



Department of Health

ANDREW M. CUOMO
Governor

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

LISA J. PINO, M.A., J.D.
Executive Deputy Commissioner

June 29, 2021

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 #21-0035
Non-Institutional Services

Dear Mr. McMillion:

The State requests approval of the enclosed amendment #21-0035 to the Title XIX (Medicaid) State Plan for non-institutional services to be effective April 1, 2021 (Appendix I). This amendment is being submitted based on enacted legislation. 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.

A copy of pertinent sections of enacted legislation is 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 March 31, 2021, 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

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

1. TRANSMITTAL NUMBER <u>2</u> <u>1</u> — <u>0</u> <u>0</u> <u>3</u> <u>5</u>	2. STATE New York
3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID) TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
4. PROPOSED EFFECTIVE DATE April 01, 2021	

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

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(a) of the Social Security Act and 42 CFR 447	7. FEDERAL BUDGET IMPACT a. FFY <u>04/01/21-09/30/21</u> \$ <u>35,898.94</u> b. FFY <u>10/01/21-09/30/22</u> \$ <u>35,898.94</u>
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT Attachment 4.19-B Page: 2(c)(v.2)	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (<i>If Applicable</i>) Attachment 4.19-B Page: 2(c)(v.2)

10. SUBJECT OF AMENDMENT
2021 Voluntary OP UPL Payments
(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 	16. RETURN TO New York State Department of Health Division of Finance and Rate Setting 99 Washington Ave – One Commerce Plaza Suite 1432 Albany, NY 12210
13. TYPED NAME Donna Frescatore	
14. TITLE Medicaid Director, Department of Health	
15. DATE SUBMITTED June 29, 2021	

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
2021 Title XIX State Plan
Second Quarter Amendment
Amended SPA Pages

**New York
2(c)(v.2)**

Hospital Outpatient Supplemental Payments – Non-government Owned or Operated General Hospitals

Effective for the period April 1, [2020]2021 through March 31, [2021]2022, supplemental payments are authorized for certain general hospitals for outpatient services furnished in the [2020]2021 calendar year. Payments under this provision will not exceed [\$140,961,900] \$143,595,774.

To receive payment under this provision, a general hospital, as defined in Attachment 4.19-A of the state plan, must meet all of the following:

- (i) must be non-government owned or operated;
- (ii) must operate an emergency room; and
- (iii) must have received an Indigent Care Pool payment for the [2020] 2021 rate year; and/or must have a facility specific projected disproportionate share hospital payment ceiling for the 2020 rate year that is greater than zero.

The amount paid to each eligible hospital will be determined based on an allocation methodology utilizing data reported in eligible hospitals' most recent Institutional Cost Report submitted to the New York State Department of Health as of October 1, 2019:

- (a) Thirty percent of the payments under this provision will be allocated to eligible general hospitals classified as a safety net hospital, based on each hospital's proportionate share of all safety net hospitals' Medicaid discharges for inpatient hospital services, including both Medicaid fee-for-service and managed care discharges for acute and exempt services.

For this purpose, a safety net hospital is defined as an eligible general hospital having either: a Medicaid share of total inpatient hospital discharges of at least 35%, including both fee-for-service and managed care discharges for acute and exempt services; or a Medicaid share of total discharges of at least 30%, including both fee-for-service and managed care discharges for acute and exempt services, and also providing obstetrical services.

- (b) Seventy percent of the payments under this provision will be allocated to eligible general hospitals based on each hospital's proportionate share of all eligible hospitals' Medicaid discharges for inpatient hospital services, including both Medicaid fee-for-service and managed care discharges for acute and exempt services.

Eligible Hospitals will receive payment under (a) and/or (b), as eligible, with each hospital's payment made in a lump sum distribution.

TN #21-0035 _____

Supersedes TN # 20-0025 _____

Approval Date _____

Effective Date April 1, 2021

Appendix II
2021 Title XIX State Plan
Second Quarter Amendment
Summary

SUMMARY
SPA #21-0035

This State Plan Amendment proposes to extend supplemental upper payment limit distributions for outpatient hospital services to voluntary sector hospitals, excluding government general hospitals, not to exceed in aggregate \$339 million annually in combination with the inpatient voluntary hospital Upper Payment Limit SPA.

Appendix III
2021 Title XIX State Plan
Second Quarter Amendment
Authorizing Provisions

Chapter 57 of the Laws of 2015 - Part E

§ 2. Notwithstanding any inconsistent provision of law, rule 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 periods on and after April 1, 2015, payments pursuant to paragraph (i) of subdivision 35 of section 2807-c of the public health law may be made as outpatient upper payment limit payments for outpatient hospital services, not to exceed an amount of three hundred thirty-nine million dollars annually between payments authorized under this section and such section of the public health law. Such payments shall be made as medical assistance payments for outpatient 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 for general hospital outpatient services and general hospital emergency room services issued pursuant to paragraph (g) of subdivision 2 of section 2807 of the public health law to general hospitals, other than major public general hospitals, providing emergency room services and including safety net hospitals, which shall, for the purpose of this paragraph, be defined as having either: a Medicaid share of total inpatient hospital discharges of at least thirty-five percent, including both fee-for-service and managed care discharges for acute and exempt services; or a Medicaid share of total discharges of at least thirty percent, including both fee-for-service and managed care discharges for acute and exempt services, and also providing obstetrical services. Eligibility to receive such additional payments shall be based on data from the period two years prior to the rate year, as reported on the institutional cost report submitted to the department as of October first of the prior rate year. No eligible general hospital's annual payment amount pursuant to this section shall exceed the lower of the sum of the annual amounts due that hospital pursuant to section twenty-eight hundred seven-k and section twenty-eight hundred seven-w of the public health law; or the hospital's facility specific projected disproportionate share hospital payment ceiling established pursuant to federal law, provided, however, that payment amounts to eligible hospitals in excess of the lower of such sum or payment ceiling shall be reallocated to eligible hospitals that do not have excess payment amounts. Such reallocations shall be proportional to each such hospital's aggregate payment amount pursuant to paragraph (i) of subdivision 35 of section 2807-c of the public health law and this section to the total of all payment amounts for such eligible hospitals. Such adjustment payment may be added to rates of payment or made as aggregate payments to eligible general hospitals other than major public general hospitals. The distribution of such payments shall be pursuant to a methodology approved by the commissioner of health in regulation.

**Appendix IV
2021 Title XIX State Plan
Second Quarter Amendment
Public Notice**

greater than zero trend factors, pursuant to the provisions of Public Health Law § 2807-c(10)(c), will be applied to rates of payment for hospital inpatient and outpatient services, inpatient and adult day health care outpatient services provided by residential health care facilities pursuant to Article 28 of the Public Health Law (except for residential health care facilities or units of such facilities providing services primarily to children under 21 year of age), for certified home health agencies, long term home health care programs, AIDS home care programs, and for personal care services pursuant to section 365-a of the Social Services Law, including personal care services provided in those local social services districts, including New York City, whose rates of payment for services is established by such social services districts pursuant to a rate-setting exemption granted by the Department, and assisted living program services.

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

Non-Institutional Services

Effective on or after April 1, 2021, 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 state fiscal year beginning April 1, 2021 through March 31, 2022, 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 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 state fiscal year beginning April 1, 2021 through March 31, 2022, 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.

Effective on or after April 1, 2021, this amendment proposes to revise the State Plan to reduce the Worker Recruitment and Retention add-on percentage by an additional 25 percent as compared to 2020/2021, for Certified Home Health Agencies (CHHA) and Hospice programs.

The estimated annual net aggregate decrease in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2021/2022 is (\$1.5 million).

Effective on or after April 1, 2021 the Department will reduce coverage of certain over the counter (OTC) products. Clinically critical products such as aspirin and vitamins and minerals used for deficiencies will continue to be covered, as will less expensive OTC products that are in Preferred Drug Program (PDP) drug classes. The estimated annual net aggregate decrease in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2021/2022 is (\$17.4 million).

Effective on and after April 1, 2021, this notice provides for a

temporary rate adjustment with an aggregate payment amounts totaling no less than \$10,001,000 annually, for Essential Community Providers (ECPs) for the periods April 1, 2021 through March 31, 2022 and April 1, 2022 through March 31, 2023. These payments will be made to the following approved providers: A.O Fox Memorial Hospital, Adirondack Medical Center, Alice Hyde Hospital Association, Auburn Memorial Hospital, Bassett Hospital of Schoharie County-Cobleskill Regional, Brooks Memorial Hospital, Canton-Potsdam Hospital, Carthage Area Hospital, Catskill Regional Hospital – Sullivan, Catskill Regional Medical Center-Hermann Div, Cayuga Medical Center-Ithaca, Champlain Valley Physicians HMC, Chenango Memorial Hospital, Claxton Hepburn Hospital, Clifton-Fine Hospital, Columbia Memorial Hospital, Community Memorial Hospital, Corning Hospital, Cortland Memorial Hospital, Cuba Memorial Hospital, Delaware Valley Hospital, Elizabethtown Community Hospital, Ellenville Community Hospital, Gouverneur Hospital, Ira Davenport Memorial Hospital, Jones Memorial Hospital, Lewis County General Hospital, Little Falls Hospital, Margaretville Memorial Hospital, Mary Imogene Bassett Hospital, Massena Memorial Hospital, Medina Memorial Hospital, Moses-Ludington Hospital, Nathan Littauer Hospital, Northern Dutchess Hospital, Noyes Memorial Hospital, O'Connor Hospital, Olean General Hospital – Main, Oneida City Hospital, Oswego Hospital, River Hospital, Samaritan Medical Center, Schuyler Hospital, Soldiers and Sailors Memorial Hospital, St. James Mercy Hospital, Tri Town Regional, Westfield Memorial Hospital, Wyoming County Community Hospital, WCA Hospital, United Memorial Medical Center, as well as St. Mary's Healthcare.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2021/2022 is \$10.0 million.

Effective on and after April 1, 2021, this notice provides for a temporary rate adjustment with an aggregate payment totaling no less than \$7.5 million annually for Critical Access Hospitals (CAHs), for the periods April 1, 2021 through March 31, 2022 and April 1, 2022 through March 31, 2023. These payments will be made to the following:

Bassett Hospital of Schoharie County-Cobleskill Regional, Carthage Area Hospital, Catskill Regional Medical Center-Hermann, Clifton-Fine Hospital, Community Memorial Hospital, Cuba Memorial Hospital, Delaware Valley Hospital, Elizabethtown Community

Hospital, Ellenville Regional Hospital, Gouverneur Hospital, Lewis County General Hospital, Little Falls Hospital, Margaretville Hospital, O'Connor Hospital, River Hospital, Schuyler Hospital, Soldiers and Sailors Memorial Hospital of Yates, as well as Medina Memorial Hospital.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2021/2022 is \$7.5 million.

Effective on or after April 1, 2021, the State is advancing a comprehensive set of telehealth reforms for the purposes of strengthening and sustaining telehealth as a high-quality, cost effective, and consumer-oriented form of care delivery.

The estimated annual net aggregate decrease in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2021/2022 is (\$79.0 million).

Effective on or after April 1, 2021, and each fiscal year thereafter, the State proposes to establish a 340B Reimbursement Fund for the purposes of supporting activities that expand health services to the Medicaid members, the uninsured, and low-income patients, as supported by the 340B program.

The annual gross Medicaid expenditures as a result of this proposed amendment is \$102.0 million.

Effective on or after April 1, 2021, and for each State Fiscal Year thereafter, the State proposes to revise the method of distributing the funding for the Clinic Safety Net (CSN) distribution for comprehensive diagnostic and treatment centers that are other than Federally Qualified Health Centers (referred to as the non-FQHC CSN distribution).

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

Appendix V
2021 Title XIX State Plan
Second Quarter Amendment
Responses to Standard Funding Questions

**NON-INSTITUTIONAL SERVICES
State Plan Amendment #21-0035**

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 the state plan. 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 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 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 Medicaid General Fund Local Assistance Account, which is part of the Global Cap. The Global Cap is funded by General Fund and HCRA resources. There are no new provider taxes and no modifications to existing taxes have been made.

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

Response: The Medicaid payments authorized for this provision are supplemental payments in the amount of \$143,595,774.

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: NYS officially submitted the 2021 Outpatient UPL calculation on 4/30/2021. The UPL demonstration includes a detail description of the methodology used to estimate the upper payment limit for each class of providers. A cost methodology is used to estimate the UPL for each class

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: Hospital-Based Outpatient: The rate methodologies included in the State Plan for outpatient hospital services are either cost-based subject to ceilings or based upon the Ambulatory Patient Group (APG) system. We are unaware of any requirement under current federal law or regulation that limits individual provider's 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.