## Table of Contents

**State/Territory Name: New York**

**State Plan Amendment (SPA) #: 13-0071A**

This file contains the following documents in the order listed:

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

August 26, 2015

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) #13-0071A has been approved for adoption into the State Medicaid Plan with an effective date of January 1, 2014. This State Plan Amendment provides a temporary rate adjustment under New York's VAP program to Medicaid fee for service rates for certain Certified Home Health Agencies. Enclosed are copies of SPA #13-0071A 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: HCFA-179 Form
State Plan Page

cc: J. Ulberg
K. Knuth
R. Gallagher
M. Ryan
M. Melendez
R. Weaver
S. Jew
J. Hounsell
M. Lopez

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<br><br>FOR: HEALTH CARE FINANCING ADMINISTRATION | 1. TRANSMITTAL NUMBER: **13-0071A** | 2. STATE<br>**New York** |
|---|---|---|
| | 3. PROGRAM IDENTIFICATION: **TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)** | |
| TO: REGIONAL ADMINISTRATOR<br>HEALTH CARE FINANCING ADMINISTRATION<br>DEPARTMENT OF HEALTH AND HUMAN SERVICES | 4. PROPOSED EFFECTIVE DATE<br>**January 1, 2014** | |

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:<br>**§ 1902(a) of the Social Security Act, and 42 CFR 447** | 7. FEDERAL BUDGET IMPACT: **(in thousands)**<br>**a. FFY 01/01/14-09/30/14 $ 94.96**<br>**b. FFY 10/01/14-09/30/15 $126.61** |
|---|---|
| 8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:<br>**Attachment 4.19-B: Page 4(9)** | 9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:<br>**Attachment 4.19-B: Page 4(9)** |

10. SUBJECT OF AMENDMENT:
**Safety Net/VAP – CHHA – Phase 2 (Jefferson County)**
**(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:<br>[redacted] | 16. RETURN TO:<br>**New York State Department of Health**<br>**Division of Finance and Rate Setting**<br>**99 Washington Ave – One Commerce Plaza**<br>**Suite 1460**<br>**Albany, NY 12210** |
|---|---|
| 13. TYPED NAME: **Jason A. Helgerson** | |
| 14. TITLE: **Medicaid Director**<br>**Department of Health** | |
| 15. DATE SUBMITTED: FEB 11 2014 | |

**FOR REGIONAL OFFICE USE ONLY**

| 17. DATE RECEIVED: | 18. DATE APPROVED:<br>August 26, 2015 |
|---|---|
| PLAN APPROVED – ONE COPY ATTACHED | |
| 19. EFFECTIVE DATE OF APPROVED MATERIAL:<br>January 01, 2014 | 20. SIGNATURE OF REGIONAL OFFICIAL:<br>[redacted] |
| 21. TYPED NAME:<br>Ricardo Holligan | 22. TITLE:<br>Division of Medicaid & Children's Health Operations |

23. REMARKS:

FORM HCFA-179 (07-92)

New York
4(9)

**Temporary Rate Adjustments for Mergers, Acquisitions, Consolidations, Restructurings, and Closures – Certified Home Health Agencies (CHHAs)**

A temporary rate adjustment will be provided to eligible CHHA 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 CHHA 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 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.

**Certified Home Health Agencies:**

| Provider Name | Gross Medicaid Rate Adjustment | Rate Period Effective |
|---|---|---|
| Visiting Nurse Association of Long Island, Inc. | $168,006 | 01/01/2014 – 03/31/2014 |
| | $672,020 | 04/01/2014 – 03/31/2015 |
| | $672,020 | 04/01/2015 – 06/30/2015 |
| | | |
| Jefferson County Public Health Service | $63,306 | 01/01/2014 – 03/31/2014 |
| | $253,222 | 04/01/2014 – 03/31/2015 |
| | $253,222 | 04/01/2015 – 03/31/2016 |
| | $189,916 | 04/01/2016 – 12/31/2016 |
| | | |