



## 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 30, 2020

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

RE: SPA #20-0030  
Long Term Care Facility Services

Dear Mr. Cooley:

The State requests approval of the enclosed amendment #20-0030 to the Title XIX (Medicaid) State Plan for long term care facility services to be effective April 1, 2020 (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). Copies of the public notice of this proposed amendment, which was given in the New York State Register on March 25, 2020 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: Todd McMillion

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

1. TRANSMITTAL NUMBER

2 0 — 0 0 3 0

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, 2020

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 04/01/20-09/30/20 \$ 11,500,000.00

b. FFY 10/01/20-09/30/21 \$ 23,000,000.00

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT

Attachment: 4.19-D Page(s): 110(d)(29), 110(d)(29.1)

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (*If Applicable*)

Attachment: 4.19-D Page(s): 110(d)(29), 110(d)(29.1)

10. SUBJECT OF AMENDMENT

ATI (Advanced Training Initiative)  
(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

[Redacted Signature]

13. TYPED NAME

Donna Frescatore

14. TITLE

Medicaid Director, Department of Health

15. DATE SUBMITTED

June 30, 2020

16. RETURN TO

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

**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED

18. DATE APPROVED

**PLAN APPROVED - ONE COPY ATTACHED**

19. EFFECTIVE DATE OF APPROVED MATERIAL

20. SIGNATURE OF REGIONAL OFFICIAL

21. TYPED NAME

22. TITLE

23. REMARKS

**Appendix I**  
**2020 Title XIX State Plan**  
**Second Quarter Amendment**  
**Amended SPA Pages**

**New York  
110(d)(29)**

**Nursing Home Advanced Training Incentive Payments**

Advanced Training Incentive Payments to Eligible Facilities. Effective June 1, 2015, the state will annually distribute \$46 million to eligible nursing facilities in State Fiscal Years 2016, [and in] 2017, 2020 and thereafter. The purpose of these incentive payments is to reduce avoidable hospital admissions for nursing home residents. New York will incentivize and encourage facilities to develop training programs aimed at early detection of patient decline. Such programs will allow frontline caregivers to provide staff with the training/tools needed to identify resident characteristics that may signify clinical complications. A comprehensive training program will lead to consistent staff assignment to ensure that families and residents can rely on highly trained caregivers to provide effective, high quality, individualized care.

Patient decline detection programs will assist caregivers with identifying residents who are exhibiting warning signs for worsening clinical conditions and allow for rapid intervention to avoid the decline and possible hospitalization. The goal of such training programs will be to reign in the high costs of avoidable hospitalizations, improving the quality of life for New York's nursing home residents. This initiative will reward eligible nursing home providers who are those that have shown a commitment to giving direct care staff the tools to help lower resident hospitalization rates.

The annual amount will be distributed proportionally to each eligible facility based on its relative share of Medicaid bed days to total Medicaid bed days of all such eligible facilities. Incentive payments will be paid in two lump sum adjustments to supplement nursing facility rates. 75% will be paid in the October - December quarter and the 25% will be paid in the January - March quarter.

To be eligible for this incentive payment, in each state fiscal year a facility must:

- 1) Provide a training program to direct care staff that has been reviewed and approved by the Department to assist direct care staff identify changes in a resident's physical, mental, or functional status that could lead to hospitalization. The training program will be subject to Department of Health oversight; and
- 2) Have a direct care staff retention rate above the statewide median; and
- 3) Not be excluded from participating in this program.

New York  
110(d)(29.1)

**Nursing Home Advanced Training Incentive Payments (cont'd)**

Excluded Facilities are:

- Hospital based nursing facilities; and
- Nursing Facilities that have been approved to receive Vital Access Provider (VAP) payments during the same state fiscal year the incentive payment is available.

Calculation Statewide Median and Staff Retention Percentage: Data from Schedule P (Staff Turnover) of the most recently filed Cost Report will be used to measure staff turnover and retention rates for direct care staff. For the [2016] current payment, the State will use the [2014] latest available cost report. For example, for the 2017 payment, the state will use the 2015 cost report. The staff retention percentage will be equal to the number of employees retained as of December 31, who were employed on January 1 of the same year by the number of staff as of January 1 of that year.

(# of Employees Retained as of December 31, 20XX, who were Employed on January 1, 20XX)  
= Staff Retention %  
divided by (# of Staff as of January 1, 20XX)

XX = [2014 or 2015] latest available cost report as applicable.

A statewide staff retention median was derived by sorting the provider percentages from high to low and selecting the percentage in the middle of the range.

**Restorative (Intensive) Care in a Nursing Home**

Effective December 1, 2016 NYSDOH will implement a Restorative Care Unit Program to reduce hospital admissions and readmissions from residential health care facilities through the establishment of restorative care units. These restorative care units will provide higher-intensity treatment services to residents who are at risk of hospitalization upon an acute change in condition and seeks to improve the capacity of nursing facilities to identify and treat higher acuity patients with multiple co-morbidities as effectively as possible in place, rather than through admission to an acute care facility. Eligible facilities are required to institute new programs through which residents normally transported to hospital will be cared for in the nursing facility through the use of more intensive nursing home units.

The targeted population receiving restorative care unit services are participating in the restorative care program, post hospital admission and have an overall goal of discharging to the community.

Rate payments will be provided, semi-annually, to eligible residential health care facilities which meet the criteria of providing intensive treatments to nursing home residents in the facility and thereby avoid hospitalization. The rate adjustment is intended to:

TN #20-0030  
Supersedes TN #16-0051

Approval Date \_\_\_\_\_  
Effective Date April 1, 2020

**Appendix II**  
**2020 Title XIX State Plan**  
**Second Quarter Amendment**  
**Summary**

**SUMMARY**  
**SPA #20-0030**

This state plan amendment proposes to continue 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, coupled 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 must be submitted for Department review before implementation. 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 State fiscal year 2020/2021 is \$46 million.

**Appendix III**  
**2020 Title XIX State Plan**  
**Second Quarter Amendment**  
**Authorizing Provisions**



**20-0030 Authorizing Language**

This SPA was submitted based on State budgeted allocations; \$46 million has been appropriated in each state fiscal year beginning with the 2015 -2016 enacted budget. The broader “long term care services appropriation”, referenced below, includes this allocation.

Chapter 50 of the Laws of 2020

Medicaid General Fund Local Assistance Appropriation

For services and expenses of the medical assistance program including other long term care services.

Notwithstanding any provision of law to the contrary, the portion of this appropriation covering fiscal year 2020-21 shall supersede and replace any duplicative (i) reappropriation for this item covering fiscal year 2020-21, and (ii) appropriation for this item covering fiscal year 2020-21 set forth in chapter 53 of the laws of 2019 (26951) ..... 11,438,391,000

**Appendix IV**  
**2020 Title XIX State Plan**  
**Second Quarter Amendment**  
**Public Notice**

cally 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.

For state fiscal year beginning April 1, 2020 through March 31, 2021, 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 state fiscal year beginning April 1, 2020 through March 31, 2021, 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 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.

#### Institutional Services

Effective on or after April 1, 2020, the temporary rate adjustment has been reviewed and approved for the St. Joseph's Hospital Health Center with aggregate payment amounts totaling up to \$4,000,000 for the period April 1, 2020 through March 31, 2021.

Effective on or after April 1, 2020, 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, 2020 through March 31, 2021, 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 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.

For state fiscal year beginning April 1, 2020 through March 31, 2021, supplemental payments will be made 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.

Effective on or after April 1, 2020, the temporary rate adjustment has been reviewed and approved for Long Island Jewish Medical Center with aggregate payment amounts totaling up to \$1,000,000 for the period April 1, 2020 through March 31, 2021.

#### Long Term Care Services

Effective on or after April 1, 2020, 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 2018 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, 2020, the Department of Health

proposes to amend the Title XIX (Medicaid) State Plan for institutional services related to temporary rate adjustments to long term care providers that are undergoing closure, merger, consolidation, acquisition or restructuring themselves or other health care providers. These payments are authorized by current State statutory and regulatory provisions. The temporary rate adjustments will be reviewed and approved by the CINERGY Collaborative.

The estimated net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2020-2021 is \$30 million.

Effective on or after April 1, 2020, the Department of Health (DOH) will continue the nursing home advanced training program, aimed at teaching staff how to detect early changes in a resident's physical and mental or functional status that could lead to hospitalization. Clinical findings show early detection of patient decline by front line workers, coupled with clinical care models aimed at fostering consistent and continuous care between care givers and patients/families result in better care outcomes. Similarly, nursing homes with higher staff retention rates correlate with better care outcomes and avoided hospital stays. This training program will be developed in cooperation between Nursing Home providers and union representatives offering training opportunities for staff or other qualifying training programs.

These programs and their curricula will be submitted to DOH for review. In addition to offering a training program, eligible facilities must have direct care staff retention rates above the state median. However, hospital-based nursing homes and free standing nursing homes already receiving VAP payments would not be eligible to participate.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2020/2021 is \$46 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](http://www.health.ny.gov/regulations/state_plans/status). In addition, approved SPA's beginning in 2011 are also available for viewing on this website.

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

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

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

Queens County, Queens Center  
3220 Northern Boulevard  
Long Island City, New York 11101

Kings County, Fulton Center  
114 Willoughby Street  
Brooklyn, New York 11201

Bronx County, Tremont Center  
1916 Monterey Avenue  
Bronx, New York 10457

Richmond County, Richmond Center  
95 Central Avenue, St. George  
Staten Island, New York 10301

*For further information and to review and comment, please contact:* Department of Health, Division of Finance and Rate Setting, 99 Washington Ave., One Commerce Plaza, Suite 1432, Albany, NY 12210, [spa\\_inquiries@health.ny.gov](mailto:spa_inquiries@health.ny.gov)

**Appendix V**  
**2020 Title XIX State Plan**  
**Second Quarter Amendment**  
**Responses to Standard Funding Questions**

**APPENDIX V**  
**LONG TERM CARE SERVICES**  
**State Plan Amendment #20-0030**

**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 through a budget appropriation received by the State agency that oversees medical assistance (Medicaid), which is the Department of Health. The source of the appropriation is the Medicaid General Fund Local Assistance Account, which is part of the Global Cap. The Global Cap is funded by General Fund and HCRA resources. There have been no new provider taxes and no existing taxes have been modified.

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

**Response:** The payments authorized for this provision are not supplemental or enhanced payments.

- 3. 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.

- 4. 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, 2015.

- 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 the original submission. To date, no feedback has been received from any tribal representative in response to the proposed change in this SPA.