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: **04-07**

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
January 1, 2004

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:
42 CFR 447.204

7. FEDERAL BUDGET IMPACT:
a. FFY 01/01/04 – 09/30/04 $0
b. FFY 10/01/04 – 09/30/05 $0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-B, Page 2(c)(iv)(a)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
New Page NewYork (04-07)
Approved: 06/15/04
Effective: 01/01/04

10. SUBJECT OF AMENDMENT:
Non-Institutional, Federally Qualified Health Centers and Rural Health Centers

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: Kathryn Kuhmerker

13. TYPED NAME: **Kathryn Kuhmerker**

14. TITLE: **Deputy Commissioner**
Department of Health

15. DATE SUBMITTED:
March 19, 2004

16. RETURN TO:
New York State Department of Health, Corning Tower, Empire State Plaza, Room 1466, Albany, New York 12237

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. [illegible]

PLAN APPROVED – OFFICIALLY APPROVED

19. EFFECTIVE DATE OF APPROVED MATERIAL: JAN 01 2004

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: See Sally

22. TITLE:

23. REMARKS:

FORM HCFA-179 (07-92)

OFFICIAL

Diagnostic and treatment centers eligible for rates of payment as a federally qualified or rural health center, which were also certified by the Department of Health as a preferred primary care provider as of December 31, 2000, and receiving rates of payment through the Products of Ambulatory Care reimbursement system as of such date, may elect to continue to be reimbursed via this alternative method of reimbursement. In no event shall rates of payment to these facilities be less than those computed as described on page 2(c)(iv) of this plan.