



Department of Health

KATHY HOCHUL
Governor

MARY T. BASSETT, M.D., M.P.H.
Commissioner

KRISTIN M. PROUD
Acting Executive Deputy Commissioner

March 31, 2022

Todd McMillion
Director
Department of Health and Human Services
Centers for Medicare and Medicaid Services
233 North Michigan Ave, Suite 600
Chicago, IL 60601

Re: SPA #22-0005
Inpatient Hospital Services

Dear Mr. McMillion:

The State requests approval of the enclosed amendment #22-0005 to the Title XIX (Medicaid) State Plan for inpatient hospital services to be effective January 1, 2022 (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 December 29, 2021.

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,

Brett R. Friedman
Acting Medicaid Director
Office of Health Insurance Programs

Enclosures

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

1. TRANSMITTAL NUMBER ____ _	2. STATE ____
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3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT XIX XXI
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TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE

5. FEDERAL STATUTE/REGULATION CITATION
--

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY _____ \$ _____
b. FFY _____ \$ _____

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
--

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable)

9. SUBJECT OF AMENDMENT

10. GOVERNOR'S REVIEW (Check One)	OTHER, AS SPECIFIED:
GOVERNOR'S OFFICE REPORTED NO COMMENT	
COMMENTS OF GOVERNOR'S OFFICE ENCLOSED	
NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL	

11. [REDACTED]
12. TYPED NAME
13. TITLE
14. DATE SUBMITTED March 31, 2022

15. RETURN TO

FOR CMS USE ONLY	
16. DATE RECEIVED	17. DATE APPROVED

PLAN APPROVED - ONE COPY ATTACHED	
18. EFFECTIVE DATE OF APPROVED MATERIAL	19. SIGNATURE OF APPROVING OFFICIAL
20. TYPED NAME OF APPROVING OFFICIAL	21. TITLE OF APPROVING OFFICIAL

22. REMARKS

Appendix I
2022 Title XIX State Plan
First Quarter Amendment
Amended SPA Pages

**New York
117(i)**

1905(a)(1) Inpatient Hospital Services

772	1	Alcohol & Drug Dependence w Rehab or Rehab/Detox Therapy, SOI-1	0.8373
772	2	Alcohol & Drug Dependence w Rehab or Rehab/Detox Therapy, SOI-2	0.8373
772	3	Alcohol & Drug Dependence w Rehab or Rehab/Detox Therapy, SOI-3	0.8373
772	4	Alcohol & Drug Dependence w Rehab or Rehab/Detox Therapy, SOI-4	0.8373
773	1	Opioid Abuse & Dependence, SOI-1	1.0204
773	2	Opioid Abuse & Dependence, SOI-2	1.0204
773	3	Opioid Abuse & Dependence, SOI-3	1.0361
773	4	Opioid Abuse & Dependence, SOI-4	1.0361
774	1	Cocaine Abuse & Dependence, SOI-1	0.9807
774	2	Cocaine Abuse & Dependence, SOI-2	1.0360
774	3	Cocaine Abuse & Dependence, SOI-3	1.0513
774	4	Cocaine Abuse & Dependence, SOI-4	1.0513
775	1	Alcohol Abuse & Dependence, SOI-1	1.0196
775	2	Alcohol Abuse & Dependence, SOI-2	1.0709
775	3	Alcohol Abuse & Dependence, SOI-3	1.0709
775	4	Alcohol Abuse & Dependence, SOI-4	1.0709
776	1	Other Drug Abuse & Dependence, SOI-1	0.9363
776	2	Other Drug Abuse & Dependence, SOI-2	1.0926
776	3	Other Drug Abuse & Dependence, SOI-3	1.0926
776	4	Other Drug Abuse & Dependence, SOI-4	1.0926

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- iii. A rural adjustment factor of 1.2309 will be applied to the operating per diem for those hospitals designated as rural hospitals. A rural facility is a general hospital with a service area which has an average population of less than 175 persons per square mile, or a general hospital with a service area which has an average population of less than 200 persons per square mile measured as population density by zip code. For dates of service beginning on or after July 1, 2014, rural designation will be applicable to hospitals located in an upstate region, as defined in subparagraph (l) of this section, and with population densities of 225 persons or fewer per square mile as determined based on the New York State 2010 Vital Statistics table of estimated population, land area, and population density. Accordingly, there are 27 rural facilities that provide inpatient psychiatric services.
 - iv. An age adjustment payment factor of 1.3597 will be applied to the per diem operating component for adolescents ages 17 and under. For ages 18 and over, an adjustment payment factor of 1 will be applied.]

TN #22-0005 _____ **Approval Date** _____
Supersedes TN #18-0059 _____ **Effective Date** January 1, 2022

**New York
117(i)(1)**

1905(a)(1) Inpatient Hospital Services

- iii. A rural adjustment factor of 1.2309 will be applied to the operating per diem for those hospitals designated as rural hospitals. A rural facility is a general hospital with a service area which has an average population of less than 175 persons per square mile, or a general hospital with a service area which has an average population of less than 200 persons per square mile measured as population density by zip code. For dates of service beginning on or after July 1, 2014, rural designation will be applicable to hospitals located in an upstate region, as defined in subparagraph (l) of this section, and with population densities of 225 persons or fewer per square mile as determined based on the New York State 2010 Vital Statistics table of estimated population, land area, and population density. For dates of service beginning on or after January 1, 2022, rural designation will be applicable to hospitals located in an upstate region, as defined in subparagraph (l) of this section, and with population densities of 300 persons or fewer per square mile as determined based on the New York State 2020 Vital Statistics table of estimated population, land area, and population density.

- iv. An age adjustment payment factor of 1.3597 will be applied to the per diem operating component for adolescents ages 17 and under. For ages 18 and over, an adjustment payment factor of 1 will be applied.

TN #22-0005

Approval Date _____

Supersedes TN #NEW

Effective Date January 1, 2022

Appendix II
2022 Title XIX State Plan
First Quarter Amendment
Summary

SUMMARY
SPA #22-0005

This State Plan Amendment proposes to redefine rural designation of hospitals for the Article 28 psychiatric services to better meet community mental health needs in rural areas in the State of New York.

Appendix III
2022 Title XIX State Plan
First Quarter Amendment
Authorizing Provisions

SPA 22-0005

Section 2807 – c(4)(e-1) of Public Health Law.

4. Modifications and exceptions to case payment rates. Case based rates of payment shall be modified and per diem or other unit of service payments shall be provided, or exceptions shall be made to case payments, in accordance with rules and regulations adopted by the council and approved by the commissioner, in the following circumstances:

(e) in cases where a general hospital or distinct unit of a general hospital is not or would not have been reimbursed on a case based payment per diagnosis-related group for inpatient services provided on or before December thirty-first, two thousand one, to beneficiaries of title XVIII of the federal social security act (medicare), reimbursement shall be on a per diem basis computed for excluded general hospitals based on the hospital's reimbursable inpatient operating cost base, or for excluded distinct units of general hospitals based on the distinct unit's reimbursable inpatient operating cost base, determined in accordance with paragraph (d) of subdivision one of this section, projected to the applicable rate period by the trend factor determined in accordance with subdivision ten of this section, and increased in accordance with subparagraphs (i), (iii) and (iv) of paragraph (e) of subdivision one of this section to reflect special additional inpatient operating costs, and adjusted to exclude a factor for operating costs of patients who required an alternate level of care developed consistent with the provisions of paragraph (h) of this subdivision, and increased for excluded general hospitals to reflect the product of the group category percentage amount applicable for purposes of determining group category average inpatient reimbursable operating cost per discharge (price) in the rate period pursuant to paragraph (b) of subdivision five of this section for general hospitals reimbursed on a case based payment per diagnosis-related group applied to such excluded general hospital's additional cost increases determined in accordance with subparagraph (ii) of paragraph (e) of subdivision one of this section, and adjusted on a payor category basis to reflect allocation of malpractice insurance costs in accordance with the methodology developed pursuant to subparagraph (ii) of paragraph (h) of subdivision eleven of this section, for those patients included in the payor categories pursuant to the provisions of paragraph (a) or (b) of subdivision one of this section; provided, however, for those patients included in the payor categories pursuant to the provisions of paragraph (b) of subdivision

one of this section payment shall be at the per diem payment to the hospital or distinct unit of the hospital for services provided to subscribers of corporations organized and operating in accordance with article forty-three of the insurance law, adjusted for uncovered services, and increased by thirteen percent or by five percent, as the case may be; provided further, however, for those general hospitals that are not reimbursed on a case-based payment per diagnosis-related group for inpatient services provided to beneficiaries of title XVIII of the federal social security act (medicare) as a result of their designation by the secretary of health and human services as a comprehensive cancer hospital or as a result of their status as an acute care exempt children's hospital, the base year for determining payments for services in such facilities shall be nineteen hundred eighty-seven, provided, however, such hospitals shall be allowed adjustments in rates of payment to reflect costs incurred subsequent to nineteen hundred eighty-seven but not reflected in such base. Funds received by a general hospital based on the payment differential in accordance with paragraph (b) of subdivision one of this section applied pursuant to this paragraph shall be hospital funds for patient care purposes. For those patients not covered under the provisions of paragraph (a) or (b) of subdivision one of this section, or who are not covered under the provisions of paragraph (a) of subdivision two of this section, payment shall be on the basis of the hospital's charge schedule, limited to one hundred twenty percent of the total per diem payment that would have been made if the patient were included in the payor categories pursuant to the provisions of paragraph (b) of subdivision one of this section. Rates of payment for excluded general hospitals and excluded distinct units of general hospitals for a rate period shall be increased on a per diem basis by additions and allowances specified in subparagraphs (ii) and (iii) of paragraph (a) of subdivision one of this section. In adopting regulations for purposes of determining rates of payment for psychiatric services pursuant to this paragraph, the council and the commissioner shall consider the advice of the commissioner of mental health and may include case mix and other adjustments for such rates of payment. The commissioner of mental health shall study and report on alternative procedures for the development of rates of payment for inpatient psychiatric care. Such report shall be submitted to the governor, the legislature and the commissioner of health by January first, nineteen hundred ninety-three. Recommendations for alternative financing shall take into consideration methods to improve access to inpatient care for seriously mentally ill persons.

(e-1) Notwithstanding any inconsistent provision of paragraph (e) of this subdivision or any other contrary provision of law and subject to

the availability of federal financial participation, per diem rates of payment by governmental agencies for a general hospital or a distinct unit of a general hospital for inpatient psychiatric services that would otherwise be subject to the provisions of paragraph (e) of this subdivision shall, with regard to days of service associated with admissions occurring on and after April first, two thousand ten, be in accordance with the following:

(i) For rate periods on or after April first, two thousand ten, the commissioner, in consultation with the commissioner of the office of mental health, shall promulgate regulations, and may promulgate emergency regulations, establishing methodologies for determining the operating cost components of rates of payments for services described in this paragraph. The commissioner may make such adjustments to the methodology for computing such rates as is necessary to achieve no aggregate, net growth in overall Medicaid expenditures related to such rates, as compared to such aggregate expenditures from the prior year. In determining the updated base year to be utilized pursuant to this subparagraph, the commissioner shall take into account the base year determined in accordance with paragraph (c) of subdivision thirty-five of this section.

Furthermore, the commissioner shall establish such rates in consultation with industry representatives to achieve an appropriate base year update to the operating cost components of rates of payment for services described in this paragraph and that takes into account facility cost, mix of services, and patient specific conditions.

(ii) Rates of payment established pursuant to subparagraph (i) of this paragraph shall reflect an aggregate net statewide increase in reimbursement for such services of up to twenty-five million dollars on an annual basis.

(iii) Capital cost reimbursement for general hospitals otherwise subject to the provisions of this paragraph shall remain subject to the provisions of subdivision eight of this section.

**Appendix IV
2022 Title XIX State Plan
First Quarter Amendment
Public Notice**

(APG) reimbursement methodology is revised to include recalculated weight and component updates to reflect the APG policy updates.

There is no additional estimated annual change to gross Medicaid expenditures as a result of this proposed amendment.

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. Individuals without Internet access may view the State Plan Amendments at any local (county) social services district.

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

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

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

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

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

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

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

PUBLIC NOTICE

Department of Health

Pursuant to 42 CFR Section 447.205, the Department of Health hereby gives public notice of the following:

The Department of Health proposes to amend the Title XIX (Medicaid) State Plan for institutional services to comply with enacted statutory provisions. The following changes are proposed:

Institutional Services

Effective for dates of service on or after January 1, 2022, the Department of Health will redefine the rural designation for the inpatient psychiatric services provided in exempt general hospitals or exempt units of general hospitals by increasing the average county population density from 225 to 300 per square mile based on 2020 census data. This State Plan Amendment is necessary to adequately reimburse hospitals for providing these services and better meet the community's mental health needs.

The estimated annual increase in gross Medicaid expenditures attributable to this initiative is \$2,300,000. Funding for this redefinition is included in the State Budget for State Fiscal Year 2022.

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. Individuals without Internet access may view the State Plan Amendments at any local (county) social services district.

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

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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

PUBLIC NOTICE

Department of Health

Pursuant to 42 CFR Section 447.205, the Department of Health hereby gives public notice of the following:

The Department of Health proposes to amend the Title XIX (Medicaid) State Plan for Long Term Care services as authorized by § 2826 of New York Public Health Law. The following changes are proposed:

Long Term Care Services

Temporary rate adjustments have been approved for services related to providers that are undergoing closure, merger, consolidation, acquisition or restructuring themselves or other health care providers. The temporary rate adjustments have been reviewed and approved for the following six Nursing Homes:

- Loretto Health and Rehabilitation with aggregate payment amounts totaling up to \$4,747,976 for the period January 01, 2022 through March 31, 2022 and \$2,977,124 for the period April 1, 2022 through March 31, 2023.

- St. Vincent DePaul Residence with aggregate payment amounts totaling up to \$3,681,188 for the period January 01, 2022 through March 31, 2022 and \$1,538,986 for the period April 1, 2022 through March 31, 2023.

- Fort Hudson Nursing Center with aggregate payment amounts totaling up to \$1,129,968 for the period January 01, 2022 through March 31, 2022, \$475,930 for the period April 1, 2022 through March 31, 2023 and \$551,772 for the period April 1, 2023 through March 31, 2024.

- Adirondack Health - Mercy Living Center with aggregate payment amounts totaling up to \$500,000 for the period January 01, 2022 through March 31, 2022.

- Greenfield Health and Rehabilitation Center with aggregate payment amounts totaling up to \$695,000 for the period January 01, 2022 through March 31, 2022, \$1,647,500 for the period April 1, 2022 through March 31, 2023, and \$620,000 for the period April 1, 2023 through March 31, 2024.

- The Trustees of Eastern Star Hall and Home of New York with aggregate payment amounts totaling up to \$869,050 for the period January 01, 2022 through March 31, 2022.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2021/2022 is \$11,623,182. The Medicaid expenditures attributable to state fiscal year 2022/2023 and state fiscal year 2023/2024 are \$6,639,540 and \$1,172,772, respectively.

The public is invited to review and comment on this proposed State Plan Amendment, a copy of which will be available for public review

Appendix V
2022 Title XIX State Plan
First Quarter Amendment
Responses to Standard Funding Questions

HOSPITAL SERVICES
State Plan Amendment #22-0005

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 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 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 and CMS are working toward completing and approval of current year UPL.

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.