

<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</b>  <b>FOR: HEALTH CARE FINANCING ADMINISTRATION</b>		1. TRANSMITTAL NUMBER:  <b>09-43-B</b>	2. STATE  <b>New York</b>
		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 <b>September 1, 2009</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>Section 1902(a)(30) of the Social Security Act</b> <b>42 CFR Part 447.204</b>		7. FEDERAL BUDGET IMPACT: a. FFY 09/01/09 - 09/30/09    \$ 598,206 b. FFY 10/01/09 - 09/30/10    \$7,178,499	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:  <b>Attachment 4.19-B: Pages 2(p) and 2(p)(i)</b>  <b>** SEE REMARKS</b>		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable):  <b>Attachment 4.19-B: Page 2(p)</b>	
10. SUBJECT OF AMENDMENT: <b>Freestanding Clinic Svcs. &amp; Payments (inc. smoking cessation, wheelchair evaluations, eyeglass dispensing and individual psychotherapy)</b> <b>FMAP = 61.59% Impact Based on Start Date of 9/1/09</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:	
13. TYPED NAME: <b>Jason A. Helgerson</b>		<b>New York State Department of Health</b>	
14. TITLE: <b>Medicaid Director &amp; Deputy Commissioner</b> <b>Department of Health</b>		<b>Corning Tower</b>	
15. DATE SUBMITTED:		<b>Empire State Plaza</b>	
		<b>Albany, New York 12237</b>	
<b>FOR REGIONAL OFFICE USE ONLY</b>			
17. DATE RECEIVED:		18. DATE APPROVED: <b>APR 05 2011</b>	
<b>PLAN APPROVED - ONE COPY ATTACHED</b>			
19. EFFECTIVE DATE OF APPROVED MATERIAL: <b>SEP 01 2009</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>This SPA approval consists of 2 Pages. We are approving the following Pages which were submitted with the State's February 14, 2011 electronic submission to the CMS SPA Mailbox: Attachment 4.19-B-Pages 2(p), and 2(p)(i). On August 20, 2010, the State had requested the original SPA 09-43 (which was submitted on March 31, 2009) be split into 2 new and separate SPAs: 09-43-A and 09-43-B. These 2 Pages replace the 2 Pages which were provided with its SPA submission of March 31, 2009 (Attachment 4.19-B, page 2(c)(A) and 2(c)(B)). In addition, in its letter of February 14, 2011, New York has revised and requested that the original March 1, 2009 requested effective date for 09-43 be changed to September 1, 2009 for SPA 09-43-B.</b>			