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State/Territory Name:

State Plan Amendment (SPA) #: NY 17-0019

This file contains the following documents in the order listed:

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

CENTERS FOR MEDICARE & MEDICAID SERVICES

Financial Management Group

APR 04 2017

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) 17-0019

Dear Commissioner Helgerson:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State Plan submitted under transmittal number (TN) 17-0019. Effective January 1, 2017 this amendment proposes a temporary rate adjustment for one additional hospital.

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 letter is to inform you SPA 17-0019 is approved effective January 1, 2017. We are enclosing the CMS-179 and the amended approved plan page.

If you have any questions, please contact Charlene Holzbaur at 609-882-4103 Ext. 104.

Sincerely,

[redacted]

Kristin Fan
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: **17-0019**

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
January 1, 2017

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 01/01/17-09/30/17 $250.00
b. FFY 10/01/17-09/30/18 $ 0.00

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-A: 136(b.1)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-A: 136(b.1)

10. SUBJECT OF AMENDMENT:
Safety Net/VAP-IP-Long Island Jewish Medical Center
(FMAP = 50%) ***The payment is for the period 1/1/17-3/31/17**

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]

13. TYPED NAME: **Jason A. Helgerson**

14. TITLE: **Medicaid Director**
Department of Health

15. DATE SUBMITTED: MAR 2 8 2017

16. RETURN TO:
New York State Department of Health
Division of Finance and Rate Setting
99 Washington Ave – One Commerce Plaza
Suite 1432
Albany, NY 12210

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED: APR 04 2017

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: JAN 01 2017

20. SIGNATURE OF REGIONAL OFFICIAL:
[redacted]

21. TYPED NAME: Kristin FAN

22. TITLE: Director, FMCO

23. REMARKS:

FORM HCFA-179 (07-92)

New York
136(b.1)

Hospitals Continued:

Provider Name	Gross Medicaid Rate Adjustment	Rate Period Effective
Carthage Hospital	$250,000	01/01/2013 – 03/31/2013
Long Island Jewish Medical Center	$500,000	01/01/2017 – 03/31/2017
Woodhull Medical Center	$1,929,877	01/01/2013 – 03/31/2013
	$1,499,996	04/01/2013 – 03/31/2014
	$878,996	04/01/2014 – 03/31/2015