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State/Territory Name: NY

State Plan Amendment (SPA) #: 22-0011

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

April 12, 2024

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

RE: State Plan Amendment (SPA) TN 22-0011

Dear Director Bassiri:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 22-0011. Effective February 1, 2022, this amendment revises Psychiatric Residential Treatment Facility (PRTF) rates to include a twenty-five (25%) rate adjustment to the clinical/direct care component of the rate.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1923 and 1903(a) of the Social Security Act and the implementing Federal regulations at 42 CFR Part 447. This letter is to inform you that New York 22-0011 is approved effective February 1, 2022. The CMS-179 and approved plan pages are enclosed.

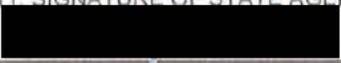
If you have any questions, please contact Novena James-Hailey at (617) 565-1291 or Novena.JamesHailey@cms.hhs.gov.

Sincerely,



Rory Howe
Director

Enclosures

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES		1. TRANSMITTAL NUMBER <u>2 2</u> - <u>0 0 1 1</u>	2. STATE <u>NY</u>
TO: CENTER DIRECTOR CENTERS FOR MEDICAID & CHIP SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES		3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT <input checked="" type="radio"/> XIX <input type="radio"/> XXI	
5. FEDERAL STATUTE/REGULATION CITATION 42 CFR § 447.272(a) § 1905(a)(16) Inpatient Psychiatric Hospital – PRTF		4. PROPOSED EFFECTIVE DATE February 01, 2022	
7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT Attachment 4.19-A Part III Page: 3 Pages: 4, 4.1		6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars) a. FFY <u>02/01/22-09/30/22</u> \$ <u>2,000,000</u> b. FFY <u>10/01/22-09/30/23</u> \$ <u>3,000,000</u>	
9. SUBJECT OF AMENDMENT RTF C/DC Percentage Increase PRTF C/DC Percentage Increase		8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable) Attachment 4.19-A Part III Page: 3 4	
10. GOVERNOR'S REVIEW (Check One) <input checked="" type="radio"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input type="radio"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="radio"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL <input type="radio"/> OTHER, AS SPECIFIED:			
11. SIGNATURE OF STATE AGENCY OFFICIAL 		15. RETURN TO New York State Department of Health Division of Finance and Rate Setting 99 Washington Ave – One Commerce Plaza Suite 1432 Albany, NY 12210	
12. TYPED NAME Brett R. Friedman			
13. TITLE Acting Medicaid Director			
14. DATE SUBMITTED March 31, 2022			
FOR CMS USE ONLY			
16. DATE RECEIVED March 31, 2022		17. DATE APPROVED April 12, 2024	
PLAN APPROVED - ONE COPY ATTACHED			
18. EFFECTIVE DATE OF APPROVED MATERIAL February 1, 2022		19. SIGNATURE OF APPROVING OFFICIAL 	
20. TYPED NAME OF APPROVING OFFICIAL Rory Howe		21. TITLE OF APPROVING OFFICIAL Director, Financial Management Group	
22. REMARKS Pen and ink changes: Box 5. Federal Statute/ Regulation Citation: 1905(a)(16) Inpatient Psychiatric Hospital – PRTF Box 7. Page Number of the Plan Section or Attachment - Page 4, 19-A Part III Page: 4, 4.1 Box 8. Page Number of the Superseded Plan Section or Attachment (if Applicable) -Page 4, 19-A Part III Page: 4 Box 9. Subject of Amendment - PRTF C/DC Percentage Increase			

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1905(a)(16) Inpatient Psychiatric Hospital – PRTF

Allowable operating costs as determined in the preceding paragraphs will be trended by the Medicare inflation factor.

Effective July 01, 2021 through March 31, 2022, operating rates of payment will be increased for a Cost of Living Adjustment (COLA), calculated to support a one percent (1.0%) annual aggregate payment to be paid out over the 9 month period between July 1, 2021 and March 31, 2022, and a one percent (1%) annual increase to be paid out over 12 months in subsequent years until such time as the COLA increase is reflected in the base period cost reports.

Effective on or after February 1, 2022, the C/DC rate component will be adjusted to include a twenty-five percent (25%) increase to include additional funds, not included in the base year, appropriate to maintain the required level of care. This increase will be included until such a time as the increase is reflected in the base period cost reports.

TN **#22-0011**

Approval Date April 12, 2024

Supersedes TN **#21-0045**

Effective Date **February 1, 2022**

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1905(a)(16) Inpatient Psychiatric Hospital – PRTF (Continued)

2. CAPITAL COSTS

To allowable operating costs are added allowable capital costs. Allowable capital costs are determined by the application of principles developed for determining reasonable cost payments under the Medicare program. Allowable capital costs include an allowance for depreciation and interest. To be allowable, capital expenditures which are subject to the Office of Mental Health’s Prior Approval Review (PAR) procedures must be reviewed and approved by the Office of Mental Health.

Transfer of Ownership

In establishing an appropriate allowance for depreciation and for interest on capital indebtedness and (if applicable) a return on equity capital with respect to an asset of a hospital which has undergone a change of ownership, that the valuation of the asset after such change of ownership will be the lesser of the allowable acquisition cost of such asset to the owner of record as of July 18, 1984 (or, in the case of an asset not in existence as of such date, the first owner of record of the asset after such date), or the acquisition cost of such asset to the new owner.

3. APPEALS

The Commissioner will consider requests for rate revisions which are based on errors in the calculation of the rate or based on significant changes in costs resulting from changes in:

- Capital projects approved by the Commissioner in connection with OMH’s PAR procedures.
- OMH approved changes in staffing plans submitted to DOH in a form as determined by the DOH.
- OMH approved changes in capacity approved by the Commissioner in connect with OMH’s PAR procedures;
- Other rate revisions will be based on requirements to meet accreditation standards of the Joint Commission on Accreditation of Hospitals, or other Federal or State mandated requirements resulting in increased costs.

Revised rates will utilize existing facility cost reports, adjusted as necessary. The rates of payment will be subject to total allowable costs, total allowable days, staffing standards as approved by the Commissioner, and a limitation on operating expenses as determined by the Commissioner. These rates must be certified by the Commissioners of OMH and DOH and approved by the Director of the Budget.

TN #22-0011

Approval Date April 12, 2024

Supersedes TN #NEW

Effective Date February 1, 2022