

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL		1. TRANSMITTAL NUMBER: 09-08-MA	2. STATE New Jersey
FOR: HEALTH CARE FINANCING ADMINISTRATION		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
10. REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE July 1, 2009	
5. TYPE OF PLAN MATERIAL (Check One): <input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)			
6. FEDERAL STATUTE/REGULATION CITATION: Section 1902(a)(13)(A) of the Social Security Act		7. FEDERAL BUDGET IMPACT: a. FFY 2009 \$2.8 Million b. FFY 2010 \$8.3 Million	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-D Page 171.1 Attachment 4 19-D, Page 191.14		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Same New	

10. SUBJECT OF AMENDMENT: **Additional Reimbursement for Nursing Facilities with High Medicaid Occupancy**

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:

13. TYPED NAME: **Jennifer Velez**

14. TITLE: **Commissioner**

15. DATE SUBMITTED: **9/28/09**

16. RETURN TO:

**John R. Guhl, Director
Division of Medical Assistance and Health Services
P.O. Box 712, #26
Trenton, NJ 08625-0712**

17. DATE RECEIVED:		FOR OFFICIAL USE ONLY DATE APPROVED: 5-11-10	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: JUL - 1 2009		20. SIGNATURE OF REGIONAL OFFICIAL: Bill Keough, Jr. CM	
21. TYPE NAME: William Lasowski		22. TITLE: Deputy Director CMCS	
23. REMARKS:			