DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 12-001

2. STATE: Kentucky

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
01/01/12

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:
42 CFR 433, Subpart D

7. FEDERAL BUDGET IMPACT:
a. FFY 2011 - Budget Neutral
b. FFY 2012 - Budget Neutral

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Att. 4.22-A, Page 1

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Same

10. SUBJECT OF AMENDMENT
The purpose of this State Plan Amendment is to establish a timeline (3 year Look Back Period) for the state to review Third Party Liability claims.

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: Review delegated to Commissioner, Department for Medicaid Services

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Neville I Wise

13. TYPED NAME: Neville Wise

14. TITLE: Acting Commissioner, Department for Medicaid Services

15. DATE SUBMITTED: January 19, 2012

16. RETURN TO:
Department for Medicaid Services
275 East Main Street 6W-A
Frankfort, Kentucky 40621

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED: 03/19/12

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 01/01/12

20. SIGNATURE OF REGIONAL OFFICIAL:
Jackie Glaze

21. TYPED NAME: Jackie Glaze

22. TITLE: Associate Regional Administrator
Division of Medicaid & Children Health Opns

23. REMARKS:

FORM HCFA-179 (07-92)