DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL
FOR: CENTER FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 1 1 — 0 0 3

2. STATE: Puerto Rico

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

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFECTIVE DATE
November 1, 2011

5. TYPE OF PLAN MATERIAL (Check One)

☐ NEW STATE PLAN ☐ AMENDMENT TO 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
Section 1916 of the Social Security Act and 42 CFR 447.50 – 447.60

7. FEDERAL BUDGET IMPACT
a. FFY 2011 $ ~~0~~ 3.1m
b. FFY 2012 $ ~~0~~ 3.4m

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHEMENT

4.18-A p.1, ~~4.18-A p.1a~~, 4.18-A p.2, 4.18-A p. 2a, 4.18-A p.3,
4.18-C p.1, ~~4.18-C p.1a~~, 4.18-C p. 2, 4.18-C p.2a, 4.18-C p.3

* THE STATE AGREED TO REMOVE THE PAGES CROSSED ABOVE.

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable)

4.18-A p.1, 4.18-A p.2, 4.18-A p. 2a, 4.18-A p.3,
4.18-C p.1, 4.18-C p. 2, 4.18-C p.2a, 4.18-C p.3

10. SUBJECT OF AMENDMENT
Cost Sharing

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

12. SIGNATURE OF STATE AGENCY OFFICIAL

13. TYPE NAME
MIGUEL NEGRÓN-RIVERA

14. TITLE
EXECUTIVE DIRECTOR

15. DATE SUBMITTED
12/27/2011

16. RETURN TO
PUERTO RICO MEDICAID PROGRAM
PUERTO RICO DEPARTMENT OF HEALTH
PO BOX 70184
SAN JUAN PR 00935-8184

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED

18. DATE APPROVED
March 19, 2012

PLAN APPROVED – ONE COPY ATTACHED

19. EFECTIVE DATE OF APPROVED MATERIAL
November 01, 2011

20. SIGNATURE OF REGIONAL OFFICIAL

21. TYPED NAME
Michael Melendez

21. TITLE
Associate Regional Administrator
Division of Medicaid and State Operations

23. REMARKS

FORM CMS-179 (07/92)

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