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| <b>TRANSMITTAL AND NOTICE OF APPROVAL OF<br/>STATE PLAN MATERIAL</b><br>FOR: HEALTH CARE FINANCING ADMINISTRATION | 1. TRANSMITTAL NUMBER:<br><u>1 2 -- 2 0</u>                                      | 2. STATE<br>Missouri |
|   | 3. PROGRAM IDENTIFICATION:<br>TITLE XIX OF THE SOCIAL SECURITY ACT<br>(MEDICAID) |                      |
| TO: REGIONAL ADMINISTRATOR<br>HEALTH CARE FINANCING ADMINISTRATION<br>DEPARTMENT OF HEALTH AND HUMAN SERVICES     | 4. PROPOSED EFFECTIVE DATE<br><del>July 1, 2012</del> * January 1, 2013          |                      |

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)

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| 6. FEDERAL STATUTE/REGULATION CITATION:<br><br>42 CFR 440.60   | 7. FEDERAL BUDGET IMPACT:<br>a. FFY <u>2012</u> \$ <u>635</u><br>b. FFY <u>2013</u> \$ <u>2,455</u> |
| 8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:<br><br>Attachment 3.1-A, page 12BB<br>Attachment 4.19-B, page 3D | 9. PAGE NUMBER OF THE SUPERSEDES PLAN SECTION<br>OR ATTACHMENT (If Applicable):<br>New Material     |

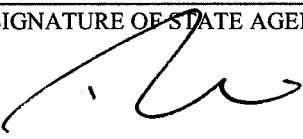
10. SUBJECT OF AMENDMENT:  
This State Plan Amendment provides for the implementation of Medication Therapy Management services by qualified, licensed pharmacists.

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

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| 12. SIGNATURE OF STATE AGENCY OFFICIAL:<br> | 16: RETURN TO:<br>MO HealthNet Division<br>P.O. Box 6500<br>Jefferson City, MO 65102 |
| 13. TYPE NAME: Brian Kinkade   |  |
| 14. TITLE: Interim Director  |  |
| 15. DATE SUBMITTED:<br>September 27, 2012  |  |

**FOR REGIONAL OFFICE USE ONLY**

|                                       |                                   |
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| 17. DATE RECEIVED: September 27, 2012 | 18. DATE APPROVED: April 29, 2013 |
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**PLAN APPROVED - ONE COPY ATTACHED**

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| 19. EFFECTIVE DATE OF APPROVED MATERIAL:<br>January 1, 2013 | 20. SIGNATURE OF REGIONAL OFFICIAL:<br>/s/   |
| 21. TYPED NAME:<br>James G. Scott                           | 22. TITLE: Associate Regional Administrator<br>for Medicaid and Children's Health Operations |

23. REMARKS:  
\* - Per State response dated 12.14.12.