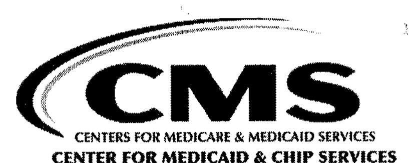
DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850



Center for Medicaid and CHIP Services (CMCS)

Jason A. Helgerson
State Medicaid Director
Deputy Commissioner
Office of Health Insurance Programs
NYS Department of Health
Empire State Plaza
Corning Tower (OCP - 1211)
Albany, NY 12237

SEP 26 2012

RE: TN 12-20

Dear Mr. Helgerson:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 12-20. Effective July 1, 2012 this amendment proposes that the capital cost component of the rate for eligible residential health care facilities shall be adjusted to reflect Medicaid's share of the costs of the annual debt service related to the financing of an automatic sprinkler system that will be in compliance with new federal regulations.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13)(A), 1902(a)(30) and 1903(a) of the Social Security Act and the regulations at 42 CFR 447 Subpart C. This is to inform you that New York (TN) 12-20 is approved effective July 1, 2012. The CMS-179 and the approved plan pages are enclosed.

If you have any questions, please contact Tom Brady at 518-396-3810.

Sincerely,

Cindy Mann
Director, CMCS

Enclosures

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: **12-20**

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, 2012**

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:
Section 1902(a) of the Social Security Act, and 42 CFR 447

7. FEDERAL BUDGET IMPACT:
a. FFY 10/01/11 – 09/30/12 $2,125,000
b. FFY 10/01/12 – 09/30/13 $8,500,000

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-D: Pages 88(e) and 88(f)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

10. SUBJECT OF AMENDMENT:
Nursing Home Sprinklers
(FMAP = 50%)

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: [signature]

13. TYPED NAME: **Jason A. Helgerson**

14. TITLE: **Medicaid Director & Deputy Commissioner**
Department of Health

15. DATE SUBMITTED: JUN 28 2012

16. RETURN TO:
New York State Department of Health
Corning Tower
Empire State Plaza
Albany, New York 12237

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED: SEP 26 2012

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: JUL - 1 2012

20. SIGNATURE OF REGIONAL OFFICIAL: [signature]

21. TYPED NAME: Penny Thompson

22. TITLE: Deputy Director, CMCS

23. REMARKS:

FORM HCFA-179 (07-92)

(k) Effective July 1, 2012, the capital cost component of the rate for eligible residential health care facilities will be adjusted to reflect the costs of the annual debt service related to the financing of equipment and other capital improvements directly related to the financing of an automatic sprinkler system that will be in compliance with the federal regulations set forth in 42 CFR 483.70(a)(8). Facilities that submit a request to the Commissioner and meet at least three of the following criteria, using financial information obtained from the facility's latest cost report and more recent financial information provided by the facility, shall be eligible for such capital rate adjustment:

- (i) Operating losses;
- (ii) Negative unrestricted fund balances;
- (iii) Documentation demonstrating the inability of the facility to obtain credit, at current market rates, without the reimbursement treatment accorded pursuant to this section ;
- (iv) Negative working capital;
- (v) Less than 30 days of cash expense on hand;
- (vi) More than 30 days of revenue in accounts receivable;
- (vii) Cash flow statements and budget projections demonstrating material deterioration in fiscal stability of facility.

Eligible facilities will also be required to:

1) File the required certificate of need information with the Department of Health and obtain any required certificate of need approvals.

2) Provide information documenting the costs of the sprinkler project and that such costs are necessary to achieve compliance with the federal regulations set forth in 42 CFR 483.70(a)(8).

3) Submit to the Commissioner, for review and approval, a schedule setting forth by month the estimated debt service payable over the life of the financing. Such schedule will be provided to the Commissioner at least 60 days prior to the due date of the first debt service payment (or such shorter timeframe as the Commissioner may authorize).

4) Deposit into a separate account maintained by the facility, Medicaid revenues attributable to the capital rate adjustments for such sprinklers and any other additional facility revenues needed to cover the scheduled debt service payments attributable to such sprinklers. All such deposits in such account may only be used solely for the purpose of satisfying such debt service payments.