NEW YORK
state department of
HEALTH

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

Sue Kelly
Executive Deputy Commissioner

June 26, 2013

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

RE: SPA #13-37
Long Term Care Facility Services

Dear Mr. Cooley:

The State requests approval of the enclosed amendment #13-37 to the Title XIX (Medicaid) State Plan for long term care facility services to be effective April 1, 2013 (Appendix I). This amendment is being submitted based on enacted legislation. 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 enacted 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 27, 2013, 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
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: **13-37**	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 **April 1, 2013**	

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: **§1902(a) of the Social Security Act, and 42 CFR 447**	7. FEDERAL BUDGET IMPACT: **a. FFY 04/01/13-09/30/13 $ 0** **b. FFY 10/01/13-09/30/14 $ 0**
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: **Attachment 4.19-D: Pages 50, 50(b)**	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: **Attachment 4.19-D: Pages 50, 50(b)**

10. SUBJECT OF AMENDMENT:
NH Rebasing Rates & Transition Payments
(FMAP = 50%)

11. GOVERNOR'S REVIEW *(Check One)*:

☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:	16. RETURN TO: **New York State Department of Health** **Bureau of HCRA Operations & Financial Analysis** **99 Washington Ave – One Commerce Plaza** **Suite 810** **Albany, NY 12210**
13. TYPED NAME: **Jason A. Helgerson**	
14. TITLE: **Medicaid Director** **Department of Health**	
15. DATE SUBMITTED: June 26, 2013	

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
2013 Title XIX State Plan
Second Quarter Amendment
Long-Term Care Facility Services
Amended SPA Pages

New York
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(a) The operating cost component of residential health care facilities (RHCF's) rates of payment effective for the January 1, 2007 through December 31, 2007 and January 1, 2008 through December 31, 2008 rate periods, respectively, shall consist of the sum of the Direct, Indirect and Non-Comparable components of the rate

(1) in effect as of October 1, 2006 and adjusted for inflation to the 2007 rate period;
(2) in effect as of December 31, 2006 and adjusted for inflation to the 2008 rate period;
(3) the rates shall be further adjusted as follows:
   i. a per diem add-on reflecting the proportional amount of each facility's projected Medicaid benefit to total Medicaid benefit for all facilities of the imputed rate methodology to be effective April 1, 2009, including use of the allowable operating costs as reported in each facility's 2002 calendar year cost report, adjusted for inflation to the applicable rate period and reflecting the expiration of the productivity and efficiency limitation and the fiscal and administrative cap adjustments; and
   ii. for those facilities which do not receive a benefit from the incorporation of 2002 allowable operating costs, rates for 2007 and 2008 shall be adjusted by a per diem add-on reflecting a proportional benefit of the expiration of the productivity and efficiency limitation and the fiscal and administrative cap adjustments.
(4) aggregate Medicaid payments for the rate adjustments as stated in (i) and (ii) of paragraph (3) of this section will not exceed $137.5 million for the 2007 rate period, and $167.5 million for the 2008 rate period, and such rate adjustments made prior to 2012 will not be subject to subsequent adjustment or reconciliation.

(b) Additionally, the rates effective January 1, 2007 and January 1, 2008 shall

(1) include any revisions to the 2006 rates occurring on and after January 1, 2007. Such revisions shall be incorporated into the 2007 and 2008 rate periods on an annual basis on or about November 30, 2007 and November 30, 2008, respectively. These rate adjustments shall be made on a retroactive and prospective basis;
(2) include the cost of local property taxes and payments made in lieu of local property taxes as reported in each facility's cost report for the period two years prior to the rate period;

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50(b)

(5) Cost reports submitted by facilities for the 2002 calendar year or any subsequent year used to determine the operating component of the 2009 rate shall be subject to audit through December 31, 2014. Facilities will therefore retain all fiscal and statistical records relevant to such costs reports. Any audit of the 2002 cost report, which is commenced on or before December 31, [2014] 2018, may be completed subsequent to that date and used for adjusting the Medicaid rates that are based on such costs.

(e) Additionally, the operating component of the rates effective April 1, 2009 shall

(1) be subject to a case mix adjustment through application of the relative Resource Utilization Groups System (RUGS-III) used by the federal government for Medicare, revised to reflect NYS wage and fringe benefits, and based on Medicaid only patient data. New York State wages are used to determine the weight of each RUG. The cost for each RUG is calculated using the relative resources for registered nurses, licensed practical nurses, aides, therapists, and therapy aides using the 1995 – 97 federal time study. The minutes from the study are multiplied by the NY average dollar per hour to determine the fiscal resources needed to care for that patient type for one day. This amount is multiplied by the number of patients in that RUG. RUG weights are assigned based on the distance from the statewide average. The RUGS-III weights shall be increased for the following resident categories:

(i) 30 minutes for impaired cognition A;
(ii) 40 minutes for impaired cognition B; and
(iii) 25 minutes for reduced physical functions B.

Medicaid only case mix adjustments shall be made in January and July of each calendar year, except that no case mix adjustment shall be made in January 2011 and July 2011. The adjustments and related patient classifications for each facility shall be subject to audit review in accordance with regulations promulgated by the Commissioner of Health, and effective January 1, 2009 shall

(2) incorporate the continuation, through 2009 and subsequent years, of the adjustment for extended care of persons with traumatic brain injury in accordance with the provisions of this Attachment;

(3) incorporate the continuation, through 2009 and subsequent years, of the adjustment for the cost of providing Hepatitis B vaccinations in accordance with the provisions of this Attachment;

(4) reflect a per diem add-on of $8, trended from 2006 to 2009 and thereafter, for each patient who:

Appendix II
2013 Title XIX State Plan
Second Quarter Amendment
Long-Term Care Facility Services
Summary

SUMMARY
SPA #13-37

This State Plan Amendment (SPA) proposes to extend the audit authority for calendar year 2002 cost reports filed by nursing homes from December 31, 2014 through December 31, 2018. In addition, this SPA eliminates the requirement that certain rate adjustments for nursing homes be subject to reconciliation.

Appendix III
2013 Title XIX State Plan
Second Quarter Amendment
Long-Term Care Facility Services
Authorizing Provisions

CHAPTER 56 OF THE LAWS OF 2013 - PART A

§ 59. Paragraph (d) of subdivision 2-b of section 2808 of the public health law, as added by section 47 of part C of chapter 109 of the laws of 2006, is amended to read as follows:

(d) Cost reports submitted by residential health care facilities for the two thousand two calendar year or any part thereof shall, notwithstanding any contrary provision of law, be subject to audit through December thirty-first, two thousand [~~fourteen~~] **eighteen** and facilities shall retain for the purpose of such audits all fiscal and statistical records relevant to such cost reports, provided, however, that any such audit commenced on or before December thirty-first, two thousand [~~fourteen~~] **eighteen**, may be completed and used for the purpose of adjusting any Medicaid rates which utilize such costs.

§ 60. Subparagraph (ii) of paragraph (a) of subdivision 2-b of section 2808 of the public health law, as added by section 47 of part C of chapter 109 of the laws of 2006, is amended to read as follows:

(ii) Rates for the periods two thousand seven and two thousand eight shall be further adjusted by a per diem add-on amount, as determined by the commissioner, reflecting the proportional amount of each facility's projected Medicaid benefit to the total projected Medicaid benefit for all facilities of the imputed use of the rate-setting methodology set forth in paragraph (b) of this subdivision, provided, however, that for those facilities that do not receive a per diem add-on adjustment pursuant to this subparagraph, rates shall be further adjusted to include the proportionate benefit, as determined by the commissioner, of the expiration of the opening paragraph and paragraph (a) of subdivision sixteen of this section and of paragraph (a) of subdivision fourteen of this section, provided, further, however, that the aggregate total of the rate adjustments made pursuant to this subparagraph shall not exceed one hundred thirty-seven million five hundred thousand dollars for the two thousand seven rate period and one hundred sixty-seven million five hundred thousand dollars for the two thousand eight rate period **and provided further, however, that such rate adjustments as made pursuant to this subparagraph prior to two thousand twelve shall not be subject to subsequent adjustment or reconciliation**.

§ 61. Subparagraph (i) of paragraph (b) of subdivision 2-b of section 2808 of the public health law, as amended by section 94 of part H of chapter 59 of the laws of 2011, is amended to read as follows:

(i) **(A)** Subject to the provisions of subparagraphs (ii) through (xiv) of this paragraph, for periods on and after April first, two thousand nine the operating cost component of rates of payment shall reflect allowable operating costs as reported in each facility's cost report for the two thousand two calendar year, as adjusted for inflation on an annual basis in accordance with the methodology set forth in paragraph (c) of subdivision ten of section twenty-eight hundred seven-c of this article, provided, however, that for those facilities which [~~do not receive a per diem add-on adjustment pursuant to subparagraph (ii) of paragraph (a) of this subdivision~~] **are determined by the commissioner to be qualifying facilities in accordance with the provisions of clause (B) of this subparagraph**, rates shall be further adjusted to include the proportionate benefit, as determined by the commissioner, of the expiration of the opening paragraph and paragraph (a) of subdivision sixteen of this section and of paragraph (a) of subdivision fourteen of this section, and provided further that the operating cost component of rates of payment for those facilities which [~~did not receive a per diem~~

~~adjustment in accordance with subparagraph (ii) of paragraph (a) of this subdivision~~] are determined by the commissioner to be qualifying facilities in accordance with the provisions of clause (B) of this subparagraph shall not be less than the operating component such facilities received in the two thousand eight rate period, as adjusted for inflation on an annual basis in accordance with the methodology set forth in paragraph (c) of subdivision ten of section twenty-eight hundred seven-c of this article and further provided, however, that rates for facilities whose operating cost component reflects base year costs subsequent to January first, two thousand two shall have rates computed in accordance with this paragraph, utilizing allowable operating costs as reported in such subsequent base year period, and trended forward to the rate year in accordance with applicable inflation factors.

(B) For the purposes of this subparagraph qualifying facilities are those facilities for which the commissioner determines that their reported two thousand two base year operating cost component, as defined in accordance with the regulations of the department as set forth in 10 NYCRR 86-2.10(a)(7); is less than the operating component such facilities received in the two thousand eight rate period, as adjusted by applicable trend factors.

Appendix IV
2013 Title XIX State Plan
Second Quarter Amendment
Long-Term Care Facility Services
Public Notice

• Continues, effective April 1, 2013 through March 31, 2015, budgeted capital inpatient costs of a general hospital applicable to the rate year shall be decreased to reflect the percentage amount by which the budgeted costs for capital related inpatient costs of the hospital for the base year two years prior to the rate year exceeded actual costs.

The annual decrease in gross Medicaid expenditures attributable to these initiatives for state fiscal year 2013/14 is $114.5 million.

• Effective April 1, 2013, rates of payments for general hospitals certified by the Office of Alcoholism and Substance Abuse Services who provide inpatient detoxification and withdrawal services and, for inpatient services provided for patients discharged on and after December 1, 2008, and who are determined to be in diagnosis-related groups as identified and published on the New York State Department of Health website will be made on a per diem basis. Such payments will be made in accordance with existing methodology previously noticed on June 10, 2009.

• The base period reported costs and statistics used for case based rate-setting operating cost components, including the weights assigned to diagnostic related groups, will be updated no less frequently than every four years and the new base period will be no more than four years prior to the first applicable rate period that utilizes such new base period provided, however, that the first updated base period shall begin on January 1, 2014.

• Effective January 1, 2014, the payment rates for hospital DRG exempt services may be adjusted periodically to reflect a more current cost and statistical base year including adjustments deemed necessary by the Commissioner.

• Effective January 1, 2014, hospital inpatient payment rates may be adjusted to include changes to the base year statistics and costs used to determine the direct and indirect graduate medical education components of the rates as a result of new teaching programs at new teaching hospitals and/or as a result of residents displace and transferred as a result of a teaching hospital closure.

• Continues, effective January 1, 2014, the current methodology established to incorporate quality related measures, including, but not limited to potentially preventable re-admissions (PPRs) and provide for rate adjustments or payment disallowances related to PPRs and other potentially preventable negative outcomes (PPNOs), shall be calculated in accordance with the existing methodology.

- Such methodology will be based on a risk adjusted comparison of the actual and the expected number of PPRs and other PPNOs in a given hospital and with benchmarks established by the Commissioner.

- Such rate adjustments or payment disallowances will result in an aggregate reduction in Medicaid payments of no less than $51 million for the period April 1, 2013 through March 31, 2014.

- Such aggregate reductions shall be offset by Medicaid payment reductions occurring as a result of decreased PPRs during the period April 1, 2013 through March 31, 2014 and as a result of decreased PPNOs during the period April 1, 2013 through March 31, 2014. Such rate adjustments or payment disallowances will not apply to behavioral health PPRs or to readmissions that occur on or after 15 days following an initial admission.

Long Term Care Services

• Continues, effective for periods April 1, 2013 through March 31, 2015, the total reimbursable state assessment on each residential health care facility's gross receipts received from all patient care services and other operating income on a cash basis for inpatient or health-related services, including adult day service, but excluding gross receipts attributable to payments received pursuant to Title XVIII of the federal Social Security Act (Medicare), at six percent. The extent to which a facility is reimbursed for the additional cost of the assessment is dependent upon Medicaid volume of services.

The annual increase in gross Medicaid expenditures attributable to these initiatives for state fiscal year 2013/14 is $420 million.

• Continues, effective April 1, 2013 through March 31, 2015, the provision that rates of payment for RHCFs shall not reflect trend factor projections or adjustments for the period April 1, 1996 through March 31, 1997.

• Extends current provisions to services April 1, 2013 through March 31, 2015, the reimbursable operating cost component for RHCFs rates will be established with the final 2006 trend factor equal to the final Consumer Price Index (CPI) for all urban consumers less 0.25%.

Continues, effective April 1, 2013 through March 31, 2015, long-term care Medicare maximization initiatives.

The annual decrease in gross Medicaid expenditures attributable to these initiatives for state fiscal year 2013/14 is $117 million.

• Extends the provision, cost reports submitted by facilities for the 2002 calendar year or any subsequent year used to determine the operating component of the 2009 rate will be subject to audit through December 31, 2018. Facilities will therefore retain all fiscal and statistical records relevant to such cost reports. Any audit of the 2002 cost report, which is commenced on or before December 31, 2018, may be completed subsequent to that date and used for adjusting the Medicaid rates that are based on such costs.

• For state fiscal years beginning April 1, 2013, continues additional payments to non-state government operated public residential health care facilities, including public residential health care facilities located in Nassau, Westchester, and Erie counties, but excluding public residential health care facilities operated by a town or city within a county, in aggregate amounts of up to $300 million. The amount allocated to each eligible public RHCF will be in accordance with the previously approved methodology, provided, however that, in consultation with impacted providers, of the funds allocated for distribution in state fiscal year beginning April 1, 2013, up to $32 million may be allocated proportionally to those public residential health care facilities which were subject to retroactive reductions in payments made for state fiscal year periods beginning April 1, 2006. Payments to eligible RHCF's may be added to rates of payment or made as aggregate payments.

Non-institutional Services

• For state fiscal year beginning April 1, 2013 through March 31, 2014, continues hospital outpatient payment adjustments that increase the operating cost components of rates of payment for hospital outpatient and emergency departments for public general hospitals other than those operated by the State of new York or the State University of New York, which are located in a city with a population of over one million. The eligibility criteria remain unchanged. The amount to be paid will be up to $287 million. Payments to eligible public general hospitals may be added to rates of payment or made as aggregate payments.

• Continues, effective April 1, 2013 through March 31, 2015, the provision that rates of payment for adult day health services shall not reflect trend factor projections or adjustments for the period April 1, 1996 through March 31, 1997.

• Extends current provisions to services April 1, 2013 through March 31, 2015, the reimbursable operating cost component for general hospital outpatient rates and adult day health care services provided by RHCFs rates will be established with the final 2006 trend factor equal to the final consumer price index (CPI) for all urban consumers less 0.25%.

• Extends current provisions for certified home health agency administrative and general cost reimbursement limits for the periods April 1, 2013 through March 31, 2015.

• Continues, effective April 1, 2013 through March 31, 2015, home health care Medicare maximization initiatives.

The annual decrease in gross Medicaid expenditures attributable to these initiatives for state fiscal year 2013/14 is $17.8 million.

• The current authority to adjust Medicaid rates of payment for services provided by certified home health agencies (CHHAs) for such services provided to children under 18 years of age and for services provided to a special needs population of medically complex and fragile children, adolescents and young disabled adults by a CHHA, AIDS home care programs, and hospice programs for purposes of supporting recruitment and retention of non-supervisory health care workers or any worker with direct patient care responsibility has been extended for the period April 1, 2013 through March 31, 2014. Payments shall not exceed in the aggregate, $100 million for such period, and shall be calculated in accordance with the previously approved methodology.

Appendix V
2013 Title XIX State Plan
Second Quarter Amendment
Long-Term Care Facility Services
Responses to Standard Funding Questions

APPENDIX V
LONG TERM CARE SERVICES
State Plan Amendment #13-37

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 will submit the current nursing home UPL demonstration by June 30, 2013.

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: Effective January 1, 2012, the rate methodology included in the approved State Plan for non-specialty nursing facility services for the operating component of the rate is a blended statewide/peer group price adjusted for case mix and wage differentials (WEF). Specialty nursing facility and units are paid the operating rate in effect on January 1, 2009. The capital component of the rate for all specialty and non-specialty facilities is based upon a cost based methodology. 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: Tribal consultation was performed in accordance with the State's tribal consultation policy as approved in SPA 11-06, and documentation of such will be included with this submission. To date, no feedback has been received from any tribal representative in response to the proposed change in this SPA.