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State/Territory Name: Kentucky

State Plan Amendment (SPA) #:16-0002

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) CMS 179 Form
- 3) Approved SPA Pages

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 12, 2016

Stephen P. Miller, Commissioner
Department for Medicaid Services
275 East Main Street, 6WA
Frankfort, KY 40621-0001

Re: Kentucky State Plan Amendment 16-0002

Dear Mr. Miller:

We have reviewed the proposed Kentucky state plan amendment, KY 16-0002, which was submitted to the Centers for Medicare & Medicaid Services (CMS) on February 9, 2016. This amendment designates Stephen P. Miller, Commissioner of the KY Department for Medicaid Services, as the Governor's designee for review and approval of state plan amendments.

Based on the information provided, the Medicaid State Plan Amendment KY 16-0002 was approved on February 12, 2016. The effective date of this amendment is February 8, 2016. We are enclosing the approved HCFA-179 and a copy of the new state plan pages.

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,

//s//

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: 16-002	2. STATE Kentucky
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 February 8, 2016	
5. TYPE OF PLAN MATERIAL (<i>Check One</i>):			
<div style="display: flex; justify-content: space-between;"> <input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT </div>			
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (<i>Separate Transmittal for each amendment</i>)			
6. FEDERAL STATUTE/REGULATION CITATION: 42 CFR 430.12(b)		7. FEDERAL BUDGET IMPACT: <div style="display: flex; justify-content: flex-end;"> <div style="text-align: right;">a. FFY 2016 \$0</div> <div style="text-align: right;">b. FFY 2017 \$0</div> </div>	
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	
10. SUBJECT OF AMENDMENT: State Governor's Review appoint Stephen P. Miller, Commissioner			
11. GOVERNOR'S REVIEW (<i>Check One</i>): <div style="display: flex; justify-content: space-between; margin-top: 10px;"> <div> <input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL </div> <div style="text-align: right;"> <input checked="" type="checkbox"/> OTHER, AS SPECIFIED: Review delegated to Commissioner, Department for Medicaid Services </div> </div>			
12. SIGNATURE OF STATE AGENCY OFFICIAL: //s//		16. RETURN TO:	
13. TYPED NAME: Stephen P. Miller		Department for Medicaid Services 275 East Main Street 6W-A Frankfort, Kentucky 40621	
14. TITLE: Commissioner, Department for Medicaid Services			
15. DATE SUBMITTED: 2/8/16			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED: 02-09-16		18. DATE APPROVED: 02-12-16	
PLAN APPROVED – ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: 02-08-16		20. SIGNATURE OF REGIONAL OFFICIAL: //s//	
21. TYPED NAME: Jackie Glaze		22. TITLE: Associate Regional administrator Division of Medicaid & Children Health O ns	
23. REMARKS:			

State: KentuckyCitation 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 8, 2016

Stephen P. Miller, Commissioner
Department for Medicaid Services

TN#: 16-002

Supersedes

TN#: 16-001Approval Date: 02-12-16Effective Date: February 8, 2016