DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
New York Regional Office
26 Federal Plaza, Room 37-100
New York, NY 10278

CENTERS FOR MEDICARE & MEDICAID SERVICES

DIVISION OF MEDICAID AND CHILDREN'S HEALTH OPERATIONS

May 31, 2013

Jason A. Helgerson
State Medicaid Director
Deputy Commissioner
Office of Health Insurance Programs
NYS Department of Health
Corning Tower (OCP - 1211)
Albany, NY 12237

Dear Mr. Helgerson:

We have reviewed the proposed amendment to Attachment 4.19-C of your Medicaid State plan submitted under transmittal number (TN) 10-22-B. Effective April 1, 2013, this amendment correctly places the State's policy to cover and pay for reserve beds during an individual's temporary absence from an intermediate care facility for individuals with intellectual disabilities. For a covered absence, the State will pay a facility at the same rate that has been established for an occupied bed.

We conducted our review of your submittal according to the regulatory requirements at 42 CFR 447 Subpart C. This is to inform you that New York 10-22-B is approved effective April 1, 2013, enclosed are the HCFA-179 and the approved plan pages.

If you have any questions, please call Tom Brady at 518-396-3810 or Rob Weaver at 410-786-5914.

Sincerely,

[redacted]

Michael J. Melendez
Associate Regional Administrator
Division of Medicaid & Children's Health Operations

Enclosures

cc: PMossman
KKnuth
IMatthews
RWeaver
TBrady

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

| TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL<br><br>FOR: HEALTH CARE FINANCING ADMINISTRATION | 1. TRANSMITTAL NUMBER:<br>**10-22-B** | 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, 2013** | |

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:<br>**Section 1902(a) of the Social Security Act, and 42 CFR 447** | 7. FEDERAL BUDGET IMPACT:<br>a. FFY **04/01/13-09/30/13 $0**<br>b. FFY **10/01/13-09/30/14 $0** |
|---|---|
| 8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:<br>**Attachment 4.19-C: Page 1(a)** | 9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:<br>**Attachment 4.19-C: Page 1(a)** |

10. SUBJECT OF AMENDMENT:
**Reserved Bed Days– NHs (ICF-MR for state government owned & operated facilities only)**
**(FMAP = 50% based on effective date)**

11. 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:

| [redacted]IAL: | 16. RETURN TO:<br>**New York State Department of Health**<br>**Bureau of HCRA Operations & Financial Analysis**<br>**99 Washington Ave – One Commerce Plaza**<br>**Suite 810**<br>**Albany, NY 12210** |
|---|---|
| 13. TYPED NAME: **Jason A. Helgerson** | |
| 14. TITLE: **Medicaid Director**<br>**Department of Health** | |
| 15. DATE SUBMITTED:<br>**May 31, 2013** | |

**FOR REGIONAL OFFICE USE ONLY**

| 17. DATE RECEIVED: | 18. DATE APPROVED:<br>**May 31, 2013** |
|---|---|

PLAN APPROVED – ONE COPY ATTACHED

| 19. EFFECTIVE DATE OF APPROVED MATERIAL:<br>**April 01, 2013** | [redacted] |
|---|---|
| 21. TYPED NAME:<br>**Michael Melendez** | 22. TITLE: **Associate Regional Administrator**<br>**Division of Medicaid and State Operations** |

23. REMARKS:

FORM HCFA-179 (07-92)

OFFICIAL



**Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) - General**

Absences from all ICF/IIDs, other than for hospitalization, must be provided for in an individual's plan of care.

**State Government Owned and Operated ICF/IID Facilities**

All recipients eligible after 30 days in the facility. There is no limitation on the number of days a resident may be absent.

(i) payments for reserved bed days for ICF/IIDs are paid at the same rate as occupied days.

**All Other [Intermediate Care Facilities for the Mentally Retarded and Specialty Hospitals for the Developmentally Disabled (ICF/MR)] ICF/IIDs [– Non-state Government Owned & Operated Facilities]**

All recipients eligible after 30 days in the facility [, subject to a facility vacancy rate, on the first day of the resident's absence, of no more than 5%. ICF/MR with a bed capacity in excess of 30 beds is exempt from this vacancy rate requirement]. There is no limitation on the number of days a patient/resident may be absent.

(i) payments for reserved bed days for ICF/IIDs are paid at the same rate as occupied days.

**Psychiatric or Rehabilitation Facility Patients (Other than RTFs)**

As provided for recipients receiving similar treatment in general hospitals, as described [above] in the General Hospital Patients section of this Attachment.