

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

February 26, 2015

Ms. Lisa Lee, Commissioner
Department for Medicaid Services
275 East Main Street, 6WA
Frankfort, KY 40621-0001

Re: Kentucky State Plan Amendment 15-0001

Dear Ms. Lee:

We have reviewed the proposed Kentucky state plan amendment, KY 15-0001, which was submitted to the Centers for Medicare & Medicaid Services (CMS) on February 11, 2015. This amendment authorizes the Kentucky Medicaid Commissioner, Lisa Lee, to submit state plan amendments for the KY Department for Medicaid Services.

Based on the information provided, the Medicaid State Plan Amendment KY 15-0001 was approved on February 26, 2015. The effective date of this amendment is February 1, 2015. We are enclosing the approved HCFA-179 and a copy of the new state plan page.

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,

A handwritten signature in black ink that reads "Jackie Glaze for". The signature is written in a cursive style.

Jackie Glaze
Associate Regional Administrator
Division of Medicaid & Children's Health Operations

Enclosures

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL	1. TRANSMITTAL NUMBER: 15-001	2. STATE Kentucky
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FOR: HEALTH CARE FINANCING ADMINISTRATION	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)
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TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE February 1, 2015
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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 2012 \$0 b. FFY 2013 \$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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (<i>If Applicable</i>): Same
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10. SUBJECT OF AMENDMENT:

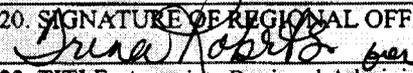
State Governor's Review appoint Lisa Lee

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:
13. TYPED NAME: Lisa Lee	Department for Medicaid Services 275 East Main Street 6W-A Frankfort, Kentucky 40621
14. TITLE: Commissioner, Department for Medicaid Services	
15. DATE SUBMITTED: 2/3/2015	

FOR REGIONAL OFFICE USE ONLY	
17. DATE RECEIVED: 02-11-15	18. DATE APPROVED: 02-26-15

PLAN APPROVED - ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: 02-01-15	20. SIGNATURE OF REGIONAL OFFICIAL: 
21. TYPED NAME: Jackie Glaze	22. TITLE: Associate Regional Administrator Division of Medicaid & Children 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: February 4, 2015

Lisa Lee, Commissioner
Department for Medicaid Services