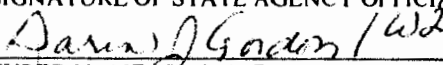
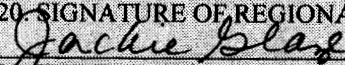


TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL		1. TRANSMITTAL NUMBER: 11-014	2. STATE TENNESSEE
FOR: CENTERS FOR MEDICARE AND MEDICAID SERVICES		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
		4. PROPOSED EFFECTIVE DATE January 1, 2012	
TO: REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE AND MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES			
5. TYPE OF PLAN MATERIAL (<i>Check One</i>):			
<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 (<i>Separate Transmittal for each amendment</i>)			
6. FEDERAL STATUTE/REGULATION CITATION: 1905(a)(26) and 1934 of the SSA; 42 CFR 435		7. FEDERAL BUDGET IMPACT: a. FFY 2012 \$0 b. FFY 2013 \$0	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Supplement 3 to Attachment 3.1-A, pages 1, 2, 4, 5, 6, 6a, and 6b		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (<i>If Applicable</i>): Supplement 3 to Attachment 3.1-A, pages 1, 2, 4, 5, and 6	
10. SUBJECT OF AMENDMENT: Amount, Duration, and Scope of Medical and Remedial Care and Services Provided to the Categorically Needy – Program of All-Inclusive Care for the Elderly (PACE)			
11. GOVERNOR'S REVIEW (<i>Check One</i>):			
<input checked="" type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT		<input 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: Tennessee Department of Finance and Administration Division of Health Care Finance and Administration Bureau of TennCare 310 Great Circle Road Nashville, Tennessee 37243 Attention: George Woods	
13. TYPED NAME: Darin J. Gordon			
14. TITLE: Director, Bureau of TennCare			
15. DATE SUBMITTED: 12/22/11			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED: 12/22/11		18. DATE APPROVED: 09/21/12	
PLAN APPROVED – ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: 01/01/12		20. SIGNATURE OF REGIONAL OFFICIAL: 	
21. TYPED NAME: Jackie Glaze		22. TITLE: Associate Regional Administrator Division of Medicaid & Children Health Opns	
23. REMARKS: Approved with the following changes to item 8 and 9 as authorized by State Agency on email dated 09/06/12: <u>Block # 8 changed to read:</u> Supplement 3 to Attachment 3.1-A, pages 1, 2, 4, 5, 6, 6a, 6b and 6c and Attachment 2.2-A, page 11. <u>Block # 9 changed to read:</u> Supplement 3 to Attachment 3.1-A, pages 1, 2, 4, 5, 6 and Attachment 2.2-A, page 11.			