DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEICARE & MEDICAID 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: 10-02	2. STATE Maryland
	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 December 1, 2009	

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN X 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: a. FFY 2010 $ 0 b. FFY 2011 $ 0
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19D, page 1 CONTINUED ON NEXT PAGE	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: Attachment 4.19D, page 1 (~~09-04~~) (TN 09-12) CONTINUED ON NEXT PAGE

10. SUBJECT OF AMENDMENT: This amendment is being submitted to reflect changes in the regulations related to reimbursement for nursing facility services. No impact on net reimbursement to nursing facilities is projected.

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
- 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, 1st floor Baltimore MD 21201
13. TYPED NAME: John M. Colmers	
14. TITLE: Secretary, Department of Health & Mental Hygiene	
15. DATE SUBMITTED: DECEMBER 29, 2009	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:	18. DATE APPROVED: 7-12-10
PLAN APPROVED - ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: DEC - 1 2009	20. SIGNATURE OF REGIONAL OFFICIAL: [signature]
21. TYPED NAME: William Lasowski	22. TITLE: Deputy Director, CMCS

23. REMARKS:

#3 + #9 PEN AND INK CHANGES WERE MADE PER INSTRUCTIONS FROM THE MEDICAID STATE AGENCY.

FORM CMS-179 (07-92)

CMS Form 179 Transmittal
MD SPA 10-002
Continued from previous page

8. Page number of the plan section or attachment:	9. Page number of the superseded plan section or attachment:
Attachment 4.19D, Page 2 Attachment 4.19D, Page 2-A Attachment 4.19D, Page 4 Attachment 4.19D, Page 6	Attachment 4.19D, Page 2 (TN 09-12) Attachment 4.19D, Page 2-A (TN 09-12) Attachment 4.19D, Page 4 (TN 09-12) Attachment 4.19D, Page 6 (TN 08-03)