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State/Territory Name: **NEW YORK**

State Plan Amendment (SPA) #: **14-028**

This file contains the following documents in the order listed:

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

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Financial Management Group

JAN 30 2015

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) 14-0028

Dear Commissioner Helgerson:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 14-0028. Effective April 1, 2014, this amendment proposes to terminate a 2 percent rate cut on certain inpatient hospital services and disproportionate share hospital payments that the State had implemented under NY 13-20.

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. We have found that the proposed reimbursement methodology complies with applicable requirements and therefore have approved them with an effective date of April 1, 2014. We are enclosing the CMS-179 and the amended approved plan pages.

If you have any questions, please contact Tom Brady at (518) 396-3810 or Rob Weaver at (410) 786-5914.

Sincerely,

[redacted]

Timothy Hill
Director

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: HEALTH CARE FINANCING ADMINISTRATION	1. TRANSMITTAL NUMBER: **14-0028**	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 **April 1, 2014**	

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ 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 04/01/14-09/30/14 $ 29,235.38** **b. FFY 10/01/14-09/30/15 $ 29,235.38**
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: **Attachment 4.19-A: Page A(1)(b)**	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: **Attachment 4.19-A: Page A(1)(b)**

10. SUBJECT OF AMENDMENT:
Elimination of 2% ATB Reduction – IP
(FMAP = 50%)

11. GOVERNOR'S REVIEW *(Check One)*:
☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL: [redacted]	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. Helgerson**	
14. TITLE: **Medicaid Director** **Department of Health**	
15. DATE SUBMITTED: JUN 2 3 2014	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:	18. DATE APPROVED: JAN 3 0 2015
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: APR 0 1 2014	20. SIGNATURE OF REGIONAL OFFICIAL: [redacted]
21. TYPED NAME: Kristin Fan	22. TITLE: Deputy Director, FMCa

23. REMARKS:

FORM HCFA-179 (07-92)

New York
A(1)(b)

Across the Board 2% Payment Reduction – effective 4/1/13 - 3/31/[15]14

(1) For dates of service on and after April 1, 2013 through March 31, 20[15]14, payments for services as specified in paragraph (2) of this Section will be reduced by 2%.

(2) Payments in this Attachment subject to the reduction in paragraph (1) are the following:

Part I – Methods and Standards for Establishing Payments – Inpatient Hospital Care

a) Hospital Inpatient Reimbursement as calculated pursuant to Part 1 of this Attachment. Pages 103-139

b) Indigent Care Pool Reform – as calculated pursuant to Part 1 of this Attachment. Pages 161(d)-161(j)

c) Graduate Medical Education – Medicaid Managed Care Reimbursement as calculated pursuant to Part 1 of this Attachment. Pages 149-150

d) Hospital Disproportionate Share payments made to governmental general hospitals operated by the State of New York or the State University of New York as calculated pursuant to Part 1 of this Attachment. Pages 153-154

e) Government General Hospital Indigent Care Adjustment as calculated pursuant to Part 1 of this Attachment. Page 160