

<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</b>		1. TRANSMITTAL NUMBER: <b>10-10</b>	2. STATE <b>New York</b>
<b>FOR: HEALTH CARE FINANCING ADMINISTRATION</b>		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 <b>January 1, 2010</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>Section 1927 of the Social Security Act</b>		7. FEDERAL BUDGET IMPACT: a. FFY 2010 \$0 b. FFY 2011 (\$6.5 million)	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: <b>Attachment 3.1A Supplement page 2b, Attachment 3.1B Supplement page 2b</b> <b>** SEE REMARKS</b>		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): <b>Attachment 3.1A Supplement page 2b, Attachment 3.1B Supplement page 2b</b>	
10. SUBJECT OF AMENDMENT: <b>State Specific Supplemental Drug Rebate Program</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:		16. RETURN TO: <b>New York State Department of Health Corning Tower Empire State Plaza Albany, New York 12237</b>	
13. TYPED NAME: <b>Donna Frescatore</b>			
14. TITLE: <b>Deputy Commissioner Department of Health</b>			
15. DATE SUBMITTED: <b>3/31/10</b>			
<b>FOR REGIONAL OFFICE USE ONLY</b>			
17. DATE RECEIVED:		18. DATE APPROVED: <b>SEP 29 2010</b>	
<b>PLAN APPROVED - ONE COPY ATTACHED</b>			
19. EFFECTIVE DATE OF APPROVED MATERIAL: <b>JAN 01 2010</b>		20. SIGNATURE OF REGIONAL OFFICIAL:	
21. TYPED NAME: <b>Sue Kelly</b>		22. TITLE: <b>Associate Regional Administrator Division of Medicaid and State Operations</b>	
23. REMARKS: <b>Originally submitted pages on March 31, 2010 were revised with pages via State's email of July 3, 2010. (Attachment 3.1-A and Attachment 3.1-B)</b> <b>Approval date is September 29, 2010 and the effective date is January 1, 2010.</b>			