

**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**

June 21, 2021

Donna Frescatore  
Medicaid Director  
NYS Department of Health  
One Commerce Plaza  
Suite 1211  
Albany, NY 12210

Reference: TN 20-0072

Dear Director Frescatore:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 20-0072. This amendment proposes a nursing facility supplemental payment for full restoration of the alternative methods of cost containment associated with the across the board two percent annual uniform reduction of Medicaid 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 447.

This is to inform you that Medicaid State plan amendment 20-0072 is approved effective November 1, 2020. The CMS-179 and the amended plan page is attached.

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

Sincerely,

[Redacted Signature]

For  
Rory Howe  
Acting Director

Enclosures

**TRANSMITTAL AND NOTICE OF APPROVAL OF  
STATE PLAN MATERIAL  
FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES**

1. TRANSMITTAL NUMBER _____	2. STATE _____
3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
4. PROPOSED EFFECTIVE DATE	

TO: REGIONAL ADMINISTRATOR  
CENTERS FOR MEDICARE & MEDICAID SERVICES  
DEPARTMENT OF HEALTH AND HUMAN SERVICES

5. TYPE OF PLAN MATERIAL (*Check One*)

- NEW STATE PLAN       AMENDMENT TO BE CONSIDERED AS NEW PLAN       AMENDMENT

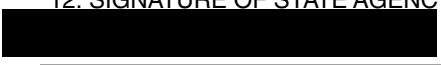
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (*Separate transmittal for each amendment*)

6. FEDERAL STATUTE/REGULATION CITATION	7. FEDERAL BUDGET IMPACT (Amount in Thousands) a. FFY _____ \$ _____ b. FFY _____ \$ _____
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT ( <i>If Applicable</i> )

10. SUBJECT OF AMENDMENT

11. GOVERNOR'S REVIEW (*Check One*)


- GOVERNOR'S OFFICE REPORTED NO COMMENT       OTHER, AS SPECIFIED  
 COMMENTS OF GOVERNOR'S OFFICE ENCLOSED  
 NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

12. SIGNATURE OF STATE AGENCY OFFICIAL 	16. RETURN TO
13. TYPED NAME	
14. TITLE	
15. DATE SUBMITTED December 30, 2020	

**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED December 30, 2020	18. DATE APPROVED 06/21/21
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**PLAN APPROVED - ONE COPY ATTACHED**

19. EFFECTIVE DATE OF APPROVED MATERIAL November 1, 2020	20. SIGNATURE OF REGIONAL OFFICIAL 
21. TYPED NAME Rory Howe	22. TITLE Acting Director, Financial Management Group

23. REMARKS

**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
<b>Total</b>		<b>\$140.0</b>	
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
<b>Total</b>		<b>\$140.0</b>	
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] 10/31/20	[\$52.5] \$40.8	[Monthly] Lump Sum
2020-2021	11/1/20 - 12/31/20	\$64.2	Lump Sum
2020-2021	01/01/21 - 03/31/21	[\$17.5] \$35.0	[Monthly] Lump Sum
<b>Total</b>		<b>[\$140.0] \$210.0</b>	
2021-2022	04/01/21 - 12/31/21	[\$105.0] \$157.5	[Monthly] Lump Sum
2021-2022	01/01/22 - 03/31/22	[\$35.0] \$52.5	[Monthly] Lump Sum
<b>Total</b>		<b>[\$140.00] \$210.0</b>	
2022-2023 and SFYs thereafter	04/01/22 - 12/31/22	[\$52.5] \$105.0	[Monthly] Lump Sum
2022-2023 and SFYs thereafter	01/01/23 - 03/31/23	[\$17.5] \$35.0	[Monthly] Lump Sum
<b>Total</b>		<b>[\$70.00] \$140.0</b>	

TN   #20-0072    
Supersedes TN   #15-0056  

Approval Date   June 21, 2021    
Effective Date   November 1, 2020