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: **10-016**

2. STATE: CA

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:
Social Security Act 1905 (a)(1)
Social Security Act 1905 (a)(4)(B)
Social Security Act 1905 (a)(13)

7. FEDERAL BUDGET IMPACT:
a. FFY N/A $ N/A
b. FFY N/A $ N/A

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Supplement 3 to Attachment 3.1-A, Pages 1-2, 2a-2n
Supplement 2 to Attachment 3.1-B, Pages 1-16
Limitations on Attachment 3.1-A, Page 1, 1a, 1b
Limitations on Attachment 3.1-B, Page 1, 1a, 1b
~~Limitations on Attachment 3.1-A, Page 9~~
~~Limitations on Attachment 3.1-B, Page 9~~
Limitations on Attachment 3.1-A, Page 20
Limitations on Attachment 3.1-B, Page 20

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Supplement 3 to Attachment 3.1-A, Pages 1-2
Supplement 2 to Attachment 3.1-B, Pages 1-2
Limitations on Attachment 3.1-A, Page 1
Limitations on Attachment 3.1-B, Page 1
~~Limitations on Attachment 3.1-A, Page 9~~
~~Limitations on Attachment 3.1-B, Page 9~~
Limitations on Attachment 3.1-A, Page 20
Limitations on Attachment 3.1-B, Page 20

10. SUBJECT OF AMENDMENT:
Rehabilitative Mental Health Services, Psychiatric Inpatient Hospital Services, and EPSDT.

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:
The Governor's Office does not wish to review the State Plan Amendment.

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Vanessa M Baird

13. TYPED NAME:
Toby Douglas

14. TITLE:
Chief Deputy Director

15. DATE SUBMITTED: DEC 2 9 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: 12/29/10

18. DATE APPROVED: 3/21/11

PLAN APPROVED – ONE COPY ATTACHED

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

20. SIGNATURE OF REGIONAL OFFICIAL:
Ronald Nat - acting for -

21. TYPED NAME: Gloria Nagle

22. TITLE: Associate Regional Administrator

Pen and ink changes to Boxes 8 and 9 confirmed via emails dated 2/18/11 and 3/21/11.

FORM HCFA-179 (07-92)