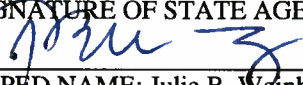


<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</b>		1. TRANSMITTAL NUMBER: 14-14	2. STATE New Mexico
		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
FOR: HEALTH CARE FINANCING ADMINISTRATION		4. PROPOSED EFFECTIVE DATE January 1, 2015	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES			
5. TYPE OF PLAN MATERIAL ( <i>Check One</i> ): <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 ( <i>Separate Transmittal for each amendment</i> )			
6. FEDERAL STATUTE/REGULATION CITATION:  42 CFR Part 438, 441, and 447  Sections 1902(a)(13), 1902(jj), 1932(f), and 1905(dd) of the Social Security Act, as amended by the Affordable Care Act.		7. FEDERAL BUDGET IMPACT:  for FFY 2015: 11,025,000 for FFY 2016 : 14,700,000	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:  Attachment 4.19-B; pages ii.d, ii e, and ii f.		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT ( <i>If Applicable</i> ):  Supercedes none; new pages	
10. SUBJECT OF AMENDMENT: Continuation of Primary Care Increase			
11. GOVERNOR'S REVIEW ( <i>Check One</i> ): <input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input checked="" type="checkbox"/> OTHER, AS SPECIFIED: Authority Delegated to the Medicaid Director. <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: Julie B. Weinberg, Director Medical Assistance Division P.O. Box 2348 Santa Fe, NM 87504 – 2348	
13. TYPED NAME: Julie B. Weinberg			
14. TITLE: Director, Medical Assistance Division			
15. DATE SUBMITTED: November 20, 2014 Resubmitted January 7, 2015			
<b>FOR REGIONAL OFFICE USE ONLY</b>			
17. DATE RECEIVED: 25 November, 2014		18. DATE APPROVED: 16 April, 2015	
<b>PLAN APPROVED – ONE COPY ATTACHED</b>			
19. EFFECTIVE DATE OF APPROVED MATERIAL: 1 January, 2015		20. SIGNATURE OF REGIONAL OFFICIAL:	
21. TYPED NAME: Bill Brooks		22. TITLE: Associate Regional Administrator (ARA) Division of Medicaid and Children's Health (DMCH)	
23. REMARKS:			