
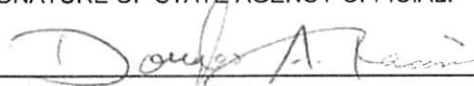
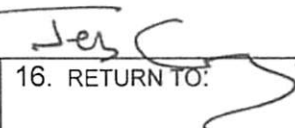


TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTERS FOR MEDICARE AND MEDICAID SERVICES		1. TRANSMITTAL NUMBER: 13 -- 009	2. STATE: VERMONT
		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE & MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE(S) JANUARY 1, 2013	
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: 42 CFR §430.12(c)(ii), 42 CFR 447.405, 447.410, and 447.415		7. FEDERAL BUDGET IMPACT: a. FFY 2013 \$ 7,531,603 b. FFY 2014 \$ 10,162,644	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: ATT 4.19-B PG 21, ATT4.19-B PG 22, ATT 4.19-B PG 23		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable)	
10. SUBJECT OF AMENDMENT: INCREASED MEDICAID PAYMENTS TO PRIMARY CARE PHYSICIANS PCP RATE INCREASE			
11. GOVERNOR'S REVIEW (Check One): <input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL		<input checked="" type="checkbox"/> OTHER, AS SPECIFIED SIGNATURE OF SECRETARY OF ADMINISTRATION 	
12. SIGNATURE OF STATE AGENCY OFFICIAL: 		16. RETURN TO: 	
13. TYPED NAME: DOUGLAS A. RACINE		ASHLEY BERLINER	
14. TITLE: SECRETARY, AGENCY FOR HUMAN SERVICES		DEPARTMENT OF VERMONT HEALTH ACCESS 312 HURRICANE LANE, SUITE 201 WILLISTON, VT 05495	
15. DATE SUBMITTED: 3/29/2013			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED: 3/29/2013		18. DATE APPROVED: 6/5/13	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: 1/1/13		20. SIGNATURE OF REGIONAL OFFICIAL: /s/	
21. TYPED NAME: Richard R. McGreal		22. TITLE Associate Regional Administrator, Division of Medicaid and Children's Health Operations, Boston Regional Office	
23. REMARKS Per email dated 5/10/13, VT and CMS agree to the following pen and ink changes to Box 6 of the CMS-179 Form: Add 42 CFR 447.405, 447.410, and 447.415.			