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: 10-005

2. STATE: Kentucky

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
7/1/2010

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 CFS 431.54(e)

7. FEDERAL BUDGET IMPACT:
a. FFY 2010 - ($1.0 Million)
b. FFY 2011 - ($3.5 Million)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 3.1-A, Page 7.2.1(a)
Attachment 3.1-B, Page 22
Attachment 3.1-A, Page 7.5.2
Attachment 3.1-B, Page 31.1
Attachment 4.19-B, Page 20.4
Attachment 3.1-A, Page 7.1.1(a)
Attachment 3.1-B, Page 13.2
Attachment 4.19-B, Page 20.12(f)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Same

10. SUBJECT OF AMENDMENT
This State Plan Amendment will prevent Medicaid recipients from refilling a prescription until 90% of the prior fill has been utilized. However, in the case of an emergency, recipients may obtain a refill earlier if the prescribing physician or pharmacy submits a prior authorization.

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: Review delegated to Commissioner, Department for Medicaid Services

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME: Elizabeth A. Johnson

14. TITLE: Commissioner, Department for Medicaid Services

15. DATE SUBMITTED: July 26, 2010

16. RETURN TO:
Department for Medicaid Services
275 East Main Street 6W-A
Frankfort, Kentucky 40621

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED: 04/15/11

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 07/01/10

20. SIGNATURE OF REGIONAL OFFICIAL: Jackie Glaze

21. TYPED NAME: Jackie Glaze

22. TITLE: Associate Regional Administrator
Division of Medicaid & Children's Health Opns

23. REMARKS:

Approved with following changes as authorized by State Agency on email dated 03/15/11:

Block # 8 **Changed to read**: Attachment 3.1-A, page 7.1.1(a), attachment 3.1-A page 7.2.1(a), Attachment 3.1-A page 7.2.1(a)(o), Attachment 3.1-F (Lock-in program) pages 1 thru 14 new and Attachment 3.1-F (KenPac) pages 1 thru 15.

FORM HCFA-179 (07-92)