NEW YORK
state department of
HEALTH

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

Sue Kelly
Executive Deputy Commissioner

June 28, 2012

National Institutional Reimbursement Team
Attention: Mark Cooley
CMS, CMCS
7500 Security Boulevard, M/S S3-14-28
Baltimore, MD 21244-1850

RE: SPA #12-20
Long-Term Care Facility Services

Dear Mr. Cooley:

The State requests approval of the enclosed amendment #12-20 to the Title XIX (Medicaid) State Plan for long-term care facility services to be effective July 1, 2012 (Appendix I). This amendment is being submitted based on proposed regulation. 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.

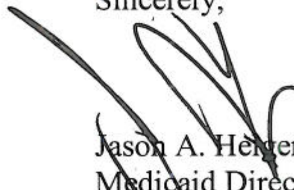
   (c) It is estimated that the changes represented by the estimated average payment rates for long-term care facility services will have no noticeable short-term or long-term effect on the extent of provider participation.

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 regulation is enclosed for your information (Appendix III). A copy of the public notice for this proposed amendment, which was given in the New York State Register on April 25, 2012, is also enclosed for your information (Appendix IV). In addition, responses to the five standard funding questions are also enclosed (Appendix V).

If you have any questions regarding this 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,



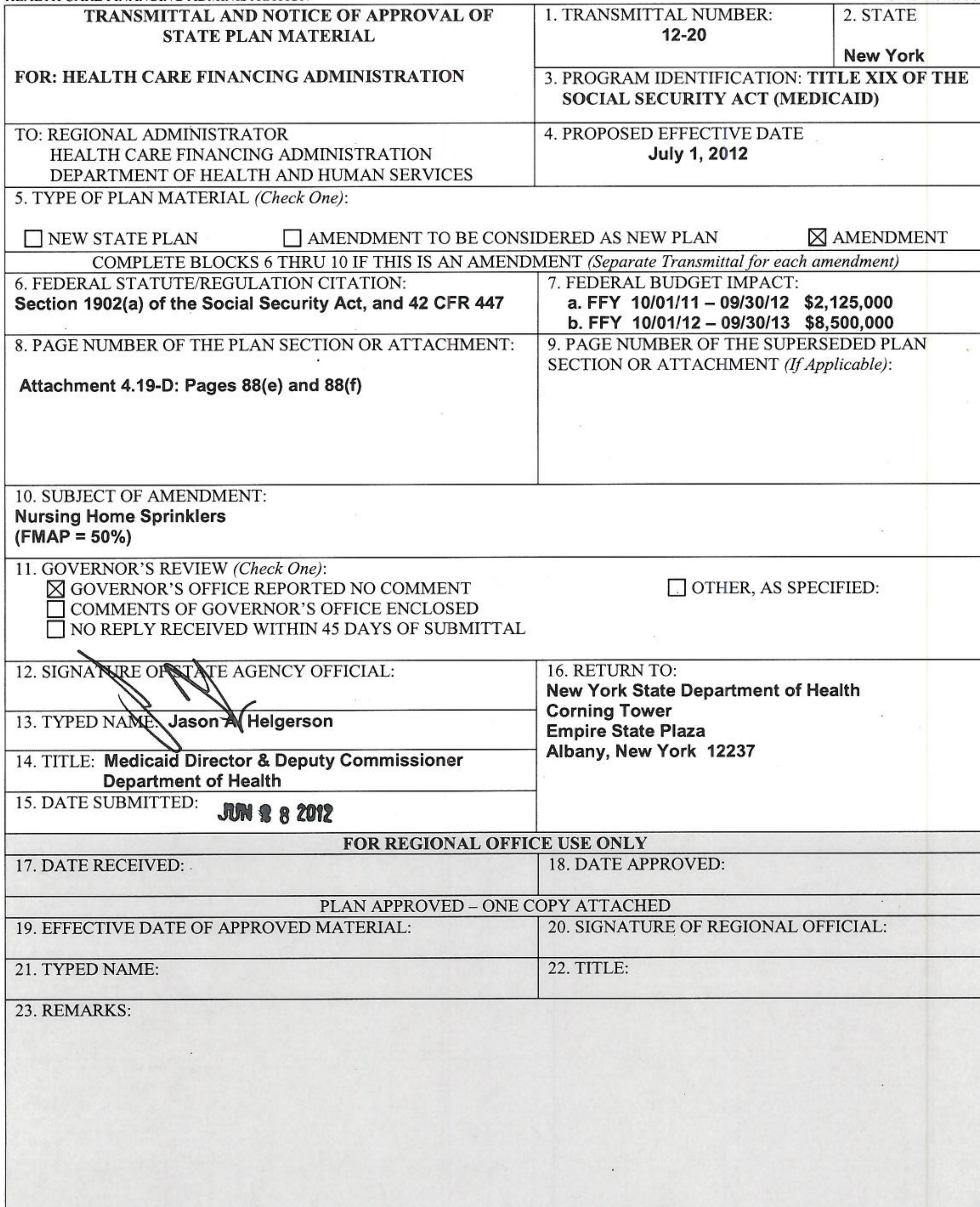
Jason A. Helgerson
Medicaid Director
Deputy Commissioner
Office of Health Insurance Programs

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: **12-20**

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: **July 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, and 42 CFR 447

7. FEDERAL BUDGET IMPACT:
a. FFY 10/01/11 – 09/30/12 $2,125,000
b. FFY 10/01/12 – 09/30/13 $8,500,000

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-D: Pages 88(e) and 88(f)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

10. SUBJECT OF AMENDMENT:
Nursing Home Sprinklers
(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:

13. TYPED NAME: **Jason A. Helgerson**

14. TITLE: **Medicaid Director & Deputy Commissioner**
Department of Health

15. DATE SUBMITTED: JUN 28 2012

16. RETURN TO:
New York State Department of Health
Corning Tower
Empire State Plaza
Albany, New York 12237

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:

Appendix I
2012 Title XIX State Plan
Third Quarter Amendment
Long-Term Care Facility Services
Amended SPA Pages

(k) Effective July 1, 2012, the capital cost component of the rate for eligible residential health care facilities will be adjusted to reflect the costs of the annual debt service related to the financing of equipment and other capital improvements directly related to the financing of an automatic sprinkler system that will be in compliance with the federal regulations set forth in 42 CFR 483.70(a)(8). In determining if a facility is eligible for such capital rate adjustment, the Commissioner of Health will consider:

1) A facility's eligibility for financially disadvantaged facility funding; and

2) Financial information obtained from the facility's cost report and more recent financial information provided by facility including:

    (i) Operating profits and losses;
    (ii) Unrestricted fund balances;
    (iii) Documentation demonstrating the inability of the facility to obtain credit, at reasonable terms given current market rates, without the reimbursement treatment accorded pursuant to this section ;
    (iv) Working capital;
    (v) Days of cash expense on hand;
    (vi) Days of revenue in accounts receivable;
    (vii) Transfers and withdrawals;
    (viii) Information related to the health and safety of a facility's residents; and
    (ix) Other information related to the financial condition of the facility, including cash flow statements and budget projections.

Eligible facilities will also be required to:

1) File the required certificate of need information with the Department of Health and obtain any required certificate of need approvals.

2) Provide information documenting the costs of the sprinkler project and that such costs are necessary to achieve compliance with the federal regulations set forth in 42 CFR 483.70(a)(8).

3) Submit to the Commissioner, for review and approval, a schedule setting forth by month the estimated debt service payable over the life of the financing. Such schedule will be provided to the Commissioner at least 60 days prior to the due date of the first debt service payment (or such shorter timeframe as the Commissioner may authorize).

4) Deposit into a separate account maintained by the facility, Medicaid revenues attributable to the capital rate adjustments for such sprinklers and any other additional facility revenues needed to cover the scheduled debt service payments attributable to such sprinklers. All such deposits in such account may only be used solely for the purpose of satisfying such debt service payments.

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

SUMMARY
SPA #12-20

This state plan amendment proposes that the capital cost component of the rate for eligible residential health care facilities shall be adjusted to reflect the costs of the annual debt service related to the financing of an automatic sprinkler system that will be in compliance with federal regulations.

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

Pursuant to the authority vested in the Public Health and Health Planning Council and the Commissioner of Health by section 2803(2) of the Public Health Law, Subpart 86-2 of Title 10 (Health) of the Official Compilation of Codes, Rules and Regulations of the State of New York, is amended by adding a new section 86-2.41 to be effective upon filing with the Secretary of State, to read as follows:

86-2.41 Sprinkler systems

(a) Subject to the availability of federal financial participation, the capital cost components of the rates of eligible residential health care facilities for periods on and after the effective date of this regulation shall be adjusted in accordance with the following:

(1) For the purposes of this subdivision, eligible facilities are those facilities which the commissioner determines are financially distressed in terms of their being unable to finance, at terms acceptable to the commissioner, the installation of automatic sprinkler systems, in conformity with the provisions of federal regulations set forth in 42 CFR 483.70(a)(8). In making such determinations of eligibility the commissioner shall consider information obtained from a facility's cost report, other more recent financial information to be provided by the facility, and such other information as may be required by the commissioner, including, but not limited to:

(i) operating profits and losses;

(ii) eligibility for funding pursuant to subdivision twenty-one of section 2808 of the Public Health Law;

(iii) unrestricted fund balances;

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(iv) documentation demonstrating the inability of the facility to obtain credit, at terms acceptable to the commissioner, without the reimbursement treatment accorded pursuant to this section ;

(v) working capital;

(vi) days of cash expense on hand;

(vii) days of revenue in accounts receivable;

(viii) transfers and withdrawals;

(ix) information related to the health and safety of a facility's residents;

(x) other financial information as may be required from the facility by the commissioner; and

(xi) the filing of a Notice pursuant to Subdivision 1-a of Section 2802 of the Public Health Law, or the receipt of required CON approvals, as appropriate.

(2) The capital cost component of the Medicaid rates of each eligible facility shall be adjusted in an amount, as determined by the commissioner, to reflect the costs of the annual debt service related to the financing of equipment and other capital improvements directly related to the financing of an automatic sprinkler system that will be in compliance with applicable federal regulations.

(3) As a condition for receipt of funding pursuant to this section, each such facility shall submit to the commissioner the costs of the project, the proposed terms of the financing, including interest rate and term of the financing, and other such information as may be required by the Commissioner. Prior to the due date of the first debt service payment related

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to such financing, each eligible facility shall prepare a schedule setting forth by month the estimated debt service payable over the life of the financing. Such schedule, project and financing terms, along with such other information as may be required by the commissioner, shall be provided to the commissioner for review and approval at least sixty days prior to the due date of such first debt service payment, or such shorter period as the commissioner may permit.

(4) As a condition for receipt of funding pursuant to this section, Medicaid revenues attributable to the rate adjustments authorized by this subdivision and any other additional facility revenues needed to cover scheduled debt service payments relating to the financing of an automatic sprinkler system that is in compliance with federal regulation as described in this section, shall be deposited into a separate account maintained by the facility and the deposits in such account shall be used solely for the purpose of satisfying such debt service payments.

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Appendix IV
2012 Title XIX State Plan
Third Quarter Amendment
Long-Term Care Facility Services
Public Notice

- The Commissioner of Health will also provide for reimbursement of the cost of preadmission assessments conducted directly by ALPs, which previously would have been performed by and reimbursed to the CHHA. There is no annual increase or decrease in gross Medicaid dollars for this initiative in state fiscal year 2012/13.

Non-institutional Services

- Effective April 1, 2012, the APG investment for hospital outpatient payments will be reduced by $25 million.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to these initiatives contained in the budget for state fiscal year 2012/2013 is $26.4 million.

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

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), 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 long term care services to comply with regulations authorized under existing State statute. The following significant changes are proposed:

Long Term Care Services

- Effective for services provided on and after May 1, 2012, Medicaid payments for certified home health care agencies (CHHA), except for such services provided to children under 18 years of age and except for services provided to a special needs population of medically complex and fragile children, adolescents and young disabled adults by a CHHA operating under a pilot program approved by the Department of Health, shall be based on payment amounts calculated for 60-day episodes of care.
  - The base price paid for 60-day episodes of care shall be adjusted by an individual patient case mix index, and also by a regional wage index factor. Such case mix adjustments shall include an adjustment factor for CHHAs providing care primarily to a special needs patient population coming under the jurisdiction of the Office of People with Developmental Disabilities (OPWDD) and consisting of no fewer than 200 such patients. The annual increase in gross Medicaid expenditures attributable to this initiative for state fiscal year 2012/13 is $600,000.
- Effective July 1, 2012 or upon the effective date of the applicable regulation, the capital cost component of the Medicaid rates of eligible residential health care facilities (RHCF) shall be adjusted, as determined by the Commissioner of Health, to reflect the costs of the annual debt service related to the financing of an automatic sprinkler system that will be in compliance with applicable federal regulations set forth in 42 CFR 483.70(a)(8).
  - Eligible facilities are those facilities which the Commissioner determines are financially distressed in terms of their being unable to finance the installation of automatic sprinkler systems as required by the federal regulations. In making such determinations of eligibility, the Commissioner shall consider information obtained from a facility's cost report, and such other information as may be required by the Commissioner, including, but not limited to:
    - operating profits and losses;
    - eligibility for funding pursuant to the capital cost reimbursement section of Subpart 86-2 of the Public Health Law;
    - unrestricted fund balances;
    - documentation demonstrating the inability of the facility to independently access the credit markets;
    - information related to the health and safety of a facility's residents;
    - other financial information as may be required from the facility by the Commissioner; and
    - the filing of Certificate of Need (CON) information, or the receipt of required CON approvals, as appropriate.
  - As a condition for the receipt of sprinkler funding, each eligible RHCF shall:
    - Prepare a schedule setting forth, by month, the estimated debt service payable, assuming level principal and interest payments over the life of the financing. Such schedule, along with such other information as may be required by the Commissioner, shall be provided to the Commissioner for review and approval at least 60 days prior to the due date of such first debt service payment (or such shorter period as the Commissioner may permit); and
    - Deposit into a separate account maintained by the facility, Medicaid revenues attributable to the capital rate adjustments for such sprinklers, and any other additional facility revenues needed to cover the scheduled debt service payments attributable to such sprinklers. All such deposits in such account shall be used solely for the purpose of satisfying such debt service payments.
  - The estimated annual increase in gross Medicaid expenditures attributable to this initiative for state fiscal year 2102/13 is $17 million.
- Effective for services provided on and after May 1, 2012, rates of payment for residential health care facilities which have received approval by the Commissioner of Health to provide services to more than 25 patients whose medical condition is HIV Infection Symptomatic, and the facility is not eligible for separate and distinct payment rates for AIDS facilities or discrete AIDS units, shall be adjusted by a per diem adjustment that shall not be in excess of the difference between such facility's 2010 allowable cost per day, as determined by the Commissioner, and the weighted average non-capital component of the rate in effect on and after January 1, 2012, and as subsequently updated by case mix adjustments made in July and January of each calendar year. The estimated annual increase in gross Medicaid expenditures attributable to this initiative for state fiscal year 2012/13 is $1 million.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to these initiatives for state fiscal year 2012/2013 is $18.6 million.

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

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), spa_inquiries@health.state.ny.us

PUBLIC NOTICE

Department of State

Proclamation

Revoking Limited Liability Partnerships

WHEREAS, Article 8-B of the Partnership Law, requires registered limited liability partnerships and New York registered foreign limited liability partnerships to furnish the Department of State with a statement every five years updating specified information, and

WHEREAS, the following registered limited liability partnerships and New York registered foreign limited liability partnerships have not furnished the department with the required statement, and

WHEREAS, such registered limited liability partnerships and New York registered foreign limited liability partnerships have been provided with 60 days notice of this action;

NOW, THEREFORE, I, Cesar A. Perales, Secretary of State of the State of New York, do declare and proclaim that the registrations of the following registered limited liability partnerships are hereby revoked and the status of the following New York foreign limited liability partnerships are hereby revoked pursuant to the provisions of Article 8-B of the Partnership Law, as amended:

DOMESTIC REGISTERED LIMITED LIABILITY PARTNERSHIPS

A

A. JAMES DE BRUIN & SONS, LLP (95)
ADLER, CALONITA & ASSOCIATES, LLP (01)
ADVOCATE & LICHTENSTEIN, LLP (06)
ALLEN JOHNSON & LONERGAN, LLP (95)
ALTER & KENDRICK, LLP (06)
ANDREAS ESBERG & COMPANY, LLP (95)
ANDREOZZI & FICKESS, LLP (04)
ANTONUCCI LAW FIRM LLP (95)
ARTISTIC DENTAL ASSOCIATES OF COMMACK, LLP (01)
ASONYE & ASONYE, LLP (01)
AUGUSTINE & EBERLE LLP (06)
AURORA PET HOSPITAL, LLP (05)
AXELROD AND GOTTLIEB, LLP (06)
AXIOTIS, MICHALOVITS & HUEBNER LLP (06)

B

B FIVE STUDIO LLP (95)
BADIAK & WILL, LLP (96)
BALL & RUBIN, LLP (01)
BARON & BARON, LLP (01)
BART AND SCHWARTZ, LLP (00)
BATH AVENUE ANIMAL CLINIC, L.L.P. (00)
BECKHARD RICHLAN SZERBATY + ASSOCIATES, LLP (95)
BELKIN BURDEN WENIG & GOLDMAN, LLP (95)
BENDER, CICCOTTO & CO., C.P.A.'S, L.L.P. (95)
BERNSTEIN AND BERNSTEIN DDS, LLP (96)
BERWITZ & DITATA LLP (00)
BLATT & DAUMAN LLP (04)
BLOOM & CO., LLP (00)
BRAND BRAND NOMBERG & ROSENBAUM, LLP (04)
BRATSAFOLIS & FEINERMAN, LLP (05)
BREATON & DOMINGUEZ LLP (06)
BREGER BERMEL LLP (06)
BRIGUGLIO & ASSOCIATES LLP (06)
BRONSTEIN, VAN VEEN & SCHUCK, LLP (05)
BUDAY & SCHUSTER ARCHITECTS, LLP (96)
BUFFALO EMERGENCY ASSOCIATES, L.L.P. (00)

C

CALLAGHAN AND NAWROCKI LLP (96)
CAMERON ERSKINE LLP (05)
CAMPBELL & SHELTON LLP (04)
CARABBA, LOCKE LLP (99)
CARLOS M. VELAZQUEZ & ASSOCIATES, LLP (05)
CASPER & FISCHER, LLP (05)
CASTLE HILL MEDICAL CARE LLP (05)
CASTRO & KARTEN LLP (00)
CATSKILL NEUROSCIENCES & RADIOLOGY ASSOCIATES, LLP (00)
CENTER FOR SINUS AND NASAL DISEASE, L.L.P. (96)
CHEHEBAR & DEVENEY LLP (05)
CHERIAN, O'SULLIVAN & TATAPUDY, LLP (01)
CHRISTOPHER CHIROPRACTIC CENTER, L.L.P. (00)
CIVARDI, OBIOL & BERDNIK, LLP (01)
CLARK, CUYLER, MAFFEI & MEDEROS, LLP (05)
CLINIC FITNESS LLP (06)
COFFINAS & COFFINAS, LLP (00)
COHEN & COLEMAN, LLP (06)
COLAMARINO & SOHNS, LLP (95)
COLEMAN, RHINE & GOODWIN LLP (95)
COLLEN INTELLECTUAL PROPERTY LAWYERS LLP (06)
CONDOR ROCK CONSULTING, LLP (04)
CORNICELLO, TENDLER & BAUMEL-CORNICELLO, LLP (01)
COSTAS KONDYLIS AND PARTNERS LLP (00)
CRONIN & VRIS, LLP (00)
CROWLEY, CROWLEY & KAUFMAN LLP (01)
CSI GROUP, LLP (06)
CURRY & WELCH, LLP (06)

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

APPENDIX V
LONG TERM CARE SERVICES
State Plan Amendment #12-20

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 facility 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 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 complies with the requirements of section 1902(a)(37) of the Act regarding prompt payment of claims.

Tribal Assurance:

Section 1902(a)(73) of the Social Security Act the Act requires a State in which one or more Indian Health Programs or Urban Indian Organizations furnish health care services to establish a process for the State Medicaid agency to seek advice on a regular ongoing basis from designees of Indian health programs whether operated by the Indian Health Service HIS Tribes or Tribal organizations under the Indian Self Determination and Education Assistance Act ISDEAA or Urban Indian Organizations under the Indian Health Care Improvement Act.

IHCIA Section 2107(e)(I) of the Act was also amended to apply these requirements to the Children's Health Insurance Program CHIP. Consultation is required concerning Medicaid and CHIP matters having a direct impact on Indian health programs and Urban Indian organizations.

a) **Please describe the process the State uses to seek advice on a regular ongoing basis from federally recognized tribes Indian Health Programs and Urban Indian Organizations on matters related to Medicaid and CHIP programs and for consultation on State Plan Amendments waiver proposals waiver extensions waiver amendments waiver renewals and proposals for demonstration projects prior to submission to CMS.**

b) Please include information about the frequency inclusiveness and process for seeking such advice.

c) Please describe the consultation process that occurred specifically for the development and submission of this State Plan Amendment when it occurred and who was involved.

<u>**Response**</u>**:** Documentation of tribal consultation is attached and was performed in accordance with the State's tribal consultation policy as approved in SPA 11-06. To date, no feedback has been received from any tribal representative in response to the proposed change in this SPA.