

## **Table of Contents**

**State/Territory Name: New York**

**State Plan Amendment (SPA) NY: 21-0051**

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) CMS 179 Form/Summary Form (with 179-like data)
- 3) Approved SPA Pages

**DEPARTMENT OF HEALTH & HUMAN SERVICES**

Centers for Medicare & Medicaid Services  
Center for Medicaid & CHIP Services  
233 North Michigan Ave., Suite 600  
Chicago, Illinois 60601



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**Financial Management Group**

Mr. Amir Bassiri  
Acting Medical Director  
New York State Department of Health  
Division of Finance and Rate Setting  
99 Washington Avenue  
One Commerce Plaza, Suite 1432  
Albany, NY 12210

RE: TN 21-0051

Dear Mr. Bassiri:

We have reviewed the proposed New York State Plan Amendment (SPA) to Attachment 4.19-B NY 21-0051, which was submitted to the Centers for Medicare & Medicaid Services (CMS) on September 30, 2021. This plan amendment updates the Ambulatory Patient Group (APG) for freestanding clinics.

Based upon the information provided by the State, we have approved the amendment with an effective date of July 1, 2021. We are enclosing the approved CMS-179 and a copy of the new state plan pages.

If you have any additional questions or need further assistance, please contact Jerica Bennett at (410)-786-1167 or [Jerica.Bennett@cms.hss.gov](mailto:Jerica.Bennett@cms.hss.gov).

Sincerely,

Todd McMillion  
Director  
Division of Reimbursement Review

Enclosures

**TRANSMITTAL AND NOTICE OF APPROVAL OF  
STATE PLAN MATERIAL  
FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES**

1. TRANSMITTAL NUMBER _____	2. STATE
3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
4. PROPOSED EFFECTIVE DATE	

TO: REGIONAL ADMINISTRATOR  
CENTERS FOR MEDICARE & MEDICAID SERVICES  
DEPARTMENT OF HEALTH AND HUMAN SERVICES

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	7. FEDERAL BUDGET IMPACT a. FFY _____ \$ _____ b. FFY _____ \$ _____
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT ( <i>If Applicable</i> )

10. SUBJECT OF AMENDMENT

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 	16. RETURN TO
13. TYPED NAME	
14. TITLE	
15. DATE SUBMITTED      September 30, 2021	

**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED September 30, 2021	18. DATE APPROVED
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**PLAN APPROVED - ONE COPY ATTACHED**

19. EFFECTIVE DATE OF APPROVED MATERIAL July 1, 2021	20. SIGNATURE OF REGIONAL OFFICIAL
21. TYPED NAME Todd McMillion	22. TITLE Director Division of Reimbursement Review

23. REMARKS





