

March 11, 2008

Ms. Elizabeth A. Johnson
Commissioner
Cabinet for Health and Family Services
Department of Medicaid Services
275 East Main Street, 6W-A
Frankfort, Kentucky 40621-0001

Attention: Kevin Skeeters

RE: Kentucky Title XIX State Plan Amendment, Transmittal #08-002

Dear Ms. Johnson:

We have reviewed the proposed amendment to the Kentucky Medicaid State Plan that was submitted under transmittal number 08-002. This amendment reflects the change in name of the Commissioner only.

Based on the information provided, we are pleased to inform you that Medicaid State Plan Amendment 08-002 was approved on March 07, 2008. The effective date for this amendment is January 16, 2008. We are also enclosing the approved HCFA-179 and plan page.

If you have any questions or need any further assistance, please contact Maria Donatto at 404-562-3697 or Yvette Moore at (404) 562-7327.

Sincerely,



Jay Gavens
Acting Associate Regional Administrator
Division of Medicaid & Children's Health Operations

Enclosures

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL	1. TRANSMITTAL NUMBER: 08-002	2. STATE Kentucky
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
DR: HEALTH CARE FINANCING ADMINISTRATION		4. PROPOSED EFFECTIVE DATE January 16, 2008
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		

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 2005 \$0 b. FFY 2006 \$0
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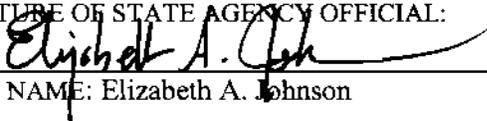
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Page 89	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Same
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10. SUBJECT OF AMENDMENT:

State Governor's Review

11. GOVERNOR'S REVIEW (Check One):

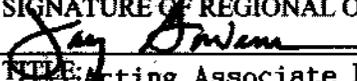
GOVERNOR'S OFFICE REPORTED NO COMMENT OTHER, AS SPECIFIED: Review delegated
 COMMENTS OF GOVERNOR'S OFFICE ENCLOSED to Commissioner, Department for Medicaid
 NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL Services

12. SIGNATURE OF STATE AGENCY OFFICIAL: 	16. RETURN TO: Department for Medicaid Services 275 East Main Street 6W-A Frankfort, Kentucky 40621
13. TYPED NAME: Elizabeth A. Johnson	
14. TITLE: Commissioner, Department for Medicaid Services	
15. DATE SUBMITTED: February 6, 2008	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 02/06/08	18. DATE APPROVED: 03/07/08
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PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 01/16/08	20. SIGNATURE OF REGIONAL OFFICIAL: 
21. TYPED NAME: Jay Gavens	22. TITLE: Acting Associate Regional Administrator Division of Medicaid & Children's Health OPNS

23. REMARKS:

State: Kentucky

Citation

7.4 State Governor's Review

42 CFR 430.12(b)

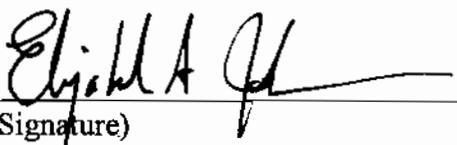
The Medicaid Agency will provide opportunity for the Office of Governor to review State plan amendments, long-range program planning projections, and other periodic reports thereon, excluding periodic statistical, budget and fiscal reports. Any comments made will be transmitted to the Centers for Medicare 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: January 16, 2008


(Signature)

Elizabeth A. Johnson, Commissioner
Department for Medicaid Services
 (Title)

TN#: 08-002

Supersedes

TN#: 07-006Approval Date: 03/07/08Effective Date: 1/16/2008