

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

FOR: HEALTH CARE FINANCING ADMINISTRATION

**TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE AND MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES**

1. TRANSMITTAL NUMBER:
09-016

2. STATE
Pennsylvania

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE
SOCIAL SECURITY ACT (MEDICAID)

4. PROPOSED EFFECTIVE DATE
JANUARY 1, 2009

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 447 SUBPART C

7. FEDERAL BUDGET IMPACT: Estimated increased FMAP ARRA
a. FFY 2009 - \$18,543,468.
b. FFY 2010 - \$27,363,835.

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
PAGE 4.19D PART III PAGES 1 -2

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION
OR ATTACHMENT (If Applicable):
PAGE 4.19D PART III PAGES 1 - 3

10. SUBJECT OF AMENDMENT:
METHODS AND STANDARDS FOR REASONABLE COST-RELATED REIMBURSEMENT FOR STATE OPERATED NURSING FACILITIES

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:
Review and approval authority has been
delegated to the Department of Public

Welfare
12. SIGNATURE OF STATE AGENCY OFFICIAL:
Estelle B. Richman

13. TYPED NAME:
ESTELLE B. RICHMAN

14. TITLE:
SECRETARY OF PUBLIC WELFARE

15. DATE SUBMITTED: **MAR 31 2009**

16. RETURN TO:

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED:
8-5-10

19. EFFECTIVE DATE OF APPROVED MATERIAL:
JAN - 1 2009

20. SIGNATURE OF REGIONAL OFFICIAL:
William Lasowski

21. TYPED NAME:
William Lasowski

22. TITLE:
Deputy Director, CMCS

23. REMARKS: