NEW YORK STATE OF OPPORTUNITY. Department of Health

**ANDREW M. CUOMO**
Governor

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

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

JUN 26 2015

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

Re: SPA #15-0048
Inpatient Hospital Services

Dear Mr. Cooley:

The State requests approval of the enclosed amendment #15-0048 to the Title XIX (Medicaid) State Plan for inpatient hospital services to be effective April 1, 2015 (Appendix I). This amendment is being submitted based upon enacted legislation. A summary of the proposed amendment is contained 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 (CFR), Part 447, Subpart C.

Notice of the changes in the methods and standards for setting payment rates for general hospital inpatient services were given in the New York State Register on March 25, 2015.

Copies of pertinent sections of enacted State statute are enclosed for your information (Appendix III). In addition, responses to the five standard funding questions are also enclosed (Appendix V).

If you have any questions regarding this matter, please do not hesitate to contact John E. Ulberg, Jr., Medicaid Chief Financial Officer, Division of Finance and Rate Setting at (518) 474-6350.

Sincerely,

Jason A. Helgerson
Medicaid Director
Office of Health Insurance Programs

Enclosures

cc: Mr. Michael Melendez
Mr. Tom Brady

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

| 1TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL<br><br>**FOR: HEALTH CARE FINANCING ADMINISTRATION** | 1. TRANSMITTAL NUMBER: **15-0048** | 2. STATE<br>**New York** |
|---|---|---|
| | 3. PROGRAM IDENTIFICATION: **TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)** | |
| TO: REGIONAL ADMINISTRATOR<br>HEALTH CARE FINANCING ADMINISTRATION<br>DEPARTMENT OF HEALTH AND HUMAN SERVICES | 4. PROPOSED EFFECTIVE DATE<br>**April 1, 2015** | |
| 5. TYPE OF PLAN MATERIAL *(Check One)*:<br><br>☐ 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:<br>**§1902(a) of the Social Security Act, and 42 CFR 447** | 7. FEDERAL BUDGET IMPACT: **(in thousands)**<br>**a. FFY 04/01/15-09/30/15 $ 2,791.19**<br>**b. FFY 10/01/15-09/30/16 $ 5,582.38** | |
| 8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:<br><br>**Attachment 4.19-A: Page 106(a)** | 9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:<br><br>**Attachment 4.19-A: Page 106(a)** | |
| 10. SUBJECT OF AMENDMENT:<br>**Eliminate Reduction to Statewide Base Price (FMAP = 50%)** | | |
| 11. GOVERNOR'S REVIEW *(Check One)*:<br>☒ GOVERNOR'S OFFICE REPORTED NO COMMENT<br>☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED<br>☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL | ☐ OTHER, AS SPECIFIED: | |
| 12. SIGNATURE OF STATE AGENCY OFFICIAL: | 16. RETURN TO:<br>**New York State Department of Health**<br>**Division of Finance and Rate Setting**<br>**99 Washington Ave – One Commerce Plaza**<br>**Suite 1460**<br>**Albany, NY 12210** | |
| 13. TYPED NAME: **Jason A. Helgerson** | | |
| 14. TITLE: **Medicaid Director**<br>**Department of Health** | | |
| 15. DATE SUBMITTED: JUN 2 6 2015 | | |
| **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: | | |

FORM HCFA-179 (07-92)

**Appendix I**
**2015 Title XIX State Plan**
**Second Quarter Amendment**
**Amended SPA Pages**

**New York**
**106(a)**

4. To maintain budget neutrality to the targeted statewide Medicaid inpatient hospital acute operating expenditures, a "budget neutrality factor" will be applied to the operating cost neutral statewide price, graduate medical education add-ons, and non-comparable cost add-ons utilized in the Medicaid payments for acute discharges.

5. Discharges used for direct graduate medical education adjustments for this Section will be as defined in the Definitions Section. Discharges, as defined in such paragraph, but excluding the factors set forth in paragraph (14)(c), as used for non-comparable adjustments for this Section, will be as defined in paragraph (22) in the Definitions Section of this Attachment.

6. To establish the Transition II Pool, effective October 20, 2010, the statewide base price will be reduced such that the level of total Medicaid payments will be decreased for the periods specified on the 'Transition II Pool' section by the corresponding Transition II fund amount.

7. For the period effective July 1, 2011 through March 31, 2012, the statewide base price will be adjusted such that total Medicaid payments are decreased by $24,200,000.

8. For the period May 1, 2012 through March 31, 2013 and for state fiscal year periods on and after April 1, 2013 through March 31, 2015, the statewide base price will be adjusted such that total Medicaid payments are decreased for such period and for each such state fiscal year period by $19,200,000.

[8] 9. High-cost outlier payments from hospitals with ancillary and routine charge schedules will be excluded from the statewide base price and will equal 100 percent of the excess costs above the high cost outlier threshold. The thresholds will be developed using acute Medicaid operating costs derived from the discharges pursuant to paragraph (7) of the Definitions Section of this Attachment. For discharges on or after July 1, 2014, the high cost thresholds will be scaled to maintain budget neutrality to estimated outlier payments pursuant to paragraph (4) of this Section. For purposes of determining budget neutrality, the Medicaid discharges to be applied to the high-cost outlier thresholds will be as defined in the Definitions Section of this Attachment.

[9] 10. Transfer case payments will be excluded from the statewide base price by excluding the transfer discharges will be defined as in the Definitions Section of this Attachment except for those transfer cases that are assigned to a DRG specifically identified as a DRG for transferred patients only.

# Appendix II
# 2015 Title XIX State Plan
# Second Quarter Amendment
# Summary

**SUMMARY**
**SPA #15-0048**

This State Plan Amendment proposes to eliminate the $19.2 million reduction to the statewide base price for acute per case inpatient services.

**Appendix III**
**2015 Title XIX State Plan**
**Second Quarter Amendment**
**Authorizing Provisions**

SPA 15-0048

Pursuant to the authority vested in the Commissioner of Health by sections 2807(c)(35), 2807(c)(4)(e-2), and 2807-k(5-b)(a)(ii) of the Public Health Law, Subpart 86-1 of Title 10 of the Official Compilation of Codes, Rules and Regulations of the State of New York, is hereby amended, effective upon filing with the Department of State, to read as follows:

Section 86-1.16 is amended to read as follows:

86-1.16 Statewide base price.

(a) (1) For periods on and after December 1, 2009, a statewide base price per discharge shall be established based on targeted statewide Medicaid inpatient hospital acute operating expenditures. Medicaid shall be as defined in section 86-1.15(s) of this Subpart.[and case-mix and wage neutral reimbursable Medicaid acute operating costs derived from the base period in subdivision (b) of this section, and as adjusted for inflation between the base period and the rate period in accordance with trend factors determined pursuant to applicable provisions of section 2807-c(10) of the Public Health Law, but]

(2) The Medicaid inpatient hospital operating expenditures utilized to derive the statewide base price shall be developed by calculating total targeted Medicaid acute operating payments as identified in subdivision (a)(1) of this section, for acute discharges, identified in subdivision (c) of this section, and excluding the payments [costs] related to graduate medical education,[ exempt units,] patient transfers, high-cost outliers,[ alternate level of care,] and non-comparables. [Such trended operating costs shall then be divided by Medicaid inpatient discharges in the base period identified in subdivision (b) of this section to establish the average statewide base price per discharge for the applicable rate period.]

(b) (1) For periods beginning on and after July 1, 2014, base year operating cost data, as defined in section 86-1.15(t) of this Subpart, shall be utilized to calculate an operating cost neutral statewide price. [For periods on and after December 1, 2009, the "base period" shall be the 2005 calendar year and "operating costs" shall be those reported by each facility to the department prior to July 1, 2009].

[(1) For those hospitals operated by the New York City Health and Hospitals Corporation, the base period shall be for the period which ended June 30, 2005, and for those hospitals operated by New York State, excluding the hospitals operated by the State University of New York, the base period shall be the 12-month period which ended March 31, 2006.]

(2) To maintain budget neutrality to the targeted statewide Medicaid inpatient hospital acute operating expenditures, pursuant to subdivision (a)(1) of this section, a "budget neutrality factor" shall be applied to the operating cost neutral statewide price, graduate medical education add-ons and non-comparable cost add-ons utilized in the Medicaid payments for acute discharges.

(c)(1)[(2)] Discharges [as defined in section 86-1.15(n) of this Subpart,] used for direct graduate

medical education adjustments for this section shall be as defined in sections 86-1.15(n) and 86-1.15(v) of this Subpart [based on reported 2007 data].

(2)[(3)] Discharges, as defined in [subdivision (n) of] section 86-1.15(n) of this Subpart, but excluding the factors set forth in paragraph (3) of such subdivision (n), as used for non-comparable adjustments for this section shall be as defined in section 86-1.15(v) of this Subpart [based on reported 2007 data].

(d)[(c)] (1) For the period effective July 1, 2011 through March 31, 2012, the statewide base price shall be adjusted such that total Medicaid payments are decreased by $24,200,000.

(2) For the period May 1, 2012 through March 31, 2013 and for state fiscal year periods on and after April 1, 2013 through March 31, 2015, the statewide base price shall be adjusted such that total Medicaid payments are decreased for such period and for each such state fiscal year period by $19,200,000.

(e) High-cost outlier payments, from hospitals with ancillary and routine charges schedules, shall be excluded from the statewide base price and shall equal 100 percent of the excess costs above the high cost outlier threshold. The thresholds shall be developed using acute Medicaid operating costs derived from the discharges pursuant to section 86-1.15(v) of this Subpart. For discharges on or after July 1, 2014, the high cost thresholds shall be scaled to maintain budget neutrality to estimated outlier payments pursuant to subdivision (b)(2) of this section. For purposes of determining budget neutrality, the Medicaid discharges to be applied to the high-cost outlier thresholds shall be pursuant to section 86-1.15(v) of this Subpart.

(f) Transfer case payments shall be excluded from the statewide base price by excluding the transfer discharges pursuant section 86-1.15(v) of this Subpart except for those transfer cases that are assigned to a DRG specifically identified as a DRG for transferred patients only.

**Appendix IV**
**2015 Title XIX State Plan**
**Second Quarter Amendment**
**Public Notice**

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, which shall be reconciled to the final adjustment determinations after the disproportionate share hospital payment adjustment caps have been calculated for such period under sections 1923(f) and (g) of the federal Social Security Act. Payments to eligible public general hospitals may be added to rates of payment or made as aggregate payments.

• Effective April 1, 2015, continues the supplemental upper payment limit payments made to general hospitals, other than major public general hospitals of $339 million annually.

• Extends effective beginning April 1, 2015 and for each state fiscal year thereafter, Intergovernmental Transfer Payments to eligible major public general hospitals run by counties and the State of New York.

There is no additional estimated annual change to gross Medicaid expenditures attributable to this initiative for state fiscal year 2015/2016.

• Continues, effective April 1, 2015, and thereafter, budgeted capital inpatient costs of a general hospital applicable to the rate year shall be decreased to reflect the percentage amount by which the budgeted costs for capital related inpatient costs of the hospital for the base year two years prior to the rate year exceeded actual costs.

• Extends current provisions for services on and after April 1, 2015, the reimbursable operating cost component for general hospital inpatient rates will be established with the 2006 final trend factor equal to the final Consumer Price Index (CPI) for all urban consumers less 0.25%.

The estimated annual net decrease in gross Medicaid expenditures attributable to these cost containment initiatives contained in the budget for state fiscal year 2015/2016 is $114.5 million.

• Effective April 1, 2015, authorizes the Commissioner of Health to establish a general hospital quality pool for the purpose of incentivizing and facilitating quality improvements. Payments for the period April 1, 2015 through March 31, 2016 will total $90.8 million gross and $87.8 million gross for the period April 1, 2016 through March 31, 2017.

• Effective June 1, 2015, provides that sole community hospitals, as defined in accordance with Title XVIII of the Federal Social Security Act, are eligible for enhanced payment and/or reimbursement for inpatient and/or outpatient services for the purpose of promoting patient access and improving quality of care. Payments for the period April 1, 2015 through March 31, 2016 will total $9.0 million gross and $12 million for each state fiscal year thereafter.

• Effective April 1, 2015, the amount allocated for Essential Community Provider Network and Vital Access Provider initiatives for Critical Access Hospital (CAHs) will be no less than $7.5 million annually. In addition, the Department of Health will provide a report to the Governor and legislature no later than June 1, 2015 providing recommendation on how to ensure the financial stability of, and preserve patient access to, CAHs, including an examination of permanent Medicaid rate methodology changes.

• Effective April 1, 2015, the amount allocated for Essential Community Provider Network and Vital Access Provider initiatives for essential community providers serving rural areas, including but not limited to hospitals; residential health care facilities; diagnostic and treatment centers; ambulatory surgery centers and clinics will be no less than $10 million. Payments will be made under a supplemental rate methodology for the purpose of promoting access and improving the quality of care. Such payments may include, but not be limited to, temporary rate adjustments; lump sum Medicaid payments; supplemental rate methodologies and any other payment as determined by the Commissioner.

• Effective April 1, 2015, any amount provided to public general hospitals related to payments for the hospital quality pool; sole community hospitals; and essential community provider network and vital access provider initiatives where the federal approvals for such payments on amounts or components thereof are not granted, such payments to public general hospitals shall be determined without consideration of such amounts or components. Public general hospitals shall refund to the State, or the State may recoup from prospective payments, any overpayment received, including those based on a retroactive reduction in the payments. Any reduction in the federal share related to federal upper payment limits applicable to public general hospitals other than those operated by the State University of New York shall apply first to amounts provided for such payments.

• Effective April 1, 2015, the $19.2 million reduction to the statewide base price will be eliminated.

Indigent Care

• Continues, effective for the period January 1, 2016 through December 31, 2018, indigent care pool payments will be made using an uninsured units methodology. Each hospital's uncompensated care need amount will be determined as follows:

- Inpatient units of service for the cost report period two years prior to the distribution year (excluding hospital-based residential health care facility (RHCF) and hospice) will be multiplied by the average applicable Medicaid inpatient rate in effect for January 1 of the distribution year;

- Outpatient units of service for the cost report period two years prior to the distribution year (excluding referred ambulatory and home health) will be multiplied by the average applicable Medicaid outpatient rate in effect for January 1 of the distribution year;

- Inpatient and outpatient uncompensated care amounts will then be summed and adjusted by a statewide adjustment factor and reduced by cash payments received from uninsured patients; and

- Uncompensated care nominal need will be based on a weighted blend of the net adjusted uncompensated care and the Medicaid inpatient utilization rate. The result will be used to proportionately allocate and make Medicaid disproportionate share hospital (DSH) payments in the following amounts:

• $139.4 million to major public general hospitals, including hospitals operated by public benefit corporations; and

• $994.9 million to general hospitals, other than major public general hospitals.

There is no additional estimated annual change to gross Medicaid expenditures attributable to this initiative for state fiscal year 2015/2016.

• For eligible public general hospitals effective with calendar years beginning January 1, 2015 and subsequent calendar years, the Indigent Care Adjustment will be allocated proportionately by group with public hospitals under the New York City Health & Hospitals Corporation at $376 million; State of New York or the State University of New York public hospitals at $4 million; and County public hospitals at $32 million and based on each eligible hospital's Medicaid and uninsured losses to the total of such losses for eligible hospitals. The Medicaid and uninsured losses will be determined based on the latest available data reported to the Department of Health as required by the Commissioner on a specified date through the Data Collection Tool.

There is no additional estimated annual change to gross Medicaid expenditures attributable to this initiative for state fiscal year 2015/2016.

Long Term Care Services

• Effective April 1, 2015, medical assistance shall be furnished to applicants in cases where, although such applicant has a responsible relative with sufficient income and resources to provide medical assistance, the income and resources of the responsibility relative are not available to such applicant because of the absence of such relative and the refusal or failure of such absent relative to provide the necessary care and assistance. In such cases, however, the furnishing of such assistance shall create an implied contract with such relative, and the cost thereof may be recovered from such relative in accordance with Title 6 of Article 3 and other applicable provisions of law.

The estimated annual net aggregate decrease in gross Medicaid

# Appendix V
# 2015 Title XIX State Plan
# Second Quarter Amendment
# Responses to Standard Funding Questions

**APPENDIX V**
**HOSPITAL SERVICES**
**State Plan Amendment #15-0048**

**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-A of your 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 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 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 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 not supplemental or enhanced payments.

4. **Please provide a detailed description of the methodology used by the state to estimate the upper payment limit (UPL) for each class of providers (State owned or operated, non-state government owned or operated, and privately owned or operated). Please provide a current (i.e. applicable to the current rate year) UPL demonstration. Under regulations at 42 CFR 4447.272, 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 having ongoing discussions to develop a strategic plan to complete the inpatient UPL demonstration for 2014 , which the 2015 UPL 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 approved State Plan for institutional services is prospective payment. We are unaware of any requirement under current federal law or regulation that limits individual provider payments to their actual costs.

**ACA Assurances:**

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

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

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

2. **Section 1905(y) and (z) of the Act provides for increased FMAPs for expenditures made on or after January 1, 2014 for individuals determined**

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

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

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

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

   **Response:** This SPA 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.