

<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</b>		1. TRANSMITTAL NUMBER: <b>07-12</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>April 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) Social Security Act</b> <b>42 CFR Part 447.204</b>		7. FEDERAL BUDGET IMPACT: a. FFY <b>4/1/07-9/30/07</b> <b>(\$349,772)</b> b. FFY <b>10/1/07-9/30/08</b> <b>(\$699,544)</b>	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:  <b>Attachment 4.19-B, Pages 1(b)(i), 1(b)(ii), 2(b)(i), 2(c), 2(c)(A) &amp; 7(a)(i)</b>  <b>** SEE REMARKS</b>		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable):  <b>Attachment 4.19-B, Pages 1(b)(i), 2(b)(i), 2(c), 2(c)(A) &amp; 7(a)(i)</b>	
10. SUBJECT OF AMENDMENT: <b>Trend Factor Reduction—Non-Institutional (FMAP = 50% as of effective date)</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:  <b>Jason A. Helgerson</b>		16. RETURN TO: <b>New York State Department of Health</b> <b>Corning Tower</b> <b>Empire State Plaza</b> <b>Albany, New York 12237</b>	
13. TYPED NAME: <b>Jason A. Helgerson</b>			
14. TITLE: <b>Medicaid Director &amp; Deputy Commissioner</b>			
15. DATE SUBMITTED: <b>JAN 31 2011</b>			
<b>FOR REGIONAL OFFICE USE ONLY</b>			
17. DATE RECEIVED:		18. DATE APPROVED: <b>MAR 18 2011</b>	
<b>PLAN APPROVED - ONE COPY ATTACHED</b>			
19. EFFECTIVE DATE OF APPROVED MATERIAL: <b>APR 01 2007</b>		20. SIGNATURE OF REGIONAL OFFICIAL:	
21. TYPED NAME: <b>Michael Melendez</b>		22. TITLE: <b>Acting Associate Regional Administrator</b> <b>Division of Medicaid and State Operations</b>	
23. REMARKS: <b>The following Attachment 4.19B Pages were submitted with the State's January 31, 2011 electronic submission to the CMS SPA Mailbox: Page 1(b)(i), 2(b)(i), 2(b)(ii), and 7(a)(i).</b> <b>Attachment 4.19B Page 2(c) and 2(c)(A), were submitted by the State on February 4, 2011 via electronic transmission to CMS. The 6 Pages in these 2 transmissions replaced the Attachment 4.19B Page 1(b)(i), 2(b)(i), 2(c) and 7(a)(i), which were provided with the State's original June 28, 2007 SPA submission.</b> <b>The newly submitted Attachment 4.19B Page 1(b)(ii) and 2(c)(A) were not provided in the original SPA submission.</b>			