TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL **FOR: HEALTH CARE FINANCING ADMINISTRATION**	1. TRANSMITTAL NUMBER: 18-0007	2. STATE Maine
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR Centers for Medicare and Medicaid Services Department of Health and Human Services	4. PROPOSED EFFECTIVE DATE 9/4/18	

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: 1902 (a)(10)(A)(i)(VIII) 42 CFR 435.119	7. FEDERAL BUDGET IMPACT: a. FFY 2018 increase: accounted for in ME.18-0006 b. FFY 2019 increase: accounted for in ME.18-0006
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Supplement 18 to Attachment 2.6A	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: New

10. SUBJECT OF AMENDMENT:
Methodology for Identification of Applicable FMAP Rates for Expansion of Medicaid coverage to the 1902(a)(10)(A)(i)(VIII) eligibility group

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:

12. SIGNATURE OF STATE AGENCY OFFICIAL:	16. RETURN TO: Bethany L. Hamm Acting Commissioner, Maine DHHS #11 State House Station 221 State Street Augusta, Maine 04333-0011
13. TYPED NAME: Bethany L. Hamm	
14. TITLE: Acting Commissioner, Maine DHHS	
15. DATE SUBMITTED: September 4, 2018	

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: