

<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</b>		1. TRANSMITTAL NUMBER: <b>06-61</b>	2. STATE <b>New York</b>
<b>FOR: HEALTH CARE FINANCING ADMINISTRATION</b>		3. PROGRAM IDENTIFICATION: <b>TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)</b>	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE <b>January 1, 2007</b>	
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: <b>§1902(a)(30) of the Social Security Act 42 CFR 447.204</b>		7. FEDERAL BUDGET IMPACT: a. FFY <b>1/1/07-9/30/07</b> \$ <b>1,312,653</b> b. FFY <b>10/1/07-9/30/08</b> \$ <b>1,859,597</b>	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: <b>Attachment 4.19-B: Pages 2, 2(a), 2(a)(i), 7(b)(i), 7(b)(ii), 7(b)(ii)(A) Attachment 3.1A: Pages 6, 7 Attachment 3.1B: Pages 6, 7</b>		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): <b>Attachment 4.19-B: Pages 2, 2(a), 7(b)(i), 7(b)(ii) Attachment 3.1A Supplement: Pages 6, 7 Attachment 3.1B Supplement: Pages 6, 7</b>	
10. SUBJECT OF AMENDMENT: <b>AIDS ADHC Annual COLA      ** SEE REMARKS</b>			
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: <b>New York State Department of Health Corning Tower Empire State Plaza Albany, New York 12237</b>	
13. TYPED NAME: <b>Donna Frescatore</b>			
14. TITLE: <b>Medicaid Director &amp; Deputy Commissioner Department of Health</b>			
15. DATE SUBMITTED: <b>May 18, 2010 (originally submitted September 6, 2006)</b>			
<b>FOR REGIONAL OFFICE USE ONLY</b>			
17. DATE RECEIVED:		18. DATE APPROVED: <b>JUN 10 2010</b>	
<b>PLAN APPROVED - ONE COPY ATTACHED</b>			
19. EFFECTIVE DATE OF APPROVED MATERIAL: <b>JAN 01 2007</b>		20. SIGNATURE OF REGIONAL OFFICIAL:	
21. TYPED NAME: <b>Sue Kelly</b>		22. TITLE: <b>Division of Medicaid and State Operations</b>	
23. REMARKS: <p><b>The following pages were submitted via State's May 18, 2010 electronic submission:</b></p> <p><b>Attachment 4.19-B-Pages 2, 2(a), 2(a)(i), 7(b)(ii), and 7(b)(ii)(A), Attachment 3.1-A-Pages 6 and 7, and Attachment 3.1-B-Pages 6 and 7. At that time, New York requested that these 10 Pages replace the Pages which were provided with its SPA submission of September 6, 2006 (originally, only Attachment 4.19-B-Page 2, 7(b)(i) and 7(b)(ii), a total of 3 Pages, were submitted).</b></p> <p><b>In addition, in that electronic transmission, New York requested that originally requested effective date of August 1, 2006 be changed to January 1, 2007.</b></p> <p><b>This approval reflects the change in the effective date for 06-61 to January 1, 2007 and is for the 10 newly provided Pages.</b></p>			