



Department of Health

ANDREW M. CUOMO
Governor

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

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

MAR 08 2016

Mr. Michael Melendez
Associate Regional Administrator
Department of Health & Human Services
Centers for Medicare & Medicaid Services
New York Regional Office
Division of Medicaid and Children's Health Operations
26 Federal Plaza - Room 37-100 North
New York, New York 10278

RE: SPA #16-0023
Non-Institutional Services

Dear Mr. Melendez:

The State requests approval of the enclosed amendment #16-0023 to the Title XIX (Medicaid) State Plan for non-institutional services to be effective March 1, 2016 (Appendix I). This amendment is being submitted based on State Regulations. A summary of the plan amendment is provided in Appendix II.

The State of New York reimburses these services through the use of rates that are consistent with and promote efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area as required by §1902(a)(30) of the Social Security Act and 42 CFR §447.204.

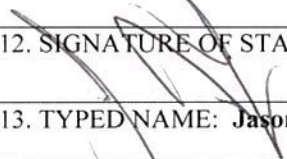
Copies of pertinent sections of proposed State Regulations are enclosed for your information (Appendix III). A copy of the public notice of this plan amendment, which was given in the New York State Register on February 24, 2016, is also enclosed for your information (Appendix IV). In addition, responses 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 John E. Ulberg, Jr., Medicaid Chief Financial Officer, Division of Finance and Rate Setting, Office of Health Insurance Programs at (518) 474-6350.

Sincerely,


Jason Helgerson
Medicaid Director
Office of Health Insurance Programs

Enclosures

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: HEALTH CARE FINANCING ADMINISTRATION		1. TRANSMITTAL NUMBER: 16-0023	2. STATE New York
		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE March 1, 2016	
5. TYPE OF PLAN MATERIAL (<i>Check One</i>): <input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (<i>Separate Transmittal for each amendment</i>)			
6. FEDERAL STATUTE/REGULATION CITATION: § 1902(a) of the Social Security Act, and 42 CFR 447		7. FEDERAL BUDGET IMPACT: (<i>in thousands</i>) a. FFY 03/01/16-09/30/16 \$ 2,882.95 b. FFY 10/01/16-09/30/17 \$ 1,833.16	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-B: 2(am)(3); 2(am)(4); 2(am)(5)		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (<i>If Applicable</i>): Attachment 4.19-B: 2(am)(3); 2(am)(4); 2(am)(5)	
10. SUBJECT OF AMENDMENT: Safety Net/VAP-Article 31 OMH Freestanding Clinics (FMAP = 50%)			
11. GOVERNOR'S REVIEW (<i>Check One</i>): <input checked="" type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input type="checkbox"/> OTHER, AS SPECIFIED: <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL			
12. SIGNATURE OF STATE AGENCY OFFICIAL: 		16. RETURN TO: New York State Department of Health Division of Finance and Rate Setting 99 Washington Ave – One Commerce Plaza Suite 1460 Albany, NY 12210	
13. TYPED NAME: Jason A. Helgerson			
14. TITLE: Medicaid Director Department of Health			
15. DATE SUBMITTED: MAR 08 2016			
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
2016 Title XIX State Plan
First Quarter Amendment
Amended SPA Pages

**New York
2(am)(3)**

Article 31 Freestanding Clinics (continued):

Provider Name	Gross Medicaid Rate Adjustment	Rate Period Effective
Family Services of Westchester	\$259,803	12/01/2015 – 03/31/2016
	\$179,803	04/01/2016 – 03/31/2017
	\$151,000	12/01/2015 – 03/31/2016
Hamilton-Madison House, Inc.	\$257,080	04/01/2016 – 03/31/2017
	\$190,080	04/01/2017 – 03/31/2018
	\$259,695	02/01/2016 – 03/31/2016
Lexington Center for Mental Health Services, Inc.	\$351,700	04/01/2016 – 03/31/2017
	\$296,700	04/01/2017 – 03/31/2018
	\$105,310	12/01/2015 – 03/31/2016
Madison County Mental Health Clinic	\$290,418	04/01/2016 – 03/31/2017
	\$290,418	04/01/2017 – 03/31/2018
	\$ 99,234	02/01/2016 – 03/31/2016
Mental Health Association of Westchester County	\$581,473	04/01/2016 – 03/31/2017
	\$674,728	04/01/2017 – 03/31/2018
	\$521,667	12/01/2015 – 03/31/2016
Northeast Parent and Child Society	\$170,000	04/01/2016 – 03/31/2017
	\$150,000	04/01/2017 – 03/31/2018
	\$115,512	02/01/2016 – 03/31/2016
Northshore Child & Family Guidance Association, Inc.	\$437,124	04/01/2016 – 03/31/2017
	\$219,791	04/01/2017 – 03/31/2018
	\$684,778	02/01/2016 – 03/31/2016
Northside Center for Child Development Inc.	\$937,328	04/01/2016 – 03/31/2017
	\$223,367	04/01/2017 – 03/31/2018
	\$ 68,362	02/01/2016 – 03/31/2016
Occupation Now Access Support for the Living	\$400,572	04/01/2016 – 03/31/2017
	\$464,814	04/01/2017 – 03/31/2018
	\$ 19,198	03/01/2016 – 03/31/2016
Ontario County Department of Health	\$201,024	04/01/2016 – 03/31/2017
	\$180,695	04/01/2017 – 03/31/2018

TN #16-0023 Approval Date Supersedes TN #16-0010 Effective Date

Appendix II
2016 Title XIX State Plan
First Quarter Amendment
Summary

SUMMARY
SPA #16-0023

This State Plan Amendment proposes to award the Article 31 Freestanding Clinics listed below that are approved to receive temporary rate adjustments under the closure, merger, consolidation, acquisition or restructuring of a health care provider.

- Ontario County Department of Health
- Richmond University Medical Center/Staten Island Mental Health Society, Inc.

Appendix III
2016 Title XIX State Plan
First Quarter Amendment
Authorizing Provisions



14 NYCRR Part 530
Express Terms

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

PART 530

VITAL ACCESS PROGRAM and PROVIDERS

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

Section:

- 530.1 Background and Intent
- 530.2 Legal Base
- 530.3 Definitions
- 530.4 Vital Access Program

530.1 Background and Intent.

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

530.2 Legal Base.

- (a) Section 7.09 of the Mental Hygiene Law authorizes the Commissioner to adopt regulations that are necessary and proper to implement matters under his or her jurisdiction.
- (b) Section 31.02 of the Mental Hygiene Law authorizes the Commissioner to issue operating certificates for the provision of inpatient and outpatient mental health services.

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

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

530.3 Definitions.

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

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

530.4 Vital Access Program.

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

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

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

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

(i) protect or enhance access to care;

- (ii) protect or enhance quality of care;
- (iii) improve the cost effectiveness of the delivery of health care services; or
- (iv) otherwise protect or enhance the health care delivery system, as determined by the Commissioner.

(b) Application.

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

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

(c) Reimbursement.

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

(d) Conditions on Approval.

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

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

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

**Appendix IV
2016 Title XIX State Plan
First Quarter Amendment
Public Notice**

- Upstate Cerebral Palsy, Inc.
- Wayne County Mental Health Department
- Westchester Jewish Community Services

The aggregate payment amounts total up to \$4,443,675 for the period February 1, 2016 through March 31, 2016.

The aggregate payment amounts total up to \$11,132,503 for the period April 1, 2016 through March 31, 2017.

The aggregate payment amounts total up to \$7,633,971 for the period April 1, 2017 through March 31, 2018.

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

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

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

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

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

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

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

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

For further information and to review and comment, please contact: Department of Health, Division of Finance and Rate Setting, 99 Washington Ave. – One Commerce Plaza, Suite 1460, Albany, NY 12210, or e-mail: spa_inquiries@health.ny.gov

PUBLIC NOTICE

Office of Mental Health and Department of Health

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

The Office of Mental Health and the Department of Health propose to amend the Title XIX (Medicaid) State Plan for non-institutional services related to temporary rate adjustments to Article 31 Freestanding Clinics that are undergoing a closure, merger, consolidation, acquisition or restructuring of themselves or other health care providers. These payments are currently authorized by current State statutory and regulatory provisions. The following changes are proposed:

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

- Richmond University Medical Center/Staten Island Mental Health Society, Inc.
- Ontario County Department of Mental Health

The aggregate payment amounts total up to \$2,885,721 for the period March 1, 2016 through March 31, 2016.

The aggregate payment amounts total up to \$5,760,369 for the period April 1, 2016 through March 31, 2017.

The aggregate payment amounts total up to \$1,572,258 for the period April 1, 2017 through March 31, 2018.

The aggregate payment amounts total up to \$100,000.00 for the period April 1, 2018 through March 31, 2019.

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

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

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

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114 Willoughby Street
Brooklyn, New York 11201

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

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

For further information and to review and comment, please contact: Department of Health, Division of Finance and Rate Setting, 99 Washington Ave. – One Commerce Plaza, Suite 1460, Albany, NY 12210, or e-mail: spa_inquiries@health.ny.gov

PUBLIC NOTICE

Department of State

The New York State Appearance Enhancement Advisory Committee will hold an open board meeting on May 25, 2016 at 10:30 a.m. at the Department of State, 99 Washington Ave., 5th Fl. Conference Rm. (alternate Rm. 1135), Albany; 65 Court St., 2nd Fl. Conference Rm., Buffalo; and, 123 William St., 2nd Fl. Conference Rm., New York City.

Should you require further information, please contact Sharon Charland at sharon.charland@dos.ny.gov or 518-473-2733.

PUBLIC NOTICE

Department of State

The New York State Real Estate Board will hold an open board meeting on April 27, 2016 at 10:30 a.m. at Department of State, 99 Washington Ave., Rm. 505 (alternate Rm. 1112), Albany; 123 William St., Rm. 231, New York; and 65 Court St., Rm. 208, Buffalo. The Board will hold a public hearing on general real estate issues immediately following the board meeting at the same locations.

Should you require further information, please contact Sharon Charland at sharon.charland@dos.ny.gov or 518-473-2733.

PUBLIC NOTICE

**Department of State
F-2016-0092 (DA)**

Date of Issuance – February 24, 2016

The New York State Department of State (DOS) is required by Federal regulations to provide timely public notice for the activities

Appendix V
2016 Title XIX State Plan
First Quarter Amendment
Responses to Standard Funding Questions

NON-INSTITUTIONAL SERVICES
State Plan Amendment #16-0023

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-B of this SPA. For SPAs that provide for changes to payments for clinic or outpatient hospital services or for enhanced or supplemental payments to physician or other practitioners, the questions must be answered for all payments made under the state plan for such service.

- 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 payments, a complete listing of providers that return a portion of their payments, 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 A-87 regarding Cost Principles for State, Local, and Indian Tribal Governments. The existence of such transfers should in no way negate the legitimacy of these facilities' Medicaid payments or result in reduced Medicaid federal financial participation for the State. This position was further supported by CMS in review and approval of SPA 07-07C when an on-site audit of these transactions for New York City's Health and Hospitals Corporation was completed with satisfactory results.

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

Response: Payments made to service providers under the provisions of this SPA are funded through a general appropriation received by the State agency that oversees medical assistance (Medicaid), which is the Department of Health. The source of the appropriation is the Local Assistance Account under the General Fund/Aid to Localities.

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

Response: The payments authorized for this provision are add-on services payments made to those providers listed who will receive temporary rate adjustments to be paid quarterly during each period in equal installments.

4. **For clinic or outpatient hospital services 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.

Response: The State and CMS staff are having ongoing conversations related to prior years' freestanding clinic UPL demonstrations which the 2015 demonstration is contingent upon.

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

Response: The rate methodology included in the State Plan for freestanding diagnostic and treatment and ambulatory surgery center services is based upon the Ambulatory Patient Group (APG) system with the exception of Federally Qualified Health Centers who have the option to opt into the APG system or remain on the Prospective Payment Methodology (PPS) as approved by CMS in SPA 01-03. We are unaware of any requirement under current federal law or regulation that limits individual providers' payments to their actual costs.

ACA Assurances:

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

MOE Period.

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

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

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

expenditures at a greater percentage than would have been required on December 31, 2009.

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

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

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

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

Tribal Assurance:

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

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

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

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