



Department of Health

ANDREW M. CUOMO
Governor

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

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

June 28, 2019

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

RE: SPA #19-0025
Long Term Care Facility Services

Dear Mr. Cooley:

The State requests approval of the enclosed amendment #19-0025 to the Title XIX (Medicaid) State Plan for long term care facility services to be effective April 1, 2019 (Appendix I). This amendment is being submitted based on enacted legislation. A summary of the proposed amendment is provided 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, Part 447, Subpart C, (42 CFR §447).

A copy of the pertinent section of enacted legislation is enclosed for your information (Appendix III). A copy of the public notice of this proposed amendment, which was given in the New York State Register on March 27, 2019, 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,



Donna Frescatore
Medicaid Director
Office of Health Insurance Programs

Enclosures
cc: Mr. Ricardo Holligan
Mr. Tom Brady

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

1. TRANSMITTAL NUMBER
1 9 — 0 0 2 5

2. STATE
New York

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

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
April 1, 2019

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(r)(5) of the Social Security Act, and 42 CFR 447

7. FEDERAL BUDGET IMPACT
a. FFY 04/01/19-09/30/19 \$ 125,000.00
b. FFY 10/01/19-09/30/20 \$ 250,000.00

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT

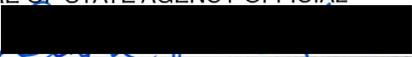
Attachment: 4.19-D Part I Page: 47(x)(2)(b)

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (*If Applicable*)

Attachment: 4.19-D Part I Page: 47(x)(2)(b)

10. SUBJECT OF AMENDMENT
2019 Nursing Home UPL
(FMAP=50%)

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

12. SIGNATURE OF STATE AGENCY OFFICIAL


13. TYPED NAME
Donna Frescatore

14. TITLE
Medicaid Director, Department of Health

15. DATE SUBMITTED
June 28, 2019

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

21. TYPED NAME

20. SIGNATURE OF REGIONAL OFFICIAL

22. TITLE

23. REMARKS

Appendix I
2019 Title XIX State Plan
Second Quarter Amendment
Amended SPA Pages

**New York
47(x)(2)(b)**

For the period April 1, 1997 through March 31, 1999, proportionate share payments in an annual aggregate amount of \$631.1 million will be made under the medical assistance program to non-state public operated residential health care facilities, excluding public residential health care facilities operated by a town or city within a county. For the period April 1, 1999 through March 31, 2000, proportionate share payments in an annual aggregate amount of \$982 million will be made under the medical assistance program to non-state operated public residential health care facilities, excluding public residential health care facilities operated by a town or city within a county. For annual state fiscal year periods commencing April 1, 2000 and ending March 31, 2005, and April 1, 2005, through March 31, 2009, proportionate share payments in an annual aggregate amount of up to \$991.5 million and \$150.0 million, respectively, for state fiscal year April 1, 2009 through March 31, 2010, \$167 million, and for state fiscals years commencing April 1, 2010 through March 31, 2011, \$189 million in an annual aggregate amount , and for the period April 1, 2011 through March 31, 2012 an aggregate amount of \$172.5 million and for state fiscal years commencing April 1, 2012 through March 31, 2013, an aggregate amount of \$293,147,494, and for the period April 1, 2013 through March 31, 2014, \$246,522,355, and for the period April 1, 2014 through March 31, 2015, \$305,254,832, and for the period April 1, 2015 through March 31, 2016, \$255,208,911, for the period April 1, 2016 through March 31, 2017, \$198,758,133 in an annual aggregate amount, and for the period April 1, 2017 through March 31, 2018, the aggregate amount of \$167,600,071, will be paid semi-annually in September and March, and for the period April 1, 2018 through March 31, 2019, the aggregate amount of \$225,104,113, will be paid semi-annually in September and March, and for the period April 1, 2019 through March 31, 2020, the aggregate amount of \$500,000,000 will be paid semi-annually in September and March, which will be made under the medical assistance program to non-state operated public residential health care facilities, including public residential health care facilities located in the counties of Erie, Nassau and Westchester, but excluding public residential health care facilities operated by a town or city within a county.

The amount allocated to each eligible public residential health care facility for the period April 1, 1997 through March 31, 1998 will be calculated as the result of \$631.1 million multiplied by the ratio of their 1995 Medicaid days relative to the sum of 1995 Medicaid days for all eligible public residential health care facilities. The amount allocated to each eligible public residential health care facility for the period April 1, 1998 through March 31, 1999 will be calculated as the result of \$631.1 million multiplied by the ratio of their 1996 Medicaid days relative to the sum of 1996 Medicaid days for all eligible public residential health care facilities. The amount allocated to each public residential health care facility for the period April 1, 1999 through March 31, 2000 will be calculated as the result of \$982 million multiplied by the ratio of their 1997 Medicaid days relative to the sum of 1997 Medicaid days for all eligible public residential health care facilities. The amount allocated to each public residential health care facility for annual state fiscal year periods commencing April 1, 2000 and ending March 31, 2005, and for annual state fiscal year periods commencing April 1, 2005 through March 31, 2009, and for state fiscal years commencing April 1, 2009 through March 31, 2011; April 1, 2011 through March 31, 2012; April 1, 2012 through March 31, 2013; April 1, 2013 through March 31, 2014; and April 1, 2014 through March 31, 2015; April 1, 2015 through March 31, 2016; April 1, 2016 through March 31, 2017; April 1, 2017 through March 31, 2018; and April 1, 2018 through March 31, 2019; and April 1, 2019 through March 31, 2020 will be calculated as the result of the respective annual aggregate amount multiplied by the ratio of their Medicaid days relative to the sum of Medicaid days for all eligible public residential health care facilities for the calendar year period two years prior provided, however, that an additional amount of \$26,531,995 for the April 1, 2013 through March 2014 period will be distributed to those public residential health care facilities in the list which follows.

TN #19-0025

Approval Date _____

Supersedes TN #18-0026

Effective Date _____

Appendix II
2019 Title XIX State Plan
Second Quarter Amendment
Summary

SUMMARY
SPA #19-0025

This amendment proposes to continue 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.

Appendix III
2019 Title XIX State Plan
Second Quarter Amendment
Authorizing Provisions

SPA 19-0025

Public Health Law § 2808(12) (e-1)

(e-1) Notwithstanding any inconsistent provision of law or regulation, the commissioner shall provide, in addition to payments established pursuant to this article prior to application of this section, additional payments under the medical assistance program pursuant to title eleven of article five of the social services law for non-state operated public residential health care facilities, including public residential health care facilities located in the county of Nassau, the county of Westchester and the county of Erie, but excluding public residential health care facilities operated by a town or city within a county, in aggregate annual amounts of up to one hundred fifty million dollars in additional payments for the state fiscal year beginning April first, two thousand six and for the state fiscal year beginning April first, two thousand seven and for the state fiscal year beginning April first, two thousand eight and of up to three hundred million dollars in such aggregate annual additional payments for the state fiscal year beginning April first, two thousand nine, and for the state fiscal year beginning April first, two thousand ten and for the state fiscal year beginning April first, two thousand eleven, and for the state fiscal years beginning April first, two thousand twelve and April first, two thousand thirteen, and of up to five hundred million dollars in such aggregate annual additional payments for the state fiscal years beginning April first, two thousand fourteen, April first, two thousand fifteen and April first, two thousand sixteen and of up to five hundred million dollars in such aggregate annual additional payments for the state fiscal years beginning April first, two thousand seventeen, April first, two thousand eighteen, and April first, two thousand nineteen. The amount allocated to each eligible public residential health care facility for this period shall be computed in accordance with the provisions of paragraph (f) of this subdivision, provided, however, that patient days shall be utilized for such computation reflecting actual reported data for two thousand three and each representative succeeding year as applicable, and provided further, however, that, in consultation with impacted providers, of the funds allocated for distribution in the state fiscal year beginning April first, two thousand thirteen, up to thirty-two million dollars may be allocated in accordance with paragraph (f-1) of this subdivision.

Appendix IV
2019 Title XIX State Plan
Second Quarter Amendment
Public Notice

the 2006 final trend factor equal to the final Consumer Price Index (CPI) for all urban consumers less 0.25%.

Institutional Services

Effective on or after April 1, 2019, annual indigent care pool distributions for certain providers will be reduced.

The estimated annual net aggregate decrease in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2019/2020 is (\$275.6 million).

Effective on or after April 1, 2019, continues the supplemental upper payment limit payments made to general hospitals, other than major public general hospitals under institutional services of \$339 million annually.

For state fiscal year beginning April 1, 2019 through March 31, 2020, 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. 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.

Additional medical assistance, known as, Intergovernmental Transfer (IGT) payments, for inpatient hospital services may be made to public general hospitals operated by the State of New York or the State University of New York, or by a county which shall not include a city with a population over one million, and those public general hospitals located in the counties of Westchester, Erie, or Nassau, up to one hundred percent (100%) of each such public hospital's medical assistance, and uninsured patient losses after all other medical assistance, including disproportionate share hospital (DSH) payments to such public general hospitals. Payments will be made by means of one or more estimated distributions initially based on the latest DSH audit results, which shall later be reconciled to such payment year's actual DSH audit uncompensated care costs. Payments may be added to rates of payment or made as aggregate payments. Such payments will continue April 1, 2019 through March 31, 2021.

There is no change in gross Medicaid expenditures for this update.

Extends current provisions for services on April 1, 2019 through March 31, 2024 and thereafter, 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 aggregate decrease in gross Medicaid expenditures for state fiscal year 2019/2020 is (\$114.5 million).

Capital related costs of a general hospital excluding 44% of the major movable costs and excluding staff housing costs will continue effective April 1, 2019 through March 31, 2024 and thereafter.

The estimated annual net aggregate decrease in gross Medicaid expenditures for state fiscal year 2019/2020 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, 2019 through March 31, 2024 and thereafter.

The estimated annual net aggregate decrease in gross Medicaid expenditures for state fiscal year 2019/2020 is (\$15.9 million).

Effective for dates of service on or after April 1, 2019, update the historical year Medicaid claims used in the general hospital acute rate statewide price development from 2014 to 2017.

There is no change in gross Medicaid expenditures for this update.

Long Term Care Services

Effective on or after April 1, 2019, continues additional payments to non-state government operated public residential health care facili-

ties, 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 2016 and each representative succeeding year as applicable. Payments to eligible RHCF's may be added to rates of payment or made as aggregate payments.

Effective on or after April 1, 2019 and thereafter, the appeals cap in PHL 2808(1)(a)(17)(b) is extended. The current appeals cap provision establishes an eighty-million-dollar annual budget for the processing of rate appeals or reimbursement for construction that has been approved by the commissioner.

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

Effective on or after April 1, 2019 and thereafter the provision that rates of payment for RHCFs shall not reflect trend factor projection or adjustments for the period April 1, 1996 through March 31, 1997 is extended.

The estimated annual net aggregate decrease in gross Medicaid expenditures attributable to this initiative is (\$12.7 million).

Effective on or after April 1, 2019 and thereafter this provision continues a 0.25 reduction in the statutory trend factors of 2006.

The estimated annual net aggregate decrease in gross Medicaid expenditures attributable to this initiative is (\$13.4 million).

Effective on or after April 1, 2019 nursing home reimbursement case mix collections which impact the direct price component of nursing home Medicaid reimbursement. The direct statewide price shall be adjusted by a Medicaid-only case mix and shall be updated for a Medicaid-only case mix in January and July of each year, using the case mix data applicable to the previous period.

The estimated annual net aggregate decrease in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2019-2020 is (\$191 million).

Effective for dates of service on or after April 1, 2019 and thereafter, Certified Home Health Agencies (CHHAs) payments will continue to be based on episodic payments, except for such services provided to children under 18 years of age.

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

Effective on or after April 1, 2019, The Consumer Directed Personal Assistance Program (CDPAP), a personal care service model, permits chronically ill and/or physically disabled individuals receiving home care under the medical assistance program greater flexibility and freedom of choice in obtaining such services. Reimbursement for CDPAP services has been based on a per hour billing methodology. This change will move the administrative reimbursement methodology for CDPAP to a per member per month basis and maintains an hourly/daily reimbursement for service delivery.

The estimated annual net aggregate decrease in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2019-2020 is (\$28.7 million).

Effective on or after April 1, 2019 and thereafter, current provisions for certified home health agency administrative and general costs reimbursement limits are extended.

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

Effective on or after April 1, 2019 and thereafter, 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 XVII 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.

Appendix V
2019 Title XIX State Plan
Second Quarter Amendment
Responses to Standard Funding Questions

**APPENDIX V
LONG TERM CARE SERVICES
State Plan Amendment #19-0025**

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-D of the state plan.

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

Response: Providers do retain the payments made pursuant to this amendment. However, this requirement in no way prohibits the public provider, including county providers, from reimbursing the sponsoring local government for appropriate expenses incurred by the local government on behalf of the public provider. The State does not regulate the financial relationships that exist between public health care providers and their sponsoring governments, which are extremely varied and complex. Local governments may provide direct and/or indirect monetary subsidies to their public providers to cover on-going unreimbursed operational expenses and assure achievement of their mission as primary safety net providers. Examples of appropriate expenses may include payments to the local government which include reimbursement for debt service paid on a provider's behalf, reimbursement for Medicare Part B premiums paid for a provider's retirees, reimbursement for contractually required health benefit fund payments made on a provider's behalf, and payment for overhead expenses as allocated per federal Office of Management and Budget Circular 2 CFR 200 regarding Cost Principles for State, Local, and Indian Tribal Governments. The existence of such transfers should in no way negate the legitimacy of these facilities' Medicaid payments or result in reduced Medicaid federal financial participation for the State. This position was further supported by CMS in review and approval of SPA 07-07C when an on-site audit of these transactions for New York City's Health and Hospitals Corporation was completed with satisfactory results.

- 2. Section 1902(a)(2) provides that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan. Please describe how the**

state share of each type of Medicaid payment (normal per diem, supplemental, enhanced, other) is funded. Please describe whether the state share is from appropriations from the legislature to the Medicaid agency, through intergovernmental transfer agreements (IGTs), certified public expenditures (CPEs), provider taxes, or any other mechanism used by the state to provide state share. Note that, if the appropriation is not to the Medicaid agency, the source of the state share would necessarily be derived through either an IGT or CPE. In this case, please identify the agency to which the funds are appropriated. Please provide an estimate of total expenditure and State share amounts for each type of Medicaid payment. If any of the non-federal share is being provided using IGTs or CPEs, please fully describe the matching arrangement including when the state agency receives the transferred amounts from the local government entity transferring the funds. If CPEs are used, please describe the methodology used by the state to verify that the total expenditures being certified are eligible for Federal matching funds in accordance with 42 CFR 433.51(b). For any payment funded by CPEs or IGTs, please provide the following:

- (i) a complete list of the names of entities transferring or certifying funds;
- (ii) the operational nature of the entity (state, county, city, other);
- (iii) the total amounts transferred or certified by each entity;
- (iv) clarify whether the certifying or transferring entity has general taxing authority; and,
- (v) whether the certifying or transferring entity received appropriations (identify level of appropriations).

Response: Payments made to service providers under the provisions of this SPA are funded with federal and local funding through an Intergovernmental Transfer (IGT). For these payments, the non-Federal share totals of up to \$250 million and is transferred from the sponsoring local county governments, who do have general taxing authority. There are no State appropriations for these governments for this purpose.

Regarding your question on the matching arrangement when the state receives the transferred amounts from the local government entity, please refer to the October 23, 2006 letter from Nicholas Meister, previously provided to CMS, whereby instructions are provided to local government entities when transferring funds for this purpose.

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: For the period April 1, 2019 through March 31, 2020 supplemental payments authorized in this attachment will be paid to providers of services in an amount up to \$500 million. These payments will be made to the non-state government owned or operated provider category.

4. **Please provide a detailed description of the methodology used by the state to estimate the upper payment limit (UPL) for each class of providers (State owned or operated, non-state government owned or operated, and privately owned or operated). Please provide a current (i.e. applicable to the current rate year) UPL demonstration. Under regulations at 42 CFR 447.272, States are prohibited from setting payment rates for Medicaid inpatient services that exceed a reasonable estimate of the amount that would be paid under Medicare payment principals.**

Response: The state and CMS are working toward completing and approval of current year UPL.

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

Response: Effective January 1, 2012, the rate methodology included in the approved State Plan for non-specialty nursing facility services for the operating component of the rate is a blended statewide/peer group price adjusted for case mix and wage equalization factor (WEF). Specialty nursing facility and units are paid the operating rate in effect on January 1, 2009. The capital component of the rate for all specialty and non-specialty facilities is based upon a cost-based methodology.

We are unaware of any requirement under current federal law or regulation that limits individual provider payments to their actual costs.

ACA Assurances:

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

MOE Period.

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

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

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

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

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

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

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

Tribal Assurance:

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

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

- a) Please describe the process the State uses to seek advice on a regular ongoing basis from federally recognized tribes Indian Health Programs and Urban Indian Organizations on matters related to Medicaid and CHIP programs and for consultation on State Plan Amendments waiver proposals waiver extensions waiver amendments waiver renewals and proposals for demonstration projects prior to submission to CMS.**
- b) Please include information about the frequency inclusiveness and process for seeking such advice.**
- c) Please describe the consultation process that occurred specifically for the development and submission of this State Plan Amendment when it occurred and who was involved.**

Response: Tribal consultation was performed in accordance with the State's tribal consultation policy as approved in SPA 17-0065, and documentation of such is included with this submission. To date, no feedback has been received from any tribal representative in response to the proposed change in this SPA.