



OCT 17 2013

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

RE: TN 11-24A

Dear Mr. Helgeson:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 11-24A. Effective April 1, 2012 this amendment proposes supplemental payments to certain providers for inpatient hospital services.

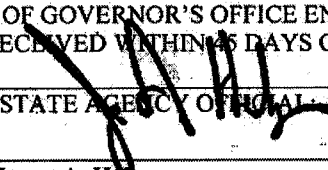
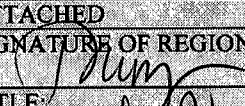
We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903(a) and 1923 of the Social Security Act and the implementing Federal regulations at 42 CFR Part 447. This is to inform you that New York 11-24A is approved effective April 1, 2012 and I have enclosed the CMS-179 and the approved plan page. If you have any questions, please contact Tom Brady at 518-396-3810 or Rob Weaver at 410-786-5914.

Sincerely,

A handwritten signature in black ink, appearing to read 'Cindy Mann'.

Cindy Mann  
Director

Enclosures

|                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                       |                             |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------|
| <b>TRANSMITTAL AND NOTICE OF APPROVAL OF<br/>STATE PLAN MATERIAL</b><br><br><b>FOR: HEALTH CARE FINANCING ADMINISTRATION</b>                                                                                                                                                                               |  | 1. TRANSMITTAL NUMBER:<br><b>#11-24-A</b>                                                                                                                                                             | 2. STATE<br><b>New York</b> |
|                                                                                                                                                                                                                                                                                                            |  | 3. PROGRAM IDENTIFICATION: <b>TITLE XIX OF THE<br/>SOCIAL SECURITY ACT (MEDICAID)</b>                                                                                                                 |                             |
| TO: REGIONAL ADMINISTRATOR<br>HEALTH CARE FINANCING ADMINISTRATION<br>DEPARTMENT OF HEALTH AND HUMAN SERVICES                                                                                                                                                                                              |  | 4. PROPOSED EFFECTIVE DATE<br><b>April 1, 2012</b>                                                                                                                                                    |                             |
| 5. TYPE OF PLAN MATERIAL (Check One):<br><br><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:<br><b>Section 1902(a) of the Social Security Act, and 42 CFR 447</b>                                                                                                                                                                                               |  | 7. FEDERAL BUDGET IMPACT:<br>a. FFY 04/01/12-09/30/12 <b>\$4,169,560</b><br>b. FFY 10/01/12-09/30/13 <b>\$7,150,542</b>                                                                               |                             |
| 8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:<br><br><b>Attachment 4.19-A: Pages 136, 136(a), 136(b)</b>                                                                                                                                                                                               |  | 9. PAGE NUMBER OF THE SUPERSEDED PLAN<br>SECTION OR ATTACHMENT (If Applicable):<br><br><b>Attachment 4.19-A: Pages 136, 136(a)</b>                                                                    |                             |
| 10. SUBJECT OF AMENDMENT:<br><b>Assist Preservation of Essential Safety-Nets – IP<br/>(FMAP = 50%)</b>                                                                                                                                                                                                     |  |                                                                                                                                                                                                       |                             |
| 11. GOVERNOR'S REVIEW (Check One):<br><input checked="" type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input type="checkbox"/> OTHER, AS SPECIFIED:<br><input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED<br><input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL |  |                                                                                                                                                                                                       |                             |
| 12. SIGNATURE OF STATE AGENCY OFFICIAL:<br>                                                                                                                                                                             |  | 16. RETURN TO:<br><b>New York State Department of Health<br/>Bureau of Federal Relations &amp; Provider Assessments<br/>99 Washington Ave – One Commerce Plaza<br/>Suite 810<br/>Albany, NY 12210</b> |                             |
| 13. TYPED NAME: <b>Jason A. Hengerson</b>                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                       |                             |
| 14. TITLE: <b>Medicaid Director<br/>Department of Health</b>                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                       |                             |
| 15. DATE SUBMITTED: <b>July 29, 2013</b>                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                       |                             |
| <b>FOR REGIONAL OFFICE USE ONLY</b>                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                       |                             |
| 17. DATE RECEIVED:                                                                                                                                                                                                                                                                                         |  | 18. DATE APPROVED: <b>OCT 17 2013</b>                                                                                                                                                                 |                             |
| <b>PLAN APPROVED – ONE COPY ATTACHED</b>                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                       |                             |
| 19. EFFECTIVE DATE OF APPROVED MATERIAL: <b>APR 01 2012</b>                                                                                                                                                                                                                                                |  | 20. SIGNATURE OF REGIONAL OFFICIAL:<br>                                                                           |                             |
| 21. TYPED NAME: <b>Penny Thompson</b>                                                                                                                                                                                                                                                                      |  | 22. TITLE: <b>Deputy Director, Policy &amp; Financial Mgmt, HCFS</b>                                                                                                                                  |                             |
| 23. REMARKS:                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                       |                             |

**New York**  
**136**

**Mergers, acquisitions, [and] consolidations, restructurings, and closures.**

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 that complete a merger, acquisition or consolidation 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) 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 #11-24-A  
Supersedes TN #10-45

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**New York  
136(a)**

[whichever is earlier, and shall consist of the various operating rate components of the surviving entity. 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.]

**2. Temporary rate adjustment.**

- a. A temporary rate adjustment will be provided to eligible hospital providers 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 hospital 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.

- [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.]

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136(b)**

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

**Hospital:**

| <b><u>Provider Name</u></b>                       | <b><u>Gross Medicaid<br/>Rate Adjustment</u></b> | <b><u>Rate Period Effective</u></b> |
|---------------------------------------------------|--------------------------------------------------|-------------------------------------|
| <u>Niagara Falls Memorial Medical Center</u>      | \$228,318                                        | 4/1/2012 – 3/31/2013                |
|                                                   | \$228,317                                        | 4/1/2013 – 3/31/2014                |
|                                                   | \$228,317                                        | 4/1/2014 – 3/31/2015                |
| <u>NuHealth (Nassau County Medical Center)</u>    | \$4,000,000                                      | 4/1/2012 – 3/31/2013                |
|                                                   | \$6,500,000                                      | 4/1/2013 – 3/31/2014                |
|                                                   | \$7,000,000                                      | 4/1/2014 – 3/31/2015                |
| <u>Lincoln Medical &amp; Mental Health Center</u> | \$963,687                                        | 4/1/2012 – 3/31/2013                |
|                                                   | \$963,687                                        | 4/1/2013 – 3/31/2014                |
| <u>Richmond University</u>                        | \$8,897,955                                      | 1/1/2013 – 3/31/2013                |
|                                                   | \$2,355,167                                      | 4/1/2013 – 3/31/2014                |
|                                                   | \$1,634,311                                      | 4/1/2014 – 3/31/2015                |
| <u>St. Barnabas Hospital</u>                      | \$2,588,278                                      | 1/1/2013 – 3/31/2013                |
|                                                   | \$1,876,759                                      | 4/1/2013 – 3/31/2014                |
|                                                   | \$1,322,597                                      | 4/1/2014 – 3/31/2015                |

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Supersedes TN NEW

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APR 01 2012