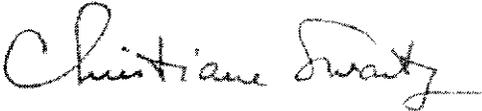


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|---|--|---|--------------------|
| <b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</b><br><br><b>FOR: HEALTH CARE FINANCING ADMINISTRATION</b>  |  | 1. TRANSMITTAL NUMBER:<br>SPA #KS 12-02   | 2. STATE<br>Kansas |
|   |  | 3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)  |                    |
| TO: REGIONAL ADMINISTRATOR<br>HEALTH CARE FINANCING ADMINISTRATION<br>DEPARTMENT OF HEALTH AND HUMAN SERVICES   |  | 4. PROPOSED EFFECTIVE DATE<br>January 1, 2012   |                    |
| 5. TYPE OF PLAN MATERIAL (Check One):<br><br><input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT<br>COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)   |  |   |                    |
| 6. FEDERAL STATUTE/REGULATION CITATION:<br>42 CFR 455 Subpart E   |  | 7. FEDERAL BUDGET IMPACT:<br>a. FFY 2012                      \$ 0<br>b. FFY 2013                      \$ 0   |                    |
| 8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:<br><br>Preprint 4.46 (New)  |  | 9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable):  |                    |
| 10. SUBJECT OF AMENDMENT:<br>Provider Screening and Enrollment  |  |   |                    |
| 11. GOVERNOR'S REVIEW (Check One):<br><input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input checked="" type="checkbox"/> OTHER, AS SPECIFIED:<br><input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED                      Christiane Swartz is the<br><input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL                      Governor's Designee |  |   |                    |
| 12. SIGNATURE OF STATE AGENCY OFFICIAL:<br><br>  |  | 16. RETURN TO:<br>Christiane Swartz<br>KDHE; Division of Health Care Finance<br>Landon State Office Building<br>900 SW Jackson, Room 900-N<br>Topeka, KS 66612-1220 |                    |
| 13. TYPED NAME:<br>for Kari Bruffett  |  | 17. DATE RECEIVED: <u>January 24, 2012</u><br>18. DATE APPROVED: <u>February 17, 2012</u><br>PLAN APPROVED - ONE COPY ATTACHED                                      |                    |
| 14. TITLE:<br>Director; KDHE; Division of Health Care Finance   |  |   |                    |
| 15. DATE SUBMITTED:<br>January 24, 2012   |  |   |                    |
| <b>FOR REGIONAL OFFICE USE ONLY</b>   |  |   |                    |
| 19. EFFECTIVE DATE OF APPROVED MATERIAL:<br><u>January 1, 2012</u>  |  | 20. SIGNATURE OF REGIONAL OFFICIAL:<br>   |                    |
| 21. TYPED NAME:<br><u>James G. Scott</u>  |  | 22. TITLE: <u>Associate Regional Administrator for Medicaid and Children's Health Operations</u>  |                    |
| 23. REMARKS:  |  |   |                    |