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

January 3, 2014

Lawrence Kissner, Commissioner
Department for Medicaid Services
275 East Main Street, 6WA
Frankfort, KY 40621-0001

Re: Kentucky State Plan Amendment 13-023

Dear Mr. Kissner:

We have reviewed the proposed Kentucky state plan amendment (SPA) 13-023, which was submitted to the Centers for Medicare & Medicaid Services (CMS) on October 2, 2013. Kentucky SPA 13-023 revises cost sharing for Kentucky Medicaid and increases various copay amounts for beneficiaries.

Based on the information provided, the Medicaid State Plan Amendment KY 13-023 was approved on December 31, 2013. The effective date of this amendment is January 1, 2014. Enclosed are 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 Alice Hogan at (404) 562-7432 or Alice.Hogan@cms.hhs.gov.

Sincerely,

Jackie Glaze
Associate Regional Administrator
Division of Medicaid & Children's Health Operations

Enclosures

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: 13-022

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
January 1, 2014

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:
Affordable Care Act

7. FEDERAL BUDGET IMPACT:
a. FFY 2014 ($2 million)
b. FFY 2015 ($2.7 million)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Att. 3.1-A, Page 7.6.1 – 7.6.1-16
Att. 3.1-B, Page 31.5 – 31.5.16
Att. 4.19-B, Page 20.15

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: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 revise the State Plan to revise cost sharing for KY Medicaid

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:

13. TYPED NAME: Lawrence Kissner

14. TITLE: Commissioner, Department for Medicaid Services

15. DATE SUBMITTED: 10/1/13

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

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
10-02-13

18. DATE APPROVED: 12-31-13

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
01/01/14

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Jackie Glaze

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

23. REMARKS: Approved with the following changes as authorized by the state agency email dated 12-31-13.

Block # 1 changed to read: 13-023

Block # 8 changed to read: Attachment 4.18-A pages 1, 1(a) ,1(b) ,1(c) ,1(d), 2 and 3; Attachment 4.18-C pages 1, 1(a), 1(b), 1(c), 1(d), 2 and 3.

Block # 9 changed to read: Attachment 4.18-A pages 1, 1(a) ,1(b) ,1(c) ,1(d), 2 and 3; Attachment 4.18-C pages 1, 1(a), 1(b), 1(c), 1(d), 2 and 3.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

A. Cost Sharing Provisions Under the KyHealth Choices Benefit Plan: The following charges are imposed on the categorically needy for services other than those provided under section 1905(a)(1) through (5) and (7) of the Act. Cost sharing is being imposed under 1916 of the Social Security Act.

Service	Co-pay	Amount and Basis for Determination
Prescription Drugs	X	$1 for each preferred and non-preferred generic drug or atypical antipsychotic drug that does not have a generic equivalent; $4 for each preferred brand name drug that does not have a generic equivalent and is available under the supplemental rebate program; or $8 for each non-preferred brand name drug. The Department for Medicaid Services (DMS) shall reduce a pharmacy provider's reimbursement by the applicable co-pay outlined above.
Audiology		$0.00
Chiropractor	X	$3.00 for each visit. DMS shall reduce a provider's reimbursement by $3.00.
Dental	X	$3.00 for each visit. DMS shall reduce a provider's reimbursement by $3.00.
Hearing Aid Dealer		A co-payment will not be imposed on hearing aids.
Podiatry	X	$3.00 for each visit. DMS shall reduce a provider's reimbursement by $3.00.
Optometry*	X	$3.00 for each visit. DMS shall reduce a provider's reimbursement by $3.00.
General ophthalmological services*	X	$3.00 for each visit. DMS shall reduce a provider's reimbursement by $3.00.
Eyewear		A co-payment will not be imposed on eyewear.
Office visit for care by a physician,** physician's assistant, advanced registered nurse practitioner, certified pediatric and family nurse practitioner, or nurse midwife or behavioral health professional	X	$3.00 per each visit. DMS shall reduce a provider's reimbursement by $3.00.
Physician Service	X	$3.00 per each service. DMS shall reduce a provider's reimbursement by $3.00.

*CPT codes 92002, 92004, 92012, and 92014
**CPT codes 99201, 99202, 99203, 99204, 99211, 99212, 99213, and 99214

B. Preventive Health Services, including "A" and "B" services recommended by the United State Preventive Services Task Force; Advisory Committee for Immunization Practices (ACIP) recommended vaccines; preventive care and screening for infants, children and adults recommended by HRSA's Bright Futures program project; and additional preventive services for women recommended by the Institute of Medicine (IOM) shall not be subject to co-pays.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Cost Sharing Provisions Under the KyHealth Choices Benefit Plan, continued:

Service	Co-pay	Amount and Basis for Determination
Visit to a rural health clinic, primary care center, or federally qualified health center	X	$3.00 per each visit. DMS shall reduce a provider's reimbursement by $3.00.
Outpatient hospital service	X	$4.00 for each visit. DMS shall reduce a provider's reimbursement by $4.00.
Emergency room visit for a non-emergency service	X	$8 for each visit. DMS shall reduce a provider's reimbursement by $8.
Inpatient hospital admission	X	$50.00 per admission. DMS shall reduce a provider's reimbursement by $50.00.
Physical Therapy, Speech Pathology Services, Speech/Hearing/Language Therapy Services and Occupational Therapy	X	$3.00 per each visit. DMS shall reduce a provider's reimbursement by $3.00.
Durable Medical Equipment	X	$4 per date of service. DMS shall reduce a provider's reimbursement by $4.00.
Ambulatory Surgical Center	X	$4.00 for each visit. DMS shall reduce a provider's reimbursement by $4.00.
Laboratory, diagnostic, or x-ray service	X	$3.00 for each visit. DMS shall reduce a provider's reimbursement by $3.00.

C. The following shall not be subject to a copayment, with the exception of the $8 co-pay for non-preferred brand drugs:
   (a) Individuals excluded in accordance 42 CFR 447.56(a) and 1916(a)(2) and (j) and 1916A(b) of the Social Security Act.
   (b) A service provided to a recipient who has reached his or her 18th birthday.
   (c) A service provided to a recipient in an optional group, such as foster care who remains on Medicaid, who has reached his or her 18th birthday but has not turned 19.
   (d) Individuals who are pregnant.
   (e) Individuals receiving hospice service.

D. Services included and related to established age and periodicity screenings pursuant to Centers for Disease Control guidelines shall not be subject to co-pays.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

E. The maximum amount of total cost-sharing shall not exceed 5% of a family's total income for a quarter. Kentucky has a program called copayment tracking within the MMIS system that will track the member's co-pays to ensure that they are not charged more than the 5% during a quarter. Information regarding the quarterly amount of household income for each case is stored in the MMIS and is updated on a quarterly basis. As claims are processed, the billed services evaluated to determine if a copayment should have been assessed. If the service was subject to co-payment based on service and member category, the system calculates the amount of the copayment and maintains that amount in the system. If 5% of the stored income is reached, the copayment indicator for the member or household is turned off in the system and providers can see the copayment is no longer applicable. Additionally, Members will be notified through mail when they have incurred out-of-pocket expenses up to the aggregate family limit and individual family members are no longer subject to cost sharing for the remainder of the family's current quarterly cap period. Current methodology assumes that all copayments are paid by the member. This will be coordinated with the pharmacy benefit manager (PBM) as well.

F. Definition of non-emergency care is defined as any health care service provided to evaluate and/or treat any medical condition such that a prudent layperson possessing an average knowledge of medicine and health determines that immediate unscheduled medical care is **not** required. Hospitals will operationalize this process by performing the required EMTALA screening on the patient and if they determine the condition non-emergent (determined by medical professional at the hospital), the ER staff (either a nurse, doctor or intake staff) will advise the recipient that it is not a condition that requires emergency treatment, and that they (the hospital) will assist them in locating another facility (late night clinic, etc.), call their primary care physician when they are open, or go to urgent care clinic that may be available. If the individual still opts to be treated at the ER, they will be required to pay the $8 co-pay.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE: KENTUCKY

B. The method used to collect cost sharing charges for categorically needy individuals:

☒ Providers are responsible for collecting the cost sharing charges from individuals.

☐ The agency reimburses providers the full Medicaid rate for services and collects the cost sharing charges from individuals.

C. The basis for determining whether an individual is unable to pay the charge, and the means by which such an individual is identified to providers, is described below:

Federal limits on the services for which copayment applies restrict the maximum copayment charges. The State's scope of services is broad and eligible recipients have low, if any, out-of-pocket medical expenses; therefore, the state believes that all recipients within the class that are subject to copayments should be able to pay the required copayment.

Should a recipient claim to be unable to pay the required copayment, the provider may not deny service, but may arrange for the recipient to pay the copayment at a later date. Any uncollected amount is considered a debt to providers.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE: KENTUCKY

D. The procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.56(a) are described below:

KY has a "Y/N" indicator switch in the MMIS system. At the time of enrollment and renewal, if the recipient is exempt from cost sharing the indicator switch is set to indicate that they are exempt from any cost sharing. MMIS has been programmed not to deduct copayments from claims for Medicaid recipients and services that are exempt from cost sharing as identified in 42 CFR 447.56(a) and 1916(a)(2) and (j) and 1916A(b) of the Social Security Act. MMIS will identify the exempt recipients by age for children under age 18 (or 19 for optional groups), by aid category and recipient status for pregnant women and institutionalized individuals. Recipients outside the exempt status will have a copayment due and printed on the Medicaid cards they received each month. Providers will use the Medicaid card to identify those recipients who should pay a copayment.

If an individual notifies us that they are an American Indians/Alaska Natives (AI/AN) who currently or have previously received services by the Indian Health Service (IHS), an Indian Tribe, Tribal Organization, or Urban Indian Organization (I/T/U), or through a referral under contract health services in any State, we will use the same "Y/N" indicator switch in the MMIS system and set that individual to be exempt from cost-sharing.

KY imposes cost-sharing for non-preferred drugs to individuals otherwise exempt from cost-sharing.

E. Cumulative maximums on charges:

☒ State policy does not provide for cumulative maximums.

☐ Cumulative maximums have been established as described below:

N/A

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE: KENTUCKY

A. Cost Sharing Provisions Under the Ky Health Choices Benefit Plan: The following charges are imposed on the medically needy for services. Cost sharing is being imposed under 1916 of the Social Security Act.

Service	Type of Charge Co-pay	Amount and Basis for Determination
Prescription Drugs	X	$1 for each preferred and non-preferred generic drug or atypical antipsychotic drug that does not have a generic equivalent; $4 for each preferred brand name drug that does not have a generic equivalent and is available under the supplemental rebate program; or $8 for each non-preferred brand name drug. The Department for Medicaid Services (DMS) shall reduce a pharmacy provider's reimbursement by the applicable co-pay/co-insurance outlined above.
Audiology		$0.00
Chiropractor	X	$3.00 for each visit. DMS shall reduce a provider's reimbursement by $3.00.
Dental	X	$3.00 for each visit. DMS shall reduce a provider's reimbursement by $3.00.
Hearing Aid Dealer		A co-payment will not be imposed on hearing aids.
Podiatry	X	$3.00 for each visit. DMS shall reduce a provider's reimbursement by $3.00.
Optometry*	X	$3.00 for each visit. DMS shall reduce a provider's reimbursement by $3.00.
General ophthalmological services*	X	$3.00 for each visit. DMS shall reduce a provider's reimbursement by $3.00.
Eyewear		A co-payment will not be imposed on eyewear.
Office visit for care by a physician,** physician's assistant, advanced registered nurse practitioner, certified pediatric and family nurse practitioner, or nurse midwife or behavioral health practitioner	X	$3.00 per visit. DMS shall reduce a provider's reimbursement by $3.00.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

A. Cost Sharing Provisions Under the KyHealth Choices Benefit Plan, continued:

Service	Type of Charge Deduct. Coins. Co-pay	Amount and Basis for Determination
Physician Service	X	$3.00 per each service. DMS shall reduce a provider's reimbursement by $3.00.
Visit to a rural health clinic, primary care center, or federally qualified health center	X	$3.00 per visit. DMS shall reduce a provider's reimbursement by $3.00.
Outpatient hospital service	X	$4.00 for each visit. DMS shall reduce a provider's reimbursement by $4.00.
Emergency room visit for a non-emergency service	X	$8 for each visit. DMS shall reduce a provider's reimbursement by $8.
Inpatient hospital admission	X	$50.00 per admission. DMS shall reduce a provider's reimbursement by $50.00.
Physical Therapy, Speech, hearing, language therapy and occupational therapy	X	$3.00 per each visit. DMS shall reduce a provider's reimbursement by $3.00.
Durable Medical Equipment	X	$4.00 per date of service. DMS shall reduce a provider's reimbursement by $4.00.
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B. The following shall not be subject to a copayment with the exception of the $8 co-pay for non-preferred drugs:
   (a) Individuals excluded in accordance 42 CFR 447.56(a) and 1916(a)(2) and (j) and 1916A(b)of the Social Security Act.
   (b) A service provided to any recipient who has reached his or her 18th birthday.
   (c) A service provided to a recipient in an optional group, such as foster care who remains on Medicaid, who has reached his or her 18th birthday but has not turned 19.
   (d) Individuals who are pregnant.
   (e) Individuals receiving hospice service.

C. Services included and related to established age and periodicity screenings pursuant to Centers for Disease Control guidelines shall not be subject to co-pays.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

D. The maximum amount of total cost sharing shall not exceed 5% of a family's total income for a quarter. Kentucky has a program called copayment tracking within the MMIS system that will track the member's co-pays to ensure that they are not charged more than the 5% during a quarter. Information regarding the quarterly amount of household income for each case is stored in the MMIS and is updated on a quarterly basis. As claims are processed, the billed services evaluated to determine if a copayment should have been assessed. If the service was subject to co-payment based on service and member category, the system calculates the amount of the copayment and maintains that amount in the system. If 5% of the stored income is reached, the copayment indicator for the member or household is turned off in the system and providers can see the copayment is no longer applicable. Additionally, Members will be notified through mail when they have incurred out-of-pocket expenses up to the aggregate family limit and individual family members are no longer subject to cost sharing for the remainder of the family's current quarterly cap period. Current methodology assumes that all copayments are paid by the member. This will be coordinated with the PBM as well.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE: KENTUCKY

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