

## **Table of Contents**

**State/Territory Name: NY**

**State Plan Amendment (SPA) #: 18-0015**

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**

January 16, 2025

Amir Bassiri  
State Medicaid/CHIP Director  
New York State Department of Health  
99 Washington Ave- One Commerce Plaza, Suite 1605  
Albany, NY 12237

RE: New York 18-0015

Dear Director Bassiri:

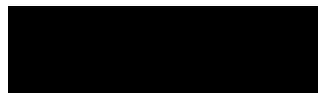
The Centers for Medicare & Medicaid Services (CMS) has reviewed the proposed New York state plan amendment (SPA) to Attachment 4.19-D NY-18-0015, which was submitted to CMS on March 22, 2018. This plan amendment proposes a specified increase of 3.25 percent to reimbursement rates for intermediate care facilities for the intellectually disabled) (ICF/ID).

We reviewed your SPA submission for compliance with statutory requirements, including in sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903 as it relates to the identification of an adequate source for the non-federal share of expenditures under the plan, as required by 1902(a)(2), of the Social Security Act and the applicable implementing Federal regulations.

Based upon the information provided by the state, we have approved the amendment with an effective date of January 1, 2018. We are enclosing the approved CMS-179 and a copy of the new state plan pages.


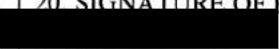
If you have any additional questions or need further assistance, please contact Novena James-Hailey at 617-565-1291 or via email at [Novena.JamesHailey@cms.hhs.gov](mailto:Novena.JamesHailey@cms.hhs.gov).

Sincerely,



Rory Howe  
Director  
Financial Management Group

Enclosures

<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</b>		1. TRANSMITTAL NUMBER: <b>18-0015</b>	2. STATE <b>New York</b>
<b>FOR: HEALTH CARE FINANCING ADMINISTRATION</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>January 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: <del>§1902(a) of the Social Security Act, and 42 CFR 447-</del> <b>1905(a)(15) ICF/IID</b>		7. FEDERAL BUDGET IMPACT: (in thousands) a. FFY 01/01/18-09/30/18 <del>\$ 1845.12</del> <b>3,321,224.50</b> b. FFY 10/01/18-09/30/19 <del>\$ 5503.77</del> <b>5,503,768.00</b>	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: <del>Attachment 4.19-B Pages: 116(a), 116(b)</del> <b>Attachment 4.19-D Pages: 22(a), 22(a.1), 22(b.1), 22(c)</b>		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): <del>Attachment 4.19-B Pages: 116(a), 116(b)</del> <b>Attachment 4.19-D Pages: 22(a), 22(c)</b>	
10. SUBJECT OF AMENDMENT: <del>OPWDD 3.25% ICFDD</del> <b>OPWDD 3.25% ICFIID</b> (FMAP = 50%)			
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: 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: <b>Jason A. Helgerson</b>			
14. TITLE: <b>Medicaid Director Department of Health</b>			
15. DATE SUBMITTED: <b>MAR 22 2018</b>			
<b>FOR REGIONAL OFFICE USE ONLY</b>			
17. DATE RECEIVED: <b>March 22, 2018</b>		18. DATE APPROVED: <b>January 16, 2025</b>	
<b>PLAN APPROVED – ONE COPY ATTACHED</b>			
19. EFFECTIVE DATE OF APPROVED MATERIAL: <b>January 1, 2018</b>		20. SIGNATURE OF REGIONAL OFFICIAL: 	
21. TYPED NAME: <b>Rory Howe</b>		22. TITLE: <b>Director, Financial Management Group</b>	
23. REMARKS: <b>The State authorizes the following pen and ink revisions to the HCFA 179:</b> Box 6. Federal Statute/ Regulation Citation: <b>1905(a)(15) ICF/IID</b> Box 7. Federal Budget Impact: a. FFY 01/01/18-09/30/18 <b>\$3,321,224.50</b> b. FFY 10/01/18-09/30/19 <b>\$5,503,768.00</b> Box 8. Page Number of the Plan Section or Attachment: <b>Attachment 4.19-D Pages: 22(a), 22(a.1), 22(b.1), 22(c)</b> Box 9. Page Number of the Superseding Plan Section or Attachment (If Applicable) : <b>Attachment 4.19-D Pages: 22(a), 22(c)</b> Box 10. Subject of Amendment: <b>OPWDD 3.25% ICFIID</b>			



**New York  
22(a.1)**

**1905(a)(15) ICF/IID**

- 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.

**TN**           #18-0015                **Approval Date**           January 16, 2025            
**Supersedes TN**           NEW                **Effective Date**           January 1, 2018



**New York  
22(c)**

d. Minimum Wage Adjustment - Effective January 1, 2017, and every January 1 thereafter until the minimum wage reaches the state statutorily described per hour wage as shown below, a minimum wage add-on will be developed and applied to all ICF/IID rates.

<b>Minimum Wage Region</b>	<b>31-Dec-16</b>	<b>31-Dec-17</b>	<b>31-Dec-18</b>	<b>31-Dec-19</b>	<b>31-Dec-20</b>	<b>31-Dec-21</b>
New York City	\$11.00	\$13.00	\$15.00	\$15.00	\$15.00	\$15.00
Nassau, Suffolk & Westchester	\$10.00	\$11.00	\$12.00	\$13.00	\$14.00	\$15.00
Remainder of State	\$9.70	\$10.40	\$11.10	\$11.80	\$12.50	\$13.20

The minimum wage adjustment will be developed and implemented as follows:

1. Minimum wage costs will mean the additional costs incurred beginning January 1, 2017 and thereafter, as a result of New York State statutory increases to minimum wages.
2. The 2017 facility specific minimum wage add-on will be developed based on collected survey data received and attested to by ICF/IID providers. If a facility does not submit a survey, the minimum wage add-on will be calculated based on the facility's Consolidated Fiscal Report wage data from the 2014 ICF/IID cost report data. In the subsequent year, the Department will survey providers, utilizing the methodology employed in year one. Once the costs are included in a CFR utilized in a base year, such reimbursement will be excluded from the add-on. If a facility fails to submit both the attested survey and the CFR cost report, the facility's minimum wage add-on will not be calculated.
  - a. Minimum wage cost development based on survey data collected.
    - i. Survey data will be collected for facility specific wage data.
    - ii. Facilities will report by wage bands, the total count of FTEs and total hours paid to all employees (contracted and non-contracted staff) earning less than the statutory minimum wage applicable for each region.
    - iii. Facilities will report an average fringe benefit percentage for the employees directly affected by the minimum wage increase.
    - iv. The minimum wage costs are calculated by multiplying the total hours paid by the difference between the statutory minimum wage and the midpoint of each wage band where the facility has reported total hours paid. To this result, the facility's average fringe benefit percentage is applied and added to the costs.
  - b. Minimum wage cost development based on the CFR cost report data.
    - i. The average hourly wages of employees where the reported average hourly wage is below the regional statutory minimum wage are identified.
    - ii. The total payroll hours of the employees identified are then multiplied by the regional statutory minimum wage resulting in a projected payroll. The actual payroll as reported in the cost report is then subtracted from the projected payroll resulting in the expected wage costs increase.
    - iii. The facility's fringe benefit costs directly affected by the wage increase are identified, and the average fringe benefit percentage is calculated.
    - iv. The fringe benefit percentage is applied to the increased wage costs and added resulting in the minimum wage costs.

**TN**           #18-0015           **Approval Date**           January 16, 2025          

**Supersedes TN**           #17-0015           **Effective Date**           January 1, 2018