NEW YORK
state department of
HEALTH

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

Sue Kelly
Executive Deputy Commissioner

March 20, 2012

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

RE: SPA #11-87
Long Term Care Facility Services

Dear Mr. Cooley:

The State requests approval of the enclosed amendment #11-87 to the Title XIX (Medicaid) State Plan for long term care facility services to be effective March 15, 2012 (Appendix I). This amendment is being submitted based on Social Services Law section 366(6)(a). A summary of the proposed amendment is provided 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, Part 447, Subpart C, (42 CFR §447).

1. The State of New York pays for long-term care services using rates determined in accordance with methods and standards specified in an approved State Plan following a public process which complies with §1902(a)(13)(A) of the Social Security Act.

2. (a) It is estimated that the changes represented by the estimated average payment rates for long-term care facility services will have no noticeable short-term or long-term effect on the availability of services on a statewide and geographic area basis.

   (b) It is estimated that the changes represented by the estimated average payment rates for long-term care facility services will have no noticeable short-term or long-term effect on care furnished.

   (c) It is estimated that the changes represented by the estimated average payment rates for long-term care facility services will have no noticeable short-term or long-term effect on the extent of provider participation.

In accordance with 42 CFR §447.272, New York assures that the aggregate Medicaid payments for inpatient services provided by nursing facilities for each prescribed category of providers does not exceed the upper payment limit for the particular category of providers.

A copy of the pertinent section of proposed state statute is enclosed for your information (Appendix III). Copies of the public notice of this proposed amendment, which was given in the New York State Register on March 14, 2012, is also enclosed for your information (Appendix IV). In addition responses to the five standard funding 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 and 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

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: **11-87**	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 **March 15, 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, and 42 CFR 447**	7. FEDERAL BUDGET IMPACT: **a. FFY 03/15/12-09/30/12 $46,000** **b. FFY 10/01/12-09/30/13 $84,000**
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: **Attachment 4.19-D: Page 110(d)**	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: **Attachment 4.19-D: Page 110(d)**

10. SUBJECT OF AMENDMENT:
Allow Short-term Stays for DOH Home & Community Based Waiver Services (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 20, 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
First Quarter Amendment
Long-Term Care Facility Services
Amended SPA Pages

86-2.36 Scheduled short term care.

(a) Residential health care facilities which provide scheduled short term care for residents [shall] will be paid a per diem rate of reimbursement for such services which is the average per diem rate of reimbursement for such services which is the average per diem rate of reimbursement for the facility as established pursuant to this [Subpart] Attachment.

(b) The requirements of sections 86-2.11 and 86-2.30 relating to resident assessments (PRI) and the submission of case mix information to the Department shall not apply to scheduled short term care.

Clarifying information:

1. Scheduled short term care is care provided to individuals who are determined to need nursing facility care but are being cared for by someone in the community, and who do not participate in a Home and Community Based Waiver program. Though eligible clients participating in the Care At Home I/II waiver are part of a home and community based services (HCBS) waiver, such clients can receive scheduled short term care services.

2. All federal nursing facility statutory and regulatory requirements, including those related to admission, discharge and transfer, continue to apply to scheduled short term care services.

3. Individuals may receive no more than 30 days of scheduled short term care for a given admission, and no more than a total of 42 days of scheduled short term care during a given year.

4. If an individual receives services in the nursing facility for a time period exceeding the maximum limits specified in (3), the admission will be considered as a normal nursing facility admission for state and federal regulatory purposes, and the reimbursement for such services will be according to the standard state nursing facility rate-setting methodology contained in this [Part of the plan] Attachment.

Appendix II
2012 Title XIX State Plan
First Quarter Amendment
Long-Term Care Facility Services
Summary

SUMMARY
SPA #11-87

This State Plan Amendment proposes to revise the State Plan to allow Medicaid eligible children under the age of eighteen who are enrolled in the Care At Home (CAH) I/II home and community based services waiver to be able to access short term care in a nursing facility.

Appendix III
2012 Title XIX State Plan
First Quarter Amendment
Long-Term Care Facility Services
Authorizing Provisions

* 6. a. The commissioner of health shall apply for a home and community-based services waiver pursuant to subdivision (c) of section nineteen hundred fifteen of the federal social security act in order to provide home and community-based services, not included under the medical assistance program.

b. A person eligible for participation in the waiver program shall:

(i) be eighteen years of age or under;

(ii) be physically disabled, according to the federal supplemental security income program criteria, including but not limited to a person who is multiply disabled;

(iii) require the level of care provided by a nursing facility or by a hospital;

(iv) be capable of being cared for in the community if provided with case management services and/or other services specified in paragraph f of this subdivision, in addition to other services provided under this title, as determined by the assessment required by paragraph d of this subdivision;

(v) meet the requirements of paragraph i of this subdivision; and

(vi) meet such other criteria as may be established by the commissioner as may be necessary to administer the provisions of this subdivision in an equitable manner.

c. Social services districts shall assess the eligibility of persons in accordance with the provisions of paragraphs b and d of this subdivision and shall refer persons who appear to meet the criteria set forth in such paragraphs to the commissioner of health for consideration for participation in the waiver program and final determinations of their eligibility for participation in the waiver program.

d. The commissioner of health shall designate persons to assess the eligibility of persons in accordance with paragraphs b and c of this subdivision under consideration for participation in the waiver program. Persons designated by such commissioner may include the person's physician, a representative of the social services district, a representative of the provider of a long term home health care program or certified home health agency and, where appropriate, the discharge coordinator of the hospital or nursing facility and such other persons as such commissioner deems appropriate. The assessment shall include, but need not be limited to, an evaluation of the medical, social, habilitation, and environmental needs of the person and shall serve as the basis for the development and provision of an appropriate plan of care for the person.

e. Prior to a person's participation in the waiver program, the social services district or the commissioner of health, as appropriate, shall undertake or arrange for the development of a written plan of care for the provision of services consistent with the level of care determined by the assessment, in accordance with criteria established by the commissioner of health.

f. Home and community-based services which may be provided to persons specified in paragraph b of this subdivision include: (i) case management services; (ii) respite services; (iii) home adaptation; (iv) hospice and palliative care services; and (v) such other home and community-based services, other than room and board, as may be approved by the secretary of the federal department of health and human services.

g. Social services districts shall designate who may provide the home and community-based services identified in paragraph f of this subdivision, subject to the approval of the commissioner of health.

h. Notwithstanding any other provision of this chapter or any other law to the contrary, for purposes of determining medical assistance eligibility for persons specified in paragraph b of this subdivision, the income and resources of responsible relatives shall not be deemed

available for as long as the person meets the criteria specified in this subdivision.

i. Before a person may participate in the waiver program specified in paragraph a of this subdivision, the department of health shall determine that the annual medical assistance expenditures for home and community-based services for all persons participating in the waiver program would not exceed the annual medical assistance expenditures for nursing facility and hospital services for all such persons had the waiver not been granted.

j. The commissioner shall review the plans of care and expenditure estimates determined by social services districts prior to the participation of any person in the waiver program.

k. This subdivision shall be effective only if, and as long as, federal financial participation is available for expenditures incurred under this subdivision.

* NB Repealed December 31, 2013

6-a. a. The commissioner of health shall apply for a nursing facility transition and diversion medicaid waiver pursuant to subdivision (c) of section nineteen hundred fifteen of the federal social security act in order to provide home and community based services to individuals who would otherwise be cared for in a nursing facility and who would be considered to be part of an aggregate group of individuals who, taken together, will be cared for at less cost in the community than they would have otherwise and to provide reimbursement for several home and community based services not presently included in the medical assistance program. The initial application shall provide for no less than five thousand persons to be eligible to participate in the waiver spread over the first three years and continue to increase thereafter.

b. A person eligible for participation in the nursing facility transition and diversion medicaid waiver program shall:

(i) be at least eighteen years of age;

(ii) be eligible for and in receipt of medicaid authorization for long term care services, including nursing facility services;

(iii) have resided in a nursing facility and/or have been assessed and determined to require the level of care provided by a nursing facility;

(iv) be capable of residing in the community if provided with services specified in paragraph f of this subdivision, in addition to other services provided under this title, as determined by the assessment required by paragraph d of this subdivision; and

(v) meet such other criteria as may be established by the commissioner of health as may be necessary to administer the provision of this subdivision in an equitable manner.

c. The department of health shall develop such waiver application in conjunction with independent living centers, representatives from disability and senior groups and such other interested parties as the department shall determine to be appropriate.

d. The commissioner of health shall contract with not-for-profit agencies around the state that have experience with providing community based services to individuals with disabilities, hereinafter referred to as regional resource development specialists, who shall be responsible for initial contact with the prospective waiver participant, for assuring the waiver candidates have choice in selecting a service coordinator and other providers, and for assessing applicants including decisions for eligibility for participation in the waiver, which contain the original service plan and all subsequent revised service plans. Regional resource development specialists shall be responsible for approving service plans and the department of health shall provide technical assistance and oversight.

e. Prior to the person's participation in the waiver program, a

Appendix IV
2012 Title XIX State Plan
First Quarter Amendment
Long-Term Care Facility 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
Education Department

In accordance with the standing of the Board of Regents and the Commissioner of Education as the nationally recognized accrediting agency for purposes of Title IV and other Federal funds for Phillips Beth Israel School of Nursing located in New York City, the State Education Department hereby gives notice that the Board of Regents has taken the following action:

• On January 10, granted institutional accreditation to Phillips Beth Israel School of Nursing for a period of five years, beginning Jan. 10, 2011 and ending Jan. 9, 2017.

PUBLIC NOTICE
Department of Environmental Conservation

Pursuant to subdivision 5 of Section 23-1101 of the Environmental Conservation Law, the New York State Department of Environmental Conservation hereby gives public notice of the following:

Consent to the requested Assignment of NYSDEC Leases / Revenue Contracts R-76665 and R-73715 from Grayhawk Energy, LLC. with offices located at 1315 Old Freeport Road Pittsburgh, Pennsylvania 15238 to Empire Energy E&P, LLC with offices located at 17 Arentzen Blvd., Suite 203, Charieroi, Pennsylvania 15022. Revenue Contract R-76665 was originally leased to Columbia Gas Transmission Corporation on January 17, 1974, consisting of 2,561.00 acres more or less of State owned lands known as Chautauqua County State Reforestation Area #2 and being located in the Towns of North Harmony and Sherman, Chautauqua County, New York. Revenue Contract R-73715 was originally leased to Columbia Gas Transmission Corporation on February 1, 1974, consists of 1,325.00 acres more or less of State owned lands Chautauqua County State Reforestation Area #11 and being located in the Town of North Harmony, Chautauqua County, New York. The Department intends to lease approved portions of such lands to Empire Energy E&P, LLC through the approval of the above referenced assignments for oil and gas well development.

For further information contact: Charles C. Roll, Department of Environmental Conservation, Division of Mineral Resources, 625 Broadway, 3rd Fl., Albany, NY 12233-6500, (518) 402-8072

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 long term care services to comply with enacted statutory provisions. The following significant changes are proposed:

Long Term Care Services

Scheduled short term care in nursing facilities is available to individuals who are determined to need nursing facility care but are being cared for by someone in the community and are not in a home and community based services (HCBS) waiver. Short term care admissions are intended to provide temporary relief to the client's caregiver(s). The proposed amendment to the State Plan will enable clients under age eighteen, who are in the Care At Home (CAH) I/II waiver, to access short term care stays in nursing facilities and will allow Medicaid reimbursement for the short term stay on or after the effective date of March 15, 2012.

The additional estimated annual change to gross Medicaid expenditures as a result of the clarifying proposed amendment is minimal and is essentially cost neutral as demonstrated through the waiver.

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.

Copies of the proposed state plan amendment[s] will be on file in each local (county) social services district and available for public review.

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

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

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

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

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

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

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 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 non-institutional services to comply with enacted State statute. This notice provides clarification to the Certified Home Health Agency episodic pricing provisions previously noticed on March 30, 2011 and December 28, 2011:

Non-Institutional Services

The following clarifies and expands upon the previously noticed provisions, effective April 1, 2012, related to Medicaid payments for services provided by Certified Home Health Agencies (CHHAs):

- Reimbursement for maternity patients, defined as patients who are currently or were recently pregnant and are receiving treatment as a direct result of such pregnancy, may be made pursuant to this section without the submission of an OASIS form, provided that providers billing for such patients must bill in accordance with such special billing instructions as may be established by the commissioner and such patients shall be grouped in a case mix designation based on the lowest acuity resource group.

Copies of the proposed state plan amendments will be available for public review on the Department's website at: http://www.health.ny.gov/regulations/state_plans/status

In addition, copies will be on file 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 or to submit a 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

Monroe County, New York

Notice of Final Request for Proposals (RFP)

NOTICE IS HEREBY GIVEN, that sealed proposals are sought and requested by the County of Monroe, New York for the performance of the following contract, according to terms of the final RFP:

PROPOSAL FOR THE OPERATION AND MAINTENANCE OF THE MONROE COUNTY RECYCLING CENTER AND PROGRAM

Monroe County, New York is soliciting proposals for the Operation and Maintenance of the County Recycling Center and Program for a Contract with a minimum term of approximately six (6) years, unless Respondents can justify a longer-term Contract, such as by capital investment, up to a maximum of twenty-five (25) years. These operations include the receiving, processing, marketing and residual disposal associated with residential-generated recyclables collected by private and public haulers. Prospective Respondents must offer a proposal that will meet the scope of services, qualifications and general description of work activities identified in the final Request for Proposals (RFP).

A draft RFP was issued on December 30, 2011 pursuant to the provisions of New York General Municipal Law (NY GML) § 120-w. All comments and questions regarding the draft RFP from prospective Respondents and the public will be incorporated as appropriate into the final RFP, or filed with the final RFP, as set forth in the RFP document.

The final RFP will be released on March 16, 2012 in accordance with the timeline and regulations set forth in New York General Municipal Law (NY GML) § 120-w. The final RFP will be available for download from the Monroe County website, at http://www.monroecounty.gov/bid/rfps. Individuals must register through the Monroe County website to obtain the PDF version of the final RFP. In addition, the final RFP will be on file at the Monroe County Clerk's Office, 39 West Main Street, Room 101, Rochester, NY, 14614, and at the Central Library of Rochester and Monroe County, 115 South Avenue, Rochester, NY, 14604.

Monroe County is soliciting proposals by 3:00 PM EST on April 6, 2012. Any verbal or other communication sent or made to anyone other than to the RFP Coordinator will not be considered and may be cause for rejection of the Respondent's proposal. Respondents' proposals are due to the RFP Coordinator in accordance with the timeline and proposal requirements listed in the final RFP at the Monroe County Division of Purchasing and Central Services, 39 West Main Street, Room 200, Rochester, NY, 14614.

PUBLIC NOTICE

Department of State

F-2011-0198 (DA)

Date of Issuance - March 14, 2012

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

The United States Department of Defense, Army Corps of Engineers - has determined that the proposed activity complies with and will be conducted in a manner consistent to the maximum extent practicable with the approved New York State Coastal Management Program. The consistency determination and accompanying public information and data is 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-2011-0198 (DA), The U.S. Army Corps of Engineers (Corps) has submitted a consistency determination for the Final Notice for the reissuance of the Nationwide Permits (NWPs), general conditions, and definitions. The Corps also announced the issuance of two new NWPs, three new general conditions, and three new definitions. These NWPs are issued on a national basis to streamline the authorization of activities that result in minimal individual and cumulative adverse ef-

Appendix V
2012 Title XIX State Plan
First Quarter Amendment
Long-Term Care Facility Services
Responses to Standard Funding Questions

APPENDIX V
LONG TERM CARE SERVICES
State Plan Amendment 11-87

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-D 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.

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 long term care 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 long term care 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. Copies of the notifications are enclosed.