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: 12-002

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
01/01/12

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 1902(a)(77), 1902(a)(39), 1902(kk); P.L. 111-148
And P.L. 111-152
42 CFR 455

7. FEDERAL BUDGET IMPACT:
a. FFY 2011 - $66,700
b. FFY 2012 - $100,000

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Section 4, Page 80.1
Section 4, Page 80.2
Section 4, Page 80.3

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

New pages

10. SUBJECT OF AMENDMENT
The purpose of this State Plan Amendment is to provide assurances that the State is in compliance with the screening and enrollment of providers pursuant 42 CFR 445.

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 I. Wise

13. TYPED NAME: Neville Wise

14. TITLE: Acting Commissioner, Department for Medicaid Services

15. DATE SUBMITTED: January 19, 2012

16. RETURN TO:

Department for Medicaid Services
275 East Main Street 6W-A
Frankfort, Kentucky 40621

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 01-20-12

18. DATE APPROVED: 03/14/12

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 01-01-12

20. SIGNATURE OF REGIONAL OFFICIAL:
Jackie Glaze

21. TYPED NAME: Jackie Glaze

22. TITLE: Associate Reg. Administrator
Division of Medicaid & Children's Health Operations

23. REMARKS:

FORM HCFA-179 (07-92)