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**State/Territory Name:**                      **New York**

**State Plan Amendment (SPA) #:**      **14-010**

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) CMS 179 Form
- 3) Approved SPA Page



DIVISION OF MEDICAID AND CHILDREN'S HEALTH OPERATIONS

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DMCHO: JH

August 8, 2014

Jason Helgerson  
Deputy Commissioner  
Office of Health Insurance Programs  
New York State Department of Health  
Corning Tower (OCP 1211)  
Empire State Plaza  
Albany, New York 12237

Dear Commissioner Helgerson:

This is to notify you that New York State Plan Amendment (SPA) #14-10 has been approved for adoption into the State Medicaid Plan with an effective date of March 1, 2014. This State Plan Amendment adjusts Medicaid rates of payment for services provided by Certified Home Health Agencies (CHHAs) to address cost increases stemming from wage increases to comply with certain State law provisions. Enclosed are copies of SPA #14-10 and the HCFA- 179 form, as approved.

If you have any questions or wish to discuss this SPA further, please contact Shing Jew at (212) 616-2426 or Joanne Hounsell at (212) 616-2446.

Sincerely,

/s/

Ricardo Holligan  
Acting Associate Regional Administrator  
Division of Medicaid and Children's Health Operations

Enclosures: Form HCFA-179  
State Plan Pages

cc: J. Ulberg  
P. Mossman  
K. Knuth  
I. Matthews  
R. Weaver  
M. Cieslicki  
J. Guhl  
N. McKnight  
S. Jew  
L. Tavener  
M. Lopez  
J. Hounsell

<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</b>  <b>FOR: HEALTH CARE FINANCING ADMINISTRATION</b>		1. TRANSMITTAL NUMBER: <b>14-10</b>	2. STATE <b>New York</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>March 1, 2014</b>	
5. TYPE OF PLAN MATERIAL ( <i>Check One</i> ):  <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 ( <i>Separate Transmittal for each amendment</i> )			
6. FEDERAL STATUTE/REGULATION CITATION: <b>Section 1902(a) of the Social Security Act, and 42 CFR 447</b>		7. FEDERAL BUDGET IMPACT: a. FFY 03/01/14-09/30/14 \$ 8,087,500 b. FFY 10/01/14-09/30/15 \$ 7,975,000	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:  <b>Attachment 4.19-B Page: 4(8)</b>		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT ( <i>If Applicable</i> ):  <b>Attachment 4.19-B Page: 4(8)</b>	
10. SUBJECT OF AMENDMENT: <b>CHHA Fee-for-Service Wage Parity (FMAP = 50%)</b>			
11. GOVERNOR'S REVIEW ( <i>Check One</i> ): <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:  /s/		16. RETURN TO: <b>New York State Department of Health Bureau of Federal Relations &amp; Provider Assessments 99 Washington Ave – One Commerce Plaza Suite 1430 Albany, NY 12210</b>	
13. TYPED NAME: <b>Jason A. Helgeson</b>			
14. TITLE: <b>Medicaid Director Department of Health</b>			
15. DATE SUBMITTED: <b>March 26, 2014</b>			
<b>FOR REGIONAL OFFICE USE ONLY</b>			
17. DATE RECEIVED:		18. DATE APPROVED: <b>AUGUST 08, 2014</b>	
<b>PLAN APPROVED - ONE COPY ATTACHED</b>			
19. EFFECTIVE DATE OF APPROVED MATERIAL: <b>MARCH 01, 2014</b>		20. SIGNATURE OF REGIONAL OFFICIAL:  /s/	
21. TYPED NAME: <b>RICARDO HOLLIGAN</b>		22. TITLE: <b>ACTING, ASSOCIATE REGIONAL ADMINISTRATOR DIVISION OF MEDICAID AND CHILDREN'S HEALTH OPERATIONS</b>	
23. REMARKS:			

**OFFICIAL**

**New York  
4(8)**

For services provided on and after May 1, 2012, please see the website below for detailed information, which includes information related to the following components of payments for 60-day episodes of care including (as posted on March 14, 2012):

- Definition of 60-day episode of care
- Base price
- Resource groups
- Case mix indices
- Outlier thresholds
- Regional wage index factors
- Weighted average rates used to calculate total costs

[www.health.ny.gov/facilities/long\\_term\\_care/reimbursement/chha/index.htm](http://www.health.ny.gov/facilities/long_term_care/reimbursement/chha/index.htm)

For periods on and after March 1, 2014, the Commissioner of Health will increase Medicaid rates of payment for services provided by certified home health agencies (CHHA) to address cost increases stemming from the wage increases required by implementation of the provisions of section 3614-c of the Public Health Law.

The payment increase for CHHA episodic rates will equal the difference between the minimum per hour rate and the weighted average home health aide rate reflected in the 2009 episodic expenditure base. This amount will be further adjusted for accurate application to the episodic bundled payment to insure the adjustment is applied to the estimated home health aide portion of the episodic payment and not to the estimated professional nursing and therapy services portions of the payment. An adjustment is also made to reflect the minimum home health aide rate in the low utilization and outlier components of the rate calculation.

For CHHA non-episodic rates (the payment for qualified individuals under 18 years of age), an add-on will be provided which represents the difference between the home health hourly rate in the current rate and the minimum home health aide hourly rate.

TN #14-10  
Supersedes TN #11-51

Approval Date AUG 08 2014  
Effective Date MAR 01 2014