

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 State Operations**

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Jason A. Helgerson  
State Medicaid Director  
Deputy Commissioner  
Office of Health Insurance Programs  
NYS Department of Health  
Empire State Plaza  
Corning Tower, Room 1466  
Albany, NY 12237

**AUG 26 2011**

RE: TN 10-45

Dear Mr. Helgerson

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 10-45. Effective December 2, 2010 this amendment proposes to provide for temporary rates increases for Inpatient Hospital services where the facilities complete a merger, acquisition, or consolidation.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2) 1902(a)(13), 1902(a)(30), 1903(a) and 1923 of the Social Security Act and the regulations at 42 CFR 447 Subpart C. This is to inform you that New York 10-45 is approved effective December 2, 2010 and I 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,

A solid black rectangular box redacting the signature of the sender.

Cindy Mann  
Director  
Center for Medicaid, CHIP, and Survey & Certification

Enclosures

<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</b>		1. TRANSMITTAL NUMBER: <b>10-45</b>	2. STATE <b>NY</b>
<b>FOR: HEALTH CARE FINANCING ADMINISTRATION</b>		3. PROGRAM IDENTIFICATION: <b>TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)</b>	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE <b>December 2, 2010</b>	
5. TYPE OF PLAN MATERIAL (Check One):  <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 (Separate Transmittal for each amendment)			
6. FEDERAL STATUTE/REGULATION CITATION: <b>Part 86-1.31</b>		7. FEDERAL BUDGET IMPACT: a. FFY <b>12/2/10 – 9/30/11</b> <b>\$3,628,218</b> b. FFY <b>10/1/11 – 9/30/12</b> <b>\$3,900,000</b>	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: <b>Attachment 4.19-A pages 136 and 136(a)</b>		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): <b>Attachment 4.19-A pages 136 and 136(a)</b>	
10. SUBJECT OF AMENDMENT: <b>Amending the requirements in order for a hospital to receive a temporary rate adjustment in the case of a merger, acquisition or consolidation.</b>			
11. GOVERNOR'S REVIEW (Check One): <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:  <b>New York State Department of Health Corning Tower Empire State Plaza Albany, New York 12237</b>	
13. TYPED NAME: <b>Donna Frescatore</b>			
14. TITLE: <b>Medicaid Director &amp; Deputy Commissioner Department of Health</b>			
15. DATE SUBMITTED: <b>December 31, 2010</b>			
<b>FOR REGIONAL OFFICE USE ONLY</b>			
17. DATE RECEIVED:		18. DATE APPROVED: <b>AUG 26 2011</b>	
<b>PLAN APPROVED – ONE COPY ATTACHED</b>			
19. EFFECTIVE DATE OF APPROVED MATERIAL: <b>DEC - 2 2010</b>		20. OFFICIAL: 	
21. TYPED NAME: <b>Penny Thompson</b>		22. TITLE: <b>Deputy Director, CMCS</b>	
23. REMARKS:			

**Mergers, acquisitions and consolidations.**

1. *Rates of Payment.* As used in this Section, the terms merger, acquisition and consolidation shall mean the combining of two or more general hospitals where such combination is consistent with the public need, would create a new, more economical entity, reduce the costs of operation, result in the reduction of beds and/or improve service delivery and approved through the Department's Certificate of Need process. Payments for hospitals subject to a merger, acquisition or consolidation for inpatient acute care services that are not otherwise exempt from DRG case-based rates of payment will be effective on the date the transaction is effected and shall be computed in accordance with this Section except as follows:
  - a. The WEF used to adjust the statewide base price shall be calculated by combining all components used in the calculation pursuant to the WEF Section for all hospitals subject to the merger, acquisition or consolidation.
  - b. The direct GME payment per discharge added to the case payment rates of teaching hospitals shall be calculated by dividing the total reported Medicaid direct GME costs for all teaching hospitals subject to the merger, acquisition, or consolidation by the total reported Medicaid discharges reported by such hospitals in the applicable base period.
  - c. The indirect GME payment per discharge added to the case payment rates of teaching hospitals shall be calculated in accordance with the Add-ons to the Case Payment Rate Per Discharge Section, except the ratio of residents to beds used in the calculation shall be based on the total residents and beds of all such hospitals subject to the merger, acquisition, or consolidation.
  - d. The non-comparable payment per discharge added to the case payment rates shall be calculated by dividing the total reported Medicaid costs for qualifying non-comparable cost categories for all hospitals subject to the merger, acquisition, or consolidation by the total reported Medicaid discharges reported by such hospitals in the applicable base period.
2. *Temporary rate adjustment.*
  - a. The Commissioner may grant approval of a temporary adjustment to rates calculated pursuant to this Section for hospitals [subject to] that complete a merger[s], acquisition[s] or consolidation[s] occurring on or after the year the rate is based upon,] provided such hospitals demonstrate through submission of a written proposal that the merger, acquisition or consolidation will result in an improvement to (i) cost effectiveness of service delivery, (ii) quality of care, and (iii) [other] factors deemed appropriate by the Commissioner. Such written proposal shall be submitted to the Department sixty days prior to the requested effective date of the temporary rate adjustment. The temporary rate adjustment shall be in effect for no longer than such time as base year costs are updated for the development of these temporary rates or such time as statewide base year costs are updated for the development of rates,

TN #10-45

Approval Date AUG 26 2011

Supersedes TN #09-34

Effective Date DEC - 2 2010

**New York  
136(a)**

**Attachment 4.19-A  
(12/10)**

whichever is earlier, and shall consist of the various operating rate components of the surviving entity.[consist of the various rate components of the surviving entity for a specified amount of time as approved by the Commissioner]. At the end of the specified timeframe, the hospital will be reimbursed in accordance with the statewide methodology set forth in this Attachment. The Commissioner may establish, as a condition of receiving such a temporary rate adjustment, benchmarks and goals to be achieved as a result of the ongoing consolidation efforts and may also require that the hospital submit such periodic reports concerning the achievement of such benchmarks and goals as the Commissioner deems necessary. Failure to achieve satisfactory progress, as determined by the Commissioner, in accomplishing such benchmarks and goals shall be a basis for ending the hospital's temporary rate adjustment prior to the end of the specified timeframe.

- b. The Commissioner shall withdraw approval of a temporary rate adjustment for hospitals which (i) fail to demonstrate compliance with and continual improvement on the approved proposal or (ii) an update to the base year is made by the Department.

TN   #10-45  

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