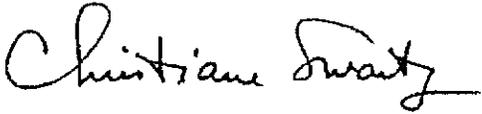
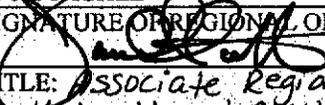


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|---|--|---|--------------------|
| TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL | | 1. TRANSMITTAL NUMBER: SPA KS #12-01 | 2. STATE Kansas |
| FOR: HEALTH CARE FINANCING ADMINISTRATION | | 3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID) | |
| TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES | | 4. PROPOSED EFFECTIVE DATE January 1, 2012 | |
| 5. TYPE OF PLAN MATERIAL (Check One): <input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT | | | |
| COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment) | | | |
| 6. FEDERAL STATUTE/REGULATION CITATION: Section 1902(a)(42)(B) of the Social Security Act | | 7. FEDERAL BUDGET IMPACT: a. FFY 2012 \$ (973,590) b. FFY 2013 \$(4,108,500) | |
| 8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Preprint Page Section 4.5, pages 36b & 36c | | 9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Preprint Page Section 4.5, pages 36b & 36c | |
| 10. SUBJECT OF AMENDMENT: Medicaid Recovery Audit Contractor Program (RAC) | | | |
| 11. GOVERNOR'S REVIEW (Check One): <input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input checked="" type="checkbox"/> OTHER, AS SPECIFIED: <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED Christiane Swartz is the <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL Governor's Designee | | | |
| 12. SIGNATURE OF STATE AGENCY OFFICIAL:  | | 16. RETURN TO: Christiane Swartz KDHE; Division of Health Care Finance Landon State Office Building 900 SW Jackson, Room 900-N Topeka, KS 66612-1220 | |
| 13. TYPED NAME: for Kari Bruffett, Director | | | |
| 14. TITLE: KDHE; Division of Health Care Finance | | | |
| 15. DATE SUBMITTED: January 9, 2012 | | | |
| FOR REGIONAL OFFICE USE ONLY | | | |
| 17. DATE RECEIVED: January 9, 2012 | | 18. DATE APPROVED: February 1, 2012 | |
| PLAN APPROVED -- ONE COPY ATTACHED | | | |
| 19. EFFECTIVE DATE OF APPROVED MATERIAL: January 1, 2012 | | 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: | | | |