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| TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: HEALTH CARE FINANCING ADMINISTRATION | | 1. TRANSMITTAL NUMBER: 08-27 | 2. STATE New York |
| | | 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 April 1, 2008 | |
| 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: Section 1902(a) of the Social Security Act, and 42 CFR 447.204 | | 7. FEDERAL BUDGET IMPACT: a. FFY 04/01/08-09/30/08 \$ 92,125,000 b. FFY 10/01/08-09/30/09 \$220,491,975 | |
| 8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-B: Pages 6(a), 6(a)(i), 6(a)(i)(1), 6(a)(i)(2) ** SEE REMARKS | | 9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Attachment 4.19-B: Pages 6(a), 6(a)(i) & 6(a)(i)(1) | |
| 10. SUBJECT OF AMENDMENT: New York City & Non-New York City Personal Care Recruitment & Retention FMAP = 50% for 4/1/08-9/30/08; 58.78% for 10/1/08 - 3/31/09; 60.19% for 4/1/09 - 6/30/09; 61.59% for 7/1/09 - 9/30/09 | | | |
| 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 Corning Tower Empire State Plaza Albany, New York 12237 | |
| 13. TYPED NAME: Jason A. Helgerson | | | |
| 14. TITLE: Medicaid Director & Deputy Commissioner Department of Health | | | |
| 15. DATE SUBMITTED: April 14, 2011 | | | |
| FOR REGIONAL OFFICE USE ONLY | | | |
| 17. DATE RECEIVED: | | 18. DATE APPROVED: MAY 11 2011 | |
| PLAN APPROVED - ONE COPY ATTACHED | | | |
| 19. EFFECTIVE DATE OF APPROVED MATERIAL: APR 01 2008 | | 20. SIGNATURE OF REGIONAL OFFICIAL: | |
| 21. TYPED NAME: Michael Melendez | | 22. TITLE: Associate Regional Administrator Division of Medicaid and State Operations | |
| 23. REMARKS: Attachment 4.19B Pages were submitted via State's April 14, 2011 electronic submission to the CMS SPA Mailbox: Attachment 4.19-B-Page 6(a), Page 6(a)(i), Page 6(a)(i)(1) and Page 6(a)(i)(2). These Pages replace the Attachment 4.19-B-Page 6(a)(i), and Page 6(a)(i)(A), which were provided with the State's original June 23,2008 SPA submission. | | | |