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State/Territory Name: **New York**

State Plan Amendment (SPA) #: **15-0056**

This file contains the following documents in the order listed:

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, MD 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAIDSERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Financial Management Group

JUN 26 2018

Ms. Donna Frescatore
State Medicaid Director
Office of Health Insurance Programs
NYS Department of Health
One Commerce Plaza, Suite 1211
Albany, NY 12210

RE: TN 15-0056

Dear Ms. Frescatore:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State Plan submitted under transmittal number (TN) 15-0056. Effective July 1, 2015, this amendment provides annual payments of $70 million to be distributed proportionally among all nursing homes to supplement rate year base payments.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30)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 17-0007 is approved effective January 1, 2017. The CMS-179 and approved plan pages are enclosed.

If you have any questions, please contact Betsy Pinho at 518-396-3810.

Sincerely,

[redacted]

Kristin Fan
Director

Enclosures

cc: R. Deyette
M. Levesque
P.LaVenia
R. Holligan
R. Weaver
M. Tabakov
B. Pinho

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: **15-0056**	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 **July 1, 2015**	

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)*

6. FEDERAL STATUTE/REGULATION CITATION: **§1902(a) of the Social Security Act, and 42 CFR 447**	7. FEDERAL BUDGET IMPACT: **(in thousands)** a. **FFY 07/01/15-09/30/15** $ ~~**52.50**~~ /3,125.00 b. **FFY 10/01/15-09/30/16** $ ~~**35.00**~~ 39,375.00
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: **Attachment 4.19-D: Page A** (1)	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: ~~**Attachment 4.19-D: Page A**~~

10. SUBJECT OF AMENDMENT:
~~**Restoration of one-half of the value of the 2% Across the Board Reduction – Effective 7/1/15 (FMAP – 50%)**~~ Nursing Home supplemental payments.

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]	16. RETURN TO: **New York State Department of Health** **Division of Finance and Rate Setting** **99 Washington Ave – One Commerce Plaza** **Suite 1460** **Albany, NY 12210**
13. TYPED NAME: **Jason A. Helgerson**	
14. TITLE: **Medicaid Director** **Department of Health**	
15. DATE SUBMITTED: SEP 2 0 2015	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:	18. DATE APPROVED: JUN 26 2016
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL:	20. SIGNATURE OF REGIONAL OFFICIAL: [redacted]
21. TYPED NAME:	22. TITLE:

23. REMARKS:
New York State authorized pen & ink changes to Boxes 7, 8, 9 & 10.

New York
A(1)

Supplemental Payments

(1) Effective July 1, 2015 and State Fiscal Years thereafter, supplemental payments will be distributed to all nursing home facilities through lump sum or monthly payments and calculated as follows:

a) An individual facility revenue will be calculated by taking each facility's promulgated rate in effect for the given period multiplied by actual Medicaid days for the corresponding period as reported in the facility's cost report or an estimate of Medicaid days based on most recent available data. If a facility fails to submit a timely filed cost report, the most recent cost report will be utilized.

b) The resulting individual facility revenue will be divided by total Medicaid revenues of all facilities. The result will be multiplied by the appropriate total dollar amount to be distributed per the chart below to determine each facility's portion of the supplemental payment.

2) After the end of each State Fiscal Year, a reconciliation of any estimated Medicaid days to actual Medicaid days will be conducted. Any resulting payment adjustments will be made within the 2-year claiming rule.

Supplemental Payment Schedule

State Fiscal Year	Rate Period	Amount in Millions	Distribution
2018-2019	07/01/15 - 12/31/15	$52.5	Lump Sum
2018-2019	01/01/16 - 12/31/16	$70.0	Lump Sum
2018-2019	01/01/17 - 03/31/17	$17.5	Lump Sum
Total		**$140.0**	
2019-2020	04/01/17 - 12/31/17	$52.5	Lump Sum
2019-2020	01/01/18 - 12/31/18	$70.0	Lump Sum
2019-2020	01/01/19 - 03/31/19	$17.5	Lump Sum
Total		**$140.0**	
2020-2021	04/01/19 - 12/31/19	$52.5	Lump Sum
2020-2021	01/01/20 - 03/31/20	$17.5	Lump Sum
2020-2021	04/01/20 - 12/31/20	$52.5	Monthly
2020-2021	01/01/21 - 03/31/21	$17.5	Monthly
Total		**$140.0**	
2021-2022	04/01/21 - 12/31/21	$105.0	Monthly
2021-2022	01/01/22 - 03/31/22	$35.0	Monthly
Total		**$140.00**	
2022-2023 and SFYs thereafter	04/01/22 - 12/31/22	$52.5	Monthly
2022-2023 and SFYs thereafter	01/01/23 - 03/31/23	$17.5	Monthly
Total		**$70.00**	