

Table of Contents

State/Territory Name: New York

State Plan Amendment (SPA) #: 11-0026-A

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) Approval Letter - Good Cause Waiver
- 3) CMS 179 Form
- 4) Approved SPA Page

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
New York Regional Office
26 Federal Plaza, Room 37-100
New York, NY 10278



DIVISION OF MEDICAID AND CHILDREN'S HEALTH OPERATIONS

DMCHO: PM:SPA-NY-11-0026-A

October 6, 2016

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

RE: TN 11-0026-A

Dear Commissioner Helgeson:

This is to notify you that New York State Plan Amendment (SPA) #11-0026-A has been approved for adoption into the State Medicaid Plan with an effective date of April 1, 2012. The SPA provides for a \$300,000 supplemental payment to Oswego Hospital which the state has designated to be a Vital Access Provider for outpatient hospital services furnished during the period 01/01/2013 – 03/31/2013.

Enclosed are copies of SPA #11-0026-A and the CMS-179 form, as approved.

If you have any questions, please contact Tom Brady at 518-396-3810.

Sincerely,

A redacted signature of Michael Melendez, consisting of a black rectangular box covering the handwritten name and a smaller black box below it.

Michael Melendez, LMSW
Associate Regional Administrator
Division of Medicaid and Children's Health Operations

Enclosures

cc. J. Ulberg
R. Gallagher
L. Tavener
R. Weaver
J. Guhl
R. Holligan
T. Brady
M. Lopez

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
New York Regional Office
26 Federal Plaza, Room 37-100
New York, NY 10278



DIVISION OF MEDICAID AND CHILDREN'S HEALTH OPERATIONS

October 06, 2016

Jason Helgeson
Deputy Commissioner
New York State Department of Health
Coming Tower
Empire State Plaza
Albany, New York 12237

RE: Two Year Claiming Waiver

Dear Commissioner Helgeson:

I am responding to your August 8, 2016 letter requesting a "good cause" waiver to the two year timely filing limit for the supplemental payment relating to the outpatient hospital services payment adjustment initiated by State Plan Amendment (SPA) 11-0026-A. CMS has determined that since the State did not receive approval of SPA 11-0026-A until recently; these circumstances resulted in the late filing, and were beyond the State's control. This letter approves your request for a good cause waiver of the two-year timely filing limit; in accordance with 45 Code of Federal Regulations 95.19(d), for the aforementioned claims.

SPA 11-0026 was originally submitted on March 20, 2012; subsequently split; and a portion of it amended and re-submitted as 11-0026-A on August 3, 2016. The SPA requested approval to adjust the operating component of the outpatient hospital rate for Oswego Hospital for the period January 1, 2013 through March 31, 2013. This rate adjustment was subject to the corresponding Upper Payment Limit demonstration. The approval of SPA 11-0026A was delayed while the State and CMS worked on finalizing the State's UPL demonstration.

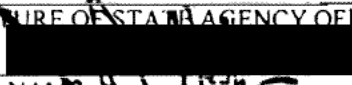
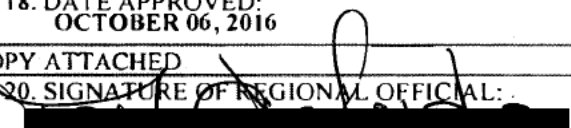
State claims for Federal financial participation for expenditures made in accordance with SPA 11-0026-A must be submitted in the October to December 2016 Quarterly Expenditure Report (CMS-64); any related claims made after this date that exceed the two-year timely filing period will be considered outside of this waiver approval.

If you have any questions, please contact John Guhl at 212-616-2438.

Sincerely,

A black rectangular redaction box covers the signature of Michael Melendez. A blue ink scribble is visible below the redaction.

Michael Melendez, LMSW
Associate Regional Administrator
Division of Medicaid & Children's Health Operations

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL		1. TRANSMITTAL NUMBER: #11-0026-A	2. STATE New York
FOR: HEALTH CARE FINANCING ADMINISTRATION		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 April 1, 2012	
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: Section 1902(a) of the Social Security Act, and 42 CFR 447		7. FEDERAL BUDGET IMPACT: (in thousands) a. FFY 04/01/12-09/30/12 \$ 0.00 b. FFY 10/01/12-09/30/13 \$ 150.00	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-B: 1(q)		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable):	
10. SUBJECT OF AMENDMENT: Assist Preservation of Essential Safety-Net (Hospital Outpatient) – Non-Institutional (FMAP = 50%)			
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: New York State Department of Health Bureau of Federal Relations & Provider Assessments 99 Washington Ave – One Commerce Plaza Suite 1460 Albany, NY 12210	
13. TYPED NAME: Jason A. Helgeson			
14. TITLE: Medical Director Department of Health			
15. DATE SUBMITTED: MAR 20 2012			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED:		18. DATE APPROVED: OCTOBER 06, 2016	
PLAN APPROVED – ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: APRIL 01, 2012		20. SIGNATURE OF REGIONAL OFFICIAL: 	
21. TYPED NAME: MICHAEL MELENDEZ		22. TITLE: Associate Regional Administrator Division of Medicaid & Children's Health Operations	
23. REMARKS:			

**New York
1(q)**

Temporary Rate Adjustments for Mergers, Acquisitions, Consolidations, Restructurings, and Closures – Hospital-Based Outpatient

A temporary rate adjustment will be provided to eligible providers of outpatient services that are subject to or impacted by the closure, merger, and acquisition, consolidation, or restructuring of a health care provider. The rate adjustment is intended to:

- Protect or enhance access to care;
- Protect or enhance quality of care; or
- Improve the cost effectiveness.

Eligible providers, the annual amount of the temporary rate adjustment, and the duration of the adjustment shall be listed in the table which follows. The total annual adjustment amount will be paid quarterly with the amount of each quarterly payment being equal to one fourth of the total annual amount established for each provider. The quarterly payment made under this section will be an add-on to services payments made under this Attachment to such facilities during the quarter.

To remain eligible, providers must submit benchmarks and goals acceptable to the Commissioner and must submit periodic reports, as requested by the Commissioner, concerning the achievement of such benchmarks and goals. Failure to achieve satisfactory progress in accomplishing such benchmarks and goals will result in termination of the provider's temporary rate adjustment prior to the end of the specified timeframe. Once a provider's temporary rate adjustment ends, the provider will be reimbursed in accordance with the otherwise applicable rate-setting methodology as set forth in this Attachment.

Temporary rate adjustments have been approved for the following providers in the amounts and for the effective periods listed:

Hospital-Based Outpatient Services:

<u>Provider Name</u>	<u>Gross Medicaid Rate Adjustment</u>	<u>Rate Period Effective</u>
<u>Oswego Hospital</u>	<u>\$300,000</u>	<u>01/01/2013 – 03/31/2013</u>

TN #11-0026-A

Supersedes TN NEW

Approval Date OCTOBER 06, 2016

Effective Date APRIL 01, 2012