

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



Financial Management Group

APR 15 2015

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 14-0036

Dear Mr. Helgeson:

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.

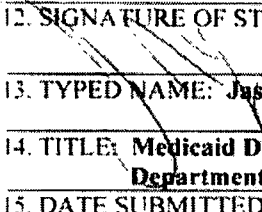

Sincerely,

A handwritten signature in black ink, appearing to read "Tim Hill", is written over the word "Sincerely,".

Tim Hill
Director

A second handwritten signature in black ink, appearing to read "Tim Hill", is written below the typed name and title.

Enclosures

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL		1. TRANSMITTAL NUMBER: 14-0036	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 September 11, 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 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%) <i>Pen + Ink Change to Add Original Submission Date of 9/30/2014</i>			
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. Helgerson			
14. TITLE: Medicaid Director Department of Health			
15. DATE SUBMITTED:			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED:		18. DATE APPROVED: APR 15 2019	
PLAN APPROVED – ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: SEP 11 2014		20. SIGNATURE OF REGIONAL OFFICIAL: 	
21. TYPED NAME: Kristin FAN		22. TITLE: Deputy Director, FMC	
23. REMARKS: <i>Pen + Ink Change to Box # 10 To Add Original Submission Date of 9/30/2014</i>			

New York
136(b.2)

Hospitals (Continued):

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

TN #14-0036
Supersedes TN #NEW

Approval Date APR 15 2015
Effective Date SEP 11 2014