NEW YORK
state department of
HEALTH

Nirav R. Shah, M.D., M.P.H.
Commissioner

Sue Kelly
Executive Deputy Commissioner

December 27, 2012

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

RE: SPA #12-38
Non-Institutional Services

Dear Mr. Melendez:

The State requests approval of the enclosed amendment #12-38 to the Title XIX (Medicaid) State Plan for non-institutional services to be effective October 1, 2012 (Appendix I). This amendment is being submitted based on regulation. 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.

Copies of pertinent sections of adopted State regulation is enclosed for your information (Appendix III). Copies of the public notices of this plan amendment, which were given in the New York State Register on September 26, 2012, and December 26, 2012, are also enclosed for your information (Appendix IV). In addition, responses to the five standard funding questions (Appendix V) and evidence of tribal consultation are also enclosed.

If you have any questions regarding this State Plan Amendment submission, please do not hesitate to contact John E. Ulberg, Jr., Medicaid Chief Financial Officer, Division of Finance and Rate Setting, at (518) 474-6350.

Sincerely,

Jason A. Helgerson
Medicaid Director
Office of Health Insurance Programs

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: HEALTH CARE FINANCING ADMINISTRATION	1. TRANSMITTAL NUMBER: **12-38**	2. STATE **New York**
	3. PROGRAM IDENTIFICATION: **TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)**	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE **October 1, 2012**	

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: **Section 1902(a)(30) of the Social Security Act and 42 CFR Part 447.204**	7. FEDERAL BUDGET IMPACT: **a. FFY 10/01/12-09/30/13 $ 0** **b. FFY 10/01/13-09/30/14 $ 0**
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: **Attachment 4.19-B: 1(e)(2)**	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: **Attachment 4.19-B: 1(e)(2)**

10. SUBJECT OF AMENDMENT:
October 2012 and January 2013 Hospital OP APG Weight Adjustments (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:	16. RETURN TO: **New York State Department of Health** **Bureau of HCRA Oper & Financial Analysis** **99 Washington Ave – One Commerce Plaza** **Suite 810** **Albany, NY 12210**
13. TYPED NAME: **Jason A. Helgerson**	
14. TITLE: **Medicaid Director** **Department of Health**	
15. DATE SUBMITTED: December 27, 2012	

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:

FORM HCFA-179 (07-92)

Appendix I
2012 Title XIX State Plan
Fourth Quarter Amendment
Non-Institutional Services
Amended SPA Pages

New York
1(e)(2)

APG Reimbursement Methodology – Hospital Outpatient

The following links direct users to the various definitions and factors that comprise the APG reimbursement methodology, which can also be found in aggregate on the APG website at http://www.health.ny.gov/health_care/medicaid/rates/apg/index.htm. In addition, prior period information associated with these links is available upon request to the Department of Health.

Contact Information:
http://www.health.ny.gov/health_care/medicaid/rates/apg/index.htm Click on "Contacts."

3M APG Crosswalk, version 3.3:
http://www.health.ny.gov/health_care/medicaid/rates/crosswalk/index.htm
http://dashboard.emedny.org/CrossWalk/html/cwAgreement.html Click on "Accept" at bottom of page to gain access.

APG Alternative Payment Fee Schedule; updated as of 12/01/09:
http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm Click on "Alternative Payment Fee Schedule."

APG Consolidation Logic; logic is from the version of 4/01/08, updated as of 12/01/09:
http://www.health.ny.gov/health_care/medicaid/rates/bundling/2008/index.htm

APG 3M Definitions Manual Versions; updated as of 12/01/09:
http://www.health.ny.gov/health_care/medicaid/rates/crosswalk/index.htm

APG Investments by Rate Period; updated as of 12/01/09:
http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm Click on "Investments by Rate Period."

APG Relative Weights; updated as of [4/1/12 and 7/1/12] 10/01/12:
http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm Click on "Weights, Proc Weights, and APG Fee Schedule Amounts" file.

Associated Ancillaries; effective 7/01/09:
http://www.health.ny.gov/health_care/medicaid/rates/apg/index.htm Click on "Ancillary Policy."

TN #12-38 **Approval Date** _____

Supersedes TN #12-13 **Effective Date** _____

Appendix II
2012 Title XIX State Plan
Fourth Quarter Amendment
Non-Institutional Services
Summary

SUMMARY
SPA #12-38

This State Plan Amendment revises the Ambulatory Patient Group (APG) reimbursement methodology for hospital-based outpatient clinic and ambulatory surgery services, including emergency room services, to reflect the recalculated weights for October 1, 2012 and January 1, 2013.

Appendix III
2012 Title XIX State Plan
Fourth Quarter Amendment
Non-Institutional Services
Authorizing Provisions

and there is no local share for administrative costs over and above the Medicaid administrative cap.

The Medicaid managed care program utilizes existing state systems for operation (Welfare Management System, eMedNY, etc.).

The Department provides ongoing technical assistance to counties to assist in all aspects of planning, implementing and operating the local program.

Rural Area Participation:

The proposed regulations do not reflect new policy. Rather, they codify current program policies and requirements and make the regulations consistent with section 364-j of the SSL. During the development of the 1115 waiver application and the design of the managed care program, input was obtained from many interested parties.

Job Impact Statement

Nature of Impact:

The rule will have no negative impact on jobs and employment opportunities. The mandatory Medicaid managed care program authorized by Section 364-j of the Social Services Law (SSL) will expand job opportunities by encouraging managed care plans to locate and expand in New York State.

Categories and Numbers Affected:

Not applicable.

Regions of Adverse Impact:

None.

Minimizing Adverse Impact:

Not applicable.

Self-Employment Opportunities:

Not applicable.

Assessment of Public Comment

The agency received no public comment since publication of the last assessment of public comment.

NOTICE OF ADOPTION

October 2011 Ambulatory Patient Groups (APGs) Payment Methodology

I.D. No. HLT-50-11-00015-A
Filing No. 172
Filing Date: 2012-02-28
Effective Date: 2012-03-14

PURSUANT TO THE PROVISIONS OF THE State Administrative Procedure Act, NOTICE is hereby given of the following action:

Action taken: Amendment of Subpart 86-8 of Title 10 NYCRR.

Statutory authority: Public Health Law, section 2807(2-a)(e)

Subject: October 2011 Ambulatory Patient Groups (APGs) Payment Methodology.

Purpose: To refine the APG payment methodology.

Text or summary was published in the December 14, 2011 issue of the Register, I.D. No. HLT-50-11-00015-P.

Final rule as compared with last published rule: No changes.

Text of rule and any required statements and analyses may be obtained from: Katherine Ceroalo, DOH, Bureau of House Counsel, Regulatory Affairs Unit, Room 2438, ESP, Tower Building, Albany, NY 12237, (518) 473-7488, email: regsqna@health.state.ny.us

Assessment of Public Comment

The agency received no public comment.

Office of Mental Health

NOTICE OF ADOPTION

Clinic Treatment Programs

I.D. No. OMH-46-11-00006-A
Filing No. 169
Filing Date: 2012-02-27
Effective Date: 2012-03-14

PURSUANT TO THE PROVISIONS OF THE State Administrative Procedure Act, NOTICE is hereby given of the following action:

Action taken: Amendment of Part 599 of Title 14 NYCRR.

Statutory authority: Mental Hygiene Law, sections 7.09, 31.04, 43.01 and 43.02; Social Services Law, art. 33, sections 364, 364-a and 365-m

Subject: Clinic Treatment Programs.

Purpose: Amend and clarify existing regulation and enable providers to seek reimbursement for certain services using State-only dollars.

Substance of final rule: This final adoption amends Part 599 of Title 14 NYCRR which governs the licensing, operation, and Medicaid fee-for-service funding of mental health clinics. 14 NYCRR Part 599 was originally adopted as final on October 1, 2010 and resulted in major changes in the delivery and financing of mental health clinic services. When the regulation was promulgated, the Office of Mental Health understood that there would be issues that might require clarification once providers and recipients of services had experience in operating under the new regulation. This rule making was designed to address those issues and add relatively minor program modifications that have occurred since the initial regulation was promulgated. Non-substantive changes were made to the final rule to further clarify the requirements found in 14 NYCRR Part 599. A summary of all changes, including those non-substantive changes that were made since publication of the Notice of Proposed Rule Making, are found in the narrative below.

- Clarification of the distinction between ''injectable psychotropic medication administration'' and ''injectable psychotropic medication administration with monitoring and education'' and the provisions regarding reimbursement for these services;

- Clarification of the definition of ''health monitoring'', ''hospital-based clinic'', ''modifiers'', and ''psychiatric assessment'', and inclusion of definitions for ''Behavioral Health Organization'' and ''concurrent review''. The final version of this regulation also expands the definitions of ''diagnostic and treatment center'', ''hospital-based clinic'' and ''heath monitoring''. The term ''smoking status'' has been changed to ''smoking cessation'' for both adults and children, and the definition of ''health monitoring'' now includes ''substance use'' as an indicator for both adults and children - see new Subdivisions (r), (w) and (ab) of Section 599.4;

- Repeal of provisions requiring a treating clinician to determine the need for continued clinic treatment beyond 40 visits for adults and children;

-Amendment of the provisions regarding screening of clinic treatment staff by the New York Statewide Central Register of Child Abuse and Maltreatment;

- Clarification of requirements regarding required signatures on treatment plans. The final version of the regulation further clarifies that, for recipients receiving services reimbursed by Medicaid on a fee-for-service basis, the signature of the physician is required on the treatment plan. For recipients receiving services that are not reimbursed by Medicaid on a fee-for-service basis, the signature of the physician, licensed psychologist, LCSW, or other licensed individual within his/her scope of practice involved in the treatment plan is required - see Section 599.10(j)(4);

- Addition of provisions regarding reimbursement modifications for visits in excess of 30 and 50 respectively (excluding crisis visits) for fiscal years commencing on or after April 1, 2011. Note - the final version of the regulation lists other services that are excluded from the 30/50 thresholds. These services, in addition to crisis visits, include off-site visits, complex care management and any services that are counted as health services - see Section 599.13(e);

Appendix IV
2012 Title XIX State Plan
Fourth Quarter Amendment
Non-Institutional Services
Public Notice

- Extends effective beginning April 1, 2013 and for each state fiscal year thereafter, Intergovernmental Transfer Payments to eligible major public general hospitals run by counties and the State of New York.

There is no additional estimated annual change to gross Medicaid expenditures attributable to this initiative for state fiscal year 2013/14.

- Effective beginning April 1, 2013 and for state fiscal years thereafter, the supplemental upper payment limit payments made to general hospitals, other than major public general hospitals, increases to $339 million annually.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2013/2014 is $25 million.

Long Term Care Services

- Effective with the 2013 rate year, the Department of Health will implement quality measures and benchmarks and against those parameters make payments related to the implementation of a Quality Pool for non-specialty residential health care facilities (i.e., non-specialty nursing homes). The quality measures and benchmarks used to score and measure nursing home quality will include the following three categories.

1) Quality MDS Measures - will be calculated using data from MDS 3.0 data, New York State employee flu vaccination data, and the Centers for Medicare & Medicaid Services (CMS) 5-Star staffing measure;

2) Compliance Measures - will be calculated using data from the CMS' 5-Star Rating for health inspections, the timely filing of certified nursing home cost reports, and the timely filing of employee flu immunization data; and

3) Avoidable hospitalizations - will be calculated using MDS 3.0 data, and will be based upon a potentially preventable hospitalization quality indicator for short and long stay hospitalizations.

The scores will be based upon performance in the current year (as defined by the measures and the time period for which data is available) and improvements from the prior year. Certain nursing homes, including those which receive a survey outcome of immediate jeopardy, or substandard quality of care, a J, K, or L deficiency will be not be eligible for quality payments. Funding for the quality payments will be made from a redistribution of existing resources paid through the nursing home pricing methodology to non-specialty nursing homes, and as a result, the Quality Pool will not have an impact on annual gross Medicaid expenditures.

Non-Institutional Services

- Effective January 1, 2013, the State will be adding a new reimbursement methodology for providers who are participating in a Medicaid program integrating the delivery of physical and behavioral health services at a single clinic site.

The goal of this program is to improve the quality and coordination of care provided to individuals who have multiple physical and behavioral health needs. Presently, individuals with serious mental illness and/or addictions often receive regular care in specialized behavioral health settings. The specific clinic site in which these services are provided is licensed to provide such services by the Office of Mental Health (OMH) or the Office of Alcohol and Substance Abuse Services (OASAS) and is not licensed or authorized to provide physical/medical care under Article 28 of the Public Health Law. Patients receiving treatment in these clinics may therefore forgo primary care or, when they do receive physical/medical health care from an Article 28 Department of Health (DOH) certified clinic, the DOH certified clinic site is separate and distinct from the behavioral health clinic site. This leads to fragmented care, poorer health outcomes, and higher rates of emergency room and inpatient services. The goal of this program is to facilitate and promote the availability of both physical and behavioral health services at the site where that individual receives their regular care. For example, if an individual receives regular care in a mental health or substance abuse clinic, that clinic will now be authorized to provide both the physical/medical as well as behavioral health services required by that individual.

A number of steps will be undertaken by DOH, OMH and OASAS to facilitate and streamline this health care delivery model. DOH, OMH and OASAS will work together to:

- Provide an efficient approval process to add new services to a site that is not licensed for those services;
- Establish a single set of administrative standards and survey process under which providers will operate and be monitored; and
- Provide single state agency oversight of compliance with administrative standards for providers offering multiple services at a single site.

To insure quality and coordination of care provided to people with multiple needs, DOH, OMH and OASAS will:

- Ensure appropriate compliance with applicable federal and State requirements for confidentiality of records;
- Work with providers to ensure optimal use of clinical resources jointly developed by OASAS and OMH that support evidence based approaches to integrated dual disorders treatment; and
- Provide an opportunity for optimal clinical care provided in a single setting creating cost efficiencies and promoting quality of care.

Providers eligible to participate in the program include those with two or more licenses at different physical locations, providers who have co-located clinics (i.e., two separately licensed clinics that operate in the same physical location) and providers who are licensed by one State agency but choose to provide an array of services that would fall under the license or certification of another State agency.

Participating providers will be paid through the Ambulatory Patient Group (APG) reimbursement methodology when offering integrated services at an authorized clinic site. Recognizing that integration of physical and behavioral services may result in lower clinic patient billing volume, OMH and OASAS providers will have their APG payment blend accelerated so that they will now receive a 100% calculated APG payment instead of a blended payment - 25% or 50% of existing payment for blend/75% or 50% of APG payment (Note: DOH clinics are already receiving 100% APG payment with no blend). Additionally, the overall APG calculated payment for all providers will be increased by 5%.

The DOH projects that the new payment methodology will be cost neutral.

- The Ambulatory Patient Group (APG) reimbursement methodology is revised to include recalculated weights that will become effective on or after January 1, 2013.

There is no estimated annual change to gross Medicaid expenditures attributable to this initiative in state fiscal year 2013/14.

- Effective January 1, 2013, Medicaid will provide reimbursement to hospital and diagnostic and treatment center physicians for providing home visits to chronically ill patients.

There is no additional estimated annual change to gross Medicaid expenditures attributable to this initiative for state fiscal year 2013/14.

Pharmacy

- The Department of Health proposes to remove coverage of benzodiazepines as well as barbiturates used in the treatment of epilepsy, cancer, or a chronic mental health disorder for dually eligible beneficiaries, effective January 1, 2013.

Section 175 of the Medicare Improvement for Patients and Providers Act of 2008 (MIPPA) amended section 1860D-2(e)(2)(A) of the Act to include barbiturates "used in the treatment of epilepsy, cancer, or a chronic mental health disorder" and benzodiazepines in Part D drug coverage, effective as of January 1, 2013. Currently, barbiturates and benzodiazepines are among the excluded drugs covered for all Medicaid beneficiaries.

Since the coverage of barbiturates under Part D is limited to the treatment of epilepsy, cancer or a chronic mental health disorders, New York State (NYS) proposes to continue to cover barbiturates for conditions other than the three covered by Part D. The coverage of benzodiazepines under Part D is inclusive of all indications, so NYS proposes to provide coverage for only non-dually eligible beneficiaries.

Appendix V
2012 Title XIX State Plan
Fourth Quarter Amendment
Non-Institutional Services
Responses to Standard Funding Questions

NON-INSTITUTIONAL SERVICES
State Plan Amendment #12-38

CMS Standard Funding Questions

The following questions are being asked and should be answered in relation to all payments made to all providers reimbursed pursuant to a methodology described in Attachment 4.19-B of this SPA. For SPAs that provide for changes to payments for clinic or outpatient hospital services or for enhanced or supplemental payments to physician or other practitioners, the questions must be answered for all payments made under the state plan for such service.

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

   Response: Providers do retain the payments made pursuant to this amendment. However, this requirement in no way prohibits the public provider, including county providers, from reimbursing the sponsoring local government for appropriate expenses incurred by the local government on behalf of the public provider. The State does not regulate the financial relationships that exist between public health care providers and their sponsoring governments, which are extremely varied and complex. Local governments may provide direct and/or indirect monetary subsidies to their public providers to cover on-going unreimbursed operational expenses and assure achievement of their mission as primary safety net providers. Examples of appropriate expenses may include payments to the local government which include reimbursement for debt service paid on a provider's behalf, reimbursement for Medicare Part B premiums paid for a provider's retirees, reimbursement for contractually required health benefit fund payments made on a provider's behalf, and payment for overhead expenses as allocated per federal Office of Management and Budget Circular A-87 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 Local Assistance Account under the General Fund/Aid to Localities.

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 are not supplemental or enhanced payments.

4. **For clinic or outpatient hospital services please provide a detailed description of the methodology used by the state to estimate the upper payment limit (UPL) for each class of providers (State owned or operated,**

non-state government owned or operated, and privately owned or operated). Please provide a current (i.e., applicable to the current rate year) UPL demonstration.

Response: Based on guidance from CMS, the State and CMS staff will engage in discussions to develop a strategic plan to complete the appropriate UPL demonstration for 2012.

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

   Response: The rate methodology included in the State Plan for hospital-based outpatient clinic and ambulatory surgery services is based upon the Ambulatory Patient Group (APG) system with the exception of Federally Qualified Health Centers who have the option to opt into the APG system or remain on the Prospective Payment Methodology (PPS) as approved by CMS in SPA 01-03. We are unaware of any requirement under current federal law or regulation that limits individual providers' payments to their actual costs.

ACA Assurances:

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

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

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

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

expenditures at a greater percentage than would have been required on December 31, 2009.

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

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

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

   Response: This SPA 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: The process that New York State uses is detailed in SPA #11-06, which was approved by CMS on 8/4/11. Tribal leaders were sent information regarding this SPA via U.S. Postal Service, and health clinic administrators were sent the information via e-mail. Evidence of the mailing is attached to this SPA submission.