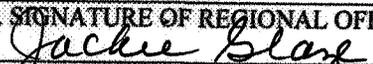


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|--|--|---|---------------------|
| <b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</b>   |  | 1. TRANSMITTAL NUMBER:<br>13-008  | 2. STATE<br>GEORGIA |
|  |  | 3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)  |                     |
| TO: REGIONAL ADMINISTRATOR<br>CENTERS FOR MEDICARE AND MEDICAID SERVICES<br>DEPARTMENT OF HEALTH AND HUMAN SERVICES  |  | 4. PROPOSED EFFECTIVE DATE<br>April 1, 2013   |                     |
| 5. TYPE OF PLAN MATERIAL (Check One):  |  |   |                     |
| <input type="checkbox"/> NEW STATE PLAN                      AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT<br>COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment) |  |   |                     |
| 6. FEDERAL STATUTE/REGULATION CITATION:  |  | 7. FEDERAL BUDGET IMPACT:<br>FFY 2013 \$<br>FFY 2014 \$   |                     |
| 8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:<br><br>Attachment 3.1-A, Page 7  |  | 9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable):<br><br>Attachment 3.1-A, Page 7                            |                     |
| 10. SUBJECT OF AMENDMENT: The Department of Community Health will provide both curative and hospice services in accordance with the Affordable Care Act.   |  |   |                     |
| 11. GOVERNOR'S REVIEW (Check One):   |  |   |                     |
| <input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT   |  | <input checked="" type="checkbox"/> OTHER, AS SPECIFIED:  |                     |
| <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED  |  | Single State Agency Comments Attached   |                     |
| <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL   |  |   |                     |
| 12. SIGNATURE OF STATE AGENCY OFFICIAL:<br>  |  | 16. RETURN TO:  |                     |
| 13. TYPED NAME: JERRY DUBBERLY   |  | Department of Community Health<br>Division of Medicaid<br>2 Peachtree Street, NW, 36 <sup>th</sup> Floor<br>Atlanta, Georgia 30303-3159 |                     |
| 14. TITLE: CHIEF, DIVISION OF MEDICAID   |  |   |                     |
| 15. DATE SUBMITTED:  |  |   |                     |

|  |   |
|--|---|
| <b>FOR REGIONAL OFFICE USE ONLY</b>  |   |
| 17. DATE RECEIVED: 05-24-13  | 18. DATE APPROVED: 07-03-13   |
| <b>PLAN APPROVED - ONE COPY ATTACHED</b>   |   |
| 19. EFFECTIVE DATE OF APPROVED MATERIAL: 04-01-13  | 20. SIGNATURE OF REGIONAL OFFICIAL:<br> |
| 21. TYPED NAME:<br>Jackie Glaze  | 22. TITLE: Associate Regional Administrator<br>Division of Medicaid & Children Health Opns                                  |
| 23. REMARKS:<br><br>Approved with the following changes to item 6, 7a, 7b, 8 and 9 as authorized by State Agency e-mails dated 07/01/13<br>Block # 6 Changed to read: 42 USCS 1396d (0)(1)(C) as amended by Section 2302 of the Affordable Care Act. Block # 7 Changed to read: FFY 13 0 and FFY 14 0.<br>Block # 8 Changed to read: Attachment 3.1-A page 7 and Attachment 3.1-B page 6; Block # 9 Changed to read: Attachment 3.1-A page 7 and Attachment 3.1-B page 6 |   |