



JUN 19 2014

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) 14-020

Dear Mr. Helgeson:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 14-020. Effective March 13, 2014 this amendment proposes to set the inpatient hospital payment rate for those out-of-state hospitals in larger cities - with a population equal to or greater than 500,000 people - at a rate equal to the weighted average rate for in-state rate hospitals in the Downstate Region.

We conducted our review of your submittal according to the statutory requirements at sections 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. We have found that the proposed reimbursement methodology complies with applicable requirements and therefore have approved them with an effective date of March 13, 2014. We are enclosing the CMS-179 and the amended approved plan page.

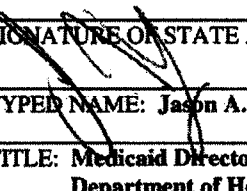
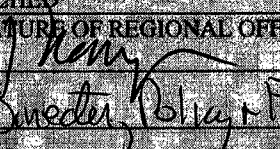
If you have any questions, please contact Tom Brady at (518) 396-3810 or Rob Weaver at (410) 786-5914.

Sincerely,

A handwritten signature in black ink, appearing to read "Cindy Mann", is written over the typed name.

Cindy Mann
Director

Enclosures

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL		1. TRANSMITTAL NUMBER: 14-20	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 March 13, 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: a. FFY 03/13/14-09/30/14 \$ 169,167 b. FFY 10/01/14-09/30/15 \$ 290,000	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-A Page: 139		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Attachment 4.19-A Page: 139	
10. SUBJECT OF AMENDMENT: Revision to the downstate region qualifications for out-of-state acute hospitals. (FMAP = 50%)			
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 HCRA Operations & Financial Analysis 99 Washington Ave - One Commerce Plaza Suite 1430 Albany, NY 12210	
13. TYPED NAME: Jason A. Helgerson			
14. TITLE: Medicaid Director Department of Health			
15. DATE SUBMITTED: March 31, 2014			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED:		18. DATE APPROVED: JUN 19 2014	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: MAR 13 2014		20. SIGNATURE OF REGIONAL OFFICIAL: 	
21. TYPED NAME: Penny Thompson		22. TITLE: Deputy Director, Policy & Financial Affairs	
23. REMARKS:			

