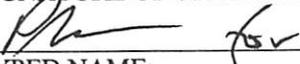
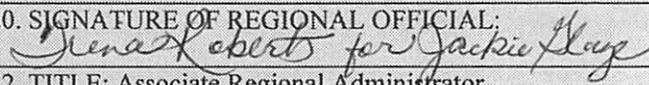


<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</b>		1. TRANSMITTAL NUMBER: 2011-015	2. STATE Florida
<b>FOR: HEALTH CARE FINANCING ADMINISTRATION</b>		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE October 1, 2011	
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: 1932 (B)(2) of the Act		7. FEDERAL BUDGET IMPACT: (in thousands) No Fiscal Impact	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 3.1-A Page 21 Attachment 3.1-B Page 20		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT ( <i>If Applicable</i> ): Attachment 3.1-A Page 21 Attachment 3.1-B Page 20	
10. SUBJECT OF AMENDMENT: Inpatient Hospital Services			
11. GOVERNOR'S REVIEW ( <i>Check One</i> ): <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                      Reviewed by the Deputy Secretary for Medicaid <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL                      who is the Governor's designee.			
12. SIGNATURE OF STATE AGENCY OFFICIAL: 		16. RETURN TO: Mr. Justin M. Senior Deputy Secretary for Medicaid Agency for Health Care Administration 2727 Mahan Drive, Mail Stop #8 Tallahassee, FL 32308  Attention: Robin Ingram	
13. TYPED NAME: Mr. Justin M. Senior			
14. TITLE: Deputy Secretary for Medicaid			
15. DATE SUBMITTED: 11/8/11			
<b>FOR REGIONAL OFFICE USE ONLY</b>			
17. DATE RECEIVED: 11/08/11		18. DATE APPROVED: 07/12/12	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: 10/01/11		20. SIGNATURE OF REGIONAL OFFICIAL: 	
21. TYPED NAME: Jackie Glaze		22. TITLE: Associate Regional Administrator Division of Medicaid & Children Health Opns	
23. REMARKS:			