

<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</b>  <b>FOR: HEALTH CARE FINANCING ADMINISTRATION</b>		1. TRANSMITTAL NUMBER:  09-52	2. STATE  New York
		3. PROGRAM IDENTIFICATION: <b>TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)</b>	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE <b>October 1, 2009</b>	
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: <b>NYS Social Services Law Section 365-a(4)(a-1)(ii) &amp; 367-a(9)(d)(ii)</b>		7. FEDERAL BUDGET IMPACT: a. FFY <del>2010</del> (\$2,343,700) b. FFY <del>2010</del> (\$5,998,700)	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:  Attachment 4.18-A, page 1c, Attachment 4.18-C page 1c, Attachment 3.1-A Supplement page 2b, Attachment 3.1-B Supplement page 2b, Attachment 4.19-B, pages 4(d) & 4(e) <b>** SEE REMARKS</b>		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable):  Attachment 4.18-A, page 1c, Attachment 4.18-C page 1c, Attachment 3.1-A Supplement page 2b, Attachment 3.1-B Supplement page 2b, Attachment 4.19-B, pages 4(d) & 4(e)	
10. SUBJECT OF AMENDMENT: <b>Dispense Brand Drugs When Less Expensive</b>			
11. GOVERNOR'S REVIEW (Check One): <input checked="" 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: <i>Deborah Bachrach</i>		16. RETURN TO: <b>New York State Department of Health Corning Tower Empire State Plaza Albany, New York 12237</b>	
13. TYPED NAME: <b>Deborah Bachrach</b> <i>DF</i>			
14. TITLE: <b>Deputy Commissioner Department of Health</b>			
15. DATE SUBMITTED: 10/8/09			
<b>FOR REGIONAL OFFICE USE ONLY</b>			
17. DATE RECEIVED:		18. DATE APPROVED: <b>MAR 12 2010</b>	
<b>PLAN APPROVED - ONE COPY ATTACHED</b>			
19. EFFECTIVE DATE OF APPROVED MATERIAL: <b>OCT 01 2009</b>		20. SIGNATURE OF REGIONAL OFFICIAL: <i>[Signature]</i>	
21. TYPED NAME: <b>Michael Melendez</b>		22. TITLE: <b>Acting Associate Regional Administrator Division of Medicaid and State Operations</b>	
23. REMARKS:  <b>Pen &amp; Ink change in Block 7 to reflect FFY 2010 &amp; 2011 authorized by State in e-mail of 12/10/09.</b>  <b>Originally submitted pages Attachment 4.18A, page 1c and Attachment 4.18C, page 1c were replaced with revised pages via State e-mail of 01/21/2010.</b>			