DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Refer to DMCH: SJ

Region II
Federal Building
26 Federal Plaza
New York, N.Y. 10278

March 21, 2011

Jason A. Helgerson
State Medicaid Director
Deputy Commissioner
New York State Department of Health
Corning Tower
Empire State Plaza
Albany, New York 12237

Dear Commissioner Helgerson:

This is to notify you that New York State Plan Amendment (SPA) #07-12 has been approved for adoption into the State Medicaid Plan with an effective date of April 1, 2007. The SPA, concerning rates of payment for outpatient general hospitals and adult day health care services, provides for a trend factor that is equal to 75 percent of the otherwise applicable trend factor projection attributable to the January 1 to December 31, 2007 period, to be given for outpatient services on and after April 1, 2007 through March 31, 2008.

This SPA approval consists of 6 Pages. As New York has requested, we are approving the following Attachment 4.19B Pages which 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) In addition, we are approving Attachment 4.19B-Page 2(c) and 2(c)(A), which were by the State in its February 4, 2011 electronic transmission to CMS. The 6 Pages in these 2 transmissions replace the Attachment 4.19-B-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. The newly submitted Attachment 4.19B-Page 1(b)(ii) and 2(c)(A) were not provided in the original SPA submission.

This amendment satisfies all of the statutory requirements at sections 1902(a)(13) and (a)(30) of the Social Security Act, and the implementing regulations at 42 CFR 447.250 and 447.272. Enclosed are copies of SPA #07-12 and the HCFA-179 form, as approved.

If you have any questions or wish to discuss this SPA further, please contact Ricardo Holligan or Shing Jew of this office. Mr. Holligan may be reached at (212) 616-2424, and Mr. Jew's telephone number is (212) 616-2426.

Sincerely,

/s/

Michael J. Melendez
Acting Associate Regional Administrator
Division of Medicaid and Children's Health

Enclosure: SPA #07-12
HCFA-179 Form

CC: JUlberg
PMossman
KKnuth
SGaskins
RWeaver
LTavener
GCritelli
MSamuel
SJew

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: HEALTH CARE FINANCING ADMINISTRATION	1. TRANSMITTAL NUMBER: **07-12**	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, 2007**	

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: **§1902 (a)(30) Social Security Act** **42 CFR Part 447.204**	7. FEDERAL BUDGET IMPACT: a. FFY **4/1/07-9/30/07** **($349,772)** b. FFY **10/1/07-9/30/08** **($699,544)**
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: **Attachment 4.19-B, Pages 1(b)(i), 1(b)(ii), 2(b)(i), 2(c), 2(c)(A) & 7(a)(i)** **** SEE REMARKS**	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: **Attachment 4.19-B, Pages 1(b)(i), 2(b)(i), 2(c), 2(c)(A) & 7(a)(i)**

10. SUBJECT OF AMENDMENT:
Trend Factor Reduction—Non-Institutional
(FMAP = 50% as of effective date)

11. GOVERNOR'S REVIEW *(Check One)*:
☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

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**	
15. DATE SUBMITTED: **JAN 3 1 2011**	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:	18. DATE APPROVED: **MAR 1 8 2011**
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: **APR 0 1 2007**	20. SIGNATURE OF REGIONAL OFFICIAL:
21. TYPED NAME: **Michael Melendez**	22. TITLE: **Acting Associate Regional Administrator Division of Medicaid and State Operations**

23. REMARKS:

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).

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 4.19-B 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.

The newly submitted Attachment 4.19B Page 1(b)(ii) and 2(c)(A) were not provided in the original SPA submission.

FORM HCFA-179 (07-92)