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State/Territory Name: New York

State Plan Amendment (SPA) #: 14-0022

This file contains the following documents in the order listed:

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

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



Financial Management Group

SEP 01 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: State Plan Amendment (SPA) 14-0022

Dear Commissioner Helgeson:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 14-0022. Effective November 1, 2014, this amendment proposes additional temporary enhanced Vital Access Provider / Safety Net Provider (VAP/SNP) payments to a specific provider 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 regulations at 42 CFR 447 Subpart C. This letter is to inform you that New York 14-0022 is approved effective November 1, 2014. We are enclosing the CMS-179 and the approved plan page.



If you have any questions, please contact Betsy Pinho at 518-396-3810 ext 111.

Sincerely,



Timothy Hill
Director

A handwritten signature in black ink, appearing to be "TH", located to the right of the printed name and title.

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL		1. TRANSMITTAL NUMBER: 14-022	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 November 1, 2014	
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: § 1902(a) of the Social Security Act, and 42 CFR 447		7. FEDERAL BUDGET IMPACT: (in thousands) a. FFY 11/01/14-09/30/15 S 1,295 b. FFY 10/01/15-09/30/16 S 789	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-A: Page 136(b.1.1)		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable):	
10. SUBJECT OF AMENDMENT: Safety Net/VAP - Mary Imogene Bassetts Hospital (FMAP = 50%)			
11. GOVERNOR'S REVIEW (Check One):			
<input checked="" type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL			
<input type="checkbox"/> OTHER, AS SPECIFIED:			
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. Helgerson			
14. TITLE: Medicaid Director Department of Health			
15. DATE SUBMITTED: DEC 9 1 2014			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED:		18. DATE APPROVED: SEP 01 2015	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: NOV 01 2014		20. SIGNATURE OF REGIONAL OFFICIAL: 	
21. TYPED NAME: Kristin Fan		22. TITLE: Deputy Director, FMC	
23. REMARKS:			

New York
136(b.1.1)

Hospitals Continued:

Provider Name	Gross Medicaid Rate Adjustment	Rate Period Effective
<u>Mary Imogene Bassett Hospital</u>	<u>\$1,563,900</u>	<u>11/01/2014 – 03/31/2015</u>
	<u>\$2,050,438</u>	<u>04/01/2015 – 03/31/2016</u>
	<u>\$1,104,187</u>	<u>04/01/2016 – 03/31/2017</u>
	<u>\$281,250</u>	<u>04/01/2017 – 03/31/2018</u>

TN #14-0022Approval Date SEP 01 2015Supersedes TN NEWEffective Date NOV 01 2014