DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Refer to DMCH: SJ

Region II
Federal Building
26 Federal Plaza
New York, N.Y. 10278

OCT 17 2011

Jason A. Helgerson
Deputy Commissioner
New York State Department of Health
Corning Tower, Empire State Plaza
Albany, New York 12237

Dear Commissioner Helgerson:

This is to notify you that New York State Plan Amendment (SPA) #10-27-A has been approved for adoption into the State Medicaid Plan with an effective date of August 1, 2010. The SPA authorizes payment adjustments that increase the operating cost components of rates of payment for New York City Health and Hospitals Corporation clinics and certain county operated freestanding clinics, for the period August 1, 2010 through March 31, 2011.

Originally, the State submitted SPA #10-27 on September 30, 2010. However, on August 4, 2011, the State request that the SPA be split into 2 separate SPAs: #10-27-A and #10-27-B. We have approved the State's request, and, at this time, we are approving #10-27-A. Processing of SPA #10-27-B will be completed at a later time.

This SPA approval consists of 1 Page. As New York has requested, we are approving the following Attachment 4.19-B Page which was submitted by the State via electronic transmission on August 4, 2011 to CMS: Attachment 4.19-B-Page 2(v). In addition, we are processing the SPA using the HCFA-179 which was provided by the State to CMS on August 4, 2011. These replace the materials provided in the State's original September 30, 2010 submission.

This amendment satisfies all of the statutory requirements at sections 1902(a)(13) and (a)(30) of the Social Security Act, and the implementing regulations at 42 CFR 447.250 and 447.272. Enclosed are copies of #10-27-A and the HCFA-179 form, as approved.

If you have any questions or wish to discuss this SPA further, please contact Ricardo Holligan or Shing Jew of this office. Mr. Holligan may be reached at (212) 616-2424, and Mr. Jew's telephone number is (212) 616-2426.

Sincerely,

Michael Melendez
Associate Regional Administrator
Division of Medicaid and Children's Health

Enclosure: SPA #10-27-A
HCFA-179 Form

CC: JUlberg
PMossman
KKnuth
RWeaver
LTavener
MRoss
AHiggs
GCritelli
SJew

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: **10-27-A**	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 **August 1, 2010**	

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 **08/01/10-09/30/10 $2.77 million** b. FFY **10/01/10-03/31/11 $8.12 million**
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: **Attachment 4.19-B: Pages 2(v)** **** SEE REMARKS**	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

10. SUBJECT OF AMENDMENT:
D&TC UPL Payments (HHC & non-HHC)
Tiered FMAP = 61.59% (08/01/10-12/31/10); **58.77%** (01/01/11-03/31/11)

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:	16. RETURN TO: **New York State Department of Health** **Corning Tower** **Empire State Plaza** **Albany, New York 12237**
13. TYPED NAME: **Jason A. Helgerson**	
14. TITLE: **Medicaid Director & Deputy Commissioner Department of Health**	
15. DATE SUBMITTED: **AUG 04** [redacted]	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:	18. DATE APPROVED: **October 17, 2011**

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: **August 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:

The SPA authorizes payment adjustment to increase the operating cost components of the rates of payment for New York City Health and Hospitals Corporation clinics and certain county operated freestanding clinics.

FORM HCFA-179 (07-92)