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State/Territory Name: New York

State Plan Amendment (SPA) #: 15-0014

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, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Financial Management Group

April 16, 2021

Donna Frescatore
Medicaid Director
NYS Department of Health
One Commerce Plaza
Suite 1211
Albany, NY 12210

Reference: TN 15-0014

Dear Ms. Frescatore:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number 15-0014. Effective January 1, 2015, this amendment proposes to add a compensation increase for intermediate care facilities.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), and 1903(a) of the Social Security Act and the implementing Federal regulations at 42 CFR 447 Subpart C.

This letter is to inform you that Medicaid State Plan Amendment NY-15-0014 is approved effective January 1, 2015. The CMS-179 (HCFA-179) and the plan pages are attached.

If you have any additional questions or need further assistance, please contact Novena James-Hailey at 617-565-1291 or Novena.JamesHailey@cms.hhs.gov.

Sincerely,

[redacted]

For
Rory Howe
Acting 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: **15-0014**

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 **January 1, 2015**

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 01/01/15 - 09/30/15 $ ~~3,798.64~~ $3,786.61
b. FFY 10/01/15 –09/30/16 $ ~~5,470.22~~ $5,454.18

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

~~Attachment 4.19-D, Part II: Pages 101, 101.1, 101.2, 101.3~~

Attachment 4.19-D Part I Page 110(d)(30)
Attachment 4.19-D Part II Pages 22, 22(a) 22(b), 23

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

~~Attachment 4.19-D, Part II - Page101~~

Attachment 4.19-D Part II Pages 22, 23

10. SUBJECT OF AMENDMENT:
Intermediate Care Facility (ICF) 2% COLA
(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. [redacted] GENCY OFFICIAL:

13. TYPED NAME: **Jason A. Helgerson**

14. TITLE: **Medicaid Director**
Department of Health

15. DATE SUBMITTED:
MAR 31 2015

16. RETURN TO:
~~New York State Department of Health~~
~~Bureau of Federal Relations & Provider Assessments~~
~~99 Washington Ave – One Commerce Plaza~~
~~Suite 1460~~
~~Albany, NY 12210~~

New York State Department of Health
99 Washington Avenue - OCP -1430
Albany, NY 12210

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
March 31, 2015

18. DATE APPROVED:
4/16/21

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
January 1, 2015

20. [redacted] AL:
For

21. TYPED NAME:
Rory Howe

[redacted] oup

23. REMARKS:
Pen-and-ink changes made to Boxes 7, 8, 9, and 16 per state request.

Per Diem Reduction to all qualified facilities.

(a) Qualified facilities are residential health care facilities other than those facilities or units within facilities that provide extensive nursing, medical, psychological and counseling support services solely to children.

(b) Effective January 1, 2015, all qualified residential health care facilities will be subject to a per diem adjustment that is calculated to reduce Medicaid payments by $24 million for the period January 1, 2015 through March 31, 2015.

Effective January 1, 2015, all qualified residential health care facilities will be subject to a per diem adjustment that is calculated to reduce Medicaid payments by $19 million for each state fiscal year beginning April 1, 2015.

(c) An interim per diem adjustment for each facility will be calculated as follows:

(1) For each such facility, facility Medicaid revenues, calculated by multiplying each facility's promulgated rate in effect for such period by reported Medicaid days as reported in a facility's most recently available cost report, will be divided by total Medicaid revenues of all qualified facilities. The result will be multiplied by the amount of savings identified above for each such fiscal year, and divided by each facility's most recently reported Medicaid days.

(2) Following the close of each fiscal year, the interim per diem adjustment effective January 1, 2015 through March 31, 2015, and April 1, 2015 through March 31, 2016 and in each state fiscal year thereafter will be reconciled using actual Medicaid claims data to determine the actual combined savings from the per diem adjustment and from the reduction in the payment for reserve bed days for hospitalizations from 95% to 50% of the Medicaid rate for such fiscal year. To the extent that such interim savings is greater than or less than $40 million, the per diem adjustment for each eligible provider in effect during such prior fiscal year will be adjusted proportionately such that $40 million in savings is achieved.

iii. If a provider fails to file a cost report (including the capital reimbursement reconciliation schedule) by the due date (including one 30-day extension, if granted by OPWDD), OPWDD will impose a penalty of 2% on the provider's Medicaid reimbursement. For cost reporting periods ending December 31, 2014 and later, if a provider fails to file a cost report (including the capital schedule) by the due date (including one 30 day extension, if granted by OPWDD), OPWDD will impose a penalty of 2% on the provider's Medicaid reimbursement, effective the first day of the sixth month following the end of the cost reporting period. However, OPWDD will not impose such a penalty if it determines that there were unforeseeable circumstances beyond the provider's control (such as a natural disaster) that prevented the provider from filing the cost report by the due date.

If a provider has not filed a complete and compliant annual Consolidated Fiscal Report (CFR) for any CFR reporting period ending between January 1, 2013 and January 1, 2015, the provider will be considered delinquent. The State will give notice to delinquent providers that to avoid the loss of Federal Financial Participation (FFP) effective April 1, 2016, a complete and compliant CFR must be submitted by October 1, 2015. The State will not claim FFP for any ICF/IID Service provided by the delinquent provider after April 1, 2016.

For CFR cost reporting periods beginning July 1, 2014 and thereafter, providers are required to file an annual CFR to the State within 120 days (150 with a requested extension) following the end of the provider's fiscal reporting period.

If a provider fails to file a complete and compliant CFR within 60 days following the imposition of the 2% penalty, the State must provide timely notice to the delinquent provider that FFP will end 240 days following the imposition of the 2% penalty; and the State will not claim FFP for any ICF/IID service provided by the provider with a date of service after the 240 day period.

(11) Trend Factors <u>and Increases to Compensation</u>

i. **<u>Trend Factors</u>**

<u>a.</u> The trend factor used will be the applicable years from the Medical Care Services Index for the period April to April of each year from www.BLS.gov/cpi; Table 1 Consumer Price Index for All Urban Consumers (CPI-U); U.S. city average, by expenditure category and commodity and service group.

[ii.]<u>b.</u> Generally, actual index values will be used for all intervening years between the base period and the rate period. However, because the index value for the last year immediately preceding the current rate period will not be available when the current rate is calculated, an average of the previous five years actual known indexes will be calculated and used as a proxy for that one year.

c. A compounded trend factor will be calculated in order to bring base period costs to the appropriate rate.

ii. **Increases for Providers that Operate ICF/IIDs.**

a. **January 1, 2015 Increase.** Rates for providers that operate ICF/IIDs will be revised to incorporate funding for compensation increases to direct support professional employees. The compensation increase funding will be included in the provider's rate issued for January 1, 2015. The compensation increase funding will include associated fringe benefits.

b. **April 1, 2015 Increase.** In addition to the compensation funding effective January 1, 2015, providers that operate ICF/IIDs will receive a compensation increase targeted to direct support professionals and clinical employees. The compensation increase funding will include associated fringe benefits. The April 1, 2015 direct support professionals' compensation funding will be the same, on an annualized basis, as that which was calculated for the January 1, 2015 compensation increase.

iii. **Calculations.** The basis for the calculation of provider and regional direct support and clinical salary averages and associated fringe benefit percentages will be the data reported on the providers' CFRs for July 1, 2010 through June 30, 2011 for providers reporting on a fiscal year basis or January 1, 2011 through December 31, 2011 for providers reporting on a calendar year basis.

a. The January 1, 2015 and April 1, 2015 Direct Support Professionals' compensation increase funding formula will be as follows:

1. The annual impact of a two percent increase to 2010-11 or 2011 salaried direct support dollars and associated fringe benefits will be calculated.

2. The annual impact of the two percent increase for salaried direct support dollars, and associated fringe will be added to the appropriate operating components in the rate methodology. This will result in a recalculation of provider and regional average direct support wages, provider and regional average employee-related components, provider and regional average program support components, and provider and regional average direct support hourly rates.

3. The provider direct support hourly rate – adjusted for wage equalization factor will be recalculated to utilize the provider average direct support hourly rate and regional average direct support hourly rate, as calculated in subparagraph 2 of this paragraph.

4. An identification will be made of the dollar difference between the provider direct support hourly rate – adjusted for wage equalization factor, which is in the rate in effect on December 31, 2014, and the provider direct support hourly rate – adjusted for wage equalization factor, as calculated in subparagraph 3 of this paragraph.

5. The rate difference identified in subparagraph 4 of this paragraph will be multiplied by the calculated direct support hours in the rate in effect on December 31, 2014 to calculate the additional funding generated by the direct support compensation adjustment.

6. The rate add-on for the compensation increase will be determined by dividing the additional funding, as calculated in subparagraph 5 of this paragraph by the rate sheet units in effect on January 1, 2015 and comports with the State Plan in effect on that date.

b. The April 1, 2015 Clinical compensation increase funding formula will be as follows:

1. The annual impact of a two percent increase to 2010-11 or 2011 salaried clinical dollars and associated fringe benefits will be calculated.

2. The annual impact of the two percent increase for salaried clinical dollars and associated fringe will be added to the appropriate operating components in the rate methodology. This will result in a recalculation of provider and regional average employee-related components, provider and regional average clinical hourly wages.

3. The provider clinical hourly wage – adjusted for wage equalization factor will be recalculated to utilize the provider average clinical hourly wage and regional average clinical hourly wage, as calculated in subparagraph 2 of this paragraph.

4. An identification will be made of the dollar difference between the provider clinical hourly wage – adjusted for wage equalization factor, which is in the rate in effect on December 31, 2014, and the provider clinical hourly wage – adjusted for wage equalization factor, as calculated in subparagraph 3 of this paragraph.

5. The rate difference identified in subparagraph 4 of this paragraph will be multiplied by the provider salaried clinical hours in the rate in effect on December 31, 2014 to calculate the additional funding generated by the clinical compensation adjustment.

6. The rate add-on for the compensation increase will be determined by dividing the additional funding, as calculated in subparagraph 5 of this paragraph by the rate sheet units in effect on January 1, 2015 and comports with the State Plan in effect on that date.

[iii. A compounded trend factor will be calculated in order to bring base period costs to the appropriate rate.]

(12) Transition to New Methodology

i. The reimbursement methodology described in this Attachment will be phased-in over a three-year period, with a year for purposes of the transition period meaning a 12-month period from July 1st to the following June 30th, and with full implementation in the beginning of the fourth year. During this transition period, the base operating rate will transition to the target rate as determined by the reimbursement methodology described in this Attachment, according to the phase-in schedule outlined below. The base operating rate will remain fixed and the target rate, as determined by the reimbursement methodology in this Attachment, will be updated to reflect rebasing of cost data, trend factors and/or other appropriate adjustments.

	Phase-in Percentage	
Transition Year	**Base Operating Rate**	**New Methodology**
Year 1 (July 1, 2014 – June 30, 2015)	75%	25%
Year 2 (July 1, 2015 – June 30, 2016)	50%	50%
Year 3 (July 1, 2016 - June 30, 2017)	25%	75%
Year 4 (July 1, 2017 – June 30, 2018)	0%	100%

ii. Providers will have the opportunity to apply for additional funding in order to help individuals maintain access to services during the current financial transformation, as well as assist providers in achieving the larger transformation agenda of deinstitutionalization. In order for a provider to receive additional funding the following criteria must be met:

(a) Provider must submit a completed application to OPWDD.

(b) Provider must be in a fiscal deficit.

(c) Provider must be in compliance with CFR submission requirements.

iii. DOH and OPWDD will utilize the January 1, 2013 through December 31, 2013 CFR for non-New York City providers and the July 1, 2013 through June 30, 2014 CFR for New York City providers to determine the provider's three year deficit for rate periods July 1, 2014 through June 30, 2015; July 1, 2015 through June 30, 2016; and July 1, 2016 through June 30, 2017.

iv. Providers will be reimbursed 60% of the total deficit over three years beginning with the period July 1, 2014 through June 30, 2015.