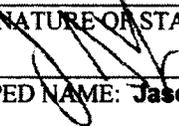
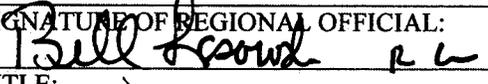


TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL		1. TRANSMITTAL NUMBER: 09-14-A	2. STATE New York
FOR: HEALTH CARE FINANCING ADMINISTRATION		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE April 1, 2009	
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 Subpart C		7. FEDERAL BUDGET IMPACT: a. FFY 04/01/09-09/30/09 \$102.27 million b. FFY 10/01/09-09/30/10 \$ 58.20 million c. FFY 10/01/10-03/31/11 \$ 56.87 million	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-D, page 47(x)(2)(b)		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Attachment 4.19-D, page 47(x)(2)(b)	
10. SUBJECT OF AMENDMENT: IGT/UPL for Nursing Homes Movement of the Base (FMAP=60.19% (4/1/09-6/30/09); 61.59% (7/1/09-12/31/10); 58.77% (1/1/11-3/31/11))			
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: May 6, 2011			

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:	18. DATE APPROVED: 05-16-11
PLAN APPROVED - ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: APR - 1 2009	20. SIGNATURE OF REGIONAL OFFICIAL: 
21. TYPED NAME: William Lasowski	22. TITLE: Deputy Director, CMCS
23. REMARKS:	