

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL		1. TRANSMITTAL NUMBER: 10-11	2. STATE Maryland
FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES		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 July 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: <i>SECTION 1902(m) OF THE SSA</i>		7. FEDERAL BUDGET IMPACT: a. FFY <u>2010</u> \$ 6.8 million b. FFY <u>2011</u> \$ 20.6 million	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Supplement 1 to Attachment 4.19, Page 3 <i>SUPPLEMENT 1 TO ATTACHMENT 4.19-B, PAGE 4</i>		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Supplement 1 to Attachment 4.19, Page 3 (06-03) <i>NEW</i>	
10. SUBJECT OF AMENDMENT: Defines the State's payment coinsurance payment for Part B claims for all dual Medicare and Medicaid covered individuals and QMB-only individuals.			
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: The Secretary of the Department of Health and Mental Hygiene	
12. SIGNATURE OF STATE AGENCY OFFICIAL: <i>[Signature]</i>		16. RETURN TO: Susan Tucker Executive Director Office of Health Services Department of Health & Mental Hygiene 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: <i>SEPTEMBER 30, 2010</i>			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED: <i>SEPTEMBER 30, 2010</i>		18. DATE APPROVED: <i>DEC 08 2010</i>	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: <i>JULY 1, 2010</i>		20. SIGNATURE OF REGIONAL OFFICIAL: <i>[Signature]</i>	
21. TYPED NAME: <i>TED GALLAGHER</i>		22. TITLE: <i>ASSOCIATE REGIONAL ADMINISTRATOR DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS</i>	
23. REMARKS: <i>CHANGE IN ITEM 6 WAS MADE IN ACCORDANCE WITH MARYLAND MEDICAID OFFICIALS. CHANGES IN ITEM 8 AND 9 WERE MADE AT THE REQUEST OF MARYLAND MEDICAID OFFICIALS</i>			