

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTERS FOR MEDICARE AND MEDICAID SERVICES	1. TRANSMITTAL NUMBER: <u>1 0 - 1 4</u>	2. STATE <u>MO</u>
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE AND MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE <u>October 1, 2010</u>	

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: <u>1902(a)(10)(D)</u>	7. FEDERAL BUDGET IMPACT: a. FFY <u>2010</u> \$ <u>0</u> b. FFY <u>2011</u> \$ <u>0</u>
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8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: <u>Attachment 3.1-A Page 13</u> <u>Attachment 3.1-A Page 14, 14a</u> <u>Attachment 4.19-B Page 1, 1b, 3, 4, 4a, 4aa</u> <u>Attachment 3.1-A, Page 17 aaaaaaa</u> <u>Attachment 4.19-B, Page 18a (New material)</u>	9. PAGE NUMBER OF THE SUPERSEDES PLAN SECTION OR ATTACHMENT (If Applicable): <u>Attachment 3.1-A Page 13</u> <u>Attachment 3.1-A Page 14, 14a</u> <u>Attachment 4.19-B Page 1, 1b, 3, 4, 4a, 4aa</u> <u>Attachment 3.1-A, Page 17 aaaaaaa</u>
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10. SUBJECT OF AMENDMENT:

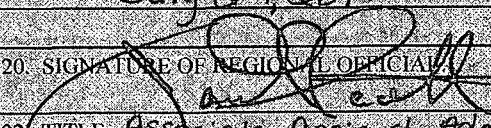
Amendment to the State Plan is in response to CMS' letter dated June 11, 2010. This amendment revises the text on page 13 of Attachment 3.1-A regarding home health aide services; removes Adult Day Health Care Centers from clinic services on page 14 of Attachment 3.1-A; and adds the requested language regarding fee schedules to page 1 of Attachment 4.19-B.

11. GOVERNOR'S REVIEW (Check One)

- GOVERNOR'S OFFICE REPORTED NO COMMENT *su* OTHER, AS SPECIFIED:
 COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
 NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

12. SIGNATURE OF STATE AGENCY OFFICIAL: 	16: RETURN TO: Department of Social Services MO HealthNet Division 615 Howerton Court P.O. Box 6500 Jefferson City, MO 65109
13. TYPE NAME: <u>Ronald J. Levy</u>	
14. TITLE: <u>Director</u>	
15. DATE SUBMITTED: <u>December 20, 2010</u>	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: <u>December 20, 2010</u>	18. DATE APPROVED: <u>July 29, 2011</u>
PLAN APPROVED - ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: <u>October 1, 2011</u>	20. SIGNATURE OF REGIONAL OFFICIAL: 
21. TYPED NAME: <u>James G. Scott</u>	22. TITLE: <u>Associate Regional Administrator for Medicaid and Children's Health Operations</u>

23. REMARKS:

Pen and ink changes per letter dtd 7.22.11 from MD.