

## **Table of Contents**

**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



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**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.

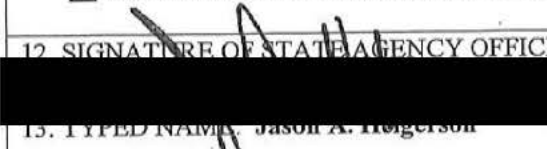
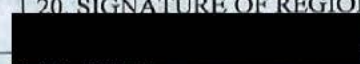
This is to inform you that Medicaid State Plan Amendment NY-18-0012 is approved effective January 1, 2018. The CMS-179 and the amended plan pages are attached.

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](mailto:James.Francis@cms.hhs.gov).

Sincerely,



Rory Howe  
Director

<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</b>		1. TRANSMITTAL NUMBER: <b>18-0012</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) (whole numbers)			
6. FEDERAL STATUTE/REGULATION CITATION: <del>1905(a)(1) Inpatient §1902(a) of the Social Security Act and 42 CFR 447 Hospital Services</del>		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: Attachment 4.19-A: <del>1, 2, 2(a), 2(b), 2(c), 2(d), 2(e), 2(f), 2(g)</del> Part VII Pages:		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Attachment 4.19-A: 1, 2 Part VII Pages:	
10. SUBJECT OF AMENDMENT: <b>OPWDD Specialty Hospital (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>Jason A. Hoegerson</b>			
14. TITLE: <b>Medicaid Director Department of Health</b>			
15. DATE SUBMITTED: <b>MAR 29 2018</b>			
<b>FOR REGIONAL OFFICE USE ONLY</b>			
17. DATE RECEIVED: <b>March 29, 2018</b>		18. DATE APPROVED: <b>March 13, 2024</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 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			

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

TN: #18-0012

Approval Date: March 13, 2024

Superseding TN: #11-0086

Effective Date: January 1, 2018

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.

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