

## MAC Binder Section 2 – Letters to CMS

### Table of Contents with Document Summary

Located online at <http://chfs.ky.gov/dms/mac.htm>

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#### **1 – CMS-IAPDU4-KY Health NW to JH\_dte110514:**

Kentucky Health Information Technology Implementation Advance Planning Document Update #4 requesting funding for continued operation of the Kentucky Electronic Health Records Incentive.

#### **2 – CMS-Substance Abuse-Ltr from LK to KL re Sub Use Disor\_dte111914:**

Application to the Substance Use Disorder High-Intensity Learning Collaborative through the Medicaid Innovation Accelerator Program.

#### **3 – CMS-Ltr to JG from LK re KY Pharmacy Ben Prog AAPDU\_dte112014:**

DMS requests approval to carry forward funding approved by CMS through FFY 2016 for the Commonwealth's Pharmacy Benefits Management contract.

#### **4 – CMS-Ltr to JG from LK re MMIS IAPDU 13\_dte112414:**

DMS requests review and approval of the Implementation Advanced Planning Update (IAPDU) for the Commonwealth's Medicaid Management Information System (KY MMIS) requesting emergency FFP for funding activities necessary to execute a new four-year contract for operating the KY MMIS.

#### **5 – CMS-Ltr to JG from LK re MMIS IAPDU 14 Cont Ext\_dte112414:**

DMS requests review and approval of IAPDU #14 requesting a six month contract extension of the KY MMIS operations contract with Hewlett Packard Enterprise Services.

#### **6 – CMS-MEMS-Ltr to JG from LK re MEMS Update 1-Project Status Update\_dte120314:**

DMS requests a status update on the MEMS project and requests a budgetary line item shift of funds from the MEMS Replacement solution budget line to the Medicaid Waiver Management Application budget line; and to create a budget line item for the DDI estimates of the MEMS partner portal.

#### **7 – CMS-SPA 14-007 RAI Response-Ltr to JG from LK\_dte120514:**

DMS response to CMS Request for Additional Information dated Sept. 11, 2014. SPA 14-007 proposes to revise the nursing facility reimbursement methodology for determining payment rates.

#### **8 – CMS-SPA 14-008-Clarification of After Hours\_dte121914:**

SPA 14-008 is to clarify Kentucky's reimbursement for services performed in a provider's office after normal business hours.

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#### **9 – CMS-SPA 14-009-Ltr to JG from LK re Enh Wellness Reimb\_dte121914:**

SPA 14-009 is to extend, in part, select enhanced primary care services that were enacted as a result of the ACA.

#### **10 – CMS-Ltr to JG from LK re DSH Verification-W attachments\_dte121914:**

DMS enclosed the Kentucky report on Disproportionate Share Hospital Verifications for DSH year 2011, includes the Independent Accountant's report.

#### **11 – CMS-Ltr to JG from NW re IAPDU 14\_dte123014:**

DMS requests review and approval of IAPDU #14 for the MMIS; this IAPDU supersedes the IAPDU #14 previously submitted. This IAPDU requests funding necessary for executing a new four-year contract for operating the KY MMIS.

#### **12 – CMS-Ltr to CMS from NW re KY Medicaid and CHIP R1 Elig Review Pilot Results\_dte123114:**

Kentucky's Medicaid and CHIP round 1 eligibility review pilot results; testing conducted in the UAT environment of the Kentucky Health Benefit Exchange system.



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

**Steven L. Beshear**  
Governor

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Frankfort, KY 40621  
[www.chfs.ky.gov](http://www.chfs.ky.gov)

**Audrey Tayse Haynes**  
Secretary

**Lawrence Kissner**  
Commissioner

November 5, 2014

DHHS/CMS  
Atlanta Regional Office  
Attn: Jackie Glaze, Associate Regional Administrator  
Division of Medicaid & Children's Health Operations  
61 Forsyth Street SW, Suite 4T20  
Atlanta, GA 30303 8909

**RE: Kentucky Health Information Technology Implementation Advance Planning Document  
Update #4**

The Kentucky Cabinet for Health and Family Services (CHFS) is requesting funding through the attached Kentucky Health Information Technology Implementation Advance Planning Document Update #4 (IAPDU) for continued operation of the Kentucky Electronic Health Records Incentive Program. Requested funding is for provider incentive payments during FFY 2015 and FFY 2016 and personnel costs to administer the program.

Please contact me at (502) 564-4321, ext. 2020 if you have any questions.

Sincerely,

A handwritten signature in blue ink that reads "Neville J. Wise".

Neville Wise  
Deputy Commissioner  
Kentucky Department for Kentucky Medicaid Services



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

**Steven L. Beshear**  
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**Audrey Tayse Haynes**  
Secretary

**Lawrence Kissner**  
Commissioner

November 19, 2014

Karen Llanos  
Acting Staff Director  
Innovation Accelerator Program  
Center for Medicaid and CHIP Services  
7500 Security Blvd.  
Baltimore, MD 21244

Dear Ms. Llanos,

We are writing in application to the Substance Use Disorder High-Intensity Learning Collaborative through the Medicaid Innovation Accelerator Program. This opportunity is timely for Kentucky given our recent addition of substance use services as a covered benefit through Medicaid and our strong partnership with Kentucky's Department for Behavioral Health, Developmental and Intellectual Disabilities. We look forward to collaborating on the development of a robust substance use benefit and adequate provider network to meet the needs of Kentucky's 1.1 million Medicaid members.

Sincerely,

A handwritten signature in black ink, appearing to read "Lawrence Kissner".

Lawrence Kissner  
Commissioner  
Kentucky Department for Medicaid Services

A handwritten signature in black ink, appearing to read "John Langefeld".

Dr. John Langefeld  
Chief Medical Officer  
Kentucky Department for Medicaid Services

**Substance Use Disorder High-Intensity Learning Collaborative**

*Expression of Interest*

**State/Territory: Kentucky**

In May 2013, Governor Steve Beshear signed an executive order to implement Medicaid expansion as authorized by the Affordable Care Act. At that point, Kentucky had already been building its state-based marketplace, kynect, making it the first state in the south to both expand Medicaid and have a state-based marketplace. As a result, an additional 360,000 Kentuckians were eligible for health coverage through Medicaid, bringing the total number of members to nearly 1.1 million. This number represents about one fourth of Kentucky's entire population. Prior to the implementation of Medicaid expansion, treatment for substance use disorder (SUD) was not a covered service under Medicaid. Kentucky residents with SUD had the option of receiving services through programs overseen by the Kentucky Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID). Kentucky Department for Medicaid Services (DMS) has added a comprehensive, evidence based continuum of substance abuse services to its Medicaid State Plan. It is now critical that the Department for Medicaid Services (DMS) and BHDID work collaboratively to implement this new benefit. Kentucky's provider community is in the early stages of building an adequate network and will benefit from support and technical assistance in implementing quality services across the continuum. Quality and data metrics will be crucial to monitor access, quality of services and outcomes.

Substance abuse is a major concern across the country, but it is particularly pervasive in Kentucky. There were 13,533 Medicaid members diagnosed with a SUD in June 2010, 8,140 of which were diagnosed with drug dependence and 4,969 with drug abuse. In Kentucky, 23.6 per 100,000 people died from a drug overdose in 2010, giving Kentucky the third highest drug overdose mortality rate in the country, according to a report by the Trust for America's Health. The report Kentucky possesses nine of out ten possible indicators of strategies that may help control prescription drug abuse, including lock-in programs, rescue drug laws and SUD treatment through expanded Medicaid. In Kentucky Medicaid, we have established a data analytics team within our Division of Program Quality and Outcomes to integrate data from disparate systems that exist outside of our Medicaid Management Information Systems (MMIS) and create linkages. Within the Cabinet for Health and Family Services (CHFS), one of our partner agencies is the Kentucky Health Information Exchange (KHIE), which provides the technical infrastructure to support the statewide exchange of health information among healthcare providers and organizations across the commonwealth. We have also partnered with external entities such as the University of Kentucky, which is building an all-payer claims database.

We hope to work with CMS through the Substance Use Disorder High-Intensity Learning Collaborative to develop a robust substance use benefit which utilizes data analysis and builds upon evidence-based practices to construct an adequate network for our Medicaid members diagnosed with SUD. We realize that participating in this Learning Collaborative will require the time and resources of state agency personnel. We have identified key staff from Kentucky DMS, DBHDID and other stakeholders and are committed to participating fully in the Learning Collaborative to provide the resources necessary to ensure the success of this partnership with CMS.

This timing of this Collaborative could not be better for Kentucky as we have the opportunity to build services and a provider community from the ground up using data and outcomes to guide the process.

Team Members	Name and Contact Information
Medicaid lead*	Erin Hoben, Chief Policy Advisor, Department for Medicaid Services <a href="mailto:Erin.Hoben@ky.gov">Erin.Hoben@ky.gov</a> 502.564.4321x2555
Data lead	Dr. John Langefeld, Chief Medical Officer, Department for Medicaid Services <a href="mailto:John.Langefeld@ky.gov">John.Langefeld@ky.gov</a> 502.564.4321x2038
SSA for Substance Use Disorder lead	Natalie Kelly, LCSW, Director, Division of Behavioral Health Department for Behavioral Health, Developmental and Intellectual Disabilities <a href="mailto:Natalie.Kelly@ky.gov">Natalie.Kelly@ky.gov</a> 502.564.4456
Other potential stakeholders for team (e.g., health plans, provider groups)	Additional Cabinet Departments: <i>Office of Inspector General, Office of Health Policy, Department for Public Health</i> Managed Care Organizations: <i>Anthem, Coventry, Humana, Passport and WellCare</i> Provider Groups: <i>Medicaid Advisory Council, Kentucky Psychological Association, Kentucky Medical Association</i> Licensing Boards Clinicians, Pharmacists, Facilities Judges, Probation and Parole Officers

\*Please identify a single point-of-contact

Please email this form to [MedicaidIAP@cms.hhs.gov](mailto:MedicaidIAP@cms.hhs.gov) with "SUD LC" in the subject line no later than *November 21, 2014*. Please provide the name and contact information for the representative from the Medicaid agency that will be the primary point of contact for the Learning Collaborative.



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

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**Audrey Tayse Haynes**  
Secretary

**Lawrence Kissner**  
Commissioner

November 20, 2014

DHHS/CMS  
Atlanta Regional Office  
Attn: Jackie Glaze, Associate Regional Administrator  
Division of Medicaid & Children's Health Operations  
61 Forsyth Street SW, Suite 4T20  
Atlanta, GA 30303 8909

**RE: Kentucky's Pharmacy Benefits Management Program**

The Kentucky Cabinet for Health and Family Services (CHFS) is requesting approval of the attached Annual Advanced Planning Document Update (AAPDU) to carry forward \$6,821,829 in funding approved by CMS through FFY 2016 for the Commonwealth's Pharmacy Benefits Management (PBM) contract. The contract became effective January 1, 2014 and expires on December 31, 2015 with three (3) additional one (1) year optional extension years. This AAPDU also reflects actual contract costs for Federal Fiscal Year 2014.

The total cost of this AAPDU is \$6,821,829 (\$5,160,380 Federal share and \$1,661,449 Commonwealth share).

Please contact John Hoffmann at (502) 564-5183, ext. 2077, if you have any questions.

Sincerely,

A handwritten signature in black ink, appearing to read "Lawrence Kissner", with a long horizontal stroke extending to the right.

Lawrence Kissner  
Commissioner



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

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**Audrey Tayse Haynes**  
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**Lawrence Kissner**  
Commissioner

November 24, 2014

DHHS/CMS  
Atlanta Regional Office  
Attn: Jackie Glaze, Associate Regional Administrator  
61 Forsyth Street, Suite 4T20  
Atlanta, GA 30303 8909

**RE: Kentucky's Medicaid Management Information system (MMIS) Implementation Advanced Planning Document Update (IAPDU) #14**

The Kentucky Department for Medicaid Services (DMS) within the Kentucky Cabinet for Health and Family Services (CHFS) is requesting review and approval of the attached Implementation Advanced Planning Update (IAPDU) for the Commonwealth's Medicaid Management Information System (MMIS) in accordance with 45 CFR, Part 95, Subpart F, and with particular emphasis on §95.624. This IAPDU requests emergency FFP for funding activities necessary to execute a new four-year contract for operating the KY MMIS. The Commonwealth will be unable to process claims using Automated Data Processing (ADP) equipment without approval of this contract by CMS prior to the expiration of the current KY MMIS contract on November 30, 2014 with Hewlett Packard Enterprise Services (HPES). The four-year contract proposed in this IAPDU represents a cost-saving alternative to a six-month extension of a prior contract with the current MMIS vendor, HPES and will enable the Commonwealth to continue processing Medicaid claims using ADP equipment. Specifically, DMS is requesting:

- \$164,903,729 for KY MMIS projects at 75% Federal match (\$123,677,798 Federal share and \$41,225,931 Commonwealth share). Of this request, \$150,145,274 represents new funding (\$112,608,956 Federal Share and \$37,536,318 Commonwealth share) for the new KY MMIS contract;
- \$866,887 for MMIS at 90% Federal match (\$780,199 Federal Share and \$86,688 in Commonwealth share);
- Request \$136,000 for MMIS at 50% Federal match (\$68,000 Federal share and \$68,000 Commonwealth share);
- Expedited review and approval of this IAPDU and notification of FFP availability prior to November 30, 2014.

The total cost of this IAPDU is \$165,906,616 (\$124,525,997 Federal share and \$41,380,619 Commonwealth share).

Please contact John Hoffman at (502), 564-6479 ext. 2077 if you have any questions.

Sincerely,



Lawrence Kissner,  
Commissioner





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

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**Lawrence Kissner**  
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November 24, 2014

DHHS/CMS  
Atlanta Regional Office  
Attn: Jackie Glaze, Associate Regional Administrator  
Division of Medicaid & Children's Health Operations  
61 Forsyth Street SW, Suite 4T20  
Atlanta, GA 30303 8909

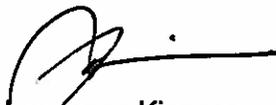
**RE: Withdrawal of Kentucky (KY) Medicaid Management Information System (MMIS)  
Implementation Advance Planning Document Update (IAPDU) #14 – KY MMIS Six Month Contract  
Extension**

Dear Ms. Glaze:

The Kentucky Cabinet for Health and Family Services (CHFS) is requesting withdrawal of KY MMIS IAPDU #14 submitted to the Centers for Medicare and Medicaid Services (CMS) on November 3, 2014. The Commonwealth was requesting review and approval of a six-month extension of the KY MMIS operations contract with Hewlett Packard Enterprise Services (HPES) through this IAPDU.

On November 20, 2014, the Commonwealth submitted KY MMIS IAPDU #14 to CMS for review and approval. The more recent KY MMIS IAPDU #14 submitted on November 20, 2014 replaces the IAPDU submitted to CMS on November 3, 2014. The updated KY MMIS IAPDU #14 reflects a new four (4) year contract with HPES for operating the legacy KY MMIS as negotiations between the Commonwealth and HPES have concluded, therefore nullifying the need for CHFS to exercise the 6-month optional extension in the earlier request. Please contact John Hoffmann at (502) 564-6479 ext. 2077 if you have any questions.

Sincerely,

  
Lawrence Kissner  
Commissioner

LK/jh/kl





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

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**Audrey Tayse Haynes**  
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**Lawrence Kissner**  
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December 3, 2014

DHHS/CMS

Atlanta Regional Office

Attn: Jackie Glaze, Associate Regional Administrator Division of Medicaid & Children's Health Operations  
61 Forsyth Street SW, Suite 4T20

Atlanta, GA 30303-8909

**RE: Medicaid Enterprise Management System Implementation Annual Advance Planning Document Update #1: Project Status Update**

The Kentucky Cabinet for Health and Family Services (CHFS) is submitting this request through the attached Annual Implementation Advance Planning Document Update to provide a status update on the MEMS project and request a budgetary line item shift of funds from the MEMS Replacement solution budget line to the Medicaid Waiver Management Application (MWMA) budget line. Additionally, the Commonwealth is requesting to create a budget line for the Design Development and Implementation (DDI) estimates of the MEMS Partner Portal as well as expanding the scope of this IAPDU to include an All Payer Claims Database (APCD) in the MEMS project budget with a line item shift. This IAPDU does not request new funding.

Please contact Jennifer Harp at (502) 564-0105, ext. 2076, if you have any questions.

Sincerely,

Lawrence Kissner  
Commissioner



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

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Secretary

**Lawrence Kissner**  
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December 5, 2014

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 14-007 RAI Response

Dear Ms. Glaze:

This letter is in response to your Request for Additional Information dated September 11, 2014. Upon receipt of this letter, Kentucky requests that this SPA be put back on the clock and approved.

**GENERAL**

1. **CMS Form 179 - Box 7.** The state estimates a federal budget impact of \$0 for FY 2014 and \$0 FY 2015. Please provide a detailed analysis showing how the state determined the federal budget impact.

**DMS Response** - Please see attached Excel spreadsheet showing our analysis.

2. **Public Process.** Please provide information demonstrating that the changes proposed in SPA 14-007 comport with public process requirements at section 1902(a)(13)(A) of the Act.

**DMS Response** - Please see attached Administrative Register.

3. Please provide an analysis of what would be paid for prescription drugs for these nursing home residents through the state's pharmacy fee for services system versus cost through the annual cost report.



**DMS Response** - Please see attached Excel spreadsheet showing our analysis.

4. Please provide any information the providers submitted regarding the purchasing program used by the veterans hospitals and nursing homes that satisfied the state the cost would be less if reimbursed through the cost reports.

**DMS Response** - Please see attached Excel spreadsheet showing our analysis.

### **STANDARD FUNDING QUESTIONS**

5. 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 the 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** - Providers retain all funds paid under this benefit.

6. 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 - Please see below:**

- (i) State Department of Veteran Affairs
- (ii) This entity is a state agency
- (iii) The State Department of Veteran Affairs pays all non-FMAP share
- (iv) The State Department of Veteran Affairs receives monies from the General Fund appropriations
- (v) Yes, they receive state General Fund appropriations.

7. 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**

8. Does any governmental provider receive payments that in the aggregate (normal per diem, supplemental, enhance, other) exceed their reasonable cost 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**

### **Maintenance of Effort (MOE)**

9. Under section 1902(gg) of 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 Kentucky 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 KY is in compliance with section 1902(gg) of the Act.

10. 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.

11. 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 FFP and is not in violation of this requirement.

Ms. Jackie Glaze  
December 5, 2014  
Page 5

12. Does TN 14-007 comply with the requirements of section 1902(a)(37) of the Act regarding prompt payment of claims?

**DMS Response** - Yes, this SPA does comply with prompt payment of claims

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

Sincerely,



Lawrence Kissner  
Commissioner

LK/sjh

Enclosure



# ADMINISTRATIVE REGISTER OF KENTUCKY

LEGISLATIVE RESEARCH COMMISSION  
Frankfort, Kentucky

VOLUME 41, NUMBER 1  
TUESDAY, JULY 1, 2014

The submission deadline for this edition of the *Administrative Register of Kentucky* was noon, June 13, 2014.

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**ARRS - JULY 8, 2014, TENTATIVE AGENDA**  
**REGULATION REVIEW PROCEDURE**

**EMERGENCIES:**

**FINANCE AND ADMINISTRATION CABINET: Department of Revenue: Office of Income Taxation: Income Tax; General Administration**  
**103 KAR 15:180E**, Kentucky new markets development program tax credit.

**AS AMENDED:**

**EDUCATION PROFESSIONAL STANDARDS BOARD: Teaching Certificates**  
**16 KAR 2:010**, Kentucky teaching certificates.

**SECRETARY OF STATE: Address Confidentiality Program**  
**30 KAR 6:010**, Kentucky address confidentiality program.

**FINANCE AND ADMINISTRATION CABINET: Department of Revenue: Office of Sales and Excise Taxes: Selective Excise Tax; Motor Fuels**  
**103 KAR 43:330**, Measurement of compressed natural gas (CNG) and liquefied natural gas (LNG) in gallons.

**GENERAL GOVERNMENT CABINET: Board of Medical Licensure: Board**

**201 KAR 9:305**, Continued licensure of athletic trainers.

**201 KAR 9:307**, Fee schedule regarding athletic trainers.

**Board of Barbering: Board**

**201 KAR 14:085**, Sanitation requirements.

**Board of Licensure for Professional Engineers and Land Surveyors: Board**

**201 KAR 18:192**, Continuing professional development for professional land surveyors.

**Board of Nursing: Board**

**201 KAR 20:056**, Advanced practice registered nurse licensure and certification requirements

**201 KAR 20:057**, Scope and standards of practice of advanced practice registered nurses.

**201 KAR 20:161**, Investigation and disposition of complaints.

**201 KAR 20:360**, Evaluation of prelicensure registered nurse and practical nurse programs. (Deferred from May)

**201 KAR 20:370**, Applications for licensure.

**201 KAR 20:411**, Sexual Assault Nurse Examiner Program standards and credential requirements.

**201 KAR 20:450**, Alternative program.

**Board of Physical Therapy: Board**

**201 KAR 22:040**, Procedure for renewal or reinstatement of a credential for a physical therapist or a physical therapist assistant.

**201 KAR 22:160**, Telehealth and telephysical therapy.

**Board of Social Work: Board**

**201 KAR 23:015**, Temporary permission to practice.

**Board of Licensure for Professional Art Therapists: Board**

**201 KAR 34:060**, Qualifying experience under supervision.

**Kentucky Applied Behavior Analysis Licensing Board: Board**

**201 KAR 43:100**, Telehealth and telepractice.

**TOURISM, ARTS AND HERITAGE CABINET: Department of Fish and Wildlife Resources: Game**  
**301 KAR 2:300**, Black bear seasons and requirements.

**JUSTICE AND PUBLIC SAFETY CABINET: Department of Corrections: Office of the Secretary**  
**201 KAR 6:020**, Corrections policies and procedures.

**EDUCATION AND WORKFORCE DEVELOPMENT CABINET: Board of Education: Department of Education: School Terms, Attendance and Operation**  
**702 KAR 7:065**, Designation of agent to manage middle and high school interscholastic athletics.

**KENTUCKY COMMUNITY AND TECHNICAL COLLEGE SYSTEM: Kentucky Fire Commission: Commission on Fire Protection Personnel Standards and Education**  
**739 KAR 2:090**, Candidate Physical Ability Test.

**PUBLIC PROTECTION CABINET: Department of Insurance: Financial Standards and Examination Division: Insurance Premium Finance Companies**

806 KAR 30.020, Abuse of minimum service charge.

**Division of Insurance Fraud Investigation: Insurance Fraud**

806 KAR 37.010, Designation of a contact person.

**CABINET FOR HEALTH AND FAMILY SERVICES: Department for Medicaid Services: Division of Policy and Operations: Veterans Affairs Nursing Facilities**

907 KAR 18.001, Definitions for 907 KAR Chapter 18.

907 KAR 18.003, Reimbursement provisions and requirements regarding Veterans Affairs nursing facility services.

**Department for Aging and Independent Living: Division of Guardianship: Guardianship**

910 KAR 2.040, Service provisions for adult guardianship.

**AMENDED AFTER COMMENTS:**

**GENERAL GOVERNMENT CABINET: Board of Dentistry: Board**

201 KAR 8.130, Anesthesia and sedation.

**EDUCATION AND WORKFORCE DEVELOPMENT CABINET: Board of Education: Department of Education: Office of Instruction**

704 KAR 1.370, Professional Growth and Effectiveness System.

**CABINET FOR HEALTH AND FAMILY SERVICES: Department for Community Based Services: Division of Family Support: K-TAP, Kentucky Works, Welfare to Work, State Supplementation**

921 KAR 2.055, Hearings and appeals.

**Supplemental Nutrition Assistance Program**

921 KAR 3.070, Fair hearings.

**Commissioner's Office: Child Welfare**

922 KAR 1.320, Service appeals.

**Division of Protection and Permanency: Child Welfare**

922 KAR 1.480, Appeal of child abuse and neglect investigative findings.

**PROPOSED AMENDMENTS:**

**FINANCE AND ADMINISTRATION CABINET: Department of Revenue: Office of Income Taxation: Income Tax; General Administration**

102 KAR 15.180, Kentucky new markets development program tax credit.

**GENERAL GOVERNMENT CABINET: Kentucky Board of Licensed Diabetes Educators: Board**

201 KAR 45.110, Supervision and work experience.

201 KAR 45.120, Renewal, reinstatement, and inactive status.

**TOURISM, ARTS AND HERITAGE CABINET: Kentucky Department of Fish and Wildlife Resources: Game**

101 KAR 2.178, Deer hunting on Wildlife Management Areas, state parks, other public lands, and federally controlled areas.

**JUSTICE AND PUBLIC SAFETY CABINET: Department of Criminal Justice Training: General Traffic**

503 KAR 3.005, Definitions.

503 KAR 3.010, Basic law enforcement training course recruit conduct requirements; procedures and penalties.

503 KAR 3.040, Telecommunications (Public Safety Dispatch) Academy trainee requirements; misconduct; penalties; discipline procedures.

503 KAR 3.110, Certified Court Security Officers academy trainee requirements; misconduct; penalties; discipline procedures.

**EDUCATION AND WORKFORCE DEVELOPMENT CABINET: Kentucky Commission on Proprietary Education: Commission**

791 KAR 1.020, Standards for licensure.

791 KAR 1.025, Fees.

791 KAR 1.030, Procedures for hearings.

791 KAR 1.035, Student protection fund.

791 KAR 1.050, Application for license for commercial driver license training school.

791 KAR 1.060, Application for renewal of license for commercial driver license training school.

791 KAR 1.070, Commercial driver license training school instructor and agent application and renewal procedures.

**ENERGY AND ENVIRONMENT CABINET: Public Service Commission: Utilities**

807 KAR 5.001, Rules of procedure.

807 KAR 5.011, Tariffs.

807 KAR 5.068, Purchased water adjustment for water districts and water associations.

807 KAR 5.069, Filing requirements and procedures for federally funded construction project of a water association, a water district, or a combined water, gas, or sewer district.

807 KAR 5.075, Treated sewage adjustment for water districts and water associations.

807 KAR 5.076, Alternative rate adjustment procedure for small utilities.

**Kentucky State Board on Electric Generation and Transmission Siting: Utilities**

807 KAR 5.110, Board proceedings.

**Public Service Commission: Utilities**

807 KAR 5.120, Applications for certificate of public convenience and necessity for certain electric transmission lines.

**PUBLIC PROTECTION CABINET: Department of Housing, Buildings and Construction: Division of Plumbing: Plumbing**

815 KAR 20.040, Vehicle identification.

815 KAR 20.050, Installation permits.

815 KAR 20.060, Quality and weight of materials.

815 KAR 20.070, Plumbing fixtures.

815 KAR 20.090, Soil, waste, and vent systems.

815 KAR 20.130, House sewers and storm water piping; methods of installation.

815 KAR 20.191, Minimum fixture requirements.

**CABINET FOR HEALTH AND FAMILY SERVICES: Office of Health Policy: Certificate of Need**

900 KAR 6.030, Certificate of Need expenditure minimums.

900 KAR 6.125, Certificate of Need annual surveys.

**Office of Inspector General: Division of Health Care: Health Services and Facilities**

907 KAR 20.008, License procedures and fee schedule.

**Department for Aging and Independent Living: Division of Quality Living: Aging Services**

910 KAR 1.180, Homecare program for the elderly.

**Department for Community Based Services: Division of Family Support: Supplemental Nutrition Assistance Program**

921 KAR 3.035, Certification process.

**PROPOSED NEW ADMINISTRATIVE REGULATIONS:**

**GENERAL GOVERNMENT CABINET: Board of Registration for Professional Geologists: Board**

201 KAR 31.100, Administrative subpoenas.

**Kentucky Board of Licensed Diabetes Educators: Board**

201 KAR 45.170, Application procedures.

201 KAR 45.180, Diabetes Education Courses.

**JUSTICE AND PUBLIC SAFETY CABINET: Office of the Secretary: Telecommunicators**

500 KAR 4.011, Repeal of 500 KAR Chapter 4.

**EDUCATION AND WORKFORCE DEVELOPMENT CABINET: Kentucky Commission on Proprietary Education: Commission**

791 KAR 1.010, Applications, permits and renewals.

791 KAR 1.091, Repeal of 791 KAR 1.090.

**CABINET FOR HEALTH AND FAMILY SERVICES: Department for Public Health: Division of Public Health Protection and Safety: Radon**

902 KAR 25.040, Radon Contractor Certification Program

**Department for Medicaid Services: Commissioner's Office: Payment and Services**

907 KAR 3.111, Repeal of 907 KAR 3.110.

**JUNE 10, 2014, MINUTES OF THE ARRS**

**OTHER COMMITTEE REPORTS**

**LOCATOR INDEX**

**KRS INDEX**

**TECHNICAL AMENDMENT INDEX**

**SUBJECT INDEX**

**ARRS MEETING NOTICE**

The Administrative Regulation Review Subcommittee is tentatively scheduled to meet at 1:00 p.m., Tuesday, July 8, 2014, in room 149, Capitol Annex, Frankfort, Kentucky.

~~of KRS 304.47-050].~~

Section 1. Every insurer shall designate at least ~~two (2)~~~~(one~~ (4) primary contact ~~persons~~~~(person)~~ but not more than four (4) primary contact persons who shall communicate with the Division of Insurance Fraud Investigation~~[Insurance-Fraud-Unit]~~ on matters relating to the reporting, investigation, and prosecution of suspected fraudulent insurance acts, as defined in KRS 304.47-020.

Section 2. Every insurer shall notify the Division of Insurance Fraud Investigation~~[Insurance-Fraud-Unit]~~ in writing of the names, addresses, and telephone numbers of:

- (1) The insurer's primary contact~~(person or)~~ persons; and
- (2) The primary person responsible for the insurer's investigative unit.

SHARON P. CLARK, Commissioner  
ROBERT D. VANCE, Secretary

APPROVED BY AGENCY: April 10, 2014

FILED WITH LRC: April 15, 2014 at 10 a.m.

CONTACT PERSON: DJ Wasson, Administrative Coordinator,  
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**CABINET FOR HEALTH AND FAMILY SERVICES**  
Department for Medicaid Services  
Division of Policy and Operations  
(As Amended at ARRS, June 10, 2014)

907 KAR 18:001. Definitions for 907 KAR Chapter 18.

RELATES TO: 42 U.S.C. 1396a(a)(13)(A), 42 U.S.C. 1396a(a)(30)(A), 42 C.F.R. Part 413, 42 C.F.R. 447.204

STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3)

NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services, Department for Medicaid Services has responsibility to administer the Medicaid Program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with any requirement that may be imposed, or opportunity presented, by federal law to qualify for federal Medicaid funds. This administrative regulation establishes the definitions for 907 KAR Chapter 18.

Section 1. Definitions. (1) "Allowable cost" means that portion of a facility's cost which may be allowed by the department for reimbursement purposes.

(2) "Ancillary service" means an ancillary service as established in 907 KAR 1:023.

(3) "Capital costs" means capital costs as established in 42 C.F.R. 413.130 through 157.

(4) "Cost report" means a copy of the cost report that a VA NF submits to the Medicare program.

(5) "Department" means the Department for Medicaid Services or its designee.

(6) "Federal financial participation" is defined by 42 C.F.R. 400.203.

(7) "Global Insight Index" means an indication of changes in health care costs from year to year developed by Global Insights Index.

(8) "Pro forma cost data" means estimated cost data for a specific future period of time.

(9) "Prospective payment rate" means a payment rate for services based on allowable costs and other factors.

(10) "Recipient" is defined by KRS 205.8451(9).

(11) "Regular part-time employee" means an employee who works part-time:

(a) On a continual basis; and

(b) Not on a short-term or temporary basis.

(12) "State fiscal year" means the twelve (12) month period

beginning on July 1 of one year and ending on June 30 of the following year.

~~(13)~~~~(43)~~ "Upper payment limit" means an amount of reimbursement that:

(a) Equates to a Veterans Affairs nursing facility's Medicaid-allowable cost; and

(b) Does not exceed the limit established in 42 C.F.R. 447.272.

~~(14)~~~~(43)~~ "VA NF" means a nursing facility that meets the requirements of 907 KAR 18:005, Section 1~~(is currently:~~

~~(a) Licensed by the Cabinet for Health and Family Services, Office of Inspector General as a nursing facility;~~

~~(b) Approved by the department for Medicaid program participation; and~~

~~(c) Certified by the United States Department of Veterans Affairs as a state veterans home).~~

LAWRENCE KISSNER, Commissioner  
AUDREY TAYSE HAYNES, Secretary

APPROVED BY AGENCY: March 7, 2014

FILED WITH LRC: March 24, 2014 at 4 p.m.

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**CABINET FOR HEALTH AND FAMILY SERVICES**  
Department for Medicaid Services  
Division of Policy and Operations  
(As Amended at ARRS, June 10, 2014)

907 KAR 18:005. Reimbursement provisions and requirements regarding Veterans Affairs nursing facility services.

RELATES TO: 42 U.S.C. 1396a(a)(13)(A), 42 U.S.C. 1396a(a)(30)(A), 42 C.F.R. Part 413, 42 C.F.R. 447.204

STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3)

NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services, Department for Medicaid Services has responsibility to administer the Medicaid Program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with any requirement that may be imposed, or opportunity presented, by federal law to qualify for federal Medicaid funds. This administrative regulation establishes the Department for Medicaid Services' reimbursement provisions and requirements regarding Veterans Affairs nursing facility services in Kentucky.

Section 1. Provider Participation. To be eligible to be reimbursed for services and drugs under this administrative regulation, a VA NF shall be currently:

(1) Enrolled in the Kentucky Medicaid Program in accordance with 907 KAR 1:672;

(2) Participating in the Kentucky Medicaid Program in accordance with 907 1:671;

(3) Licensed by the Cabinet for Health and Family Services, Office of Inspector General as a nursing facility; and

(4) Certified as a state veterans home by the United States Department of Veterans Affairs.

Section 2. General Requirements. To be reimbursable by the department, a service shall be:

(1) Medically necessary;

(2) Provided to a recipient who is eligible for nursing facility services in accordance with 907 KAR 1:022;

(3) Provided in accordance with 907 KAR 1:022; and

(4) Provided by a VA NF ~~[that meets the requirements established in Section 1 of this administrative regulation].~~

Section 3. Covered Services and Drugs. The following ~~[services]~~, if provided by a VA NF in accordance with this administrative regulation, shall be covered under this administrative regulation:

- (1) Nursing facility services;
- (2) Ancillary services;
- (3) Laboratory procedures or radiological services if ordered by

[a]

~~(a) A[1.]~~ physician;

~~(b)[2.]~~ An advanced practice registered nurse if the laboratory test or radiological service is within the scope of the advance practice registered nurse's practice; or

~~(c) A[3.]~~ physician assistant if the laboratory test or radiological service is:

~~1.[a.]~~ Authorized by the supervising physician; and

~~2.[b. The laboratory test or radiological service is]~~ Within the scope of the physician assistant's practice;~~or]~~

(4) Psychological or psychiatric therapy; or

~~(5) Drugs.~~

Section 4. Reimbursement. (1) The department shall reimburse a VA NF for services and drugs under this administrative regulation on a cost basis.

(2)(a) The cost basis shall include reimbursing:

1. A VA NF for services and drugs on an interim basis during a state fiscal year using a prospective payment rate; and

2. A final reimbursement to a VA NF for services and drugs for a state fiscal year:

a. Equal to the VA NF's Medicaid allowable cost for the state fiscal year; and

b. That results from a reconciliation of the:

(i) Interim prospective reimbursement paid by the department to the VA NF for the state fiscal year; and

(ii) Actual Medicaid allowable costs experienced by the VA NF for the state fiscal year as reflected on the cost report that has been desk reviewed and approved by the department for the state fiscal year.

(b)1. Except as provided by subsection (3)(b) of this section, the prospective payment rate referenced in paragraph (a)1 of this subsection shall be:

a. Established using the most recently submitted cost report available to ~~and reviewed by~~ the department as of May 16 prior to the beginning of the state fiscal year; and

b. Trended and indexed to the midpoint of the state fiscal year.

2. For example, to set a prospective payment for a VA NF effective July 1, 2014, for the state fiscal year beginning July 1, 2014, the department shall:

a. Use the most recently submitted cost report available to the department as of May 16, ~~2014[2013]~~; and

b. Trend and index the prospective payment rate to December 31, ~~2014[2013]~~.

(3)(a) A prospective payment rate for services and drugs shall:

1. Be specific to the VA NF;

2. Not be subject to retroactive adjustment except as specified in this section;

3. Be determined by the department on a cost basis annually; and

4. Except as established in paragraph (b) of this subsection, be based on a VA NF's Medicaid allowable costs.

(b)1. If no cost report containing a full state fiscal year of cost data for a VA NF is available as of May 16, to set a prospective payment rate for the VA NF, the department shall:

a. If at least six (6) months of cost data is available, use pro forma cost data:

(i) Submitted to the department by the VA NF; and

(ii) Approved by the department; or

b. If less than six (6) months of cost data is available, establish a prospective payment rate equal to the statewide average prospective payment rate of existing VA NFs until the department receives[a] pro forma cost data including at least six (6) months of cost data.

2. Pro forma cost data shall be trended and indexed in the same way as established in subsection (2)(b) of this section.

(c) The department ~~shall may~~ adjust a prospective payment rate during the state fiscal year if the prospective payment rate that was established appears likely to result in a substantial cost

settlement that could be avoided by adjusting the prospective payment rate.

(d)1. If the latest available cost report data has not been audited or desk-reviewed prior to rate setting for the universal year beginning July 1, a prospective rate based on a cost report which has not been audited or desk-reviewed shall be subject to adjustment when the audit or desk review is completed.

2. An unaudited cost report shall be subject to an adjustment to the audited amount after auditing has occurred.

(e)1. If the department has made a separate rate adjustment as compensation to a VA NF for a minimum wage update, the department shall:

a. Not pay the VA NF twice for the same costs; and

b. Adjust downward the trending and indexing factors to the extent necessary to remove from the factors costs relating to the minimum wage updates already provided for by the separate rate adjustment.

2. If the trending and indexing factors include costs related to a minimum wage increase:

a. The department shall not make a separate rate adjustment; and

b. The minimum wage costs shall not be deleted from the trending and indexing factors.

(4) The department shall consider an adjustment to a VA NF's prospective rate (subject to the upper payment limit) if:

(a) The VA NF's increased costs are attributable to:

1. A governmentally imposed minimum wage increase, staffing ratio increase, or a level of service increase; and

2. The increase was not included in the Global Insight Index;

(b) A new licensure requirement or new interpretation of an existing requirement by the appropriate governmental agency as issued in an administrative regulation results in changes that affect all VA NFs; or

(c) The VA NF experiences a governmentally-imposed displacement of residents.

(5)~~(e)~~ The amount of any prospective payment rate adjustment resulting from a governmentally-imposed minimum wage increase or licensure requirement change or interpretation as cited in subsection (4) of this section shall not exceed the amount by which the cost increase resulting directly from the governmental action exceeds on an annualized basis the inflation allowance amount included in the prospective rate for the general cost area in which the increase occurs.

~~(e)[1.]~~ For purposes of this determination, costs shall be classified as either:

~~1.[a.]~~ Salaries; or

~~2.[b.]~~ Other.

~~(b)[2.]~~ The effective date of an interim rate adjustment shall be the first day of the month in which the adjustment is requested or in which the cost increase occurred, whichever is later.

(6) A year-end adjustment of a prospective rate and a retroactive cost settlement adjustment shall be made if:

(a) An incorrect payment has been made due to a computational error (other than an omission of cost data) discovered in the cost basis or establishment of the prospective rate;

(b) An incorrect payment has been made due to a misrepresentation on the part of a facility (whether intentional or unintentional);

(c) A facility is sold and the funded depreciation account is not transferred to the purchaser; or

(d) The prospective rate has been set based on unaudited cost reports and the prospective rate is to be adjusted based on audited reports with the appropriate cost settlement made to adjust the unaudited prospective payment amounts to the correct audited prospective payment amounts.

(7)(a) The department shall retroactively cost settle reimbursement for services and drugs.

(b) Retroactive settlement shall entail:

1. Comparing interim prospective payments with the properly apportioned cost of Medicaid services and drugs rendered;

2. A tentative cost report settlement based upon:

a. Eighty (80) percent of any amount due the facility after a

preliminary review is performed; or

b. 100 percent settlement of any liability due the department, and

3. A final cost report settlement after the allowed billing period has elapsed for the dates of service and drugs identified within the cost report.

(c) To be considered final, a cost report shall have been reviewed and approved by the department.

Section 5. Allowable and Non-allowable Costs. (1) Nursing facility services' and drugs~~services~~ costs shall be the direct costs associated with nursing facility services and drugs.

(2)(a) Except as provided in paragraph (d) of this subsection, interest expense used in settling a prospective rate shall be an allowable cost if:

1. Permitted pursuant to 42 C.F.R. 413.153; and

2. The interest expense:

a. Represents interest on:

(i) Long term debt existing at the time the provider enters the program, or

(ii) New long-term debt, if the proceeds are used to purchase fixed assets relating to the provision of the appropriate level of care; or

b. Is for working capital and operating needs that directly relate to providing patient care.

(b) The forms of indebtedness may include:

1. Notes, advances, and various types of receivable financing; or

2. Mortgages, bonds, and debentures if the principal is to be repaid over a period in excess of one (1) year.

(c) If a debt is subject to variable interest rates found in balloon-type financing, renegotiated interest rates shall be allowable.

(d) Interest on a principal amount used to purchase goodwill or other intangible assets shall not be considered an allowable cost.

(3)(a) The allowable cost for a service or good purchased by a VA NF from a related organization shall be the cost to the related organization unless it can be demonstrated that the related organization is equivalent to a second party supplier.

(b) Except as provided in paragraph (c) of this subsection, an organization shall be considered a related organization if an individual possesses five (5) percent or more of ownership or equity in the facility and the supplying business.

(c) An organization shall not be considered a related organization if fifty-one (51) percent or more of the supplier's business activity of the type carried on with the VA NF is transacted with persons and organizations other than the VA NF and its related organizations

(4) The amount allowable for leasing costs shall not exceed the amount which would be allowable based on the computation of historical costs.

(5) A cost shall be allowable and eligible for reimbursement if the cost is:

(a) Reflective of the provider's actual expenses of providing a service; and

(b) Related to Medicaid patient care pursuant to 42 C.F.R. 413.9.

(6) The following costs shall be allowable:

(a) Costs to related organizations pursuant to 42 C.F.R. 413.17;

(b) Costs of educational activities pursuant to 42 C.F.R. 413.85;

(c) Research costs pursuant to 42 C.F.R. 413.90;

(d) Value of services of nonpaid workers pursuant to 42 C.F.R. 413.94;

(e) Purchase discounts and allowances pursuant to 42 C.F.R. 413.98;

(f) Refunds of expenses pursuant to 42 C.F.R. 413.98;

(g) Depreciation on buildings and equipment if a cost is:

1. Identifiable and recorded in the provider's accounting records;

2. Based on historical cost of the asset or, if donated, the fair market value; or

3. Prorated over the estimated useful life of the asset using the straight-line method, which is a method that depreciates the value of an asset evenly over the life of the asset;

(h) Interest on current and capital indebtedness;

(i) Professional costs of services of full-time or regular part-time employees not to exceed what a prudent buyer would pay for comparable services; or

(j) A provider tax on a VA NF.

(7) The following costs shall not be allowable:

(a) The value of services provided by nonpaid members of an organization if there is an agreement with the provider to furnish the services at no cost;

(b) Political contributions;

(c) Legal fees for unsuccessful lawsuits against the Cabinet for Health and Family Services;

(d) Travel and associated costs outside of the Commonwealth of Kentucky to conventions, meetings, assemblies, conferences, or any related activities that are not related to NF training or educational purposes; or

(e) Costs related to lobbying.

~~(8) To determine the gain or loss on the sale of a facility for purposes of determining a purchaser's cost basis in relation to depreciation and interest costs, the following methods shall be used for changes of ownership occurring before July 18, 1984:~~

~~(a) 1. Determine the actual gain on the sale of the facility; and~~

~~2. Add to the seller's depreciated basis two-thirds (2/3) of one (1) percent of the gain for each month of ownership since the date of acquisition of the facility by the seller to arrive at the purchaser's cost basis;~~

~~(b) Gain shall be the amount in excess of a seller's depreciated basis as computed under program policies at the time of a sale, excluding the value of goodwill included in the purchase price;~~

~~(c) 1. A sale shall be any bona fide transfer of legal ownership from an owner to a new owner for reasonable compensation, which shall usually be fair market value; and~~

~~2. A lease purchase agreement or other similar arrangement which does not result in a transfer of legal ownership from the original owner to the new owner shall not be considered a sale until legal ownership of the property is transferred; and~~

~~(d) If an enforceable agreement for a change of ownership was entered into prior to July 18, 1984, the purchaser's cost basis shall be determined pursuant to paragraphs (a) through (c) of this subsection.~~

~~(9)(a) An increase in valuation in relation to depreciation and interest costs shall not be allowed for changes of ownership occurring after July 18, 1984, and before October 1, 1985.~~

~~(b) For a bona fide change[changes] of ownership[entered into on or after October 1, 1985], the depreciation and interest costs shall be increased in valuation in accordance with 42 U.S.C. 1395x(v)(1)(O)(i).~~

~~(10)(a) Maximum allowable costs shall be the maximum amount which may be allowed to a VA NF as reasonable cost for the provision of a supply, drug, or service while complying with limitations expressed in related federal or state regulations.~~

~~(b) Costs shall be subject to allowable cost limits pursuant to 42 C.F.R. 413.106.~~

Section 6. Cost Report Requirements. (1)(a) A VA NF shall, no later than five (5) months following the end of a state fiscal year, submit to the department a cost report stating the VA NF's costs for the state fiscal year.

(b) The time limit stated in paragraph (a) of this subsection shall~~may~~ be extended at the specific request of the facility with the department's concurrence.

(2) If the VA NF experienced a new item or expansion representing a departure from current service levels and for which the VA NF requested prior approval by the department, the VA NF shall submit a supplement to the cost report to the department

VOLUME 41, NUMBER 1 – JULY 1, 2014

which:

- (a) Describes the new item or expansion; and
- (b) States the rationale for the new item or expansion.

(3)(a) Department approval or rejection of a projection of the cost of a new item or expansion shall be made on a prospective basis in the context that if a new item or an expansion and related costs are approved they shall be considered when actually incurred as an allowable cost.

(b) Rejection of an item or costs shall represent notice that the costs shall not be considered as part of the cost basis for reimbursement.

(c) Unless otherwise specified, approval shall relate to the substance and intent rather than the cost projection.

(d) If a request for prior approval of a projection or expansion is made, absence of a response by the department shall not be construed as approval of the item or expansion.

(4)(a) The department shall perform a desk review of each cost report to determine whether an audit is necessary and, if so, the scope of the audit.

(b) If the department determines that an audit is not necessary, the cost report shall be settled without an audit.

(c) A desk review or audit shall be used for purposes of verifying ~~costs/costs~~ to be used in setting the prospective rate or for purposes of adjusting prospective rates which have been set based on unaudited data.

(d) ~~An audit shall~~~~Audits may~~ be conducted annually or at less frequent intervals.

(5)(a) A VA NF shall maintain and make available any records and data necessary to justify and document:

- 1. Costs to the VA NF; and
- 2. Services performed and drugs provided by the VA NF.

(b) The department shall have unlimited on-site access to all of a VA NF's fiscal and service records for the purpose of:

- 1. Accounting;
- 2. Auditing;
- 3. Medical review;
- 4. Utilization control, or
- 5. Program planning.

Section 7. Preadmission Screening Resident Review (PASRR). (1) Prior to an admission of an individual to a VA NF, a VA NF shall conduct a level I PASRR in accordance with 907 KAR 1:755.

(2)(a) The department shall not reimburse a VA NF for a service delivered to an individual if the VA NF did not comply with the requirements of 907 KAR 1:755.

(b) Failure to comply with 907 KAR 1:755 may be grounds for termination of a VA NF's participation in the Medicaid Program.

Section 8. No Duplication of Service. The department shall not reimburse for a service provided by a VA NF to a recipient if the same service is provided at the same time to the recipient by another Medicaid program provider.

Section 9. Records Maintenance, Protection, and Security. (1)(a) A VA NF shall maintain a current health record for each recipient.

(b)1. A health record shall document each service provided to the recipient including the date of the service and the signature of the individual who provided the service.

2. The individual who provided the service shall date and sign the health record on the date that the individual provided the service.

(2)(a) A VA NF shall maintain a health record regarding a recipient for at least five (5) years from the date of the service.

(b) If the United States Department of Health and Human Services secretary requires a longer document retention period than the period referenced in paragraph (a) of this subsection, pursuant to 42 C.F.R. 431.17, the period established by the secretary shall be the required period.

(3) A VA NF shall comply with 45 C.F.R. Part 164.

Section 10. Medicaid Program Participation Compliance. (1) A

VA NF shall comply with:

- (a) 907 KAR 1.671,
- (b) 907 KAR 1.872; and
- (c) All applicable state and federal laws.

(2)(a) If a VA NF receives any duplicate payment or overpayment from the department, regardless of reason, the VA NF shall return the payment to the department.

(b) Failure to return a payment to the department in accordance with paragraph (a) of this subsection may be:

- 1. Interpreted to be fraud or abuse; and
- 2. Prosecuted in accordance with applicable federal or state law.

Section 11. Third Party Liability. A VA NF shall comply with KRS 205.622.

Section 12. Use of Electronic Signatures. (1) The creation, transmission, storage, and other use of electronic signatures and documents shall comply with the requirements established in KRS 369.101 to 369.120.

(2) A VA NF that chooses to use electronic signatures shall:

(a) Develop and implement a written security policy that shall:

- 1. Be adhered to by each of the VA NF's employees, officers, agents, or contractors;
- 2. Identify each electronic signature for which an individual has access; and

3. Ensure that each electronic signature is created, transmitted, and stored in a secure fashion;

(b) Develop a consent form that shall:

1. Be completed and executed by each individual using an electronic signature;

2. Attest to the signature's authenticity; and

3. Include a statement indicating that the individual has been notified of his or her responsibility in allowing the use of the electronic signature; and

(c) Provide the department, immediately upon request, with:

- 1. A copy of the VA NF's electronic signature policy;
- 2. The signed consent form; and
- 3. The original filed signature~~[immediately upon request]~~.

Section 13. Auditing Authority. The department shall have the authority to audit any claim, medical record, or documentation associated with any claim or medical record.

Section 14. Federal Approval and Federal Financial Participation. The department's reimbursement and coverage of services and drugs pursuant to this administrative regulation shall be contingent upon:

(1) Receipt of federal financial participation for the reimbursement and coverage; and

(2) Centers for Medicare and Medicaid Services' approval for the reimbursement and coverage.

Section 15.~~Drug Reimbursement. Drugs to a recipient in a VA NF shall:~~

~~(1) Be reimbursed via the department's outpatient pharmacy program in accordance with 907 KAR 1:018;~~

~~(2) Not be included in VA NF Medicaid allowable costs; and~~

~~(3) Not be reimbursed pursuant to this administrative regulation.~~

~~Section 16.]~~ Appeal Rights. A participating VA NF may appeal a department decision as to the application of this administrative regulation as it impacts the VA NF's reimbursement in accordance with 907 KAR 1:671.

LAWRENCE KISSNER, Commissioner  
AUDREY TAYSE HAYNES, Secretary

APPROVED BY AGENCY: March 7, 2014

FILED WITH LRC: March 24, 2014 at 4 p.m.

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**CABINET FOR HEALTH AND FAMILY SERVICES**  
 Department for Aging and Independent Living  
 Division of Guardianship  
 (As Amended at ARRS, June 10, 2014)

**910 KAR 2:040. Service provisions for adult guardianship.**

RELATES TO. KRS ~~17.500 - 17.540~~, 202A, 202B, 209.990, 210.290(3), (4), ~~367.97501~~, 367.97524, 367.97527, 387.500-387.990, 389A.010, 389.015, 20 C.F.R. 416.212, 42 U.S.C. 1382(e)(1)(G)

STATUTORY AUTHORITY: KRS ~~387.600(1)~~, 194A.050(1) NECESSITY, FUNCTION, AND CONFORMITY: ~~[KRS 387.600(1) authorizes the Cabinet for Health and Family Services to be appointed as limited guardian, guardian, limited conservator, or conservator to conduct an active guardianship or conservatorship program.]~~ KRS 194A.050(1) requires the secretary of the cabinet to promulgate administrative regulations necessary under applicable state laws to protect, develop, and maintain the health, personal dignity, integrity, and sufficiency of the individual citizens of the commonwealth. This administrative regulation establishes service provisions for adult guardianship.

Section 1. Definitions. (1) "Adult" is defined by KRS 209.020(4).

(2) "Best interest" means a course of action that maximizes what is best for a ward and that includes consideration of the least intrusive, most normalizing, and least restrictive course of action possible given the needs of a ward.

(3) ~~"BHDID" means the Department for Behavioral Health, Developmental and Intellectual Disabilities.~~

(4) "Conservator" is defined by KRS 387.510(1).

(4)(5)(4) "Court" means a court of competent jurisdiction.

(5) ~~"DBHDID" means the Department for Behavioral Health, Developmental and Intellectual Disabilities.~~

(6) ~~"Department" or "DAIL" means the Department for Aging and Independent Living (DAIL).~~

(7)(6) "Division" means the Division of Guardianship.

(8)(6) ~~"DMHDDAS" means the Department for Mental Health, Developmental Disabilities and Addiction Services.~~

(7) "Fiduciary Services Branch" means a central office branch under the Division of Operations and Support (Guardianship).

(9)(8) "Field Services Branch" means a central office branch under the Division of Guardianship.

(10)(9) "Guardian" is defined by KRS 387.510(3).

(11)(10) "Guardian ad Litem" means a guardian appointed to represent the interests of a person with respect to a single action in litigation.

(12) ~~"Guardianship advisory committee" means a review panel of at least two (2) cabinet medical directors to review records to assist in decision making regarding end of life decisions.~~

(13)(11) "Informed consent" means a person's agreement to a particular course of action based on a full disclosure of facts needed to make the decision intelligently.

(14)(12) ~~"Interested party" is defined by KRS 387.600(5) [means an individual or agency interested in assuming duties and responsibilities on behalf of a ward].~~

(15)(13) "Least restrictive alternatives" means the guardianship options that have been exhausted such as:

- (a) Power of attorney;
- (b) Living wills;
- (c) Advanced directives;
- (d) Case management;
- (e) Representative payee;
- (f) Curator;
- (g) Trustee;
- (h) Health care surrogate;
- (i) Ex-parte order;
- (j) Emergency protective services;
- (k) Adult protective ongoing services; or

(l) Informal network of support.

(16)(14) "Limited conservator" is defined by KRS 387.510(2).

(17)(15) "Limited guardian" is defined by KRS 387.510(4).

(18) ~~"Nurse consultant" means a nurse consultant, inspector employed by the Cabinet for Health and Family Services.~~

(19)(16) "Provider" means a facility or entity providing services for a ward such as:

- (a) Self;
- (b) Caretaker;
- (c) Relative;
- (d) Group home placement;
- (e) Hospital;
- (f) Psychiatric hospital;
- (g)(17) Personal care home; or
- (h) Supports for Community Living facility.

(20) ~~"Quit claim deed" means a document by which an individual disclaims an interest in a piece of real property and passes that claim to another person.~~

(21)(17) "Substituted judgment" means principle of decision-making made by the Field Services Branch which comports with the individual ward or beneficiary's known wishes expressed prior to the appointment of a guardian, if the individual was once capable of developing views relevant to the matter at issue and reliable evidence of these views remains.

(22)(18) "Successor guardian" means an individual, agency, or corporation who is appointed to succeed a current guardian removed by the court.

(23)(19) ~~"Quit claim deed" means a document by which an individual disclaims an interest in a piece of real property and passes that claim to another person.~~

(20) "Ward" is defined by KRS 387.510(15).

Section 2. Annual Court Report. (1) Within thirty (30) calendar days of the anniversary date of the guardianship appointment, the Field Services Branch shall submit to the court an annual report on the ward's personal status.

(2) In order to complete the annual report the Field Services Branch shall:

- (a) Visit the ward and use an Initial Field Visit Report to assess current physical condition and needs;
- (b) Review the ward's records at the ward's place of residence;
- (c) Consult with the provider concerning the ward's care;
- (d) Verify the names, addresses, and telephone numbers of the ward's relatives; and
- (e) Verify with Fiduciary Services Branch the ward's burial arrangements in accordance with 910 KAR 2:030, Section 12.

(3) The Field Services Branch shall:

- (a) Review, sign, and notarize an annual report; and
- (b) Maintain a scheduling system that ensures the timely filing of annual reports in court for each guardianship ward.

Section 3. Renewal of Limited Appointments. (1) A limited guardian or limited conservator shall not be appointed for more than five (5) years pursuant to KRS 387.590(7).

(2) The Field Services Branch shall be responsible for initiating procedures for continued guardianship or conservatorship, if appropriate.

(3) To make this determination, the Field Services Branch shall review the last annual court report to determine if continued guardianship was recommended.

(4) The Field Services Branch shall secure a verified affidavit from a physician, psychiatrist, or social worker, not serving in the division, verifying the ward's petition to continue guardianship.

(5) At least sixty (60) calendar (60) days prior to the date of the expiration of the limited guardianship, the Field Services Branch shall file with the court the following:

- (a) Petition for Relief Modification or Termination (AOC-795) issued by the Administrative Office of the Courts and available at [www.courts.ky.gov](http://www.courts.ky.gov);
- (b) Application for Appointment for Fiduciary (AOC-745) issued by the Administrative Office of the Courts and available at [www.courts.ky.gov](http://www.courts.ky.gov); and
- (c) A verified affidavit as specified in subsection (4) of this



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

**Steven L. Beshear**  
Governor

275 East Main Street, 6W-A  
Frankfort, KY 40621  
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F: 502-564-0509  
[www.chfs.ky.gov](http://www.chfs.ky.gov)

**Audrey Tayse Haynes**  
Secretary

**Lawrence Kissner**  
Commissioner

December 19, 2014

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 14-008 - Clarification of "After Hours"

Dear Ms. Glaze:

Attached please find Kentucky State Plan Amendment 14-008. The purpose of this SPA is to clarify Kentucky's reimbursement for services performed in a provider's office after normal business hours. Kentucky believes this change will be budget neutral because we are currently paying a flat \$72 for any after hours. Now the reimbursement will be the allowed amount for the E&M code plus \$25, which should equal out on average around \$72.

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:  
14-008

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  
January 1, 2015

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:

7. FEDERAL BUDGET IMPACT:  
a. FFY 2015                      Budget Neutral  
b. FFY 2016                      Budget Neutral

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Att. 4.19-B, Page 20.5

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

10. SUBJECT OF AMENDMENT:

The purpose of this SPA is to clarify after hours reimbursement for physicians.

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: 12/19/14

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:

(16) Physicians, who are not enrolled in the VFC Program, will be reimbursed for the administration of immunizations, to include the influenza vaccine, as well as the vaccine cost, as defined in the Center for Disease Control (CDC) Vaccine Price List published as of January 1, 2014 to a Medicaid recipient of any age.

(17) After Hours Services - CPT 99050 is reported when services are provided in the office at times other than regularly scheduled office hours or days when the office is normally closed. DMS refers to this time as "After Hours," and defines "After Hours" as services rendered between 5:00 p.m. and 8:00 a.m. on weekdays, and anytime on weekends and holidays when the office is usually closed. For example - if normal office hours are scheduled from 9:00 - 5:00 and service is provided at 7:00, the provider would bill CPT 99050. However, if normal office hours are scheduled from 9:00 am - 7:00 pm and the service is performed at 6:00, the provider would NOT bill for CPT code 99050.

CPT code 99050 is eligible for separate reimbursement, in addition to the basic covered service, if the basic service provided meets all of the criteria described below:

- It is reported with an office setting place of service;
- It is rendered at a time other than the regularly scheduled and/or posted office hours; and
- The basic service time is based on arrival time, not actual time services commence.

CPT code 99050 is not eligible for separate reimbursement when it is reported with a preventive diagnosis and/or a preventive service.

Reimbursement for CPT Code 99050 will be \$25.00

~~The department shall reimburse a flat rate of seventy-two (72) dollars per office visit for an office visit beginning after 5:00pm Monday through Friday or beginning after 12:00pm on Saturday through the remainder of the weekend.~~

- (18) Deep sedation of general anesthesia relating to oral surgery performed by an oral surgeon shall have a fixed rate of \$150.
- (19) For an evaluation and management service with a corresponding CPT of 99214 or 99215 exceeding the limit outlined in Att. 3.1-A p. 7.2.1 & Att. 3.1-B p. 21, DMS will reimburse any such claim as a CPT code 99213 evaluation and management visit.
- (20) The evaluation and management services with a corresponding CPT of 99201-99205 and 99211-99215 will be reimbursed at eighty-seven and one half (87.5) percent of Medicare Fee Schedule in effect as of January 1, 2006.

- 
- (16) Physicians, who are not enrolled in the VFC Program, will be reimbursed for the administration of immunizations, to include the influenza vaccine, as well as the vaccine cost, as defined in the Center for Disease Control (CDC) Vaccine Price List published as of January 1, 2014 to a Medicaid recipient of any age.
- (17) After Hours Services - CPT 99050 is reported when services are provided in the office at times other than regularly scheduled office hours or days when the office is normally closed. DMS refers to this time as "After Hours," and defines "After Hours" as services rendered between 5:00 p.m. and 8:00 a.m. on weekdays, and anytime on weekends and holidays when the office is usually closed. For example – if normal office hours are scheduled from 9:00 – 5:00 and service is provided at 7:00, the provider would bill CPT 99050. However, if normal office hours are scheduled from 9:00 am – 7:00 pm and the service is performed at 6:00, the provider would NOT bill for CPT code 99050.

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

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Governor

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**Audrey Tayse Haynes**  
Secretary

**Lawrence Kissner**  
Commissioner

December 19, 2014

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 14-009 - Enhanced Wellness Reimbursement

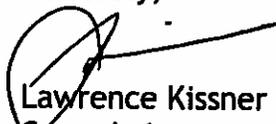
Dear Ms. Glaze:

Attached please find Kentucky State Plan Amendment 14-009. The purpose of this SPA is to extend, in part, some of the enhanced Primary Care Services that were enacted as a result of the Affordable Care Act (ACA). Kentucky has selected specific wellness services that we believe would enhance the health of our recipients and would like to incentivize our providers to perform these services. We have listed a Federal Fiscal Impact since this is a new benefit. However, this could also qualify as a cost savings since this program is replacing the current enhanced Primary Care Payment that ACA implemented.

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:  
14-008

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  
January 1, 2015

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:

7. FEDERAL BUDGET IMPACT:  
a. FFY 2015      \$4,609,000  
b. FFY 2016      \$4,609,000

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Att. 4.19-B, Page 20.5(2) – Att. 4.19-B, Page 20.5(15)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION  
OR ATTACHMENT (If Applicable):  
Att. 4.19-B, Page 20.5(2) – 20.5(6) – Same  
Att. 4.19-B, Page 20.5(7) – 20.5(15) - New

10. SUBJECT OF AMENDMENT:

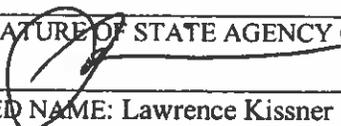
The purpose of this SPA is to clarify after hours reimbursement for physicians.

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: 12/19/14

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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**Physician Services - Wellness Incentive**

**Method of Payment**

- The state has adjusted its fee schedule to make payment at the higher rate for each CPT Code the State has included in the Enhanced Wellness Fee Schedule.
- The state reimburses a supplemental amount equal to the difference between the Medicaid rate in effect on July 1, 2009 and the minimum payment required at 42 CFR 447.405.

Supplemental payment is made:  monthly  quarterly  semi-annually  annually

**Primary Care Services Affected by this Payment Methodology**

- This payment applies to all billing codes listed below. Multiple services performed on the same day by the same provider will be processed using Modifier 1 and Modifier 2. Multiple "bonus" payments may be paid for same day/same provider up to the Medicare Allowed Amount for the CPT Code listed. The State has included quantity limits that apply to the number of bonus payments a provider will receive per year for each CPT code listed.
- The State did not make payment as of July 1, 2009 for the following codes and will not make payment for those codes under this SPA (specify codes).

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TN #: 14-009  
Supersedes  
TN #: 13-003

Approval Date: \_\_\_\_\_

Effective Date: January 1, 2015

**Physician Services - Wellness Incentive (cont.)**

**Primary Care Services Affected by this Payment Methodology**

Modifier Descriptions	
33/U5 identifies vaccine administration	33/UA identifies well child visits first 15 months of life
33/U7 identifies screenings	33/UB identifies BMI/Weight Counseling
33/U8 identifies after hours	33/UD identifies controlling BP

Bonus Fee CPT Code	Modifier 1	Modifier 2	Medicare Rate	Medicaid P40 P41	Add-On	Modified Rate	Modified Rate Medicare	Rate Description	Quantity Limits
83655	33	U7	\$0.00	\$17.13	\$16.00	\$33.13	\$33.13	Modified Rate	Once annually
99381	33	UA	\$103.36	\$78.58	\$16.00	\$94.58	\$94.58	Modified Rate	up to 6 from 1/1/15 through 6/30/16 in children < 15 months
99382	33	UA	\$107.92	\$89.90	\$16.00	\$105.90	\$105.90	Modified Rate	up to 6 from 1/1/15 through 6/30/16 in children < 15 months
99391	33	UA	\$93.12	\$67.57	\$16.00	\$83.57	\$83.57	Modified Rate	up to 6 from 1/1/15 through 6/30/16 in children < 15 months
99392	33	UA	\$99.61	\$78.58	\$16.00	\$94.58	\$94.58	Modified Rate	up to 6 from 1/1/15 through 6/30/16 in children < 15 months

TN #: 14-009  
Supersedes  
TN #: 13-003

Approval Date: \_\_\_\_\_

Effective Date: January 1, 2015

**Physician Services - Wellness Incentive (cont.)**

Bonus Fee CPT Code	Modifier 1	Modifier 2	Medicare Rate	Medicaid P-10 P-11	Add-On	Modified Rate	Modified Rate Medicare	Rate Description	Quantity Limits
99461	33	UA	\$91.40	\$75.36	\$16.00	\$91.36	\$91.36	Modified Rate	up to 6 from 1/1/15 through 6/30/16 in children < 15 months
99201	33	UA	\$39.86	\$29.66	\$16.00	\$45.66	\$39.86	Medicare Rate	up to 6 from 1/1/15 through 6/30/16 in children < 15 months
99202	33	UA	\$68.99	\$53.00	\$16.00	\$69.00	\$68.99	Medicare Rate	up to 6 from 1/1/15 through 6/30/16 in children < 15 months
99203	33	UA	\$100.39	\$79.04	\$16.00	\$95.04	\$95.04	Modified Rate	up to 6 from 1/1/15 through 6/30/16 in children < 15 months
99204	33	UA	\$155.31	\$112.27	\$16.00	\$128.27	\$128.27	Modified Rate	up to 6 from 1/1/15 through 6/30/16 in children < 15 months

TN #: 14-009  
Supersedes  
TN #: 13-003

Approval Date: \_\_\_\_\_

Effective Date: January 1, 2015

**Physician Services - Wellness Incentive (cont.)**

Bonus Fee CPT Code	Modifier 1	Modifier 2	Medicare Rate	Medicaid P40/ P41	Add-On	Modified Rate	Modified Rate Medicare	Rate Description	Quantity Limits
99205	33	UA	\$194.18	\$143.29	\$16.00	\$159.29	\$159.29	Modified Rate	up to 6 from 1/1/15 through 6/30/16 in children < 15 months
99211	33	UA	\$18.28	\$16.98	\$16.00	\$32.98	\$18.28	Medicare Rate	up to 6 from 1/1/15 through 6/30/16 in children < 15 months
99214	33	UA	\$100.55	\$67.10	\$16.00	\$83.10	\$83.10	Modified Rate	up to 6 from 1/1/15 through 6/30/16 in children < 15 months
99215	33	UA	\$135.11	\$98.39	\$16.00	\$114.39	\$114.39	Modified Rate	up to 6 from 1/1/15 through 6/30/16 in children < 15 months
77055	33	U7	\$81.75	\$56.43	\$17.00	\$73.43	\$73.43	Modified Rate	Once annually
77056	33	U7	\$104.99	\$70.46	\$17.00	\$87.46	\$87.46	Modified Rate	Once annually
77057	33	U7	\$75.19	\$58.97	\$17.00	\$75.97	\$75.19	Medicare Rate	Once annually
G0202	33	U7	\$120.80	\$91.56	\$17.00	\$108.56	\$108.56	Modified Rate	Once annually
G0204	33	U7	\$147.47	\$99.65	\$17.00	\$116.65	\$116.65	Modified Rate	Once annually
G0206	33	U7	\$116.11	\$80.34	\$17.00	\$97.34	\$97.34	Modified Rate	Once annually
88141	33	U7	\$29.62	\$18.02	\$13.00	\$31.02	\$29.62	Medicare Rate	Once annually
88142	33	U7	\$0.00	\$27.64	\$13.00	\$40.64	\$40.64	Modified Rate	Once annually

TN #: 14-009  
Supersedes  
TN #: 13-003

Approval Date: \_\_\_\_\_

Effective Date: January 1, 2015

**Physician Services - Wellness Incentive (cont.)**

Bonus Fee CPT Code	Modifier 1	Modifier 2	Medicare Rate	Medicaid P40/ P41	Add- On	Modified Rate	Modified Rate/Medicare	Rate Description	Quantity Limits
88143	33	U7	\$0.00	\$27.64	\$13.00	\$40.64	\$40.64	Modified Rate	Once annually
88147	33	U7	\$0.00	\$14.42	\$13.00	\$27.42	\$27.42	Modified Rate	Once annually
88148	33	U7	\$0.00	\$14.42	\$13.00	\$27.42	\$27.42	Modified Rate	Once annually
88150	33	U7	\$0.00	\$14.42	\$13.00	\$27.42	\$27.42	Modified Rate	Once annually
88160	33	U7	\$58.45	\$36.56	\$13.00	\$49.56	\$49.56	Modified Rate	Once annually
88161	33	U7	\$53.45	\$36.81	\$13.00	\$49.81	\$49.81	Modified Rate	Once annually
88162	33	U7	\$87.37	\$45.06	\$13.00	\$58.06	\$58.06	Modified Rate	Once annually
G0123	33	U7	\$0.00	\$27.64	\$13.00	\$40.64	\$40.64	Modified Rate	Once annually
G0144	33	U7	\$0.00	\$29.15	\$13.00	\$42.15	\$42.15	Modified Rate	Once annually
G0145	33	U7	\$0.00	\$35.04	\$13.00	\$48.04	\$48.04	Modified Rate	Once annually
P3000	33	U7	\$0.00	\$14.42	\$13.00	\$27.42	\$27.42	Modified Rate	Once annually
Q0091	33	U7	\$40.64	\$33.66	\$13.00	\$46.66	\$40.64	Medicare Rate	Once annually
90655	33	U5	\$0.00	\$17.24	\$10.00	\$27.24	\$27.24	Modified Rate	Once annually
90656	33	U5	\$0.00	\$12.40	\$10.00	\$22.40	\$22.40	Modified Rate	Once annually
90657	33	U5	\$0.00	\$6.02	\$10.00	\$16.02	\$16.02	Modified Rate	Once annually
90658	33	U5	\$0.00	\$14.35	\$10.00	\$24.35	\$24.35	Modified Rate	Once annually
90660	33	U5	\$0.00	\$21.70	\$10.00	\$31.70	\$31.70	Modified Rate	Once annually
90661	33	U5	\$0.00	\$20.66	\$10.00	\$30.66	\$30.66	Modified Rate	Once annually

TN #: 14-009  
Supersedes  
TN #: 13-003

Approval Date: \_\_\_\_\_

Effective Date: January 1, 2015

**Physician Services - Wellness Incentive (cont.)**

Bonus Fee CPT Code	Modifier 1	Modifier 2	Medicare Rate	Medicaid P40 P41	Add-On	Modified Rate	Modified Rate Medicare	Rate Description	Quantity Limits
90662	33	U5	\$0.00	\$31.82	\$10.00	\$41.82	\$41.82	Modified Rate	Once annually
90672	33	U5	\$0.00	\$24.60	\$10.00	\$34.60	\$34.60	Modified Rate	Once annually
90649	33	U5	\$0.00	\$141.38	\$10.00	\$151.38	\$151.38	Modified Rate	Up to 3 annually
90650	33	U5	\$0.00	\$128.75	\$10.00	\$138.75	\$138.75	Modified Rate	Up to 3 annually
44388	33	U7	\$322.86	\$191.73	\$15.00	\$206.73	\$206.73	Modified Rate	Once annually
44389	33	U7	\$362.87	\$210.07	\$15.00	\$225.07	\$225.07	Modified Rate	Once annually
44391	33	U7	\$457.41	\$280.73	\$15.00	\$295.73	\$295.73	Modified Rate	Once annually
44392	33	U7	\$404.58	\$267.50	\$15.00	\$282.50	\$282.50	Modified Rate	Once annually
44394	33	U7	\$457.15	\$285.40	\$15.00	\$300.40	\$300.40	Modified Rate	Once annually
45330	33	U7	\$124.52	\$64.08	\$15.00	\$79.08	\$79.08	Modified Rate	Once annually
45331	33	U7	\$148.99	\$83.80	\$15.00	\$98.80	\$98.80	Modified Rate	Once annually
45332	33	U7	\$265.56	\$108.61	\$15.00	\$123.61	\$123.61	Modified Rate	Once annually
45341	33	U7	\$150.29	\$148.42	\$15.00	\$163.42	\$150.29	Medicare Rate	Once annually
45342	33	U7	\$228.98	\$171.39	\$15.00	\$186.39	\$186.39	Modified Rate	Once annually
45345	33	U7	\$167.48	\$142.59	\$15.00	\$157.59	\$157.59	Modified Rate	Once annually
45355	33	U7	\$198.12	\$137.10	\$15.00	\$152.10	\$152.10	Modified Rate	Once annually
45378	33	U7	\$359.50	\$228.82	\$15.00	\$243.82	\$243.82	Modified Rate	Once annually
45379	33	U7	\$461.67	\$292.40	\$15.00	\$307.40	\$307.40	Modified Rate	Once annually

TN #: 14-009  
Supersedes  
TN #: New

Approval Date: \_\_\_\_\_

Effective Date: January 1, 2015

**Physician Services - Wellness Incentive (cont.)**

Bonus Fee CPT Code	Modifier 1	Modifier 2	Medicare Rate	Medicaid P40/ P41	Add-On	Modified Rate	Modified Rate Medicare	Rate Description	Quantity Limits
45380	33	U7	\$428.21	\$255.86	\$15.00	\$270.86	\$270.86	Modified Rate	Once annually
45381	33	U7	\$428.82	\$284.36	\$15.00	\$299.36	\$299.36	Modified Rate	Once annually
45382	33	U7	\$556.15	\$335.55	\$15.00	\$350.55	\$350.55	Modified Rate	Once annually
45383	33	U7	\$522.37	\$343.18	\$15.00	\$358.18	\$358.18	Modified Rate	Once annually
45386	33	U7	\$607.98	\$530.14	\$15.00	\$545.14	\$545.14	Modified Rate	Once annually
45387	33	U7	\$332.42	\$232.95	\$15.00	\$247.95	\$247.95	Modified Rate	Once annually
45391	33	U7	\$283.59	\$212.17	\$15.00	\$227.17	\$227.17	Modified Rate	Once annually
45392	33	U7	\$364.54	\$268.20	\$15.00	\$283.20	\$283.20	Modified Rate	Once annually
82270	33	U7	\$0.00	\$4.44	\$15.00	\$19.44	\$19.44	Modified Rate	Once annually
82274	33	U7	\$0.00	\$21.70	\$15.00	\$36.70	\$36.70	Modified Rate	Once annually
G0105	33	U7	\$359.50	\$255.86	\$15.00	\$270.86	\$270.86	Modified Rate	Once annually
G0121	33	U7	\$359.50	\$297.76	\$15.00	\$312.76	\$312.76	Modified Rate	Once annually
G0328	33	U7	\$0.00	\$21.70	\$15.00	\$36.70	\$36.70	Modified Rate	Once annually
94010	33	U7	\$32.26	\$24.44	\$12.00	\$36.44	\$32.26	Medicare Rate	Once annually
94014	33	U7	\$47.92	\$12.62	\$12.00	\$24.62	\$24.62	Modified Rate	Once annually
94016	33	U7	\$24.53	\$4.89	\$12.00	\$16.89	\$16.89	Modified Rate	Once annually
94060	33	U7	\$54.27	\$45.35	\$12.00	\$57.35	\$54.27	Medicare Rate	Once annually
94375	33	U7	\$35.71	\$28.04	\$12.00	\$40.04	\$35.71	Medicare Rate	Once annually

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Effective Date: January 1, 2015

**Physician Services - Wellness Incentive (cont.)**

Bonus Fee CPT Code	Modifier 1	Modifier 2	Medicare Rate	Medicaid P40 P41	Add-On	Modified Rate	Modified Rate Medicare	Rate Description	Quantity Limits
99201	33	UB	\$39.86	\$29.66	\$10.00	\$39.66	\$39.66	Modified Rate	1 each (Counseling for Nutrition and Counseling for physical activity) per yr
99202	33	UB	\$68.99	\$53.00	\$10.00	\$63.00	\$63.00	Modified Rate	1 each (Counseling for Nutrition and Counseling for physical activity) per yr
99203	33	UB	\$100.39	\$79.04	\$10.00	\$89.04	\$89.04	Modified Rate	1 each (Counseling for Nutrition and Counseling for physical activity) per yr
99204	33	UB	\$155.31	\$112.27	\$10.00	\$122.27	\$122.27	Modified Rate	1 each (Counseling for Nutrition and Counseling for physical activity) per yr

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TN #: New

Approval Date: \_\_\_\_\_

Effective Date: January 1, 2015

**Physician Services - Wellness Incentive (cont.)**

Bonus Fee CPT Code	Modifier 1	Modifier 2	Medicare Rate	Medicaid P40/P41	Add-On	Modified Rate	Modified Rate Medicare	Rate Description	Quantity Limits
99211	33	UB	\$18.28	\$16.98	\$10.00	\$26.98	\$18.28	Medicare Rate	1 each (Counseling for Nutrition and Counseling for physical activity) per yr
99212	33	UB	\$40.17	\$31.08	\$10.00	\$41.08	\$40.17	Medicare Rate	1 each (Counseling for Nutrition and Counseling for physical activity) per yr
99214	33	UB	\$100.55	\$67.10	\$10.00	\$77.10	\$77.10	Modified Rate	1 each (Counseling for Nutrition and Counseling for physical activity) per yr
99215	33	UB	\$135.11	\$98.39	\$10.00	\$108.39	\$108.39	Modified Rate	1 each (Counseling for Nutrition and Counseling for physical activity) per yr

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TN #: New

Approval Date: \_\_\_\_\_

Effective Date: January 1, 2015

**Physician Services - Wellness Incentive (cont.)**

Bonus Fee CPT Code	Modifier 1	Modifier 2	Medicare Rate	Medicaid P40 P41	Add-On	Modified Rate	Modified Rate Medicare	Rate Description	Quantity Limits
99382	33	UB	\$107.92	\$89.90	\$10.00	\$99.90	\$99.90	Modified Rate	1 each (Counseling for Nutrition and Counseling for physical activity) per yr
99383	33	UB	\$112.71	\$89.90	\$10.00	\$99.90	\$99.90	Modified Rate	1 each (Counseling for Nutrition and Counseling for physical activity) per yr
99384	33	UB	\$127.76	\$101.22	\$10.00	\$111.22	\$111.22	Modified Rate	1 each (Counseling for Nutrition and Counseling for physical activity) per yr
99385	33	UB	\$123.96	\$95.21	\$10.00	\$105.21	\$105.21	Modified Rate	1 each (Counseling for Nutrition and Counseling for physical activity) per yr

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Effective Date: January 1, 2015

**Physician Services - Wellness Incentive (cont.)**

Bonus Fee CPT Code	Modifier 1	Modifier 2	Medicare Rate	Medicaid P40 P41	Add-On	Modified Rate	Modified Rate Medicare	Rate Description	Quantity Limits
99386	33	UB	\$143.58	\$116.70	\$10.00	\$126.70	\$126.70	Modified Rate	1 each (Counseling for Nutrition and Counseling for physical activity) per yr
99387	33	UB	\$155.84	\$127.40	\$10.00	\$137.40	\$137.40	Modified Rate	1 each (Counseling for Nutrition and Counseling for physical activity) per yr
99392	33	UB	\$99.61	\$78.58	\$10.00	\$88.58	\$88.58	Modified Rate	1 each (Counseling for Nutrition and Counseling for physical activity) per yr
99393	33	UB	\$99.30	\$78.58	\$10.00	\$88.58	\$88.58	Modified Rate	1 each (Counseling for Nutrition and Counseling for physical activity) per yr

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Effective Date: January 1, 2015

**Physician Services - Wellness Incentive (cont.)**

Bonus Fee CPT Code	Modifier 1	Modifier 2	Medicare Rate	Medicaid P40 P41	Add-On	Modified Rate	Modified Rate Medicare	Rate Description	Quantity Limits
99394	33	UB	\$108.97	\$89.90	\$10.00	\$99.90	\$99.90	Modified Rate	1 each (Counseling for Nutrition and Counseling for physical activity) per yr
99395	33	UB	\$111.38	\$84.80	\$10.00	\$94.80	\$94.80	Modified Rate	1 each (Counseling for Nutrition and Counseling for physical activity) per yr
99396	33	UB	\$118.91	\$100.83	\$10.00	\$110.83	\$110.83	Modified Rate	1 each (Counseling for Nutrition and Counseling for physical activity) per yr
99397	33	UB	\$127.76	\$106.26	\$10.00	\$116.26	\$116.26	Modified Rate	1 each (Counseling for Nutrition and Counseling for physical activity) per yr
99201	33	UD	\$39.86	\$29.66	\$16.00	\$45.66	\$39.86	Medicare Rate	Once annually

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Effective Date: January 1, 2015

**Physician Services - Wellness Incentive (cont.)**

Bonus Fee CPT Code	Modifier 1	Modifier 2	Medicare Rate	Medicaid P40 P41	Add-On	Modified Rate	Modified Rate Medicare	Rate Description	Quantity Limits
99202	33	UD	\$68.99	\$53.00	\$16.00	\$69.00	\$68.99	Medicare Rate	Once annually
99203	33	UD	\$100.39	\$79.04	\$16.00	\$95.04	\$95.04	Modified Rate	Once annually
99204	33	UD	\$155.31	\$112.27	\$16.00	\$128.27	\$128.27	Modified Rate	Once annually
99205	33	UD	\$194.18	\$143.29	\$16.00	\$159.29	\$159.29	Modified Rate	Once annually
99211	33	UD	\$18.28	\$16.98	\$16.00	\$32.98	\$18.28	Medicare Rate	Once annually
99212	33	UD	\$40.17	\$31.08	\$16.00	\$47.08	\$40.17	Medicare Rate	Once annually
99213	33	UD	\$67.93	\$42.63	\$16.00	\$58.63	\$58.63	Modified Rate	Once annually
99214	33	UD	\$100.55	\$67.10	\$16.00	\$83.10	\$83.10	Modified Rate	Once annually
99215	33	UD	\$135.11	\$98.39	\$16.00	\$114.39	\$114.39	Modified Rate	Once annually
99241	33	UD	\$45.48	\$36.55	\$16.00	\$52.55	\$45.48	Medicare Rate	Once annually
99242	33	UD	\$85.97	\$67.83	\$16.00	\$83.83	\$83.83	Modified Rate	Once annually
99243	33	UD	\$117.67	\$90.43	\$16.00	\$106.43	\$106.43	Modified Rate	Once annually
99245	33	UD	\$214.66	\$166.18	\$16.00	\$182.18	\$182.18	Modified Rate	Once annually
99386	33	UD	\$143.58	\$116.70	\$16.00	\$132.70	\$132.70	Modified Rate	Once annually
99387	33	UD	\$155.84	\$127.40	\$16.00	\$143.40	\$143.40	Modified Rate	Once annually
99394	33	UD	\$108.97	\$89.90	\$16.00	\$105.90	\$105.90	Modified Rate	Once annually
99395	33	UD	\$111.38	\$84.80	\$16.00	\$100.80	\$100.80	Modified Rate	Once annually
99396	33	UD	\$118.91	\$100.83	\$16.00	\$116.83	\$116.83	Modified Rate	Once annually
99397	33	UD	\$127.76	\$106.26	\$16.00	\$122.26	\$122.26	Modified Rate	Once annually

TN #: 14-009  
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TN #: New

Approval Date: \_\_\_\_\_

Effective Date: January 1, 2015

**Physician Services - Wellness Incentive (cont.)**

**Effective Date of Payment**

E & M Services

This reimbursement methodology applies to services delivered on and after January 1, 2015, ending on June 30, 2016. All rates are published at <http://chfs.ky.gov/dms/fee.htm>.

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TN #: 14-009  
Supersedes  
TN #: New

Approval Date: \_\_\_\_\_

Effective Date: January 1, 2015



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

**Steven L. Beshear**  
Governor

275 East Main Street, 6W-A  
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**Audrey Tayse Haynes**  
Secretary

**Lawrence Kissner**  
Commissioner

**December 19, 2014**

**Jackie Glaze**  
Associate Regional Administrator  
Division of Medicaid & Children's Health Operations  
61 Forsyth Street, SW, Suite 4T20  
Atlanta, Georgia 30303-8909

**RE: Kentucky Report on DSH Verifications**

**Dear Ms. Glaze:**

Attached please find the Kentucky Report on Disproportionate Share Hospital Verifications for DSH Year 2011. The report includes the Independent Accountant's Report. We look forward to your review and comment.

If you have additional questions please contact Neville Wise of my staff.

Sincerely,

A handwritten signature in blue ink, appearing to read "Lawrence Kissner".

**Lawrence Kissner**  
Commissioner

Enclosure

**Report on Disproportionate Share Hospital Verifications  
(With Independent Accountant's Report Thereon)**

**State of Kentucky  
Kentucky Department for Medicaid Services  
275 East Main Street  
Frankfort, Kentucky 40621**

**DSH Year Ended June 30, 2011**

**Prepared by:**



**MYERS AND  
STAUFFER** LLC  
CERTIFIED PUBLIC ACCOUNTANTS

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## Table of Contents

■ I. Independent Accountant's Report .....	1
■ II. Report on DSH Verifications.....	2
■ III. Report on DSH Verifications (table).....	4
■ IV. Schedule of Data Caveats Relating to the DSH Verifications.....	6
■ V. Schedule of Annual Reporting Requirements.....	10
■ VI. Independence Declaration.....	12

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**Independent Accountant's Report,  
Report on DSH Verifications,  
and  
Schedule of Data Caveats Relating to the DSH Verifications**

COPY



**MYERS AND  
STAUFFER** LC  
CERTIFIED PUBLIC ACCOUNTANTS

Kentucky Department for Medicaid Services  
275 East Main Street  
Frankfort, KY 40621

Independent Accountant's Report

We have examined the state of Kentucky's compliance with Disproportionate Share Hospitals (DSH) payment requirements listed in the Report on DSH Verifications as required by 42 CFR §455.301 and §455.304(d) for the year ending June 30, 2011. The state of Kentucky is responsible for compliance with federal Medicaid DSH program requirements. Our responsibility is to express an opinion on the state of Kentucky's compliance with federal Medicaid DSH program requirements based on our examination.

Except as discussed in the Schedule of Data Caveats Relating to the DSH Verifications, we conducted our examination in accordance with attestation standards established by the American Institute of Certified Public Accountants, and General DSH Audit and Report Protocol as required by 42 CFR §455.301 and §455.304(d). Based on these standards, our examination included examining, on a test basis, evidence about the state of Kentucky's compliance with those requirements and performing such other procedures we considered necessary in the circumstances. We believe that our examination provides a reasonable basis for our opinion. Our examination does not provide a legal determination of the state of Kentucky's compliance with federal Medicaid DSH requirements.

Our examination was conducted for the purpose of forming an opinion on the state of Kentucky's compliance with federal Medicaid DSH program requirements included in the Report on DSH Verifications. The Schedule of Annual Reporting Requirements provided in accordance with 42 CFR §447.299 is presented for purposes of additional analysis and is not a required part of the Report on DSH Verifications. Such information has not been subjected to the procedures applied in the examination of the Report on DSH Verifications, and, accordingly, we express no opinion on it.

In our opinion, except for the effect of the items addressed in the Schedule of Data Caveats Relating to the DSH Verifications, the Report on DSH Verifications presents fairly the state of Kentucky's compliance with federal Medicaid DSH program requirements addressed by the DSH verifications for the year ending June 30, 2011.

*Myers and Stauffer LC*

Myers and Stauffer LC

December 4, 2014

**COPY**

State of Kentucky Disproportionate Share Hospital (DSH)

Report on DSH Verifications

For the Year Ended June 30, 2011

As required by 42 CFR §455.304(d) the state of Kentucky must provide an annual independent certified examination report verifying the following items with respect to its disproportionate share hospital (DSH) program.

**Verification 1:** Each hospital that qualifies for a DSH payment in the State was allowed to retain that payment so that the payment is available to offset its uncompensated care costs for furnishing inpatient hospital and outpatient hospital services during the Medicaid State plan rate year to Medicaid eligible individuals and individuals with no source of third party coverage for the services in order to reflect the total amount of claimed DSH expenditures.

**Findings:** The results of testing performed related to this verification are summarized in the Report on DSH Verifications (table) included with this report.

**Verification 2:** The DSH payments made in the Medicaid State plan rate year must be measured against the actual uncompensated care cost in that same Medicaid State plan rate year. The actual uncompensated care costs for the Medicaid State plan rate year have been calculated and compared to the DSH payments made. Uncompensated care costs for the Medicaid State plan rate year were calculated in accordance with Federal Register/Vol. 73, No. 245, December 19, 2008 and Federal Register/Vol. 79, No. 232, December 3, 2014.

**Findings:** The results of testing performed related to this verification are summarized in the Report on DSH Verifications (table) included with this report.

**Verification 3:** Only uncompensated care costs of furnishing inpatient and outpatient hospital services to Medicaid eligible individuals and individuals with no third party coverage for the inpatient and outpatient hospital services they received as described in Section 1923(g)(1)(A) of the Act are eligible for inclusion in the calculation of the hospital-specific disproportionate share limit payment limit, as described in Section 1923 (g)(1)(A) of the Act.

**Findings:** The total uncompensated care costs reflected in the Report on DSH Verifications (table) reflects the uncompensated care costs of furnishing inpatient and outpatient hospital services to Medicaid eligible individuals and individuals with no third party coverage.

State of Kentucky Disproportionate Share Hospital (DSH)

Report on DSH Verifications

For the Year Ended June 30, 2011

**Verification 4:** For purposes of this hospital-specific limit calculation, any Medicaid payments (including regular Medicaid fee-for-service rate payments, supplemental/enhanced Medicaid payments, and Medicaid managed care organization payments) made to a disproportionate share hospital for furnishing inpatient hospital and outpatient hospital services to Medicaid eligible individuals, which are in excess of the Medicaid incurred costs of such services, are applied against the uncompensated care costs of furnishing inpatient hospital and outpatient hospital services to individuals with no source of third party coverage for such services.

**Findings:** In calculating the hospital-specific DSH limit represented in the Report on DSH Verifications (table), if a hospital had total Medicaid payments in excess of the calculated Medicaid cost, the excess was used to reduce the total uncompensated care costs.

**Verification 5:** Any information and records of all of its inpatient and outpatient hospital service costs under the Medicaid program; claimed expenditures under the Medicaid program; uninsured inpatient and outpatient hospital service costs in determining payment adjustments under this Section; and any payments made on behalf of the uninsured from payment adjustments under this Section have been separately documented and retained by the State.

**Findings:** The state of Kentucky has retained documentation of costs and payments associated with calculating the hospital-specific DSH limits contained in this report. The state retains cost data through the collection of cost reports; Medicaid expenditure data through the MMIS and other documentation; and uninsured data through the DSH payment calculations and DSH examination. In addition, the state of Kentucky has represented that they will retain the documented cost and payments associated with calculating the hospital specific DSH limits contained in this report.

**Verification 6:** The information specified in verification 5 above includes a description of the methodology for calculating each hospital's payment limit under Section 1923(g)(1) of the Act. Included in the description of the methodology, the audit report must specify how the State defines incurred inpatient hospital and outpatient hospital costs for furnishing inpatient hospital and outpatient hospital services to Medicaid eligible individuals and individuals with no source of third party coverage for the inpatient hospital and outpatient services they received.

**Findings:** The documentation retained related to the calculation of the hospital-specific DSH limits contained in this report includes a description of the methodology used to calculate each hospital's DSH limit under Section 1923(g)(1) of the Act. For DSH payment purposes, the state defines the hospitals' payment limits in accordance with its state plan. For purposes of this examination, the state defines the hospitals' payment limits in accordance with 42 CFR §455.304.

State of Kentucky  
Report on DSH Verifications (table)  
For the Medicaid State Plan Rate Year Ended June 30, 2011

Hospital	Verification #1		Verification #2		Verification #3		Verification #4		Verification #5		Verification #6	
	Was Hospital Allowed to Receive DSH Payments?	DSH Payment for Medicaid State Plan Rate Year (In-State and Out-of-State)	Total Uncompensated Care Costs for Medicaid State Plan Rate Year	DSH Payment Under or <Over> Total Uncompensated Care Costs (LUCY)	Were only IP and OP Hospital Costs to Medical Eligible and Uninsured Included in LUCY?	If Medicaid Payments were in excess of Medical cost was the Total LUCY reduced by this amount?	Have all claimed expenditures for Medicaid and Uninsured been documented and retained?	Does the retained documentation include a description of the methodology used to calculate the LUCY?				
Baptist Hospital East	Yes	465,490	2,416,179	7,916,689	Yes	Yes	Yes	Yes				
Baptist Hospital Heartland	Yes	120,228	2,608,026	2,487,208	Yes	Yes	Yes	Yes				
Baptist Regional Medical Center	Yes	3,900,193	11,619,813	7,715,617	Yes	Yes	Yes	Yes				
Baptist Community Hospital	Yes	150,822	853,712	733,890	Yes	Yes	Yes	Yes				
Baptist Community Hospital	Yes	318,837	993,645	674,808	Yes	Yes	Yes	Yes				
Breckinridge Memorial Hospital, Inc.	Yes	196,438	487,379	298,941	Yes	Yes	Yes	Yes				
Calhoun County Hospital, Inc.	Yes	117,852	923,393	805,541	Yes	Yes	Yes	Yes				
Cardinal Hill Rubob Hospital	Yes	1,668,114	494,998	334,184	Yes	Yes	Yes	Yes				
Cardinal Hill Specialty Hospital	Yes	132,229	(826,258)	(132,229)	Yes	Yes	Yes	Yes				
Carroll County Memorial Hospital	Yes	212,291	200,292	(16,998)	Yes	Yes	Yes	Yes				
Clay County Hospital	Yes	439,225	1,269,702	930,477	Yes	Yes	Yes	Yes				
Covington Memorial Hospital	Yes	116,851	951,145	834,294	Yes	Yes	Yes	Yes				
Central Baptist Hospital	Yes	1,234,590	13,052,932	11,818,342	Yes	Yes	Yes	Yes				
Clark State Hospital	Yes	12,224,208	15,715,163	3,490,955	Yes	Yes	Yes	Yes				
Clark Regional Medical Center	Yes	1,249,094	3,102,205	1,853,111	Yes	Yes	Yes	Yes				
Clinton County Hospital	Yes	210,390	859,488	649,098	Yes	Yes	Yes	Yes				
Crossroads County Hospital, Inc.	Yes	198,900	415,641	216,743	Yes	Yes	Yes	Yes				
Cumberland County Hospital	Yes	271,993	815,222	543,229	Yes	Yes	Yes	Yes				
Eastern State Hospital	Yes	10,236,307	17,053,206	6,816,999	Yes	Yes	Yes	Yes				
Eastern McDowell Regional Medical Center	Yes	2,053,099	7,542,327	5,489,228	Yes	Yes	Yes	Yes				
Flagler Memorial Hospital	Yes	1,168,911	2,399,394	1,230,483	Yes	Yes	Yes	Yes				
Fleming County Hospital	Yes	427,464	1,723,304	1,295,840	Yes	Yes	Yes	Yes				
Fort Logan Hospital	Yes	594,855	2,310,622	1,715,767	Yes	Yes	Yes	Yes				
Frankfort Regional Medical Center	Yes	549,475	1,187,597	638,122	Yes	Yes	Yes	Yes				
Georgetown Community Hospital	Yes	287,392	3,997,077	3,709,685	Yes	Yes	Yes	Yes				
Georgetown Regional Hospital	Yes	844,751	3,154,148	2,309,397	Yes	Yes	Yes	Yes				
Harbin Memorial Hospital	Yes	3,511,262	6,263,597	2,752,335	Yes	Yes	Yes	Yes				
Harbor AHH	Yes	2,652,800	499,373	2,153,427	Yes	Yes	Yes	Yes				
Harrison Memorial Hospital	Yes	567,843	2,243,402	1,675,559	Yes	Yes	Yes	Yes				
Hazard AHH	Yes	4,240,091	3,005,637	1,234,454	Yes	Yes	Yes	Yes				
Highlands Regional Medical Center	Yes	1,505,158	4,070,867	2,565,709	Yes	Yes	Yes	Yes				
Jackson Purchase Medical Center	Yes	636,603	1,344,592	707,989	Yes	Yes	Yes	Yes				
James B. Hoggins Memorial Hospital	Yes	236,559	1,072,402	845,843	Yes	Yes	Yes	Yes				
John Todd Crawford Memorial Hospital	Yes	441,660	1,134,317	712,654	Yes	Yes	Yes	Yes				
Jones Stuart Medical Center	Yes	637,346	5,706,786	5,069,440	Yes	Yes	Yes	Yes				
Jewish Hospital Shelbyville	Yes	421,359	1,344,773	923,414	Yes	Yes	Yes	Yes				
Kentucky River Medical Center	Yes	3,338,278	29,167,808	25,829,530	Yes	Yes	Yes	Yes				
King's Daughters Medical Center	Yes	371,923	2,109,366	1,737,443	Yes	Yes	Yes	Yes				
Logan County Hospital	Yes	2,265,678	23,114,877	20,849,199	Yes	Yes	Yes	Yes				
Lake Cumberland Regional Hospital	Yes	647,732	976,143	308,411	Yes	Yes	Yes	Yes				
Lincoln Trail Behavioral Health System	Yes	2,195,263	3,642,176	1,446,913	Yes	Yes	Yes	Yes				
Livingston Hospital & Healthcare Services	Yes	183,574	549,392	365,818	Yes	Yes	Yes	Yes				
Logan Memorial Hospital	Yes	209,556	184,081	(25,475)	Yes	Yes	Yes	Yes				
Louisville Hospital	Yes	233,600	1,128,765	895,165	Yes	Yes	Yes	Yes				
Marion & Wilkes Memorial Hospital	Yes	1,055,653	10,159,280	9,103,627	Yes	Yes	Yes	Yes				
Marshall County Hospital	Yes	591,640	1,572,202	980,562	Yes	Yes	Yes	Yes				
Mary Breckinridge Hospital	Yes	278,210	764,773	486,543	Yes	Yes	Yes	Yes				
McDowell AHH	Yes	585,942	817,261	231,319	Yes	Yes	Yes	Yes				
McDowell Regional Medical Center	Yes	533,890	776,916	243,026	Yes	Yes	Yes	Yes				
Memorial Hospital, Inc.	Yes	385,501	1,802,779	1,422,278	Yes	Yes	Yes	Yes				
Methodist Hospital	Yes	737,775	2,228,113	1,490,333	Yes	Yes	Yes	Yes				
Methodist Hospital Union County	Yes	1,231,427	5,575,144	4,343,717	Yes	Yes	Yes	Yes				
Methodist AHH	Yes	221,495	651,187	434,692	Yes	Yes	Yes	Yes				
Mid-America AHH	Yes	558,915	2,054,492	1,495,577	Yes	Yes	Yes	Yes				
Monroe County Medical Center	Yes	324,481	(1,485)	(1,513)	Yes	Yes	Yes	Yes				

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State of Kentucky  
Report on DSH Verifications (table)  
For the Medicaid State Plan Rate Year Traded June 30, 2011

Hospital	Verification #1		Verification #2		Verification #3		Verification #4		Verification #5		Verification #6	
	Was Hospital Allowed to Receive DSH Payments?	DSH Payment for Medicaid State Plan Rate Year (In-State and Out-of-State)	Total Uncompensated Care Costs for Medicaid State Plan Rate Year	DSH Payment Under "Over-Total Uncompensated Care Costs (UCC)"	Were only IP and OP Hospital Costs to Medicaid eligible and Uncompensated Care included in UCC?	If Medicaid Payments were in excess of Medicaid cost was the Total UCC returned to the account?	Have all claimed expenses and payments for Medicaid and Uncompensated Care documented and returned?	Does the returned documentation include a statement of the methodology used to calculate the UCC?				
Morgan County ARH	Yes	425,281	321,200	(104,081)	Yes	Yes	Yes	Yes				
Murray Community Hospital	Yes	275,975	1,637,100	1,361,605	Yes	Yes	Yes	Yes				
New Horizons Medical Center	Yes	91,411	55,797	3,989,032	Yes	Yes	Yes	Yes				
Norton Hospital, Inc.	Yes	106,987	519,447	(15,614)	Yes	Yes	Yes	Yes				
Ohio County Hospital	Yes	4,044,554	30,042,001	36,597,447	Yes	Yes	Yes	Yes				
Owensboro Medical Health System	Yes	741,356	5,306,822	4,565,466	Yes	Yes	Yes	Yes				
Parkland Regional Hospital	Yes	1,790,593	21,681,449	19,893,856	Yes	Yes	Yes	Yes				
Platts A. Clay Hospital	Yes	1,232,572	1,250,807	1,139,335	Yes	Yes	Yes	Yes				
Presbyterian Medical Center	Yes	1,264,743	3,611,229	4,338,697	Yes	Yes	Yes	Yes				
Princeton Community Hospital	Yes	2,856,340	3,862,795	2,658,032	Yes	Yes	Yes	Yes				
Randolph Medical Center	Yes	533,669	2,827,903	3,735,809	Yes	Yes	Yes	Yes				
Regional Medical Center	Yes	827,232	2,025,842	2,794,234	Yes	Yes	Yes	Yes				
River Valley Behavioral Health	Yes	112,413	(533,306)	(112,143)	Yes	Yes	Yes	Yes				
Riverside Community Hospital, Inc.	Yes	437,120	(408,236)	(250,338)	Yes	Yes	Yes	Yes				
Russell County Hospital	Yes	468,908	336,557	99,437	Yes	Yes	Yes	Yes				
Saint Joseph Breast Hospital	Yes	932,019	3,231,814	847,305	Yes	Yes	Yes	Yes				
Saint Joseph East	Yes	280,466	1,654,528	2,761,795	Yes	Yes	Yes	Yes				
Saint Joseph Hospital	Yes	996,943	2,747,044	4,308,287	Yes	Yes	Yes	Yes				
Saint Joseph London	Yes	2,155,846	13,668,133	13,512,289	Yes	Yes	Yes	Yes				
Saint Joseph Martin	Yes	1,311,200	2,741,977	1,429,897	Yes	Yes	Yes	Yes				
Saint Joseph Mount Sterling Hospital	Yes	708,666	3,195,268	2,494,202	Yes	Yes	Yes	Yes				
Spring View Hospital	Yes	274,608	(1,043,690)	(202,698)	Yes	Yes	Yes	Yes				
St. Clara Medical Center, Inc.	Yes	1,232,358	7,302,880	6,070,522	Yes	Yes	Yes	Yes				
St. Elizabeth Florence	Yes	2,693,377	6,708,790	6,013,413	Yes	Yes	Yes	Yes				
St. Elizabeth Ft. Thomas	Yes	2,378,929	7,281,048	5,502,074	Yes	Yes	Yes	Yes				
St. Elizabeth Medical Center	Yes	6,630,091	29,611,571	23,981,480	Yes	Yes	Yes	Yes				
St. Elizabeth Medical Center - Grant County	Yes	799,291	1,970,321	1,171,020	Yes	Yes	Yes	Yes				
T. J. Samson Community Hospital	Yes	942,995	5,077,673	4,084,678	Yes	Yes	Yes	Yes				
Taylor Regional Hospital	Yes	377,164	1,975,326	1,598,162	Yes	Yes	Yes	Yes				
The Break Hospital-DuPont	Yes	771,957	(26,933)	(771,957)	Yes	Yes	Yes	Yes				
The Break Hospital-KM	Yes	1,078,149	13,333	(1,014,816)	Yes	Yes	Yes	Yes				
The Medical Center	Yes	2,784,170	14,804,768	12,020,049	Yes	Yes	Yes	Yes				
The Medical Center of Franklin, Inc.	Yes	420,561	1,231,977	811,416	Yes	Yes	Yes	Yes				
The Medical Center at Scottsville	Yes	546,289	955,730	409,441	Yes	Yes	Yes	Yes				
Three Rivers Medical Center	Yes	724,329	3,328,917	2,604,318	Yes	Yes	Yes	Yes				
Town County Hospital	Yes	309,076	668,502	416,026	Yes	Yes	Yes	Yes				
Town Letcher Regional Medical Center	Yes	350,941	653,999	303,858	Yes	Yes	Yes	Yes				
University of Kentucky Hospital	Yes	75,300,737	75,041,483	49,660,746	Yes	Yes	Yes	Yes				
University of Louisville Hospital	Yes	50,247,204	61,155,097	10,907,893	Yes	Yes	Yes	Yes				
Wayne County Hospital, Inc.	Yes	292,300	882,232	589,929	Yes	Yes	Yes	Yes				
Western Baptist Hospital	Yes	906,007	14,281,782	13,345,295	Yes	Yes	Yes	Yes				
Western State Hospital	Yes	12,099,461	17,212,613	11,131,172	Yes	Yes	Yes	Yes				
Wendover Regional Hospital	Yes	784,313	801,640	21,327	Yes	Yes	Yes	Yes				
Whitesburg ARH	Yes	491,246	2,370,376	1,818,063	Yes	Yes	Yes	Yes				
Williamson ARH	Yes	239,466	3,781,875	3,662,609	Yes	Yes	Yes	Yes				

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State of Kentucky Disproportionate Share Hospital (DSH)  
Schedule of Data Caveats Relating to the DSH Verifications  
For the Year Ended June 30, 2011

During the course of the engagement, the following data issues or other caveats were identified and are being reported in accordance with the requirements of 42 CFR 455.301.

**(1) Uninsured Patient Payments**

The following hospitals were unable to satisfactorily document uninsured patient payments received during the DSH year. These hospitals could not provide the date of collection and/or reported the payments on an accrual basis instead of the required cash basis. These payment issues may result in a misstated uncompensated care cost calculation. These difficulties were most often related to the time period between the patient service dates and/or cash receipt dates (DSH year 2011) and the timing of the DSH examination (Calendar 2014) and not necessarily due to inaction or lack of cooperation by the hospitals listed.

Clinton County Hospital
Jewish Hospital, Inc.
Monroe County Medical Center

**(2) Undocumented Uninsured Uncompensated Care Cost**

The following hospitals were unable to satisfactorily document all of the services they provided to uninsured patients and, in most cases, the uninsured payments received during the DSH year. These undocumented services were excluded resulting in a potentially understated uncompensated care calculation. These difficulties were most often related to the time period between the patient service dates and/or cash receipt dates (DSH year 2011) and the timing of the DSH examination (Calendar 2014) and not necessarily due to inaction or lack of cooperation by the hospitals listed.

Carroll County Memorial Hospital
Clark Regional Medical Center
Livingston Hospital & Healthcare Services
New Horizons Medical Center

**(3) Partially Documented Uninsured Uncompensated Care Cost**

The following hospital was unable to satisfactorily document the services they provided to uninsured patients and the uninsured payments received during the DSH year. The hospital was able to estimate the uninsured services provided and payments received using hospital records; however, no detail data is available. Due to lack of detailed data, we were unable to fully test the reasonableness of the hospital's estimates and the impact of any potential misstatement on their uncompensated care cost calculations.

Westlake Regional Hospital
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State of Kentucky Disproportionate Share Hospital (DSH)  
Schedule of Data Caveats Relating to the DSH Verifications  
For the Year Ended June 30, 2011

- (4) **Dual Eligible (Patients with both Medicare and Medicaid)**  
Medicare payment data required for dual eligible patients (patients with both Medicare and Medicaid) and provided by the state's fiscal intermediary could not be validated to include all Medicare payments such as Medicare Graduate Medical Education. We were able to reasonably estimate the Medicare payments using the cost report to calculate the Medicare overall payment percentage. These estimates do not consider differences in case-mix or services provided to dual eligible patients compared to the hospital's entire Medicare patient population.
- (5) **Out-of-State (non-Kentucky) Medicaid**  
The majority of hospitals were unable to obtain Medicaid MMIS out-of-state paid claims reports to satisfactorily document the out of state services provided and payments received. Out-of-state (non-Kentucky) Medicaid services are included in the uncompensated care cost calculation for hospitals that were able to provide their own internal data or out of state paid claims reports. Several hospitals did not report any out of state Medicaid services.
- (6) **Court-Ordered Patients**  
In accordance with CMS guidance, prisoners and those meeting the definition of inmate were excluded from the uninsured category as presented in this report. However, the following state owned and operated psychiatric hospitals included court-ordered patients in the uninsured category, which may need to be excluded based on CMS guidance related to prisoners and other wards of the state. There remains a question as to whether patients should be considered uninsured when they have been involuntarily hospitalized under a 72-hour hold that has been court-ordered. Some of these individuals may have committed a crime, while others have no criminal activity associated with their 72-hour hold. Regardless, these individuals remain in the uninsured category in accordance with 42 CFR Section 435.1010 which exempts individuals from the definition of an inmate that are in a public institution for a temporary period pending other arrangements appropriate to their needs.

Central State Hospital
Eastern State Hospital
Western State Hospital

- (7) **Bankrupt / Closed Hospitals**  
The following hospitals have filed bankruptcy prior to issuance of this report. Additionally, Nicholas County hospital closed in May 2014.

Clinton County Hospital
Nicholas County Hospital
Westlake Regional Hospital

State of Kentucky Disproportionate Share Hospital (DSH)

Schedule of Data Caveats Relating to the DSH Verifications

For the Year Ended June 30, 2011

**(8) Hospital Health Care Taxes**

CMS indicated in the final DSH audit rule (Federal Register/Vol. 73, No. 245, December 19, 2008) that existing Medicaid policy recognizes permissible health care taxes as an allowable cost for the purposes of Medicaid reimbursement, and that a portion of the tax may also be apportioned to uninsured services. CMS also indicated in a letter to at least one state that the August 2010 Medicare clarifications related to health care related taxes did not impact existing Medicaid policy.

Due to the different treatment of the health care related taxes for Medicare and Medicaid purposes, adjustments were made, when needed, during the DSH examination, to properly include the full health care related tax expense as allowable costs for apportionment to Medicaid and uninsured services. The health care related tax expense initially excluded from the cost report was added to allowable cost for the DSH examination, on the basis of total cost in each hospital reimbursable cost center. The adjusted total allowable cost is then apportioned to Medicaid and uninsured using Medicare cost reporting mechanics. This allows for the Medicaid and uninsured share of the full health care related tax expense to be recognized in accordance with the final DSH audit rule (Federal Register/Vol. 73, No. 245, December 19, 2008).

**(9) Medicaid Cost Report Settlements**

Kentucky Medicaid calculates cost report settlements related to outpatient payments for acute care, critical access, rehab, and long term acute care hospital (LTACH) if applicable. As of the date of this report, the final outpatient cost report settlements overlapping the 2011 DSH year were not yet completed for all hospitals. For incomplete settlements, the state was able to provide preliminary settlement amounts for most providers based on estimates or other as-filed data. These estimated settlements have been included in the uncompensated care cost calculations. When completed in future years, the final cost report settlements may result in additional Medicaid payments or recoupments.

**(10) Children's Health Insurance Program**

The paid claims data provided by the Department for Medicaid Services (DMS), managed care organizations, and provider's submitted data, if applicable, may include individuals paid by CHIP. For SFY 2011, Title XXI CHIP data is not able to be separated from other Medicaid individuals.

**(11) Kentucky State DSH Plan**

Kentucky hospitals were not required to report uncompensated care cost (UCC) for DSH payment purposes in 2011 under the same requirements as required by the DSH examination in accordance with the Federal Register/Vol. 73, No. 245, dated December 19, 2008. The hospitals were paid DSH under a Centers for Medicare and Medicaid Services (CMS) approved state plan that did not include the same calculations for UCC as required under the DSH examination. The UCC may have been significantly higher had the hospitals been allowed to report them in accordance with the CMS approved Kentucky state plan for the DSH examination year 2011.

**State of Kentucky Disproportionate Share Hospital (DSH)**

**Schedule of Data Caveats Relating to the DSH Verifications**

**For the Year Ended June 30, 2011**

**(12) Hospital Lawsuits**

It has come to our attention that there are False Claims Act violation allegations against Saint Joseph Hospital London and certain physicians they employ. The hospital and physicians have been accused in lawsuits of submitting bills to Medicare and Medicaid programs for unnecessary heart procedures from January 2008 through August 2011. As reported at the Department of Justice website [www.justice.gov](http://www.justice.gov), an estimated \$16.5 million dollars is the agreed upon amount to settle the lawsuit. We do not have specific claim information related to this lawsuit.

## **Schedule of Annual Reporting Requirements**

**COPY**





**Independence Declaration**

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**MYERS AND  
STAUFFER** LC  
CERTIFIED PUBLIC ACCOUNTANTS

**To Whom it May Concern:**

**Myers and Stauffer declares it is independent of the state of Kentucky and its DSH hospitals for the state plan rate year June 30, 2011.**

*Myers and Stauffer LC*

**Myers and Stauffer LC**

**December 4, 2014**

**COPY**

**DEDICATED TO GOVERNMENT HEALTH PROGRAMS**

104 Progress Drive | Frankfort, KY 40601  
PH 502.695.6870 | PH 888.749.5799 | FX 502.695.3068  
www.mslc.com



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

**Steven L. Beshear**  
Governor

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

**Audrey Tayse Haynes**  
Secretary

**Lawrence Kissner**  
Commissioner

December 30, 2014

DHHS/CMS  
Atlanta Regional Office  
Attn: Jackie Glaze, Associate Regional Administrator  
61 Forsyth Street, Suite 4T20  
Atlanta, GA 30303 8909

**RE: Kentucky's Medicaid Management Information system (MMIS) Implementation Advanced Planning Document Update (IAPDU) #14**

The Department for Medicaid Services (DMS) within the Kentucky Cabinet for Health and Family Services (CHFS) is requesting review and approval of the attached Implementation Advanced Planning Update #14 (IAPDU) for the Commonwealth's Medicaid Management Information System (MMIS). This IAPDU supersedes the Kentucky MMIS Implementation Advanced Planning Document Update #14 dated December 19, 2014.

This IAPDU requests funding necessary for executing a new four-year contract for operating the KY MMIS. The four-year contract proposed in this IAPDU represents a cost-saving alternative to a six-month extension of a prior contract with the current MMIS vendor. Specifically, DMS is requesting:

- \$115,764,438 for KY MMIS projects at 75% Federal match (\$86,823,330 Federal share and \$28,941,108 Commonwealth share). Of this request, \$100,704,052 represents funding (\$75,528,039 Federal Share and \$25,176,013 Commonwealth share) for the new KY MMIS agreement and SOW for KY MMIS hardware/software refresh;
- \$893,083 for MMIS at 90% Federal match (\$803,775 Federal Share and \$89,308 in Commonwealth share);
- Request \$136,000 for MMIS at 50% Federal match (\$68,000 Federal share and \$68,000 Commonwealth share).

The total cost of this is \$116,793,521 (\$87,695,105 Federal share and \$29,098,416 Commonwealth share).

Please contact John Hoffman at (502) 564-6479 ext. 2077 if you have any questions.

Sincerely,

Neville Wise,  
Deputy Commissioner





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

**Steven L. Beshear**  
Governor

275 East Main Street, 6E-A  
P: (502) 564-5472  
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Frankfort, KY 40621  
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**Audrey Tayse Haynes**  
Secretary

**Lawrence Kissner**  
Commissioner

December 31, 2014

Department for Health and Human Services  
Centers for Medicare & Medicaid Services  
Office of Financial Management  
Provider Compliance Group  
Division of Error Rate Measurement  
7500 Security Boulevard, Mail Stop C3-09-27  
Baltimore, Maryland 21244-1850

Dear Federal Health Official:

This correspondence accompanies Kentucky's Medicaid and CHIP Round 1 eligibility review pilot results.

Testing for this pilot was conducted in the UAT environment of the Kentucky Health Benefit Exchange system.

The following is a list of test cases selected for each scenario:

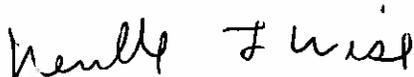
- a. Mixed Household, individuals eligible for different categories – TC20025, TC20058, TC80015
- b. Non-citizens eligible for emergency services only – TC10009, TC20004, TC20007
- c. Nuclear family, eligible – TC20615, TC80015, TC80034
- d. Ineligible individual, Over-income, Medicaid and CHIP – TC20210, TC80034, TC80036
- e. Ineligible individual, non-financial factors – TC20025, TC20058, TC20204
- f. Applicant, reasonable opportunity period – TC700008, TC80036, TC80038
- g. Adult 19-64 – TC20007, TC70008, TC80038

Department for Health and Human Services  
Centers for Medicare & Medicaid Services  
December 31, 2014  
Page 2

We determined all eligibility results correctly, but had several variances in countable income. It is our understanding that CMS did not expect us to round the income. In reference to the results spreadsheet, Columns G-S are the State results, T-AF are the CMS expected results, AG-AS shows whether we matched the CMS expected results, AT-BF are the reasons we did not match the CMS expected results and the State explanations and comments are in Column BG.

"I certify that this information is accurate and that the State will maintain the results reported in the reporting template for a minimum of three years from this date. I understand that this information may be subject to Federal review and that our reported results are subject to Federal audit."

Sincerely,

A handwritten signature in black ink that reads "Neville Wise". The signature is written in a cursive style.

Neville Wise, Deputy Commissioner  
The Department for Medicaid Services

NW/JM/er  
Attachment