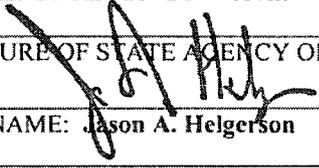


TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL		1. TRANSMITTAL NUMBER: 10-23	2. STATE New York
FOR: HEALTH CARE FINANCING ADMINISTRATION		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE April 1, 2010	
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 447.204		7. FEDERAL BUDGET IMPACT: a. FFY 04/01/10-09/30/10 \$47,373,314 b. FFY 10/01/10-03/31/11 \$46,288,781	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-B, pages 2(c)(v) **SEE REMARKS BELOW		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Attachment 4.19-B, pages 2(c)(v)	
10. SUBJECT OF AMENDMENT: Hospital Outpatient UPL (FMAP = 61.59% (4/1/10-12/31/10); 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 Bureau of HCRA Oper & Financial Analysis 99 Washington Ave – One Commerce Plaza Suite 810 Albany, NY 12210	
13. TYPED NAME: Jason A. Helgerson			
14. TITLE: Medicaid Director Department of Health			
15. DATE SUBMITTED: November 5, 2012			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED:		18. DATE APPROVED: November 8, 2012	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: April 01, 2010		20. SIGNATURE OF REGIONAL OFFICIAL: 	
21. TYPED NAME: Michael Melendez		22. TITLE: Associate Regional Administrator Division of Medicaid and State Operations	
23. REMARKS:			