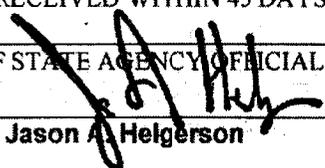
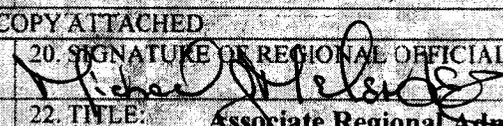


<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</b>  <b>FOR: HEALTH CARE FINANCING ADMINISTRATION</b>		1. TRANSMITTAL NUMBER: <b>#11-72</b>	2. STATE <b>New York</b>
		3. PROGRAM IDENTIFICATION: <b>TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)</b>	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE <b>April 1, 2011</b>	
5. TYPE OF PLAN MATERIAL ( <i>Check One</i> ):  <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 ( <i>Separate Transmittal for each amendment</i> )			
6. FEDERAL STATUTE/REGULATION CITATION: <b>Section 1902(a) of the Social Security Act, and 42 CFR 447</b>		7. FEDERAL BUDGET IMPACT: a. FFY 04/1/11-9/30/11 (\$47.5 million) b. FFY 10/1/11-9/30/12 (\$88.9 million)	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:  <b>Attachment 4.19-B: Pages A(4), A(5), A(6), A(7), 4(d)</b>  <b>** SEE REMARKS</b>		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT ( <i>If Applicable</i> ):  <b>Attachment 4.19-B: Page A(4), 4(d)</b>	
10. SUBJECT OF AMENDMENT: <b>ATB Reduction – Non-Institutional (FMAP = 56.88% 4/1/11-6/30/11; 50% 7/1/11 forward)</b>			
11. GOVERNOR'S REVIEW ( <i>Check One</i> ): <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: <b>New York State Department of Health Corning Tower Empire State Plaza Albany, New York 12237</b>	
13. TYPED NAME: <b>Jason A. Helgerson</b>			
14. TITLE: <b>Medicaid Director &amp; Deputy Commissioner Department of Health</b>			
15. DATE SUBMITTED: <b>NOV 02 2011</b>			
<b>FOR REGIONAL OFFICE USE ONLY</b>			
17. DATE RECEIVED:		18. DATE APPROVED: <b>December 8, 2011</b>	
<b>PLAN APPROVED – ONE COPY ATTACHED</b>			
19. EFFECTIVE DATE OF APPROVED MATERIAL: <b>April 1, 2011</b>		20. SIGNATURE OF REGIONAL OFFICIAL: 	
21. TYPED NAME: <b>Michael Melendez</b>		22. TITLE: <b>Associate Regional Administrator Division of Medicaid and State Operations</b>	
23. REMARKS:  <b>Across the Board Reduction – Non-Institutional</b>			