

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL**

1. TRANSMITTAL NUMBER:
11-009

2. STATE
California

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
June 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:
42 CFR, Sections

7. FEDERAL BUDGET IMPACT:
a. FFY 2010-11 -\$56. M (4 mo.) (savings)
b. FFY 2011-12 -\$194 M (savings)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-B: amended pages 3, 3.1 and 64

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION
OR ATTACHMENT (*If Applicable*):
Attachment 4.19-B, pages 3, 3.1 and 64 (10-022)

10. SUBJECT OF AMENDMENT:
Ten Percent Payment Reduction for Medi-Cal Outpatient Services

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:
The Governor's Office does not
wish to review the State Plan Amendment.

12. SIGNATURE OF STATE AGENCY OFFICIAL:



13. TYPED NAME:
Toby Douglas

14. TITLE:
Director

15. DATE SUBMITTED:

16. RETURN TO:

**Department of Health Care Services
Attn: State Plan Coordinator
1501 Capitol Avenue, Suite 71.3.26
P.O. Box 997417
Sacramento, CA 95899-7417**

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED:

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:

22. TITLE:

23. REMARKS: