



ANDREW M. CUOMO
Governor

Department of Health

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

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

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

JUN 23 2017

Re: SPA #17-0039
Inpatient Hospital Services

Dear Mr. Cooley:

The State requests approval of the enclosed amendment #17-0039 to the Title XIX (Medicaid) State Plan for inpatient hospital services to be effective April 1, 2017 (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.

In accordance with 42 CFR §447.272(c), New York assures that its aggregate disproportionate share hospital payments do not exceed the disproportionate share hospital payment limit.

Notice of the changes in the methods and standards for setting payment rates for general hospital inpatient services were given in the New York State Register on March 29, 2017.

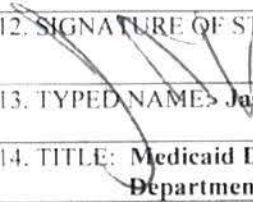
Copies of pertinent sections of enacted State statute are enclosed for your information (Appendix III). In addition, responses to the five standard funding questions are also enclosed (Appendix V).

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 at (518) 474-6350.

Sincerely,

Jason A. Helgeson
Medicaid Director
Office of Health Insurance Programs

Enclosures
cc: Mr. Michael Melendez
Mr. Tom Brady

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: HEALTH CARE FINANCING ADMINISTRATION		1. TRANSMITTAL NUMBER: 17-0039	2. STATE New York
		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE April 1, 2017	
5. TYPE OF PLAN MATERIAL <i>(Check One)</i> : <input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT <i>(Separate Transmittal for each amendment)</i>			
6. FEDERAL STATUTE/REGULATION CITATION: § 1902(a) of the Social Security Act and 42 CFR 447		7. FEDERAL BUDGET IMPACT: <i>(in thousands)</i> a. FFY 04/01/17-09/30/17 \$ 84,750.00 b. FFY 10/01/17-09/30/18 \$ 84,750.00	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-A: Page 161(1)		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT <i>(If Applicable)</i> : Attachment 4.19-A: Page 161(1)	
10. SUBJECT OF AMENDMENT: 2017 Voluntary UPL Payments (FMAP = 50%)			
11. GOVERNOR'S REVIEW <i>(Check One)</i> : <input checked="" type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input type="checkbox"/> OTHER, AS SPECIFIED: <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL			
12. SIGNATURE OF STATE AGENCY OFFICIAL: 		16. RETURN TO: New York State Department of Health Division of Finance and Rate Setting 99 Washington Ave – One Commerce Plaza Suite 1432 Albany, NY 12210	
13. TYPED NAME: Jason A. Helgerson			
14. TITLE: Medicaid Director Department of Health			
15. DATE SUBMITTED: JUN 23 2017			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED:		18. DATE APPROVED:	
PLAN APPROVED – ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL:		20. SIGNATURE OF REGIONAL OFFICIAL:	
21. TYPED NAME:		22. TITLE:	
23. REMARKS:			

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

**New York
161(1)**

Voluntary Supplemental Inpatient Payments

Effective for the period July 1, 2010 through March 31, 2011, additional inpatient hospital payments are authorized to voluntary sector hospitals, excluding government general hospitals, for inpatient hospital services after all other medical assistance payments, of [\$235.5M] \$235,500,000 for the period July 1, 2010 through March 31, 2011; [\$314M] \$314,000,000 for the period April 1, 2011 through March 31, 2012; \$281,778,852 for the period April 1, 2012 through March 31, 2013; \$298,860,732 for the period April 1, 2013 through March 31, 2014; and \$226,443,721 for the period April 1, 2014 through March 31, 2015; and \$264,916,150 for the period April 1, 2015 through March 31, 2016; and [339,000,000] \$271,204,805 for the period of April 1, 2016 through March 31, 2017; and \$339,000,000 for the period of April 1, 2017 through March 31, 2018 subject to the requirements of 42 CFR 447.272 (upper payment limit) . Such payments are paid monthly to eligible voluntary sector owned or operated general hospitals, excluding government general hospitals.

Eligibility to receive such additional payments, and the allocation amount paid to each hospital, will be based on data from the period two years prior to the rate year, as reported on the Institutional Cost Report (ICR) submitted to the Department as of October 1 of the prior rate year.

- (a) Thirty percent of such payments will be allocated to safety net hospitals based on each eligible hospital's proportionate share of all eligible safety net hospitals' Medicaid discharges for inpatient hospital services, including both Medicaid fee-for-service and managed care discharges for acute and exempt services;
- (i) Safety net hospitals are defined as non-government owned or operated hospitals which provide emergency room services having either: a Medicaid share of total inpatient hospital discharges of at least 35%, including both fee-for-service and managed care discharges for acute and exempt services; or a Medicaid share of total discharges of at least 30%, including both fee-for-service and managed care discharges for acute and exempt services, and also providing obstetrical services.
- (b) Seventy percent of such payments will be allocated to eligible general hospitals, which provide emergency room services, based on each such hospital's proportionate share of all eligible hospitals' Medicaid discharges for inpatient hospital services, including both Medicaid fee-for-service and managed care discharges for acute and exempt services;
- (c) No payment will be made to a hospital described in (i) and (ii). Payment amounts will be reduced as necessary not to exceed the limitations described in (iii).
- (i) did not receive an Indigent Care Pool (ICP) payment;
- (ii) the hospital's facility specific projected disproportionate share hospital payment ceiling is zero; or,
- (iii) the annual payments amount to eligible hospitals exceeds the Medicaid customary charge limit at 42 CFR 447.271.
- (d) Any amounts calculated under paragraphs (a) and (b) but not paid to a hospital because of the requirements in paragraph (c) will be allocated proportionately to those eligible general hospitals that provide emergency room services and which would not be precluded by paragraph (c) from receiving such additional allocations.

TN #17-0039 _____

Approval Date _____

Supersedes TN #16-0036

Effective Date _____

Appendix II
2017 Title XIX State Plan
Second Quarter Amendment
Summary

SUMMARY
SPA #17-0039

This State Plan Amendment proposes to extend supplemental upper payment limit distributions for inpatient hospital services to voluntary sector hospitals excluding government general hospitals, not to exceed in aggregate \$339M annually in combination with the outpatient voluntary hospital UPL SPA for the period April 1, 2017 through March 31, 2018.

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

Pub Health §2807-c(35) (i) (i)

Notwithstanding any inconsistent provision of this subdivision or any other contrary provision of law and subject to the availability of federal financial participation, for the period July first, two thousand ten through March thirty-first, two thousand eleven, and each state fiscal year period thereafter, the commissioner shall make additional inpatient hospital payments up to the aggregate upper payment limit for inpatient hospital services after all other medical assistance payments, but not to exceed two hundred thirty-five million five hundred thousand dollars for the period July first, two thousand ten through March thirty-first, two thousand eleven [and], three hundred fourteen million dollars for each state fiscal year beginning April first, two thousand eleven, through March thirty-first, two thousand thirteen, and no less than three hundred thirty-nine million dollars for each state fiscal year thereafter, to general hospitals, other than major public general hospitals, providing emergency room services and including safety net hospitals, which shall, for the purpose of this paragraph, be defined as having either: a Medicaid share of total inpatient hospital discharges of at least thirty-five percent, including both fee-for-service and managed care discharges for acute and exempt services; or a Medicaid share of total discharges of at least thirty percent, including both fee-for-service and managed care discharges for acute and exempt services, and also providing obstetrical services. Eligibility to receive such additional payments shall be based on data from the period two years prior to the rate year, as reported on the institutional cost report submitted to the department as of October first of the prior rate year. Such payments shall be made as medical assistance payments for fee-for-service inpatient hospital services pursuant to title eleven of article five of the social services law for patients eligible for federal financial participation under title XIX of the federal social security act and in accordance with the following:

§ 5. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2013 provided that:

- a. sections one, two and four of this act shall be deemed to have been in full force and effect on and after January 1, 2013; and
- b. the amendments to subdivision 14-f of section 2807-c of the public health law made by section two of this act shall not affect the expiration of such subdivision and shall be deemed to expire therewith.

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

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

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

Institutional Services

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

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

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

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

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

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

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

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

Long Term Care Services

- For state fiscal year beginning April 1, 2017, continues additional payments to non-state government operated public residential health care facilities, including public residential health care facilities located in Nassau, Westchester, and Erie counties, but excluding public residential health care facilities operated by a town or city within a county, in aggregate amounts of up to \$500 million. The amount allocated to each eligible public RHCF will be in accordance with the previously approved methodology, provided, however that patient days shall be utilized for such computation reflecting actual reported data for 2014 and each representative succeeding year as applicable. Payments to eligible RHCF's may be added to rates of payment or made as aggregate payments.

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

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

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

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

- Continues, effective for periods on and after April 1, 2017, the

total reimbursable state assessment on each residential health care facility's gross receipts received from all patient care services and other operating income on a cash basis for inpatient or health-related services, including adult day service, but excluding gross receipts attributable to payments received pursuant to Title XVIII of the federal Social Security Act (Medicare), at six percent. The extent to which a facility is reimbursed for the additional cost of the assessment is dependent upon Medicaid volume of services.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2017/2018 is \$513 million.

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

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

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

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

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

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

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

Non-Institutional Services

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

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

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

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

**APPENDIX V
HOSPITAL SERVICES
State Plan Amendment #17-0039**

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. Private providers do not return to the State any amount or percentage of the payment. However, this requirement in no way prohibits the public provider, including county providers, from reimbursing the sponsoring local government for appropriate expenses incurred by the local government on behalf of the public provider. The State does not regulate the financial relationships that exist between public health care providers and their sponsoring governments, which are extremely varied and complex. Local governments may provide direct and/or indirect monetary subsidies to their public providers to cover on-going unreimbursed operational expenses and assure achievement of their mission as primary safety net providers. Examples of appropriate expenses may include payments to the local government which include reimbursement for debt service paid on a provider's behalf, reimbursement for Medicare Part B premiums paid for a provider's retirees, reimbursement for contractually required health benefit fund payments made on a provider's behalf, and payment for overhead expenses as allocated per federal Office of Management and Budget Circular A-87 regarding Cost Principles for State, Local, and Indian Tribal Governments. The existence of such transfers should in no way negate the legitimacy of these facilities' Medicaid payments or result in reduced Medicaid federal financial participation for the State. This position was further supported by CMS in review and approval of SPA 07-07C when an on-site audit of these transactions for New York City's Health and Hospitals Corporation was completed with satisfactory results.

2. Section 1902(a)(2) provides that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan. Please describe how the state share of each type of Medicaid payment (normal per diem, supplemental, enhanced, other) is funded. Please describe whether the state share is from appropriations from the legislature to the Medicaid agency, through intergovernmental transfer agreements (IGTs), certified public expenditures (CPEs), provider taxes, or any other mechanism used by the state to provide state share. Note that, if the appropriation is not to the Medicaid agency, the source of the state share would necessarily be derived through either an IGT or CPE. In this case, please identify the agency to which the funds are appropriated. Please provide an estimate of total expenditure and State share amounts for each type of Medicaid payment. If any of the non-federal share is being provided using IGTs or CPEs, please fully describe the matching arrangement including when the state agency receives the transferred amounts from the local government entity transferring the funds. If CPEs are used, please describe the methodology used by the state to verify that the total expenditures being certified are eligible for Federal matching funds in accordance with 42 CFR 433.51(b). For any payment funded by CPEs or IGTs, please provide the following:
- (i) a complete list of the names of entities transferring or certifying funds;
 - (ii) the operational nature of the entity (state, county, city, other);
 - (iii) the total amounts transferred or certified by each entity;
 - (iv) clarify whether the certifying or transferring entity has general taxing authority; and,
 - (v) whether the certifying or transferring entity received appropriations (identify level of appropriations).

Response: 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 are no new provider taxes and no modifications to existing taxes have been made.

3. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan. If supplemental or enhanced payments are made, please provide the total amount for

each type of supplemental or enhanced payment made to each provider type.

Response: The Medicaid payments authorized for this provision are supplemental payments. The amount of the supplemental payment for voluntary hospitals for the period April 1, 2017 through March 31, 2018 is \$339M.

- 4. Please provide a detailed description of the methodology used by the state to estimate the upper payment limit (UPL) for each class of providers (State owned or operated, non-state government owned or operated, and privately owned or operated). Please provide a current (i.e. applicable to the current rate year) UPL demonstration. Under regulations at 42 CFR 4447.272, States are prohibited from setting payment rates for Medicaid inpatient services that exceed a reasonable estimate of the amount that would be paid under Medicare payment principals.**

Response: The State and CMS are engaged in discussions to develop a strategic plan to complete the prior year's UPL demonstrations, which the 2017 UPL 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 a 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: 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 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.