

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL	1. TRANSMITTAL NUMBER: 11-09	2. STATE District of Columbia
--	---	---

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES	3. PROGRAM IDENTIFICATION: Title XIX of the Social Security Act
--	---

TO: Regional Administrator Centers for Medicare & Medicaid Services Department of Health and Human Services	4. PROPOSED EFFECTIVE DATE SM March 17, 2012
---	---

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 42 CFR Part 440, Subpart B	7. FEDERAL BUDGET IMPACT a. FFY 12 \$ 4,062,822 b. FFY 13 \$ 4,339,094
--	---

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT Supplement 1 to Attachment 3.1-A p 20, p 21 Supplement 1 to Attachment 3.1-B p 19, p 20 Supplement 6 to Attachment 3.1-A p 1, pp 11-19 (NEW) Supplement 3 to Attachment 3.1-B p 1, pp 11-19 (NEW) Supplement 2 to Attachment 4.19-B p2	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable) Supplement 1 to Attachment 3.1-A p 20, p 21 Supplement 1 to Attachment 3.1-B p 19, p 20 Supplement 6 to Attachment 3.1-A p 1 Supplement 3 to Attachment 3.1-B p 1 Supplement 2 to Attachment 4.19-B p2
---	--

10. SUBJECT OF AMENDMENT:

Medicaid Adult Substance Abuse Rehabilitation Services SPA

11. GOVERNOR'S REVIEW (Check One)

GOVERNOR'S OFFICE REPORTED NO COMMENT
 OTHER, AS SPECIFIED:
 Resolution Number: 19-478


COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
 NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

12. SIGNATURE OF STATE AGENCY OFFICIAL	16. RETURN TO Linda Elam, Ph.D. Deputy Director/Medicaid Director Department of Health Care Finance 899 N. Capitol St., NE, 6 th Floor Washington, DC 20002
13. TYPED NAME Linda Elam, Ph.D.	
14. TITLE Deputy Director/ Medicaid Director	
15. DATE SUBMITTED March 16, 2012	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED	18. DATE APPROVED MAR 22 2012
--------------------------	--

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL	20. SIGNATURE OF REGIONAL OFFICIAL 
21. TYPED NAME Francis McCullough	22. TITLE Associate Regional Administrator Division of Medicaid and Children's Health Operations