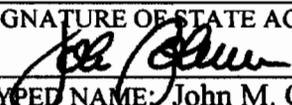


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|--|--|--|----------------------|
| TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL | | 1. TRANSMITTAL NUMBER: 10-05 | 2. STATE Maryland |
| FOR: HEALTH CARE FINANCING ADMINISTRATION | | 3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID) | |
| TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES | | 4. PROPOSED EFFECTIVE DATE January 1, 2010 | |
| 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: 42CFR§440.90 | | 7. FEDERAL BUDGET IMPACT: a. FFY 2010: \$ (24,800) b. FFY 2011: \$ (33,066) | |
| 8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 3.1-A, Page 22-C Attachment 3.1-A, Page 22-C1 Attachment 3.1-A, Page 22-C2 See attached PAGE | | 9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Attachment 3.1-A, Page 22-C, Effective 09/10/84 New New | |
| 10. SUBJECT OF AMENDMENT: . This amendment is being submitted to update services and revise the payment methodologies related to Ambulatory Surgery services and to comply with the Deficit Reduction Act of 2005. | | | |
| 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: Susan J. Tucker, Executive Director Office of Health Services | |
| 12. SIGNATURE OF STATE AGENCY OFFICIAL:  | | 16. RETURN TO: Susan J. Tucker, Executive Director OHS - DHMH 201 W. Preston St., 1 st floor Baltimore, MD 21201 | |
| 13. TYPED NAME: John M. Colmers | | | |
| 14. TITLE: Secretary, Department of Health & Mental Hygiene | | | |
| 15. DATE SUBMITTED: MARCH 30, 2010 | | | |
| FOR REGIONAL OFFICE USE ONLY | | | |
| 17. DATE RECEIVED: MARCH 30, 2010 | | 18. DATE APPROVED: JUN 21 2010 | |
| PLAN APPROVED - ONE COPY ATTACHED | | | |
| 19. EFFECTIVE DATE OF APPROVED MATERIAL: JANUARY 1, 2010 | | 20. SIGNATURE OF REGIONAL OFFICIAL:  | |
| 21. TYPED NAME: TED GALLAGHER | | 22. TITLE: ASSOCIATE REGIONAL ADMINISTRATOR DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS | |
| 23. REMARKS: | | | |