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State/Territory Name: Kentucky

State Plan Amendment (SPA) #: 18-0008

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) CMS 179 Form
- 3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Atlanta Regional Office
61 Forsyth Street, Suite 4T20
Atlanta, Georgia 30303



DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

June 27, 2018

Jill R. Hunter, Acting Commissioner
Department for Medicaid Services
275 East Main Street, 6WA
Frankfort, KY 40621-0001

Re: Kentucky State Plan Amendment 18-0008

Dear Ms. Hunter:

We have reviewed the proposed Kentucky state plan amendment, KY 18-0008, which was submitted to the Centers for Medicare & Medicaid Services (CMS) on June 19, 2018. This amendment designates Jill R. Hunter, Acting Commissioner of the KY Department for Medicaid Services, as the Governor's designee for review and approval of state plan amendments.

Based on the information provided, the Medicaid State Plan Amendment KY 18-0008 was approved on June 27, 2018. The effective date of this amendment is June 15, 2018. We are enclosing the approved HCFA-179 and a copy of the new state plan pages.

If you have any additional questions or need further assistance, please contact Melanie Benning at (404) 562-7414 or Melanie.Benning@cms.hhs.gov.

Sincerely,

//s//

Shantrina D. Roberts, MSN
Associate Regional Administrator
Division of Medicaid & Children's Health Operations

Enclosures

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL	1. TRANSMITTAL NUMBER: 18-008	2. STATE Kentucky
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
FOR: HEALTH CARE FINANCING ADMINISTRATION		
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE June 16, 2018	

5. TYPE OF PLAN MATERIAL (*Check One*):

NEW STATE PLAN AMENDMENT TO BE CONSIDERED AS NEW PLAN AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (*Separate Transmittal for each amendment*)

6. FEDERAL STATUTE/REGULATION CITATION: 42 CFR 430.12(b)	7. FEDERAL BUDGET IMPACT: a. FFY 2016 \$0 b. FFY 2017 \$0
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Page 89	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (<i>If Applicable</i>): Same

10. SUBJECT OF AMENDMENT:

State Governor's Review appoint Jill R. Hunter, Acting Commissioner

11. GOVERNOR'S REVIEW (*Check One*):

GOVERNOR'S OFFICE REPORTED NO COMMENT OTHER, AS SPECIFIED: Review delegated
 COMMENTS OF GOVERNOR'S OFFICE ENCLOSED to Commissioner, Department for Medicaid
 NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL Services

12. SIGNATURE OF STATE AGENCY OFFICIAL: //s//	16. RETURN TO: Department for Medicaid Services 275 East Main Street 6W-A Frankfort, Kentucky 40621
13. TYPED NAME: Jill R. Hunter	
14. TITLE: Acting Commissioner, Department for Medicaid Services	
15. DATE SUBMITTED: 6/15/18	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: June 19, 2019	18. DATE APPROVED: June 27, 2018
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PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: June 15, 2018	20. SIGNATURE OF REGIONAL OFFICIAL: //s//
21. TYPED NAME: Shantrina D. Roberts	22. TITLE: Associate Regional Administrator Division of Medicaid & Children's Health Operations

23. REMARKS: Approved with following changes to block# 4 and 7 as authorized by state agency.

Block# 4 changed to read: Proposed Effective Date June 15, 2018.

Block# 7 changed to read: FFY 2018 \$-0-and FFY 2019 \$-0-.

State: Kentucky

Citation 7.4 State Governor's Review

42 CFR 430.12(b)

The Medicaid Agency will provide opportunity for the Office of Governor to review State plan amendments, long-range program planning projections, and other periodic reports thereon, excluding periodic statistical, budget and fiscal reports. Any comments made will be transmitted to the Centers for Medicare and Medicaid Services with such documents.

Not Applicable. The Governor-

Does not wish to review any plan material.

Wishes to review only the plan materials specified in the enclosed document.

I hereby certify that I am authorized to submit this plan on behalf of

Department for Medicaid Services
(Designated Single State Agency)

Date: June 15, 2018

Jill R. Hunter, Acting Commissioner
Department for Medicaid Services

TN#: 18-008
Supersedes
TN#: 16-002

Approval Date: 06/27/18

Effective Date: June 15, 2018