



## Department of Health

KATHY HOCHUL  
Governor

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

KRISTIN M. PROUD  
Acting Executive Deputy Commissioner

June 23, 2022

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

RE: SPA #22-0027  
Non-Institutional Services

Dear Mr. McMillion:

The State requests approval of the enclosed amendment #22-0027 to the Title XIX (Medicaid) State Plan for non-institutional services to be effective April 1, 2022 (Appendix I). This amendment is being submitted based on enacted legislation. A summary of the plan amendment is provided in Appendix II.

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

A copy of pertinent sections of enacted legislation is enclosed for your information (Appendix III). A copy of the public notice of this plan amendment, which was given in the New York State Register on March 30, 2022, is also enclosed for your information (Appendix IV). In addition, responses to the five standard funding questions are also enclosed (Appendix V).

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

Sincerely,



Amir Bassiri  
Acting 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

2. STATE

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

5. FEDERAL STATUTE/REGULATION CITATION

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)

a. FFY \_\_\_\_\_ \$ \_\_\_\_\_

b. FFY \_\_\_\_\_ \$ \_\_\_\_\_

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable)

9. SUBJECT OF AMENDMENT

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

15. RETURN TO

12. TYPED NAME

13. TITLE

14. DATE SUBMITTED  
June 23, 2022

**FOR CMS USE ONLY**

16. DATE RECEIVED

17. DATE APPROVED

**PLAN APPROVED - ONE COPY ATTACHED**

18. EFFECTIVE DATE OF APPROVED MATERIAL

19. SIGNATURE OF APPROVING OFFICIAL

20. TYPED NAME OF APPROVING OFFICIAL

21. TITLE OF APPROVING OFFICIAL

22. REMARKS

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

**New York**  
**1.1**

**1905(a) (5)(A) Physicians' Services**

**Supplemental Medicaid Payments for Eligible Professional Services**

**1. State University of New York (SUNY)**

- (a) Effective April 1, 2011, supplemental payments will be made to State University Eligible Medical Professional Providers for services eligible under this provision ("Eligible Services"). Supplemental payments for Eligible Services will be equal to the difference between the Average Commercial Rate, as defined below, and Medicaid payments otherwise made under this state plan. The supplemental payment will only be applicable to the professional component of the services provided.
- (b) State University Eligible Medical Professional Providers are:
- (1) Physicians, nurse practitioners and physician assistants;
  - (2) Licensed in the State of New York; and
  - (3) Participating in a plan for the management of clinical practice at the State University of New York.

Excluded providers are federally qualified health centers (FQHCs) and rural health centers (RHCs).

- (c) Eligible Services include only those services provided by a State University Eligible Medical Professional Provider while acting in their capacity as a participant in a plan for the management of clinical practice at the State University of New York. The following clinical practices will participate:
- (1) SUNY Syracuse
  - (2) SUNY Buffalo, and
  - (3) SUNY Stony Brook
- (d) Services excluded are those utilizing procedure codes not reimbursed by Medicaid, clinical laboratory services, dual eligibles except where Medicaid becomes the primary payer, and Managed Care. Managed Care data will be included only when a separate fee for service payment has been made to an eligible provider. Noncommercial payers such as Medicare are excluded. Additionally, supplemental payment will not be allowed on all inclusive payments where the base payment includes the physician cost.
- (e) Supplemental payments will be made as an annual aggregate lump sum payment, based on the Medicaid data applicable to dates of service in the calendar year. Initial payments will be based on claims processed within 3 months after the calendar year for those dates of service. [A final payment will be made one year following the initial payment to capture those claims for the payment year date of service processed subsequent to the initial payment.] A run out factor will be added to the initial payment to capture all incurred claims applicable to the base period. Supplemental payments will not be made prior to the delivery of services.

## New York

## 1.6

**1905(a) (5)(A) Physicians' Services**

(e) Supplemental payments will be made as an annual aggregate lump sum payment, based on the Medicaid data applicable to dates of service in the calendar year. Initial payments will be based on claims processed within 3 months after the calendar year for those dates of service. [A final payment will be made one year following the initial payment to capture those claims for the payment year date of service processed subsequent to the initial payment.] A run out factor will be added to the initial payment to capture all incurred claims applicable to the base period. Supplemental payments will not be made prior to the delivery of services.

**(f) Calculating the Average Commercial Rate (ACR) For Matched Procedures.**

- (1) The ACR will be calculated for Roswell based on applicable rates for the appropriate region, utilizing the top 5 commercial payers based on volume.
- (2) The ACR will be calculated annually before each state fiscal year using commercial payer data from the most recently completed twelve-month period by Date of Service between July and June. The initial calculation, effective beginning April 1, 2011, will be based on commercial payer data from the period of July 1, 2010, through June 30, 2011, Date of Service.
- (3) For Eligible Service procedures (additionally distinguished by modifier and point of service) that are billed to Medicaid using codes that correspond to those recognized by commercial payers ("Matched Procedures"), a Procedure-Specific ACR will be calculated for each Matched Procedure by dividing the sum of total commercial payments for the Matched Procedure by the total number of the Matched Procedures paid by commercial payers. For services where physician extenders may be used the applicable percentage of the ACR will be applied.

**(g) Calculating ACR for Non-Matched Procedures**

- (1) For Eligible Service procedures that are billed to Medicaid using codes that do not correspond to those recognized by commercial payers ("Non-Matched Procedures"), a Procedure-Specific ACR will be calculated for each Non-Matched Procedure by calculating the overall average percentage of the matched procedures commercial payments to Medicaid payments.
- (2) This percentage is applied to the average Medicaid payments per unit for the non-matched services to establish an ACR proxy payment per unit. The units for each non-matched Medicaid service [is]are multiplied by the ACR proxy, and then totaled to determine the payment ceiling.
- (3) The difference between the total Medicaid payments for the unmatched services and the ACR proxy total is the supplemental payment for unmatched services.

TN #22-0027

Approval Date \_\_\_\_\_

Supersedes TN #11-07-BEffective Date April 1, 2022

**New York**  
**1.9**

**1905(a) (5)(A) Physicians' Services**

**Supplemental Medicaid Payments for Professional Services**

**3. Medicare Fee Equivalent Calculation**

- a. Effective April 1, 2011, supplemental payments will be made to physicians, nurse practitioners and physician assistants who are employed by a Public Benefit Corporation (PBC), or a non-state operated public general hospital operated by a PBC or who are providing professional services at a PBC facility as either a member of a practice plan or an employee of a professional corporation or limited liability corporation under contract to provide services to patients of such a public benefit corporation for those patients eligible for Medicaid. The supplemental payments will be applicable only to the professional component of the eligible services provided.
- b. Eligible providers are affiliated with:
- i. New York City Health and Hospital Corporation (HHC), excluding facilities participating in the Medicare Teaching Election Amendment.
  - ii. Nassau University Medical Center,
  - iii. Westchester Medical Center, and
  - iv. Erie County Medical Center, effective July 1, 2015.

Excluded facilities are Federal Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs).

- c. Supplemental payments for eligible services will equal the difference between the Medicare Part B fee schedule rate and the average Medicaid payment per unit otherwise made under this Attachment.
- d. Supplemental payments will be made as an annual aggregate lump sum, and be based on the Medicaid data applicable to the calendar year. Initial payments will be based on claims processed within 3 months after the calendar year. [A final payment will be made one year following the initial payment to capture those claims for the payment year date of service processed subsequent to the initial payment.] A run out factor will be added to the initial payment to capture all incurred claims applicable to the base period. Supplemental payments will not be made prior to the delivery of services.
- e. Services excluded are those utilizing procedure codes not reimbursed by Medicaid, clinical laboratory services, dual eligibles except where Medicaid becomes the primary payer, and Managed Care. Managed Care data will be included only when a separate fee-for-service payment has been made to an eligible provider. Non-commercial payers such as Medicare are excluded. Additionally, supplemental payment will not be allowed on all inclusive payments where the base payment includes the physician cost.

TN 22-0027

Approval Date \_\_\_\_\_

Supersedes TN #15-0005

Effective Date April 1, 2022

**Appendix II**  
**2022 Title XIX State Plan**  
**Second Quarter Amendment**  
**Summary**

**SUMMARY**  
**SPA #22-0027**

This State Plan Amendment proposes to update the final payment method for supplemental payments for professional services provided by physicians, nurse practitioners, and physician assistants all other components will remain the same. Those who will be eligible for such payments will be physicians who are currently authorized. Fees will increase in an amount equal to the average commercial rate or Medicare rate for services supplied to patients eligible for Medicaid.



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

Chapter 59 of the Law of 2011 (enacted budget)

S.2809-D/A.4009-D - Part B

Section 1. (a) 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 April 1, 2011 through March 31, 2012, and each state fiscal year thereafter, the department of health is authorized to make supplemental Medicaid payments for professional services provided by physicians, nurse practitioners and physician assistants who are participating in a plan for the management of clinical practice at the State University of New York, in accordance with 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, in amounts that will increase fees for such professional services to an amount equal to the average commercial or Medicare rate that would otherwise be received for such services rendered by such physicians, nurse practitioners and physician assistants. The calculation of such supplemental fee payments shall be made in accordance with applicable federal law and regulation and subject to the approval of the division of the budget. Such supplemental Medicaid fee payments may be added to the professional fees paid under the fee schedule or made as aggregate lump sum payments to eligible clinical practice plans authorized to receive professional fees.

(b) The affiliated State University of New York health science centers shall be responsible for payment of one hundred percent of the non-federal share of such supplemental Medicaid payments for all services provided by physicians, nurse practitioners and physician assistants who are participating in a plan for the management of clinical practice, 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.

Chapter 59 of the Law of 2011 (enacted budget)

**S.2809-D/A.4009-D – Part H**

§ 93. 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 April 1, 2011 through March 31, 2012, and each state fiscal year thereafter, the department of health is authorized to make supplemental Medicaid payments for professional services provided by physicians, nurse practitioners and physician assistants who are employed by a public benefit corporation or a non-state operated public general hospital operated by a public benefit corporation or who are providing professional services at a facility of such public benefit corporation as either a member of a practice plan or an employee of a professional corporation or limited liability corporation under contract to provide services to patients of such a public benefit corporation, in accordance with 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, in amounts that will increase fees for such professional services to an amount equal to either the Medicare rate or the average commercial rate that would otherwise be received for such services rendered by such physicians, nurse practitioners and physician assistants, provided, however, that such supplemental fee payments shall not be available with regard to services provided at facilities participating in the Medicare Teaching Election Amendment. The calculation of such supplemental fee payments shall be made in accordance with applicable federal law and regulation and subject to the approval of the division of the budget. Such supplemental Medicaid fee payments may be added to the professional fees paid under the fee schedule or made as aggregate lump sum payments to entities authorized to receive professional fees.

2. The supplemental Medicaid payments for professional services authorized by subdivision one of this section may be made only at the election of the public benefit corporation or the local social services district in which the non-state operated public general hospital is located. The electing public benefit corporation or local social services district shall, notwithstanding the social services district Medicaid cap provisions of Part C of chapter 58 of the laws of 2005, be responsible for payment of one hundred percent of the non-federal share of such supplemental Medicaid payments, 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. Social services district or public benefit corporation funding of the non-federal share of any such payments 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, the provisions of this section shall be null and void.

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

## 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:

## All Services

Effective on or after April 1, 2022, the Department of Health will adjust rates statewide to reflect a 5.4% percent Cost of Living Adjustment for the following Office of Mental Health (OMH), Office of Addiction Services and Supports (OASAS), and Office for People With Developmental Disabilities (OPWDD) State Plan Services: OMH Outpatient Services, OMH Clinic Services, OMH Rehabilitative Services, Children Family Treatment Support Services, Health Home Plus, Residential Treatment Facilities for Children and Youth, OASAS outpatient addiction services, OASAS freestanding (non-hospital) inpatient rehabilitation services, OASAS freestanding inpatient detox services, OASAS addiction treatment centers, OASAS Part 820 residential services, OASAS residential rehabilitation services for youth, Intermediate Care Facility (ICF/IDD), Day Treatment, Article 16 Clinic services, Specialty Hospital, Health Home Services Provided by Care Coordination Organizations, Independent Practitioner Services for Individual with Developmental Disabilities (IPSIDD), and OPWDD Crisis Services.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to the April 1, 2022, 5.4% percent Cost of Living Adjustment contained in the budget for State Fiscal Year 2023 is \$109.9 million.

Effective on or after April 1, 2022, Health care and mental hygiene worker bonuses will be provided to New York's essential front line health care and mental hygiene workers. These bonuses are intended to attract talented people into the profession and retain people who have been working during the COVID-19 Pandemic by rewarding them financially for their service.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for State Fiscal Year 2023 is \$1.85 billion.

Effective for dates of service on or after April 1, 2022, through March 31, 2024, all Medicaid rate-based claims will receive a 1% operating increase. Payments exempted from this increase, are as follows:

- Payments not subject to federal financial participation;
- Payments that would violate federal law including, but not limited to, hospital disproportionate share payments that would be in excess of federal statutory caps;
- Payments made by other state agencies including, but not limited to, those made pursuant to articles 16, 31 and 32 of the mental hygiene laws;
- 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
- At the discretion of the Commissioner of Health and the Director of the Budget, payments with regard to which it is determined that application of increases pursuant to this section would result, by operation of federal law, in a lower federal medical assistance percentage applicable to such payments.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for State Fiscal Year 2023 is \$165 million.

Effective for dates of service on or after April 1, 2022, the 1.5% uniform reduction for all non-exempt Department of Health state funds Medicaid payments will be restored.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for State Fiscal Year 2023 is \$280 million.

## Non-Institutional Services

Effective on or after April 1, 2022, 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, 2022, through March 31, 2023, 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, 2022, through March 31, 2023, 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, 2022, and each state fiscal year thereafter, this amendment proposes to revise the final payment component of the calculation to account for claim runout. The current authority to make 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.

Effective on or after April 1, 2022, payments in quarter-hour units for the following harm reduction services for people who actively use drugs provided at New York State Commissioner of Health waived comprehensive harm reduction programs (community-based organizations) will be revised. The intention is to combat the opioid overdose crisis and reduce health care costs for people who use drugs. Harm reduction services improve population health and have been shown to reduce health care costs by preventing disease transmission (HIV, HBV, and HCV), injection site infections, emergency department and inpatient care from drug overdose, injury, and death. Comprehensive harm reduction programs are effective at engaging high-risk populations and serving as a bridge for entry into drug treatment and other health and social services.

Regional monthly rates will be established for New York City and the rest of the state and are based on the expected direct service costs in each region. Billable activities encompass those components of harm reduction attributable to direct client service, such as brief assessment and treatment planning, harm reduction counseling, linkage and navigation, medication management and treatment adherence counseling, psychoeducation support groups. Direct and indirect costs are budgeted as part of the rate. No funds shall be used to carry out the purchase or distribution of sterile needles or syringes for the hypodermic injection of any illegal drug.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for State Fiscal Year 2023 is \$34.6 million.

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

**NON-INSTITUTIONAL SERVICES  
State Plan Amendment #22-0027**

**CMS Standard Funding Questions**

The following questions are being asked and should be answered in relation to all payments made to all providers reimbursed pursuant to a methodology described in Attachment 4.19-B of the state plan.

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

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

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

433.51(b). For any payment funded by CPEs or IGTs, please provide the following:

- (i) a complete list of the names of entities transferring or certifying funds;
- (ii) the operational nature of the entity (state, county, city, other);
- (iii) the total amounts transferred or certified by each entity;
- (iv) clarify whether the certifying or transferring entity has general taxing authority; and,
- (v) whether the certifying or transferring entity received appropriations (identify level of appropriations).

**Response:** The Non-Federal share Medicaid provider payment is funded by an IGT transferred from the counties.

		4/1/22 – 3/31/23	
Payment Type	Non-Federal Share Funding	Non-Federal	Gross
Supplemental	IGT	\$18,950,000	\$37,900,000

**IGT Funding:** New York requests the transfer of the IGT amounts prior to the release of payments to the providers. Please note that counties have taxing authority and the State does not provide appropriations to the counties for IGTs. Distribution by provider in the table below will be completed upon approval of the UPL calculation.

Provider	Entity Transferring IGT Funds	4/1/22-3/31/23 IGT Amount
SUNY Syracuse	SUNY Health Center	
SUNY Buffalo	SUNY Health Center	
SUNY Stonybrook	SUNY Health Center	
Roswell Park Cancer Institute	Roswell Park Cancer Institute Corporation	
Westchester Medical Center	Westchester County	
Nassau University Medical Center	Nassau County	
Erie County Medical Center	Erie County	
Health & Hospital Corporation	New York City	
<b>Total</b>		<b>\$37,900,000</b>

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 \$37.9 million for State Fiscal Year 2022-23. Please note that the dollar amount currently listed in the plan page is a placeholder and will be updated once the calculation is completed.



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 physician UPL demonstration utilizes a cost methodology to estimate the upper payment limit for each provider. The State is in the process of completing the 2022 physician 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.