DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICIAD SERVICES

FORM APPROVED
OMB NO 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES	1. TRANSMITTAL NUMBER: 011-016	2. STATE MA
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE AND MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE 10/01/11	

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:	7. FEDERAL BUDGET IMPACT: (7,388,781.)
42 USC 1396a(a)(13); 42 USC 1315; 42CFR Part 447; 42CFR 440.20	a. FFY12 $ ~~(51,728,833)~~ ~~(49,478,033)~~ b. FFY13 $ ~~(51,556,814)~~ ~~(49,306,814)~~ 7,835,315
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: **Attachment 4.19-B (1), pages 1-12**	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: **Attachment 4.19-B (1), pages 1- 11**

10. SUBJECT OF AMENDMENT:

Methods Used to Determine Rates of Payment for Acute Outpatient Hospital Services

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 under 42 CFR 430.12(b)(2)(ii)**

12. SIGNATURE OF STATE AGENCY OFFICIAL: [redacted]	16. RETURN TO:
13. TYPED NAME: **JudyAnn Bigby, M.D.**	**Michael P. Coleman** **State Plan Coordinator** **Executive Office of Health and Human Services** **Office of Medicaid** **One Ashburton Place, 11th Floor** **Boston, MA 02108**
14. TITLE: **Secretary**	
15. DATE SUBMITTED: **12/28/11**	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 12/29/2011	18. DATE APPROVED: 09/18/2012

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 10/01/2011	20. SIGNATURE OF REGIONAL OFFICIAL: /s/
21. TYPED NAME: Richard R. McGreal	22. TITLE: Associate Regional Administrator, Division of Medicaid & Children's Health Operations, Boston, MA

23. REMARKS:

State made pen&ink changes to box #7.

FORM CMS-179 (07-92)