

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:  <b>09-49-C</b>	2. STATE  <b>New York</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>December 1, 2009</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 447.204</b>	7. FEDERAL BUDGET IMPACT: a. FFY 12/01/09-09/30/10 \$ 594,241 b. FFY 10/01/10-09/30/11 \$ 1,799,211	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:  <b>Attachment 4.19-B, pages 1(c)(i)(E), 1(c)(i)(F)</b>  <b>** SEE REMARKS</b>	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable):	

10. SUBJECT OF AMENDMENT:  
**Patient Centered Medical Home Programs (Freestanding D&TCs) - 61.59% FMAP**

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

12. SIGNATURE OF STATE AGENCY OFFICIAL: <i>Deborah Bachrach</i>	16. RETURN TO: New York State Department of Health Corning Tower Empire State Plaza Albany, New York 12237
13. TYPED NAME: <b>Deborah Bachrach</b>	
14. TITLE: <b>Deputy Commissioner Department of Health</b>	
15. DATE SUBMITTED: <b>September 24, 2009</b>	

FOR REGIONAL OFFICE USE ONLY	
17. DATE RECEIVED	18. DATE APPROVED <b>Nov 23 2009</b>
19. EFFECTIVE DATE OF APPROVED MATERIAL <b>DEC 01 2009</b>	20. SIGNATURE OF REGIONAL OFFICIAL <i>[Signature]</i>
21. TYPED NAME <b>[Name]</b>	22. TITLE <b>Regional Administrator Division of Medicaid and State Operations</b>
23. REMARKS	