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: **11-12**

2. STATE: Oregon

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID) Medical Assistance

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
11/15/11

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 440.100

7. FEDERAL BUDGET IMPACT:
a. FFY 2012 $(49,500)
b. FFY 2013 $(56,250)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 3.1-A, Page 4-b, 4-b.1, ~~4-b.2~~ and 5-d
P&I add 4-c

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 3.1-A, Page 4-b and 5-d
P&I 4-c

10. SUBJECT OF AMENDMENT: This transmittal is being submitted to revise coverage for dental services.

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:

[redacted]

14. TITLE: Director, Division of Medical Assistance Programs

15. DATE SUBMITTED: 9-29-11

16. RETURN TO:
Division of Medical Assistance Programs
Oregon Health Authority
500 Summer Street NE E-35
Salem, OR 97301

ATTN: Jesse Anderson, State Plan Manager

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: September 29, 2011

18. DATE APPROVED: DEC 2 1 2011

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: NOV 15 2011

20. SIGNATURE OF REGIONAL OFFICIAL: [redacted]

21. TYPED NAME: [redacted]

22. TITLE: Associate Regional Administrator
Division of Medicaid & Children's Health

23. REMARKS:

10/31/11 state authorized changes to Box 8 and Box 9

FORM HCFA-179 (07-92)