



Department of Health

KATHY HOCHUL
Governor

JAMES V. McDONALD, MD, MPH
Commissioner

JOHANNE E. MORNE, MS
Executive Deputy Commissioner

March 28, 2025

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 #25-0014
Inpatient Hospital Services

Dear Director McMillion:

The State requests approval of the enclosed amendment #25-0014 to the Title XIX (Medicaid) State Plan for inpatient hospital services to be effective January 1, 2025 (Appendix I). This amendment is being submitted based upon enacted legislation. A summary of the proposed amendment is contained in Appendix II.

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

Notice of the changes in the methods and standards for setting payment rates for general hospital inpatient services was given in the *New York State Register* on December 11, 2024. A copy of pertinent sections of enacted legislation is enclosed for your information (Appendix III). In addition, responses to the five standard funding questions are also enclosed (Appendix V).

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

Sincerely,

A black rectangular box redacting the signature of Amir Bassiri.

Amir Bassiri
Medicaid Director
Office of Health Insurance Programs

Enclosures

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

1. TRANSMITTAL NUMBER

2 5 — 0 0 1 4

2. STATE

N Y3. 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

January 01, 2025

5. FEDERAL STATUTE/REGULATION CITATION

§ 1905(a)(1) Inpatient Hospital Services

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)

a. FFY 01/01/25-09/30/25 \$ 125,000,000b. FFY 10/01/25-09/30/26 \$ 125,000,000

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT

Attachment 4.19-A Part I Page: 161

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION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

Attachment 4.19-A Part I Page: 161

9. SUBJECT OF AMENDMENT

2025 Inpatient Public UPL Payments

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

March 28, 2025

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
2025 Title XIX State Plan
First Quarter Amendment
Amended SPA Pages

**New York
161****1905(a)(1) Inpatient Hospital Services****Additional Inpatient Governmental Hospital Payments**

For the period beginning ~~State Fiscal Year April 1, 2024, and ending December, 31 2024~~ calendar year January 1, 2025, and ending December 31, 2025, the State will provide a supplemental payment for all inpatient services provided by eligible government general hospitals located in a city with a population over one million and not operated by the State of New York or the State University of New York. The amount of the supplemental payment will be ~~\$400,000,000~~ \$500,000,000 and paid semi-annually in September and March. It will be distributed to hospitals proportionately using each hospital's proportionate share of total Medicaid days reported for the base year two years prior to the rate year. Such payments, aggregated with other medical assistance payments will not exceed 100% of a reasonable estimate of the amount that would be paid for such services under Medicare payment principles for non-state government owned or operated government general hospitals for the respective period.

TN #25-0014 Approval Date Supersedes TN #24-0008 Effective Date January 1, 2025

Appendix II
2025 Title XIX State Plan
First Quarter Amendment
Summary

SUMMARY
SPA #25-0014

This State Plan Amendment proposes to extend supplemental payments made for inpatient hospital services in non-state public hospitals in cities with more than one million persons. These payments reflect adjustments to qualifying hospitals.

Appendix III
2025 Title XIX State Plan
First Quarter Amendment
Authorizing Provisions

SPA 25-0014

Chapter 57 of the Laws of 2015

§§ 18

§ 18. Notwithstanding any inconsistent provision of law or regulation to the contrary, and subject to the availability of federal financial participation pursuant to title XIX of the federal social security act, effective for the period April 1, 2012, through March 31, 2013, and state fiscal years thereafter, the department of health is authorized to pay a public hospital adjustment to public general hospitals, as defined in subdivision 10 of section 2801 of the public health law, other than those operated by the state of New York or the state university of New York, and located in a city with a population of over 1 million, of up to one billion eighty million dollars annually as medical assistance payments for inpatient services pursuant to title 11 of article 5 of the social services law for patients eligible for federal financial participation under title XIX of the federal social security act based on such criteria and methodologies as the commissioner may from time to time set through a memorandum of understanding with the New York city health and hospitals corporation, and such adjustments shall be paid by means of one or more estimated payments, with such estimated payments to be reconciled to the commissioner of health's final adjustment determinations after the disproportionate share hospital payment adjustment

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CHAP. 57

caps have been calculated for such period under sections 1923(f) and (g) of the federal social security act. Such adjustment payment may be added to rates of payment or made as aggregate payments to eligible public general hospitals.

Appendix IV
2025 Title XIX State Plan
First Quarter Amendment
Public Notice

Non-Institutional Services

The following is a clarification to the September 25, 2024, noticed provision to amend the total of encounters/services per member per day from three (3) to five (5), that Indian Health Services (IHS)/Tribal 638 facilities, including Tribal Federally Qualified Health Centers (TFQHCs), will be reimbursed for any combination of medical, behavioral health, dental, and ambulatory visits delivered face-to-face (either in-person or via telehealth/telemedicine) as part of an eligible threshold visit. Eligible threshold visits are limited to Medicaid-covered services rendered by qualified healthcare practitioners who are recognized/approved under the NYS Medicaid State Plan. IHS/Tribal 638/TFQHC providers may offer an array of distinct, non-related services to a member during a single encounter. This change would allow IHS/Tribal 638/TFQHC providers the ability to be reimbursed the full alternative payment methodology (APM)/all-inclusive rate (AIR) for up to a total of five (5) eligible threshold visits rendered face-to-face (either in person or via telehealth/telemedicine) when distinct, non-related services are provided to a member during a member encounter or when delivered as a part of a care coordination agreement per member per day.

With clarification, the estimated net aggregate increase in gross Medicaid expenditures as a result of this proposed amendment for state fiscal year 2024-2025 is \$2.7 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 Health

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

The Department of Health proposes to amend the Title XIX (Medicaid) State Plan for institutional, non-institutional and long-term care services to comply with statutory provisions. The following changes are proposed:

Non-Institutional Services

Effective on or after January 1, 2025, this proposal continues the supplemental upper payment limit payments made to general hospitals,

other than major public general hospitals under non-institutional services of \$339 million annually.

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

For the period beginning January 1, 2025 through December 31, 2025, this proposal 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 the current criteria and methodology set by the Commissioner of Health, which the Commissioner may periodically set through a memorandum of understanding with the New York City Health and Hospitals Corporation. Such adjustments shall be paid by means of one or more estimated payments. Payments may be added to rates of payment or made as aggregate payments.

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

For the period beginning January 1, 2025 through December 31, 2025, this proposal continues payment of up to \$5.4 million in additional annual Medicaid payments to county operated free-standing clinics, not including facilities operated by the New York City Health and Hospitals Corporation, for services provided by such DTC and those provided by a county operated freestanding mental health or substance abuse DTC. Distributions shall be based on each eligible facility's proportionate share of the sum of all DTC and clinic visits for all eligible facilities receiving payments for the base year two years prior to the rate year. The proportionate share payments may be added to rates of payment or made as aggregate payments to eligible facilities.

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

Institutional Services

Effective on or after January 1, 2025, this proposal continues the supplemental upper payment limit payments made to general hospitals, other than major public general hospitals under institutional services of \$339 million annually.

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

For the period beginning January 1, 2025 through December 31, 2025, this proposal continues adjustments for hospital inpatient services provided on and after April 1, 2012, to public general hospitals, other than those operated by the State of New York or the State University of New York, located in a city with a population of over one million and receiving reimbursement of up to \$1.08 billion annually based on the current criteria and methodology set by the Commissioner of Health, which the Commissioner may periodically set through a memorandum of understanding with the New York City Health and Hospitals Corporation. Such adjustments shall be paid by means of one or more estimated payments. Payments to eligible public general hospitals may be added to rates of payment or made as aggregate payments.

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

For the period beginning January 1, 2025 through December 31, 2025, this proposal continues supplemental payments to State government owned hospitals. These payments will not exceed the upper payment limit for inpatient services provided by State government-owned hospitals when aggregated with other Medicaid payments.

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

Long Term Care Services

Effective on or after January 1, 2025, this proposal 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 not excluding public residential health care facilities operating by a town or city

Appendix V
2025 Title XIX State Plan
First Quarter Amendment
Responses to Standard Funding Questions

INSTITUTIONAL SERVICES
State Plan Amendment #25-0014

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-A of the state plan.

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

Response: Providers 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 or is funded by an IGT transferred from the counties.

		4/1/24 – 3/31/25	
Payment Type	Non-Federal Share Funding	Non-Federal	Gross
Hospital Inpatient Normal Per Diem	General Fund; Special Revenue Funds; County Contribution	\$2.355B	\$4.711B
Residential Treatment Facilities Normal Per Diem	General Fund; County Contribution	\$51M	\$103M
Hospital Inpatient Supplemental	General Fund	\$142M	\$284M
Indigent Care Pool	General Fund; Special Revenue Funds	\$300M	\$600M
Voluntary UPL	General Fund	\$170M	\$339M
Indigent Care Pool Adjustment	General Fund; IGT	\$206M	\$412M
Disproportionate Share Program	General Fund; IGT	\$1,026M	\$2,051M
State Public Inpatient UPL	General Fund	\$10M	\$20M
Non-State Government Inpatient UPL	IGT	\$210M	\$421M
Totals		\$4.470B	\$8.940B

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 Medicaid 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 and 2807-s (surcharges), 2807-c (1 percent), and 2807-d-1 (1.6 percent). HCRA resources include:
 - Surcharge on net patient service revenues for Inpatient Hospital Services.
 - 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.
 - 1 percent assessment on General Hospital Inpatient Revenue.
 - 1.6 percent Quality Contribution on Maternity and Newborn (IP) Services.
- 2) Health Facility Cash Assessment Program (HFCAP) Fund: Pursuant to New York State Public Health Law 2807-d, the total state assessment on each hospital's gross receipts received from all patient care services and other operating income, excluding gross receipts attributable to payments received pursuant to Title XVIII of the federal Social Security Act (Medicare), is 0.35 percent.

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 percent 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. Each deposit received is reviewed and compared to the amount each county is responsible to contribute to the Medicaid program to verify the county funds received are eligible for Medicaid expenses.

D. IGT Funding:

New York State requests the transfer of the IGT amounts from entities prior to the release of payments to the providers. The entities transferring IGT amounts are all units of government, and the nonfederal share is derived from state or local tax revenue funded accounts only. The providers keep and retain Medicaid payments. Please note that entities have taxing authority, and the State does not provide appropriations to the entities for IGTs.

Provider	Entity Transferring IGT Funds	4/1/24-3/31/25 IGT Amount
Bellevue Hospital Center	New York City	\$14M
Coney Island Hospital	New York City	\$1M
City Hospital Center at Elmhurst	New York City	\$6M
Harlem Hospital Center	New York City	\$30M
Henry J Carter Spec Hospital	New York City	(\$8M)
Jacobi Medical Center	New York City	\$3M
Kings County Hospital Center	New York City	(\$32M)
Lincoln Medical & Mental Health Center	New York City	\$30M
Metropolitan Hospital Center	New York City	\$78M
North Central Bronx Hospital	New York City	(\$28M)
Queens Hospital Center	New York City	(\$4M)
Woodhull Medical and Mental Health Center	New York City	\$65M
Erie County Medical Center	Erie County	\$118M
Lewis County General Hospital	Lewis County	\$9M
Nassau County Medical Center	Nassau County	\$76M

Westchester County Medical Center	Westchester County	\$362M
Wyoming County Community Hospital	Wyoming County	\$8M
NYC Health + Hospitals	New York City	\$210M
Total		\$938M

- 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: Please see list of supplemental payments below:

Payment Type	Private	State Government	Non-State Government	4/1/24-3/31/25 Gross Total
Indigent Care Pool/Voluntary UPL \$339M Guarantee	\$816M	\$7M	\$116M	\$939M
Indigent Care Pool Adjustment	\$0	\$134M	\$278M	\$412M
Disproportionate Share Program	\$0	\$877M	\$1.174B	\$2.051B
Vital Access Program	\$284M	\$0	\$0	\$284M
State Public Inpatient UPL	\$0	\$20M	\$0	\$20M
Non-State Government Inpatient UPL	\$0	\$0	\$421M	\$421M
Total	\$1.100B	\$1.037B	\$1.989B	\$4.126B

The Medicaid payments authorized under this State Plan Amendment are supplemental payments and total \$500 million for calendar year 2025. Please note that the dollar amount currently listed in the plan page is a placeholder and will be updated once the calculation is completed.

- 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 inpatient UPL demonstration utilizes cost-to-payment and payment-to-payment methodologies to estimate the upper payment limit for each class of providers. The State is in the process of completing the 2025 inpatient UPL as well as the Procedural

Manual which describes the methodology for eligible providers and will be submitting both documents 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?**

Response: 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.

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 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.