

## **Table of Contents**

**State/Territory Name: New York**

**State Plan Amendment (SPA) #: 18-0048**

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) CMS 179 Form
- 3) Approved SPA Page

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

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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

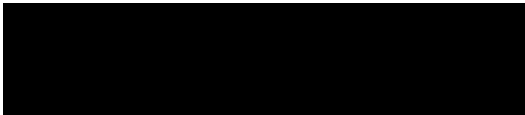
Dear Ms. Frescatore:

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](mailto:Joanne.Hounsell@cms.hhs.gov).

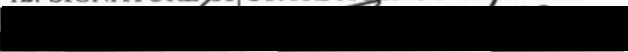

Sincerely,



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

Enclosures: HCFA-179 Form  
State Plan Page

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

<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</b>  <b>FOR: HEALTH CARE FINANCING ADMINISTRATION</b>		1. TRANSMITTAL NUMBER: <b>18-0048</b>	2. STATE <b>New York</b>
		3. PROGRAM IDENTIFICATION: <b>TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)</b>	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE <b>April 1, 2018</b>	
5. TYPE OF PLAN MATERIAL (Check One):  <input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)			
6. FEDERAL STATUTE/REGULATION CITATION: <b>§ 1902(a) of the Social Security Act, and 42 CFR § 447</b>		7. FEDERAL BUDGET IMPACT: (in thousands) a. FFY 04/01/18-09/30/18 <del>\$482.24</del> <b>\$492.02</b> b. FFY 10/01/18-09/30/19 <del>\$964.48</del> <b>\$984.04</b>	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:  <b>Attachment 4.19-B Pages: 2(t.6)</b>		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable):  <b>Attachment 4.19-B Pages: 2(t.6)</b>	
10. SUBJECT OF AMENDMENT: <b>Article 16 Clinic 3.25% (FMAP = 50%)</b>			
11. GOVERNOR'S REVIEW (Check One): <input checked="" type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input type="checkbox"/> OTHER, AS SPECIFIED: <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL			
12. SIGNATURE OF STATE AGENCY OFFICIAL: 		16. RETURN TO: <b>New York State Department of Health Division of Finance &amp; Rate Setting 99 Washington Ave – One Commerce Plaza Suite 1432 Albany, NY 12210</b>	
13. TYPED NAME: <b>Donna Frescatore</b>			
14. TITLE: <b>Medicaid Director Department of Health</b>			
15. DATE SUBMITTED: <b>JUN 27 2018</b>			
<b>FOR REGIONAL OFFICE USE ONLY</b>			
17. DATE RECEIVED:		18. DATE APPROVED: <b>AUGUST 10, 2018</b>	
<b>PLAN APPROVED – ONE COPY ATTACHED</b>			
19. EFFECTIVE DATE OF APPROVED MATERIAL: <b>APRIL 01, 2018</b>		20. SIGNATURE OF REGIONAL OFFICIAL: 	
21. TYPED NAME: <b>MICHAEL MELENDEZ</b>		22. TITLE: <b>Associate Regional Administrator Division of Medicaid &amp; Children's Health</b>	
23. REMARKS:  <i>Pen + Ink changes have been made to Box 7 as authorized by New York State.</i>			

**New York  
2(t.6)**

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

<b>Peer Group</b>	<b>Base Rate</b>	<b>Effective Date of Base Rate</b>
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
<u>Peer Group A</u>	<u>\$184.65</u>	<u>4/1/18</u>
<u>Peer Group B</u>	<u>\$192.90</u>	<u>4/1/18</u>
<u>Peer Group C</u>	<u>\$276.88</u>	<u>4/1/18</u>

TN 18-0048

Approval Date 08/10/2018

Supersedes TN 10-0018

Effective Date 04/01/2018