

<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</b>	1. TRANSMITTAL NUMBER: 12-011	2. STATE Indiana
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
FOR: HEALTH CARE FINANCING ADMINISTRATION		4. PROPOSED EFFECTIVE DATE July 1, 2012
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		

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)(13)(A) of the Social Security Act (42 USC 1396a(a)(13)) and 42 CFR 447, Subpart C	7. FEDERAL BUDGET IMPACT: a. FFY 2012 \$0.00 Thousands b. FFY 2013 \$0.00 Thousands
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:  Attachment 4.19D Pages 2, 4, 8, 9, 22 Continued, 22A, 23, 25, 26, 27, 28, 29, 37, 42, 43, 44, 70, 74, 90, 91, 117, 118	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable):  Attachment 4.19D Pages 2, 4, 8, 9, 22 Continued, 22A, 23, 25, 26, 27, 28, 29, 37, 42, 43, 44, 70, 74, 90, 91, 117, 118

10. SUBJECT OF AMENDMENT:  
This SPA makes conforming changes to the State Plan to implement changes made to 405 IAC 1-12 and 405 IAC 1-14.6, limiting certain nursing facility rental costs and other administrative changes to nursing facility and ICF/MR reimbursement

11. GOVERNOR'S REVIEW (Check One):

GOVERNOR'S OFFICE REPORTED NO COMMENT       OTHER, AS SPECIFIED:  
 COMMENTS OF GOVERNOR'S OFFICE ENCLOSED  
 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: Audie Gilmer, State Plan Coordinator
13. TYPED NAME: Patricia Casanova	
14. TITLE: Director of Medicaid	
15. DATE SUBMITTED: 9-28-12	

**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED:	18. DATE APPROVED: FEB 25 2013
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**PLAN APPROVED - ONE COPY ATTACHED**

19. EFFECTIVE DATE OF APPROVED MATERIAL:	20. SIGNATURE OF REGIONAL OFFICIAL: 
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21. TYPED NAME: Penny Thompson	22. TITLE: Deputy Director
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23. REMARKS