Department of Health

ANDREW M. CUOMO
Governor

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

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

JUN 1 5 2017

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

Re: SPA #17-0045
Inpatient Hospital Services

Dear Mr. Cooley:

The State requests approval of the enclosed amendment #17-0045 to the Title XIX (Medicaid) State Plan for inpatient hospital services to be effective May 1, 2017 (Appendix I). This amendment is being submitted based upon State Regulations. A summary of the proposed amendment is contained in Appendix II.

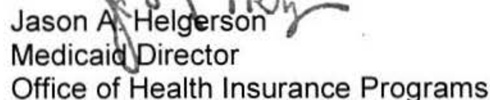
This amendment is submitted pursuant to §1902(a) of the Social Security Act (42 USC 1396a(a)) and Title 42 of the Code of Federal Regulations (CFR), Part 447, Subpart C.

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 April 26, 2017.

Copies of pertinent sections of enacted State Regulations are 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 matter, please do not hesitate to contact John E. Ulberg, Jr., Medicaid Chief Financial Officer, Division of Finance and Rate Setting, Office of Health Insurance Programs at (518) 474-6350.

Sincerely,

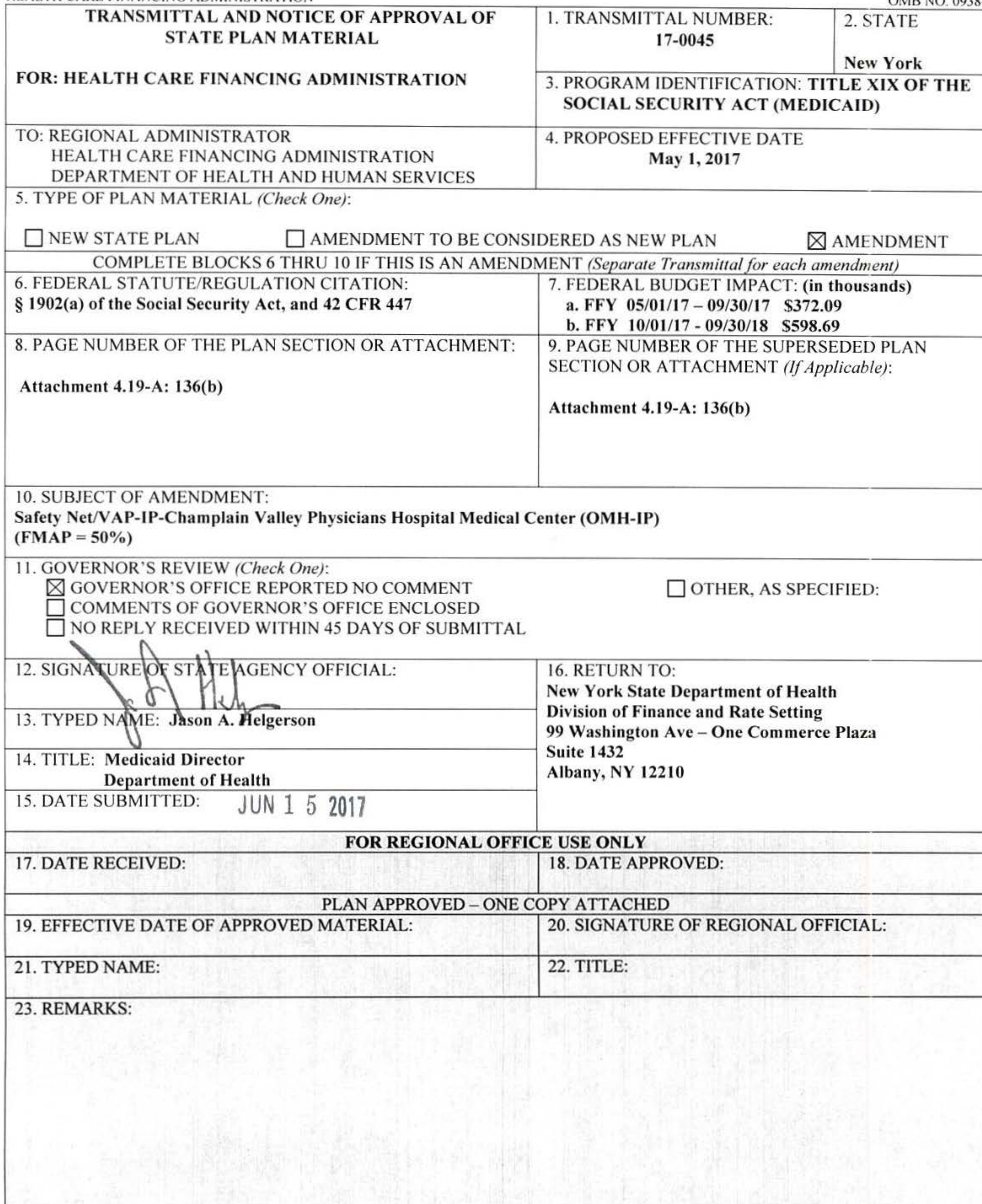


Jason A. Helgerson
Medicaid Director
Office of Health Insurance Programs

Enclosures
cc: Mr. Michael Melendez
Mr. Tom Brady

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193



TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: **17-0045**

2. STATE: **New York**

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

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: **May 1, 2017**

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
§ 1902(a) of the Social Security Act, and 42 CFR 447

7. FEDERAL BUDGET IMPACT: **(in thousands)**
a. FFY 05/01/17 – 09/30/17 $372.09
b. FFY 10/01/17 - 09/30/18 $598.69

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-A: 136(b)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-A: 136(b)

10. SUBJECT OF AMENDMENT:
Safety Net/VAP-IP-Champlain Valley Physicians Hospital Medical Center (OMH-IP) (FMAP = 50%)

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

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME: **Jason A. Helgerson**

14. TITLE: **Medicaid Director**
Department of Health

15. DATE SUBMITTED: JUN 1 5 2017

16. 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 REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED:

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:

22. TITLE:

23. REMARKS:

Appendix I
2017 Title XIX State Plan
Second Quarter Amendment
Amended SPA Pages

b. Temporary rate adjustments have been approved for the following hospital providers in the amounts and for the effective periods listed:

Hospitals:

Provider Name	Gross Medicaid Rate Adjustment	Rate Period Effective
Beth Israel Medical Center	$15,000,000	11/01/2014 – 03/31/2015
	$33,200,000	04/01/2015 – 03/31/2016
	$33,200,000	04/01/2016 – 03/31/2017
Brookdale University Hospital and Medical Center	$14,000,000	02/01/2014 – 03/31/2014
Brooklyn Hospital Center	$5,000,000	02/01/2014 – 03/31/2014
	$5,000,000	04/01/2014 – 03/31/2015
Canton Potsdam Hospital/EJ Noble	$2,000,000	01/01/2014 – 03/31/2014
	$400,000	04/01/2014 – 03/31/2015
Catskill Regional Medical Center	$889,105	01/01/2014 – 03/31/2014
	$1,040,305	04/01/2014 – 03/31/2015
	$1,164,505	04/01/2015 – 03/31/2016
Champlain Valley Physicians Hospital Medical Center	$1,450,852	05/01/2017 - 03/31/2018
	$ 981,422	04/01/2018 - 03/31/2019
	$ 660,708	04/01/2019 - 03/31/2020
Healthalliance Mary's Ave Campus Benedictine Hospital	$2,500,000	02/01/2014 – 03/31/2014
Interfaith Medical Center	$12,900,000	11/01/2013 – 03/31/2014
Kingsbrook Jewish Medical Center	$1,480,000	11/01/2013 – 12/31/2013
	$2,320,000	01/01/2014 – 03/31/2014
Kings County Hospital Center	$1,000,000	01/01/2014 – 03/31/2014
Lewis County General Hospital*	$ 65,564	01/01/2014 – 03/31/2014
	$262,257	04/01/2014 – 03/31/2015
	$262,257	04/01/2015 – 03/31/2016
Lincoln Medical Center	$963,687	04/01/2012 – 03/31/2013
	$963,687	04/01/2013 – 03/31/2014
Little Falls Hospital*	$21,672	01/01/2014 – 03/31/2014
	$86,688	04/01/2014 – 03/31/2015
	$86,688	04/01/2015 – 03/31/2016

*Denotes this provider is a Critical Access Hospital (CAH).

Appendix II
2017 Title XIX State Plan
Second Quarter Amendment
Summary

SUMMARY
SPA #17-0045

This amendment proposes to revise the State Plan to modify the listing of hospitals previously approved to receive temporary rate adjustments under the closure, merger, consolidation, acquisition or restructuring of a health care provider. The additional provider for which approval is being requested is Champlain Valley Physicians Hospital Medical Center.

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

14 NYCRR Part 530
Express Terms

A new Part 530 is added to 14 NYCRR to read as follows:

PART 530

VITAL ACCESS PROGRAM and PROVIDERS

(Statutory authority: Mental Hygiene Law §§7.09, 31.02, 43.02, Chapter 53 of the Laws of 2014)

Section:

530.1 Background and Intent

530.2 Legal Base

530.3 Definitions

530.4 Vital Access Program

530.1 Background and Intent.

The purpose of this Part is to provide a means to support the stability and geographic distribution of mental health clinic services throughout all geographic and economic regions of the State. A designation of Vital Access Provider denotes the Commissioner's determination to ensure patient access to a provider's essential services otherwise jeopardized by the provider's payer mix or geographic isolation.

530.2 Legal Base.

(a) Section 7.09 of the Mental Hygiene Law authorizes the Commissioner to adopt regulations that are necessary and proper to implement matters under his or her jurisdiction.

(b) Section 31.02 of the Mental Hygiene Law authorizes the Commissioner to issue operating certificates for the provision of inpatient and outpatient mental health services.

(c) Section 43.02 of the Mental Hygiene Law authorizes the Office to establish rates or methods of payment for services at facilities subject to licensure or certification by the Office.

(d) Chapter 53 of the Laws of 2014 authorizes the Commissioner to provide special funding to certain designated providers.

530.3 Definitions.

(a) *Vital Access Program ("VAP")* means a program of supplemental funding and/or temporary rate or fee adjustments available to providers of mental health services that are determined by the Commissioner to be essential to the availability of mental health services in a geographic or economic region of the State but in financial jeopardy due to their payer mix or geographic isolation.

(b) *Vital Access Provider* means a provider of mental health clinic services that is licensed under Article 31 of the Mental Hygiene Law and that is designated by the Commissioner as eligible for participation in the Vital Access Program. It does not include a provider that is licensed under Article 28 of the Public Health Law.

530.4 Vital Access Program.

(a) The Commissioner may accept applications from licensed providers of mental health clinic services requesting designation as a Vital Access Provider eligible to receive supplemental funding or a temporary rate adjustment. The Commissioner may give priority to providers serving regions or populations in the State that he or she shall determine are in special need of services. Such applications must sufficiently demonstrate that:

(1) The provider is essential to maintaining access to the mental health services it is authorized to provide to individuals with mental illness who reside in the geographic or economic region of the State served by the provider;

(2) The provider is in financial jeopardy due to payer mix or geographic isolation;

(3) The additional resources provided by supplemental funding or a rate or fee adjustment will achieve one or more of the following:

(i) protect or enhance access to care;

(ii) protect or enhance quality of care;

(iii) improve the cost effectiveness of the delivery of health care services; or

(iv) otherwise protect or enhance the health care delivery system, as determined by the Commissioner.

(b) Application.

(1) The written application required pursuant to subdivision (a) of this Section shall be submitted to the Commissioner at least sixty (60) days prior to the requested effective date of the designation as a Vital Access Provider and shall include a proposed budget to achieve the goals identified in the application.

(2) The Commissioner may require that applications submitted pursuant to this Section be submitted in response to, and in accordance with, a Request For Applications or a Request For Proposals issued by the Office.

(c) Reimbursement.

A provider that is designated as a Vital Access Provider shall be eligible to receive supplemental funding or a temporary rate or fee adjustment.

(d) Conditions on Approval.

(1) Any temporary rate adjustment issued pursuant to this section shall be in effect for a specified period of time of no more than three years, as determined by the Commissioner, based upon review and approval of a specific plan of action to achieve one or more of the goals set forth in subdivision (a) of this section. At the end of the specified timeframe, the provider shall be reimbursed in accordance with the otherwise applicable rate-setting methodology or fee schedule pertaining to such provider.

(2) The Commissioner may establish, as a condition of designation as a Vital Access Provider, benchmarks, goals and standards to be achieved, and may require such periodic reports as he or she shall determine to be necessary to ensure their achievement. A determination by the Commissioner of a failure to demonstrate satisfactory progress in achieving such benchmarks, goals and standards shall be a basis for revoking the provider's designation as a Vital Access Provider, and terminating the supplemental funding or temporary rate or fee adjustment prior to the end of the specified timeframe.

(3) No portion of the funds received pursuant to this Part shall be used for the payment of any prior debt or obligation incurred by the designated provider, or for any purpose not related to the purposes set forth in this Part.

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

reimbursement for services provided in accordance with Public Health Law section 2803(11). The following changes are proposed:

Non-Institutional Services

Subject to the availability of Federal Financial Participation, effective on or after May 1, 2017, Medicaid reimbursement will be available to hospitals and diagnostic and treatment centers for primary care practitioners providing off-site primary care services to Medicaid recipients. These off-site services are primary care services that are ordinarily provided to patients on-site at the hospital outpatient clinic (OPD) or diagnostic and treatment center (DTC) and are not home care services. These services are provided by a primary care practitioner to a Medicaid recipient (patient) with a pre-existing clinical relationship with the OPD or DTC and the patient is unable to leave his or her residence to receive services without unreasonable difficulty due to circumstances such as clinical impairment.

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

The public is invited to review and comment on this proposed State Plan Amendment. Copies of which will be available for public review on the Department's website at http://www.health.ny.gov/regulations/state_plans/status.

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 1460, Albany, NY 12210, spa_inquiries@health.ny.gov

PUBLIC NOTICE

Office of Mental Health and Department of Health

Pursuant to 42 CFR Section 447.205, the Office of Mental Health and the Department of Health hereby give public notice of the following:

The Office of Mental Health and the Department of Health propose to amend the Title XIX (Medicaid) State Plan for institutional services related to temporary rate adjustments to Article 28 Hospitals that are undergoing a closure, merger, consolidation, acquisition or restructuring of themselves or other health care providers. These payments are currently authorized by current State statutory and regulatory provisions. The following changes are proposed:

Additional temporary rate adjustments have been reviewed and approved for the following hospital:

• Champlain Valley Physicians Hospital Medical Center

The aggregate payment amounts total up to $1,450,852 for the period May 1, 2017 through March 31, 2018.

The aggregate payment amounts total up to $981,422 for the period April 1, 2018 through March 31, 2019.

The aggregate payment amounts total up to $660,708 for the period April 1, 2019 through March 31, 2020.

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 of Health's website at http://www.health.ny.gov/regulations/state_plans/status.

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

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

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

Queens County, Queens Center
3220 Northern Boulevard
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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 1460, Albany, NY 12210, spa_inquiries@health.ny.gov

PUBLIC NOTICE

Department of State
F-2017-0013
Date of Issuance –April 26, 2017

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 (NYSCMP). The applicant's consistency certification and accompanying public information and data 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.

In F-2017-0013, "Roberto Clemente State Park North Shoreline and Upland Improvements", the applicant or NYS Office of Parks and Recreation and Historic Preservation (OPRHP), is proposing to stabilize the shoreline through implementation of various upland improvements in the northern portion of the 25 acre Roberto Clemente State Park, located along the Harlem River in the Bronx, NY. The project includes installation of approximately 1,160 feet of rock revetment and 170 feet of living shoreline, relocation of storm water outlets, and rehabilitation and relocation of a concrete floating dock. Upland improvements include new ball fields, landscaping, and pedestrian pathways. The park is located on the eastern shore of the Harlem River

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

APPENDIX V
HOSPITAL SERVICES
State Plan Amendment #17-0045

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 your state plan.

1. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by States for services under the approved State plan. Do providers receive and retain the total Medicaid expenditures claimed by the State (includes normal per diem, supplemental, enhanced payments, other) or is any portion of the payments returned to the State, local governmental entity, or any other intermediary organization? If providers are required to return any portion of payments, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the amount or percentage of payments that are returned and the disposition and use of the funds once they are returned to the State (i.e., general fund, medical services account, etc.)

Response: Providers do retain the payments made pursuant to this amendment. However, this requirement in no way prohibits the public provider, including county providers, from reimbursing the sponsoring local government for appropriate expenses incurred by the local government on behalf of the public provider. The State does not regulate the financial relationships that exist between public health care providers and their sponsoring governments, which are extremely varied and complex. Local governments may provide direct and/or indirect monetary subsidies to their public providers to cover on-going unreimbursed operational expenses and assure achievement of their mission as primary safety net providers. Examples of appropriate expenses may include payments to the local government which include reimbursement for debt service paid on a provider's behalf, reimbursement for Medicare Part B premiums paid for a provider's retirees, reimbursement for contractually required health benefit fund payments made on a provider's behalf, and payment for overhead expenses as allocated per federal Office of Management and Budget Circular 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 Medicaid General Fund Local Assistance Account, which is part of the Global Cap. The Global Cap is funded by General Fund and HCRA resources. There have been no new provider taxes and no existing taxes have been modified as a result of this State Plan Amendment.

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 add-on services payments made to those providers listed who will receive temporary rate adjustments to be paid quarterly during each period in equal installments.

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 having ongoing discussions regarding the inpatient UPL demonstration for 2016, which the 2017 UPL demonstration is contingent upon.

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

Response: The rate methodology included in the approved State Plan for institutional services is prospective payment. We are unaware of any requirement under current federal law or regulation that limits individual provider payments to their actual costs.

ACA Assurances:

1. Maintenance of Effort (MOE). Under section 1902(gg) of the Social Security Act (the Act), as amended by the Affordable Care Act, as a condition of receiving any Federal payments under the Medicaid program during the MOE period indicated below, the State shall not have in effect any eligibility standards, methodologies, or procedures in its Medicaid program which are more restrictive than such eligibility provisions as in effect in its Medicaid program on March 10, 2010.

MOE Period.

- **Begins on: March 10, 2010, and**
- **Ends on: The date the Secretary of the Federal Department of Health and Human Services determines an Exchange established by a State under the provisions of section 1311 of the Affordable Care Act is fully operational.**

Response: This SPA complies with the conditions of the MOE provision of section 1902(gg) of the Act for continued funding under the Medicaid program.

2. Section 1905(y) and (z) of the Act provides for increased FMAPs for expenditures made on or after January 1, 2014 for individuals determined eligible under section 1902(a)(10)(A)(i)(VIII) of the Act. Under section 1905(cc) of the Act, the increased FMAP under sections 1905(y) and (z) would not be available for States that require local political subdivisions to contribute amounts toward the non-Federal share of the State's expenditures at a greater percentage than would have been required on December 31, 2009.

Prior to January 1, 2014 States may potentially require contributions by local political subdivisions toward the non-Federal share of the States' expenditures at percentages greater than were required on December 31, 2009. However, because of the provisions of section 1905(cc) of the Act, it is important to determine and document/flag any SPAs/State plans which have such greater percentages prior to the January 1, 2014 date in order to anticipate potential violations and/or appropriate corrective actions by the States and the Federal government.

Response: This SPA would [ ] / would not [✓] violate these provisions, if they remained in effect on or after January 1, 2014.

3. Please indicate whether the State is currently in conformance with the requirements of section 1902(a)(37) of the Act regarding prompt payment of claims.

Response: This State does comply with the requirements of section 1902(a)(37) of the Act regarding prompt payment of claims.

Tribal Assurance:

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

IHCIA Section 2107(e)(I) of the Act was also amended to apply these requirements to the Children's Health Insurance Program CHIP. Consultation is required concerning Medicaid and CHIP matters having a direct impact on Indian health programs and Urban Indian organizations.
a) Please describe the process the State uses to seek advice on a regular ongoing basis from federally recognized tribes Indian Health Programs and Urban Indian Organizations on matters related to Medicaid and CHIP programs and for consultation on State Plan Amendments waiver proposals waiver extensions waiver amendments waiver renewals and proposals for demonstration projects prior to submission to CMS.
b) Please include information about the frequency inclusiveness and process for seeking such advice.
c) Please describe the consultation process that occurred specifically for the development and submission of this State Plan Amendment when it occurred and who was involved.

Response: Tribal consultation was performed in accordance with the State's tribal consultation policy as approved in SPA 11-06, and documentation of such is included with this submission. To date, no feedback has been received from any tribal representative in response to the proposed change in this SPA.