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State/Territory Name: **New York**

State Plan Amendment (SPA) #: **16-0025**

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) CMS 179 Form
- 3) Approved SPA Page

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



Financial Management Group

AUG 25 2016

Jason A. Helgerson
State Medicaid Director
Deputy Commissioner
Office of Health Insurance Programs
NYS Department of Health
Corning Tower (OCP – 1211)
Albany, NY 12237

RE: State Plan Amendment (SPA) TN 16-0025

Dear Mr. Helgerson:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State Plan submitted under transmittal number (TN) 16-0025. Effective June 1, 2016 this amendment provides temporary Vital Access Provider / Safety Net Provider (VAP/SNP) enhanced payments to one financially distressed nursing home.

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 implementing Federal regulations at 42 CFR Part 447. This letter is to inform you that New York 16-0025 is approved effective June 1, 2016. The CMS-179 and approved plan page are enclosed.

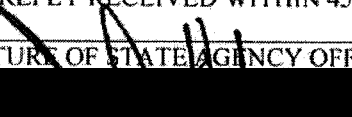

If you have any questions, please contact Betsy Pinho at 518-396-3810.

Sincerely,

A solid black rectangular box redacts the signature of Kristin Fan.

Kristin Fan
Director

Enclosures

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: HEALTH CARE FINANCING ADMINISTRATION	1. TRANSMITTAL NUMBER: 16-0025	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 June 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: (in thousands) a. FFY 06/01/16-09/30/16 \$ 155.83 b. FFY 10/01/16-09/30/17 \$ 299.79	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-D: 47(aa)(12)	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (<i>If Applicable</i>):	
10. SUBJECT OF AMENDMENT: Safety Net/VAP-Good Shepherd Fairview Home (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. Helgeson		
14. TITLE: Medicaid Director Department of Health		
15. DATE SUBMITTED: JUN 27 2016		
FOR REGIONAL OFFICE USE ONLY		
17. DATE RECEIVED:	18. DATE APPROVED: AUG 25 2016	
PLAN APPROVED – ONE COPY ATTACHED		
19. EFFECTIVE DATE OF APPROVED MATERIAL: JUN 01 2016	20. SIGNATURE OF REGIONAL OFFICIAL: 	
21. TYPED NAME: Kristin Fan	22. TITLE: Director, FMC	
23. REMARKS:		

**New York
47(aa)(12)**

Financially Distressed Nursing Homes (continued):

Provider Name	Gross Medicaid Rate Adjustment	Rate Period Effective
<u>Good Shepherd Fairview Home</u>	<u>\$779,167</u>	<u>06/01/2016 – 03/31/2017</u>
	<u>\$264,167</u>	<u>04/01/2017 – 03/31/2018</u>
	<u>\$ 21,667</u>	<u>04/01/2018 – 05/31/2018</u>

TN #16-0025

Approval Date AUG 25 2016

Supersedes TN #NEW

Effective Date JUN 01 2016