NEW YORK
state department of
HEALTH

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

Sue Kelly
Executive Deputy Commissioner

March 7, 2012

National Institutional Reimbursement Team
Attention: Mark Cooley
CMS, CMCS
7500 Security Boulevard, M/S S2-01-16
Baltimore, MD 21244-1850

Re: SPA #12-04
Inpatient Hospital Services

Dear Mr. Cooley:

The State requests approval of the enclosed amendment #12-04 to the Title XIX (Medicaid) State Plan for inpatient hospital services to be effective January 1, 2012 (Appendix I). This amendment is being submitted based upon regulation. A summary of the proposed amendment is contained in Appendix II.

This amendment is submitted pursuant to §1902(a) of the Social Security Act (42 USC 1396a(a)) and Title 42 of the Code of Federal Regulations (CFR), Part 447, Subpart C.

The State of New York pays for inpatient general hospital services using rates determined in accordance with methods and standards specified in an approved State Plan, following a public process, which complies with Social Security Act §1902(a)(13)(A).

Notice of the changes in the methods and standards for setting payment rates for general hospital inpatient services were given in the New York State Register on December 7, 2011 (Appendix IV).

It is estimated that the changes represented by 2012 payment rates for inpatient general hospital services will have no noticeable short-term or long-term effect on the availability of services on a statewide or geographic area basis, the type of care furnished, or the extent of provider participation.

In accordance with 42 CFR §447.272(c), New York assures that its aggregate disproportionate share hospital payments do not exceed the disproportionate share hospital payment limit.

In accordance with §1923(g) of the Social Security Act, New York assures that it has calculated facility specific limits for disproportionate share payments for each disproportionate

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: #12-04	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 **January 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) of the Social Security Act**	7. FEDERAL BUDGET IMPACT: **a. FFY 01/01/12 - 09/30/12 $ 0** **b. FFY 10/01/12 - 09/30/13 $ 0**
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: **Attachment 4.19-A - Page 108**	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: **Attachment 4.19-A - Page 108**

10. SUBJECT OF AMENDMENT:
Service Intensity Weights (SIW) and average Length-of-stay (LOS)
(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** **Corning Tower** **Empire State Plaza** **Albany, New York 12237**
13. TYPED NAME: **Jason A. Helgerson**	
14. TITLE: **Medicaid Director & Deputy Commissioner Department of Health**	
15. DATE SUBMITTED: March 7, 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:

share hospital. New York assures that it will not make disproportionate share payments to a hospital in excess of the facility specific limits established for such hospital.

Copies of pertinent sections of enacted state statute are enclosed for your information (Appendix III). In addition, responses to the five standard funding questions are also enclosed (Appendix V).

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

Sincerely,

Jason A. Helgerson
Medicaid Director
Deputy Commissioner
Office of Health Insurance Programs

Enclosures

cc: Mr. Michael Melendez
Mr. Tom Brady

Appendix I
2012 Title XIX State Plan
First Quarter Amendment
Hospital Inpatient Services
Amended SPA Pages

Service Intensity Weights (SIW) and average length-of-stay (LOS).

1. The table of SIWs and statewide average LOS for each effective period is published on the New York State Department of Health website at: http://www.health.ny.gov/nysdoh/hospital/drg/index.htm and reflects the cost weights and LOS assigned to each All-Patient Refined (APR) diagnosis related group (DRG) patient classification category. The SIWs assigned to each APR-DRG indicates the relative cost variance of that APR-DRG classification from the average cost of all inpatients in all APR-DRGs. Such SIWs are developed using three years of Medicaid fee-for-service cost data, Medicaid managed care data and commercial third party payor data as reported to the Statewide Planning and Research Cooperative System (SPARCS) for the years set forth in paragraph (2) below. Costs associated with hospitals that do not have an ancillary charge structure or associated with hospitals and services exempt from the case payment methodology, and costs associated with statistical outliers are excluded from the SIW calculations.

2. For periods on and after December 1, 2009 through December 31, 2010, the SIW and statewide average LOS table shall be computed using SPARCS and reported cost data from the 2005, 2006 and 2007 calendar years as submitted to the Department by September 30, 2009.

3. For periods on and after January 1, 2011 through December 31, 2011, the SIW and statewide average LOS table shall be computed using SPARCS and reported cost data from the 2006, 2007 and 2008 calendar years as submitted to the Department by June 30, 2010.

4. For periods on and after January 1, 2012 through December 31, 2012, the SIW and statewide average LOS table shall be computed using SPARCS and reported cost data from the 2007, 2008 and 2009 calendar years as submitted to the Department by September 30, 2011.

Appendix II
2012 Title XIX State Plan
First Quarter Amendment
Hospital Inpatient Services
Summary

SUMMARY
SPA #12-04

This state plan amendment proposes to update the service intensity weights and average lengths of stays, for the All Patient Refined (APR) case mix methodology which utilizes diagnostic related groups (DRG) with assigned weights that incorporate differing levels of severity of patient condition and associated risk of mortality.

Based on previously enacted legislation and regulation, the service intensity weights and average lengths of stays (LOS) are updated annually by the Commissioner. For each effective period, the cost weights and LOS assigned to each APR-DRG are reflected in a table published on the New York State Department of Health website at: http://www.health.ny.gov/nysdoh/hospital/drg/index.htm.

Effective for the period January 1, 2012 through December 31, 2012, the SIWs and statewide average LOS table will be computed using the Statewide Planning and Research Cooperative System (SPARCS) and reported cost data from the 2007, 2008 and 2009 calendar years.

Appendix III
2012 Title XIX State Plan
First Quarter Amendment
Hospital Inpatient Services
Authorizing Provisions

NOTICE OF ADOPTION

DRGs, SIWs, Trimpoints and the Mean LOS

I.D. No. HLT-42-08-00011-A
Filing No. 1312
Filing Date: 2008-12-16
Effective Date: 2008-12-31

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

Action taken: Amendment of sections 86-1.55, 86-1.62 and 86-1.63 of Title 10 NYCRR.

Statutory authority: Public Health Law, sections 2803(2), 2807(3), 2807-c(3) and (4)

Subject: DRGs, SIWs, Trimpoints and the Mean LOS.

Purpose: Updates the calculation of outlier payments based on HHS audit findings and recommendations.

Text or summary was published in the October 15, 2008 issue of the Register, I.D. No. HLT-42-08-00011-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.

PROPOSED RULE MAKING
NO HEARING(S) SCHEDULED

Service Intensity Weights (SIW) and Average Lengths of Stay

I.D. No. HLT-53-08-00007-P

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

Proposed Action: Amendment of section 86-1.62 of Title 10 NYCRR.

Statutory authority: Public Health Law, section 2807-c(3)

Subject: Service Intensity Weights (SIW) and Average Lengths of Stay.

Purpose: Modifies the Service Intensity Weights (SIW) for DRGs.

Substance of proposed rule (Full text is posted at the following State website:www.health.state.ny.us): 86-1.62 - Service Intensity Weights and Group Average Arithmetic Inlier Lengths of Stay

The proposed amendments of section 86-1.62 of Title 10 (Health) NYCRR are intended to change the service intensity weights (SIWs) for the diagnosis related group (DRG) classification system for inpatient hospital services.

Effective January 1, 2008, the DRG classification system used in the hospital case payment system was updated to incorporate those changes made by Medicare for use in the prospective payment system, and additional changes to identify medically appropriate patterns of health resource use for services that are efficiently and economically provided. The SIWs were revised accordingly to reflect the costs of the redistributed cases.

In addition, the SIWs were updated to reflect 2004 costs and statistics reported to the Department for a representative sample of hospitals. This update ensures a reflection of more current clinical practices, advances in technology, changes in patient resource consumption, and changes in hospital length of stay patterns. The revised service intensity weights based on 2004 data are being phased-in over a three year period. The weights effective for the period January 1, 2008 through December 31, 2008, were based on 75% of the service intensity weights in effect as of December 31, 2007 based on 1992 data, and 25% of the service intensity weights based on 2004 data. The service intensity weights effective for the period January 1, 2009 through December 31, 2009, will be based on 33% of the service intensity weights in effect as of December 31, 2007 that are based on 1992 data, and 67% of the service intensity weights based on 2004 data. Effective January 1, 2010 and thereafter, the service intensity weights will be based on 2004 data. Effective January 1, 2009, the service intensity weights are being revised to reflect the phase-in described above.

General Summary for 86-1.62

The changes in the service intensity weights for the DRG classification system described above (Section 86-1.62 of Title 10 (Health) NYCRR) will enable providers to place patients in the most appropriate DRG and, therefore, they will receive adequate reimbursement for services provided. In the aggregate, these changes will have a budget-neutral impact on the reimbursement system.

The Department is statutorily required to update the grouper to be consistent with changes made to the DRG classification system used by the Medicare prospective payment system (PPS) and to modify existing and add new DRGs to more accurately reflect patterns of health resource use.

Text of proposed 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

Data, views or arguments may be submitted to: Same as above.

Public comment will be received until: 45 days after publication of this notice.

Regulatory Impact Statement

Statutory Authority:

The authority for the subject regulations is contained in sections 2803(2), and 2807(3) and 2807(4) of the Public Health Law (PHL), which require the State Hospital Review and Planning Council (SHRPC), subject to the approval of the Commissioner, to adopt and amend rules and regulations for hospital reimbursement rates that are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated facilities. PHL section 2807-c(3) authorizes the SHRPC to adopt rules subject to the Commissioner's approval, to adjust the service intensity weights (SIWs) for the diagnosis related groups (DRGs). Sections 34, 34-a and 34-b, of Part C of Chapter 58 of the Laws of 2007 authorizes the SHRPC and the Commissioner to update the cost and statistical base used to determine the SIWs to calendar year 2004 data and to provide for a phase-in of the new weights. PHL section 2807-c (4) authorizes the SHRPC to adopt rules, subject to the Commissioner's approval, for exceptions to case based payments for cost outliers.

Legislative Objectives:

The Legislature sought to have the DRGs used in the hospital reimbursement methodology be consistent with those used in Medicare reimbursement and reflect medically appropriate, efficient and economic patterns of health resource use and services.

Needs and Benefits:

The proposed amendments to sections 86-1.62 of Title 10 (Health) NYCRR are intended to make current regulations consistent with changes made to the service intensity weights (SIWs) for the diagnosis related group (DRG) classification system used by the Medicare prospective payment system (PPS). The SIWs are an integral part of the hospital Medicaid

Delaware	Oswego	Warren
Essex	Otsego	Washington
Franklin	Putnam	Wayne
Fulton	Rensselaer	Wyoming
Genesee	St. Lawrence	Yates
Greene	Saratoga	

The following 9 counties have certain townships with population densities of 150 persons or less per square mile:

Albany	Erie	Oneida
Broome	Monroe	Onondaga
Dutchess	Niagara	Orange

Compliance Requirements:

No new reporting, record keeping, or other compliance requirements are being imposed as a result of this proposal.

Professional Services:

No new additional professional services are required in order for providers in rural areas to comply with the proposed amendments.

Compliance Costs:

No initial capital costs will be imposed as a result of this rule, nor will there be an annual cost of compliance. As a result of the amendment to 86-1.62 there will be no increases or decreases in hospitals' revenues. Revenues will shift among individual hospitals depending upon the diagnoses of and approved procedures performed on the patients they treat.

Minimizing Adverse Impact:

The proposed amendments will be applied to all general hospitals. The Department of Health considered the approaches specified in section 202-bb (2) of the State Administrative Procedure Act in drafting the proposed amendments and rejected them as inappropriate given the reimbursement system mandated in statute.

Opportunity for Rural Area Participation:

Rural areas were given notice of this proposal by its inclusion in the agenda of the Fiscal Policy Committee of the State Hospital Review and Planning Council for its November 20, 2008 meeting. That agenda is mailed to members of the Fiscal Policy Committee, the New York State Legislature and representatives of the hospital associations, among others. The associations are member organizations, which represent the needs and concerns of providers across New York State, including rural areas. The amendment was described at meetings of the Fiscal Policy Committee prior to the filing of the notice of proposed rulemaking.

This outreach resulted in the Department of Health receiving comments and suggestions related to additional changes that industry representatives recommended be implemented. Based on this feedback, the Department did make additional changes to the service intensity weights to incorporate several of these comments and suggestions.

Job Impact Statement

A Job Impact Statement is not required pursuant to Section 201-a(2)(a) of the State Administrative Procedure Act. It is apparent, from the nature and purpose of the proposed rules, that they will not have a substantial adverse impact on jobs or employment opportunities. The proposed regulations revise the service intensity weights for the diagnosis related group (DRG) classification system for inpatient hospital services. The DRG classification system, which also has been in effect since 1988, is utilized to reimburse hospitals for inpatient services rendered to Medicaid beneficiaries. The proposed regulations have no implications for job opportunities.

Appendix IV
2012 Title XIX State Plan
First Quarter Amendment
Hospital Inpatient Services
Public Notice

MISCELLANEOUS NOTICES/HEARINGS

Notice of Abandoned Property Received by the State Comptroller

Pursuant to provisions of the Abandoned Property Law and related laws, the Office of the State Comptroller receives unclaimed monies and other property deemed abandoned. A list of the names and last known addresses of the entitled owners of this abandoned property is maintained by the office in accordance with Section 1401 of the Abandoned Property Law. Interested parties may inquire if they appear on the Abandoned Property Listing by contacting the Office of Unclaimed Funds, Monday through Friday from 8:00 a.m. to 4:30 p.m., at:

1-800-221-9311
or visit our web site at:
www.osc.state.ny.us

Claims for abandoned property must be filed with the New York State Comptroller's Office of Unclaimed Funds as provided in Section 1406 of the Abandoned Property Law. For further information contact: Office of the State Comptroller, Office of Unclaimed Funds, 110 State St., Albany, NY 12236.

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 inpatient services to comply with enacted statutory provisions and adopted regulations. The following significant changes are proposed:

Institutional Services

The All Patient Refined (APR) case mix methodology utilizes diagnostic related groups with assigned weights that incorporate differing levels of severity of patient condition and associated risk of mortality. Based on previously enacted legislation and adopted regulation, these service intensity weights (SIWs) are updated annually by the Commissioner. The table of SIWs and statewide average lengths of stay (LOS) for each effective period is published on the New York State Department of Health website at: http://www.health.ny.gov/nysdoh/hospital/drg/index.htm and reflects the cost weights and LOS assigned to each All-Patient Refined (APR) diagnosis related group (DRG) patient classification category. For the period January 1, 2012 through December 31, 2012, the SIW and statewide average LOS table shall be computed using the Statewide Planning and Research Cooperative System (SPARCS) and reported cost data from the 2007, 2008 and 2009 calendar years as submitted to the Department by September 30, 2011.

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

The public is invited to review and comment on this proposed state plan amendment. Copies 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, copies of the proposed state plan amendments will be on file and available for public review in each local (county) social services district.

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

The public is invited to review and comment on this proposed state plan amendment.

For further information and to review and comment, please contact: Department of Health, Bureau of HCRA Operations & Financial Analysis, Corning Tower Bldg., Rm. 984, Empire State Plaza, Albany, NY 12237, (518) 474-1673, (518) 473-8825 (FAX), e-mail: spa_inquiries@health.state.ny.us

PUBLIC NOTICE
Department of State
F-2011-0690
Date of Issuance -December 7, 2011

The New York State Department of State (DOS) is required by Federal regulations to provide timely public notice for the activities described below, which are subject to the consistency provisions of the Federal Coastal Zone Management Act of 1972, as amended.

The applicant has certified that the proposed activity complies with and will be conducted in a manner consistent with the approved New York State Coastal Management Program. The applicant's consistency certification and accompanying public information and data are available for inspection at the New York State Department of State offices located at One Commerce Plaza, 99 Washington Avenue in Albany, New York.

In F-2011-0690, Metro-North Commuter Railroad is proposing the improvement in Sing Sing Creek to alleviate flooding of the Metro-North's bridges carrying tracks 1, 2, 3, and 4. The action involves the removal of 950 cubic yards of the existing accumulated material in the streambed that inhibits flow. Also, over a linear distance of 248' beneath the bridges the 950 cubic yards of the existing accumulated material will be replaced by a bottom slab. This slab consists of 14'' of reinforced steel underlain by 6'' of crushed stone with perforated

Appendix V
2012 Title XIX State Plan
First Quarter Amendment
Hospital Inpatient Services
Responses to Standard Funding Questions

APPENDIX V
HOSPITAL SERVICES
State Plan Amendment 12-04

CMS Standard Funding Questions (NIRT Standard Funding Questions)

The following questions are being asked and should be answered in relation to all payments made to all providers under Attachment 4.19-A of your 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 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 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: 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. **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 4447.272, 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: Based on guidance from CMS, the State and CMS staff will engage in discussions to develop a strategic plan to complete the UPL demonstration for 2012. However, since the UPL calculations for 2011 demonstrated compliance with the UPL limitations and this SPA is cost neutral, the submission of the 2012 demonstration should not delay approval of this SPA.

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 approved state plan for institutional services is prospective payment. We are unaware of any requirement under current federal law or regulation that limits individual provider 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: In New York State, Indian Health Programs and Urban Indian Organizations do not furnish hospital services; therefore, solicitation of advice on this issue was not applicable. However, as detailed in SPA #11-06, which was approved by CMS on 8/4/11, information relating to this SPA was shared with the tribal leaders and clinic administrators for their review and comment. Copies of the notifications are enclosed.