

**FILE COPY**

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**

---

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

**SEP 28 2011**

RE: TN 11-049

Dear Mr. Helgerson

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 11-049. Effective April 1, 2011 this amendment proposes to reduce out of state Nursing Facility (NF) rates by 2% through March 31, 2013, and for in-State NFs both eliminate the return on equity for the capital portion of NF rates and reduce the return of equity for NF rates through 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. This is to inform you that New York 11-049 is approved effective April 1, 2011. 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,

A large black rectangular redaction box covering the signature of the sender.

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

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
HEALTH CARE FINANCING ADMINISTRATION

<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</b>		1. TRANSMITTAL NUMBER: <b>#11-49</b>	2. STATE <b>New York</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>April 1, 2011</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>Section 1902(a) of the Social Security Act, and 42 CFR 447</b>		7. FEDERAL BUDGET IMPACT: a. FFY 04/1/11 - 9/30/11 (\$9,645,920) b. FFY 10/1/11 - 9/30/12 (\$9,900,000)	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: <b>Attachment 4.19-D: Page A, 84, 84(a)</b>		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): <b>Attachment 4.19-D: Page A, 84</b>	
10. SUBJECT OF AMENDMENT: <b>Restructure Reimbursement for Proprietary Nursing Homes &amp; Across the Board Reduction-LTC FMAP - 56.88% for 4/1/11-6/30/11; 50% 7/1/11 forward</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>Jason A. Helgerson</b>			
14. TITLE: <b>Medicaid Director &amp; Deputy Commissioner Department of Health</b>			
15. DATE SUBMITTED:			
<b>FOR REGIONAL OFFICE USE ONLY</b>			
17. DATE RECEIVED:		18. DATE APPROVED: <b>SEP 23 2011</b>	
<b>PLAN APPROVED - ONE COPY ATTACHED</b>			
19. EFFECTIVE DATE OF APPROVED MATERIAL: <b>APR - 1 2011</b>		20. REGIONAL OFFICIAL:	
21. TYPED NAME: <b>Penny Thompson</b>		22. TITLE: <b>Deputy Director, CMCS</b>	
23. REMARKS:			

**Across-the-Board Reductions to Payments – Effective 9/16/10 – 3/31/11**

- (1) For dates of service on and after September 16, 2010, through and including March 31, 2011, payments for services as specified in paragraph (2) of this Attachment shall be reduced by 1.1%, provided payment is made no later than March 31, 2011.
- (2) Payments in this Attachment subject to the reduction in paragraph (1) include the following:

**Part I – Residential Health Care Facilities**

- a) Voluntary Health Care Facility Right Sizing Program. Page 16
- b) Services provided by Residential Health Care Facilities, excluding proportionate share payments to non-state operated public facilities (found on page 47(x)(2)(b)). Pages 17-87

**Part III – Methods and Standards for Establishing Payment Rates (Out of State Services) – Nursing Facilities**

- c) Services provided by nursing facilities out of state. Page 1

**2% Across-the-Board Reductions to Payments - Effective 4/1/2011-3/31/2013**

- (1) For dates of service on and after April 1, 2011 and ending on March 31, 2013, payments for services as specified in paragraph (2) of this Attachment will be reduced by 2%.
- (2) Payments in this Attachment subject to the reduction in paragraph (1) are the following:

**Part III – Methods and Standards for Establishing Payment Rates (Out of State Services) – Nursing Facilities**

- d) Services provided by nursing facilities out of state. Page 1

TN #11-49  
Supersedes TN #10-37-A

SEP 23 2011

Approval Date \_\_\_\_\_  
Effective Date APR - 1 2011

- (2) affects the health and safety of the patients; and
- (3) the facility can demonstrate dire financial condition;

then the limitation set forth in [section 86-2.21(e)(6) of this Subpart] the Limitation subsection of the Capital Cost Reimbursement for Proprietary Residential Health Care Facilities section of this Attachment will be modified to allow for the reimbursement of the debt service associated with the financing of the approved capital improvement over the effective term of the obligation or five years, whichever is greater. Any contribution to the improvement by the facility and not financed by the debt obligation will be considered an equity contribution and an adjustment to the facility's total capital equity will be made.

(d) If a facility undertakes an authorized improvement without incurring additional debt, then the facility will receive a return on equity and, when a determination has been made in accordance with the [section 86-2.21(e)(4) of this Subpart,] Return of Equity subsection of the Capital Cost Reimbursement for Proprietary Residential Health Care Facilities section of this Attachment, a return of equity for the funds invested in the improvement.

[(e) Effective April 1, 2009, any proprietary facility entitled to residual reimbursement, will have the capital cost component of its rate recalculated by the Department to take into account any capital improvements and/or renovations made to the facility's existing infrastructure for the purpose of converting beds to alternative long-term care uses or protecting the health and safety of patients, subject to the approval of the Commissioner and all applicable certificate of need requirements. Capital improvements and/or renovation costs that are not related to the provision of nursing facility services are not eligible to be reimbursed in the capital cost component of the nursing home rate.]

(e) Effective April 1, 2011, through March 31, 2012, the capital cost component of the Medicaid rate shall reflect:

- (1) The elimination of the payment factor for return on equity on real property, moveable equipment and operating assets, and
- (2) A reduction in the payment factor for return of equity on real property which is calculated as follows:

TN# 11-49

Approval Date SEP 23 2011

Supersedes TN# 09-12-B

Effective Date APR - 1 2011

**New York  
84(a)**

**Attachment 4.19-D  
Part I  
(04/11)**

- a) If the balance of useful life is currently five years or less, such useful life will be increased by 100 percent.
- b) If the balance of useful life is currently six years or more, such useful life will be increased by five years.

The provisions of this paragraph will not apply to facilities which are entitled to residual reimbursement.

- (f)(1) With respect to facilities granted operating certificates prior to March 10, 1975, the Commissioner will modify or

TN #11-49

Approval Date SEP 28 2011

Supersedes TN NEW

Effective Date APR - 1 2011