 03/31/2017
	$432,000	08/01/2017 – 03/31/2018
	$432,000	04/01/2018 – 03/31/2019
	$432,000	07/01/2019 – 03/31/2020
	$432,000	04/01/2020 – 03/31/2021
	$432,000	04/01/2021 – 03/31/2022
	$432,000	04/01/2022 – 03/31/2023
Moses Ludington Hospital	$359,800	02/01/2014 – 03/31/2014
	$325,000	11/01/2014 – 03/31/2015
	$390,000	10/01/2015 – 03/31/2016
	$390,000	04/01/2016 – 03/31/2017
	$372,500	08/01/2017 – 03/31/2018
	$372,500	04/01/2018 – 03/31/2019
O'Connor Hospital	$363,800	02/01/2014 – 03/31/2014
	$240,000	11/01/2014 – 03/31/2015
	$327,500	10/01/2015 – 03/31/2016
	$327,500	04/01/2016 – 03/31/2017
	$310,000	08/01/2017 – 03/31/2018
	$310,000	04/01/2018 – 03/31/2019
	$310,000	07/01/2019 – 03/31/2020
	$310,000	04/01/2020 – 03/31/2021
	$310,000	04/01/2021 – 03/31/2022
	$310,000	04/01/2022 – 03/31/2023
River Hospital	$482,000	02/01/2014 – 03/31/2014
	$445,000	11/01/2014 – 03/31/2015
	$550,000	10/01/2015 – 03/31/2016
	$550,000	04/01/2016 – 03/31/2017
	$532,500	08/01/2017 – 03/31/2018
	$532,500	04/01/2018 – 03/31/2019
	$532,500	07/01/2019 – 03/31/2020
	$532,500	04/01/2020 – 03/31/2021
	$532,500	04/01/2021 – 03/31/2022
	$532,500	04/01/2022 – 03/31/2023

New York
1(q)(iv)(3)

Hospital-Based Outpatient Services – Critical Access Hospitals (CAHs) (continued):

Provider Name	Gross Medicaid Rate Adjustment	Rate Period Effective
Schuyler Hospital	$453,000	02/01/2014 – 03/31/2014
	$240,000	11/01/2014 – 03/31/2015
	$384,000	10/01/2015 – 03/31/2016
	$384,000	04/01/2016 – 03/31/2017
	$462,500	08/01/2017 – 03/31/2018
	$462,500	04/01/2018 – 03/31/2019
	$462,500	07/01/2019 – 03/31/2020
	$462,500	04/01/2020 – 03/31/2021
	$462,500	04/01/2021 – 03/31/2022
	$462,500	04/01/2022 – 03/31/2023
Soldiers & Sailors Memorial Hospital	$220,000	02/01/2014 – 03/31/2014
	$325,000	11/01/2014 – 03/31/2015
	$390,000	10/01/2015 – 03/31/2016
	$390,000	04/01/2016 – 03/31/2017
	$372,500	08/01/2017 – 03/31/2018
	$372,500	04/01/2018 – 03/31/2019
	$372,500	07/01/2019 – 03/31/2020
	$372,500	04/01/2020 – 03/31/2021
	$372,500	04/01/2021 – 03/31/2022
	$372,500	04/01/2022 – 03/31/2023

Appendix II
2021 Title XIX State Plan
Second Quarter Amendment
Summary

SUMMARY
SPA #21-0022

This State Plan Amendment proposes to extend the listing of hospitals and awards previously approved to receive temporary rate adjustments to promote efficiency, economy, and quality of care.

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

SPA 21-0022

Public Health Law

§ 2826. Temporary adjustment to reimbursement rates. (a) Notwithstanding any provision of law to the contrary, within funds appropriated and subject to the availability of federal financial participation, the commissioner may grant approval of a temporary adjustment to the non-capital components of rates, or make temporary lump-sum Medicaid payments, to eligible general hospitals, skilled nursing facilities, clinics and home care providers, provided however, that should federal financial participation not be available for any eligible provider, then payments pursuant to this subdivision may be made as grants and shall not be deemed to be medical assistance payments.

(b) Eligible providers shall include:

(i) providers undergoing closure;

(ii) providers impacted by the closure of other health care providers;

(iii) providers subject to mergers, acquisitions, consolidations or restructuring; or

(iv) providers impacted by the merger, acquisition, consolidation or restructuring of other health care providers.

(c) Providers seeking temporary rate adjustments under this section shall demonstrate through submission of a written proposal to the commissioner that the additional resources provided by a temporary rate adjustment will achieve one or more of the following:

(i) protect or enhance access to care;

(ii) protect or enhance quality of care;

(iii) improve the cost effectiveness of the delivery of health care services; or

(iv) otherwise protect or enhance the health care delivery system, as determined by the commissioner.

(c-1) The commissioner, under applications submitted to the department pursuant to subdivision (d) of this section, shall consider criteria that includes, but is not limited to:

(i) Such applicant's financial condition as evidenced by operating margins, negative fund balance or negative equity position;

(ii) The extent to which such applicant fulfills or will fulfill an unmet health care need for acute inpatient, outpatient, primary or residential health care services in a community;

(iii) The extent to which such application will involve savings to the Medicaid program;

(iv) The quality of the application as evidenced by such application's long term solutions for such applicant to achieve sustainable health care services, improving the quality of patient care, and/or transforming the delivery of health care services to meet community needs;

(v) The extent to which such applicant is geographically isolated in relation to other providers; or

(vi) The extent to which such applicant provides services to an underserved area in relation to other providers.

(d) (i) Such written proposal shall be submitted to the commissioner at least sixty days prior to the requested effective date of the temporary rate adjustment, and shall include a proposed budget to achieve the goals of the proposal. Any Medicaid payment issued pursuant to this section shall be in effect for a specified period of time as determined by the commissioner, of up to three years. At the end of the specified timeframe such payments or adjustments to the non-capital

component of rates shall cease, and the provider shall be reimbursed in accordance with the otherwise applicable rate-setting methodology as set forth in applicable statutes and regulations. The commissioner may establish, as a condition of receiving such temporary rate adjustments or grants, benchmarks and goals to be achieved in conformity with the provider's written proposal as approved by the commissioner and may also require that the facility submit such periodic reports concerning the achievement of such benchmarks and goals as the commissioner deems necessary. Failure to achieve satisfactory progress, as determined by the commissioner, in accomplishing such benchmarks and goals shall be a basis for ending the facility's temporary rate adjustment or grant prior to the end of the specified timeframe. (ii) The commissioner may require that applications submitted pursuant to this section be submitted in response to and in accordance with a Request For Applications or a Request For Proposals issued by the commissioner.

(e) Notwithstanding any law to the contrary, general hospitals defined as critical access hospitals pursuant to title XVIII of the federal social security act shall be allocated no less than seven million five hundred thousand dollars annually pursuant to this section. The department of health shall provide a report to the governor and legislature no later than June first, two thousand fifteen providing recommendations on how to ensure the financial stability of, and preserve patient access to, critical access hospitals, including an examination of permanent Medicaid rate methodology changes.

(e-1) Thirty days prior to executing an allocation or modification to an allocation made pursuant to this section, the commissioner shall provide written notice to the chair of the senate finance committee and the chair of the assembly ways and means committee with regards to the intent to distribute such funds. Such notice shall include, but not be limited to, information on the methodology used to distribute the funds, the facility specific allocations of the funds, any facility specific project descriptions or requirements for receiving such funds, the multi-year impacts of these allocations, and the availability of federal matching funds. The commissioner shall provide quarterly reports to the chair of the senate finance committee and the chair of the assembly ways and means committee on the distribution and disbursement of such funds. Within sixty days of the effectiveness of this subdivision, the commissioner shall provide a written report to the chair of the senate finance committee and the chair of the assembly ways and means committee on all awards made pursuant to this section prior to the effectiveness of this subdivision, including all information that is required to be included in the notice requirements of this subdivision.

(f) Notwithstanding any provision of law to the contrary, and subject to federal financial participation, no less than ten million dollars shall be allocated to providers described in this subdivision; provided, however that if federal financial participation is unavailable for any eligible provider, or for any potential investment under this subdivision then the non-federal share of payments pursuant to this subdivision may be made as state grants.

(i) Providers serving rural areas as such term is defined in section two thousand nine hundred fifty-one of this chapter, including but not limited to hospitals, residential health care facilities, diagnostic and treatment centers, ambulatory surgery centers and clinics shall be eligible for enhanced payments or reimbursement under a supplemental rate methodology for the purpose of promoting access and improving the quality of care.

(ii) Notwithstanding any provision of law to the contrary, and subject

to federal financial participation, essential community providers, which, for the purposes of this section, shall mean a provider that offers health services within a defined and isolated geographic region where such services would otherwise be unavailable to the population of such region, shall be eligible for enhanced payments or reimbursement under a supplemental rate methodology for the purpose of promoting access and improving quality of care. Eligible providers under this paragraph may include, but are not limited to, hospitals, residential health care facilities, diagnostic and treatment centers, ambulatory surgery centers and clinics.

(iii) In making such payments the commissioner may contemplate the extent to which any such provider receives assistance under subdivision (a) of this section and may require such provider to submit a written proposal demonstrating that the need for monies under this subdivision exceeds monies otherwise distributed pursuant to this section.

(iv) Payments under this subdivision may include, but not be limited to, temporary rate adjustments, lump sum Medicaid payments, supplemental rate methodologies and any other payments as determined by the commissioner.

(v) Payments under this subdivision shall be subject to approval by the director of the budget.

(vi) The commissioner may promulgate regulations to effectuate the provisions of this subdivision.

(vii) Thirty days prior to adopting or applying a methodology or procedure for making an allocation or modification to an allocation made pursuant to this subdivision, the commissioner shall provide written notice to the chairs of the senate finance committee, the assembly ways and means committee, and the senate and assembly health committees with regard to the intent to adopt or apply the methodology or procedure, including a detailed explanation of the methodology or procedure.

(viii) Thirty days prior to executing an allocation or modification to an allocation made pursuant to this subdivision, the commissioner shall provide written notice to the chairs of the senate finance committee, the assembly ways and means committee, and the senate and assembly health committees with regard to the intent to distribute such funds. Such notice shall include, but not be limited to, information on the methodology used to distribute the funds, the facility specific allocations of the funds, any facility specific project descriptions or requirements for receiving such funds, the multi-year impacts of these allocations, and the availability of federal matching funds. The commissioner shall provide quarterly reports to the chair of the senate finance committee and the chair of the assembly ways and means committee on the distribution and disbursement of such funds.

(g) Notwithstanding subdivision (a) of this section, and within amounts appropriated for such purposes as described herein, for the period of April first, two thousand fifteen through March thirty-first, two thousand sixteen, the commissioner may award a temporary adjustment to the non-capital components of rates, or make temporary lump-sum Medicaid payments to eligible general hospitals in severe financial distress to enable such facilities to maintain operations and vital services while such facilities establish long term solutions to achieve sustainable health services.

(i) Eligible general hospitals shall include:

(A) a public hospital, which for purposes of this subdivision, shall mean a general hospital operated by a county or municipality, but shall exclude any such hospital operated by a public benefit corporation;

(B) a federally designated critical access hospital;

(C) a federally designated sole community hospital; or

(D) a general hospital that is a safety net hospital, which for purposes of this subdivision shall mean:

(1) such hospital has at least thirty percent of its inpatient discharges made up of Medicaid eligible individuals, uninsured individuals or Medicaid dually eligible individuals and with at least thirty-five percent of its outpatient visits made up of Medicaid eligible individuals, uninsured individuals or Medicaid dually-eligible individuals; or

(2) such hospital serves at least thirty percent of the residents of a county or a multi-county area who are Medicaid eligible individuals, uninsured individuals or Medicaid dually-eligible individuals.

(ii) Eligible applicants must demonstrate that without such award, they will be in severe financial distress through March thirty-first, two thousand sixteen, as evidenced by:

(A) certification that such applicant has less than fifteen days cash and equivalents;

(B) such applicant has no assets that can be monetized other than those vital to operations; and

(C) such applicant has exhausted all efforts to obtain resources from corporate parents and affiliated entities to sustain operations.

(iii) Awards under this subdivision shall be made upon application to the department.

(A) Applications under this subdivision shall include a multi-year transformation plan that is aligned with the delivery system reform incentive payment ("DSRIP") program goals and objectives. Such plan shall be approved by the department and shall demonstrate a path towards long term sustainability and improved patient care.

(B) The department may authorize initial award payments to eligible applicants based solely on the criteria pursuant to paragraphs (i) and (ii) of this subdivision.

(C) Notwithstanding subparagraph (B) of this paragraph, the department may suspend or repeal an award if an eligible applicant fails to submit a multi-year transformation plan pursuant to subparagraph (A) of this paragraph that is acceptable to the department by no later than the thirtieth day of September two thousand fifteen.

(D) Applicants under this subdivision shall detail the extent to which the affected community has been engaged and consulted on potential projects of such application, as well as any outreach to stakeholders and health plans.

(E) The department shall review all applications under this subdivision, and a determine:

(1) applicant eligibility;

(2) each applicant's projected financial status;

(3) each applicant's proposed use of funds to maintain critical services needed by its community; and

(4) the anticipated impact of the loss of such services.

(F) After review of all applications under this subdivision, and a determination of the aggregate amount of requested funds, the department shall make awards to eligible applicants; provided, however, that such awards may be in an amount lower than such requested funding, on a per applicant or aggregate basis.

(iv) Awards under this subdivision may not be used for:

(A) capital expenditures, including, but not limited to: construction, renovation and acquisition of capital equipment, including major medical equipment;

(B) consultant fees;

(C) retirement of long term debt; or

(D) bankruptcy-related costs.

(v) Payments made to awardees pursuant to this subdivision shall be made on a monthly basis. Such payments will be based on the applicant's actual monthly financial performance during such period and the reasonable cash amount necessary to sustain operations for the following month. The applicant's monthly financial performance shall be measured by such applicant's monthly financial and activity reports, which shall include, but not be limited to, actual revenue and expenses for the prior month, projected cash need for the current month, and projected cash need for the following month.

(vi) The department shall provide a report on a quarterly basis to the chairs of the senate finance, assembly ways and means, senate health and assembly health committees. Such reports shall be submitted no later than sixty days after the close of the quarter, and shall include for each award, the name of the applicant, the amount of the award, payments to date, and a description of the status of the multi-year transformation plan pursuant to paragraph (iii) of this subdivision.

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

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

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

Non-Institutional Services

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

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

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

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

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

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

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

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

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

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

Effective on and after April 1, 2021, this notice provides for a temporary rate adjustment with an aggregate payment totaling no less than $7.5 million annually for Critical Access Hospitals (CAHs), for the periods April 1, 2021 through March 31, 2022 and April 1, 2022 through March 31, 2023. These payments will be made to the following:

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

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

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

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

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

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

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

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

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

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

NON-INSTITUTIONAL SERVICES
State Plan Amendment #21-0022

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 the state plan. For SPAs that provide for changes to payments for clinic or outpatient hospital services or for enhanced or supplemental payments to physician or other practitioners, the questions must be answered for all payments made under the state plan for such service.

1. **Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by States for services under the approved State plan. Do providers receive and retain the total Medicaid expenditures claimed by the State (includes normal per diem, supplemental, enhanced payments, other) or is any portion of the payments returned to the State, local governmental entity, or any other intermediary organization? If providers are required to return any portion of payments, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the payments, a complete listing of providers that return a portion of their payments, the amount or percentage of payments that are returned and the disposition and use of the funds once they are returned to the State (i.e., general fund, medical services account, etc.).**

   Response: Providers do retain the payments made pursuant to this amendment. However, this requirement in no way prohibits the public provider, including county providers, from reimbursing the sponsoring local government for appropriate expenses incurred by the local government on behalf of the public provider. The State does not regulate the financial relationships that exist between public health care providers and their sponsoring governments, which are extremely varied and complex. Local governments may provide direct and/or indirect monetary subsidies to their public providers to cover on-going unreimbursed operational expenses and assure achievement of their mission as primary safety net providers. Examples of appropriate expenses may include payments to the local government which include reimbursement for debt service paid on a provider's behalf, reimbursement for Medicare Part B premiums paid for a provider's retirees, reimbursement for contractually required health benefit fund payments made on a provider's behalf, and payment for overhead expenses as allocated per federal Office of Management and Budget Circular 2 CFR 200 regarding Cost Principles for State, Local, and Indian Tribal Governments. The existence of such transfers should in no way negate the legitimacy of these facilities' Medicaid payments or result in reduced Medicaid federal financial participation for the State. This position was further supported by CMS in review and approval of SPA 07-07C when an on-site audit of these transactions for New York City's Health and Hospitals Corporation was completed with satisfactory results.

2. **Section 1902(a)(2) provides that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan. Please describe how the state share of each type of Medicaid payment (normal per diem, supplemental, enhanced, other) is funded. Please describe whether the state share is from appropriations from the legislature to the Medicaid agency, through intergovernmental transfer agreements (IGTs), certified public expenditures (CPEs), provider taxes, or any other mechanism used by the state to provide state share. Note that, if the appropriation is not to the Medicaid agency, the source of the state share would necessarily be derived through either through an IGT or CPE. In this case, please identify the agency to which the funds are appropriated. Please provide an estimate of total expenditure and State share amounts for each type of Medicaid payment. If any of the non-federal share is being provided using IGTs or CPEs, please fully describe the matching arrangement including when the state agency receives the transferred amounts from the local governmental entity transferring the funds. If CPEs are used, please describe the methodology used by the state to verify that the total expenditures being certified are eligible for Federal matching funds in accordance with 42 CFR 433.51(b). For any payment funded by CPEs or IGTs, please provide the following:**
   - **(i) a complete list of the names of entities transferring or certifying funds;**
   - **(ii) the operational nature of the entity (state, county, city, other);**
   - **(iii) the total amounts transferred or certified by each entity;**
   - **(iv) clarify whether the certifying or transferring entity has general taxing authority: and,**
   - **(v) whether the certifying or transferring entity received appropriations (identify level of appropriations).**

   Response: Payments made to service providers under the provisions of this SPA are funded through a general appropriation received by the State agency that oversees medical assistance (Medicaid), which is the Department of Health.

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

   There have been no new provider taxes and no existing taxes have been modified.

3. **Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan. If supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to each provider type.**

   Response: The payments authorized for this provision total $7.502 million annually for Critical Access Hospitals.

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

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

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

ACA Assurances:

1. **Maintenance of Effort (MOE). Under section 1902(gg) of the Social Security Act (the Act), as amended by the Affordable Care Act, as a condition of receiving any Federal payments under the Medicaid program during the MOE period indicated below, the State shall not have in effect any eligibility standards, methodologies, or procedures in its Medicaid program which are more restrictive than such eligibility provisions as in effect in its Medicaid program on March 10, 2010.**

   MOE Period.
   - **Begins on: March 10, 2010, and**
   - **Ends on: The date the Secretary of the Federal Department of Health and Human Services determines an Exchange established by a State under the provisions of section 1311 of the Affordable Care Act is fully operational.**

   Response: This SPA complies with the conditions of the MOE provision of section 1902(gg) of the Act for continued funding under the Medicaid program.

2. **Section 1905(y) and (z) of the Act provides for increased FMAPs for expenditures made on or after January 1, 2014 for individuals determined eligible under section 1902(a)(10)(A)(i)(VIII) of the Act. Under section 1905(cc) of the Act, the increased FMAP under sections 1905(y) and (z) would not be available for States that require local political subdivisions to**

contribute amounts toward the non-Federal share of the State's expenditures at a greater percentage than would have been required on December 31, 2009.

Prior to January 1, 2014 States may potentially require contributions by local political subdivisions toward the non-Federal share of the States' expenditures at percentages greater than were required on December 31, 2009. However, because of the provisions of section 1905(cc) of the Act, it is important to determine and document/flag any SPAs/State plans which have such greater percentages prior to the January 1, 2014 date in order to anticipate potential violations and/or appropriate corrective actions by the States and the Federal government.

Response: This SPA would [ ] / would not [✓] violate these provisions, if they remained in effect on or after January 1, 2014.

3. **Please indicate whether the State is currently in conformance with the requirements of section 1902(a)(37) of the Act regarding prompt payment of claims.**

   Response: The State does comply with the requirements of section 1902(a)(37) of the Act regarding prompt payment of claims.

Tribal Assurance:

Section 1902(a)(73) of the Social Security Act the Act requires a State in which one or more Indian Health Programs or Urban Indian Organizations furnish health care services to establish a process for the State Medicaid agency to seek advice on a regular ongoing basis from designees of Indian health programs whether operated by the Indian Health Service HIS Tribes or Tribal organizations under the Indian Self Determination and Education Assistance Act ISDEAA or Urban Indian Organizations under the Indian Health Care Improvement Act.

IHCIA Section 2107(e)(I) of the Act was also amended to apply these requirements to the Children's Health Insurance Program CHIP. Consultation is required concerning Medicaid and CHIP matters having a direct impact on Indian health programs and Urban Indian organizations.

a) **Please describe the process the State uses to seek advice on a regular ongoing basis from federally recognized tribes Indian Health Programs and Urban Indian Organizations on matters related to Medicaid and CHIP programs and for consultation on State Plan Amendments waiver proposals waiver extensions waiver amendments waiver renewals and proposals for demonstration projects prior to submission to CMS.**
b) **Please include information about the frequency inclusiveness and process for seeking such advice.**

c) Please describe the consultation process that occurred specifically for the development and submission of this State Plan Amendment when it occurred and who was involved.

Response: Tribal consultation was performed in accordance with the State's tribal consultation policy as approved in SPA 17-0065, and documentation of such is included with this submission. To date, no feedback has been received from any tribal representative in response to the proposed change in this SPA.