CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES

Steven L. Beshear
Governor

275 East Main Street, 6W-A
Frankfort, KY 40621
P: 502-564-4321
F: 502-564-0509
www.chfs.ky.gov

Audrey Tayse Haynes
Secretary

Lawrence Kissner
Commissioner

October 1, 2013

Jackie Glaze
Associate Regional Director
Centers for Medicare and Medicaid Services
61 Forsyth Street, SW, Suite 4T20
Atlanta, Georgia 30303-8909

RE: State Plan Amendment 13-023 - Cost Sharing

Dear Ms. Glaze:

Enclosed for your review and approval is Kentucky Title XIX State Plan Amendment No. 13-0023. The purpose of this State Plan Amendment is to revise cost sharing for KY Medicaid.

The Public Notice will be submitted at a later date, but prior to the effective date of this SPA and prior to approval of this SPA.

Also, we have included the funding, tribal and maintenance of effort (MOE) questions below:

Funding Questions:

The following questions are being asked and should be answered in relation to all payments made to all providers under Attachment 4.19- D of your State plan.

Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by States for services under the approved State plan. Do providers receive and retain the total Medicaid expenditures claimed by the State (includes normal per diem, supplemental, enhanced payments, other) or is any portion of the payments returned to the State, local governmental entity, or any other intermediary organization? If providers are

required to return any portion of payments, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the payments, a complete listing of providers that return a portion of their payments, the amount or percentage of payments that are returned and the disposition and use of the funds once they are returned to the State (i.e., general fund, medical services account, etc.)

DMS Response - the provider retains all funds

1. Section 1902(a)(2) provides that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan. Please describe how the state share of each type of Medicaid payment (normal per diem, supplemental, enhanced, other) is funded. Please describe whether the state share is from appropriations from the legislature to the Medicaid agency, through intergovernmental transfer agreements (IGTs), certified public expenditures (CPEs), provider taxes, or any other mechanism used by the state to provide state share. Note that, if the appropriation is not to the Medicaid agency, the source of the state share would necessarily be derived through either an IGT or CPE. In this case, please identify the agency to which the funds are appropriated. Please provide an estimate of total expenditure and State share amounts for each type of Medicaid payment. If any of the non-federal share is being provided using IGTs or CPEs, please fully describe the matching arrangement including when the state agency receives the transferred amounts from the local government entity transferring the funds. If CPEs are used, please describe the methodology used by the state to verify that the total expenditures being certified are eligible for Federal matching funds in accordance with 42 CFR 433.51(b). For any payment funded by CPEs or IGTs, please provide the following:
   (i) a complete list of the names of entities transferring or certifying funds;
   (ii) the operational nature of the entity (state, county, city, other);
   (iii) the total amounts transferred or certified by each entity;
   (iv) clarify whether the certifying or transferring entity has general taxing authority; and,
   (v) whether the certifying or transferring entity received appropriations (identify level of appropriations).

   DMS Response - Not Applicable

2. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan. If supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to each provider type.

   DMS Response - Not Applicable

3. Please provide a detailed description of the methodology used by the state to estimate the upper payment limit (UPL) for each class of providers (State owned or operated, non-state government owned or operated, and privately owned or operated). Please provide a current (i.e. applicable to the current rate year) UPL demonstration.

   DMS Response - Not Applicable

4. Does any governmental provider receive payments that in the aggregate (normal per diem, supplemental, enhanced, other) exceed their reasonable costs of providing services? If payments exceed the cost of services, do you recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report?

   DMS Response - Not Applicable

<u>Tribal questions:</u>

The following are questions related to Section 5006(e) of the Recovery Act (Public Law (P.L.) 111-5) requirement for Tribal Consultation, please provide responses to these questions.

a. Is the submittal of this State Plan likely to have a direct impact on Indians or Indian health programs (Indian Health Service, Tribal 638 Health Programs, Urban Indian Organizations).

b. If the submittal of this State Plan is not likely to have a direct impact on Indians or Indian health programs, please explain why not.

c. If the submittal of this State Plan is likely to have a direct impact on Indians or Indian health programs please respond to the following questions.
   1. How did the State consult with the Federally-recognized tribes and Indian health programs prior to submission of this SPA?

   2. If the tribes and Indian health programs were notified in writing, please provide a copy of the notification, the date it was sent and a list of the entities notified. In addition, please provide information about any concerns expressed by the tribes and/or Indian health providers and the outcome.
   3. If the consultation with the tribes and Indians health providers occurred in a meeting please provide a list of invitees, a list of attendees, the date the meeting took place and information about any concerns expressed by the tribes and/or Indian health providers and the outcome.

DMS Response - Not Applicable

Maintenance of Effort (MOE)

A. Under section 1902(gg) of the Social Security Act (the Act), as amended by the Affordable Care Act, as a condition of receiving any Federal payments under the Medicaid program during the MOE period indicated below, the State shall not have in effect any eligibility standards, methodologies, or procedures in its Medicaid program which are more restrictive than such eligibility provisions as in effect in its Medicaid program on March 10, 2010.

MOE Period

- Begins on: March 10, 2010, and
- Ends on: The date the Secretary of the Federal Department of Health and Human Services determines an Exchange established by a State under the provisions of section 1311 of the Affordable Care Act is fully operational.

Is KY in compliance with the conditions of the MOE provision of section 1902(gg) of the Act for continued funding under the Medicaid program?

DMS Response - Yes

B. Section 1905(y) and (z) of the Act provides for increased federal medical assistance percentages (FMAP) for expenditures made on or after January 1, 2014 for individuals determined eligible under section 1902(a)(10)(A)(i)(VIII) of the Act. Under section 1905(cc) of the Act, the increased FMAP under sections 1905(y) and (z) would not be available for States that require local political subdivisions to contribute amounts toward the non-Federal share of the State's expenditures at a greater percentage than would have been required on December 31, 2009.

Prior to January 1, 2014 States may potentially require contributions by local political subdivisions toward the non-Federal share of the States' expenditures at percentages greater than were required on December 31, 2009. However, because of the provisions of section 1905(cc) of the Act, it is important to determine and document/flag any SPAs/State plans which have such greater percentages prior to the January 1, 2014 date in order to anticipate potential violations and/or appropriate corrective actions by the States and the Federal government.

This SPA would [ ] / would not [X] violate these provisions, if they remained in effect on or after January 1, 2014.

C.Section 1905(aa) of the Act provides for a "disaster-recovery FMAP" increase effective no earlier than January 1, 2011. Under section 1905(cc) of the Act, the increased FMAP under section 1905(aa) of the Act is not available for States that require local political subdivisions to contribute amounts toward the non-Federal share of the State's expenditures at a greater percentage than would have been required on December 31, 2009.

This SPA would [ ] / would not [X] qualify for such increased federal financial participation (FFP) and is not in violation of this requirement.

D. Does KY 13-004 comply with the requirements of section 1902(a)(37) of the Act regarding prompt payment of claims?

DMS Response - Yes

Any questions or correspondence relating to this SPA should be sent to Sharley Hughes.

Please let me know if you have any questions relating to this matter.

Sincerely,

Lawrence Kissner
Commissioner

LK/sjh

Enclosure

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:

18. DATE APPROVED:

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:

22. TITLE:

23. REMARKS:

FORM HCFA-179 (07-92)

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 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. Coverage of chiropractic services shall be limited to twenty-six (26) visits per recipient per calendar year.
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. However, members will be limited to one hearing aid per ear every 36 months;1 hearing aid evaluation per year (by audiologist); 1 complete hearing evaluation per year (by audiologist); 3 follow-up visits within 6 months following 1 additional follow up at least 6 months following fitting of hearing aid. Hearing coverage is limited to an individual under age twenty-one (21).
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. Eyewear coverage is limited to an individual under age twenty-one (21).
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 447.53.
   (b) A service provided to a recipient who has reached his or her 18th birthday but has not turned 19.
   (c) Individuals who are pregnant.
   (d) 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.

E. The maximum amount of total cost-sharing shall not exceed 5% of a family's total income for a quarter.

This page intentionally left blank

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

This page is intentionally left blank

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

This page is intentionally left blank

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

This page is intentionally left blank

This page is intentionally left blank

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

B. The method used to collect cost sharing charges for medically 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 447.53(b) are described below:

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 447.53(b). MMIS will identify the exempt recipients by age for children under age 18, 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 receive each month. Providers will use the Medicaid card to identify those recipients who should pay a copayment.

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			Amount and Basis for Determination
	Deduct.	Coins	Co-pay	
Prescription Drugs		X		$1 for each 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. Coverage of chiropractic services shall be limited to twenty-six (26) visits per recipient per twelve (12) month period.
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. However, members will be limited to one hearing aid per ear every 36 months;1 hearing aid evaluation per year (by audiologist); 1 complete hearing evaluation per year (by audiologist); 3 follow-up visits within 6 months following 1 additional follow up at least 6 months following fitting of hearing aid. Hearing coverage is limited to an individual under age twenty-one (21);
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. Eyewear coverage is limited to an individual under age twenty-one(21).

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

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
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.
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.
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.

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 447.53.
   (b) A service provided to a recipient who has reached his or her 18th birthday but has not turned 19.
   (c) Individuals who are pregnant.
   (d) 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.

D. The maximum amount of total cost sharing shall not exceed 5% of a family's total income for a quarter.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

This page is intentionally left blank

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

This page is intentionally left blank

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

This page is intentionally left blank

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

B. The method used to collect cost sharing charges for medically 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 him 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 447.53(b) are described below:

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 447.53(b). MMIS will identify the exempt recipients by age for children under age 18, 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.

E. Cumulative maximums on charges:

☒ State policy does not provide for cumulative maximums.

☐ Cumulative maximums have been established as described below:

N/A