
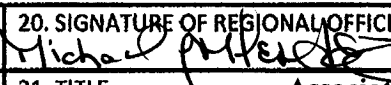


TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTER FOR MEDICARE & MEDICAID SERVICES		1. TRANSMITTAL NUMBER <u>1 1 — 0 0 3</u>	2. STATE Puerto Rico
TO: REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE & MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID) TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
5. TYPE OF PLAN MATERIAL (Check One) <input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT		4. PROPOSED EFFECTIVE DATE November 1, 2011	
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 <u>2011</u> \$ <u>3.1m</u> b. FFY <u>2012</u> \$ <u>3.4m</u>		
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHEMENT 4.18-A p.1, 4.18-A p.2a , 4.18-A p.2, 4.18-A p. 2a, 4.18-A p.3, 4.18-C p.1, 4.18-C p.2a , 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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable) 4.18-A p.1, 4.18-A p.2, 4.18-A p. 2a, 4.18-A p.3, 4.18-C p.1, 4.18-C p. 2, 4.18-C p.2a, 4.18-C p.3		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) <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 <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL			
12. SIGNATURE OF STATE AGENCY OFFICIAL 	16. RETURN TO PUERTO RICO MEDICAID PROGRAM PUERTO RICO DEPARTMENT OF HEALTH PO BOX 70184 SAN JUAN PR 00935-8184		
13. TYPE NAME MIGUEL NEGRÓN-RIVERA			
14. TITLE EXECUTIVE DIRECTOR			
15. DATE SUBMITTED 12/27/2011			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED	18. DATE APPROVED March 19, 2012		
PLAN APPROVED – ONE COPY ATTACHED			
19. EFFECTIVE 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			