

<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</b> <b>FOR: CENTERS FOR MEDICARE &amp; MEDICAID SERVICES</b>		1. TRANSMITTAL NUMBER <u>1 0 - 0 0 2</u>	2. STATE Puerto Rico
		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID) <u>Title XIX Social Security Act - Medicaid</u>	
TO: REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE & MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE October 1, 2010	
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 <u>42 CFR 447.50 447.60</u>		7. FEDERAL BUDGET IMPACT a. FFY <u>N/A</u> \$ _____ b. FFY _____ \$ _____	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT Substitute this page with the new page Attachment 4.18A Pages 1, 2, 3 and 4  Attachment 4.18C Pages 2, 2a and 3		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable)	
<b>** SEE REMARKS</b>			
10. SUBJECT OF AMENDMENT  Cost Sharing			
11. GOVERNOR'S REVIEW (Check One)			
<input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL		<input checked="" type="checkbox"/> OTHER, AS SPECIFIED Executive Director Puerto Rico Medicaid Program	
12. SIGNATURE OF STATE AGENCY OFFICIAL		16. RETURN TO	
13. TYPED NAME <u>Miguel Negrón-Rivera</u>		Miguel Negrón-Rivera Executive Director Puerto Rico Medicaid Program Puerto Rico Department of Health PO Box 70184 San Juan, PR 00936-8184	
14. TITLE <u>Executive Director</u>			
15. DATE SUBMITTED <u>March 9, 2011</u>			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED		18. DATE APPROVED <u>MAR 21 2011</u>	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL <u>OCT 1 0 2010</u>		20. SIGNATURE OF REGIONAL OFFICIAL	
21. TYPED NAME <u>Michael Melendez</u>		22. TITLE <u>Acting Associate Regional Administrator Division of Medicaid and State Operations</u>	
23. REMARKS  <b>Originally submitted plan pages were replaced with new plan pages per State's e-mail of 03/10/2011.</b>			