

<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</b>		1. TRANSMITTAL NUMBER: 10-001	2. STATE TENNESSEE
<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 January 1, 2010	
5. TYPE OF PLAN MATERIAL ( <i>Check One</i> ):			
<input type="checkbox"/> NEW STATE PLAN                      AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT ( <i>Separate Transmittal for each amendment</i> )			
6. FEDERAL STATUTE/REGULATION CITATION: 42 CFR 435		7. FEDERAL BUDGET IMPACT: Required by Federal statute; budget impact unknown.	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 2.2-A, page 9b, 9b.1, and 9b.2; Attachment 2.6-A, page 22 and 22a.		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT ( <i>If Applicable</i> ): Attachment 2.6-A, page 9b and 9b1; Attachment 2.6-A, page 22 and 22a.	
10. SUBJECT OF AMENDMENT: Groups Covered and Agencies Responsible for Eligibility Determination; Eligibility Conditions and Requirements – Medicare Improvements for Patients and Providers Act of 2008 (MIPPA).			
11. GOVERNOR'S REVIEW ( <i>Check One</i> ):			
<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:	
13. TYPED NAME: Darin J. Gordon		Tennessee Department of Finance and Administration Bureau of TennCare 310 Great Circle Road Nashville, Tennessee 37243	
14. TITLE: Director, Bureau of TennCare		Attention: George Woods	
15. DATE SUBMITTED: 3/29/10			
<b>FOR REGIONAL OFFICE USE ONLY</b>			
17. DATE RECEIVED: 03/29/10		18. DATE APPROVED: 06/25/10	
<b>PLAN APPROVED – ONE COPY ATTACHED</b>			
19. EFFECTIVE DATE OF APPROVED MATERIAL:		20. SIGNATURE OF REGIONAL OFFICIAL:	
21. TYPED NAME: Jackie Glaze		22. TITLE: Associate Regional Administrator Division of Medicaid & Children's Health Opns	
23. REMARKS:			