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State/Territory Name: **New York**

State Plan Amendment (SPA) #: **16-0013**

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) CMS 179
- 3) Approved SPA Pages

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

August 24, 2016

Jason Helgeson
Deputy Commissioner
Office of Health Insurance Programs
New York State Department of Health
Corning Tower (OCP-1211)
Albany, New York 12237
RE: New York 15-0038

Dear Mr. Helgeson:

We have reviewed the proposal for temporary adjustments to Medicaid rates for eligible Licensed Home Care Agencies. The SPA, TN 16-0013, was submitted to Centers for Medicare & Medicaid Services New York Regional Office on February 22, 2016. Effective February 1, 2016, this SPA aims to provide North Country Homes with temporary adjustments to Medicaid rates as an eligible Licensed Home Care Agency that has been subject to or impacted by the closure, merger, consolidation, acquisition or restructuring of a health care provider.

Based on the information provided, the Medicaid SPA 16-0013 is approved. We are enclosing the approved Form CMS-179 and the Medicaid state plan pages.

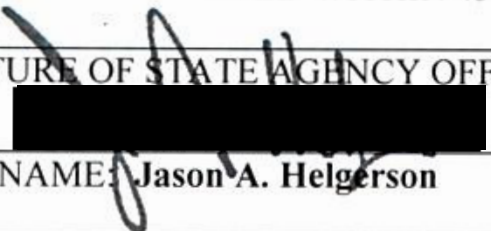
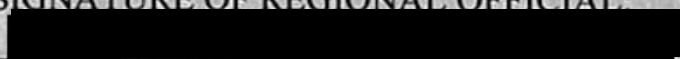
If you have any additional questions or need further assistance, please contact Erica Kisiday at (212) 616-2483.

Sincerely,

A black rectangular redaction box covering the signature area of the letter.

Ricardo Holligan
Acting Associate Regional Administrator
Division of Medicaid and Children's Health Operations

Enclosures

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: HEALTH CARE FINANCING ADMINISTRATION		1. TRANSMITTAL NUMBER: 16-0013	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 February 1, 2016	
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 02/01/16-09/30/16 \$927.83 b. FFY 10/01/16-09/30/17 \$416.88	
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>):	
10. SUBJECT OF AMENDMENT: Note: the period is 02/01/16-03/31/16 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 1460 Albany, NY 12210	
13. TYPED NAME: Jason A. Helgerson			
14. TITLE: Medicaid Director Department of Health			
15. DATE SUBMITTED: FEB 22 2016			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED:		18. DATE APPROVED: AUGUST 24, 2016	
PLAN APPROVED – ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: FEBRUARY 01, 2016		20. SIGNATURE OF REGIONAL OFFICIAL: 	
21. TYPED NAME: RICARDO HOLLIGAN		22. TITLE: ACTING ASSOCIATE REGIONAL ADMINISTRATOR DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS	
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 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:

<u>Provider Name</u>	<u>Gross Medicaid Rate Adjustment</u>	<u>Rate Period Effective</u>
<u>North Country Homes</u>	<u>\$1,045,000</u>	<u>02/01/2016 – 3/31/2016</u>
	<u>\$1,621,300</u>	<u>04/01/2016 – 3/31/2017</u>
	<u>\$ 46,200</u>	<u>04/01/2017 – 3/31/2018</u>

TN #16-0013

Approval Date AUGUST 24, 2016

Supersedes TN NEW

Effective Date FEBRUARY 01, 2016