

SEP 1 2 2013

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 13-36

Dear Mr. Helgerson:

We have reviewed the proposed amendment to Attachment 4.19 D of your Medicaid State plan submitted under transmittal number (TN) 13-36. Effective April 1, 2013, this amendment will discontinue a rate add-on for financially distressed facilities. The State intends to continue this funding through its safety net provider payment program.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30) of the Social Security Act and the regulations at 42 CFR 447 Subpart C. This is to inform you that New York State plan amendment 13-36 is approved effective April 1, 2013. We have enclosed the HCFA-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,

Cindy Mann Director

Enclosures

EPARTMENT OF HEALTH AND HUMAN SERVICES EALTH CARE FINANCING ADMINISTRATION		FORM APPROVEI OMB NO. 0938-01
TRANSMITTAL AND NOTICE OF APPROVAL OF	1. TRANSMITTAL NUMBER:	2. STATE
STATE PLAN MATERIAL	13-36	
FOR: HEALTH CARE FINANCING ADMINISTRATION	2 PROCE AM IDENTIFICATION	New York
	3. PROGRAM IDENTIFICATION: SOCIAL SECURITY ACT (ME	DICAID)
O: REGIONAL ADMINISTRATOR	4. PROPOSED EFFECTIVE DATE	
HEALTH CARE FINANCING ADMINISTRATION	April 1, 2013	
DEPARTMENT OF HEALTH AND HUMAN SERVICES		8
. TYPE OF PLAN MATERIAL (Check One):		
☐ NEW STATE PLAN ☐ AMENDMENT TO BE CON	SIDERED AS NEW PLAN	■ AMENDMENT
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMEN		amendment)
. FEDERAL STATUTE/REGULATION CITATION:	7. FEDERAL BUDGET IMPACT:	
Section 1902 of the Social Security Act, and 42 CFR 447	a. FFY 04/01/13-09/30/13 (\$ 7, b. FFY 10/01/13-09/30/14 (\$15,	
3. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:	9. PAGE NUMBER OF THE SUPE	
V 1.45 - 1	SECTION OR ATTACHMENT (If	
Attachment 4.19-D: Page 47(aa)(2)		
	Attachment 4.19-D: Page 47(aa)(2)	
0. SUBJECT OF AMENDMENT:		
Reallocate \$30M from NH FD to VAP/Safety Net		
FMAP = 50%)		
1. GOVERNOR'S REVIEW (Check One):	pt	
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT	OTHER, AS SP	ECIFIED:
COMMENTS OF GOVERNOR'S OFFICE ENCLOSED		
NO REPLY RECEIVED VITHIN 45 DAYS OF SUBMITTAL		
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2. SIGNATURE OF STATE AGENCY DEMCHAL:	16. RETURN TO:	
	New York State Department of He Bureau of HCRA Operations & Fi	
3. TYPED NAME: Jason A. Helgerson	99 Washington Ave – One Comme	
4. TITLE: Medicaid Director	Suite 810	CC A ROLLIG
Department of Health	Albany, NY 12210	
5 DATE SUBMITTED.	attack of the state of the stat	
3EF U 3 ZU13		
7. DATE RECEIVED: FOR REGIONAL OFF	10 DIGET LENDOLDER	
	18. DATE APPROVED: SEP 12	2013
PLAN APPROVED - ONE		世代美国世纪
19. EFFECTIVE DATE OF APPROVED MATERIAL:	20. SIGNATURE OF REGIONAL O	OFFICIAL:
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21. TYPED NAME:	22. TITICE:	F. INCH
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23. REMARKS:		
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New York 47(aa)(2)

- (f) The amount of any facility's financially disadvantaged RHCF distribution calculated in accordance with this section shall be reduced by the facility's rate year benefit of the 2001 update to the regional input price adjustment factors provided that such reduction shall not be applied with regard to rate periods on and after April 1, 2009. After all other adjustments to a facility's financially disadvantaged RHCF distribution have been made in accordance with this section, the amount of each facility's distribution shall be limited to no more than \$400,000 during the period October 1, 2004 through December 31, 2004, and on an annualized basis, for rate periods through March 31, 2009, and no more than one million dollars for the period April 1, 2009 through December 31, 2009, and for each annual rate period thereafter.
- (g) The adjustment made to each qualifying facility's Medicaid rate of payment determined pursuant to the section shall be calculated by dividing the facility's financially disadvantaged RHCF distribution calculated in accordance with this section by the facility's total Medicaid patient days reported in the cost report submitted two years prior to the rate year, provided however, that such rate adjustments for the period October 1, 2004 through December 31, 2004, shall be calculated based on 25% of each facility's reported total Medicaid patient days as reported in the applicable 2002 cost report. Such amounts will not be reconciled to reflect changes in medical assistance utilization between the year two years prior to the rate year and the rate year.
- (h) The total amount of funds to be allocated and distributed as medical assistance for financially disadvantaged RHCF rate adjustments to eligible facilities for a rate period in accordance with this section shall be \$30 million on and after January 1, 2009 through March 31, 2013.

		SEP 1 2 2013		
TN #13-36		Approval Date		
Supersedes TN	#09-29	Effective Date	APR 01 2013	