

<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</b>		1. TRANSMITTAL NUMBER:  <b>10-38</b>	2. STATE  <b>New York</b>
<b>FOR: HEALTH CARE FINANCING ADMINISTRATION</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 16, 2010</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) of the Social Security Act, and 42 CFR 447</b>		7. FEDERAL BUDGET IMPACT: a. FFY 9/16/10-9/30/11: \$ 4,176,250 b. FFY 10/1/10-9/30/11: \$54,291,610	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:  <b>Attachment 4.19-B: Pages A, A(1), A(2), A(3), and A(4)</b>  <b>** SEE REMARKS</b>		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable):	
10. SUBJECT OF AMENDMENT: <b>Across the Board Reduction – Non-Institutional (FMAP = 61.59% based on effective period of 9/16/10-3/31/11)</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:			
14. TITLE: <b>Medicaid Director &amp; Deputy Commissioner Department of Health</b>			
15. DATE SUBMITTED: <b>12/14/10</b>			
<b>FOR REGIONAL OFFICE USE ONLY</b>			
17. DATE RECEIVED:		18. DATE APPROVED: <b>MAR 09 2011</b>	
<b>PLAN APPROVED - ONE COPY ATTACHED</b>			
19. EFFECTIVE DATE OF APPROVED MATERIAL: <b>SEP 16 2010</b>			
21. TYPED NAME: <b>Michael Melendez</b>		22. TITLE: <b>Division of Medicaid and State Operations</b>	
23. REMARKS: <b>As previously discussed with the State, CMS has identified concerns in the coverage and reimbursement sections of the approved State Plan. In accordance with the State Medicaid Director's letter dated October 1, 2010 (SMD #10-20) regarding SPA processing, we will send a separate letter to address those concerns. With this letter, we are enclosing the copies of SPA #10-38 and the HCFA-179 form, as approved.</b>			