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State/Territory Name: New York

State Plan Amendment (SPA) #: 18-0047

This file contains the following documents in the order listed:

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

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
New York Regional Office
26 Federal Plaza, Room 37-100
New York, NY 10278



DIVISION OF MEDICAID AND CHILDREN'S HEALTH OPERATIONS

DMCHO: JH:SPA-NY-18-0047-Approval

August 10, 2018

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

Dear Ms. Frescatore:

This is to notify you that New York State Plan Amendment (SPA) #18-0047 has been approved for adoption into the State Medicaid Plan with an effective date of May 10, 2018. This SPA provides for temporary rate adjustments to Medicaid rates for the North Country Homes as an eligible Licensed Home Care Agency that has been subject to or impacted by the closure, merger, consolidation, acquisition or restructuring.

Enclosed are copies of the Plan Page for SPA #18-0047 and the HCFA-179 form, as approved.

If you have any questions regarding this amendment, please call Joanne Hounsell at 212.616.2446 or e-mail at Joanne.Hounsell@cms.hhs.gov.



Sincerely,

[Redacted signature]

Michael Melendez, LMSW
Associate Regional Administrator
Division of Medicaid and Children's Health Operations

Enclosures: HCFA-179 Form
State Plan Page

cc:	R. Deyette	R. Holligan
	P. LaVenía	N. McKnight
	M. Levesque	M. Tabakov
	J. Yungandreas	J. Hounsell
	R. Weaver	M. Lopez

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: HEALTH CARE FINANCING ADMINISTRATION		1. TRANSMITTAL NUMBER: 18-0047	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 May 10, 2018	
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: § 1902(a) of the Social Security Act and 42 CFR 447		7. FEDERAL BUDGET IMPACT: (<i>in thousands</i>) a. FFY 05/10/18-09/30/18 \$ 331.27 b. FFY 10/01/18-03/31/19 \$ 418.73	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-B: 4(10)		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (<i>If Applicable</i>): Attachment 4.19-B: 4(10)	
10. SUBJECT OF AMENDMENT: North Country Homes (LHCSA-Safety Net/VAP) (FMAP = 50%)			
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: 		16. 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	
13. TYPED NAME: <i>Donna Prescote</i>			
14. TITLE: Medicaid Director Department of Health			
15. DATE SUBMITTED: JUN 22 2018			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED:		18. DATE APPROVED: AUGUST 10, 2018	
PLAN APPROVED – ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: MAY 10, 2018		20. SIGNATURE OF REGIONAL OFFICIAL: 	
21. TYPED NAME: MICHAEL MELENDEZ		22. TITLE: strator Division of Medicaid & Children's Health	
23. REMARKS:			

**New York
4(10)**

Temporary Rate Adjustments for Mergers, Acquisitions, Consolidations, Restructurings, and Closures – Licensed Home Care Services Agencies (LHCSA)

A temporary rate adjustment will be provided to eligible LHCSA providers that are subject to or impacted by the closure, merger, and acquisition, consolidation or restructuring of a health care provider. The rate adjustment is intended to:

- Protect or enhance access to care;
- Protect or enhance quality of care; or
- Improve the cost effectiveness.

Eligible LHCSA providers, the annual amount of the temporary rate adjustment, and the duration of the adjustment shall be listed in the table which follows. The total annual adjustment amount will be paid quarterly with the amount of each quarterly payment being [equal to one fourth of] equally divided for the total annual amount established for each provider. The quarterly payment made under this section will be an add-on to services payments made under this Attachment to such facilities during the quarter.

To remain eligible, providers must submit benchmarks and goals acceptable to the Commissioner and must submit periodic reports, as requested by the Commissioner, concerning the achievement of such benchmarks and goals. Failure to achieve satisfactory progress in accomplishing such benchmarks and goals will result in termination of the provider's temporary rate adjustment prior to the end of the specified timeframe. Once a provider's temporary rate adjustment ends, the provider will be reimbursed in accordance with the otherwise applicable rate-setting methodology as set forth in this Attachment.

Temporary rate adjustments have been approved for the following providers in the amounts and for the effective periods listed.

Licensed Home Care Services Agencies:

Provider Name	Gross Medicaid Rate Adjustment	Rate Period Effective
North Country Homes	\$1,045,000	02/01/2016 – 3/31/2016
	\$1,621,300	04/01/2016 – 3/31/2017
	\$ 46,200	04/01/2017 – 3/31/2018
	\$ 450,000	07/01/2017 – 03/31/2018
	\$1,500,000	05/10/2018 – 03/31/2019

TN #18-0047

Approval Date 08/10/2018

Supersedes TN #17-0051

Effective Date 05/10/2018