



Department of Health

ANDREW M. CUOMO
Governor

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

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

June 30, 2020

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

Re: SPA #20-0032
Inpatient Hospital Services

Dear Mr. Cooley:

The State requests approval of the enclosed amendment #20-0032 to the Title XIX (Medicaid) State Plan for inpatient hospital services to be effective April 1, 2020 (Appendix I). This amendment is being submitted based upon enacted legislation. A summary of the proposed amendment is contained in Appendix II.

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

Notice of the changes in the methods and standards for setting payment rates for general hospital inpatient services were given in the New York State Register on March 25, 2020.

A copy of pertinent sections of enacted legislation is enclosed for your information (Appendix III). In addition, responses to the five standard funding questions are also enclosed (Appendix V).

If you have any questions regarding this State Plan Amendment submission, please do not hesitate to contact Regina Deyette, Medicaid State Plan Coordinator, Division of Finance and Rate Setting, Office of Health Insurance Programs at (518) 473-3658.

Sincerely,

Donna Frescatore
Medicaid Director
Office of Health Insurance Programs

Enclosures
cc: Todd McMillion

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL
FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES**

1. TRANSMITTAL NUMBER

2. STATE

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE

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

7. FEDERAL BUDGET IMPACT

a. FFY _____ \$ _____

b. FFY _____ \$ _____

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (*If Applicable*)

10. SUBJECT OF AMENDMENT

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

GOVERNOR'S OFFICE REPORTED NO COMMENT

OTHER, AS SPECIFIED

COMMENTS OF GOVERNOR'S OFFICE ENCLOSED

NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

12. SIGNATURE OF STATE AGENCY OFFICIAL



16. RETURN TO

13. TYPED NAME

14. TITLE

15. DATE SUBMITTED June 30, 2020

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
2020 Title XIX State Plan
Second Quarter Amendment
Amended SPA Pages

**New York
5(b)**

**VII. ADDITIONAL INPATIENT STATE PUBLIC HOSPITAL UPPER PAYMENT LIMIT
(UPL) ADJUSTMENTS**

1. Effective for State UPL demonstrations for calendar year 2019 and after, if CMS determines that payments for inpatient hospital services provided by State government-owned hospitals exceed the UPL, the State will remit such amount in excess of the UPL as follows: The State will process a lump sum reduction equivalent to the value of the UPL excess upon approval of the UPL.
2. For the period beginning January 1, 2019 and each calendar year thereafter, the State will provide a supplemental payment for all inpatient services provided by State government-owned hospitals. The amount of the supplemental payment, when aggregated with other Medical assistance payments, will not exceed 100% of a reasonable estimate of the amount that would be paid for such services under Medicare payment principles for State government-owned hospitals. Such a supplemental payment will be allocated and paid to OMH-operated hospitals based on the proportionate share of total base year Medicaid days used for the inpatient rate calculation and will be factored into facility-specific Disproportionate Share (DSH) limit calculations.

For the period January 1, [2019] 2020 through December 31, [2019] 2021, the supplemental payment will be \$5,046,499 and will be payable as a one-time lump sum.

TN #20-0032

Approval Date _____

Supersedes TN #18-0066

Effective Date April 1, 2020

Appendix II
2020 Title XIX State Plan
Second Quarter Amendment
Summary

SUMMARY
SPA #20-0032

This State Plan Amendment proposes to provide a supplemental payment to State government-owned hospitals which are below for the upper payment limit for inpatient services.

Appendix III
2020 Title XIX State Plan
Second Quarter Amendment
Authorizing Provisions

DEPARTMENT OF MENTAL HYGIENE

OFFICE OF MENTAL HEALTH

SPA 20-0032

STATE OPERATIONS

2020-21

ADULT SERVICES PROGRAM..... 1,406,955,000

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General Fund
State Purposes Account - 10050
For services and expenses related to the adult services program.
Funds appropriated under this program are available for the payment of tolls at the Robert F. Kennedy bridge, for vehicles driven by persons commuting to and from work who are employed at facilities located on Ward's island operated by the department of mental hygiene.
Notwithstanding any other provision of law to the contrary, any of the amounts appropriated herein may be increased or decreased by interchange or transfer without limit, with any appropriation of the office of mental health or by transfer or suballocation to any department, agency or public authority for expenditures incurred in the operation of such programs with the approval of the director of the budget.
Notwithstanding any other provision of law to the contrary, the commissioner of the office of mental health shall be authorized, subject to the approval of the director of the budget, to transfer up to \$3,000,000 of this appropriation to the department of health for the purpose of making physician loan repayment awards to psychiatrists who are licensed to practice in New York state and who agree to work for a period of at least five years in one or more hospitals or outpatient programs that are operated by the office of mental health and deemed to be in one or more underserved areas, as determined by the commissioner of mental health. Notwithstanding paragraph (d) of subdivision 5-a, and paragraphs (d), (e), and (f) of subdivision 10 of section 2807-m of the public health law, all awards made by the department of health from any of the office of mental health funds transferred herein shall be made consistent with the provisions of paragraphs (a), (b) and (c) of subdivision 10 of section 2807-m of the public health law and may not supplant or

DEPARTMENT OF MENTAL HYGIENE

OFFICE OF MENTAL HEALTH

STATE OPERATIONS 2020-21

1 otherwise support the department of
2 health's physician's loan repayment
3 program.

4 Notwithstanding any law to the contrary, no
5 funds under this appropriation shall be
6 available for certification or payment
7 until (i) the legislature has finally
8 acted upon the appropriations for the
9 office of mental health contained in the
10 aid to localities budget bill, and (ii)
11 the director of the budget has determined
12 that those aid to localities
13 appropriations as finally acted on by the
14 legislature are sufficient for the ensuing
15 fiscal year.

16 Notwithstanding any other provision of law
17 to the contrary, any of the amounts
18 appropriated herein may be increased or
19 decreased by interchange or transfer,
20 without limit, with any appropriation of
21 any other department, agency or public
22 authority or by transfer or suballocation
23 to any department, agency or public
24 authority with the approval of the
25 director of the budget.

26 Notwithstanding any provision of law to the
27 contrary, the amounts appropriated herein
28 shall be net of refunds, rebates,
29 reimbursements, credits, repayments,
30 and/or disallowances.

31 Notwithstanding any other provision of law
32 to the contrary, the OGS Interchange and
33 Transfer Authority and the IT Interchange
34 and Transfer Authority as defined in the
35 2020-21 state fiscal year state operations
36 appropriation for the budget division
37 program of the division of the budget, are
38 deemed fully incorporated herein and a
39 part of this appropriation as if fully
40 stated (36901).

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42	Personal service--regular (50100)	669,524,000
43	Temporary service (50200)	3,761,000
44	Holiday/overtime compensation (50300)	46,760,000
45	Supplies and materials (57000)	88,291,000
46	Travel (54000)	2,382,000
47	Contractual services (51000)	117,411,000
48	Equipment (56000)	2,184,000
49	Fringe benefits (60000)	447,671,000
50	Indirect costs (58800)	23,121,000
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52	Program account subtotal	1,401,105,000
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DEPARTMENT OF MENTAL HYGIENE

OFFICE OF MENTAL HEALTH

41 CHILDREN AND YOUTH SERVICES PROGRAM..... 248,263,000

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44 General Fund

45 State Purposes Account - 10050

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47 For services and expenses related to the
48 children and youth services program.

49 Notwithstanding any other provision of law
50 to the contrary, any of the amounts appro-
51 priated herein may be increased or
52 decreased by interchange or transfer with-
53 out limit, with any appropriation of the
54 office of mental health or by transfer or
55 suballocation to any department, agency or
56 public authority for expenditures incurred
57 in the operation of such programs with the
58 approval of the director of the budget.

59 Notwithstanding any law to the contrary, no
60 funds under this appropriation shall be

1 available for certification or payment
2 until (i) the legislature has finally
3 acted upon the appropriations for the
4 office of mental health contained in the
5 aid to localities budget bill, and (ii)
6 the director of the budget has determined
7 that those aid to localities
8 appropriations as finally acted on by the
9 legislature are sufficient for the ensuing
10 fiscal year.

11 Notwithstanding any provision of law to the
12 contrary, the amounts appropriated herein
13 shall be net of refunds, rebates,
14 reimbursements, credits, repayments,
15 and/or disallowances.

16 Notwithstanding any other provision of law
17 to the contrary, the OGS Interchange and
18 Transfer Authority and the IT Interchange
19 and Transfer Authority as defined in the
20 2020-21 state fiscal year state operations
21 appropriation for the budget division
22 program of the division of the budget, are
23 deemed fully incorporated herein and a
24 part of this appropriation as if fully
25 stated (36902).

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27 Personal service--regular (50100).....125,452,000

28 Temporary service (50200) 2,464,000

29 Holiday/overtime compensation (50300) 9,583,000

30 Supplies and materials (57000) 12,973,000

31 Travel (54000) 680,000

32 Contractual services (51000) 14,215,000

33 Equipment (56000) 864,000

34 Fringe benefits (60000) 78,182,000

35 Indirect costs (58800) 3,850,000

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Appendix IV
2020 Title XIX State Plan
Second Quarter Amendment
Public Notice

cally set through a memorandum of understanding with the New York City Health and Hospitals Corporation. Such adjustments shall be paid by means of one or more estimated payments. Payments may be added to rates of payment or made as aggregate payments.

For state fiscal year beginning April 1, 2020 through March 31, 2021, 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 state fiscal year beginning April 1, 2020 through March 31, 2021, 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 provided by a county operated freestanding mental health or substance abuse DTC. Distributions shall be based on each eligible facility's proportionate share of the sum of all DTC and clinic visits for all eligible facilities receiving payments 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 facilities.

Institutional Services

Effective on or after April 1, 2020, the temporary rate adjustment has been reviewed and approved for the St. Joseph's Hospital Health Center with aggregate payment amounts totaling up to \$4,000,000 for the period April 1, 2020 through March 31, 2021.

Effective on or after April 1, 2020, continues the supplemental upper payment limit payments made to general hospitals, other than major public general hospitals under institutional services of \$339 million annually.

For state fiscal year beginning April 1, 2020 through March 31, 2021, continues 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. Such adjustments shall be paid by means of one or more estimated payments. Payments to eligible public general hospitals may be added to rates of payment or made as aggregate payments.

For state fiscal year beginning April 1, 2020 through March 31, 2021, supplemental payments will be made to State government owned hospitals. These payments will not exceed the upper payment limit for inpatient services provided by state government-owned hospitals when aggregated with other Medicaid payments.

Effective on or after April 1, 2020, the temporary rate adjustment has been reviewed and approved for Long Island Jewish Medical Center with aggregate payment amounts totaling up to \$1,000,000 for the period April 1, 2020 through March 31, 2021.

Long Term Care Services

Effective on or after April 1, 2020, 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 2018 and each representative succeeding year as applicable. Payments to eligible RHCF's may be added to rates of payment or made as aggregate payments.

Effective on or after April 1, 2020, the Department of Health

proposes to amend the Title XIX (Medicaid) State Plan for institutional services related to temporary rate adjustments to long term care providers that are undergoing closure, merger, consolidation, acquisition or restructuring themselves or other health care providers. These payments are authorized by current State statutory and regulatory provisions. The temporary rate adjustments will be reviewed and approved by the CINERGY Collaborative.

The estimated net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2020-2021 is \$30 million.

Effective on or after April 1, 2020, the Department of Health (DOH) will continue the nursing home advanced training program, aimed at teaching staff how to detect early changes in a resident's physical and mental or functional status that could lead to hospitalization. Clinical findings show early detection of patient decline by front line workers, coupled with clinical care models aimed at fostering consistent and continuous care between care givers and patients/families result in better care outcomes. Similarly, nursing homes with higher staff retention rates correlate with better care outcomes and avoided hospital stays. This training program will be developed in cooperation between Nursing Home providers and union representatives offering training opportunities for staff or other qualifying training programs.

These programs and their curricula will be submitted to DOH for review. In addition to offering a training program, eligible facilities must have direct care staff retention rates above the state median. However, hospital-based nursing homes and free standing nursing homes already receiving VAP payments would not be eligible to participate.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2020/2021 is \$46 million.

The public is invited to review and comment on this proposed State Plan Amendment, a copy 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, approved SPA's beginning in 2011 are also available for viewing on this website.

Copies of the proposed State Plan Amendments will be on file in each local (county) social services district and available for public review.

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

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

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

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

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

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

For further information and to review and comment, please contact: Department of Health, Division of Finance and Rate Setting, 99 Washington Ave., One Commerce Plaza, Suite 1432, Albany, NY 12210, spa_inquiries@health.ny.gov

Appendix V
2020 Title XIX State Plan
Second Quarter Amendment
Responses to Standard Funding Questions

HOSPITAL SERVICES
State Plan Amendment #20-0032

CMS Standard Funding Questions (NIRT Standard Funding Questions)

The following questions are being asked and should be answered in relation to all payments made to all providers under Attachment 4.19-A of the 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 2 CFR 200 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 Office of Mental Health. The source of the appropriation is the General Fund Local Assistance Account which is funded primarily by tax revenues. There are no new provider taxes and no modifications to existing taxes have been made.

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 Medicaid payments authorized for this provision are supplemental payments. The amount of the supplemental payment for government hospitals will be provided once the calculation is finalized with CMS. These payments will be made to qualified hospitals in the non-state owned or operated provider category.

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 447.272, 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 State is working to complete and submit the current year UPL.

The IP UPL calculation utilizes both the cost to payment and the payment to payment methodology to complete the calculation.

The cost to payment method derives a ratio of cost to charges from the CMS 255210 and is applied to Medicaid charges to estimate the Medicaid costs, or for hospitals without a charge structure an average cost per visit/unit method is used to estimate Medicaid costs. The Medicaid costs are developed using Medicare principles and guidance from CMS, which are compared to Medicaid payments.

The payment to payment method runs the appropriate Medicaid claims through the grouper/pricer to develop the Medicare principles, which are then compared to Medicaid payments.

- 5. Does any governmental provider receive payments that in the aggregate (normal per diem, supplemental, enhanced, other) exceed their reasonable costs of providing services? If payments exceed the cost of services, do you recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report?**

Response: The rate methodology included in the approved State Plan for institutional services is prospective payment 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: The 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 17-0065, and documentation of such is included with this submission. To date, no feedback has been received from any tribal representative in response to the proposed change in this SPA.