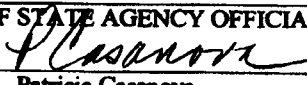



TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL		1. TRANSMITTAL NUMBER: 10-007	2. STATE Indiana
FOR: HEALTH CARE FINANCING ADMINISTRATION		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE May 1, 2010	
5. TYPE OF PLAN MATERIAL (Check One): <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 (Separate Transmittal for each amendment)			
6. FEDERAL STATUTE/REGULATION CITATION: Section 1927 (a) of the Act		7. FEDERAL BUDGET IMPACT: a. FFY 2010 \$ (1.77 million) b. FFY 2011 \$ (3.85 million)	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-B, Page 1f Attachment 3.1-A, Addendum Pages 7, 7.1		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): None Attachment 3.1-A, Addendum Page 7	
10. SUBJECT OF AMENDMENT: Revises reimbursement for physician-administered drugs by replacing the rates currently calculated based on Average Wholesale Price (AWP) with revised rates based on other pricing metrics.			
11. GOVERNOR'S REVIEW (Check One): <input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input checked="" 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 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: 		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	
13. TYPED NAME: Patricia Casanova			
14. TITLE: Director of Medicaid			
15. DATE SUBMITTED: Initially submitted 4-21-2010; Revised 10-5-2010			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED: 04-21-10		18. DATE APPROVED: 12-22-10	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: 05-01-10		20. SIGNATURE OF REGIONAL OFFICIAL: 	
21. TYPED NAME: Verlon Johnson		22. TITLE: Acting Associate Regional Administrator	
23. REMARKS:			