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: 2009-024

2. STATE: Florida

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

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

4. PROPOSED EFFECTIVE DATE
November 1, 2009

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 440.70

7. FEDERAL BUDGET IMPACT: (in thousands)
a. FFY 2009-10: $(215)
b. FFY 2010-11: $(214)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 3.1-A Page 28 and Attachment 3.1-B Page 29

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 3.1-A Page 28 and Attachment 3.1-B Page 29

10. SUBJECT OF AMENDMENT:
Prior Authorization for Home Health 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:
Reviewed by the Deputy Secretary for Medicaid who is the Governor's designee.

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Mr. Phil E. Williams

14. TITLE:
Interim Deputy Secretary for Medicaid

15. DATE SUBMITTED:
12/7/09

16. RETURN TO:
Mr. Phil E. Williams
Interim Deputy Secretary for Medicaid
Agency for Health Care Administration
2727 Mahan Drive, Mail Stop #8
Tallahassee, FL 32308

Attention: Robin Ingram

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 12/29/09

18. DATE APPROVED: 01/22/10

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
11/01/09

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: Mary Kaye Justis, RN, MBA

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

23. REMARKS:

FORM HCFA-179 (07-92)