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**State/Territory Name: Kentucky**

**State Plan Amendment (SPA)#: 22-0003**

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  
601 East 12th Street, Suite 0300  
Kansas City, Missouri 64106-2898



Medicaid and CHIP Operations Group

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June 22, 2022

Ms. Lisa Lee  
Commissioner, Department for Medicaid Services  
Commonwealth of Kentucky  
Cabinet for Health and Human Services  
275 East Main Street, 6 West A  
Frankfort, KY 40601

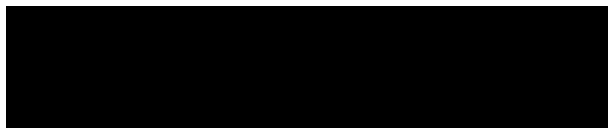
RE: State Plan Amendment (SPA) Transmittal Number 22-0003

Dear Ms. Lee:

The Centers for Medicare & Medicaid Services (CMS) reviewed your Medicaid State Plan Amendment (SPA) submitted under transmittal number (TN) 22-0003. This amendment proposes to amend the Third-Party Liability (TPL) provisions in the State Plan to make necessary updates to ensure compliance with current laws and regulations.

We conducted our review of your submittal according to statutory requirements in Title XIX of the Social Security Act and implementing regulations 42 CFR 433.139 and 1902(a)(25) and (F). This letter is to inform you that KY Medicaid SPA 22-0003 was approved on June 21, 2022 with an effective date of May 1, 2022.

If you have any questions, please contact Keri Toback at (312) 353-1754 or via email at [keri.toback@cms.hhs.gov](mailto:keri.toback@cms.hhs.gov).



James G. Scott, Director  
Division of Program Operations

Enclosures

cc: Erin Bickers, KY DMS

**TRANSMITTAL AND NOTICE OF APPROVAL OF  
STATE PLAN MATERIAL  
FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES**

1. TRANSMITTAL NUMBER

2 2 — 0 0 3

2. STATE

**KY**

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR  
CENTERS FOR MEDICARE & MEDICAID SERVICES  
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE

**5.1.2022**

5. TYPE OF PLAN MATERIAL (*Check One*)

NEW STATE PLAN

AMENDMENT TO BE CONSIDERED AS NEW PLAN

AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (*Separate transmittal for each amendment*)

6. FEDERAL STATUTE/REGULATION CITATION

42 CFR ~~433.137~~ 433.139 and 1902(a)(25)(E) and (F)

7. FEDERAL BUDGET IMPACT

a. FFY 2022 \$ 0

b. FFY 2023 \$ 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT

69, 69a, 70 Attachment 2.6a, 4.19B, Attachemnt 4.22A Exhibit A, Attachemnt 4.22A Exhibit B

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

69 - same  
69a - updated  
70 - same  
4.19B, Attachemnt - Updated  
4.22A Exhibit A - Updated Attachemnt  
4.22A Exhibit B Updated

10. SUBJECT OF AMENDMENT

Amending the Third-Party Liability (TPL) provisions in the State Plan to make necessary updates to ensure compliance with current laws and regulations.

11. GOVERNOR'S REVIEW (*Check One*)

GOVERNOR'S OFFICE REPORTED NO COMMENT

OTHER, AS SPECIFIED

COMMENTS OF GOVERNOR'S OFFICE ENCLOSED

NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

12. SIGNATURE OF STATE AGENCY OFFICIAL

[Redacted Signature]

16. RETURN TO

Lisa Lee  
275 E. Main St. 6 W-A  
Frankfort, KY 40621

13. TYPED NAME

Lisa Lee

14. TITLE

Commissioner

15. DATE SUBMITTED

4/13/2022

**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED

**04/13/2022**

18. DATE APPROVED

**06/21/2022**

**PLAN APPROVED - ONE COPY ATTACHED**

19. EFFECTIVE DATE OF APPROVED MATERIAL

**05/01/2022**

20. SIG

[Redacted Signature]

21. TYPED NAME

**James G. Scott**

22. TITL

**Director, Division of Program Operations**

23. REMARKS

**#6 SL updated Citation 6/14/22 (KMRT)**

Revision: SPA 22-0003

State/Territory: KentuckyCitation4.22 Third Party Liability

42 CFR 433.137

(a) The Medicaid agency meets all requirements of:

- (1) 42 CFR 433.138 and 433.139.
- (2) 42 CFR 433.145 through 433.148.
- (3) 42 CFR 433.15]. through 433.154.
- (4) Sections 1902(a) (25) (H) and (I) of the Act.

1902(a)(25)(H) and (I)  
of the Act

42 CFR 433.138(f)

(b) ATTACHMENT 4.22-A –

(1) Specifies the frequency with which the data exchanges required in §433.138(d)(1), (d)(3) and (d)(4) and the diagnosis and trauma code edits required in S433.138(e) are conducted;

42 CFR 433.138(g)(1)(ii)

(2) Describes the methods the agency uses for and (2)(ii) meeting the follow up requirements contained in §433.138(g)(1)(i) and (g) (2) (i);

42 CFR 433.138(g)(3)(i)  
and (iii)

(3) Describes the methods the agency uses for following up on information obtained through the State motor vehicle accident report file data exchange required under §433.138(d)(4)(ii) and specifies the time frames for incorporation into the eligibility case file and into its third party data base and third party recovery unit of all information obtained through the follow up that identifies legally liable third party resources; and

42 CFR 433.138(g)(4)(i)  
through (iii)

(4) Describes the methods the agency uses for following up on paid claims identified under S433.138(e) (methods include a procedure for periodically identifying those trauma codes that yield the highest third party collections and giving priority to following up on those codes) and specifies the time frames for incorporation into the eligibility case file and into its third party data base and third party recovery unit of all information obtained through the follow up that identifies legally liable third party resources.

TN No. 22-0003

Supersedes

TN No. 96-50Approval Date 6/21/22Effective Date 5/1/22

Revision: KY SPA 22-0003

State/Territory: KentuckyCitation

- |                             |     |  |
|-----------------------------|-----|--|
| X                           | (c) | Providers are required to bill liable third parties when services covered under the plan are furnished to an individual on whose behalf child support enforcement is being carried Out by the State IV-D agency.                                   |
|                             | (d) | <u>ATTACHMENT 4.22-B</u> specifies the following:  |
| 42 CFR 433.139(b)(3)(ii)(C) | (1) | The method used in determining a provider's compliance with the third party billing requirements at §433.139(b)(3)(ii) (C).  |
| 42 CFR 433.139(f)(2)        | (2) | The threshold amount or other guideline used in determining whether to seek recovery of reimbursement from a liable third party, or the process by which the agency determines that seeking recovery of reimbursement would not be cost effective. |
| 42 CFR 433.139(f)(3)        | (3) | The dollar amount or time period the State uses to accumulate billings from a particular liable third party in making the decision to seek recovery of reimbursement.  |
| 42 CFR 447.20               | (e) | The Medicaid agency ensures that the provider furnishing a service for which a third party is liable follows the restrictions specified in 42 CFR 447.20.  |

TN No. 22-0003

Supersedes

TN No. 96-5Approval Date: 6/21/22Effective Date: 5/1/22

Revision: HCFA-PM-94-1 (MB)  
FEBRUARY 1994

State/Territory: Kentucky

Citation 4.22 continued

42 CFR 433.151(a) (f) The Medicaid agency has written cooperative agreements for the enforcement of rights to and collection of third party benefits assigned to the State as a condition of eligibility for medical assistance with the following: (Check as appropriate.)

State title IV-D agency. The requirements of 42 CFR 433.152(b) are met.

Other appropriate State agency(s)-  
\_\_\_\_\_  
\_\_\_\_\_

Other appropriate agency(s) of another State--  
\_\_\_\_\_  
\_\_\_\_\_

Courts and law enforcement officials.

1902(a) (60) of the Act (g) The Medicaid agency assures that the State has in effect the laws relating to medical child support under section 1908 of the Act.

1906 of the Act (h) The Medicaid agency specifies the guidelines used in determining the cost effectiveness of an employer-based group health plan by selecting one of the following.

The Secretary's method as provided in the State Medicaid Manual, Section 3910.

The State provides methods for determining cost effectiveness on ATTACHMENT 4.22-C.

State: Kentucky

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Citation(s)	Condition or Requirement
435.1008	5. a. Is not an inmate of a public institution. Public institutions do not include medical institutions, nursing facilities, intermediate care/mentally retarded facilities, or publicly operated community residences that serve no more than 16 residents, or certain child care institutions.
42 CFR 435.1008 1905(a) of the Act	b. Is not a patient under age 65 in an institution for mental diseases except as an inpatient under age 22 receiving active treatment in an accredited psychiatric facility or program.  <input type="checkbox"/> Not applicable with respect to individuals under age 22 in psychiatric facilities or programs. Such services are not provided under the plan.
42 CFR 433.145 1912 of the Act	6. Is required, as a condition of eligibility, to assign rights to medical support and to payments for medical care from any third party, to cooperate in obtaining such support and payments, and to cooperate in identifying and providing information to assist in pursuing any liable third party. The assignment of rights obtained from an applicant or recipient is effective only for services that are reimbursed by Medicaid. The requirements of 42 CFR 433.146 through 433.148 are met.  <input checked="" type="checkbox"/> Assignment of rights is automatic because of State law.
42 CFR 435.910	7. Is required as a condition of eligibility, to furnish his/her social security account number (or numbers, if he/she has more than one number), except for aliens seeking medical assistance for the treatment of an emergency medical condition under Section 1903(v) (2) of the Social Security Act and newborn children who are eligible under Section 1902 (e) 4.

consistently available, taking into consideration statewide billing practices, amounts paid by Medicaid programs in selected comparable states, and consultation with the optometry Technical Advisory Committee of the Medical Assistance Advisory Council as to the reasonableness of the proposed upper limits.

- (4) Laboratory services shall be reimbursed at the lesser of the actual billed amount or the Medicare allowable reimbursement rates. If there is no established Medicare allowable reimbursement rate, the payment shall be sixty-five (65) percent of usual and customary actual billed charges.

C. Maximum Reimbursement for Covered Procedures and Materials for Ophthalmic Dispensers

Reimbursement for a covered service within the ophthalmic dispenser's scope of licensure shall be as described in Section B (above).

D Effect of Third Party Liability

When payment for a covered service is due and payable from a third party source, such as private insurance, or some other third party with a legal obligation to pay, the amount payable by the department shall be reduced by the amount of the third party payment.



State Kentucky

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Requirements for Third Party Liability  
Identifying Liable Resources

The Title XIX single state agency is committed to compliance with all third party recovery requirements, including those shown in 42 CFR 433, Subpart D, Third Party Liability. For purposes of clarification, we state herein that the \$250 threshold applies only regarding accident/trauma claims. The Kentucky Department for Medicaid Services may look back three (3) years for payment for any healthcare item or services submitted not later than three (3) years after the date such item or service was provided.

- (b) (1) An agreement has been developed with the Department for Community Based Services (DCBS) for collecting and forwarding health insurance information for Kentucky's Title XIX recipients. The local DCBS field worker collects TPL data during initial application and during the redetermination process. The information collected includes the name of the policy holder, relationship of policy holder to recipient, the social security number of the policy holder, the policy number, and type of coverage held and name and address of insurance company. The information is added daily to the TPL data base and claims are edited against the data each processing cycle. Social Security Numbers of absent parents are being obtained from Title IV-D agencies. Addresses of employers of absent parents are obtained from unemployment insurance.

Data exchanges have been arranged with Kentucky Department of Income Support (DIS) to receive the Worker's Compensation and will be done quarterly. SWICA information is obtained during application and at least quarterly. SSA information is obtained during the application process from recipients for whom the information was not previously requested.

Data exchanges have been, and will continue to be, attempted as required by regulation with Motor Vehicle Registration.

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TN No. 22-0003

Supersedes

TN No. 12-001

Approval Date: 6/21/2022

Effective Date 5/1/2022

State Kentucky

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- (2) The state follows up within 30 days on all information obtained from SWIC, SSA wage and earnings files, and Title IV- A by entering any valid or appropriate data into the TPL avoidance file, or by utilizing the data for collection. The state will follow up the data exchanges with health insurers and worker's compensation files within sixty (60) days from the date of receipt of the files.
- (3) The state has attempted, and will continue its efforts, to develop a state motor vehicle accident report file.
- (4) Claims involving trauma diagnosis codes are processed in accordance with 42 CFR 433.138(3) and 433.139 with accumulated claims in excess of \$250 pursued for possible third party payment or recovery. A weekly report is produced which identifies all recipients for whom \$250 or more has been paid within a prior ninety (90) day period with an indicator of trauma or accident. Each case is actively pursued for possible collection. The time frames within which incorporation of information from accident/trauma diagnosis code TPL procedures must be accomplished is thirty (30) days.
- (5) Providers are required to bill the third party in situations where the third party liability is derived from a parent whose obligation to pay support is being enforced by the State Title IV-D agency. Kentucky uses the pay and chase method.
- (6) The state assures that the requirements of 42 CFR 433.145 through 433.148 are met for assignment for rights to benefits. Kentucky's statute KRS 205.624 (see Attachment 4.22-A, Exhibit A) requires assignment of third party payments. The application for Medical Assistance/TANF (AFDC) has a statement notifying the applicant/recipient of the third party assignment.

## 205.624. Assignment to cabinet by recipient of rights to third party payments - Right of recovery by cabinet. –

- (1) An applicant or recipient shall be deemed to have made to the cabinet an assignment of his rights to third party payments to the extent of medical assistance paid on behalf of the recipient under title XIX of the Social Security Act. The applicant or recipient shall be informed in writing by the cabinet of such assignment.
- (2) The cabinet shall have the right of recovery which a recipient may have for the cost of hospitalization, pharmaceutical services, physician services, nursing services, and other medical services not to exceed the amount of funds expended by the cabinet for such care and treatment of the recipient under the provisions of title XIX of the Social Security Act.
  - (a) If a payment for medical assistance is made, the cabinet, to enforce its right, may:
    1. Intervene or join in an action or proceeding brought by the injured, diseased, or disabled person, his guardian, personal representative, estate, dependents, or survivors against a third party who may be liable for the injury, disease, or disability, or against contractors, public or private, who may be liable to pay or provide medical care and services rendered to an injured, diseased, or disabled recipient, in state or federal court; or
    2. Institute and prosecute legal proceedings against a third party who may be liable for the injury, disease, or disability, or against contractors, public or private, who may be liable to pay or provide medical care and services rendered to an injured, diseased, or disabled recipient, in state or federal court, either alone or in conjunction with the injured, diseased, or disabled person, his guardian, personal representative, estate, dependents, or survivors; or
    3. Institute the proceedings in its own name or in the name of the injured, diseased, or disabled person, his guardian, personal representative, estate, dependents, or survivors.
  - (b) The injured, diseased, or disabled person may proceed in his own name, collecting costs without the necessity of joining the cabinet or the Commonwealth as a named party, provided the injured, diseased, or disabled person shall notify the cabinet of the action or proceeding entered into upon commencement of the action or proceeding. The injured, diseased, or disabled person must notify the cabinet of any settlement or judgment of his or her claim.
  - (c) In the case of an applicant for or recipient of medical assistance whose eligibility is based on deprivation of parental care or support due to absence of a parent from the home, the cabinet may:
    1. Initiate a civil action or other legal proceedings to secure repayment of medical assistance expenditures for which the absent parent is liable; and
    2. Provide for the payment of reasonable administrative costs incurred by such other state or county agency requested by the cabinet to assist in the enforcement of securing repayment from the absent parent. Enact. Acts 1980, ch. 252, § 4.
- (3) Each insurer issuing policies or contracts under Subtitle 17, 18, 32, or 38 of KRS Chapter 304 shall cooperate fully with the Cabinet for Health and Family Services or an authorized designee of the cabinet in order for the cabinet to comply with the provisions of subsection (1) of this section.

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STATE LAWS REQUIRING THIRD PARTIES TO PROVIDE  
COVERAGE ELIGIBILITY AND CLAIMS DATA

1902(a)(25)(I) The State has in effect laws that require third parties to comply with the provisions, including those which require third parties to provide the State with coverage, eligibility and claims data, of 1902(a)(25)(I) of the Social Security Act.

**205.623 Information on claims paid for insurance policyholders and dependents -- Use of data --  
Confidentiality of information -- Prohibited fees.**

- (1) All health insurers and administrators as defined under KRS Chapter 304 shall provide upon request to the Department for Medicaid Services, by electronic means and in the format prescribed by the department, policy and coverage information and claims paid data on Medicaid-eligible policyholders and dependents. Any request from the department shall include a list of data elements that shall be included on the electronic file from the insurer or administrator.
- (2) All health insurers and administrators as defined under KRS Chapter 304 shall provide upon request to the department, by electronic means and in the format prescribed by the department, identifying information on all policyholders and dependents to match with the Medicaid management information system to determine which policyholders and dependents also participate in the Kentucky Medical Assistance Program. The identifying information shall include the name, address, date of birth, and Social Security number as these items appear in the companies' files and as the department may require.
- (3) No health insurer or administrator shall be required to provide information under this section if doing so would violate any provision of federal law.
- (4) All information obtained by the department pursuant to this section shall be confidential and shall not be open for public inspection.
- (5) The department shall not be charged a fee by a third party for information requested under this section, nor shall the department be charged a fee by a third party for the processing and adjudication of the department's claim for recovery, reclamation, or validation of eligibility.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kentucky

Requirements for Third Party Liability -  
Payment of Claims

1. For accident/trauma claims, the state has established a two hundred and fifty dollar threshold amount in determining whether to seek reimbursement from liable third parties based on an accumulation of claims processed within a prior ninety day period, but with recoupment applied to all accumulated accident/trauma claims processed within a prior two year period. Audits of past claim recoveries have shown when a tort case totals less than \$250 and no response has been received from recipient, it is not cost effective to pursue these cases after sending two letters unless recipient or attorney makes contact to the State Medicaid Agency.
2. The exception to the above policy is accident cases in litigation over \$250 (two hundred and fifty dollars). These cases will be pursued from the date the accident occurred, regardless of the ninety day period and two year time period.
3. The provider's compliance with the billing requirement in situations involving medical support enforcement by the state Title IV-D agency is determined by having the liable third parties notify the state at the time of the state's weekly billing if the provider has not complied with the billing requirement. Duplicate payments will be recouped. If the claim is related to medical support enforcement, providers must submit proof they billed the third party within a 100-day period and not received payment. The provider must have waited up to 100 days from the date the provider of such services has initially submitted a claim and not received payment from the third party before the state will pay, except that the State may make such payment within 30 days after such date if the State determines doing so is cost-effective and necessary to ensure access to care.
4. For preventive pediatric services, including early and periodic screening, diagnosis, and treatment services (EPSDT) payments are made without regard to potential third party liability for preventive pediatric services, including early and periodic screening, diagnosis, and treatment services (EPSDT), except if it is determined doing so is cost-effective and will not adversely affect access to care, will only make such payment if a third party so liable has not made payment within 90 days after the date the provider of such services has initially submitted a claim.
5. For prenatal services, including labor, delivery, and postpartum care services there are cost avoidance procedures in place for claims. The provider is required to bill the third party as primary. If the provider bills Medicaid as primary the claim is returned to the provider with the third party information that Medicaid believes to have legal responsibility for payment. If after the provider bills the third party and a balance remains or the claim is denied for a substantive reason, the provider can submit a claim to Medicaid for payment up to the maximum amount established for the service.