KATHY HOCHUL
Governor

JAMES V. McDONALD, M.D., M.P.H.
Commissioner

JOHANNE E. MORNE, M.S.
Executive Deputy Commissioner

September 27, 2024

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 #24-0062
Non-Institutional Services

Dear Director McMillion:

The State requests approval of the enclosed amendment #24-0062 to the Title XIX (Medicaid) State Plan for non-institutional services to be effective July 1, 2024 (Appendix I). This amendment is being submitted based on enacted legislation. A summary of the plan amendment is provided in Appendix II.

The State of New York reimburses these services through the use of rates that are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area as required by § 1902(a)(30) of the Social Security Act and 42 CFR § 447.204.

A copy of pertinent sections of enacted legislation is enclosed for your information (Appendix III). A copy of the public notice of this plan amendment, which was given in the New York State Register on June 26, 2024, 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 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,

Amir Bassiri
Medicaid Director
Office of Health Insurance Programs

Enclosures

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 2 4 — 0 0 6 2

2. STATE: N Y

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

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2024

5. FEDERAL STATUTE/REGULATION CITATION
§ 1905(a)(9) Clinic Services

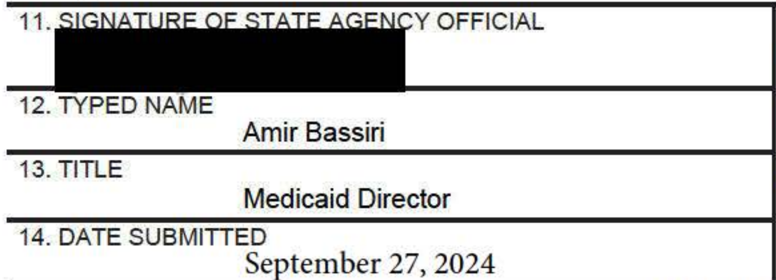
6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 07/01/24-09/30/24 $ 250,000
b. FFY 10/01/24-09/30/25 $ 1,000,000

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.19-B Page: 2(g)(a)

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*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

9. SUBJECT OF AMENDMENT
Pediatric Diagnostic & Treatment Center (D&TC) Rate

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



11. SIGNATURE OF STATE AGENCY OFFICIAL

12. TYPED NAME
Amir Bassiri

13. TITLE
Medicaid Director

14. DATE SUBMITTED
September 27, 2024

15. RETURN TO
New York State Department of Health
Division of Finance and Rate Setting
99 Washington Ave – One Commerce Plaza
Suite 1432
Albany, NY 12210

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
2024 Title XIX State Plan
Third Quarter Amendment
Amended SPA Pages

1905(a)(9) Clinic Services

Pediatric Diagnostic and Treatment Center Rate

1. Effective for services on or after July 1, 2024 through March 31, 2027, qualified pediatric Diagnostic and Treatment Centers (D&TCs) will be eligible for a Medicaid rate that reflects the approved costs associated with providing care to children with medical fragility. For the purposes of this section, children with medical fragility are individuals who are under the age of twenty-one and have a chronic debilitating condition or conditions, who may or may not be hospitalized or institutionalized, and who meets one or more of the following criteria:

    a. Is technology-dependent for life or health sustaining functions;
    b. Requires complex medication regimens or medical interventions to maintain or improve their health status; or
    c. Is in need of ongoing assessment or intervention to prevent serious deterioration of their health status or medical complications that place their life, health or development at risk.

2. To be eligible for a pediatric D&TC Medicaid rate, such D&TCs must meet the following criteria:

    a. Must be participating in a demonstration program for children with medical fragility, for which at least eighty percent (80%) of its total Medicaid fee-for-service reimbursement is derived from the provision of services to children under the age of twenty-one with medical fragility; and
    b. Must be affiliated with a pediatric residential health care facility, which is freestanding or has a discrete unit within a facility, authorized to provide extensive nursing, medical, psychological and counseling support services solely to children under the age of twenty-one.

3. For the period July 1, 2024 through December 31, 2024, and until such time as a certified annual cost report for such period is received and verified by the Department of Health (Department), the operating component of such rate will reflect budgeted costs and visits for the period January 1, 2024 through December 31, 2024, as submitted to the Department and adjusted as the commissioner deems appropriate. The capital component of the rate will reflect actual reported base year allowable costs and visits from two years prior to the rate year. Upon submission and subsequent verification of the cost report, the operating component of the rate will be reflective of actual costs and visits for the period January 1, 2024 through December 31, 2024, subject to further adjustments as the commissioner deems appropriate. Thereafter, the base period reported operating costs used to establish rates, pursuant to this section, will be updated no less frequently than every two years while the base period reported allowable capital costs will be updated annually.

    Based on the aforementioned, the total annual operating costs will be divided by the total annual visits to establish the operating cost component of the rate and the total annual capital costs will be divided by the total annual visits to establish the capital cost component of the rate.

    In addition to required annual cost reports, pediatric D&TCs, as defined by this section, will submit additional data as the commissioner requires.

Appendix II
2024 Title XIX State Plan
Third Quarter Amendment
Summary

SUMMARY
SPA #24-0062

This State Plan Amendment proposes to establish a Medicaid rate that reflects the approved costs associated with providing care to children with medical fragility, for eligible pediatric Diagnostic and Treatment Centers (D&TCs).

Appendix III
2024 Title XIX State Plan
Third Quarter Amendment
Authorizing Provisions

Chapter 57 of the Laws of 2024 (PHL 2807 (2)(g)(iii))

PART LL

24 Section 1. Paragraph (g) of subdivision 2 of section 2807 of the
25 public health law is amended by adding a new subparagraph (iii) to read
26 as follows:
27 **(iii) (A) For purposes of this subparagraph:**
28 **(1) "Children with medical fragility" shall mean an individual who is**
29 **under twenty-one years of age and has a chronic debilitating condition**
30 **or conditions, who may or may not be hospitalized or institutionalized,**
31 **and who meets one or more of the following criteria: (I) is technology-**
32 **dependent for life or health sustaining functions; (II) requires complex**
33 **medication regimens or medical interventions to maintain or to improve**
34 **their health status; or (III) is in need of ongoing assessment or inter-**
35 **vention to prevent serious deterioration of their health status or**
36 **medical complications that place their life, health or development at**
37 **risk.**
38 **(2) "Pediatric residential health care facility" shall mean a free-**
39 **standing facility or discrete unit within a facility authorized by the**
40 **commissioner to provide extensive nursing, medical, psychological, and**
41 **counseling support services solely to children under the age of twenty-**
42 **one.**
43 **(3) "Pediatric diagnostic and treatment center" shall mean a diagnos-**
44 **tic and treatment center established pursuant to this article, which as**
45 **of April first, two thousand twenty-four, has been participating in the**
46 **demonstration program authorized under subdivision one of section twen-**
47 **ty-eight hundred eight-e of this article, for which at least eighty**
48 **percent of its total Medicaid fee-for-service reimbursements derive from**
49 **the provision of services to children under the age of twenty-one with**
50 **medical fragility and is affiliated with a pediatric residential health**
51 **care facility.**
52 **(B) (1) Notwithstanding any law, rule, or regulation to the contrary,**
53 **the commissioner shall establish rates of reimbursement for pediatric**
54 **diagnostic and treatment centers for all services provided on or after**

S. 8307--C 68 A. 8807--C

1 **April first, two thousand twenty-four, to children eligible for medical**
2 **assistance that reflect the costs necessary to provide care and services**
3 **to children with medical fragility being treated at such pediatric diag-**
4 **nostic and treatment center.**
5 **(2) For the period April first, two thousand twenty-four, to December**
6 **thirty-first, two thousand twenty-four, and until such time as a certi-**
7 **fied annual cost report for such period is received and verified by the**
8 **department, the operating component of such rate shall reflect budgeted**
9 **costs for the period January first, two thousand twenty-four, through**
10 **December thirty-first, two thousand twenty-four, as submitted to the**
11 **department and adjusted as the commissioner deems appropriate. Upon**
12 **submission and subsequent verification of the cost report, the operating**
13 **component of the rate shall be reflective of actual costs for the period**
14 **January first, two thousand twenty-four, through December thirty-first,**
15 **two thousand twenty-four, subject to further adjustments as the commis-**
16 **sioner deems appropriate. Thereafter, the base period reported operating**

17 costs used to establish rates pursuant to this subparagraph shall be
18 updated no less frequently than every two years. In addition to required
19 annual cost reports, pediatric diagnostic and treatment centers, as
20 defined by this subparagraph, shall submit additional data as the
21 commissioner requires.
22 (3) Notwithstanding any law, rule, or regulation to the contrary,
23 pediatric diagnostic and treatment centers shall be reimbursed for
24 services provided to children enrolled in Medicaid managed care plans at
25 the rates of reimbursement promulgated pursuant to this subparagraph.
26 (4) The capital component of the rate shall reflect actual base year
27 costs.
28 (5) All rates established under this subparagraph shall be subject to
29 the availability of federal financial participation.
30 (6) The commissioner may promulgate or amend regulations as the
31 commissioner determines appropriate and necessary to establish the rates
32 provided for in this subparagraph and/or exempt pediatric diagnostic and
33 treatment centers from the ambulatory payment group reimbursement meth-
34 odology applicable to diagnostic and treatment centers.
35 § 2. This act shall take effect immediately and shall be deemed to
36 have been in full force and effect on and after April 1, 2024; provided,
37 however, that the provisions of this act shall expire and be deemed
38 repealed April 1, 2027.

Appendix IV
2024 Title XIX State Plan
Third Quarter Amendment
Public Notice

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 non-institutional services to comply with Public Health Law § 2807(2)(g)(iii). The following changes are proposed:

Non-Institutional Services

Effective for services on or after July 1, 2024, through March 31, 2027, qualified pediatric Diagnostic and Treatment Centers (D&TCs) will be eligible for a Medicaid rate that reflects the approved costs associated with providing care to children with medical fragility. The pediatric D&TC must be participating in a demonstration program for children with medical fragility, for which at least eighty percent of its total Medicaid fee-for-service reimbursement is derived from the provision of services to children under the age of twenty-one with medical fragility. The pediatric D&TC must also be affiliated with a pediatric residential health care facility, which is freestanding or has a discrete unit within a facility, authorized to provide extensive nursing, medical, psychological and counseling support services solely to children under the age of twenty-one.

The estimated net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2024-2025 is $1.5 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. 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 State
F-2024-0143
Date of Issuance – June 26, 2024

The New York State Department of State (DOS) is required by Federal regulations to provide timely public notice for the activities described below, which are subject to the consistency provisions of the Federal Coastal Zone Management Act of 1972, as amended.

The applicant has certified that the proposed activity complies with and will be conducted in a manner consistent with the approved New York State Coastal Management Program.

In F-2024-0143, John C Devine, is proposing to reconstruct existing deteriorated dock by driving steel pilings on the edge of the existing stone cribbing. Construct a steel frame on the pilings and wooden decking on top of the steel frame. SECTION 1: 15 ft-wide x 40 ft-long (600 sq ft) ; SECTION 2: 24 ft-wide by 20 ft-long (480 sq ft). The proposed project would be located at 23399 Road 908, Lake Ontario, Town of Brownville, Jefferson County.

The stated purpose of the proposed action is to "Reconstruct dock over original stone cribbing utilizing steel pilings, steel framing and wooden decking/staving."

The applicant's consistency certification and supporting information are available for review at: https://dos.ny.gov/system/files/documents/2024/06/f-2024-0143.pdf or at https://dos.ny.gov/public-notices

Original copies of public information and data submitted by the applicant are available for inspection at the New York State Department of State offices located at One Commerce Plaza, 99 Washington Avenue, in Albany, New York.

Any interested parties and/or agencies desiring to express their views concerning any of the above proposed activities may do so by filing their comments, in writing, no later than 4:30 p.m., 30 days from the date of publication of this notice, or July 26, 2024.

Comments should be addressed to: Consistency Review Unit, Department of State, Office of Planning, Development and Community Infrastructure, One Commerce Plaza, 99 Washington Ave., Albany, NY 12231, (518) 474-6000; Fax (518) 473-2464. Electronic submissions can be made by email at: CR@dos.ny.gov

This notice is promulgated in accordance with Title 15, Code of Federal Regulations, Part 930.

PUBLIC NOTICE
Department of State
F-2024-0250
Date of Issuance – June 26, 2024

The New York State Department of State (DOS) is required by Federal regulations to provide timely public notice for the activities described below, which are subject to the consistency provisions of the Federal Coastal Zone Management Act of 1972, as amended.

The applicant has certified that the proposed activity complies with and will be conducted in a manner consistent with the approved New York State Coastal Management Program.

In F-2024-0250, the applicant, Peter V. Moot III, is proposing to dredge approximately 193 cubic yards in a channel and boat docking area and to construct a 90-foot long living shoreline along a portion of the bank. The project is located at 45416 CR 191, Wellesley Island in Jefferson County in the Lake of the Isles on the Saint Lawrence River.

The stated purpose of the proposed action is to restore navigational access to the boat dockage area.

The applicant's consistency certification and supporting information are available for review at: https://dos.ny.gov/system/files/documents/2024/06/f-2024-0250.pdf or at https://dos.ny.gov/public-notices

Original copies of public information and data submitted by the applicant are available for inspection at the New York State Department of State offices located at One Commerce Plaza, 99 Washington Avenue, in Albany, New York.

Appendix V
2024 Title XIX State Plan
Third Quarter Amendment
Responses to Standard Funding Questions

NON-INSTITUTIONAL SERVICES
State Plan Amendment #24-0062

CMS Standard Funding Questions

The following questions are being asked and should be answered in relation to all payments made to all providers reimbursed pursuant to a methodology described in Attachment 4.19-B 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 receive and retain 100 percent of total Medicaid expenditures claimed by the State and the State does not require any provider to return any portion of such payments to the State, local government entities, or any other intermediary organization.

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 Non-Federal share Medicaid provider payment is funded by a combination of the following funds/funding sources through enacted appropriations authority to the Department of Health (DOH) for the New York State Medicaid program.

		4/1/24 – 3/31/25	
Payment Type	**Non-Federal Share Funding**	**Non-Federal**	**Gross**
Normal Per Diem	General Fund; Special Revenue Funds; County Contribution	$556M	$1,251M

A. **General Fund:** Revenue resources for the State's General Fund includes taxes (e.g., income, sales, etc.), and miscellaneous fees (including audit recoveries). Medicaid expenditures from the State's General Fund are authorized from Department of Health Medicaid.

1) New York State Audit Recoveries: The Department of Health collaborates with the Office of the Medical Inspector General (OMIG) and the Office of the Attorney General (AG) in recovering improperly expended Medicaid funds. OMIG conducts and coordinates the investigation, detection, audit, and review of Medicaid providers and recipients to ensure they are complying with all applicable laws and regulation. OMIG recovers any improper payments through cash collections and voided claim recoveries. Cash collections are deposited into the State's General Fund to offset Medicaid costs.

   In addition to cash collections, OMIG finds inappropriately billed claims within provider claims. To correct an error, OMIG and DOH process the current accurate claim, and reduce this claim by the inappropriate claim value to recoup the previous overclaim and decrease state spending.

B. Special Revenue Funds:

1) Health Care Reform Act (HCRA) Resource Fund: as authorized in section 92-dd of New York State Finance Law and was established in 1996, pursuant to New York State Public Health Law 2807-j. HCRA resources include:

   - Surcharge on net patient service revenues for specified provider types including Comprehensive Diagnostic and Treatment Centers and Ambulatory Surgery Centers.
     - The rate for commercial payors is 9.63 percent.
     - The rate for governmental payors, including Medicaid, is 7.04 percent.
     - Federal payors, including Medicare, are exempt from the surcharge.

NOTE: New York's Health Care taxes are either broad based and uniform (as in all HFCAP assessments except for the Personal Care Provider Cash Assessment) or have a specific exemption known as the "D'Amato provision (Federal PHL section 105-33 4722 (c)" which allows the HCRA surcharges to exist in their current format. The single tax which has been determined by the State to be an impermissible provider tax is the HFCAP charge on Personal Care Providers. The State does not claim any Federal dollars for the surcharge collected in this manner in order to comply with all Federal provider tax rules.

C. Additional Resources for Non-Federal Share Funding:

County Contribution: In State Fiscal Year 2006, through enacted State legislation (Part C of Chapter 58 of the laws of 2005), New York State "capped" the amount localities contributed to the non-Federal share of providers claims. This was designed to relieve pressure on county property taxes and the NYC budget by limiting local contributions having New York State absorb all local program costs above this fixed statutory inflation rate (3% at the time).

However, in State Fiscal Year 2013 New York State provided additional relief to Localities by reducing local contributions annual growth from three precent to zero over a three-year period. Beginning in State Fiscal Year 2016, counties began paying a fixed cost in perpetuity as follows:

Entity	Annual Amount
New York City	$5.210B
Suffolk County	$243M
Nassau County	$231M
Westchester County	$215M
Erie County	$205M
Rest of State (53 Counties)	$1.260B
Total	**$7.364B**

By eliminating the growth in localities Medicaid costs, the State has statutorily capped total Statewide County Medicaid expenditures at 2015 levels. All additional county Medicaid costs are funded by the State through State funding as described above. DOH provides annual letters to counties providing weekly contributions. Contributions are deposited directly into State escrow account and used to offset 'total' State share Medicaid funding.

NOTE: The Local Contribution is not tied to a specific claim or service category and instead is a capped amount based on 2015 county spending levels as stated above.

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.**

<u>Response:</u> The Medicaid payments under this State Plan Amendment are not supplemental payments.

4. **For clinic or outpatient hospital services 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.**

   <u>Response:</u> The clinic UPL demonstration utilizes cost-to-payment methodology to estimate the upper payment limit for each class of providers. The Medicaid payments under this State Plan Amendment will be included in the 2024 clinic UPL when it is submitted to CMS.

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?**

   <u>Response:</u> Providers do not receive payments that in the aggregate exceed their reasonable costs of providing services. If any providers received payments that in the aggregate exceeded their reasonable costs of providing services, the State would recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report.

<u>ACA Assurances</u>:

1. **<u>Maintenance of Effort (MOE).</u> Under section 1902(gg) of the Social Security Act (the Act), as amended by the Affordable Care Act, as a condition of receiving <u>any</u> Federal payments under the Medicaid program <u>during the MOE period</u> indicated below, the State shall <u>not</u> 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.**

   <u>MOE Period.</u>
   - **<u>Begins on:</u> March 10, 2010, and**
   - **<u>Ends on:</u> 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.**

   <u>Response:</u> 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 complies with the requirements of section 1902(a)(37) of the Act regarding prompt payment of claims.

Tribal Assurance:

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

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

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

b) **Please include information about the frequency inclusiveness and process for seeking such advice.**
c) **Please describe the consultation process that occurred specifically for the development and submission of this State Plan Amendment when it occurred and who was involved.**

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.