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State/Territory Name:

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

This file contains the following documents in the order listed:

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

Financial Management Group

APR 04 2017

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) 17-0019

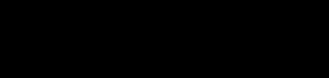
Dear Commissioner Helgeson:

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,



Kristin Fan
Director

Enclosures

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL		1. TRANSMITTAL NUMBER: 17-0019	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 January 1, 2017	
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 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): <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 Division of Finance and Rate Setting 99 Washington Ave - One Commerce Plaza Suite 1432 Albany, NY 12210	
13. TYPED NAME: Jason A. Halgerson			
14. TITLE: Medicaid Director Department of Health			
15. DATE SUBMITTED: MAR 28 2017			
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: 	
21. TYPED NAME: Kristin FAW		22. TITLE: Director, FMCA	
23. REMARKS:			

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

TN #17-0019
Supersedes TN #11-0024-C

Approval Date APR 04 2017
Effective Date JAN 01 2017