TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL	1. TRANSMITTAL NUMBER: 10-07-MA	2. STATE New Jersey
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 September 1, 2010 April 1, 2011	

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

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION: Social Security Act Section 1902(a)(13)	7. FEDERAL BUDGET IMPACT: a. FFY 2010: Anticipated to be $0 b. FFY 2011: Anticipated to be $0
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-A pages I-1	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: Same

10. SUBJECT OF AMENDMENT: Hospital Inpatient Services DRG Reimbursement for In-State General Acute Care Hospitals

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

☒ OTHER, AS SPECIFIED:
Not required, pursuant to 7.4 of the Plan

12. SIGNATURE OF STATE AGENCY OFFICIAL:	16. RETURN TO: Division of Medical Assistance and Health Services P.O. Box 712, Mail Code #26 Trenton, NJ 08625-0712
13. TYPED NAME: Jennifer Velez	
14. TITLE: Commissioner	
15. DATE SUBMITTED: 9/10/10	
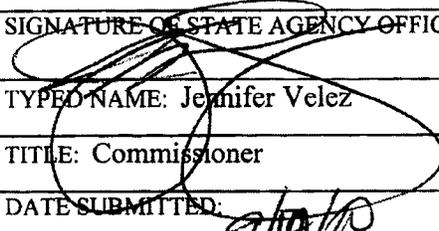
FOR REGIONAL OFFICE USE ONLY	
17. DATE RECEIVED:	18. DATE APPROVED: 05-23-11

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: APR - 1 2011	20. SIGNATURE OF REGIONAL OFFICIAL:
21. TYPED NAME: William Lasowski	22. TITLE: Deputy Director, CMCS
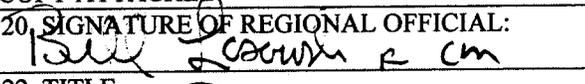
23. REMARKS: Pen & ink change made to blocks 4 and 7 per email from State dated 5/16/11.