NEW YORK STATE | Department of Health

KATHY HOCHUL
Governor

JAMES V. McDONALD, MD, MPH
Commissioner

JOHANNE E. MORNE, MS
Executive Deputy Commissioner

March 28, 2025

James G. Scott, Director
Division of Program Operations
Centers for Medicare & Medicaid Services
601 E. 12th St., Room 355
Kansas City, Missouri 64106

RE: SPA #25-0006
Non-Institutional Services

Dear Director Scott:

The State requests approval of the enclosed amendment #25-0006 the Title XIX (Medicaid) State Plan for non-institutional services to be effective January 1, 2025 (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 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). Copies of the public notices of this plan amendment, which were given in the *New York State Register* on December 31, 2024, and subsequently clarified on April 16, 2025, are 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,

[redacted]

Amir Bassiri
Medicaid Director
Office of Health Insurance Programs

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

# TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

**FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES**

1. TRANSMITTAL NUMBER: 25-0006

2. STATE: NY

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

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
January 1, 2025

5. FEDERAL STATUTE/REGULATION CITATION
§ 1902(a)(84(D) of the Social Security Act and 42 CFR 447.201

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 01/01/25-09/30/25 $ 537,438
b. FFY 10/01/25-09/30/26 $ 575,058

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 3.1-M- Page 1

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*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

9. SUBJECT OF AMENDMENT
Incarcerated Youth - Assessment Rates and Services

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

11. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

12. TYPED NAME
Amir Bassiri

13. TITLE
Medicaid Director

14. DATE SUBMITTED
March 28, 2025

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

***FOR CMS USE ONLY***

16. DATE RECEIVED

17. DATE APPROVED

***PLAN APPROVED - ONE COPY ATTACHED***

18. EFFECTIVE DATE OF APPROVED MATERIAL

19. SIGNATURE OF APPROVING OFFICIAL

20. TYPED NAME OF APPROVING OFFICIAL

21. TITLE OF APPROVING OFFICIAL

22. REMARKS



***Instructions on Back***

**Appendix I**
**2025 Title XIX State Plan**
**First Quarter Amendment**
**Amended SPA Pages**

# Mandatory Coverage for Eligible Juveniles who are Inmates of a Public Institution Post Adjudication of Charges

## State/Territory: New York

General assurances. State must indicate compliance with all four items below with a check.

X In accordance with section 1902(a)(84)(D) of the Social Security Act, the state has an internal operational plan and, in accordance with such plan, provides for the following for eligible juveniles as defined in 1902(nn) (individuals who are under 21 years of age and determined eligible for any Medicaid eligibility group, or individuals determined eligible for the mandatory eligibility group for former foster care children age 18 up to age 26, immediately before becoming an inmate of a public institution or while an inmate of a public institution) who are within 30 days of their scheduled date of release from a public institution following adjudication:

X In the 30 days prior to release (or not later than one week, or as soon as practicable, after release from the public institution), and in coordination with the public institution, any screenings and diagnostic services which meet reasonable standards of medical and dental practice, as determined by the state, or as otherwise indicated as medically necessary, in accordance with the Early and Periodic Screening, Diagnostic, and Treatment requirements, including a behavioral health screening or diagnostic service.

X In the 30 days prior to release and for at least 30 days following release, targeted case management services, including referrals to appropriate care and services available in the geographic region of the home or residence of the eligible juvenile, where feasible, under the Medicaid state plan (or waiver of such plan).

X The state acknowledges that a correctional institution is considered a public institution and may include prisons, jails, detention facilities, or other penal settings (e.g., boot camps or wilderness camps).

# Appendix II
# 2025 Title XIX State Plan
# First Quarter Amendment
# Summary

**SUMMARY**
**SPA #25-0006**

This State Plan Amendment proposes to provide the provision of the mandatory services, including limited pre-release services, for eligible juveniles leaving incarceration in Medicaid as mandated in Federal statute Consolidated Appropriations Act of 2023, Section 5121. An eligible juvenile is an individual who is under 21 years of age determined eligible in any eligibility group or an individual described in section 1902 (a) (10) (A)(i)(IX) of the Act, who was determined eligible for Medicaid before becoming an inmate of a public institution or who is determined eligible for Medicaid while an inmate of a public institution or former foster care youth up to the age of 26. The mandatory services include 30 days pre-release of physical and behavioral health screenings or diagnostic service. Providing these services to eligible juvenile's pre-release will help identify necessary treatment services so that medical and behavioral health appointments can be scheduled prior to release and occur as soon as possible after an eligible juvenile is released. The implementation of these provisions should not effectuate a delay of an individual's release or lead to increased involvement in the juvenile and adult justice systems.

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

**SPA 25-0006**

Consolidated Appropriations Act of 2023

SEC. 5121. MEDICAID AND CHIP REQUIREMENTS FOR HEALTH SCREENINGS, REFERRALS, AND CASE MANAGEMENT SERVICES FOR ELIGIBLE JUVENILES IN PUBLIC INSTITUTIONS.

(a) MEDICAID STATE PLAN REQUIREMENT.—Section 1902 of the Social Security Act (42 U.S.C. 1396a) is amended—

(1) in subsection (a)(84)—

(A) in subparagraph (A), by inserting ‘‘, subject to subparagraph (D),’’ after ‘‘but’’;

(B) in subparagraph (B), by striking ‘‘and’’ at the end;

(C) in subparagraph (C), by adding ‘‘and’’ at the end; and

(D) by adding at the end the following new subparagraph:

‘‘(D) in the case of an individual who is an eligible juvenile described in subsection (nn)(2) and is within 30 days of the date on which such eligible juvenile is scheduled to be released from a public institution following adjudication, the State shall have in place a plan, and in accordance with such plan, provide for—

‘‘(i) in the 30 days prior to the release of such eligible juvenile from such public institution (or not later than one week, or as soon as practicable, after release from the public institution), and in coordination with such institution, any screening or diagnostic service which meets reasonable standards of medical

and dental practice, as determined by the State, or

as indicated as medically necessary, in accordance with

paragraphs (1)(A) and (5) of section 1905(r), including

a behavioral health screening or diagnostic service;

and

''(ii) in the 30 days prior to the release of such

eligible juvenile from such public institution, and for

at least 30 days following the release of such eligible

juvenile from such institution, targeted case management services, including referrals for such eligible juvenile to the appropriate care and services available in

the geographic region of the home or residence of such

eligible juvenile (where feasible) under the State plan

(or waiver of such plan);''; and

(2) in subsection (nn)(3), by striking ''(30)'' and inserting

''(31)''.

(b) AUTHORIZATION OF FEDERAL FINANCIAL PARTICIPATION.—

The subdivision (A) of section 1905(a) of the Social Security Act

(42 U.S.C. 1396d(a)) following paragraph (31) of such section is

amended by inserting '', or in the case of an eligible juvenile

described in section 1902(a)(84)(D) with respect to the screenings,

diagnostic services, referrals, and targeted case management services required under such section'' after ''(except as a patient in

a medical institution''.

(c) CHIP CONFORMING AMENDMENTS.—

(1) Section 2102 of the Social Security Act (42 U.S.C.

1397bb) is amended by adding at the end the following new

subsection:

''(d) TREATMENT OF CHILDREN WHO ARE INMATES OF A PUBLIC INSTITUTION.—

''(1) IN GENERAL.—The State child health plan shall provide that—

''(A) the State shall not terminate eligibility for child health assistance under the State child health plan for a targeted low-income child because the child is an inmate of a public institution, but may suspend coverage during the period the child is such an inmate;

''(B) in the case of a targeted low-income child who was determined eligible for child health assistance under the State child health plan (or waiver of such plan) immediately before becoming an inmate of a public institution, the State shall, prior to the child's release from such public institution, conduct a redetermination of eligibility for such child with respect to such child health assistance (without requiring a new application from the child) and, if the State determines pursuant to such redetermination that the child continues to meet the eligibility requirements for such child health assistance, the State shall restore coverage for such child health assistance to such child upon the child's release from such public institution; and

''(C) in the case of a targeted low-income child who is determined eligible for child health assistance while an inmate of a public institution (subject to the exception

to the exclusion of children who are inmates of a public institution described in section 2110(b)(7)), the State shall process any application for child health assistance submitted by, or on behalf of, the child such that the State makes a determination of eligibility for the child with respect to child health assistance upon release of the child from the public institution.

''(2) REQUIRED COVERAGE OF SCREENINGS, DIAGNOSTIC SERVICES, REFERRALS, AND CASE MANAGEMENT FOR CERTAIN INMATES PRE-RELEASE.—A State child health plan shall provide that, in the case of a targeted low-income child who is within 30 days of the date on which such child is scheduled to be released from a public institution following adjudication, the State shall have in place a plan for providing, and shall provide in accordance with such plan, screenings, diagnostic services, referrals, and case management services otherwise covered under the State child health plan (or waiver of such plan) in the same manner as described in section 1902(a)(84)(D).''.

(2) Section 2110(b) of the Social Security Act (42 U.S.C. 1397jj(b)) is amended—

(A) in paragraph (2)(A), by inserting ''except as provided in paragraph (7),'' before ''a child who is an inmate of a public institution''; and

(B) by adding at the end the following new paragraph:

''(7) EXCEPTION TO EXCLUSION OF CHILDREN WHO ARE INMATES OF A PUBLIC INSTITUTION.—In the case of a child who is an inmate of a public institution, during the 30 days prior to the release of the child from such institution the

child shall not be considered to be described in paragraph (2)(A) with respect to the screenings, diagnostic services, referrals, and case management services otherwise covered under the State child health plan (or waiver of such plan) that the State is required to provide under section 2102(d)(2).''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply beginning on the first day of the first calendar quarter that begins on or after the date that is 24 months after the date of enactment of this Act.

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

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

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

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

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

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

*For further information and to review and comment, please contact:* Department of Health, Division of Finance and Rate Setting, 99 Washington Ave., One Commerce Plaza, Suite 1432, Albany, NY 12210, spa-inquiries@health.ny.gov

## PUBLIC NOTICE
### Department of Health

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

The Department of Health proposes to amend the Title XIX (Medicaid) State Plan for non-institutional services to comply with the federal statutory requirements in Section 5121 of the Consolidated Appropriations Act, 2023 (CAA, 2023) (P.L. 117-328). The following changes are proposed:

Non-Institutional Services

Effective on or after January 1, 2025, State Medicaid programs are federally required to have a plan in place and, in accordance with such plan, provide any screenings and diagnostic services which meet reasonable standards of medical and dental practice, as determined by the state, or as otherwise indicated as medically necessary, in accordance with the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) requirements, including a behavioral health screening or diagnostic service, for an eligible individual who is within 30 days of their scheduled date of release from a public carceral setting following adjudication.

Effective on or after January 1, 2025, State Medicaid programs are also federally required to have a plan in place and, in accordance with such plan, provide Targeted Case Management (TCM) services in the 30 days prior to release, and for at least 30 days following release, including referrals to appropriate care and services available in the geographic region of the home or residence of the eligible juvenile.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative is $1.5 million for screenings and diagnostic services, and $3 million for TCM services.

The public is invited to review and comment on this proposed State Plan Amendment, a copy of which will be available for public review on the Department's website at http://www.health.ny.gov/regulations/state_plans/status. Individuals without Internet access may view the State Plan Amendments at any local (county) social services district.

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

New York County
250 Church Street
New York, New York 10018
Queens County, Queens Center
3220 Northern Boulevard
Long Island City, New York 11101

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

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

Richmond County, Richmond Center
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## PUBLIC NOTICE
### Department of Health

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

The Department of Health proposes to amend the Title XIX (Medicaid) State Plan for non-institutional services to comply with PHL 2999-D and SSL § 367-u. The following changes are proposed:

Non-Institutional Services

Effective on or after January 1, 2025, The Department of Health will reimburse Federally Qualified Health Centers and Rural Health Clinics a separate payment in lieu of the Prospective Payment System rate for non-visit services, such as eConsults and remote patient monitoring.

The estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative is $86,000.

The public is invited to review and comment on this proposed State Plan Amendment, a copy of which will be available for public review on the Department's website at http://www.health.ny.gov/regulations/state_plans/status. Individuals without Internet access may view the State Plan Amendments at any local (county) social services district.

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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

For publication in the April 16th edition of the New York State Register

# Public Notice
## NYS Department of Health

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

The Department of Health proposes to amend the Title XIX (Medicaid) State Plan for non-institutional services to comply with the federal statutory requirements in Section 5121 of the Consolidated Appropriations Act, 2023 (CAA, 2023) (P.L. 117-328). The following changes are proposed:

**Non-Institutional Services**

The following is a clarification to the December 31, 2024, page 88, noticed provision to provide Targeted Case Management (TCM) services in the 30 days prior to release, and for at least 30 days following release, including referrals to appropriate care and services available in the geographic region of the home or residence of the eligible juvenile.

With clarification, the estimated annual net aggregate increase in gross Medicaid expenditures attributable to this initiative is $1.1 million for screenings and diagnostic services, and, $5.7 million for TCM services.

The public is invited to review and comment on this proposed State Plan Amendment, a copy of which will be available for public review on the Department's website at http://www.health.ny.gov/regulations/state_plans/status. Individuals without Internet access may view the State Plan Amendments at any local (county) social services district.

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

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For further information and to review and comment, please contact:

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One Commerce Plaza
Suite 1432
Albany, New York 12210
spa-inquiries@health.ny.gov

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

**NON-INSTITUTIONAL SERVICES**
**State Plan Amendment #25-0006**

**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.

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

   **Response:** Providers receive and retain 100 percent of total Medicaid expenditures claimed by the State and the State does not require any provider to return any portion of such payments to the State, local government entities, or any other intermediary organization.

2. **Section 1902(a)(2) provides that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan. Please describe how the state share of each type of Medicaid payment (normal per diem, supplemental, enhanced, other) is funded. Please describe whether the state share is from appropriations from the legislature to the Medicaid agency, through intergovernmental transfer agreements (IGTs), certified public expenditures (CPEs), provider taxes, or any other mechanism used by the state to provide state share. Note that, if the appropriation is not to the Medicaid agency, the source of the state share would necessarily be derived through either an IGT or CPE. In this case, please identify the agency to which the funds are appropriated. Please provide an estimate of total expenditure and State share amounts for each type of Medicaid payment. If any of the non-federal share is being provided using IGTs or CPEs, please fully describe the matching arrangement including when the state agency receives the transferred amounts from the local government entity transferring the funds. If CPEs are used, please describe the methodology used by the state to verify that the total expenditures being certified are eligible for Federal matching funds in accordance with 42 CFR 433.51(b). For any payment funded by CPEs or IGTs, please provide the following:**
   - **(i) a complete list of the names of entities transferring or certifying funds;**
   - **(ii) the operational nature of the entity (state, county, city, other);**

**(iii) the total amounts transferred or certified by each entity;**
**(iv) clarify whether the certifying or transferring entity has general taxing authority: and,**
**(v) whether the certifying or transferring entity received appropriations (identify level of appropriations).**

**Response:** The Non-Federal share Medicaid provider payment is funded by a combination of the following funds/funding sources through enacted appropriations authority to the Department of Health (DOH) for the New York State Medicaid program.

| | | 4/1/24 – 3/31/25 | |
|---|---|---|---|
| **Payment Type** | **Non-Federal Share Funding** | **Non-Federal** | **Gross** |
| Normal Per Diem | General Fund; County Contribution | $155 M | $ 319 M |

A. **General Fund:** Revenue resources for the State's General Fund includes taxes (e.g., income, sales, etc.), and miscellaneous fees (including audit recoveries). Medicaid expenditures from the State's General Fund are authorized from Department of Health Medicaid.

1) New York State Audit Recoveries: The Department of Health collaborates with the Office of the Medicaid Inspector General (OMIG) and the Office of the Attorney General (AG) in recovering improperly expended Medicaid funds. OMIG conducts and coordinates the investigation, detection, audit, and review of Medicaid providers and recipients to ensure they are complying with all applicable laws and regulation. OMIG recovers any improper payments through cash collections and voided claim recoveries. Cash collections are deposited into the State's General Fund to offset Medicaid costs.

In addition to cash collections, OMIG finds inappropriately billed claims within provider claims. To correct an error, OMIG and DOH process the current accurate claim, and reduce this claim by the inappropriate claim value to recoup the previous overclaim and decrease state spending.

**B. Additional Resources for Non-Federal Share Funding:**

County Contribution: In State Fiscal Year 2006, through enacted State legislation (Part C of Chapter 58 of the laws of 2005), New York State "capped" the amount localities contributed to the non-Federal share of providers claims. This was designed to relieve pressure on county property taxes and the NYC budget by limiting local contributions having New York State absorb all local program costs above this fixed statutory inflation rate (3% at the time).

However, in State Fiscal Year 2013 New York State provided additional relief to Localities by reducing local contributions annual growth from three precent to zero over a three-year period. Beginning in State Fiscal Year 2016, counties began paying a fixed cost in perpetuity as follows:

| Entity | Annual Amount |
|---|---|
| New York City | $5.210B |
| Suffolk County | $243M |
| Nassau County | $231M |
| Westchester County | $215M |
| Erie County | $205M |
| Rest of State (53 Counties) | $1.260B |
| **Total** | **$7.364B** |

By eliminating the growth in localities Medicaid costs, the State has statutorily capped total Statewide County Medicaid expenditures at 2015 levels. All additional county Medicaid costs are funded by the State through State funding as described above. DOH provides annual letters to counties providing weekly contributions. Contributions are deposited directly into State escrow account and used to offset 'total' State share Medicaid funding.

NOTE: The Local Contribution is not tied to a specific claim or service category and instead is a capped amount based on 2015 county spending levels as stated above.

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 under this State Plan Amendment are not supplemental payments.

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. 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 Medicaid payments authorized under this State Plan Amendment do not impact the UPL demonstrations.

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

**Response:** Providers do not receive payments that in the aggregate exceed their reasonable costs of providing services. If any providers received payments that in the aggregate exceeded their reasonable costs of providing services, the State would recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report.

**ACA Assurances:**

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

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

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

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

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

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

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

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

**Tribal Assurance:**

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

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

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

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