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State/Territory Name: New York

State Plan Amendment (SPA) #: 18-0048

This file contains the following documents in the order listed:

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

DIVISION OF MEDICAID AND CHILDREN'S HEALTH OPERATIONS

DMCHO: JH:SPA-NY-18-0048-Approval

August 10, 2018

Ms. Donna Frescatore
State Medicaid Director
Office of Health Insurance Programs
NYS Department of Health
One Commerce Plaza, Suite 1211
Albany, NY 12210

Dear Ms. Frescatore:

This is to notify you that New York State Plan Amendment (SPA) #18-0048 has been approved for adoption into the State Medicaid Plan with an effective date of April 1, 2018. This SPA increases Article 16 (OPWDD) clinical staff salaries by 3.25%.

Enclosed are copies of the Plan Page for SPA #18-0048 and the HCFA-179 form, as approved. Pen & Ink changes have been made to Form 179 as instructed by New York.

If you have any questions regarding this amendment, please call Joanne Hounsell at 212.616.2446 or e-mail at Joanne.Hounsell@cms.hhs.gov.

Sincerely,

[redacted]

Michael Melendez, LMSW
Associate Regional Administrator
Division of Medicaid and Children's Health Operations

Enclosures: HCFA-179 Form
State Plan Page

cc:
R. Deyette
P. LaVenia
M. Levesque
J. Yungandreas
R. Weaver
R. Holligan
N. McKnight
M. Tabakov
J. Hounsell
M. Lopez

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: 18-0048	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 April 1, 2018	

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: (in thousands) a. FFY 04/01/18-09/30/18 ~~$ 482.24~~ $492.02 b. FFY 10/01/18-09/30/19 ~~$ 964.48~~ $ 984.04
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-B Pages: 2(t.6)	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: Attachment 4.19-B Pages: 2(t.6)

10. SUBJECT OF AMENDMENT:
Article 16 Clinic 3.25%
(FMAP = 50%)

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 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: JUN 2 7 2018	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:	18. DATE APPROVED: AUGUST 10, 2018

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: APRIL 01, 2018	20. SIGNATURE OF REGIONAL OFFICIAL: [redacted]
21. TYPED NAME: MICHAEL MELENDEZ	22. TITLE: Associate Regional Administrator Division of Medicaid & Children's Health

23. REMARKS:

Pen - Ink changes have been made to Box 7 as authorized by New York State.

FORM HCFA-179 (07-92)

New York
2(t.6)

VI. APG Base Rates for OPWDD certified or operated clinics.

Peer Group	Base Rate	Effective Date of Base Rate
Peer Group A	$180.95	7/1/11
Peer Group B	$186.99	7/1/11
Peer Group C	$270.50	7/1/11
Peer Group A	$182.21	4/1/15
Peer Group B	$189.07	4/1/15
Peer Group C	$272.70	4/1/15
Peer Group A	$182.57	4/1/16
Peer Group B	$189.45	4/1/16
Peer Group C	$273.24	4/1/16
Peer Group A	$184.65	4/1/18
Peer Group B	$192.90	4/1/18
Peer Group C	$276.88	4/1/18