

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL**

1. TRANSMITTAL NUMBER:
10-018

2. STATE
California

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
October 1, 2010

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:
**42CFR 431.12, Section 1902(a)(73) of the
Social Security Act**

7. FEDERAL BUDGET IMPACT:

a. FFY \$0
b. FFY \$0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Section 1.4, pages 9-~~11~~ 9.1, 9.2, 9.3

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION
OR ATTACHMENT (*If Applicable*):
Section 1.4, page 9

10. SUBJECT OF AMENDMENT:
Tribal Consultation Requirements

11. GOVERNOR'S REVIEW (*Check One*):

GOVERNOR'S OFFICE REPORTED NO COMMENT OTHER, AS SPECIFIED:
 COMMENTS OF GOVERNOR'S OFFICE ENCLOSED The Governor's Office does not
 NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL wish to review the State Plan Amendment.

12. SIGNATURE OF STATE AGENCY OFFICIAL:


13. TYPED NAME:
Toby Douglas

14. TITLE:
Chief Deputy Director

15. DATE SUBMITTED: **12-22-2010**

16. RETURN TO:

**Department of Health Care Services
Attn: State Plan Coordinator
1501 Capitol Avenue, Suite 71.3.26
P.O. Box 997417
Sacramento, CA 95899-7417**

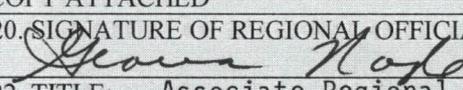
FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: **12/22/10**

18. DATE APPROVED: **MAR 16 2011**

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: **10/1/10**

20. SIGNATURE OF REGIONAL OFFICIAL:


21. TYPED NAME: **Gloria Nagle**

22. TITLE: **Associate Regional Administrator**

23. REMARKS:

Pen and ink changes to Box 8 confirmed via email on 3/8/11.