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: **09-38**	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 **January 1, 2009**	

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) of the Social Security Act**	7. FEDERAL BUDGET IMPACT: **a. FFY 01/01/09-09/30/09 $210,718,034** **b. FFY 10/01/09-09/30/10 $287,508,279**
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: **Supplement 1 to Attachment 2.6-A: Pages 8, 9** **Supplement 6 to Attachment 2.6-A** ****SEE REMARKS BELOW**	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: **Supplement 1 to Attachment 2.6-A: Pages 8, 9** **Supplement 6 to Attachment 2.6-A**

10. SUBJECT OF AMENDMENT:
Medically Needy Income & Resource Levels – Optional State Supplemental Payments (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)*:
☒ 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 Department of Health**	
15. DATE SUBMITTED: March 21, 2012	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:	18. DATE APPROVED: **June 26, 2012**
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: **January 1, 2009**	20. SIGNATURE OF REGIONAL OFFICIAL: Michael J. Melendez
21. TYPED NAME: **Michael Melendez**	22. TITLE: **Associate Regional Administrator** **Division of Medicaid and State Operations**

23. REMARKS:

** By means of this SPA, New York proposes to annually revise its income standards for its Medically Needy eligibility group and for individuals receiving Optional State Supplement Payment to reflect cost of living increases. Optional State Supplementary Payment Recipients are an optional categorically needy Medicaid eligibility group that NY covers under its state plan. This SSI related eligibility group receives state-only income supplemental payments. NY 09-38 increases the income standards for these groups to reflect increases to the cost of living in the state during calendar year 2009.