

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: HEALTH CARE FINANCING ADMINISTRATION	1. TRANSMITTAL NUMBER: 09-56-B	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 December 1, 2009
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5. TYPE OF PLAN MATERIAL (Check One):

NEW STATE PLAN AMENDMENT TO BE CONSIDERED AS NEW PLAN AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

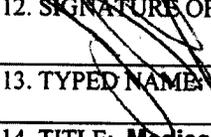
6. FEDERAL STATUTE/REGULATION CITATION: Section 1902(a)(30) of the Social Security Act 42 CFR §447.204	7. FEDERAL BUDGET IMPACT: a. FFY 12/01/09-9/30/10 \$ 150,749 b. FFY 10/01/10 - 9/30/11 \$ 166,926
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8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-B: Pages 1(c)(i)(C), 1(c)(i)(D) ** SEE REMARKS	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable):
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10. SUBJECT OF AMENDMENT:
**Adirondack Health Care Home Multipayor Program (Hospital-based Clinics)
(FMAP=61.59% (12/01/09-12/31/10); 58.77% (1/1/11-3/31/11); 56.88% (4/1/11-6/30/11); 50% (7/1/11 forward))**

11. GOVERNOR'S REVIEW (Check One):

GOVERNOR'S OFFICE REPORTED NO COMMENT OTHER, AS SPECIFIED:
 COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
 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: August 30, 2011	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED	18. DATE APPROVED
19. EFFECTIVE DATE OF APPROVED PLAN	20. SIGNATURE OF REGIONAL OFFICIAL
21. TYPED NAME	22. TITLE
23. REMARKS: Non-institutional services related to the rates of payment for hospital-based clinics	