

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL**

1. TRANSMITTAL NUMBER:
09-006

2. STATE
Indiana

FOR: HEALTH CARE FINANCING ADMINISTRATION

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, 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:
405 IAC 1-14.6-2

7. FEDERAL BUDGET IMPACT:
a. FFY 2010 \$ (\$4.7 million)
b. FFY 2011 \$ (\$6.3 million)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attach 4.19 D pgs 2, 3, 4, 5, 6, 7, 8, 10, 11, 14, 18, 19, 21, 22, 22A, 23,
23A, 23B, 23C, 23D, 24, 41, 44Cont

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION
OR ATTACHMENT (If Applicable):

Attach 4.19 D pgs 2, 3, 3A, 4, 5, 5A, 6, 7, 8, 10, 11, 14, 18, 19,
19A, 21, 22, 22A, 23, 23A, 23B, 23C, 23D, 23E, 23F, 23G, 23H,
23I, 24, 41, 44Cont

(Pgs 3A, 5A, 19A, 23E-23I are being removed)

10. SUBJECT OF AMENDMENT:

Revise the reimbursement methodology for nursing facilities and applicable definitions.

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:

Indiana's Medicaid State Plan does not require the
Governor's review. See Section 7.4 of the State Plan

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME: Patricia Casanova

14. TITLE: Director of Medicaid

15. DATE SUBMITTED: NOVEMBER 19, 2009

16. RETURN TO:

Patricia Casanova
Director of Medicaid
Indiana Office of Medicaid Policy and Planning
402 West Washington Street, Room W382
Indianapolis, IN 46204
ATTN: Bridget McLaughlin, State Plan Coordinator

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED:
5-25-10

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
JAN - 1 2010

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: William Lasowski

22. TITLE: Deputy Director, CMCS

23. REMARKS: