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

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

**Center for Medicaid, CHIP, and Survey & Certification**

Donna Frescatore
Deputy Commissioner
New York State Department of Health
Corning Tower
Empire State Plaza
Albany, New York 12237

DEC 17 2010

RE: TN 10-29

Dear Ms. Frescatore:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 10-29. Effective August 1, 2010, this SPA increases the maximum number of nursing home beds that providers may voluntarily decertify on a temporary or permanent basis from 2,500 beds to 5,000 beds statewide.

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. This is to inform you that New York 10-29 is approved effective August 1, 2010 and enclosed is 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

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: **10-29** | 2. STATE **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>**August 1, 2010** | |

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>**Section 1902(a) of the Social Security Act, and 42 CFR 447** | 7. FEDERAL BUDGET IMPACT:<br>a. FFY **08/01/10-09/30/10** **$0**<br>b. FFY **10/01/10-09/30/11** **$0** |
|---|---|
| 8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:<br>**Attachment 4.19-D: Page 16** | 9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:<br>**Attachment 4.19-D: Page 16** |

10. SUBJECT OF AMENDMENT:
**NH Bed Rightsizing Program**
**(FMAP = 61.59% based on 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. SIGN[redacted] | 16. RETURN TO:<br>**New York State Department of Health**<br>**Corning Tower**<br>**Empire State Plaza**<br>**Albany, New York 12237** |
|---|---|
| 13. TYPED NAME: **Donna Frescatore** | |
| 14. TITLE: **Medicaid Director & Deputy Commissioner Department of Health** | |
| 15. DATE SUBMITTED: **SEP 30 2010** | |

**FOR REGIONAL OFFICE USE ONLY**

| 17. DATE RECEIVED: | 18. DATE APPROVED: 12-17-10 |
|---|---|
| PLAN APPROVED – ONE COPY ATTACHED | |
| 19. EFFECTIVE DATE OF APPROVED MATERIAL: AUG - 1 2010 | 20. [redacted] |
| 21. TYPED NAME: William Lasowski | 22. Deputy Director, CMCS |

23. REMARKS:

FORM HCFA-179 (07-92)

**Attachment 4.19-D**
**Part 1**
**(07/10)**

The voluntary health care facility right-sizing program is intended to address excess capacity in residential health care facilities. Under this program, a residential health care facility may apply to temporarily decertify, or permanently convert, a portion of its existing certified beds to another level of care. The Commissioner of Health may approve temporary decertification and permanent bed conversions, which total no more than [2,500] 5,000 residential health care beds on a statewide basis.

A residential health care facility may temporarily decertify beds for up to five years. Temporarily decertified beds will remain on the facility's license during and after the five-year period.

The following adjustments to the calculation of Medicaid rates of payment for residential health care centers will be made for facilities that have temporarily decertified beds under this program:

- Capital cost reimbursement will be adjusted to reflect the new bed capacity;
- The facility's peer group assignment for indirect cost reimbursement will be based upon total certified beds less the number of temporarily decertified beds; and
- The facility's vacancy rate, for the purpose of determining eligibility for reserved bed day payments, will be calculated on the basis of the facility's total certified beds less the number of temporarily decertified beds. Payments for reserved bed days for facilities that have temporarily decertified beds will be in an amount that is fifty percent of the otherwise applicable payment amount for such beds.