

NEW YORK
state department of
HEALTH

Nirav R. Shah, M.D., M.P.H.
Commissioner

Sue Kelly
Executive Deputy Commissioner

June 30, 2011

Mr. Michael Melendez
Associate Regional Administrator
Department of Health & Human Services
Centers for Medicare & Medicaid Services
New York Regional Office
Division of Medicaid and Children's Health
26 Federal Plaza - Room 3800
New York, New York 10278

RE: SPA #11-43

Dear Mr. Melendez:

The State requests approval of the enclosed amendment #11-43 to the Title XIX (Medicaid) State Plan effective June 1, 2011 (Appendix I).

A summary of the plan amendment is provided in Appendix II. Copies of pertinent sections of proposed State statute are enclosed for your information (Appendix III).

In keeping with our continued agreement, this amendment is being sent to you prior to the end of the second quarter.

If you or your staff have any questions or need any assistance, please contact Karla Knuth, of my staff, at (518) 473-8822.

Sincerely,


Jason A. Helgeson
Medicaid Director
Deputy Commissioner
Office of Health Insurance Programs

Enclosures

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: Centers for Medicare & Medicaid Services		1. TRANSMITTAL NUMBER: 11-43	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 June 1, 2011	
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: 42 CFR 431.50		7. FEDERAL BUDGET IMPACT: a. FFY 10/1/10 – 9/30/11 \$0 b. FFY 10/1/11 – 9/30/12 \$0	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Condition or Requirement 1.3 Statewide Operation		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (<i>If Applicable</i>): Condition or Requirement 1.3 Statewide Operation	
10. SUBJECT OF AMENDMENT: Shared State and Local responsibility for administration of Medicaid program.			
11. GOVERNOR'S REVIEW (<i>Check One</i>): <input 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 Corning Tower Empire State Plaza Albany, New York 12237	
13. TYPED NAME: JASON A. HELGERSON			
14. TITLE: Medicaid Director Deputy Commissioner Office of Health Insurance Programs			
15. DATE SUBMITTED: June 30, 2011			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED:		18. DATE APPROVED:	
PLAN APPROVED – ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL:		20. SIGNATURE OF REGIONAL OFFICIAL:	
21. TYPED NAME:		22. TITLE:	
23. REMARKS:			

Appendix I
2011 Title XIX State Plan
First Quarter Amendment
Non-Institutional Services
Amended SPA Pages

HCFA-AT-30-33 (SPP)

State/Territory : New York

Citation	Condition or Requirement
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Citation
42 CFR
431.50(b)
AT-79-29

1.3 Statewide Operation

The plan is in operation on a Statewide basis in accordance with all requirements Of 42 CFR 431.50.

- The plan is State administered.
- The plan is administered by the political subdivisions of the State and is mandatory on them.

TN#: 11-43

Approval Date _____

Supersedes TN#: 74-25

Effective Date 6/1/2011

Appendix II
2011 Title XIX State Plan
First Quarter Amendment
Non-Institutional Services
Summary

Summary
SPA #11-43

This State Plan Amendment proposes to indicate the State's shared responsibility for processing renewals for a subset of Medicaid and Family Health Plus enrollees through a centralized Enrollment Center beginning in June 2011.