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, CHIP, and Survey & Certification

MAY - 6 2011

Jason Helgerson
Deputy Commissioner
New York State Department of Health
Corning Tower
Empire State Plaza
Albany, New York 12237

RE: TN 09-50

Dear Mr. Helgerson:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 09-050. This amendment provides for an annual $210 million rate increase related to rebasing for nursing facility services furnished between May 1, 2009 and March 31, 2012.

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 regulations at 42 CFR 447 Subpart C. New York State plan amendment 09-050 is approved effective May 1, 2009. We have enclosed the HCFA-179 and the approved plan pages.

If you have any questions, please contact Tom Brady at 518-396-3810 or Rob Weaver at 410-786-5914.

Sincerely,

[redacted]

Cindy Mann
Director, CMCS

Enclosures

(l) For the rate period May 1, 2009 through March 31, 2010, adjustments to the rates of payment resulting from the rebase to 2002 reported base year costs, including initial adjustments for case mix, shall be held to an aggregate increase of $210 million. If the total adjustments are more or less than $210 million, proportional adjustments to the rates shall be made as necessary to result in an increase in aggregate expenditures of $210 million. Such proportional adjustments shall be based on each facility's proportionate share of total spending from the April 1, 2009 rates that reflect the impact of rebasing and Medicaid only case mix. The rate adjustment required to adjust spending to the required $210 million amount will be reflected as the "scale back adjustment" in the rates effective May 1, 2009 through March 31, 2010. The operating component of such rates shall not be subject to the update adjustments for case mix as otherwise scheduled for January of 2010.

For the annual periods April 1, 2010 through March 31, 2012, if adjustments to the rates of payment prior to the adjustment for inflation results in an increase in total payments for such services on an annual basis, such rates shall be further adjusted proportionally as is necessary to reduce the aggregate increase to no greater than the proportionally adjusted aggregate for the period April 1, 2009 through March 31, 2010. Proportional adjustments made to rates within the aggregate expenditure limit shall not be subject to subsequent correction or reconciliation.

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: **09-50**

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 1, 2009**

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 Subpart C

7. FEDERAL BUDGET IMPACT:
a. FFY **5/01/09-9/30/09 $ 61.7 million**
b. FFY **10/01/09-9/30/10 $ 123.4 million**

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-D, page 50(h)

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

10. SUBJECT OF AMENDMENT:
Nursing Home $210 Million Rebase Payment
(FMAP = 58.78% as of effective date)

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:

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

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

15. DATE SUBMITTED: April 13, 2011

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: 05-06-11

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: MAY - 1 2009

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: William Lasowski

22. TITLE: Deputy Director, CMCS

23. REMARKS:

FORM HCFA-179 (07-92)