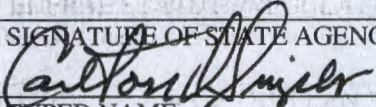
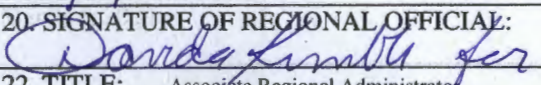


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|--|--|---|---------------------|
| TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL | | 1. TRANSMITTAL NUMBER: 09-003 | 2. STATE Florida |
| FOR: HEALTH CARE FINANCING ADMINISTRATION | | 3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID) | |
| TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES | | 4. PROPOSED EFFECTIVE DATE March 1, 2009 | |
| 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: 1902 (a) of the Act | | 7. FEDERAL BUDGET IMPACT: IN THOUSANDS 2008-09 (\$1252) 2009-10 (\$1543) | |
| 8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-B, Exhibit I, Version XIX | | 9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Attachment 4.19-B, Exhibit I, Version XVIII | |
| 10. SUBJECT OF AMENDMENT: Florida Title XIX Outpatient Hospital Reimbursement Plan | | | |
| 11. GOVERNOR'S REVIEW (Check One): <input checked="" type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input 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: Mr. Carlton D. Snipes 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. Carlton D. Snipes | | | |
| 14. TITLE: Deputy Secretary for Medicaid | | | |
| 15. DATE SUBMITTED: 3/20/09 | | | |
| FOR REGIONAL OFFICE USE ONLY | | | |
| 17. DATE RECEIVED: 03/24/09 | | 18. DATE APPROVED: 3/8/12 | |
| PLAN APPROVED - ONE COPY ATTACHED | | | |
| 19. EFFECTIVE DATE OF APPROVED MATERIAL: 03/1/09 | | 20. SIGNATURE OF REGIONAL OFFICIAL:  | |
| 21. TYPED NAME: Jackie Glaze | | 22. TITLE: Associate Regional Administrator Division of Medicaid & Children Health Opns | |
| 23. REMARKS: | | | |