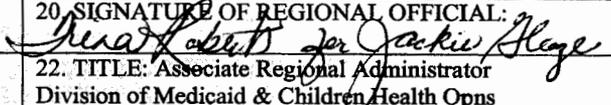


TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: HEALTH CARE FINANCING ADMINISTRATION		1. TRANSMITTAL NUMBER: 2013-002	2. STATE Florida
		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE January 1, 2013	
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: 42 CFR 447.405,447.410, 447.415		7. FEDERAL BUDGET IMPACT: (in thousands) FFY 2012-2013 \$ 524,119 FFY 2013-2014 \$ 698,825	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-B TBD Attachment 4.19-B page 28		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Attachment 4.19-B TBD Attachment 4.19-B page 28	
10. SUBJECT OF AMENDMENT: Primary Care Rate Increase			
11. GOVERNOR'S REVIEW (Check One): <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: April Cook	
13. TYPED NAME: Mr. Justin M. Senior			
14. TITLE: Deputy Secretary for Medicaid			
15. DATE SUBMITTED: 1-2-13			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED: 01-02-13		18. DATE APPROVED: 04-01-13	
PLAN APPROVED – ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: 01-01-13		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 7, 8 and 9 as authorized by State Agency e-mail dated 03/28/13: Block # 7 Changed to read: 7a – FFY 2012-2013 \$306,764 and 7b – FFY 2013-2014 \$409,019. Block # 8 Changed to read: Attachment 4.19-B, pages, 28b, 28c, and 28d, Attachment 4.19-B page 28. Block # 9 Changed to read: Attachment 4.19-B pages 28b, 28c and 28d new, Attachment 4.19-B page 28.			