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: **#11-12**

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 **April 1, 2011**

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, and 42 CFR 447

7. FEDERAL BUDGET IMPACT:
a. FFY 04/01/11-09/30/11 **$48.4 million**
b. FFY 10/01/11-09/30/12 **$90.5 million**

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-B: Pages 47(x)(9), 47(x)(11), 47(x)(12), 47(x)(13), 47(x)(14), 51(a)(1), 51(a)(1)(a), 110(E)(1)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-B: Pages 47(x)(9), 47(x)(11), 47(x)(12), 47(x)(13), 47(x)(14), 51(a)(1), 110(E)(1)

10. SUBJECT OF AMENDMENT:
2011 Cost Containment - LTC
(FMAP = 56.88% 4/1/11-6/30/11; 50% 7/1/11 forward)

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:

13. TYPED NAME: **Jason A. Helgerson**

14. TITLE: **Medicaid Director & Deputy Commissioner Department of Health**

15. DATE SUBMITTED: June 9. 2011

16. RETURN TO:
New York State Department of Health
Corning Tower
Empire State Plaza
Albany, New York 12237

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED: JUL 18 2011

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: APR - 1 2011

20. SIGNATURE OF REGIONAL OFFICIAL: Penny Thompson

21. TYPED NAME: Penny Thompson

22. TITLE: Deputy Director, CMCS

23. REMARKS:

FORM HCFA-179 (07-92)