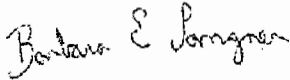



<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</b>		1. TRANSMITTAL NUMBER: SPA #10-12	2. STATE Kansas
<b>FOR: HEALTH CARE FINANCING ADMINISTRATION</b>		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE January 1, 2011	
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 1927(d), 1927(d)(2)(G) and 1927(d)(6)		7. FEDERAL BUDGET IMPACT: a. FFY 2011      \$(245,000) <del>\$(122,500)</del> b. FFY 2012      \$(245,000)	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:  Attachment 3.1-A, Pages 2 & 3		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable):  Attachment 3.1-A, Pages 2 & 3	
10. SUBJECT OF AMENDMENT: Prescribed Drug Limitations			
11. GOVERNOR'S REVIEW (Check One): <input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input checked="" type="checkbox"/> OTHER, AS SPECIFIED: <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED      Andy Allison, PhD. is the <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL      Governor's Designee			
12. SIGNATURE OF STATE AGENCY OFFICIAL:  		16. RETURN TO: Andy Allison, PhD. Kansas Health Policy Authority Landon State Office Building 900 SW Jackson, Room 900-N Topeka, KS 66612-1220	
13. TYPED NAME: for Andy Allison, PhD.			
14. TITLE: Executive Director of the Kansas Health Policy Authority			
15. DATE SUBMITTED: September 2, 2010			
<b>FOR REGIONAL OFFICE USE ONLY</b>			
17. DATE RECEIVED: September 3, 2010		18. DATE APPROVED: February 24, 2011	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: January 1, 2011		20. SIGNATURE OF REGIONAL OFFICIAL: 	
21. TYPED NAME: James G. Scott		22. TITLE: Associate Regional Administrator for Medicaid and Children's Health Operations	
23. REMARKS: pen and ink change per State's request			