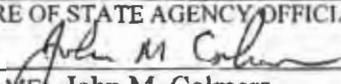


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|---|--|---|----------------------|
| TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL | | 1. TRANSMITTAL NUMBER: 10-15 | 2. STATE Maryland |
| FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES | | 3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID) | |
| TO: REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE & MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES | | 4. PROPOSED EFFECTIVE DATE October 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: 42 CFR PART 455 | | 7. FEDERAL BUDGET IMPACT: a. FFY 2010 \$ 0 b. FFY 2011 \$ 0 | |
| 8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Page 80, Section 1 PAGE 79y Page 81, Section 1 PAGE 79y-1 | | 9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): NEW NEW | |
| 10. SUBJECT OF AMENDMENT: Maryland State Attestation for compliance with provisions of the Medicaid Recovery Audit Contractor (RAC) program. | | | |
| 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 | | X OTHER, AS SPECIFIED: The Secretary of the Department of Health and Mental Hygiene | |
| 12. SIGNATURE OF STATE AGENCY OFFICIAL:  | | 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: 12/22/2010 | | | |
| FOR REGIONAL OFFICE USE ONLY | | | |
| 17. DATE RECEIVED: 12/27/2010 | | 18. DATE APPROVED: MAR 24 2011 | |
| PLAN APPROVED - ONE COPY ATTACHED | | | |
| 19. EFFECTIVE DATE OF APPROVED MATERIAL: OCTOBER 1, 2010 | | 20. SIGNATURE OF REGIONAL OFFICIAL:  | |
| 21. TYPED NAME: TED GALLAGHER | | 22. TITLE: ASSOCIATE REGIONAL ADMINISTRATOR | |
| 23. REMARKS: BOXES 6, 7, 8 PEN AND INK CHANGES WERE MADE IN ACCORDANCE WITH INSTRUCTIONS FROM THE MARYLAND MEDICAID AGENCY. | | | |