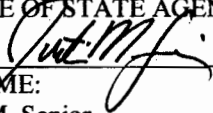
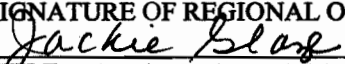


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|--|--|--|---------------------|
| <b>TRANSMITTAL AND NOTICE OF APPROVAL OF<br/>STATE PLAN MATERIAL</b>   |  | 1. TRANSMITTAL NUMBER:<br>2011-014   | 2. STATE<br>Florida |
| FOR: HEALTH CARE FINANCING ADMINISTRATION  |  | 3. PROGRAM IDENTIFICATION: TITLE XIX OF THE<br>SOCIAL SECURITY ACT (MEDICAID)  |                     |
| TO: REGIONAL ADMINISTRATOR<br>HEALTH CARE FINANCING ADMINISTRATION<br>DEPARTMENT OF HEALTH AND HUMAN SERVICES  |  | 4. PROPOSED EFFECTIVE DATE<br>October 1, 2011  |                     |
| 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<br>COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment) |  |  |                     |
| 6. FEDERAL STATUTE/REGULATION CITATION:<br>Section 1902(a)(42)(B)(i) of the Act  |  | 7. FEDERAL BUDGET IMPACT: (in thousands)<br>No Fiscal Impact   |                     |
| 8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:<br>Section 4.5   |  | 9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION<br>OR ATTACHMENT (If Applicable):<br>Section 4.5   |                     |
| 10. SUBJECT OF AMENDMENT: Exemption from Medicaid Recovery Audit Contractor Program  |  |  |                     |
| 11. GOVERNOR'S REVIEW (Check One):   |  |  |                     |
| <input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT<br><input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED<br><input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL  |  | <input checked="" type="checkbox"/> OTHER, AS SPECIFIED:<br>Reviewed by the Deputy Secretary for Medicaid<br>who is the Governor's designee.   |                     |
| 12. SIGNATURE OF STATE AGENCY OFFICIAL:<br>   |  | 16. RETURN TO:<br>Mr. Justin M. Senior<br>Deputy Secretary for Medicaid<br>Agency for Health Care Administration<br>2727 Mahan Drive, Mail Stop #8<br>Tallahassee, FL 32308<br><br>Attention: Robin Ingram |                     |
| 13. TYPED NAME:<br>Mr. Justin M. Senior  |  |  |                     |
| 14. TITLE:<br>Deputy Secretary for Medicaid  |  |  |                     |
| 15. DATE SUBMITTED:<br>12/9/11   |  |  |                     |
| <b>FOR REGIONAL OFFICE USE ONLY</b>  |  |  |                     |
| 17. DATE RECEIVED: 12/12/11  |  | 18. DATE APPROVED: 03/05/12  |                     |
| <b>PLAN APPROVED – ONE COPY ATTACHED</b>   |  |  |                     |
| 19. EFFECTIVE DATE OF APPROVED MATERIAL:<br>10/1/11  |  | 20. SIGNATURE OF REGIONAL OFFICIAL:<br>  |                     |
| 21. TYPED NAME:<br>Jackie Glaze  |  | 22. TITLE: Associate Regional Administrator<br>Division of Medicaid & Children Health Opns   |                     |
| 23. REMARKS:   |  |  |                     |