NEW YORK STATE OF OPPORTUNITY. Department of Health

KATHY HOCHUL
Governor

JAMES V. McDONALD, M.D., M.P.H.
Commissioner

JOHANNE E. MORNE, M.S.
Executive Deputy Commissioner

June 28, 2024

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 #24-0004
Non-Institutional Services

Dear Director McMillion:

The State requests approval of the enclosed amendment #24-0004 the Title XIX (Medicaid) State Plan for non-institutional services to be effective April 1, 2024 (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 February 21, 2024, 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
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: 24 — 0004

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, 2024

5. FEDERAL STATUTE/REGULATION CITATION
§ 1905(a)(9) Clinic Services

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 04/01/24-09/30/24 $ 1,350,000
b. FFY 10/01/24-09/30/25 $ 1,350,000

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.19-B: Page 2(v)

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 4.19-B: Page 2(v)

9. SUBJECT OF AMENDMENT
2024 Clinic UPL

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. Amir Bassiri

13. TITLE
Medicaid Director

14. DATE SUBMITTED June28, 2024

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
2024 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) (Supplemental Payments for Non-State Government Clinics)

1905(a)(9) Clinic Services

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

Effective for the period April 1, 2011, through March 31, 2012, 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 (FFP) under Title XIX of the federal Social Security Act 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. Such proportionate share payments will be added to rates of payment or made as aggregate payments to each eligible HHC DTC.

2. County Operated DTCs and mental hygiene clinics

Effective for the period April 1, ~~2023~~ 2024, through ~~March~~ December 31, 2024, 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 will, on an annual basis, decline such increased payments within thirty days following receipt of notification. The amount to be paid will be up to $~~1,610,987~~ 5,400,000.

Medical assistance payments will be made for patients eligible for federal financial participation (FFP) under Title XIX of the federal Social Security Act 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. Such proportionate share payments will be added to rates of payment or made as aggregate payments to each eligible county operated DTC and mental hygiene clinic.

Appendix II
2023 Title XIX State Plan
Second Quarter Amendment
Summary

SUMMARY
SPA #24-0004

This State Plan Amendment proposes to authorize adjustments that increase the operating cost components of rates of payment for County operated freestanding clinics and diagnostic and treatment centers (DTCs) licensed under Article 31 and 32 of the NYS Mental Hygiene Law.

Appendix III
2023 Title XIX State Plan
Second Quarter Amendment
Authorizing Provisions

SPA 24-0004

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 (OTC) services issued pursuant to section 2807 of the public health law for public OTCs operated by the New York City Health and Hospitals Corporation, at the election of the social services district in which an eligible OTC is physically located, of up to twelve million six hundred thousand dollars on an annualized basis for OTC 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 OTC'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 OTCs.

2. The social services district in which an eligible public OTC is physically located shall be responsible for the payment increase for such public OTC as determined in accordance with this section for all OTC services provided by such public OTC 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 OTCs 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 OTCs shall be determined without consideration of such amounts or such components. In the event of such federal disapproval, public OTCs 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 OTC 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 freestanding 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 OTC 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.

SPA 24-0004

Part C of Chapter 58 of the Laws of 2010

Notwithstanding any inconsistent provision of law, rule or regu-
46 lation to the contrary, and subject to the availability of federal
47 financial participation, effective for [~~the period~~] **each state fiscal**
48 **year from** August 1, 2010 through [~~March 31, 2011, and each state fiscal~~
49 ~~year~~] **December 31, 2024; and for the calendar year from January 1, 2025**
50 **through December 31, 2025; and for each calendar year** thereafter, the
51 department of health is authorized to make Medicaid payment increases
52 for diagnostic and treatment centers (DTC) services issued pursuant to
53 section 2807 of the public health law for public DTCs operated by the
54 New York City Health and Hospitals Corporation, at the election of the
55 social services district in which an eligible DTC is physically located,
56 of up to twelve million six hundred thousand dollars on an annualized

1 basis for DTC services pursuant to title 11 of article 5 of the social
2 services law for patients eligible for federal financial participation
3 under title XIX of the federal social security act based on each such
4 DTC's proportionate share of the sum of all clinic visits for all facil-
5 ities eligible for an adjustment pursuant to this section for the base
6 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.

§ 8. Subdivision 1 of section 3-b of part B of chapter 58 of the laws of 2010, amending the social services law and the public health law relating to prescription drug coverage for needy persons and health care initiatives pools, is amended to read as follows:

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~~] **each state fiscal year from** August 1, 2010 through [~~March 31, 2011, and each state fiscal year~~] **December 31, 2024; and for the calendar year from January 1, 2025 through December 31, 2025; and for each calendar 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

30 sponsored DTCs and free-standing clinics, provided they provide written
31 notification to the commissioner of health, within thirty days following
32 receipt of notification of a payment pursuant to this section. Distrib-
33 utions pursuant to this section shall be based on each facility's
34 proportionate share of the sum of all DTC and clinic visits for all
35 facilities receiving payments pursuant to this section for the base year
36 two years prior to the rate year. Such proportionate share payments may
37 be added to rates or payment or made as aggregate payments to eligible
38 facilities.

Appendix IV
2023 Title XIX State Plan
Second Quarter Amendment
Public Notice

Washington Ave., One Commerce Plaza, Suite 1432, Albany, NY 12210, spa_inquiries@health.ny.gov

PUBLIC NOTICE

Department of Health

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

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

Non-Institutional Services

Effective on or after April 1, 2024, 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, 2024 through March 31, 2025, 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 the current 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, 2024 through March 31, 2025, 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 April 1, 2024 and each state fiscal year thereafter, this proposal continues supplemental payments for services provided by physicians, nurse practitioners and physician assistants will continue.

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

Institutional Services

Effective on or after April 1, 2024, this proposal continues the supplemental upper payment limit payments made to general hospitals, other than major public general hospitals under 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, 2024 through March 31, 2025, this proposal continues adjustments for hospital inpatient services provided on and after April 1, 2012, to public general hospitals, other than those operated by the State of New York or the State University of New York, located in a city with a population of over one million and receiving reimbursement of up to $1.08 billion annually based on the current 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 to eligible public general hospitals 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, 2024 through March 31, 2025, this proposal continues supplemental payments to State government owned hospitals.

These payments will not exceed the upper payment limit for inpatient services provided by state government-owned hospitals when aggregated with other Medicaid payments.

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

Long Term Care Services

Effective on or after April 1, 2024, this proposal continues additional payments to non-state government operated public residential health care facilities, including public residential health care facilities located in Nassau, Westchester, and Erie Counties, but not excluding public residential health care facilities operating by a town or city within a county, in aggregate amounts of up to $500 million. The amount allocated to each eligible public RHCF will be in accordance with the previously approved methodology, provided, however that patient days shall be utilized for such computation reflecting actual reported data for 2022 and each representative succeeding year as applicable. Payments to eligible RHCF's 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.

The public is invited to review and comment on this proposed State Plan Amendment, a copy of which will be available for public review on the Department's website at http://www.health.ny.gov/regulations/state_plans/status. In addition, approved SPA's beginning in 2011 are also available for viewing on this website.

Copies of the proposed State Plan Amendments will be on file in each local (county) social services district and available for public review.

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

New York County
250 Church Street
New York, New York 10018

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

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

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

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

*For further information and to review and comment, please contact:*Department of Health, Division of Finance and Rate Setting, 99 Washington Ave., One Commerce Plaza, Suite 1432, Albany, NY 12210, spa_inquiries@health.ny.gov

Appendix V
2023 Title XIX State Plan
Second Quarter Amendment
Responses to Standard Funding Questions

NON-INSTITUTIONAL SERVICES
State Plan Amendment #24-0004

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 receive and retain 100 percent of 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 an IGT transferred from the counties.

		4/1/24 – 3/31/25	
Payment Type	**Non-Federal Share Funding**	**Non-Federal**	**Gross**
Clinic UPL	IGT	$2.7M	$5.4M

A. IGT Funding:

New York State requests the transfer of the IGT amounts from entities prior to the release of payments to the providers. The entities transferring IGT amounts are all units of government, and the nonfederal share is derived from state or local tax revenue funded accounts only. The providers keep and retain Medicaid payments. Please note that entities have taxing authority, and the State does not provide appropriations to the entities for IGTs.

Provider	**Entity Transferring IGT Funds**	**4/1/22-3/31/23 IGT Amount**
CORTLAND CTY COMM SRVCS BOARD	Cortland County	$864,054
DUTCHESS CO DEPT BEHAV & COMM HLTH	Dutchess County	$10,664
GENESEE COUNTY MNTL HLTH SVCS	Genesee County	$1,289,920
MADISON CNTY COMMUNITY SVC BD	Madison County	$2,162
ONONDAGA COUNTY DEPARTMENT OF MENTA	Onondaga County	$533,200
Total		**$2.7M**

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 authorized under this State Plan Amendment are supplemental payments and total $5.4 million for State Fiscal Year 2024-25. Please note that the dollar amount currently listed in the plan page is a placeholder and will be updated once the calculation is completed.

	Private	**State Government**	**Non-State Government**	**4/1/24-3/31/25 Total**
Clinic UPL	$0M	$0M	$5.4M	$5.4M

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 clinic UPL demonstration utilizes cost-to-payment methodology to estimate the upper payment limit for each class of providers. The State is in the process of completing the 2024 clinic UPL as well as the Procedural Manual which describes the methodology for eligible providers and will be submitting both documents to CMS.

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**
   - **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 complies 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.