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State/Territory Name: **NEW YORK**

State Plan Amendment (SPA) #: **14-0036**

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

APR 15 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: TN 14-0036

Dear Mr. Helgerson:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 14-0036. Effective September 11, 2014 this amendment proposes temporary Vital Access Provider supplemental payments to St. Joseph's Hospital 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 14-0036 is approved effective September 11, 2014 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,

[redacted]

Tim Hill
Director

Enclosures

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: **14-0036**	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 **September 11, 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: **§ 1902(a) of the Social Security Act, and 42 CFR 447**	7. FEDERAL BUDGET IMPACT: **(in thousands)** **a. FFY 09/11/14-09/30/14 $ 110.97** **b. FFY 10/01/14-09/30/15 $ 1,109.101**
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: **Attachment 4.19-A: Page 136(b.2)**	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

10. SUBJECT OF AMENDMENT:
Safety Net/VAP – St. Joseph's Hospital (FMAP = 50%)
Pen + Ink Change to Add Original Submission Date of 9/30/2014

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:	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:	18. DATE APPROVED: APR 15 2015

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: SEP 11 2014	20. SIGNATURE OF REGIONAL OFFICIAL: [redacted]
21. TYPED NAME: Kristin FAN	22. TITLE: Deputy Director, FMC

23. REMARKS:

Pen + Ink Change to Box #10 to add Original Submission Date of 9/30/2014

FORM HCFA-179 (07-92)

New York
136(b.2)

Hospitals (Continued):

Provider Name	Gross Medicaid Rate Adjustment	Rate Period Effective
St. Joseph's Hospital	$1,553,578	09/11/2014 – 03/31/2015
	$1,773,128	04/01/2015 – 03/31/2016
	$1,710,279	04/01/2016 – 03/31/2017