

<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</b>  <b>FOR: HEALTH CARE FINANCING ADMINISTRATION</b>		1. TRANSMITTAL NUMBER:  <u>08 - 018</u>	2. STATE:  MAINE
TO: REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE AND MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
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		4. PROPOSED EFFECTIVE DATE(S)  10/01/08	
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)			
6. FEDERAL STATUTE/REGULATION CITATION: CFR 440.80		7. FEDERAL BUDGET IMPACT: a. FFY <u>09</u> \$ <u>0</u> b. FFY <u>10</u> \$ <u>0</u>	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: 4.19B 1F-I 3.1-A, page 9a; 3.1-B, page 8a		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): 4.19B 1F-I None	
SUBJECT OF AMENDMENT: OUTPATIENT HOSPITAL REIMBURSEMENT - a change to the cap on the prospective interim payment (PIP) and revised the plan language to clarify the PIP is calculated independently of the final obligation.			
11. GOVERNOR'S REVIEW (Check One): <input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT      OTHER, AS SPECIFIED <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED      COMMISSIONER, DEPT. OF HUMAN SERVICES <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL			
12. SIGNATURE OF STATE AGENCY OFFICIAL:   		16. RETURN TO:   	
13. TYPED NAME: BRENDA HARVEY		ANTHONY MARPLE Director, Office of MaineCare Services #11 State House Station	
14. TITLE: Commissioner, Maine Department of Health and Human Services		442 CIVIC CENTER DRIVE Augusta, ME 04333-0011	
15. DATE SUBMITTED: DECEMBER 30, 2008			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED: December 30, 2008		18. DATE APPROVED: September 25, 2009	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: October 1, 2008		20. SIGNATURE OF REGIONAL OFFICIAL:	
21. TYPED NAME Richard R. McGreal		22. TITLE Associate Regional Administrator Division of Medicaid and Children's Health Operations	
23. REMARKS  Per agreement, Attachment 3.1-A, page 9a and Attachment 3.1-B, page 8b are added to Box 8.			