DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: **SPA #09-006**

2. STATE: **Delaware**

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
October 1, 2009

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN XXX AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:

7. FEDERAL BUDGET IMPACT:
(See CMS Cover Letter)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-A, Page 3

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-A, Page 3

10. SUBJECT OF AMENDMENT: **Inpatient Hospital Services Outlier Reimbursement Methodology**

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
XXX OTHER, AS SPECIFIED:
Governor's comments under separate correspondence

12. SIGNATURE OF STATE AGENCY OFFICIAL:
//Rosanne Mahaney – signature//

13. TYPED NAME:
Rosanne Mahaney, Acting Director, Division of Medicaid and Medical Assistance

14. TITLE: **Designee for Rita M. Landgraf, Secretary, Delaware Health and Social Services**

15. DATE SUBMITTED:
November 9, 2009

16. RETURN TO:

Rosanne Mahaney
Acting Director, Division of Medicaid and Medical Assistance
P.O. Box 906
New Castle, Delaware 19720-0906

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED:
01-27-10

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
OCT - 1 2009

20. SIGNATURE OF REGIONAL OFFICIAL:
[redacted]

21. TYPED NAME:
[redacted]

22. TITLE:
Deputy Director, CMSO

23. REMARKS:

FORM HCFA-179 (07-92)