HEALTH CARE FINANCING ADMINISTRATION	1	OMD NO. 0938-0193
TRANSMITTAL AND NOTICE OF APPROVAL OF	1. TRANSMITTAL NUMBER:	2. STATE
	10-014	GEORGIA
STATE PLAN MATERIAL	10 011	GEORGIA
FOR: HEALTH CARE FINANCING ADMINISTRATION	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
FUR: HEALTH CARE FINANCING ADMINISTRATION		
	Soom B SECORD THE CAMEBER	(HD)
TO: REGIONAL ADMINISTRATOR	4. PROPOSED EFFECTIVE DATE	
CENTERS FOR MEDICARE AND MEDICAID SERVICES	October 1, 2010	
DEPARTMENT OF HEALTH AND HUMAN SERVICES		
5. TYPE OF PLAN MATERIAL (Check One):		
5. The critical and the control of t		
TAMENDA CONTROL OF A CANDADA C		
☐ 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:	
	1	-
42 CFR 447.206	a. FFY 2011 \$3,125,000	
	FFY 2012 \$8,100,000	
"8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:	9. PAGE NUMBER OF THE SUPERS	EDED PLAN SECTION
	OR ATTACHMENT (If Applicable)	
10 1 (110 P) 10 1 10 C	OR ATTACHMENT (IJ Applicable)	•
Attachment 4.19-B, pp. 13.1 – 13.6		
	Attachment 4.19-B, pg. 13.1	
		•
10. SUBJECT OF AMENDMENT:		
CISS AND CIS PAYMENT METHODOLOGY		
CISS AND CISTATMENT METHODOLOGI		
11 COMERNORIC REVIEW (CL. 1 C)		
11. GOVERNOR'S REVIEW (Check One):		
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT ☐ OTHER, AS SPECIFIED:		
□ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED		
NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL		
	L.C. NEWVIEW INC.	
12. SIGNATURE OF STATE/AGENCY OFFICIAL:	16. RETURN TO:	
	·	
	Department of Community Health	
13-77YPED NAME: JERRY DUBBERLY	Medicaid Division	
	•	
44. TITLE: CHIEF, Medicaid Division	2 Peachtree Street, N.W.	
THE TAXABLE PROPERTY OF THE PR	Atlanta, Georgia 30303-3159	
15 DATE OUD ATTEND	-	- 1
15. DATE SUBMITTED:		
FOR REGIONAL OFFICE USE ONLY		
17. DATE RECEIVED:	18. DATE APPROVED:	
10/01/10		1
PLAN APPROVED – ONE COPY ATTACHED		
19. EFFECTIVE DATE OF APPROVED MATERIAL:	20. SIGNATURE OF REGIONAL OF	FICIAL:
10/01/10		
21. TYPED NAME:	22. TITLE: Associate Regional Administrat	
Jackie Glaze	Division of Medicaid & Childre	
` <u> </u>	Division of Medicald & Clindre	п пеаці Оріїѕ
23. REMARKS:		
Approved with the following changes to item 8 as authorized by State Agency on email dated 08/04/11:		
- TE - 2 - 2 - 2 - 2 - 2 - 2 - 2 - 2 - 2 -		
Block# 8 changed to read: Attachment 3.1-A pages 1i, 1k, 1l, 1m, 1n and 9b3; Attachment 4.19B pages 13.1 thru 13.8.		
Divers o Changed to Fead. Adachine of 3.1-A pages 11, 18, 11, 111, 111 and 903, Attachine in 4.195 pages 13.1 infu 13.8.		
Block#9 changed to read: Attachment 3.1-A pages 1i, 1k, 1l, 1m, 1n and 9b3; Attachment 4.19B pages 13.1 thru 13.8 New		
brockers changed to read; Attachment 3.1-A pages H. IK, H, Im, In and	703, Attachment 4,196 pages 13.1 thru 13.8 New	