

<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</b>	1. TRANSMITTAL NUMBER: <b>13-03 MA NJ</b>	2. STATE <b>New Jersey</b>
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
FOR: CENTERS FOR MEDICARE AND MEDICAID SERVICES	4. PROPOSED EFFECTIVE DATE <b>January 1, 2013</b>	
TO: REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE AND MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES		

5. TYPE OF PLAN MATERIAL (Check One):

NEW STATE PLAN       AMENDMENT TO BE 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: <b>42 CFR 447.405; 447.410; 447.415</b>	7. FEDERAL BUDGET IMPACT a. FFY 2013: \$17.3 Million (Fee for Service (FFS) Only) \$162.4 Million (Managed Care and FFS total) b. FFY 2014: \$23.5 Million (FFS Only) \$220.3 Million (Managed Care and FFS total)
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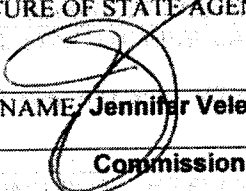
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: <b>Attachment 4.19-B page 29</b> <b>Attachment 4.19-B page 30</b> <b>Attachment 4.19-B page 31</b>	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): <b>New</b> <b>New</b> <b>New</b>
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10. SUBJECT OF AMENDMENT:  
**INCREASE PRIMARY CARE SERVICE PAYMENTS FOR PHYSICIANS.**

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

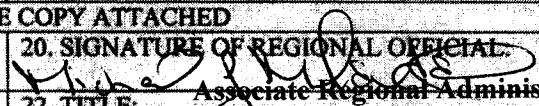
OTHER, AS SPECIFIED:  
**Not required, pursuant to 7.4 of the Plan**

12. SIGNATURE OF STATE AGENCY OFFICIAL: 	16. RETURN TO: <b>Valerie Harr, Director</b> <b>Division of Medical Assistance and Health Services</b> <b>P.O. Box 712, #26</b> <b>Trenton, NJ 08625-0712</b>
13. TYPED NAME: <b>Jennifer Velez</b>	
14. TITLE: <b>Commissioner</b>	
15. DATE SUBMITTED: <b>3/25/13</b>	

**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED:	18. DATE APPROVED: <b>June 11, 2013</b>
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**PLAN APPROVED - ONE COPY ATTACHED**

19. EFFECTIVE DATE OF APPROVED MATERIAL: <b>January 01, 2013</b>	20. SIGNATURE OF REGIONAL OFFICIAL: 
21. TYPED NAME: <b>Michael Melendez</b>	22. TITLE: <b>Associate Regional Administrator</b> <b>Division of Medicaid and State Operations</b>

23. REMARKS: