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State/Territory Name: **New York**

State Plan Amendment (SPA) #: **11-0086**

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, MD 21244-1850

CENTERS FOR MEDICARE & MEDICAID SERVICES

Financial Management Group

FEB 18 2016

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

RE: TN 11-0086

Dear Commissioner Helgerson:

We have received the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 11-0086. Effective July 1, 2011, this SPA replaces the state's methodology for setting inpatient rates for specialty hospitals certified by the New York Office for People with Developmental Disabilities (OPWDD) with a per-diem fee schedule.

We conducted our review of the submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903(a) and 1923 of the Social Security Act and the regulations at 42 CFR 447 Subpart C. This letter is to inform you that New York 11-0086 is approved effective July 1, 2011. We are enclosing the CMS-179 and the approved plan pages.

If you have any questions, please contact Betsy Pinho at (518) 396-3810 ext. 111.

Sincerely,

[redacted]

Kristin Fan
Director

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 FOR: HEALTH CARE FINANCING ADMINISTRATION	1. TRANSMITTAL NUMBER: **11-0086**	2. STATE **New York**
	3. PROGRAM IDENTIFICATION: **TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)**	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE **July 1, 2011**	

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 **07/01/11-09/30/11 ($.087 million)** b. FFY **10/01/11-09/30/12 ($.346 million)**
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: **Attachment 4.19-A-Part VII: Pages 1,2**	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: **Attachment 4.19-A, Deleted Pages - See Attachment A**

10. SUBJECT OF AMENDMENT:
OPWDD Specialty Hospital Reimbursement
(FMAP = 50% 7/1/11 forward)

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:

12. SIGNATURE OF STATE AGENCY OFFICIAL: [redacted]	16. RETURN TO: **New York State Department of Health** **Division of Finance & Rate Setting** **One Commerce Plaza** **Suite 1460** **Albany, New York 12210**
13. TYPED NAME: **Jason A. Helgerson**	
14. TITLE: **Medicaid Director** **Department of Health**	
15. DATE SUBMITTED: September 30, 2011	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:	18. DATE APPROVED: FEB 18 2016
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: JUL 01 2011	20. SIGNATURE OF REGIONAL OFFICIAL: [redacted]
21. TYPED NAME: [redacted] Kristin Fan	22. TITLE: Director, FMG

23. REMARKS:

FORM HCFA-179 (07-92)

Attachment A

Deleted Pages:

Page 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11,12,13,13a,19,20,20a,21,22,23,24

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Rates for specialty hospital services delivered on and after July 1, 2011 will be determined in accordance with the following described methodology.

(a) "**Specialty hospital**" as used in this Part of this Attachment is the program and site for which OPWDD has issued an operating certificate to operate as a specialty hospital for persons with developmental disabilities. "**Provider**" as used in this Part of this Attachment is the corporation or other organization operating a specialty hospital.

(b) **Unit of service -** The unit of service will be a day.

(c) **Rates** will be as follows:

Rate period	Rate
07/01/2011-12/31/2014	$895.16
01/01/2015-03/31/2015	$898.93
On and after 04/01/2015	$910.94

(d) **Rate appeals** - A provider may appeal for an adjustment to its rate that would result in an annual increase of $5,000 or more in the provider's allowable costs and that is needed because of bed vacancies. A bed vacancy appeal may be requested when the occupancy rate of the specialty hospital is less than 100 percent. The appeal request must be made within one year of the close of the rate period in which the bed vacancies occurred or within six months of the notification to the provider of the rate amount, whichever is later. OPWDD will only grant the appeal if the provider has demonstrated that the vacancies were unavoidable. No amount granted on appeal will result in Medicaid payments exceeding the provider's specialty hospital costs of providing Medicaid services for the rate period.

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(e) Additional Disproportionate Share Payment – Specialty Hospital

Disproportionate share hospital payments under this plan cannot exceed the State disproportionate share allotment calculated in accordance with section 1923(f) of the Social Security Act and cannot exceed the facility specific disproportionate share hospital payment limits at section 1923(g) of the Social Security Act.

Effective October 1, 2014, the State will make disproportionate share hospital (DSH) payments to privately operated specialty hospitals certified by the New York State Office for People With Developmental Disabilities (OPWDD). The annual total aggregate amount of the payment will be $10,000. Currently Terence Cardinal Cooke Health Care Center is the only privately operated specialty hospital certified by the New York State Office for People with Developmental Disabilities (OPWDD). Should additional hospitals qualify for this DSH payment, the total aggregate amount of payment will be distributed proportionately based on each hospital's relative percentage of Medicaid days to total Medicaid days of all hospitals eligible for a payment under this provision.