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State/Territory Name: New York

State Plan Amendment (SPA) #: NY-18-0012

This file contains the following documents in the order listed:

1) Approval Letter
2) CMS 179 Form/Summary Form (with 179-like data)
3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S3-14-28
Baltimore, Maryland 21244-1850

Financial Management Group

March 13, 2024

Amir Bassiri
State Medicaid Director
New York State Department of Health
99 Washington Ave
One Commerce Plaza, Suite 1432
Albany, NY 12210

RE: State Plan Amendment (SPA) NY-18-0012

Dear Director Bassiri:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State Plan submitted under transmittal number (TN) 18-0012. This State Plan Amendment updates rate schedules to reflect changes in the cost of providing services at certified Developmental Disabilities specialty hospitals.

We conducted our review of your 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 implementing Federal regulations at 42 CFR 447 Subpart C.

This is to inform you that Medicaid State Plan Amendment NY-18-0012 is approved effective January 1, 2018. The CMS-179 and the amended plan pages are attached.

If you have any questions or need further assistance, please contact James Francis at 857-357-6378 or via email at James.Francis@cms.hhs.gov.

Sincerely,

[redacted]

Rory Howe
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: **18-0012**

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, 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)* (whole numbers)

6. FEDERAL STATUTE/REGULATION CITATION: 1905(a)(1) Inpatient Hospital Services
~~§1902(a) of the Social Security Act and 42 CFR 447~~

7. FEDERAL BUDGET IMPACT: ~~(in thousands)~~
a. FFY ~~10/01/17-09/30/18~~ ~~$ 3742.20~~ 01/01/18- 09/30/18 $168,103.00
b. FFY 10/01/18-09/30/19 ~~$ 3793.17~~ 294,499.00

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Part VII Pages:
Attachment 4.19-A: 1, 2, ~~2(a), 2(b), 2(c), 2(d), 2(e), 2(f), 2(g)~~

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Part VII Pages:
Attachment 4.19-A: 1, 2

10. SUBJECT OF AMENDMENT:
OPWDD Specialty Hospital
(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]

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

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

15. DATE SUBMITTED: MAR 29 2018

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

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
March 29, 2018

18. DATE APPROVED:
March 13, 2024

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
January 1, 2018

20. SIGNATURE OF REGIONAL OFFICIAL:
[redacted]

21. TYPED NAME:
Rory Howe

22. TITLE:
Director, Financial Management Group

23. REMARKS: The State authorizes the following pen and ink revisions to the HCFA 179:

Box 6. Federal Statute/ Regulation Citation
1905(a)(1) Inpatient Hospital Services
Box 7. Federal Budget Impact (whole dollars)

a. FFY 01/01/18-09/30/18 $ 168,103.00

b. FFY 10/01/18-09/30/19 $ 294,499.00

Box 8. Page Number of the Plan Section or Attachment

Attachment 4.19-A Part VII Pages: 1, 2

Box 9. Page Number of the Plan Section or Attachment
Attachment 4.19-A Part VII Pages: 1, 2

FORM HCFA-179 (07-92)

New York
1

1905(a)(1) Inpatient Hospital Services

1. Rates for specialty hospitals for 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
04/01/2015-12/31/17	$910.94
01/01/2018-03/31/2018	$919.09
On and After 04/01/2018	$939.32

New York
2

1905(a)(1) Inpatient Hospital Services

(d) **Rate appeals** - A provider will 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 will 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.