

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

1. TRANSMITTAL NUMBER:
13-20

2. STATE
Washington

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, 2013

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:

7. FEDERAL BUDGET IMPACT:

a. FFY 2014 \$0

b. FFY 2015 \$0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Att. 3.1-C pages 16 – 28 (remove)

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION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

10. SUBJECT OF AMENDMENT:

Remove Chronic Care Management

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

☒ OTHER, AS SPECIFIED: Exempt

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:

MARYANNE LINDEBLAD

14. TITLE:

MEDICAID DIRECTOR

15. DATE SUBMITTED:

9-26-13

16. RETURN TO:

Ann Myers

Office of Rules and Publications

Legal and Administrative Services

Health Care Authority

626 8th Ave SE MS: 42716

Olympia, WA 98504-2716

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

9-26-13

18. DATE APPROVED:

10-25-13

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

10-01-13

21. TYPED NAME:

Carol J.C. Peverly

20. SIGNATURE OF REGIONAL OFFICIAL:

22. TITLE: Associate Regional Administrator

Division of Medicaid & Children's Health

23. REMARKS: