



**CABINET FOR HEALTH AND FAMILY SERVICES  
DEPARTMENT FOR MEDICAID SERVICES**

**Steven L. Beshear**  
Governor

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Frankfort, KY 40621  
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**Audrey Tayse Haynes**  
Secretary

**Lawrence Kissner**  
Commissioner

September 6, 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 13-013 - Primary Care Center reimbursement

Dear Ms. Glaze:

Enclosed for your review and approval is Kentucky Title XIX State Plan Amendment No. 13-0013. The purpose of this State Plan Amendment is to establish revised reimbursement for Primary Care Centers.

The Public Notice is included in this submission. Furthermore, the Federal Fiscal Impact on the CMS 179 form is indeterminable. However, we do not believe this will not have an impact on either the Federal or State budget.

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

Tribal questions:

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.

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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

**TRANSMITTAL AND NOTICE OF APPROVAL OF  
STATE PLAN MATERIAL**

1. TRANSMITTAL NUMBER:  
13-013

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  
Effective September 6 2013

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:  
Section 2301 of the Affordable Care Act

7. FEDERAL BUDGET IMPACT:  
a. FFY 2013<sup>4</sup> \$0.00 1,100,000  
b. FFY 2014<sup>5</sup> 1.5M \$Indeterminable (see cover letter)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Att. 4.19-B, Page 20.15(a)

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION  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

10. SUBJECT OF AMENDMENT:

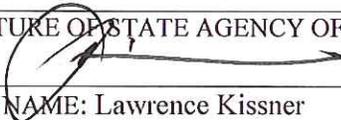
The purpose of this State Plan Amendment is to establish new reimbursement for Primary Care Centers

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

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: 9/6/13

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:

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Primary Care Centers

B. Reimbursement for Services or Drugs Provided by a PCC and provided on or after September 6, 2013 to a Medicaid Fee-For-Service Medicaid Recipient

- 1 For a service or drug provided to a recipient that is not an enrollee by a PCC that is not an FQHC, FQHC look-alike, or RHC, the department shall reimburse the rate or reimbursement established for the service or drug on the Medicare Fee Schedule established for Kentucky.
- 2 The reimbursement referenced in subsection (1) of this section shall not exceed the *federal* upper payment limit determined in accordance with 42 C.F.R. 447.321.
- 3 If a Medicare coverage provision or requirement exists regarding a given service or drug that contradicts a provision or requirement established in 907 KAR 1:054, the provision or requirement established in 907 KAR 1:054 shall supersede the Medicare provision or requirement.