DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

Revised Submission 5.24.13

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: SPA #KS 13-06

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 15, 2013

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 2013 $ 745,649
b. FFY 2014 $1,004,141

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19B, #2.c., Page 1
Attachment 4.19B, #2.c., Page 4a
Attachment 4.19B, #2.c., Page 5
Attachment 4.19B, #2.c., Page 6
Attachment 4.19B, #2.c., Page 8 thru 11

* Attachment 3.1-A, #2c

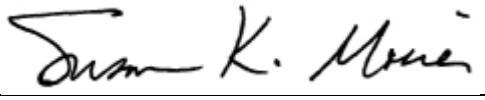
9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19B, #2.c., Page 1
Attachment 4.19B, #2.c., Page 4a
Attachment 4.19B, #2.c., Page 5
Attachment 4.19B, #2.c., Page 6
Attachment 4.19B, #2.c., Page 8 thru 11

* Attachment 3.1-A, #2c

10. SUBJECT OF AMENDMENT:
Federally Qualified Health Centers (FQHCs)

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:
Kari Bruffett is the Governor's Designee

12. SIGNATURE OF STATE AGENCY OFFICIAL:



13. TYPED NAME:
for Kari Bruffett

14. TITLE:
Director, Division of Health Care Finance

15. DATE SUBMITTED:
March 29, 2013

16. RETURN TO:
Kari Bruffett
KDHE; Division of Health Care Finance
Landon State Office Building
900 SW Jackson, Room 900-N
Topeka, KS 66612-1220

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: March 29, 2013

18. DATE APPROVED: June 24, 2013

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
March 15, 2013

20. SIGNATURE OF REGIONAL OFFICIAL:
/s/

21. TYPED NAME: James G. Scott

22. TITLE: Associate Regional Administrator for Medicaid and Children's Health Operations

23. REMARKS:

* Pen and ink changes per e-mail from state dated 6.19.13.