DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: **SPA #11-010**

2. STATE **DELAWARE**

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, 2011

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN **XXX** AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR Part 460

7. FEDERAL BUDGET IMPACT:
a. FFY 2011 $ -0-
b. FFY 2012 $ -0-

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

General Program Administration Page 19c
Attachment 2.2-A Page 11
Attachment 3.1-A Page 11
Supplement 2 to Attachment 3.1-A Pages 1 through 9

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

New
Attachment 2.2-A Page 11
New
New

10. SUBJECT OF AMENDMENT: **This State plan amendment will allow Delaware Medicaid to offer Program of All-Inclusive Care (PACE) as an optional Medicaid service.**

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
XXX OTHER, AS SPECIFIED:
Governor's comments under separate correspondence

12. SIGNATURE OF STATE AGENCY OFFICIAL:
//Rosanne Mahaney – signature//

13. TYPED NAME:
Rosanne Mahaney, Director, Division of Medicaid and Medical Assistance

14. TITLE: **Designee for Rita M. Landgraf, Secretary, Delaware Health and Social Services**

15. DATE SUBMITTED:
December 1, 2011

16. RETURN TO:

Rosanne Mahaney
Director
Division of Medicaid and Medical Assistance
P.O. Box 906
New Castle, Delaware 19720-0906

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
12/1/2011

18. DATE APPROVED: FEB 28 2012

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
10/1/2011

20. SIGNATURE OF REGIONAL OFFICIAL:
[redacted]

21. TYPED NAME:
Francis McCullough

22. TITLE: Associate Regional Administrator
Division of Medicaid and Children's Health Operations

23. REMARKS:

FORM HCFA-179 (07-92)