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: 11-011

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
07/01/2011

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:
Section 1905of the Social Security Act
Section 4107 of the Affordable Care Act

7. FEDERAL BUDGET IMPACT:
a. FFY 2011 - Budget Neutral
b. FFY 2012 - Budget Neutral

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Page 3.1-A, Page 2	Same
Page 3.1-A, Page 7.1.10 New	None
Page 3.1-A, Page 7.2.1(a)(o)	Same
Page 3.1-B, Page 2	Same
Page 3.1-B, Page 20.4 New	None
Page 3.1-B, Page 22.1(a)	Same

10. SUBJECT OF AMENDMENT
The purpose of this State Plan Amendment is to clarify language for the coverage of tobacco cessation for pregnant women per State Medicaid Director Letter 11-007.

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:
Neville J Wise

13. TYPED NAME: Neville Wise

14. TITLE: Acting Commissioner, Department for Medicaid Services

15. DATE SUBMITTED: Sept 23, 2011

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

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 09/22/11

18. DATE APPROVED: 12/07/11

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 07/01/11

20. SIGNATURE OF REGIONAL OFFICIAL:
Jackie Glaze

21. TYPED NAME: Jackie Glaze

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

23. REMARKS:

Approved with the following changes to item 4 as authorized by State Agency on email dated 11/17/11:

Block # 8 Changed to Read: Attachment 3.1-A pages 2, 7.1.10 (new), 7.2.1(a)(o), 16 and 42; Attachment 3.1-B pages 2, 20.4(new) and 22.1(a).

Block # 9 Changed to Read: Attachment 3.1-A pages 2, 7.1.10 (new), 7.2.1(a)(o), 16 and 42; Attachment 3.1-B pages 2, 20.4(new) and 22.1(a).