DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

Revised Submission 10.14.11

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: HEALTH CARE FINANCING ADMINISTRATION	1. TRANSMITTAL NUMBER: SPA #11-01	2. STATE Kansas
	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 March 1, 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:	7. FEDERAL BUDGET IMPACT: a. FFY 2011 $ 0 b. FFY 2012 $ 0
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 3.1-A, #7 Attachment 3.1-A, #7.b Attachment 3.1-A, Page 11 Attachment 3.1-A, #6.d., Page 1 Attachment 4.19-B, Page 1	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: Attachment 3.1-A, #7 Attachment 3.1-A, #7.b. Attachment 3.1-A, Page 11 Attachment 3.1-A, #6.d., Page 1 Attachment 4.19-B, Page 1

10. SUBJECT OF AMENDMENT:
Companion Question Response as related to SPA #10-03

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:
Andy Allison, PhD. is the Governor's Designee

12. SIGNATURE OF STATE AGENCY OFFICIAL: Barbara E Langren	16. RETURN TO: Andy Allison, PhD. Kansas Health Policy Authority Landon State Office Building 900 SW Jackson, Room 900-N Topeka, KS 66612-1220
13. TYPED NAME: for Andy Allison, PhD.	
14. TITLE: Executive Director of the Kansas Health Policy Authority	
15. DATE SUBMITTED: February 23, 2011	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: February 23, 2011	18. DATE APPROVED: November 2, 2011
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: March 1, 2011	20. SIGNATURE OF REGIONAL OFFICIAL:
21. TYPED NAME: James G. Scott	22. TITLE: Associate Regional Administrator for Medicaid and Children's Health Operations

23. REMARKS: