



Department of Health

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

JUN 12 2017

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

RE: SPA #17-0036
Long Term Care Facility Services

Dear Mr. Cooley:

The State requests approval of the enclosed amendment #17-0036 to the Title XIX (Medicaid) State Plan for long term care facility services to be effective April 1, 2017 (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).

A copy of the pertinent section of enacted legislation 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 29, 2017, 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, Office of Health Insurance Programs at (518) 474-6350.

Sincerely,

Jason A. Helgerson
Medicaid Director
Office of Health Insurance Programs

Enclosures
cc: Mr. Michael Melendez
Mr. Tom Brady

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: HEALTH CARE FINANCING ADMINISTRATION		1. TRANSMITTAL NUMBER: 17-0036	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, 2017	
5. TYPE OF PLAN MATERIAL <i>(Check One)</i> : <input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT <i>(Separate Transmittal for each amendment)</i>			
6. FEDERAL STATUTE/REGULATION CITATION: §1902(r)(5) of the Social Security Act, and 42 CFR 447		7. FEDERAL BUDGET IMPACT: <i>(in thousands)</i> a. FFY 04/01/17-09/30/17 \$ 0 b. FFY 10/01/17-09/30/18 \$ 0	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-D Part I: 110(d)(21), 110(d)(22), 110(d)(22.1), 110(d)(22.2), 110(d)(23), 110(d)(24), 110(d)(25), 110(d)(25.1), 110(d)(26)		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT <i>(If Applicable)</i> : Attachment 4.19-D Part I: 110(d)(21), 110(d)(22), 110(d)(22.1), 110(d)(22.2), 110(d)(23), 110(d)(24), 110(d)(25), 110(d)(25.1), 110(d)(26)	
10. SUBJECT OF AMENDMENT: Nursing Home Quality Care Incentive Changes (FMAP = 50%)			
11. GOVERNOR'S REVIEW <i>(Check One)</i> : <input checked="" type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input type="checkbox"/> OTHER, AS SPECIFIED: <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL			
12. SIGNATURE OF STATE AGENCY OFFICIAL:		16. RETURN TO: New York State Department of Health Division of Finance & Rate Setting 99 Washington Ave – One Commerce Plaza Suite 1432 Albany, NY 12210	
13. TYPED NAME: Jason A. Helgerson			
14. TITLE: Medicaid Director Department of Health			
15. DATE SUBMITTED: JUN 12 2017			
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
2017 Title XIX State Plan
Second Quarter Amendment
Amended SPA Pages

**New York
110(d)(21)**

The New York State Nursing Home Quality Pool (NHQP) is an annual budget-neutral pool of \$50 million dollars, or an amount as determined by the Commissioner. The intent of the NHQP is to incentivize Medicaid-certified nursing facilities across New York State to improve the quality of care for their residents, and to reward facilities for quality based on their performance. The set of measures used to evaluate nursing homes are part of the Nursing Home Quality Initiative (NHQI). The performances of facilities in the NHQI guide the distribution of the funds in the NHQP.

For the calendar year [2016] 2017, the Commissioner will calculate a score and quintile ranking based on data from the [2015] 2016 calendar year (January 1, [2015] 2016 through December 31, [2015] 2016), for each non-specialty facility. The score will be calculated based on measurement components comprised of Quality, Compliance, and Efficiency Measures. These measurement components and their resulting score and quintile ranking will be referred to as the Nursing Home Quality Initiative. From the NHQI, the Commissioner will exclude specialty facilities consisting of non-Medicaid facilities, Special Focus Facilities as designated by the Centers for Medicare and Medicaid Services (CMS), Continuing Care Retirement Communities, Transitional Care Units, specialty facilities, and specialty units within facilities. Specialty facilities and specialty units shall include AIDS facilities or discrete AIDS units within facilities, facilities or discrete units within facilities for residents receiving care in a long-term inpatient rehabilitation program for traumatic brain injured persons, facilities or discrete units within facilities that provide specialized programs for residents requiring behavioral interventions, facilities or discrete units within facilities for long-term ventilator dependent residents, [and] facilities or discrete units within facilities that provide services solely to children, and neurodegenerative facilities or discrete neurodegenerative units within facilities. The score for each such non-specialty facility will be calculated using the following Quality, Compliance, and Efficiency Measures.

Quality Measures		Measure Steward
1	Percent of Long Stay High Risk Residents With Pressure Ulcers (As Risk Adjusted by the Commissioner)	CMS
2	Percent of Long Stay Residents Who Received the Pneumococcal Vaccine	CMS
3	Percent of Long Stay Residents Who Received the Seasonal Influenza Vaccine	CMS
4	Percent of Long Stay Residents Experiencing One or More Falls with Major Injury	CMS
5	Percent of Long Stay Residents Who have Depressive Symptoms	CMS
6	Percent of Low Risk Long Stay Residents Who Lose Control of Their Bowels or Bladder	CMS
7	Percent of Long Stay Residents Who Lose Too Much Weight (As Risk Adjusted by the Commissioner)	CMS

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Supersedes TN #16-0024

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**New York
110(d)(23)**

The maximum points a facility may receive for the Compliance Component is 20 points. Points shall be awarded as follows:

Scoring for Compliance Measures	
CMS Five-Star Quality Rating for Health Inspections (By Region)	Points
5 Stars	10
4 Stars	7
3 Stars	4
2 Stars	2
1 Star	0
Timely Submission and Certification of Complete [2015] 2016 New York State Nursing Home Cost Report to the Commissioner	5 (Facilities that fail to submit a timely, certified, and complete cost report will receive zero points)
Timely Submission of Employee Influenza Immunization Data	5 for the May 1, [2016] <u>2017</u> deadline (Facilities that fail to submit timely influenza data by the deadline will receive zero points)

CMS Five-Star Quality Rating for Health Inspections

The CMS Five-Star Quality Rating for Health Inspections as of April 1, [2016] 2017 will be adjusted by region. This is not a risk adjustment. For eligible New York State nursing homes, the health inspection scores from CMS will be stratified by region. Cut points for health inspection scores within each region will be calculated using the CMS 10-70-20% distribution method. Per CMS' methodology, the top 10% of nursing homes receive five stars. The middle 70% receive four, three, or two stars, with an equal percentage (~23.33%) receiving four, three, or two stars. The bottom 20% receive one star. Each nursing home will be awarded a star rating based on the health inspection score cut points specific to its region. Regions include the Metropolitan Area (MARO), Western New York (WRO), Capital District (CDRO), and Central New York (CNYRO). Regions are defined by the New York State Health Facilities Information System (NYS HFIS). The counties within each region are shown below.

Metropolitan Area Regional Offices (MARO): Bronx, Dutchess, Kings, Nassau, New York, Orange, Putnam, Queens, Richmond, Rockland, Suffolk, Sullivan, Ulster, and Westchester.

Central New York Regional Offices (CNYRO): Broome, Cayuga, Chenango, Cortland, Herkimer, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, Saint Lawrence, Tioga, and Tompkins.

Capital District Regional Offices (CDRO): Albany, Clinton, Columbia, Delaware, Essex, Franklin, Fulton, Greene, Hamilton, Montgomery, Otsego, Rensselaer, Saratoga, Schenectady, Schoharie, Warren, and Washington.

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**New York
110(d)(25)**

Electrolyte imbalance	[276.0-276.9]	E860, E861, E869, E870, E871, E872, E873, E874, E875, E876, E878
Congestive heart failure	[428.0-428.9, 398.91]	I0981, I501, I5020, I5021, I5022, I5023, I5030, I5031, I5032, I5033, I5040, I5041, I5042, I5043, I509
Anemia	[280-280.9, 281.0-281.9, 285.1, 285.29]	D500, D501, D508, D509, D510, D511, D513, D518, D520, D521, D528, D529, D530, D531, D532, D538, D539, D62, D638

[*The healthcare industry began using ICD-10 in the last quarter of 2015, therefore both ICD-9 and ICD-10 codes must be used.]

Reduction of Points Base: When the number of long stay residents that contribute to the denominator of the potentially avoidable hospitalization measure is less than 30, the number of points the measure is worth will be reduced from the base of 100 maximum NHQI points. The nursing home’s total score will be the sum of its points divided by the base.

The following rate adjustments, which will be applicable to the [2016] 2017 calendar year, will be made to fund the NHQP and to make payments based upon the scores calculated from the NHQI as described above.

- Each non-specialty facility will be subject to a Medicaid rate reduction to fund the NHQI, which will be calculated as follows:
- For each such facility, Medicaid revenues, calculated by multiplying each facility’s promulgated rate in effect for such period by reported Medicaid days, as reported in a facility’s [2015] 2016 cost report, will be divided by total Medicaid revenues of all non-specialty facilities. The result will be multiplied by the \$50 million dollars, and divided by each facility’s most recently reported Medicaid days. If a facility fails to submit a timely filed [2015] 2016 cost report, the most recent cost report will be used.
- The total [quality] scores as calculated above for each such facility will be ranked and grouped by quintile. Each of the top three quintiles will be allocated a share of the \$50 million NHQI and each such facility within such top three quintiles will receive a payment. Such payments will be paid as a per diem adjustment for the [2016] 2017 calendar year. Such shares and payments will be calculated as follows:

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Appendix II
2017 Title XIX State Plan
Second Quarter Amendment
Summary

SUMMARY
SPA #17-0036

This State Plan Amendment proposes to maintain the quality incentive for nursing homes into the 2017 rate year and will continue to recognize improvement in performances as an element in the program and provide for other minor modifications. This SPA will clarify the reporting requirements related to the 2017 quality adjustments.

Appendix III
2017 Title XIX State Plan
Second Quarter Amendment
Authorizing Provisions

Pub. Health § 2808(2-c)d)

(d) The commissioner shall promulgate regulations, and may promulgate emergency regulations, to implement the provisions of this subdivision. Such regulations shall be developed in consultation with the nursing home industry and advocates for residential health care facility residents and, further, the commissioner shall provide notification concerning such regulations to the chairs of the senate and assembly health committees, the chair of the senate finance committee and the chair of the assembly ways and means committee. Such regulations shall include provisions for rate adjustments or payment enhancements to facilitate a minimum four-year transition of facilities to the rate-setting methodology established by this subdivision and may also include, but not be limited to, provisions for facilitating quality improvements in residential health care facilities. For purposes of facilitating quality improvements through the establishment of a nursing home quality pool, those facilities that contribute to the quality pool, but are deemed ineligible for quality pool payments due exclusively to a specific case of employee misconduct, shall nevertheless be eligible for a quality pool payment if the facility properly reported the incident, did not receive a survey citation from the commissioner or the Centers for Medicare and Medicaid Services establishing the facility's culpability with regard to such misconduct and, but for the specific case of employee misconduct, the facility would have otherwise received a quality pool payment. Regulations pertaining to the facilitation of quality improvement may be made effective for periods on and after January first, two thousand thirteen.

**Appendix IV
2017 Title XIX State Plan
Second Quarter Amendment
Public Notice**

established by such social services districts pursuant to a rate-setting exemption granted by the Department, and assisted living program services.

The annual decrease in gross Medicaid expenditures for state fiscal year 2017/2018 is (\$208.8) million.

Institutional Services

- For the state fiscal year beginning April 1, 2017 through March 31, 2018, continues specialty hospital adjustments for hospital inpatient services provided on and after April 1, 2012, to public general hospitals, other than those operated by the State of New York or the State University of New York, located in a city with a population of over one million and receiving reimbursement of up to \$1.08 billion annually based on criteria and methodology set by the Commissioner of Health, which the Commissioner may periodically set through a memorandum of understanding with the New York City Health and Hospitals Corporation. Payments to eligible public general hospitals may be added to rates of payment or made as aggregate payments.

- Extends current provisions for services on and after April 1, 2017 through March 30, 2020, the reimbursable operating cost component for general hospital inpatient rates will be established with the 2006 final trend factor equal to the final Consumer Price Index (CPI) for all urban consumers less 0.25%.

The estimated annual net decrease in gross Medicaid expenditures attributable to these cost containment initiatives contained in the budget for state fiscal year 2017/2018 is (\$114.5) million.

- Effective April 1, 2017, continues the supplemental upper payment limit payments made to general hospitals, other than major public general hospitals under institutional services of \$339 million annually.

- Capital related costs of a general hospital excluding 44% of the major movable costs and excluding staff housing costs will continue effective April 1, 2017 through March 31, 2020.

The estimated gross annual decrease in Medicaid expenditures for state fiscal year 2017/2018 for this initiative is (\$48.4) million.

- Budgeted capital inpatient costs of a general hospital applicable to the rate year will be decreased to reflect the percentage amount by which the budget for the base year two years prior to the rate year for capital related inpatient expenses of the hospital exceeded actual expenses will continue effective April 1, 2017 through March 31, 2020.

The estimated gross annual decrease in Medicaid expenditures for state fiscal year 2017/2018 for this initiative is (\$15.9) million.

Long Term Care Services

- For state fiscal year beginning April 1, 2017, 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 \$500 million. The amount allocated to each eligible public RHCf will be in accordance with the previously approved methodology, provided, however that patient days shall be utilized for such computation reflecting actual reported data for 2014 and each representative succeeding year as applicable. Payments to eligible RHCf's may be added to rates of payment or made as aggregate payments.

- The quality incentive program for non-specialty nursing homes will continue for the 2017 rate year to recognize improvement in performance as an element in the program and provide for other minor modifications.

There is no additional estimated annual change to gross Medicaid expenditures attributable to this initiative for state fiscal year 2017/2018.

- This proposal eliminates the reimbursement to Nursing Homes for bed hold days through the repeal of PHL § 2808(25).

The estimated annual net decrease in gross Medicaid expenditures attributable to these cost containment initiatives contained in the budget for state fiscal year 2017/2018 is (\$22) million.

- Continues, effective for periods on and after April 1, 2017, 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 estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2017/2018 is \$513 million.

- The following is notice of the continuation of the Advanced Training Program (ATI). First introduced in State fiscal year 2015/2016, ATI is a training program aimed at teaching staff to detect early changes in a resident's physical, mental, or functional status that could lead to hospitalization. Clinical findings show early detection of patient decline by front line workers, couple with clinical care models aimed at fostering consistent and continuous care between care givers and patients results in better care outcomes.

Training programs and their curricula from the previous ATI program may be used by facilities, new training programs will be submitted for Department review. In addition to offering a training program, eligible facilities must also have direct care staff retention above the statewide median. Hospital-based facilities and those receiving VAP funds will not be eligible to participate.

The estimated net aggregate cost contained in the budget for the continuation of the ATI program for 2017/2018 is \$46 million.

- The rates of payment for RHCf's shall not reflect trend factor projections or adjustments for the period April 1, 1996 through March 31, 1997 and continues the provision effective on and after April 1, 2017 through March 31, 2020.

The estimated annual net aggregate decrease in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2017/2018 is (\$12,749,000) million.

- Extends current provisions to services on and after April 1, 2017, the reimbursable operating cost component for RHCf's 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%.

The estimated annual net decrease in gross Medicaid expenditures attributable to these cost containment initiatives contained in the budget for state fiscal year 2017/2018 is (\$15,355,637) million.

Non-Institutional Services

- For state fiscal year beginning April 1, 2017 through March 31, 2018, continues hospital outpatient payment adjustments that increase the operating cost components of rates of payment for hospital outpatient and emergency departments on and after April 1, 2011, 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 amount to be paid will be up to \$287 million annually based on criteria and methodology set by the Commissioner of Health, which the Commissioner may periodically set through a memorandum of understanding with the New York City Health and Hospitals Corporation. Payments may be added to rates of payment or made as aggregate payments.

- For the state fiscal year beginning April 1, 2017 through March 31, 2018, continues upon the election of the social services district in which an eligible diagnostic and treatment center (DTC) is physically located, up to \$12.6 million in additional annual Medicaid payments may be paid to public DTCs operated by the New York City Health and Hospitals Corporation. Such payments will be based on each DTC's proportionate share of the sum of all clinic visits for all facilities eligible for an adjustment for the base year two years prior to the rate year. The proportionate share payments may be added to rates of payment or made as aggregate payments to eligible DTCs.

- For the state fiscal year beginning April 1, 2017 through March 31, 2018, continues up to \$5.4 million in additional annual Medicaid payments may be paid to county operated free-standing clinics, not including facilities operated by the New York City Health and Hospitals Corporation, for services provided by such DTC and those

Appendix V
2017 Title XIX State Plan
Second Quarter Amendment
Responses to Standard Funding Questions

**APPENDIX V
LONG TERM CARE SERVICES
State Plan Amendment #17-0036**

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: The Nursing Home Quality Pool is paid through a proportionate reduction to nursing home rates of \$50M and a reallocation of the fund to those facilities which score in the top three quintiles. The funds are general Medicaid fund paid though the non-specialty nursing home rate.

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 are not enhancements to the rates in that no additional monies are expended to fund or pay the NHQI. The pool is self-funded

and reallocates the proceeds proportionately from all nursing facilities to those in the top three quintiles.

- 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: The 2015 nursing home UPL demonstration was approved. The State and CMS are working to finalize the 2016 nursing home UPL demonstration, which the 2017 UPL demonstration is contingent upon.

- 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, 2015.

- 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 State 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 is included with the original submission. To date, no feedback has been received from any tribal representative in response to the proposed change in this SPA.