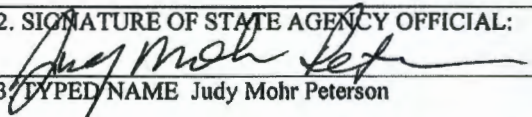
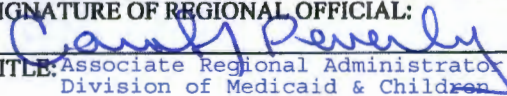


<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</b>		1. TRANSMITTAL NUMBER: <b>13-07</b>	2. STATE <b>Oregon</b>
<b>FOR: HEALTH CARE FINANCING ADMINISTRATION</b>		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID) <b>Medical Assistance</b>	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE <b>7/1/13</b>	
5. TYPE OF PLAN MATERIAL (Check One): <input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)			
6. FEDERAL STATUTE/REGULATION CITATION: <b>1902(a)(4)(A) of the Act and 42 CFR part 431.53</b>		7. FEDERAL BUDGET IMPACT: a. FFY 2013 \$ <b>0</b> b. FFY 2014 \$ <b>0</b>	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:  <b>Attachment 3.1-D, Page 1-3, Attachment 4.19-B, Page 1a.1</b>		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable):  <b>Attachment 3.1-D, Page 1-3, Attachment 4.19-B, Page 1a.1</b>	
10. SUBJECT OF AMENDMENT: This transmittal is being submitted to transition the NEMT from 1915(b) to 1115 waiver <del>authority and also include a new reimbursement methodology for volunteer transports.</del> (P&I)			
11. GOVERNOR'S REVIEW (Check One): <input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input checked="" type="checkbox"/> OTHER, AS SPECIFIED: <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL			
12. SIGNATURE OF STATE AGENCY OFFICIAL: 		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	
13. TYPED NAME <b>Judy Mohr Peterson</b>			
14. TITLE: <b>Director, Division of Medical Assistance Programs</b>			
15. DATE SUBMITTED: <b>6/10/13</b>			
<b>FOR REGIONAL OFFICE USE ONLY</b>			
17. DATE RECEIVED: <b>JUN 10 2013</b>		18. DATE APPROVED: <b>July 30, 2013</b>	
<b>PLAN APPROVED - ONE COPY ATTACHED</b>			
19. EFFECTIVE DATE OF APPROVED MATERIAL: <b>July 1, 2013</b>		20. SIGNATURE OF REGIONAL OFFICIAL: 	
21. TYPED NAME: <b>Carol J.C. Peverly</b>		22. TITLE: <b>Associate Regional Administrator Division of Medicaid &amp; Children</b>	
23. REMARKS: <b>6/17/2013: State authorized P&amp;I change to box 10</b>			