DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: HEALTH CARE FINANCING ADMINISTRATION	1. TRANSMITTAL NUMBER: **SPA #10-10**	2. STATE **Kansas**
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID) **Medicaid**	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE **July 1, 2010**	

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: 42 CFR 447.201, 42 CFR 442.10	7. FEDERAL BUDGET IMPACT: a. FFY 2010 $1~~,675,000~~.00 1,905,258 b. FFY 2011 $35~~,000,000~~.00 23,715,773
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: **See Attached**	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: **See Attached**

10. SUBJECT OF AMENDMENT:

Methods and standards for establishing nursing facility payment rates.

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: Barbara Langner is the Governor's Designee

12. SIGNATURE OF STATE AGENCY OFFICIAL: Barbara E Langner	16. RETURN TO: Barbara E Langner Medicaid Director Kansas Health Policy Authority 900 SW Jackson, Room 900N Topeka, KS 66612-1220
13. TYPED NAME: Barbara E Langner	
14. TITLE: Medicaid Director, Kansas Health Policy Authority	
15. DATE SUBMITTED: July 29, 2010	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:	18. DATE APPROVED Bill Lasowski FOR CM 02-02-11
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: JUL – 1 2010	20. SIGNATURE OF REGIONAL OFFICIAL:
21. TYPED NAME: William Lasowski	22. TITLE: Deputy Director, CMCS

23. REMARKS:
Pen & ink change made to block # 7