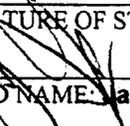


TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL		1. TRANSMITTAL NUMBER: 09-19	2. STATE New York
FOR: HEALTH CARE FINANCING ADMINISTRATION		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE: January 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)(30) of the Social Security Act 42 CFR Part 447.204		7. FEDERAL BUDGET IMPACT: a. FFY 01/01/09 - 09/30/09 (\$16,069,840) b. FFY 10/01/09 - 09/30/10 (\$21,926,040)	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-B: Pages 1(b)(i), 2(b)(ii), 2(c), 4(1), 6(a), 7(a)(ii)		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Attachment 4.19-B: Pages 1(b)(i), 2(b)(ii), 2(c), 4(1), 6(a), 7(a)(ii)	
10. SUBJECT OF AMENDMENT: Non-Institutional Trend Factor Adjustment (FMAP = 58.78% (1/1/09-3/31/09); 60.19% (4/1/09-6/30/09); 61.59% (7/1/09-9/30/10))			
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: October 26, 2011			

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED	18. DATE APPROVED December 22, 2011
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PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL January 1, 2009	20. SIGNATURE OF REGIONAL OFFICIAL 
21. TYPED NAME Michael Melendez	22. TITLE Associate Regional Administrator Division of Medicaid and Children Health Operations

22. REMARKS Non-Institutional Trend Factor Adjustment For 2008-2009
