

MAC Binder Section 1 – Letters From CMS

Table of Contents with Document Summary - Jan. 2016

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

1 – CMS-AVP Ltr to LL from JG re Medicaid Asset Verification Program_dte110215:

Requires States to implement an AVP to verify the assets of aged, blind or disabled applicants and for recipients of Medicaid Section 1940.

2 – CMS-All Payer Claims-Ltr to LL from JG re Amendment to Phase 1 approved_dte111715:

Amendment extends the period of performance for the contract through December 31, 2015. Phase 2 will be address in a separate procurement.

3 – CMS- 1915(c)-Ltr to LL from JG re Home & Community Based Waiver_dte112315:

Waiver provides services to residents who are 18 or older and have acquired brain injury, and meet the level of care for placement in a nursing home.

4 – CMS-RIDP-Ltr to LL from JG re Remote Identify Proofing Serices_dte111715:

CMS approves master agreement between CHFS and Lexis-Nexis Risk Solutions FL Inc. This contract will allow the Commonwealth to implement an enterprise-wide Software as a Service (SaaS) solution that will facilitate remote verification of providers and beneficiary using RIDP.

5 – CMS-SOW -Ltr to LL from JG re Approves Statement of Work_dte121115:

CMS approves the SOW submitted 10-15-15 to enhance Medicaid Waiver Management Application case management system needed to align system functionality with in the HCBS waiver regulations as well as the redesign program.

6 – CMS-NEMT 1915(b)-Ltr to LL from AMD re Extension Approved_dte120215:

CMS grants the temporary extension of KY's Non-Emergency Medical Transportation (NEMT) until March 31, 2016.

7 – CMS-PBM-Ltr to LL from JG re Pharmacy Benefits Manager_dte121615:

CMS approves KY request to exercise the first option year of the PBM contract with Magellan and the associated annual APD-U through December 31, 2016.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Atlanta Regional Office
61 Forsyth St., Suite 4T20
Atlanta, Georgia 30303-8909



DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

November 2, 2015

Ms. Lisa D. Lee
Commissioner
Commonwealth of Kentucky
Cabinet for Health and Family Services
Department of Medicaid Services
275 East Main Street, 6 W-A
Frankfort, KY 40621



Dear Ms. Lee:

The Centers for Medicare and Medicaid Services is reviewing the implementation of the Medicaid Asset Verification Program (AVP) requirements enacted under the Supplemental Appropriations Act of 2008 (P.L. 110-252). As you know, Section 7001(d) of that Act created a new section 1940 of the Social Security Act (the Act), which requires States to implement an AVP to verify the assets of aged, blind or disabled applicants for and recipients of Medicaid. Section 1940 also directed the Secretary to design an implementation schedule that would result in specific percentage goals outlined in the statute being met for the fiscal years (FY) 2009 – 2013.

We understand that many states have not yet fully implemented their AVP, as resources have been directed to the establishment of new eligibility systems to meet the requirements of the Affordable Care Act (ACA). However, as states are now beginning to transition eligibility determination for their non-MAGI Medicaid populations to their new or enhanced systems, they will need to integrate asset verification into that process. We need to ensure that states are working toward full implementation of an AVP.

Kentucky has an approved state plan which includes authority to implement an AVP. Please provide a detailed description of your progress to date, and the current status of your AVP. Include a discussion of any problems or obstacles that have impeded or prevented your implementation of an AVP and steps taken to overcome them. Finally, if the state has not fully implemented its AVP, include a work plan and timeline for full implementation. The description of the State's progress toward implementation of an AVP and detailed work plan are due to CMS no later than December 31, 2015.

Ms. Lisa D. Lee
Page 2

As we have stated previously in a number of forums, the statute does not provide any authority under which we can waive or otherwise delay the requirement in section 1940 of the Act that States implement an AVP. However, the statute does allow us to offer some flexibility with regard to implementation via the process for determining whether States are in compliance with the AVP requirements. Provided a State has made and continues to make a good faith effort to comply with the AVP requirements, the deadline by which a State is expected to have implemented its AVP may be extended.

We look forward to reviewing each State's updates and to providing you with technical assistance to help you move toward full AVP implementation. If you have any questions, please contact me or Judith Cash, Director, Division of Eligibility and Enrollment, at 410-786-4473 or Judith.Cash@cms.hhs.gov.

Sincerely,

A handwritten signature in cursive script that reads "Gina Roberts for".

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

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Atlanta Regional Office
61 Forsyth Street, Suite 4T20
Atlanta, Georgia 30303

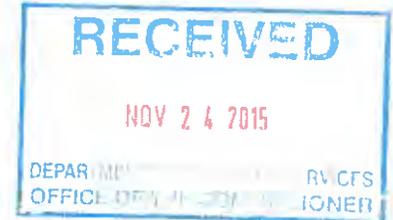


DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

November 17, 2015

KY-16-001

Ms. Lisa Lee, Commissioner
Department for Medicaid Services
275 East Main Street, 6W-A
Frankfort, KY 40621-0001



Dear Ms. Lee:

The Centers for Medicare & Medicaid Services (CMS) approves the amendment to the contract for Phase 1 of the Kentucky All Payer Claims Database project. The parties to this contract are the Cabinet for Health and Family Services/Department for Medicaid Services (CHFS/DMS), the Cabinet for Health and Family Services/Kentucky Office of Health Benefit and Health Information Exchange (CHFS/KOHBHIE), and the University of Kentucky Research Foundation. The amendment extends the period of performance for the contract through December 31, 2015.

The Cabinet for Health and Family Services contracted with the University of Kentucky Health Foundation for planning and analysis of an All Payer Claims Database (APCD) that will integrate medical claims, eligibility files, provider files, and clinical information from private and public payers. Once implemented, the APCD will facilitate analysis of healthcare utilization and quality of care delivered in the commonwealth, leading to the development of quality measures across payers and overall improvements in the population health of Kentucky.

The APCD project consists of two phases, but only Phase 1 (planning and analysis of APCD infrastructure) is included in the current contract. Phase 2 (APCD implementation) will be addressed in another procurement. Via the contract amendment, Kentucky requests to extend the contract term by three months, from September 30, 2015, through December 31, 2015, to allow for additional research related to the technical feasibility of the system, and more in-depth planning for Phase 2 activities.

The amendment to the APCD project contract is approved by CMS effective on the date of this letter, in accordance with Section 1903(a)(3) of the Social Security Act, 42 CFR § 433, subpart C, 45 CFR § 95, subpart F, and the State Medicaid Manual, Part 11. Contract costs attributable to CHFS/DMS are addressed in the budget of the Implementation Advance Planning Document-Update (IAPD-U) that CMS approved on December 29, 2014, for Kentucky's Medicaid Enterprise Management System (MEMS) project. Cost allocation with other entities accruing benefit from this project is still required.

Ms. Lisa Lee,

Page 2

The original contract was approved by CMS on April 8, 2015. The total value of the contract remains \$416,795. Kentucky is requesting no additional funding for the contract at this time.

Onsite reviews may be conducted to assure that the intentions for which federal financial participation (FFP) was approved are being accomplished. Specifically, the objective is to validate that automated data processing (ADP) equipment or services are being efficiently and effectively utilized to support the approved programs or projects as provided under 45 CFR § 95.621 and the State Medicaid Manual. As provided by the State Medicaid Manual Section 11200 and by 45 CFR § 95.611, all subsequent revisions and amendments to the separately approved IAPD-U will require CMS prior written approval to qualify for FFP.

In accordance with 45 CFR § 95.623, state acquisition of ADP equipment and services without prior approval could result in disallowance of FFP. Only actual costs incurred are reimbursable. The state must provide adequate support for all costs claimed in addition to providing detailed records and proper audit trails.

As described in regulation at 45 CFR § 95.611 and the State Medicaid Manual Section 11200, other contracts supported by funding from the approved IAPD-U must be approved by CMS prior to execution of the contracts. Failure to comply with prior approval requirements may result in either ineligibility for the enhanced federal match or disallowance for those activities.

If there are any questions concerning this information, please contact John Allison at (828) 513-1323 or via e-mail at John.Allison@cms.hhs.gov.

Sincerely,

A handwritten signature in blue ink that reads "Jackie Glaze for". The signature is written in a cursive, flowing style.

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

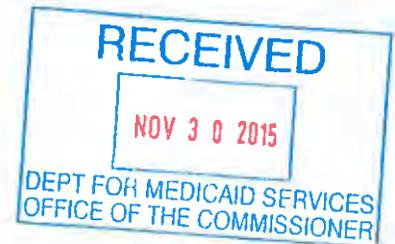
DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Atlanta Regional Office
61 Forsyth Street, Suite 4T20
Atlanta, Georgia 30303



DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

November 23, 2015

Ms. Lisa Lee, Commissioner
Cabinet for Health and Family Services
Department for Medicaid Services
275 E. Main Street, 6WA
Frankfort, KY 40621



Dear Ms. Lee:

Your request to amend Kentucky's Acquired Brain Injury Home and Community-Based Waiver, as authorized under provisions of section 1915(c) of the Social Security Act, has been approved. This amendment has been assigned control number KY 0333.R03.01, which should be used in future correspondence.

This amendment request was submitted on September 30, 2015, and was approved on November 23, 2015. The amendment is effective November 1, 2015. This amendment lifts the reserve from slots previously reserved for Money Follows the Person, and adds additional slots in waiver years 4 and 5.

This waiver provides services to Kentucky residents who are 18 years and older and have an acquired brain injury, and meet the level of care for placement in a nursing facility. The waiver provides the following supports: adult day training, case management, respite, supported employment, behavioral services, counseling, group counseling, occupational therapy, specialized medical equipment, speech therapy, community guide, financial management services, goods and services, assessment/reassessment, community living supports, environmental and minor home modifications, supervised residential care levels 1-3.

The following estimates of utilization and cost of waiver services have been approved:

	Unduplicated Recipients	Community Costs	Institutional Costs	Total Waiver Costs
Year 4 (1/1/15 – 12/31/15)	383	\$62,082.22	\$178,249.29	\$23,777,491.63
Year 5 (1/1/16 – 12/31/16)	383	\$103,975.21	\$148,050.33	\$39,822,506.77

Ms. Lisa Lee
Page 2

We sincerely appreciate the dedicated effort and cooperation provided by your staff during our review of this request. If you have any questions, please feel free to contact Melanie Benning at (404) 562-7414.

Sincerely,



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

cc: Amanda Hill, CMS Central Office

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Atlanta Regional Office
61 Forsyth Street, Suite 4120
Atlanta, Georgia 30303



DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS CENTERS FOR MEDICARE & MEDICAID SERVICES

November 17, 2015

KY-15-018

Ms. Lisa Lee, Commissioner
Department for Medicaid Services
275 East Main Street, 6W-A
Frankfort, KY 40621-0001



Dear Ms. Lee:

The Centers for Medicare & Medicaid Services (CMS) approves the master agreement for Remote Identify Proofing Services (RIDP) between the Kentucky Cabinet for Health and Family Services (CHFS) and Lexis-Nexis Risk Solutions FL Inc. As an important component of Kentucky's Medicaid Enterprise Management System (MEMS) project, this contract will allow the commonwealth to implement an enterprise-wide Software as a Service (SaaS) solution that will facilitate remote verification of Kentucky Medicaid providers and beneficiaries using RIDP services that currently do not exist in the commonwealth's Medicaid IT enterprise. Kentucky plans to leverage this solution to support future MEMS applications as appropriate.

Services that Lexis-Nexis will provide under this contract include a beneficiary screening and risk scoring pilot. Lexis-Nexis will analyze the CHFS beneficiary file to compare against the contractor's public records solution and assess for critical indications of identity-driven fraud, waste and abuse, and overall beneficiary data integrity. Lexis-Nexis will deliver a statistical analysis assessing this information by way of two analyses: beneficiary risk scoring and beneficiary data integrity screening. Beneficiary call center services will also be provided under this contract.

Kentucky's master agreement with Lexis-Nexis for Remote Identity Proofing Services is approved by CMS effective on the date of this letter, in accordance with Section 1903(a)(3) of the Social Security Act, 42 CFR § 433, subpart C, 45 CFR § 95, subpart F, and the State Medicaid Manual, Part 11. Contract expenses for RIDP services fall within the budget of Kentucky's MEMS Implementation Advance Planning Document-Update (IAPD-U) that CMS approved on December 29, 2014.

The master agreement is a firm fixed unit price contract. The initial term of the contract will be for a period of two years from the effective date of award. At the completion of the initial contract period, Kentucky reserves the right to renew the master agreement for three additional one-year periods, but the commonwealth must obtain approval from CMS prior to exercising an option year. Additionally, funding for contract option years must be approved by CMS via the IAPD process prior to Kentucky exercising option years.

Ms. Lisa Lee,
Page 2

Onsite reviews may be conducted to assure that the intentions for which federal financial participation (FFP) was approved are being accomplished. Specifically, the objective is to validate that automated data processing (ADP) equipment or services are being efficiently and effectively utilized to support the approved programs or projects as provided under 45 CFR § 95.621 and the State Medicaid Manual. As provided by the State Medicaid Manual Section 11200 and by 45 CFR § 95.611, all subsequent revisions and amendments to the separately approved IAPD-U will require CMS prior written approval to qualify for FFP.

In accordance with 45 CFR § 95.623, state acquisition of ADP equipment and services without prior approval could result in disallowance of FFP. Only actual costs incurred are reimbursable. The state must provide adequate support for all costs claimed in addition to providing detailed records and proper audit trails.

As described in regulation at 45 CFR § 95.611 and the State Medicaid Manual Section 11200, other contracts supported by funding from the approved IAPD-U must be approved by CMS prior to execution of the contracts. Failure to comply with prior approval requirements may result in either ineligibility for the enhanced federal match or disallowance for those activities.

If there are any questions concerning this information, please contact John Allison at (828) 513-1323 or via e-mail at John.Allison@cms.hhs.gov.

Sincerely,



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

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Atlanta Regional Office
61 Forsyth Street, Suite 4T20
Atlanta, Georgia 30303

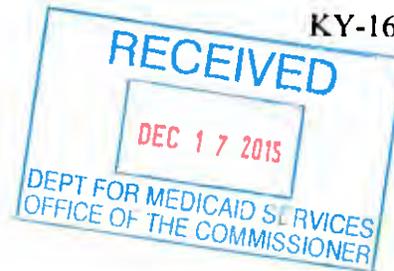


DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

December 11, 2015

KY-16-002

Ms. Lisa Lee, Commissioner
Department for Medicaid Services
275 East Main Street, 6W-A
Frankfort, KY 40621-0001



Dear Ms. Lee:

The Centers for Medicare & Medicaid Services (CMS) approves the Statement of Work (SOW) submitted by the Kentucky Cabinet for Health and Family Services (CHFS) on October 15, 2015. The SOW describes enhancements to the Commonwealth's Medicaid Waiver Management Application (MWMA) case management system needed to align system functionality with the CMS Home and Community-Based Services (HCBS) waiver regulations, as well as with Kentucky's Medicaid waiver redesign program.

The MWMA is designed to support common processes that are utilized by Kentucky's HCBS waiver programs, providing automated capabilities around the intake, assessment, eligibility determination, service plan, case management, timesheet, and reporting functions performed by waiver service providers. The first release of the MWMA took place in April 2015. Case managers, quality improvement organization staff, and other CHFS staff are the primary users of this release version, ensuring the appropriate beneficiaries are enrolled in HCBS waiver programs and are receiving the correct services.

The next release of the MWMA, which is addressed in the SOW, will add functionality to the Plan of Care module to support the person-centered service plan requirements outlined in the CMS HCBS waiver regulation. In accordance with Kentucky's redesign of the Medicaid waiver program, this release will include other enhancements to the Plan of Care module to control access to new services under the HCBS waiver program. Additional modifications required by Kentucky are addressed in the SOW, including functionality to the Level of Care module to capture additional data related to the Level of Care Assessment and Reassessment processes.

The SOW to modify MWMA system functionality is approved by CMS effective on the date of this letter, in accordance with Section 1903(a)(3) of the Social Security Act, 42 CFR Part 433, subpart C, 45 CFR Part 95, subpart F, and the State Medicaid Manual, Part 11. Contractor costs for activities described in the SOW are addressed in the budget of the Implementation Advance Planning Document-Update (IAPD-U) that CMS approved on December 29, 2014, for Kentucky's Medicaid Enterprise Management System (MEMS) project.

Ms. Lisa Lee,
Page 2

Deloitte Consulting LLP will perform the services identified in the SOW on a fixed-price basis. Costs for design, development, and implementation activities described in the SOW will amount to \$2,225,000.

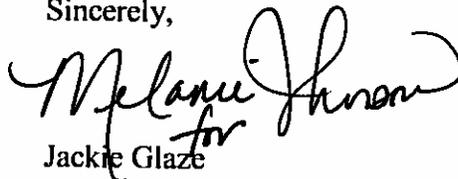
Onsite reviews may be conducted to assure that the intentions for which federal financial participation (FFP) was approved are being accomplished. Specifically, the objective is to validate that automated data processing (ADP) equipment or services are being efficiently and effectively utilized to support the approved programs or projects as provided under 45 CFR § 95.621 and the State Medicaid Manual. As provided by the State Medicaid Manual Section 11200 and by 45 CFR § 95.611, all subsequent revisions and amendments to the separately approved IAPD-U will require CMS prior written approval to qualify for FFP.

In accordance with 45 CFR § 95.623, acquisition of ADP equipment and services without prior approval could result in disallowance of FFP. Only actual costs incurred are reimbursable. The Commonwealth must provide adequate support for all costs claimed in addition to providing detailed records and proper audit trails.

As described in regulation at 45 CFR § 95.611 and the State Medicaid Manual Section 11200, other contracts supported by funding from the approved IAPD-U must be approved by CMS prior to execution of the contracts. Failure to comply with prior approval requirements may result in either ineligibility for the enhanced federal match or disallowance for those activities.

If there are any questions concerning this information, please contact John Allison at (828) 513-1323 or via e-mail at John.Allison@cms.hhs.gov.

Sincerely,

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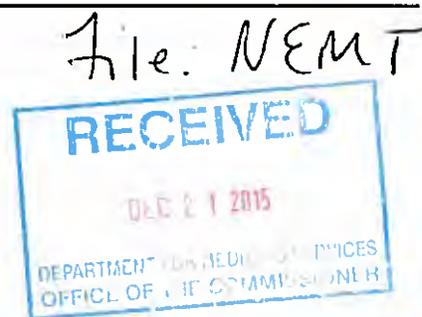
Jackie Glaze

Associate Regional Administrator

Division of Medicaid & Children's Health Operations

Disabled & Elderly Health Programs Group

DEC 16 2015



Lisa D. Lee, Commissioner
Cabinet for Health and Family Services
Department for Medicaid Services
275 East Main Street, 6W-A
Frankfort, KY 40621

Dear Ms. Lee:

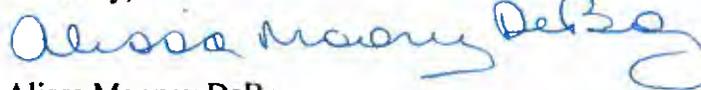
The Centers for Medicare & Medicaid Services (CMS) received your request, dated December 14, 2015, for a temporary extension of Kentucky's Non-Emergency Medical Transportation (NEMT) 1915(b) waiver program under CMS control number KY-06.R01. The current temporary waiver authority expires on December 31, 2015.

You have requested this extension to ensure CMS has adequate time to review the state's waiver renewal application submitted on November 3, 2015. The extension also provides additional time for the state to respond to CMS' informal request for additional information and submit revised cost effectiveness spreadsheets.

The CMS is granting an extension of the KY-06.R01 waiver to operate the NEMT program under section 1915(b) of the Social Security Act (the Act). This temporary extension will expire on March 31, 2016.

The CMS will continue to work with your staff during the extension period. If you have any questions, please contact Cheryl Brimage, in the Atlanta Regional Office, at (404)562-7116 or Lovie Davis, of my staff, at (410) 786-1533.

Sincerely,



Alissa Mooney DeBoy
Acting Director

cc: Cheryl Brimage, Atlanta Regional Office
Melanie Johnson, Atlanta Regional Office
Jackie Glaze, Atlanta Regional Office

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Atlanta Regional Office
61 Forsyth Street, Suite 4T20
Atlanta, Georgia 30303

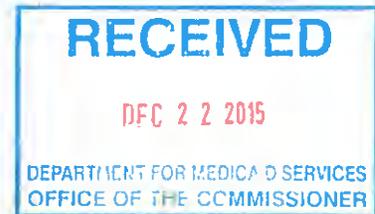


DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

December 16, 2015

KY-16-003

Ms. Lisa Lee, Commissioner
Department for Medicaid Services
275 East Main Street, 6W-A
Frankfort, KY 40621-0001



Dear Ms. Lee:

The Centers for Medicare & Medicaid Services (CMS) approves the request submitted by the Kentucky Cabinet for Health and Family Services (CHFS) to exercise the first option year of the Commonwealth's contract with Magellan Medicaid Administration, Inc., for Pharmacy Benefits Manager (PBM) system operations. Additionally, CMS approves Kentucky's annual Advance Planning Document-Update (APD-U) requesting approval of federal funding for PBM system operations through December 31, 2016. The Commonwealth submitted both of these actions to CMS on November 6, 2015.

On November 13, 2013, CMS issued a letter approving Kentucky's contract with Magellan for PBM system services. The initial term of the contract was for a period of two years, effective on January 1, 2014, with the option for renewal at the completion of the initial contract period for three additional one-year periods upon the mutual agreement of CHFS and Magellan. Kentucky submitted the annual APD-U and proposed contract extension in preparation to execute the first option year of the PBM system contract. The term of the option year is from January 1, 2016, through December 31, 2016.

In the annual APD-U, Kentucky requests new funding in the amount of \$3,666,024, with 75 percent federal financial participation (FFP) of \$2,749,518, for PBM system operations through December 31, 2016. Additionally, CHFS requests that \$2,398,103, with 75 percent FFP at \$1,798,577, be carried forward through the first quarter of FFY 2016 from the last annual APD-U approved by CMS on December 29, 2014.

Kentucky's request to exercise the first option year of the Commonwealth's PBM contract with Magellan and the associated annual APD-U are approved by CMS effective on the date of this letter, in accordance with Section 1903(a)(3) of the Social Security Act, 42 CFR Part 433, subpart C, 45 CFR Part 95, subpart F, and the State Medicaid Manual, Part 11. New funding approved under this APD-U totals \$3,666,024, with 75 percent FFP at \$2,749,518. Funding carried forward from the last APD-U amounts to \$2,398,103, with 75 percent FFP at \$1,798,577. Amounts recorded in Appendix A represent the sum of newly-approved funding and funding carried forward from the previous APD-U.

Ms. Lisa Lee,
Page 2

The amounts shown in Appendix A cannot be reallocated to other federal fiscal years, even within the period of this letter's approval, without the submission and approval of another APD-U. Funding authority under the APD-U will expire December 31, 2016. Before exercising additional options years under the PBM system contract with Magellan, Kentucky must request prior approval from CMS.

Onsite reviews may be conducted to assure that the intentions for which FFP was approved are being accomplished. Specifically, the objective is to validate that automated data processing (ADP) equipment or services are being efficiently and effectively utilized to support the approved programs or projects as provided under 45 CFR § 95.621 and the State Medicaid Manual. As provided by the State Medicaid Manual Section 11200 and by 45 CFR § 95.611, all subsequent revisions and amendments to the APD-U will require CMS prior written approval to qualify for FFP.

As described in regulation at 45 CFR § 95.611 and the State Medicaid Manual Section 11200, other contracts supported by funding from the approved APD-U must be approved by CMS prior to execution of the contract. Failure to comply with prior approval requirements may result in either ineligibility for the enhanced federal match or disallowance for those activities.

If there are any questions concerning this information, please contact John Allison at (828) 513-1323 or via e-mail at John.Allison@cms.hhs.gov.

Sincerely,



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

Enclosure

M&O	MMIS CMS Share (75% FFP)	State Share (25%)	MMIS CMS Share (75% FFP)	State Share (25%)	MMIS CMS Share (75% FFP)	State Share (25%)	MMIS ENHANCED FUNDING 75% FFP Total	State Share Total
	4A†	--	4B†	--				
FFY 2016	\$606,370	\$202,123	\$3,254,346	\$1,084,782			\$3,860,716	\$1,286,905
FFY 2017	\$151,592	\$50,531	\$535,787	\$178,596			\$687,379	\$229,126
TOTAL for FFYs 2016 - 2017	\$752,962	\$252,654	\$3,790,133	\$1,263,378			\$4,548,095	\$1,516,032

Total	MMIS CMS Share	State Share	MMIS CMS Share	State Share	MMIS CMS Share	State Share	TOTAL FFP	STATE SHARE TOTAL	APD TOTAL (TOTAL COMPUTABLE)
	2A&B†	--	4A&B†	--					
FFY 2016	\$0	\$0	\$3,860,716	\$1,286,905			\$3,860,716	\$1,286,905	\$5,147,621
FFY 2017	\$0	\$0	\$687,379	\$229,126			\$687,379	\$229,126	\$916,506
TOTAL for FFYs 2016 - 2017	\$0	\$0	\$4,548,095	\$1,516,032			\$4,548,095	\$1,516,032	\$6,064,127

†MBES Line Item

2A	MMIS- Design, Development or Installation of MMIS: Cost of In-house Activities
2B	MMIS- Design, Development or Installation of MMIS: Cost of Private Contractors
4A	Operation Approved MMIS – Cost of In-House Activities
4B	Operation Approved MMIS – Private Sector Contractors
5A	Mechanized Systems, Not Approved Under MMIS Procedures – Cost of In-House Activities
5B	Mechanized Systems, Not Approved Under MMIS Procedures – Cost of Private Sector Contractors
5C	Mechanized Systems: Not Approved Under MMIS Procedures- Interagency

FFP rates for specific MMIS activities and costs can be found at the State Medicaid Manual, Chapter 11, available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021927.html>

MAC Binder Section 1 – Letters From CMS

Table of Contents with Document Summary – March 2016

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

1-CMS-SPA-15-009-Ltr to VC from JG-012116:

CMS sent Technical Corrections to the Kentucky State Plan Amendment 15-009. Revised SPA pages were sent to reflect the technical error has been corrected.

2-CMS-ANIAPD MMIS-Ltr to VC from JG-01221:

CMS approves the request from CHFS to extend approval of your As-Needed Implementation Advance Planning Document (ANIPD) for the Medicaid Management Information System (MMIS).

3-CMS-SOW-IVV-Ltr to VC from JG-012216:

CMS approves the Statement of Work for Independent Verification and Validation (IV&V) services for the Provider Portal project of the MEMS program.

4-CMS-KSBM-Ltr to Gov MG from AS-012415:

CMS responded to letter on the intent to cease operations of Kentucky's State-Based Marketplace Kynect.

5-CMS-DME MAC-Ltr to VC from RV of CGS-012516

CMS awarded administration of the Jurisdiction B Durable Medical Equipment Medicare Administrative Contractor (DME MAC). The jurisdiction was previously contracted by National Government Services LLC.

6-CMS-CHIP-Ltr from AMD with DMS&ADA Agreement-012616

Letter to solicit participation in a license agreement between CMS, American Dental Association (ADA), and the American Medical Association (AMA)

7-CMS-NEMT-Ltr to VC from JG-012716:

CMS is requesting more information be provided for the KY-06.R002 (Non-Emergency Medical Transportation) renewal waiver application.

8-CMS-AIAPD MEMS-Ltr to VC from JG-012716:

CMS approves CHFS to extend the approval of the IAPD for the MMIS to September 30, 2016.

MAC Binder Section 1 – Letters From CMS

Table of Contents with Document Summary_March 2016

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

9-CMS-SPA 15-0008-Ltr to VC from JG-020116:

CMS has approved the SPA KY 15-0008 on February 1, 2016. This amendment revises the current reimbursement methodology for Intensive outpatient Therapy.

10-CMS-SPA 16-0001-Ltr to VC from JG-020116:

CMS has approved the SPA 16-001 on January 26, 2016. This amendment designates Veronica J Cecil, Acting Commissioner of the Department for Medicaid Services as Governors designee for review and approval of state plan amendments.

11-CMS-SPA 15-003-Ltr to VC from KF-021016-to SH:

CMS has approved SPA 15-003. Effective October 1, 2015 this amendments adds reserve bed and therapeutic leave days as a reimbursable services in psychiatrics residential treatment facilities (PRTF).

12-CMS-CHIP MEC-Ltr to SM from VW-021216:

Letter to inform the state whether certain types of Medicaid and CHIP coverage provided in Kentucky is recognized by CMS as minimum essential coverage (MEC).

13-CMS-SPA 16-0002-Ltr to SM from JG-021216-to SH:

CMS has approved the SPA 16-002 on February 9, 2016. This amendment designates Stephen P. Miller, Acting Commissioner of the Department for Medicaid Services as Governors designee for review and approval of state plan amendments.

14-CMS-IHS Tribal AI AN-Ltr to SM from VW-022616:

Letter to inform Medicaid Agencies and other state health officials about an update in payment policy affecting federal funding received by eligible members who are American Indians and Alaska Natives through facilities of the Indian Health Services(HIS) whether operated by HIS or Tribe.

15-CMS-HITECH-Ltr to SM from VW-022916:

Updates issued by CMS about the availability of federal funding at the 90 percent matching rate for state expenditures on activates to promote health information exchange (HIE) and encourage adoption of certified Electronic Health Records (EHR) technology by certain Medicaid providers.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Atlanta Regional Office
61 Forsyth Street, Suite 4T20
Atlanta, Georgia 30303



DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

January 21, 2016

Veronica J. Cecil, Acting Commissioner
Department for Medicaid Services
275 East Main Street, 6WA
Frankfort, KY 40621-0001



Re: Technical Correction to Kentucky State Plan Amendment 15-009

Dear Ms. Cecil:

This is a technical correction to Kentucky SPA 15-009. This SPA was approved on December 14, 2015. Enclosed please find the revised SPA page for KY SPA 15-009 that has been corrected to reflect the technical corrections.

If you have any questions, please contact Darlene Noonan at 404-562-2707 or Darlene.Noonan@cms.hhs.gov.

Sincerely,

A handwritten signature in black ink that reads "Jackie Glaze".

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

Enclosure

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

1. TRANSMITTAL NUMBER:
15-009

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, 2016

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 20.15(1)(a)

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

10. SUBJECT OF AMENDMENT:

The purpose of this SPA is to continue the current reimbursement that was to sunset on December 31, 2015 until July 1, 2016 for the Community Mental Health Centers.

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

GOVERNOR'S OFFICE REPORTED NO COMMENT
 COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
 NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

OTHER, AS SPECIFIED: Review delegated
to Commissioner, Department for Medicaid
Services

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME: Lisa D. Lee

14. TITLE: Commissioner, Department for Medicaid Services

15. DATE SUBMITTED: 12/2/15

16. RETURN TO:

Department for Medicaid Services
275 East Main Street 6W-A
Frankfort, Kentucky 40621

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 12-07-15

18. DATE APPROVED: 12-14-15

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
01-01-16

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: Jackie Glaze

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

23. REMARKS: Approved with the following changes to block # 7 as authorized by email dated 12-14-15:

Block # 7a changed to read: FFY 2016 Budget neutral
Block #7b changed to read: FFY 2017 Budget neutral

XVI. Other diagnostic, screening, preventive and rehabilitative services.

- v. A certified social worker, Master Level;
- vi. A marriage and family therapy associate;
- vii. A licensed assistant behavior analyst;
- viii. A physician assistant working under the supervision of a physician;
- ix. Peer Support Specialist working under the supervision of a physician, a psychiatrist, an APRN, a PA, a LP, a LPP, a LPA, a LCSW, a LMFT, a LPCC, a CSW, a LMFTA, a LPCA, a CADC, a Professional Equivalent, a psychiatric nurse, a LPAT, or a LPATA ;
- x. A certified alcohol and drug counselor (CADC) working under the supervision of a physician, a psychiatrist, an APRN, a PA, a LP, a LPP, a LPA, a LCSW, a LMFT, a LPCC, a CSW, a LMFTA, a LPCA, a LPAT, or a LPATA; and
- xi. A community support associate who is working under the supervision of a physician, a psychiatrist, an APRN, a PA, a LP, a LPP, a LPA, a LCSW, a LMFT, a LPCC, a CSW, a LMFTA, a LPCA, a CADC, a Professional Equivalent, a psychiatric nurse, a LPAT, a LPATA, a LBA, or a LABA.

The current reimbursement methodology, as outlined above, for services provided in CMHCs will end on June 30, 2016.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Atlanta Regional Office
61 Forsyth Street, Suite 4T20
Atlanta, Georgia 30303



DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

January 22, 2016

KY-16-004

Veronica Cecil, Acting Commissioner
Department for Medicaid Services
275 East Main Street, 6W-A
Frankfort, KY 40621-0001

Dear Ms. Cecil:

The Centers for Medicare & Medicaid Services (CMS) approves the request submitted by the Kentucky Cabinet for Health and Family Services (CHFS) to extend the approval of your As-Needed Implementation Advance Planning Document (ANIAPD) for the Medicaid Management Information System (MMIS) to September 30, 2016. CMS also approves new funding in the amount of \$4,370,512 (\$2,495,639 at 90 percent federal financial participation [FFP]; \$1,198,185 at 75 percent FFP; \$3,693,824 total federal share).

In the annual ANIAPD, Kentucky requested new funding in the amount of \$2,200,000 for data quality enhancement projects; \$572,932 of new funding and 5,654 project hours for an interface enhancement project between the KY MMIS, KY Health Benefits Exchange (HBE), and the State Data Hub (SDH); and \$1,597,580 of new funding and 15,763 additional modification hours needed to implement change orders to modify the KY MMIS resulting from the Medicaid expansion under the Affordable Care Act.

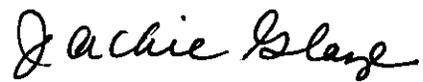
The ANIAPD is approved in accordance with Section 1903(a)(3) of the Social Security Act, 42 CFR Part 433, subpart C, 45 CFR Part 95, subpart F, and the State Medicaid Manual, Part 11. Onsite reviews may be conducted to assure that the intentions for which FFP was approved are being accomplished. Specifically, the objective is to validate that automated data processing (ADP) equipment or services are being efficiently and effectively utilized to support the approved programs or projects as provided under 45 CFR § 95.621 and the State Medicaid Manual. As provided by the State Medicaid Manual Section 11200 and by 45 CFR § 95.611, all subsequent revisions and amendments to the APD-U will require CMS prior written approval to qualify for FFP.

As described in regulation at 45 CFR § 95.611 and the State Medicaid Manual Section 11200, other contracts supported by funding from the approved ANIAPD must be approved by CMS prior to execution of the contract. Failure to comply with prior approval requirements may result in either ineligibility for the enhanced federal match or disallowance for those activities.

Ms. Veronica Cecil
Page 2

If there are any questions concerning this information, please contact L. David Hinson at (334) 791-7826 or via e-mail at lawrence.hinson@cms.hhs.gov.

Sincerely,

A handwritten signature in black ink that reads "Jackie Glaze". The signature is written in a cursive style with a large initial "J".

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

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Atlanta Regional Office
61 Forsyth Street, Suite 4T20
Atlanta, Georgia 30303

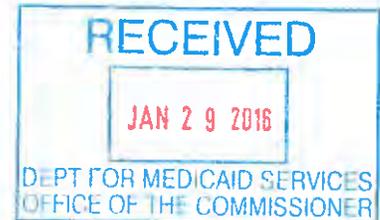


DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

January 22, 2016

KY-16-006

Veronica Cecil, Acting Commissioner
Department for Medicaid Services
275 East Main Street – 6WA
Frankfort, KY 40621-0001



Dear Ms. Cecil:

The Centers for Medicare & Medicaid Services (CMS) approves the Statement of Work (SOW) for Independent Verification and Validation (IV&V) services for the provider portal project of the Medicaid Enterprise Management System program. The State is reminded that the vendor must produce a project plan and periodic project assessment reports both to be provided directly to CMS via the Region IV corporate email address.

The SOW is approved in accordance with Section 1903(a)(3) of the Social Security Act, 42 CFR Part 433, subpart C, 45 CFR Part 95.626, and the State Medicaid Manual, Part 11. Onsite reviews may be conducted to assure that the intentions for which FFP was approved are being accomplished. Specifically, the objective is to validate that automated data processing (ADP) equipment or services are being efficiently and effectively utilized to support the approved programs or projects as provided under 45 CFR § 95.621 and the State Medicaid Manual. As provided by the State Medicaid Manual Section 11200 and by 45 CFR § 95.611, all subsequent revisions and amendments to the APD-U will require CMS prior written approval to qualify for FFP.

If there are any questions concerning this information, please contact L. David Hinson at (334) 791-7826 or via e-mail at lawrence.hinson@cms.hhs.gov.

Sincerely,

A handwritten signature in black ink that reads "Jackie Glaze".

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



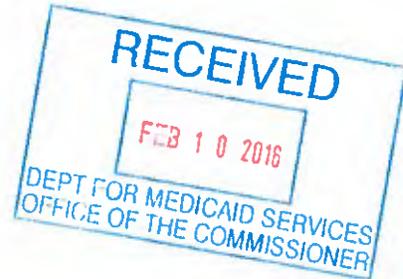
DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

 Administrator
 Washington, DC 20201

JAN 28 2016

The Honorable Matthew G. Bevin
 Governor of Kentucky
 700 Capitol Avenue, Suite 100
 Frankfort, KY 40601



Dear Governor Bevin:

We have received your letter stating your intention to cease operations of Kentucky's State-based Marketplace (SBM), Kynect.

We are strongly committed to working with the Commonwealth of Kentucky to ensure a smooth and efficient transition from an SBM to the Federally-facilitated Marketplace (FFM) for the individual and Small Business Health Options Program (SHOP) markets. Similar to instances in which other states have transitioned Marketplace functionality to the FFM, our guiding priority during any Marketplace transition is ensuring that consumers can easily access the coverage for which they are eligible, whether that is Medicaid, the Children's Health Insurance Program (CHIP) or a Marketplace Qualified Health Plan (QHP).

As you know, ceasing Kynect operations will create a number of challenges that must be addressed to ensure that access to affordable health coverage continues for Kentucky's consumers. In particular, Kentucky has been successful in fully integrating eligibility and enrollment within the Kynect system for Medicaid/CHIP and the Marketplace. As a result, Kentucky will need to undertake transition activities that are unique to the state, including decoupling and dismantling Marketplace eligibility and enrollment functionality in Kynect from those for Medicaid/CHIP. In light of these challenges, below I outline a set of activities that Kentucky will need to immediately take to ensure a smooth transition for its consumers.

In addition, your decision to transition from an SBM to the FFM means that the Centers for Medicare & Medicaid Services (CMS) must initiate grant award close out procedures with Kynect. Per Section 1311 of the Affordable Care Act, after January 1, 2015, 1311 grant funds can only be used for establishment activities and cannot be used to support ongoing operations. In addition, no 1311 funds can be used for information technology system costs that are associated with a transition to the FFM. Kynect has approximately \$57.5 million remaining of its total 1311 grant award of \$289.3 million. The closeout procedures will include a review of specific grant wind down activities that can be funded consistent with federal grant policies; thereafter, de-obligation will occur for the remaining grant funds.

Page 2 - The Honorable Matthew G. Bevin

The following are action steps that Kentucky will need to take immediately assuming the state intends to transition for the 2017 plan year. CMS's team is ready to provide you with whatever assistance you need in order to expeditiously take the following steps.

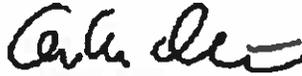
1. Identify a point of contact in the state who will have ultimate responsibility for the transition activities and will coordinate, as appropriate, with Kynect. In addition, we will require Kentucky to establish a centralized project coordination team (or Project Management Office) that will be responsible for coordinating activities among the different agencies and with Kynect, and for tracking completion of all required transition milestones.
2. Provide a detailed plan for how Kentucky will continue to meet its obligations as an SBM through the 2016 plan year, including having the eligibility and enrollment functionality to process changes in circumstances or special enrollment periods for 2016 current and new enrollees.
3. Facilitate discussions between CMS and the issuers participating in Kynect. These discussions will ensure that issuers understand the transition activities underway, the FFM's onboarding requirements, FFM deadlines, plan management and QHP certification requirements, and the 3.5 percent fee that issuers participating in the FFM must pay. The window for submission of QHP applications is proposed for April 11, 2016, and all other operational deadlines are available in the [Draft 2017 Letter to Issuers in the Federally-facilitated Marketplaces](#).
4. Begin the process required to enter into necessary contracts with a vendor to modify the Kynect system to decouple the Marketplace from Medicaid/CHIP and build new system functionality that enables bi-directional exchange of applications between the FFM and Kentucky's Medicaid/CHIP systems and to implement other system requirements unique to FFM states. CMS will work with the state on these requirements, and will provide further clarity on the availability of any Medicaid funds for the costs associated with building the new functionality.
5. Provide a detailed plan for how Kentucky will meet its ongoing statutory and regulatory requirements for 2014, 2015, and 2016 Marketplace consumers, which include:
 - Facilitating the ability of 2016 Kynect consumers to reapply to the FFM for 2017 coverage through data sharing with the FFM and focused outreach and consumer assistance;
 - Submitting outstanding monthly and annual reporting to the Internal Revenue Service (IRS);
 - Sending IRS 1095-A forms to 2016 consumers starting in January 2017 and maintaining capabilities to provide ongoing and long-term support for all consumers who require assistance or have corrections to their 1095-A forms.
 - Submitting all requested CMS policy-level enrollment reporting.
 - Maintaining capabilities to process eligibility appeals for consumers.

Page 3 - The Honorable Matthew G. Bevin

As noted, my team is available to discuss these items, in addition to the next steps to develop a transition workplan and timeline.

Please feel free to reach out to me or my staff with questions.

Sincerely,

A handwritten signature in black ink, appearing to read "Andrew M. Slavitt".

Andrew M. Slavitt
Acting Administrator



A CELERIAN GROUP COMPANY

DON "ROC" VIA
DME MAC Program Manager

January 25, 2016

Department of Medicaid Services
Cabinet for Health and Family Services
Office of the Secretary, 275 E Main Street
Frankfort, KY 40621



Dear Department of Medicaid Services:

On January 4, 2016, The Centers for Medicare & Medicaid Services (CMS) awarded administration of the Jurisdiction B Durable Medical Equipment Medicare Administrative Contractor (DME MAC) contract serving the states of Illinois, Indiana, Kentucky, Michigan, Minnesota, Ohio and Wisconsin, to CGS Administrators, LLC (CGS) headquartered in Nashville, Tennessee. This jurisdiction was previously contracted to National Government Services, LLC headquartered in Indianapolis, Indiana.

This letter is to inform you that CGS is coordinating with National Government Services (NGS), the outgoing Jurisdiction B DME MAC, to begin transitioning contract operations. CMS is reviewing the CGS contract implementation plan, and we anticipate full contract operations to begin June 27, 2016. During this time, CGS will provide you with regular implementation updates through our new Jurisdiction B website at <http://www.cgsmedicare.com/jb> as well as through scheduled teleconferences, email, and direct mail.

CGS recognizes you may receive questions from dual eligible Medicare beneficiaries regarding this change. We want to assure you and the millions of Medicare beneficiaries whose claims are processed in Jurisdiction B that there will be no impact to the services they receive. Claims for Medicare beneficiaries who receive important Durable Medical Equipment and services will continue to process without interruption. It is also important to share with them that the only change they will see is the name of the contractor who is processing their supplier's claims for Durable Medical Equipment, Prosthetics and Orthotics (DMEPOS).

CGS would like your assistance in helping us educate Medicare beneficiaries. We have enclosed a flier which you may copy and display in locations you deem appropriate to alert Medicare beneficiaries to this change in contract operations. Medicare beneficiaries who have questions about the implementation should be encouraged to call 1.800.MEDICARE. To ensure we reach as many Medicare beneficiaries as possible, CGS has sent letters to various beneficiary advocacy groups in the states of IL, IN, KY, MI, MN, OH and WI advising them of the implementation. In addition, we have notified all Social Security Administration regional offices, Governors, Mayors, state insurance agencies, supplier associations and Congressional representatives.



CGS has successfully provided contracted services to the Medicare program for nearly 50 years, and we are confident that our current contract implementation will have no negative impact on Medicare beneficiaries.

Regards,

A handwritten signature in black ink that reads "Don R. Via". The signature is written in a cursive style with a large initial "D" and "V".

**Roc Via
DME MAC Program Manager**



A CELERIAN GROUP COMPANY

MEDICARE BENEFICIARY INFORMATION

EFFECTIVE JUNE 27, 2016

CGS Administrators, LLC will begin processing your claims for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies.

There will be no impact to you or the services you currently receive! The only change you will see is the name of the Medicare contractor who is processing your claims.

FOR MORE INFORMATION, CONTACT 1.800.MEDICARE



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DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850



Disabled and Elderly Health Programs Group

January 26, 2016

Dear State Health Official:

The purpose of this letter is to solicit your participation and your fiscal agent's participation in a license agreement between the Centers for Medicare & Medicaid Services (CMS) and the American Dental Association (ADA), and the American Medical Association (AMA). The ADA owns the copyrights to its Current Dental Terminology (CDT), which is the code set that describes dental services, and the AMA owns the copyrights to Current Procedural Terminology (CPT) which is the medical code set that is used to report medical, surgical, and diagnostic procedures and services to entities such as physicians, health insurance companies and accreditation organizations. Since both the CDT and the CPT codes are copyright protected, CMS has entered into a licensing agreement with the ADA and the AMA, which permits CMS, its contracting entities and State Medicaid programs and their contracted entities to use the CDT and CPT codes on a limited basis. Under this agreement, State Medicaid agencies, Children's Health Insurance Programs (CHIP), and respective fiscal agents may agree to abide by the terms of the agreement and be protected under the agreement without further negotiation with the ADA or the AMA.

Enclosed for your review is the following: the Medicaid Agencies and CHIP Inclusion Election form for submission to us expressing your participation in these agreements; the CMS Summary of Attachment A to the CMS/ADA License Agreement for Use of CDT; Attachment A to the CMS/ADA License Agreement (with Exhibits 1, Exhibit 2, Point and Click Agreement and Exhibit 3 Shrink Wrap Agreement).

If you or your fiscal agent wishes to be covered under this agreement please complete the Election form, convert the Election form to a PDF file and return it to Fran Crystal at frances.crystal@cms.hhs.gov within six weeks of receipt of this letter. You will receive a confirmation e-mail when CMS receives the form. If CMS has not heard from you within six weeks of sending this letter, we will assume you have chosen to negotiate a separate agreement with the ADA.

If you have any questions, please contact Fran Crystal, at (410) 786-1195.

Sincerely,


Alissa Mooney DeBoy
Acting Director

Enclosures

cc:

**CMS Associate Regional Administrators
Division of Medicaid and Children's Health**

National Association of Medicaid Directors

National Academy for State Health Policy

National Governors Association

American Public Human Services Association

Association of State and Territorial Health Officials

Council of State Governments

National Conference of State Legislators

MEDICAID AGENCIES AND CHIP INCLUSION ELECTION

The Centers for Medicare & Medicaid Services (CMS) and the American Dental Association (ADA) entered into a U.S. Government License Agreement for Use of Current Dental Terminology (CDT™) (Agreement) dated January 1, 2011. Attachment A to the Agreement, as enclosed hereto and made a part hereof (Attachment A), allows certain of CMS's agents and other entities participating in programs administered by CMS (Entities) to include the ADA's Current Dental Terminology (CDT), a coding work of dental nomenclature, as contained in the Healthcare Common Procedure Coding System (HCPCS), in certain documents which may be distributed on Entities' Internet websites and in other electronic media for use only in CMS programs, as described in the Attachment. The term extends to December 31, 2020. There is no fee for the use of CDT as permitted under Attachment A.

Pursuant to Attachment A, the ADA and CMS have agreed that Medicaid agencies, CHIPs and their fiscal agents have the right to be covered under Attachment A as Entities subject to specific provisions.

In order to use CDT in CMS programs as permitted by Attachment A, your organization, as a Medicaid agency, CHIP, or its fiscal agent, agrees as follows:

1. You represent that your organization is a Medicaid agency, CHIP, or their fiscal agent, and that your organization is not excluded from participation in the Agreement by virtue of qualifying as an organization with a contract under Section 1852 of the Social Security Act.
2. You represent that you have read the enclosed Attachment A and agree to abide by all provisions as a covered Entity. You acknowledge Attachment A authorizes use of CDT only for purposes related to participating in CMS programs and that any use or distribution of materials containing CDT codes and descriptions, notes and guidelines that are unrelated to CMS programs requires a separate license agreement with the ADA.
3. You acknowledge that CMS has agreed to notify the ADA if CMS becomes aware that your organization is not in compliance with Attachment A. You further acknowledge that your organization will be subject to the appropriate action by the ADA, in the event that your organization is not in compliance with any provisions of Attachment A applicable to Entities.
4. You represent by your signature below that you have authority to enter into the agreement represented by Attachment A on behalf of your organization and that it is binding upon your organization. You acknowledge that the CDT license is only valid after this form is executed, the requested information completed and the form returned to CMS (for forwarding to the ADA).

Page 2 – Medicaid Agencies and CHIP Inclusion Election

Agreed: _____ On behalf of _____

State: Kentucky

Department for Medicaid Services
(Type full legal name of your agency or organization)

By Veronica L. Cecil
(Signature)

Date 2/2/16

Print name Veronica L. Judy-Cecil

Organization Type (check as appropriate)

Medicaid agency

CHIP

Fiscal agent for _____
(Name of applicable Medicaid agency or CHIP)

Please sign, place in pdf format and return this form to:
Fran Crystal
Centers for Medicare & Medicaid Services
Frances.crystal@cms.hhs.gov
410-786-1195

**Summary of Attachment A to
CMS and ADA License Agreement for Use of CDT**

- CMS entities have a limited right to include CDT codes, nomenclature and descriptors on certain types of materials maintained on their Internet web sites and electronic media. In this context, CMS entities are defined as CMS agents and other entities participating in programs administered by CMS, *including* Medicare contractors, State Medicaid agencies, State Children's Health Insurance Programs (CHIP) that are distinct from the State Medicaid agency, fiscal agents, and managed care organizations participating in Medicaid and/or CHIP programs. These entities do not include Medicare managed care organizations. (Attachment A, Clause 1)

- CMS entities are permitted *to* include CDT codes, nomenclature and descriptors on the following types of documents maintained on their Internet web sites and electronic media:
 - Local Medical Review Policies
 - Bulletins/ Newsletters
 - Program Memoranda and Billing Instructions
 - Coverage and Coding Policies
 - Program Integrity Bulletins and correspondence
 - Educational/Training Materials
 - Special mailings containing information that would otherwise be included in the aforementioned publication, but, due to time constraints, require expedited handling
 - Fee Schedules (codes and nomenclature only)
 - Program/policy handbooks or manuals
 - Computer based training materials (Attachment A, Clause 2)

- "Electronic Media" include e-mail, tapes, disk, or CD-ROM (page 6, clause 2 (A)). When conveying electronic media other than through the internet, State Medicaid and CHIP agencies must print on the outside of the package or packages, ship, or e-mail along with such electronic media, a copy of the "shrink wrap end user license" set forth in Exhibit 3.

- The above types of documents should be designed to convey program-specific information to providers and not CDT coding advice, which should be obtained from the official CDT publication.

- In most cases, entities may not include more than 15 percent of the descriptors in a CDT category of service in their documents. This 15 percent limitation does not apply if the category of service has less than 15 CDT codes, or if the ADA waives this limitation in a particular case (Attachment A, Clause 4 (A)). To calculate use of CDT Descriptor, each document is evaluated separately

- Fee schedules may include CDT codes and nomenclature, but not CDT descriptors (Attachment A, Clause 4 (C)).

- The following notice must appear on the Internet web page including or immediately prior to the initial appearance or display of all or any portion of CDT in the Documents and on the first page of downloaded Documents that include all or any portion of CDT:

Current Dental Terminology (including procedure codes, nomenclature, descriptors and other data contained therein) is copyright © 2015 American Dental Association. All rights reserved. Applicable FARS/DFARS apply.

For all other additions, including updates use the following Current Dental Terminology © {insert appropriate year} American Dental Association. All rights reserved. Applicable FARS/DFARS apply.

- Entities must include a "point and click" license on any internet web sites or electronic media that contain all or selected parts of CDT. If an entity is unable to use a point and click license in electronic media, that entity must include a shrink-wrap license if the electronic media contains all or selected parts of CDT. Electronic media containing a limited reference to CDT (e.g., six CDT codes) need not contain the copyright notice (Attachment A, Clause 8).
- The use of CDT is authorized only for purposes related to participating in CMS programs. Distribution of materials containing CDT codes, nomenclature, or descriptors that are unrelated to CMS programs or incorporate CDT into commercial products requires a separate license agreement with the ADA (Attachment A, Clause 12).
- Medicaid agencies and CHIPs (and their fiscal agents) have the option of being included in this license agreement. CMS will send Medicaid agencies and CHIPs copies of the Licensing Agreement and related Amendments along with an inclusion election form. The form needs to be signed and returned to CMS, if the Medicaid agencies, CHIPs and/or their fiscal agents want to obtain the benefits of CMS's agreement with the ADA. Those agencies that do not wish to be included under this agreement may contact the ADA and enter into a separate license agreement with the ADA (Attachment A, Clause 13).

ATTACHMENT A
U.S. GOVERNMENT LICENSE AGREEMENT FOR USE OF CDT

1. Limited License. ADA hereby grants Licensee a non-exclusive, non-transferable, royalty-free, limited license authorizing Licensee to distribute the CDT to Entities in the Territory. This distribution agreement (this "Attachment") will permit Entities, as mandated by Licensee requirements, to post or include certain materials that contain the CDT on their web sites or in Electronic Media as defined herein in accordance with the following terms.

2. Electronic Media.

A) The phrase "Electronic Media" means information sent via e-mail, tapes, disk or CD ROM. Entities may include CDT codes and nomenclature or descriptors (as defined herein) in the following types of materials (referred to collectively as "Documents") to be included on their Internet web sites and Electronic Media:

- 1) Local Medical Review Policies (LMRP)
- 2) Bulletins/ Newsletters
- 3) Program Memoranda and Billing Instructions
- 4) Coverage and Coding Policies
- 5) Program Integrity Bulletins and Correspondence.
- 6) Educational/Training Materials
- 7) Special mailings containing information that would otherwise be included in the aforementioned publications, but due to time constraints require expedited handling
- 8) Fee Schedules (subject to Section 4(C))
- 9) Program/policy handbooks or manuals
- 10) Computer based training manuals

B) Upon approval of ADA, other materials may be added to this list to meet Licensee's needs, including the need to reflect Licensee obligations with respect to Internet files and data containing the CDT.

C) (1) Entities may provide copies of the Document(s) in Electronic Media to requestors in order to comply with Freedom of Information Act requests provided that only CDT codes and nomenclature as defined herein are included in the Document(s) and the Entities comply with Sections 1, 2, 3, 4, 5, 6, and 8 of this Attachment.

(2) Entities may provide copies of the Document(s) to the US Department of Health and Human Services' Office of Inspector General, the General Accounting Office, and to other Federal and State agencies, provided that the Entities comply with Sections 1, 2, 3, 4, 5, 6, 7, and 8 of this Attachment. Licensee and/or the Entity will notify such Federal and State agencies in writing that its use of the Document(s) is subject to the terms of this Attachment.

D) The Documents should convey Medicare, State Children's Health Insurance Program (CHIP), or Medicaid specific information and not CDT coding advice. Documents should not be designed to substitute for the CDT publication with respect to codes, long descriptions, notes and or guidelines for any user.

E) Pursuant to this Attachment, use of the Codes is also permitted wherever use of CDT

“nomenclature” is permitted; and use of both the Codes and the “nomenclature” is also permitted wherever use of CDT “descriptors” is permitted.

3. Entities may use CDT Codes and nomenclature in their Documents subject to Sections 1, 2, 3, 4, 5, 6, 7, 8, 9, 10 and 11 of this Attachment.

4. Restrictions.

A) Except as specified in Section 4C, Entities may use CDT descriptors in Document(s), provided that use of CDT descriptors does not exceed over fifteen (15%) percent of a Category of Service. “Category of Service” means the twelve category of service descriptions used in the CDT publication (e.g. Diagnostic, Preventative, Restorative, Orthodontics, etc.). The above 15% limitation on the use of CDT descriptors shall not apply if the Category of Service of CDT as described has less than fifteen (15) CDT codes. There may be other circumstances where the fifteen (15%) percent rule may be waived by the ADA. The ADA and Licensee will address requests for waivers on a case-by-case basis. The ADA will respond by letter or other written notification of its decision regarding any such written waiver request from Licensee or its Entities.

B) For purposes of calculating the amount of “use” of CDT descriptors as permitted herein, each distinct document, such as an individual issue of a Document, is evaluated separately. The ADA agrees to provide counts (total and fifteen (15%) percent) of the number of CDT codes included in the CDT Category of Service sections on an annual basis to Licensee and/or its Entities in order to assist Entities in their compliance with this Attachment.

C) Fee Schedules may include CDT Codes and nomenclature. However, a Fee Schedule can never contain CDT descriptors. This prohibition includes, but is not limited to, Fee Schedules with listings of CDT codes and/or descriptors, with or without associated fees, and the annual new codes and descriptors included in the CDT publication (unless the Category of Service of CDT as described has less than fifteen CDT codes). Further, in no event shall a Fee Schedule be designed to substitute for the CDT publication for an individual user.

5. Sample. Licensee shall develop samples of permitted formats of display of CDT to be used by Entities as contemplated by this Attachment. The formats shall emphasize the requirements of this Attachment and the License Agreement including the requirements of copyright notices, separation of CDT material and non-CDT material via distinct sections, typography or text, and/or by separate listings of CDT where such listings are permitted. Such sample formats shall be attached to this Attachment as **Exhibit 1** and made a part of this Attachment. Licensee shall distribute such formats to Entities to implement this Attachment.

6. Copyright Notice. The following copyright notice shall appear on the Internet web page including or immediately prior to the initial appearance or display of all or any portion of CDT in the Documents and on the first page of downloaded Documents that include all or any portion of CDT:

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For all other editions, including Updates: {insert appropriate date}.

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Notwithstanding the foregoing, e-mail communications containing a limited reference to CDT codes

(e.g., six CDT codes) need not contain the copyright notice.

7. **Point and Click.** Subject to Section 8 below, , if the web site or Electronic Media contains any Document that includes all or any portion of CDT, Entities must include a “Point and Click” license (with the same terms as contained in **Exhibit 2**) on their Internet web sites and in any Electronic Media that they distribute to users outside their organizations. Notwithstanding the foregoing, Electronic Media containing a limited reference to CDT codes (e.g., six CDT codes) need not contain the copyright notice.

A) “Point and click” license, as required by this Attachment, means a license that appears on a computer screen or web page and includes a computer program or web page mechanism that requires users to indicate whether they accept the terms of the license by pointing their cursor and signaling, by clicking, that they accept the terms of said license prior to access to CDT.

B) At the Entity’s option, this Point and Click license must appear either before initial access is granted to any group of web pages within an Entity’s web site that contain CDT (e.g., before a section of bulletins or LMRPs, etc.) or prior to each Document that contains all or any portion of CDT. Additionally, the Point and Click license must appear before each file download containing all or any portion of CDT.

C) Computer-based training modules that function as software must include an embedded Point and Click license containing the provisions of **Exhibit 2** if they contain CDT codes, descriptions, notes or guidelines. The software shall include a mechanism that requires the acceptance of the Point and Click license before installation of the program. The provisions of Sections 1, 2, 3, 4, 5, 6, 7, 9, 10 and 12 of this Attachment also apply to computer-based training modules.

D) Entities may include additional terms in the Point and Click license described herein provided they do not conflict with the terms of **Exhibit 2**, and provided they do not expose the ADA to liability or jeopardize any ADA rights in CDT including copyright and trademark. Upon ADA notice to Licensee, Entities shall revise the Point and Click licenses upon reasonable notice from Licensee in order to protect the ADA’s rights including copyright and trademark in CDT and to comply with U.S. Governmental rights provisions.

8. **Shrink Wrap.** If an Entity is unable to use a Point and Click license in Electronic Media, such Entity shall include a “Shrink-Wrap” license (with the same terms as contained in **Exhibit 3**) in any Electronic Media that it distributes to users outside its organization whenever such Electronic Media contains any Document that includes all or any portion of CDT. Notwithstanding the foregoing, Electronic Media containing a limited reference to CDT codes (e.g., six CDT codes) need not contain the copyright notice.

A) A Shrink-Wrap license, as required by this Attachment, means a license that is printed on the outside packaging of the Electronic Media or other equivalent, or packaged and shipped or emailed along with, or concurrent with the shipping or e-mailing, such Electronic Media; provided, however, the Shrink-Wrap license must be conspicuous and the user of the Electronic Material must be able to see and read the entire text of the Shrink-Wrap license prior to installing the Electronic Media on a computer system.

B) Entities may include additional terms in the Shrink-Wrap license described herein provided they do not

C) Conflict with the terms of **Exhibit 3** and provided they do not expose the ADA to liability or jeopardize any ADA rights in CDT, including copyright and trademark rights. Upon notice by ADA to Licensee, Entities shall revise the Shrink-Wrap license in **Exhibit 3**, upon reasonable notice from Licensee, in order to protect the ADA's rights including copyright and trademark rights in CDT and to comply with U.S. Governmental rights provisions.

9. Entities may not charge a fee for distribution of Document(s) over the Internet or by Electronic Media, except that training materials including CDT distributed over the Internet or by Electronic Media may be distributed for no more than their cost. Should the need arise, the parties shall negotiate in good faith to allow distribution of other Document(s) over the Internet at no more than their cost. Entities may distribute Electronic Media that include Document(s) containing over fifteen (15%) percent of a section or subsection of CDT at no more than their cost.

10. Licensee will convey the requirements of this Attachment and provide a copy of **Attachment A** to the Entities through program memoranda or other normal mode of program communications as soon as possible but in no event later than eight (8) weeks after the Effective Date of this License Agreement.

11. This Attachment authorizes use of CDT only for purposes related to participating in Licensee programs. Distribution of materials containing CDT codes, nomenclature and descriptors that are unrelated to Licensee programs, including, but not limited to, incorporation of CDT into commercial products, shall require a separate license agreement with the ADA.

12. Entities shall have the option to agree to the license under this Attachment subject to the following:

A) Licensee shall send all Entities a written notification with a copy of the **Attachment A** within a reasonable time after the Effective Date of this Attachment notifying them in writing of all terms of this Attachment. This written notification shall include a form ("Form(s)"), which shall be subject to the approval of the ADA.

B) Licensee shall provide the ADA with a list of entities that have executed the Forms, which list shall be updated from time to time and sent to the ADA. Forms executed by Medicaid agencies and CHIPs will be kept on file by Licensee in accordance with its Federal record retention plan. Upon written request by the ADA, Licensee will provide copies of individual executed Forms.

C) Entities shall have the right to be covered by this Attachment, or if it so elects, it may attempt to negotiate a separate agreement with the ADA.

D) Licensee shall notify the ADA if it is aware that an Entity that has elected to be subject to the terms of Attachment A is not in compliance with this Attachment.

E) An Entity that has agreed to be subject to the terms of this Attachment will be subject to the appropriate action by the ADA, in the event that such Entity is not in compliance with any provisions of this Attachment applicable to Entities.

13. Upon written request by any Entity that entered into an agreement with the ADA regarding the specific subject matter of Attachment A, the ADA shall cancel said applicable agreement(s) to allow said Entity the benefit of this Attachment. The ADA shall notify said Entities of this provision as soon as practical after the Effective Date of this Attachment.

EXHIBIT 1
Sample CDT Nomenclature in a Fee Schedule
Revised 2016 National Dental Diagnostic Procedures Fee Schedule

<u>CDT Code*</u>	<u>Nomenclature*</u>	<u>Scheduled Amount</u>
D0120	Periodic oral evaluation – established patient	40
D0140	Limited oral evaluation- problem focused	50
D0150	Comprehensive oral evaluation- new or established patient	65
D0160	Detailed and extensive oral evaluation – problem focused, by report	100
D0210	Intraoral – complete series of radiographic images	95
D0220	Intraoral – periapical first radiographic image	22
D0230	Intraoral – periapical each additional radiographic image	15
D0272	Bitewings – two radiographic images	35
D0274	Bitewings – four radiographic images	49

* The CDT Code and Nomenclature above have been obtained from *Current Dental Terminology* (including procedure codes, nomenclatures, descriptors and other data contained therein) (“CDT”). CDT is copyright © 2015 American Dental Association. All rights reserved. Applicable FARS/DFARS apply.

Sample CDT Descriptor in a Document

Guidelines for administering the dental benefit - Diagnostic Procedures.

Clinical oral evaluations are covered diagnostic procedures that must be distinguished from preventive (e.g., dental prophylaxis) procedures. The following CDT procedure code is most common. P

Periodic evaluation is an eligible procedure. Benefits are limited to twice annually for each covered member. The date of service should be the actual date of the examination.

***D0120 periodic oral evaluation- established patient**

An evaluation performed on a patient of record to determine any changes in the patient's dental and medical health status since a previous comprehensive or periodic evaluation. This includes an oral cancer evaluation and periodontal screening where indicated, and may require interpretation of information acquired through additional diagnostic procedures. Report additional diagnostic procedures separately.

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EXHIBIT 2

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Combined CPT & CDT Point and Click language

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EXHIBIT 3

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Page 2 - Exhibit 3

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DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Atlanta Regional Office
61 Forsyth Street, Suite 4T20
Atlanta, Georgia 30303



DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

January 27, 2016

Veronica J. Cecil, Acting Commissioner
Department for Medicaid Services
275 East Main Street, 6WA
Frankfort, KY 40621-0001



RE: Non-Emergency Medical Transportation Waiver Renewal KY-06.R002

Dear Ms. Cecil:

We have completed our review of the KY-06.R002 renewal waiver application. Before we can continue processing this waiver, we are requesting additional information as follows:

1. Please explain the state's network adequacy standards (ratio of vehicles/contracted provider to beneficiaries) and whether the standards differ in urban vs rural areas. The state should set adequacy standards in order to determine if the network is adequate. Ex: Identify the number of rides requested by beneficiaries that the broker was not able to provide per month or the number of rides requested that were scheduled by the broker but the provider did not show. Also, what is the standard for a provider being late to pick up a beneficiary?
2. Page 13, Section 7(2) of the application reads: (2) The subcontractor shall not enter into an agreement with a broker without the prior approval of the Transportation Cabinet. Each broker shall submit and request approval of the cabinet for each potential subcontractor. The broker has the discretion to contract with any operating vendor. Does the Kentucky Transportation Cabinet determine the number of transportation providers that can operate in a given area? If so, are there providers that have applied to operate in a given area and been refused by the Cabinet? Please explain why and how not expanding the network of providers has impacted the ability of the broker to fill all requests for transportation in a timely manner?
3. Access to pharmaceuticals: According to 42 CFR 431.53, states are required to assure necessary transportation for recipients to and from covered medical services. The State Medicaid Manual, Section 2113 requires states to assure necessary transportation of recipients to and from providers. 42 CFR 441.62 also requires states to provide all necessary services under EPSDT regardless of whether the service is covered under the state plan. Prescription drugs are an optional medical service covered by the KY state

plan. If the state chooses not to cover NEMT to obtain prescription services please provide justification that beneficiaries do not require NEMT to access prescription drugs.

4. Medicaid beneficiaries may never have medical services suspended or refused because the beneficiary schedules an appointment and does not show. If a request for NEMT meets all of the requirements for receiving NEMT the state is obligated to provide the ride, regardless of bad behavior. Habitual no shows by the beneficiary is not cause for refusal to provide a ride. If a broker refuses to provide rides for a specific beneficiary the broker must inform the state and the state must make alternative arrangements to assure necessary NEMT for the beneficiary. Please explain how the broker deals with beneficiaries who are frequent no shows for requested rides.
5. (Populations Included and Excluded from the Waiver (pages 19-20)
Since the waiver covers separate programs (CHIP and Medicaid) is the data being reported separately? The brokers provide NEMT to programs other than Medicaid. What procedures are in place to assure that Medicaid funds are not being allocated to provide rides for individuals who are not Medicaid enrolled?
The state should remove the "X" from SCHIP Title XXI Children – Medicaid beneficiaries who receive services through the SCHIP program. The state indicated that the waiver covers children eligible under CHIP Medicaid expansion.
6. Please provide the revised cost effectiveness workbook.
7. Please provide an updated waiver renewal application.

We are requesting this additional/clarifying information under provisions of Section 1915(f) of the Social Security Act (added by PL 97-35). This has the effect of stopping the 90-day clock for CMS to take action on the waiver, which would have expired on February 1, 2016. A new 90-day clock will not begin until we receive your response to this request.

In accordance with our guidelines to all State Medicaid directors dated January 2, 2001, if we have not received the State's response to our request for additional information within 90 days from the date of this letter, we will initiate disapproval action on the amendment. In addition, because this amendment was submitted after January 2, 2001 and is effective after January 1, 2001, please be advised that we will continue to defer FFP for State payments made in accordance with this amendment until it is approved. Upon approval, FFP will be available for the period beginning with the effective date through the date of approval.

Ms. Veronica J. Cecil
Page 3

We ask that you respond to this RAI via the Atlanta Regional Office SPA/Waiver e-mail address at SPA_Waivers_Atlanta_R04@cms.hhs.gov. The original signed response should also be sent to the Atlanta Regional Office.

If you have any questions, please contact Cheryl Brimage at 404-562-7116.

Sincerely,

A handwritten signature in cursive script that reads "Jackie Glaze".

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

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Atlanta Regional Office
61 Forsyth Street, Suite 4T20
Atlanta, Georgia 30303

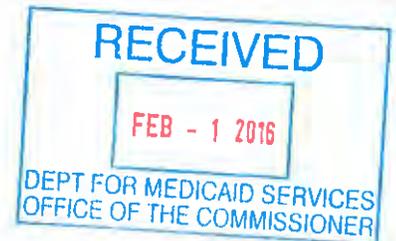


DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

January 27, 2016

KY-16-005

Ms. Veronica Cecil, Acting Commissioner
Department for Medicaid Services
275 East Main Street, 6W-A
Frankfort, KY 40621-0001



Dear Ms. Cecil:

The Centers for Medicare & Medicaid Services (CMS) approves the Medicaid Enterprise Management System (MEMS) Annual Implementation Advance Planning Document (AIAPD) #2 submitted by the Kentucky Cabinet for Health and Family Services (CHFS) to extend the approval of your IAPD for the Medicaid Management Information System (MMIS) to September 30, 2016. The Commonwealth is approved to carry forward \$26,119,301 (federal share \$23,316,632 and Commonwealth share \$2,802,669) of Design, Development, and Implementation (DDI) funding from federal Fiscal Year (FFY) 2015 funds to FFY 2016 in the following categories:

- \$25,642,452 at 90 percent federal financial participation (FFP) (federal share \$23,078,207 and Commonwealth share \$2,564,245)
- \$476,849 at 50 percent FFP (federal share \$238,425 and Commonwealth share \$238,424)

CMS also approves your request to re-categorize a portion of the approved funding from the MEMS DDI Replacement budget of \$3,298,645 (federal share \$2,968,780 and Commonwealth share \$329,865) for the following items:

- Call Center for \$702,146 (federal share \$631,931 and Commonwealth share \$70,215) to be shared equally by Partner Portal (\$351,073) and Medicaid Waiver Management Application (MWMA) (\$351,073). The original estimate was for \$351,073; the following year is estimated for the same amount.
- Customer Relationship Management (CRM) and Interactive Voice Response (IVR) modifications added to the Call Center for \$51,699 (federal share \$46,529 and Commonwealth share \$5,170). The Statement of Work (SOW) was approved by CMS on April 15, 2015.

Ms. Veronica Cecil,
Page 2

- Enhancements to MWMA for compliance with federal and Commonwealth regulations for \$2,225,000 (federal share \$2,002,500 and Commonwealth share \$222,500). The SOW was submitted to CMS the week of October 12, 2015.
- Host the Southeast Regional Consortium for HIT-HIE (SERCH) function for \$319,800 (federal share \$287,820 and Commonwealth share \$31,980). The first year was approved by CMS on August 10, 2015.

In addition realignment of the IAPD to align with federal fiscal years is also approved. No new funding is being requested under this AIAPD.

The AIAPD #2 is approved in accordance with Section 1903(a)(3) of the Social Security Act, 42 CFR Part 433, subpart C, 45 CFR Part 95, subpart F, and the State Medicaid Manual, Part 11. No new funding is approved for this project under this approval. Onsite reviews may be conducted to assure that the intentions for which FFP was approved are being accomplished. Specifically, the objective is to validate that automated data processing (ADP) equipment or services are being efficiently and effectively utilized to support the approved programs or projects as provided under 45 CFR § 95.621 and the State Medicaid Manual. As provided by the State Medicaid Manual Section 11200 and by 45 CFR § 95.611, all subsequent revisions and amendments to the IAPD will require CMS prior written approval to qualify for FFP.

As described in regulation at 45 CFR § 95.611 and the State Medicaid Manual Section 11200, other contracts supported by funding from the approved IAPD must be approved by CMS prior to execution of the contract. Failure to comply with prior approval requirements may result in either ineligibility for the enhanced federal match or disallowance for those activities.

If there are any questions concerning this information, please contact L. David Hinson at (334) 791-7826 or via e-mail at lawrence.hinson@cms.hhs.gov.

Sincerely,



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

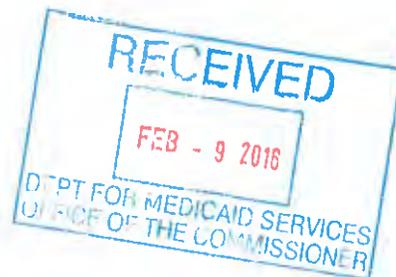
DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Atlanta Regional Office
61 Forsyth Street, Suite 4T20
Atlanta, Georgia 30303



DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

February 1, 2016

Veronica J. Cecil, Acting Commissioner
Department for Medicaid Services
275 East Main Street, 6WA
Frankfort, KY 40621-0001



Re: Kentucky State Plan Amendment 15-0008

Dear Ms. Cecil:

We have reviewed the proposed Kentucky state plan amendment, KY 15-0008, which was submitted to the Centers for Medicare & Medicaid Services (CMS) on November 17, 2015. This amendment revises the current reimbursement methodology for Intensive Outpatient Therapy by removing the actual per diem amount from the state plan and including the fee schedule language.

Based on the information provided, the Medicaid State Plan Amendment KY 15-0008 was approved on February 1, 2016. The effective date of this amendment is December 2, 2015. We are enclosing the approved HCFA-179 and a copy of the new state plan page.

If you have any additional questions or need further assistance, please contact Darlene Noonan at (404) 562-2707 or Darlene.Noonan@cms.hhs.gov.

Sincerely,

A handwritten signature in black ink that reads "Jackie Glaze".

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

Enclosures

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

1. TRANSMITTAL NUMBER:
15-008

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
December 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 2016 Budget Neutral
b. FFY 2017 Budget Neutral

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Att. 4.19-B, Page 20.15(1)(g) – Att. 4.19-B, Page 20.15(1)(h)

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

10. SUBJECT OF AMENDMENT:

The purpose of this SPA is to make change Medicaid reimbursement for Intensive Outpatient Therapy.

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

- GOVERNOR'S OFFICE REPORTED NO COMMENT
 COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
 NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

X OTHER, AS SPECIFIED: Review delegated
to Commissioner, Department for Medicaid
Services

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME: Lisa D. Lee

14. TITLE: Commissioner, Department for Medicaid Services

15. DATE SUBMITTED: 10/30/15/15

16. RETURN TO:

Department for Medicaid Services
275 East Main Street 6W-A
Frankfort, Kentucky 40621

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 11-17-15

18. DATE APPROVED: 02-01-16

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
12-02-15

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: Jackie Glaze

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

23. REMARKS: Approved with the following changes as authorized by state on email date 2-1-16:

Block # 4 changed to read: December 2, 2015.

Block # 8 changed to read: Attachment 4.19-B, page 2015.(1)(g).

XVI. Other diagnostic, screening, preventive and rehabilitative services.

Intensive outpatient program will be reimbursed on a per diem basis. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of Intensive Outpatient Therapy. The agency's fee schedule rate was set as of December 2, 2015 and is effective for services provided on or after that date. All rates are published <http://chfs.ky.gov/dms/fee.htm>. This per diem was calculated by using Kentucky's existing rate for rehabilitative children in the custody of or at risk of being in the custody of the state or for children under the supervision of the state and converting it to a per diem for the same service.

- A. Kentucky has developed a method for allocating the portion of the rate related to each of the bundled services for purposes of proper reporting on the CMS-64.
- B. The intensive outpatient program rate is based on rates currently set for state plan services. The rates for each service are multiplied by the anticipated service frequency per day. Additionally, these rates do not include costs related to room and board or any other unallowable facility costs.
- C. Per 42 CFR 431.107, each providers or organization furnishing these services shall keep any records necessary to disclose the extent of services the provider furnishes to beneficiaries and, on request, furnish the Kentucky Department for Medicaid Services any information maintained and any information regarding payments claimed by the provider for furnishing services under the plan. These records include documentation that at a minimum includes the following: date of service; name of recipient; Medicaid identification number; mane of provider agency and person providing the service; nature, extent or units of service; and the place of service." Kentucky will review the data in order to develop and revise as necessary, economic and efficient rates, and will explain how the data was used to develop the rates.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Atlanta Regional Office
61 Forsyth Street, Suite 4T20
Atlanta, Georgia 30303



DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

January 26, 2016

Veronica J. Cecil, Acting Commissioner
Department for Medicaid Services
275 East Main Street, 6WA
Frankfort, KY 40621-0001

Re: Kentucky State Plan Amendment 16-0001

Dear Ms. Cecil:



We have reviewed the proposed Kentucky state plan amendment, KY 16-0001, which was submitted to the Centers for Medicare & Medicaid Services (CMS) on January 12, 2016. This amendment designates Veronica J. Cecil, Acting Commissioner of the KY Department for Medicaid Services, as the Governor's designee for review and approval of state plan amendments.

Based on the information provided, the Medicaid State Plan Amendment KY 16-0001 was approved on January 26, 2016. The effective date of this amendment is January 11, 2016. We are enclosing the approved HCFA-179 and a copy of the new state plan pages.

If you have any additional questions or need further assistance, please contact Melanie Benning at (404) 562-7414 or Melanie.Benning@cms.hhs.gov.

Sincerely,

A handwritten signature in black ink that reads "Jackie Glaze".

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

Enclosures

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

**TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES**

1. TRANSMITTAL NUMBER:
16-001

2. STATE
Kentucky

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

4. PROPOSED EFFECTIVE DATE
January 11, 2016

5. TYPE OF PLAN MATERIAL (Check One):
 NEW STATE PLAN AMENDMENT TO BE CONSIDERED AS NEW PLAN AMENDMENT
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 430.12(b)

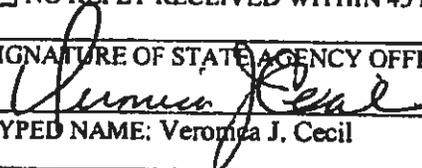
7. FEDERAL BUDGET IMPACT:
a. FFY 2012 \$0
b. FFY 2013 \$0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Page 89

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

10. SUBJECT OF AMENDMENT:
State Governor's Review appoint Veronica J. Cecil

11. GOVERNOR'S REVIEW (Check One):
 GOVERNOR'S OFFICE REPORTED NO COMMENT OTHER, AS SPECIFIED: Review delegated to Commissioner, Department for Medicaid Services
 COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
 NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

12. SIGNATURE OF STATE AGENCY OFFICIAL:


13. TYPED NAME: Veronica J. Cecil

14. TITLE: Acting Commissioner, Department for Medicaid Services

15. DATE SUBMITTED: 1/12/16

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

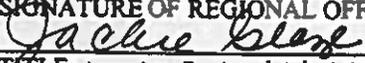
FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 01/12/16

18. DATE APPROVED: 01-26-16

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
01-11-16

20. SIGNATURE OF REGIONAL OFFICIAL:


21. TYPED NAME: Jackie Glaze

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

23. REMARKS: Approved with follow changes to block #7 as authorized by state email dated 01/26/16.
Block #7 changed to read: FFY 2016 \$0, and FFY 2017 \$0

State: Kentucky

Citation 7.4 State Governor's Review

42 CFR 430.12(b)

The Medicaid Agency will provide opportunity for the Office of Governor to review State plan amendments, long-range program planning projections, and other periodic reports thereon, excluding periodic statistical, budget and fiscal reports. Any comments made will be transmitted to the Centers for Medicare and Medicaid Services with such documents.

- Not Applicable. The Governor-
- Does not wish to review any plan material.
- Wishes to review only the plan materials specified in the enclosed document.

I hereby certify that I am authorized to submit this plan on behalf of

Department for Medicaid Services
(Designated Single State Agency)

Date: January 11, 2016

Veronica J. Cecil, Acting Commissioner
Department for Medicaid Services

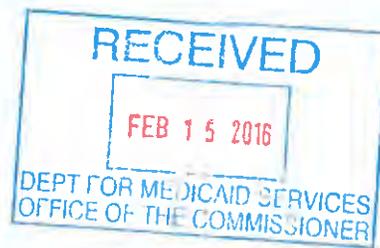
DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, MD 21244-1850



Financial Management Group

FEB 10 2016

Ms. Veronica L. Judy-Cecil
Acting Commissioner
Commonwealth of Kentucky
Cabinet for Health and Family Services
Department of Medicaid Services
275 East Main Street, 6 W-A
Frankfort, KY 40621



RE: State Plan Amendment (SPA) 15-003

Dear Ms. Cecil:

We have reviewed the proposed amendment to Attachments 4.19-A, 3.1-A and 3.1-B of your Medicaid state plan submitted under transmittal number (TN) 15-003. Effective October 1, 2015 this amendment adds reserve bed and therapeutic leave days as a reimbursable service in psychiatric residential treatment facilities (PRTF). The amendment also revises the coverage sections to include covered services in the PRTFs.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a), 1902(a)(13), 1902(a)(30), and 1903(a) of the Social Security Act and the implementing Federal regulations at 42 CFR Part 447. We have found that the proposed changes in payment methodology comply with applicable requirements and therefore have approved them with an effective date of October 1, 2015. We are enclosing the CMS-179 and the amended approved plan pages.

If you have any questions, please call Stanley Fields at (502) 223-5332.

Sincerely,

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

Kristin Fan
Director

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL	1. TRANSMITTAL NUMBER: 15-003	2. STATE Kentucky
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
FOR: HEALTH CARE FINANCING ADMINISTRATION	4. PROPOSED EFFECTIVE DATE October 1, 2015	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		

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. 3.1-A Page 7.8.3 – 7.8.4-10 Att. 3.1-B Page 33.2 – Page 33.13 Att. 4.9-A, Page 35-35-2 Att. 4.19-B, Page 20.12(i) – Page 20.12(m)	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Same Except Att. 3.1-A, Page 7.8.4.4 – Page 7.8.4.10 – New Att. 3.1-B, Page 33.3 – Page 33.13 – New <i>Att. 3.1-B Page 33.2</i> Att. 4.19-A, Page 35.3 - New <i>Page 33.5 New</i> Att. 4.19-B, Page 20.12(i) – Page 20-12(m) - New

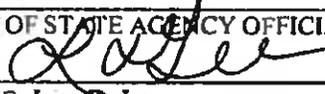
10. SUBJECT OF AMENDMENT:
The purpose of this SPA is update the inpatient Psychiatric Residential Treatment Facility (PRTF) – very limited information in Attachment 3.1-A and B sections. ~~We are also including outpatient treatment services to the PRTF.~~

11. GOVERNOR'S REVIEW (Check One):

GOVERNOR'S OFFICE REPORTED NO COMMENT OTHER, AS SPECIFIED: Review delegated to Commissioner, Department for Medicaid Services

COMMENTS OF GOVERNOR'S OFFICE ENCLOSED

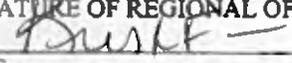
NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

12. SIGNATURE OF STATE AGENCY OFFICIAL: 	16. RETURN TO: Department for Medicaid Services 275 East Main Street 6W-A Frankfort, Kentucky 40621
13. TYPED NAME: Lisa D. Lee	
14. TITLE: Commissioner, Department for Medicaid Services	
15. DATE SUBMITTED: 7/20/15	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:	18. DATE APPROVED: FEB 10 2016
--------------------	--------------------------------

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: OCT 01 2015	20. SIGNATURE OF REGIONAL OFFICIAL: 
21. TYPED NAME: Kristin Fan	22. TITLE: Director, FMC

23. REMARKS:
Pen + ink changes made to blocks 8, 9, and 10

16. Psychiatric Residential Treatment Facility Services for Level I and II for Individuals Under 21 Years of Age**A. Covered Inpatient Admissions**

The following benefits and limitations are applicable for inpatient psychiatric facility services for individuals under 21 years of age (or under 22 years of age if an inpatient in the facility on the individual's 21st birthday):

Kentucky complies with all PRTF requirements outlined at 42 CFR 440.160; 42 CFR 483.352; 42 CFR Part 441, Subpart D and Part 483, Subpart G

Subject to the individual's plan of care, the following services are furnished to children in a PRTF, pursuant to the Inpatient Psychiatric Services to Individuals under Age 21 benefit, provided services are under the direction of a physician. Each patient's treatment plan shall specify the amount and frequency of services needed;

- 1) A covered admission for a Level I PRTF shall be prior authorized by a review agency.
- 2) A covered admission for a Level II PRTF shall be prior authorized;

B. PRTF Covered Inpatient Services.

- 1) The following services shall be available to all eligible recipients:
 - a. Diagnostic and assessment services;
 - b. Treatment plan development, review, or revision;
 - c. Psychiatric services;
 - d. Nursing services which shall be provided in compliance with 902 KAR 20:320;
 - e. Medication which shall be provided in compliance with 907 KAR 1:019;
 - f. Evidence-based treatment interventions;
 - g. Individual therapy which shall comply with 902 KAR 20:320;
 - h. Family therapy or attempted contact with family which shall comply with 902 KAR 20:320;
 - i. Group therapy which shall comply with 902 KAR 20:320;
 - j. Individual and group interventions that shall focus on additional and harmful use or abuse issues and relapse prevention if indicated;
 - k. Substance abuse education;
 - l. Activities that:
 - (1) Support the development of an age-appropriate daily living skill including positive behavior management or support; or
 - (2) Support and encourage the parent's ability to re-integrate the child into the home;
 - m. Emergency interventions pursuant to the restraint and seclusion requirement at:
 - (1) 42 C.F.R. 483.350 through 376; and
 - (2) 902 KAR 20:320;
 - n. Consultation with other professionals including case managers, primary care professionals, community support workers, school staff, or others;
 - o. Educational activities; or
 - p. Non-medical transportation services as needed to accomplish objectives;

16. Psychiatric Residential Treatment Facility Services for Level I and II for Individuals Under 21 Years of Age
- 2) A Level I PRTF service listed in a above shall be:
 - a. Provided under the direction of a physician;
 - b. If included in the recipient's treatment plan, described in the recipient's current treatment plan;
 - c. Medically necessary; and
 - d. Clinically appropriate pursuant to the criteria established in 907 KAR 3:130;
 - 3) A Level I PRTF service listed in g, h, i, k, or m. above shall be provided by a qualified mental health professional, behavioral health professional, or behavioral health professional under clinical supervision; or
 - 4) A Level II PRTF service listed shall be:
 - a. Provided under the direction of a physician;
 - b. If included in the recipient's treatment plan, described in the recipient's current treatment plan;
 - c. Provided at least once a week:
 - (1) Unless the service is necessary twice a week, in which case the service shall be provided at least twice a week; or
 - (2) Except for diagnostic and assessment services which shall have no weekly minimum requirement;
 - d. Medically necessary; and
 - e. Clinically appropriate pursuant to the criteria established in 907 KAR 3:130.
 - 5) A Level II PRTF service listed in (7), (8), (9), (11), or (13) shall be provided by a qualified mental health professional, behavioral health professional, or behavioral health professional under clinical supervision.
- C. Durational Limit, Re-evaluation, and Continued Stay for Inpatient Admissions.
- 1) A recipient's stay, including the duration of the stay, in a Level I or II PRTF shall be subject to the department's approval.
 - 2) A recipient in a Level I PRTF shall be re-evaluated at least once every thirty (30) days to determine if the recipient continues to meet Level I PRTF patient status criteria.
 - 3) A Level I PRTF shall complete a review of each recipient's treatment plan at least once every thirty (30) days.
 - 4) If a recipient no longer meets Level I PRTF patient status criteria, the department shall only reimburse through the last day of the individual's current approved stay.
 - 5) A Level II PRTF shall complete by no later than the third (3rd) business day following an admission, an initial review of services and treatment provided to a recipient which shall include:

16. Psychiatric Residential Treatment Facility Services for Level I and II for Individuals Under 21 Years of Age

D. Reserved Bed and Therapeutic Pass Days for Inpatient Admissions

Definition:

An acute care hospital bed reserve day shall be a day when a recipient is temporarily absent from a Level I or II PRTF due to an admission to an acute care hospital. A state psychiatric hospital bed reserve day, private psychiatric hospital bed reserve day, or psychiatric bed in an acute care hospital bed reserve day, respectively, shall be a day when a recipient is temporarily absent from a Level I or II PRTF due to receiving psychiatric treatment in a state psychiatric hospital, private psychiatric hospital, or psychiatric bed in an acute care hospital respectively. A therapeutic pass day shall be a day when a recipient is temporarily absent from a Level I or II PRTF for a therapeutic purpose that is:

- a. Stated in the recipient's treatment plan; and
 - b. Approved by the recipient's treatment team.
- 1) The department shall cover a bed reserve day for an acute hospital admission, a state psychiatric hospital admission, a private psychiatric hospital admission, or an admission to a psychiatric bed in an acute care hospital for a recipient's absence from a Level I or II PRTF if the recipient:
 - a. Is in Medicaid payment status in a Level I or II PRTF;
 - b. Has been in the Level I or II PRTF overnight for at least one (1) night;
 - c. Is reasonably expected to return requiring Level I or II PRTF care; and
 - c. Has not exceeded the bed reserve day limit of 5 days per calendar year in aggregate for any combination of bed reserve days associated with an acute care hospital admission, a state psychiatric hospital admission, a private psychiatric hospital admission or an admission to a psychiatric bed in an acute care hospital.
 - 2) Based on medical necessity, with a prior authorization, the five (5) day limit may be extended.
 - 3) The department shall cover a therapeutic pass day for a recipient's absence from a Level I or II PRTF if the recipient:
 - a. Is in Medicaid payment status in a Level I or II PRTF;
 - b. Has been in the Level I or II PRTF overnight for at least one (1) night;
 - c. Is reasonably expected to return requiring Level I or II PRTF care; and
 - d. Has not exceeded the therapeutic pass day limit established; or
 - e. Received an exception to the limit.
 - f. The annual therapeutic pass day limit per recipient shall be fourteen (14) days per calendar year.
 - g. The department shall allow a recipient to exceed the limit established if the department determines that an additional therapeutic pass day is in the best interest of the recipient.

16. Psychiatric Residential Treatment Facility Services for Level I and II for Individuals Under 21 Years of Age**E. Exclusions and Limitations in Coverage for Inpatient Admissions.**

- 1) The following shall not be covered as Level I or II PRTF services:
 - a. Pharmacy services, which shall be covered in accordance with Kentucky Medicaid's Pharmacy Program;
 - b. Durable medical equipment, which shall be covered in accordance with Attachment 3.1-A, Page 13 of the Medicaid State Plan;
 - c. Hospital emergency room services, which shall be covered in accordance with Attachment 3.1-A, Page 7.1.1(a);
 - d. Acute care hospital inpatient services, which shall be covered in accordance with Attachment 3.1-A, Page 7.1.1 – Page 7.1.1(a);
 - e. Laboratory and radiology services, which shall be covered in accordance with Attachment 3.1-A, Page 7.1.1(b);
 - f. Dental services, which shall be covered in accordance with Attachment 3.1-A, Page 7.4.1;
 - g. Hearing and vision services, which shall be covered in accordance with Attachment 3.1-A, Page 7.1.3; or
 - h. Ambulance services, which shall be covered in accordance with Attachment 3.1-A, Page 7.9.1.
- 2) A Level I or II PRTF shall not charge a recipient or responsible party representing a recipient any difference between private and semiprivate room charges.

to costs, volume, or proportion of services provided to patients eligible for medical assistance and to low income patients.

(9) **Payments for Inpatient Psychiatric Facility Services for Individuals Under 21 Years of Age**

- A. Covered inpatient psychiatric facility services for individuals under 21 years of age provided in psychiatric hospitals are paid in accordance with the provisions described in Attachment 4.19-A
- B. Covered inpatient psychiatric facility services for individuals under 21 years of age provided in licensed psychiatric resident treatment facilities (PRTFs) are paid in accordance with the following:

Level I PRTF

To be reimbursable under the Medicaid Program, Level I PRTF services and associated costs, respectively, shall be provided to or associated, respectively, with a recipient receiving Level I PRTF services in accordance with Attachment 3.1-A, Section 16 – Psychiatric Residential Treatment Facility Services for Level I and II for Individuals under 21 years of age.

- 1 The department shall reimburse for Level I PRTF services and costs for a recipient not enrolled in a managed care organization at the lesser of a per diem rate of \$280.09; or the usual and customary charge
- 2 The per diem rate shall be increased each biennium by 2.22 percent.
- 3 The per diem or the usual and customary charge if less than the per diem rate, shall represent the total Medicaid reimbursement for Level I PRTF services and costs:
 - (a) Including all care and treatment costs;
 - (b) Including costs for all ancillary services;
 - (c) Including capital costs;
 - (d) Including room and board costs; and
 - (e) Excluding the costs of drugs as drugs shall be covered and reimbursed under Kentucky's pharmacy program in accordance with Attachment 3.1-A and Attachment 4.19-A.

Level II PRTF

To be reimbursable under the Medicaid program, Level II PRTF services and associated costs, respectively, shall be provided to or associated, respectively, with a recipient receiving Level II PRTF services in accordance with Attachment 3.1-A, Section 16 – Inpatient Psychiatric Residential Treatment Facility Services for Level I and II for Individuals under 21 years of age.

- 1 The department shall reimburse a per diem rate as follows for Level II PRTF services and costs for a recipient not enrolled in a managed care organization:
 - (a) \$345 for Level II PRTF services to a recipient who meets the rate group one (1) criteria described below;
 - (b) \$365 for Level II PRTF services to a recipient who meets the rate group two (2) criteria described below;
 - (c) \$385 for Level II PRTF services to a recipient who meets the rate group three (3) criteria described below; or
 - (d) \$405 for Level II PRTF services to a recipient who meets the rate group four (4) criteria described below.

2 Rate Groups

- (a) Rate group one (1) criteria shall be for a recipient who:
1. Is twelve (12) years of age or younger;
 2. Is male or female; and
 3. Is sexually reactive; or
 - (i) Has a severe and persistent aggressive behavior;
 - (ii) Does not have an intellectual or a developmental disability; and
 - (iii) Has an intelligence quotient higher than seventy (70).
- (b) Rate group two (2) criteria shall be for a recipient who:
1. Is twelve (12) years of age or younger;
 2. Is male or female; and
 3. Is sexually reactive; and
 - (i) Has a severe and persistent aggressive behavior;
 - (ii) Does not have an intellectual or a developmental disability; and
 - (iii) Has an intelligence quotient higher than seventy (70).
- (c) Rate group three (3) criteria shall be for a recipient who:
1. Is thirteen (13) years of age or older;
 2. Is male or female; and
 3. Is sexually reactive; or
 - (i) Has a severe and persistent aggressive behavior;
 - (ii) Does not have an intellectual or a developmental disability; and
 - (iii) Has an intelligence quotient higher than seventy (70).
- (d) Rate group four (4) criteria shall be for a recipient who:
1. Is thirteen (13) years of age or older;
 2. Is male or female; and
 3. Is sexually reactive; and
 - (i) Has a severe and persistent aggressive behavior;
 - (ii) Does not have an intellectual or a developmental disability; and
 - (iii) Has an intelligence quotient higher than seventy (70).
- (e) Rate group four (4) criteria also includes the following for a recipient who:
1. Is under twenty-one (21) years of age;
 2. Is male or female; and
 3. Is sexually reactive; or
 - (i) Has a severe and persistent aggressive behavior;
 - (ii) Has an intellectual or a developmental disability; and
 - (iii) Has an intelligence quotient lower than seventy (70).

C. The per diem rates referenced above, or the usual and customary charge if less than the per diem rate, shall represent the total Medicaid reimbursement for Level II PRTF services and costs:

- (a) Including all care and treatment costs;
- (b) Including costs for all ancillary services;
- (c) Including capital costs;
- (d) Including room and board costs; and
- (e) Excluding the costs of drugs as drugs shall be reimbursed via the department's pharmacy program

- D. The department shall use the evaluation, review, and analysis to determine if an adjustment to the Level II PRTF reimbursement would be appropriate.
- E. (1) The department's reimbursement for a bed reserve day which qualifies as a bed reserve day for a recipient not enrolled in a managed care organization shall be:
- (a) Seventy-five (75) percent of the rate established if the Level I or II PRTF's occupancy percent is at least eighty-five (85) percent; or
 - (b) Fifty (50) percent of the rate established if the Level I or II PRTF's occupancy percent is less than eighty-five (85) percent.
 - (c) The department shall cover a bed reserve day for an acute hospital admission, a state mental hospital admission, a private psychiatric hospital admission, or an admission to a psychiatric bed in an acute care hospital for a recipient's absence from a Level I or II PRTF if the recipient:
 - i. Is in Medicaid payment status in a Level I or II PRTF;
 - ii. Has been in the Level I or II PRTF overnight for at least one (1) night;
 - iii. Is reasonably expected to return requiring Level I or II PRTF care; and
 - iv. Has not exceeded the bed reserve day limit of 5 days per calendar year in aggregate for any combination of bed reserve days associated with an acute care hospital admission, a state mental hospital admission, a private psychiatric hospital admission or an admission to a psychiatric bed in an acute care hospital
- (2) The department's reimbursement for a therapeutic pass day which qualifies as a therapeutic pass day for a recipient not enrolled in a managed care organization shall be:
- (a) 100 percent of the rate established if the Level I or II PRTF's occupancy percent is at least fifty (50) percent; or
 - (b) Fifty (50) percent of the rate established if the Level I or II PRTF's occupancy percent is below fifty (50) percent.
 - (c) The department shall cover a therapeutic pass day for a recipient's absence from a Level I or II PRTF if the recipient:
 - i. Is in Medicaid payment status in a Level I or II PRTF;
 - ii. Has been in the Level I or II PRTF overnight for at least one (1) night;
 - iii. Is reasonably expected to return requiring Level I or II PRTF care; and
 - iv. Has not exceeded the therapeutic pass day limit established; or
 - v. Received an exception to the limit.
 - vi. The annual therapeutic pass day limit per recipient shall be fourteen (14) days per calendar year.
 - vii. The department shall allow a recipient to exceed the limit established with a prior authorization based on medical necessity and reviews with the providers of service.
- (3) (a) A Level I or II PRTF's occupancy percent shall be based on a midnight census.
- (b) An absence from a Level I or II PRTF that is due to a bed reserve day for an acute hospital admission, a state mental hospital admission, a private psychiatric hospital admission, or an admission to a psychiatric bed in an acute care hospital shall count as an absence for census purposes.
- (c) An absence from a Level I or II PRTF that is due to a therapeutic pass day shall not count as an absence for census purposes.

(10) Reimbursement for Out-of-state Hospitals.

- A. As of October 15, 2007, an acute care out-of-state hospital shall be reimbursed for an inpatient acute care service on a fully-prospective per discharge basis. The total per discharge reimbursement shall be the sum of a DRG operating and capital base payment amount, and, if applicable, a cost outlier payment amount.
1. The all-inclusive DRG payment amount:
 - a. Shall be based on the patients diagnostic category; and
 - b. For each discharge by multiplying a hospital's DRG base rate by the Kentucky-specific DRG relative weight minus the adjustment mandated for in-state hospitals.
 2. Out-of-State base rates. The base rate for out-of-state hospitals shall be determined the same as an in-state base rate in accordance with section (2)A., subsections 5. through 11. of this attachment minus:

16. Psychiatric Residential Treatment Facility Services for Level I and II for Individuals Under 21 Years of Age

A. Covered Inpatient Admissions

The following benefits and limitations are applicable for inpatient psychiatric facility services for individuals under 21 years of age (or under 22 years of age if an inpatient in the facility on the individual's 21st birthday):

Kentucky complies with all PRTF requirements outlined at 42 CFR 440.160; 42 CFR 483.352; 42 CFR Part 441, Subpart D and Part 483, Subpart G

Subject to the individual's plan of care, the following services are furnished to children in a PRTF, pursuant to the Inpatient Psychiatric Services to Individuals under Age 21 benefit, provided services are under the direction of a physician. Each patient's treatment plan shall specify the amount and frequency of services needed;

- 1) A covered admission for a Level I PRTF shall be prior authorized by a review agency.
- 2) A covered admission for a Level II PRTF shall be prior authorized;

B. PRTF Covered Inpatient Services.

- 1) The following services shall be available to all eligible recipients:
 - a. Diagnostic and assessment services;
 - b. Treatment plan development, review, or revision;
 - c. Psychiatric services;
 - d. Nursing services which shall be provided in compliance with 902 KAR 20:320;
 - e. Medication which shall be provided in compliance with 907 KAR 1:019;
 - f. Evidence-based treatment interventions;
 - g. Individual therapy which shall comply with 902 KAR 20:320;
 - h. Family therapy or attempted contact with family which shall comply with 902 KAR 20:320;
 - i. Group therapy which shall comply with 902 KAR 20:320;
 - j. Individual and group interventions that shall focus on additional and harmful use or abuse issues and relapse prevention if indicated;
 - k. Substance abuse education;
 - l. Activities that:
 - (1) Support the development of an age-appropriate daily living skill including positive behavior management or support; or
 - (2) Support and encourage the parent's ability to re-integrate the child into the home;
 - m. Emergency interventions pursuant to the restraint and seclusion requirements at:
 - (1) 42 C.F.R. 483.350 through 376; and
 - (2) 902 KAR 20:320;
 - n. Consultation with other professionals including case managers, primary care professionals, community support workers, school staff, or others;
 - o. Educational activities; or
 - p. Non-medical transportation services as needed to accomplish objectives;

16. Psychiatric Residential Treatment Facility Services for Level I and II for Individuals Under 21 Years of Age
- 2) A Level I PRTF service listed in a above shall be:
 - a. Provided under the direction of a physician;
 - b. If included in the recipient's treatment plan, described in the recipient's current treatment plan;
 - c. Medically necessary; and
 - d. Clinically appropriate pursuant to the criteria established in 907 KAR 3:130;
 - 3) A Level I PRTF service listed in g, h, i, k, or m. above shall be provided by a qualified mental health professional, behavioral health professional, or behavioral health professional under clinical supervision; or
 - 4) A Level II PRTF service listed shall be:
 - a. Provided under the direction of a physician;
 - b. If included in the recipient's treatment plan, described in the recipient's current treatment plan;
 - c. Provided at least once a week:
 - (1) Unless the service is necessary twice a week, in which case the service shall be provided at least twice a week; or
 - (2) Except for diagnostic and assessment services which shall have no weekly minimum requirement;
 - d. Medically necessary; and
 - e. Clinically appropriate pursuant to the criteria established in 907 KAR 3:130.
 - 5) A Level II PRTF service listed in (7), (8), (9), (11), or (13) shall be provided by a qualified mental health professional, behavioral health professional, or behavioral health professional under clinical supervision.

C. Durational Limit, Re-evaluation, and Continued Stay for Inpatient Admissions.

- 1) A recipient's stay, including the duration of the stay, in a Level I or II PRTF shall be subject to the department's approval.
- 2) A recipient in a Level I PRTF shall be re-evaluated at least once every thirty (30) days to determine if the recipient continues to meet Level I PRTF patient status criteria.
- 3) A Level I PRTF shall complete a review of each recipient's treatment plan at least once every thirty (30) days.
- 4) If a recipient no longer meets Level I PRTF patient status criteria, the department shall only reimburse through the last day of the individual's current approved stay.
- 5) A Level II PRTF shall complete by no later than the third (3rd) business day following an admission, an initial review of services and treatment provided to a recipient which shall include:

16. Psychiatric Residential Treatment Facility Services for Level I and II for Individuals Under 21 Years of Age
- D. Reserved Bed and Therapeutic Pass Days for Inpatient Admissions

Definition:

An acute care hospital bed reserve day shall be a day when a recipient is temporarily absent from a Level I or II PRTF due to an admission to an acute care hospital. A state psychiatric hospital bed reserve day, private psychiatric hospital bed reserve day, or psychiatric bed in an acute care hospital bed reserve day, respectively, shall be a day when a recipient is temporarily absent from a Level I or II PRTF due to receiving psychiatric treatment in a state psychiatric hospital, private psychiatric hospital, or psychiatric bed in an acute care hospital respectively. A therapeutic pass day shall be a day when a recipient is temporarily absent from a Level I or II PRTF for a therapeutic purpose that is:

- a. Stated in the recipient's treatment plan; and
 - b. Approved by the recipient's treatment team.
- 1) The department shall cover a bed reserve day for an acute hospital admission, a state psychiatric hospital admission, a private psychiatric hospital admission, or an admission to a psychiatric bed in an acute care hospital for a recipient's absence from a Level I or II PRTF if the recipient:
- a. Is in Medicaid payment status in a Level I or II PRTF;
 - b. Has been in the Level I or II PRTF overnight for at least one (1) night;
 - c. Is reasonably expected to return requiring Level I or II PRTF care; and
 - c. Has not exceeded the bed reserve day limit of 5 days per calendar year in aggregate for any combination of bed reserve days associated with an acute care hospital admission, a state psychiatric hospital admission, a private psychiatric hospital admission or an admission to a psychiatric bed in an acute care hospital.
- 2) Based on medical necessity, with a prior authorization, the five (5) day limit may be extended.
- 3) The department shall cover a therapeutic pass day for a recipient's absence from a Level I or II PRTF if the recipient:
- a. Is in Medicaid payment status in a Level I or II PRTF;
 - b. Has been in the Level I or II PRTF overnight for at least one (1) night;
 - c. Is reasonably expected to return requiring Level I or II PRTF care; and
 - d. Has not exceeded the therapeutic pass day limit established; or
 - e. Received an exception to the limit.
 - f. The annual therapeutic pass day limit per recipient shall be fourteen (14) days per calendar year.
 - g. The department shall allow a recipient to exceed the limit established if the department determines that an additional therapeutic pass day is in the best interest of the recipient.

16. Psychiatric Residential Treatment Facility Services for Level I and II for Individuals Under 21 Years of Age

E. Exclusions and Limitations in Coverage for Inpatient Admissions.

- 1) The following shall not be covered as Level I or II PRTF services:
 - a. Pharmacy services, which shall be covered in accordance with Kentucky Medicaid's Pharmacy Program;
 - b. Durable medical equipment, which shall be covered in accordance with Attachment 3.1-A, Page 13 of the Medicaid State Plan;
 - c. Hospital emergency room services, which shall be covered in accordance with Attachment 3.1-A, Page 7.1.1(a);
 - d. Acute care hospital inpatient services, which shall be covered in accordance with Attachment 3.1-A, Page 7.1.1 – Page 7.1.1(a);
 - e. Laboratory and radiology services, which shall be covered in accordance with Attachment 3.1-A, Page 7.1.1(b);
 - f. Dental services, which shall be covered in accordance with Attachment 3.1-A, Page 7.4.1;
 - g. Hearing and vision services, which shall be covered in accordance with Attachment 3.1-A, Page 7.1.3; or
 - h. Ambulance services, which shall be covered in accordance with Attachment 3.1-A, Page 7.9.1.
- 2) A Level I or II PRTF shall not charge a recipient or responsible party representing a recipient any difference between private and semiprivate room charges.



FEB 12 2016

Stephen Miller
Commissioner
Department for Medicaid Services
Kentucky Cabinet for Health & Family Services
275 East Main Street, 6 West A
Frankfort, KY 40621



Re: Designation of Minimum Essential Coverage

Dear Mr. Miller:

The purpose of this letter is to inform the state whether certain types of Medicaid and CHIP coverage provided in Kentucky is recognized by the Centers for Medicare & Medicaid Services (CMS) as minimum essential coverage (MEC) under section 5000A(f)(1)(E) of the Internal Revenue Code of 1986 (the Code).

On November 7, 2014, we explained in State Health Official Letter (SHO) #14-002 that certain types of coverage are not recognized as government-sponsored MEC under section 5000A(f)(1)(A) of the Code, including certain coverage for low-income pregnant women under the Medicaid state plan, coverage for medically needy individuals under the Medicaid state plan, and coverage under a demonstration program authorized under section 1115 of the Social Security Act (the Act). These types of coverage are not included as MEC under Internal Revenue Service (IRS) regulations implementing section 5000A(f)(1)(A)(ii) of the Code.¹ However, in many states, this coverage is comparable to the coverage generally afforded to categorically needy Medicaid beneficiaries. Therefore, pursuant to the authority under section 5000A(f)(1)(E) of the Code, CMS, in consultation with the Secretary of the Treasury, would recognize as MEC, coverage which is not recognized as MEC under the IRS regulations.

Following issuance of SHO #14-002, CMS reviewed the coverage provided to medically needy individuals under Kentucky's Medicaid state plan. We requested additional information from the state to elaborate on any limitations in coverage reflected in the state plan in order to compare the coverage provided against the standard established in the SHO. In the event that the state elects to alter the benefits provided to medically needy individuals, which could affect the MEC designation discussed below, CMS will evaluate the new coverage to assess whether the designation in this letter is still appropriate.

¹ At the time of the SHO, the IRS had not finalized its proposed rule to carve out medically needy or section 1115 coverage as minimum essential coverage. The final rule, implementing 26 CFR 1.5000A-2(b), was published on November 26, 2014.

Medically Needy Coverage

Based on our evaluation of information provided by the state and discussion with state staff, we have determined that the coverage provided to individuals who meet eligibility criteria as medically needy under 42 CFR 435.300 et seq. in Kentucky is comparable to coverage available on the Marketplace. Therefore, in accordance with the guidance, CMS has determined that medically needy coverage in the state is recognized as MEC for individuals who are eligible for such coverage without having to incur medical expenses in order to establish financial eligibility for medically needy coverage. However, coverage provided to individuals who must incur medical expenses in order to establish financial eligibility for medically needy coverage is not recognized as MEC.

Implications of MEC Designation

Under section 5000A of the Code, “nonexempt individuals” must be enrolled in MEC for each month beginning after December 31, 2013, or make a payment (shared responsibility payment) with their federal income tax return. Individuals enrolled in coverage designated as MEC will not be liable for the shared responsibility payment. In addition, individuals eligible for coverage that is MEC are not eligible for advanced premium tax credits (APTC) and cost-sharing reductions (CSR).

Individuals eligible for Medicaid coverage that is not considered MEC may be eligible for APTC and CSRs for enrollment in a qualified health plan (QHP) through the Marketplace. These individuals may simultaneously elect to enroll in Medicaid and a QHP, or they may elect to enroll in Medicaid with the limited benefit. However, unless they are eligible for a hardship or other exemption from the requirement to maintain MEC, individuals who elect Medicaid coverage that is not recognized as MEC may be subject to the shared responsibility payment.

Medically needy individuals enrolled in non-MEC Medicaid after incurring medical expenses to meet their spenddown requirement are eligible for a hardship exemption. On November 21, 2014, the Center for Consumer Information and Information Oversight issued guidance explaining that medically needy individuals who are not enrolled in MEC will need to apply for this hardship exemption through the Marketplace. More information on the hardship exemptions available to Medicaid beneficiaries can be found at

<https://www.cms.gov/ccio/resources/Regulations-and-Guidance/index.html>.

States are required to comply with IRS reporting requirements with respect to individuals who are covered by minimum essential coverage and therefore are not liable for the individual shared responsibility payment. Copies of the 1095-B forms must be furnished to the person identified as the “responsible individual” on the form. For more information on the IRS reporting requirements, please visit <http://www.irs.gov/instructions/i109495b/ar01.html>. We also strongly encourage Kentucky to provide individuals enrolled in non-MEC Medicaid coverage with a notice of their coverage status as well as the availability of an exemption from the shared responsibility payment in the case of medically needy individuals enrolled in Medicaid coverage that is not recognized as MEC and how to obtain the exemption.

Page 3 – Stephen Miller

If you have questions regarding these designations, please contact Ms. Anne Marie Costello, Acting Director, Children and Adults Health Programs Group, Center for Medicaid & CHIP Services, at (410) 786-5647.

Sincerely,

A handwritten signature in black ink, appearing to read "Vikki Wachino". The signature is fluid and cursive, with the first name "Vikki" being more prominent than the last name "Wachino".

Vikki Wachino
Director

cc:

Jackie Glaze, ARA, CMS Regional Office Atlanta

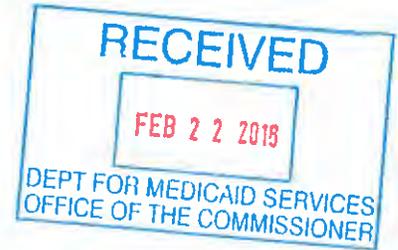
DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Atlanta Regional Office
61 Forsyth Street, Suite 4T20
Atlanta, Georgia 30303



DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

February 12, 2016

Stephen P. Miller, Commissioner
Department for Medicaid Services
275 East Main Street, 6WA
Frankfort, KY 40621-0001



Re: Kentucky State Plan Amendment 16-0002

Dear Mr. Miller:

We have reviewed the proposed Kentucky state plan amendment, KY 16-0002, which was submitted to the Centers for Medicare & Medicaid Services (CMS) on February 9, 2016. This amendment designates Stephen P. Miller, Commissioner of the KY Department for Medicaid Services, as the Governor's designee for review and approval of state plan amendments.

Based on the information provided, the Medicaid State Plan Amendment KY 16-0002 was approved on February 12, 2016. The effective date of this amendment is February 8, 2016. We are enclosing the approved HCFA-179 and a copy of the new state plan pages.

If you have any additional questions or need further assistance, please contact Melanie Benning at (404) 562-7414 or Melanie.Benning@cms.hhs.gov.

Sincerely,

A handwritten signature in black ink that reads "Jackie Glaze".

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

Enclosures

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

1. TRANSMITTAL NUMBER:
16-002

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
February 8, 2016

5. TYPE OF PLAN MATERIAL (Check One):

NEW STATE PLAN AMENDMENT TO BE CONSIDERED AS NEW PLAN AMENDMENT

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

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 430.12(b)

7. FEDERAL BUDGET IMPACT:
a. FFY 2016 \$0
b. FFY 2017 \$0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Page 89

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

Same

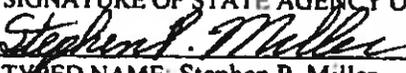
10. SUBJECT OF AMENDMENT:

State Governor's Review appoint Stephen P. Miller, Commissioner

11. GOVERNOR'S REVIEW (Check One):

GOVERNOR'S OFFICE REPORTED NO COMMENT
 COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
 NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

X OTHER, AS SPECIFIED: Review delegated
to Commissioner, Department for Medicaid
Services

12. SIGNATURE OF STATE AGENCY OFFICIAL:


16. RETURN TO:

Department for Medicaid Services
275 East Main Street 6W-A
Frankfort, Kentucky 40621

13. TYPED NAME: Stephen P. Miller

14. TITLE: Commissioner, Department for Medicaid Services

15. DATE SUBMITTED: 2/8/16

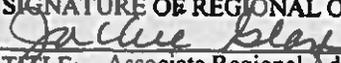
FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 02-09-16

18. DATE APPROVED: 02-12-16

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
02-08-16

20. SIGNATURE OF REGIONAL OFFICIAL:


21. TYPED NAME: Jackie Glaze

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

23. REMARKS:

State: Kentucky

Citation 7.4 State Governor's Review

42 CFR 430.12(b)

The Medicaid Agency will provide opportunity for the Office of Governor to review State plan amendments, long-range program planning projections, and other periodic reports thereon, excluding periodic statistical, budget and fiscal reports. Any comments made will be transmitted to the Centers for Medicare and Medicaid Services with such documents.

- Not Applicable. The Governor-
- Does not wish to review any plan material.
- Wishes to review only the plan materials specified in the enclosed document.

I hereby certify that I am authorized to submit this plan on behalf of

Department for Medicaid Services

(Designated Single State Agency)

Date: February 8, 2016

Stephen P. Miller, Commissioner
Department for Medicaid Services

TN#: 16-002
Supersedes
TN#: 16-001

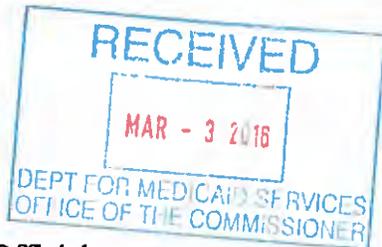
Approval Date: 02-12-16

Effective Date: February 8, 2016

SHO #16-002

Re: Federal Funding for Services "Received Through" an IHS/Tribal Facility and Furnished to Medicaid-Eligible American Indians and Alaska Natives

February 26, 2016



Dear State Health Official:

The purpose of this letter is to inform state Medicaid agencies and other state health officials about an update in payment policy affecting federal funding for services received by Medicaid-eligible individuals, who are American Indians and Alaska Natives (AI/AN) through facilities of the Indian Health Service (IHS), whether operated by IHS or by Tribes. As described in this letter, IHS/Tribal facilities¹ may enter into care coordination agreements with non-IHS/Tribal providers to furnish certain services for their patients who are AI/AN Medicaid beneficiaries, and the amounts paid by the state for services requested by facility practitioners in accordance with those agreements would be eligible for the enhanced federal matching authorized under section 1905(b) of the Social Security Act at a rate of 100 percent. Upon execution of a written care coordination agreement, this will be effective immediately for states for the expenditures for services furnished by non-IHS/Tribal providers to AI/AN Medicaid beneficiaries who are patients of an IHS/Tribal facility acting under such agreement, as described below. This update in payment policy is intended to help states, the IHS, and Tribes to improve delivery systems for AI/ANs by increasing access to care, strengthening continuity of care, and improving population health.

Background

The IHS, a federal agency within the Department of Health and Human Services, is responsible for furnishing comprehensive, culturally-appropriate health services to almost 2.2 million AI/ANs who are eligible for services from the IHS, per regulations at 42 CFR Part 136. To achieve this goal, IHS operates its own hospitals and clinics and partners with Tribes as authorized by the Indian Self-Determination and Education Assistance Act, P.L. 93-638, as amended. The IHS also provides funding for Urban Indian Health Organizations to operate Urban Indian Health Programs (UIHPs) under title V of the Indian Health Care Improvement Act, P.L. 94-437, as amended. The IHS, Tribes, and UIHPs operate health programs in 36 states.²

¹ For purposes of this document, Tribal facilities are facilities that are operated by Tribes and Tribal organizations under the Indian Self-Determination and Education Assistance Act, P.L. 93-638.

² As of the date of this SHO, the states are: AL, AK, AZ, CA, CO, CT, FL, ID, IL, IN, IA, KS, LA, ME, MD, MA, MI, MN, MS, MT, NE, NV, NM, NY, NC, ND, OK, OR, RI, SC, SD, TX, UT, WA, WI, and WY. This list is subject to change.

AI/ANs who meet the eligibility requirements for the Medicaid program in the state in which they reside are entitled to Medicaid coverage, whether or not they are eligible for services from IHS. IHS-eligible AI/ANs who are also Medicaid beneficiaries may choose to receive covered services from an IHS facility, a Tribal facility, a UIHP, or from any other provider participating in a state's Medicaid program.

Under section 1905(b) of the Social Security Act, the federal government is required to match state expenditures at the Federal Medical Assistance Percentage (FMAP) rate, which is 100 percent for state expenditures on behalf of AI/AN Medicaid beneficiaries for covered services "received through" an Indian Health Service facility whether operated by the Indian Health Service or by a Tribe or Tribal organization (as defined in section 4 of the Indian Health Care Improvement Act)." If services are not "received through" an IHS/Tribal facility, the federal government will match the state's payment for the services at the state's regular FMAP rate, which in FY 2016 ranges from 50.00 percent to 74.17 percent.

Our long-standing interpretation of this statutory provision as reflected in sub-regulatory guidance,³ Departmental Appeals Board decisions,⁴ and federal court decisions,⁵ has been that 100 percent FMAP is available for amounts expended for services under the following circumstances:

- (1) The service must be furnished to a Medicaid-eligible AI/AN;
- (2) The service must be a "facility service" – i.e., within the scope of services that a facility (e.g., inpatient hospital, outpatient hospital, clinic, Federally Qualified Health Center/Rural Health Clinic, nursing facility) can offer under Medicaid law and regulation;
- (3) The service must be furnished by an IHS/Tribal facility or by its contractual agent as part of the facility's services; and
- (4) The IHS/Tribal facility must maintain responsibility for the provision of the service and must bill the state Medicaid program directly for the service.

Last year, the Centers for Medicare & Medicaid Services (CMS) announced it was strongly considering re-interpreting the statutory language to expand the services it considers "received through" an IHS/Tribal facility and eligible for the 100 percent FMAP. Specifically, in October 2015, we posted on the CMS Medicaid.gov website a Request for Comment, in which we sought comments on a proposal to re-interpret the statutory language providing 100 percent FMAP for "services received through an IHS facility" by: (1) Modifying the scope of services eligible for enhanced FMAP; (2) Expanding the meaning of contractual agent to be an enrolled Medicaid provider that provides services that are identified in the state's approved Medicaid plan and are arranged for and overseen by the IHS/Tribal facility; and (3) Increasing the flexibility for billing arrangements so that IHS/Tribal facilities or their contractual agents could bill Medicaid directly for services. CMS received 182 comments from 91 commenters including Tribes, Tribal

³ Memorandum of Agreement (MOA) between IHS and HCFA (July 11, 1996); HCFA Memorandum to Associate Regional Administrators (May, 1997).

⁴ *North Dakota Dept. of Human Services*, DAB No. 1854 (2002); *South Dakota Dept. of Social Services*, DAB No. 1847 (2002); *Arizona Health Care Cost Containment System*, DAB No. 1779 (2001); *Alaska Department of Health and Social Services*, DAB No. 1919 (2004).

⁵ *North Dakota ex. Rel. Olson v. Centers for Medicare & Medicaid Services*, 403 F.3d 537 (8th Cir. 2005); *Alaska Department of Health & Social Services v. Centers for Medicare & Medicaid Services*, 424 F. 3rd 931 (9th Cir. 2005); *Arizona Health Care Cost Containment System v. McClellan*, 508 F.3rd 1243 (9th Cir. 2007).

organizations, Urban Indian Health Organizations, states, and other stakeholders. We have reviewed and considered those comments in establishing this new policy interpretation.

Permitting a Wider Scope of Services

In this letter, we are re-interpreting the scope of services considered to be “received through” an IHS/Tribal facility. Under our previous interpretation, in order to be “received through” an IHS/Tribal facility, and therefore, qualify for 100 percent FMAP, the service had to be a “facility service.” By that, we meant that it had to be within the scope of services that a Medicaid facility of the same type (e.g., inpatient hospital, outpatient hospital, clinic, Federally Qualified Health Center/Rural Health Clinic, nursing facility) can provide under Medicaid law and regulation. Under our new interpretation, as described more fully below, the scope of services that can be considered to be “received through” an IHS/Tribal facility for purposes of 100 percent FMAP includes any services that the IHS/Tribal facility is authorized to provide according to IHS rules, that are also covered under the approved Medicaid state plan, including long-term services and supports (LTSS). Medicaid coverable benefit categories include all 1905(a), 1915(i), 1915(j), 1915(k), 1945, and 1915(c) services set forth in the state plan, as well as any other authority established in the future as a state plan benefit.

This scope of service change also applies to transportation that is covered as a service under the state Medicaid plan. Under regulations at 42 CFR 440.170(a), a state can elect to cover transportation and other related travel expenses determined necessary to secure medical examinations and treatment for a beneficiary. Related travel expenses include the cost of meals and lodging en route to and from medical care, and while receiving medical care, as well as the cost for an attendant to accompany the beneficiary, if necessary. Covered transportation services can include both emergency medical transportation and non-emergency medical transportation.

Medicaid Beneficiary and IHS/Tribal Facility Participation is Voluntary

This new interpretation does not provide authority for states to require any AI/AN Medicaid beneficiary to receive services through an IHS/Tribal facility. Nothing in this letter affects the entitlement of AI/AN Medicaid beneficiaries to freedom of choice of provider under section 1902(a)(23) of the Social Security Act. State Medicaid agencies may not, directly or indirectly, require AI/ANs who are eligible for Medicaid to receive covered services from IHS/Tribal facilities for the purpose of qualifying the cost of their services for 100 percent FMAP. Similarly, neither state Medicaid agencies nor IHS/Tribal facilities may require an AI/AN Medicaid beneficiary to receive services from a non-IHS/Tribal provider to whom the facility has referred the beneficiary for care. Nor can a state delay the provision of medical assistance by requiring that beneficiaries initiate or continue a patient relationship with the IHS/Tribal facility. Finally, federal Medicaid law does not require either IHS/Tribal facilities or non-IHS/Tribal providers to enter into the written care coordination agreements described in this SHO.

Request for Services In Accordance With a Written Care Coordination Agreement

In this letter, CMS also revises its interpretation to provide that a service may be considered “received through” an IHS/Tribal facility when an IHS/Tribal facility practitioner requests the service, for his or her patient, from a non-IHS/Tribal provider (outside of the IHS/Tribal facility), who is also a Medicaid provider, in accordance with a care coordination agreement meeting the criteria described below. The purpose of this revised policy interpretation is to enable

IHS/Tribal facilities to expand the scope of services they are able to offer to their AI/AN patients while ensuring coordination of care in accordance with best medical practice standards.

A covered service will be considered to be “received through” an IHS/Tribal facility not only when the service is furnished directly by the facility to a Medicaid-eligible AI/AN patient, but also when the service is furnished by a non-IHS/Tribal provider at the request of an IHS/Tribal facility practitioner on behalf of his or her patient and the patient remains in the Tribal facility practitioner’s care in accordance with a written care coordination agreement meeting the requirements described below. Under this policy, both the IHS/Tribal facility and the non-IHS/Tribal provider must be enrolled in the state’s Medicaid program as rendering providers. Second, there must be an established relationship between the patient and a qualified practitioner at an IHS/Tribal facility. Third, care must be provided pursuant to a written care coordination agreement between the IHS/Tribal facility and the non-IHS/Tribal provider, under which the IHS/Tribal facility practitioner remains responsible for overseeing his or her patient’s care and the IHS/Tribal facility retains control of the patient’s medical record.

A non-IHS/Tribal provider from which an IHS/Tribal facility practitioner could request services could include an Urban Indian Health Organization that participates in Medicaid, or any other Medicaid-participating provider. Furthermore, the relationship between the IHS/Tribal facility practitioner and the patient could be based on visits, including the initial visit, through telehealth procedures that meet state and/or IHS standards for such procedures, if the IHS/Tribal facility has that capacity⁶.

A self-request by the beneficiary, or a request from a non-IHS/Tribal provider, does not suffice for purposes of 100 percent FMAP; in such circumstances, the non-IHS/Tribal provider could furnish the service and bill the state Medicaid program, but the state expenditure for the service would not qualify for 100 percent FMAP. Similarly, the non-IHS/Tribal provider may refer the facility patient to another non-IHS/Tribal provider; however, if the patient receives a covered service from that other provider without a request from the IHS/Tribal facility practitioner, or the IHS/Tribal facility practitioner does not remain responsible for the patient’s care, the state expenditure for the service would not qualify for 100 percent FMAP.

At a minimum, care coordination will involve:

- (1) The IHS/Tribal facility practitioner providing a request for specific services (by electronic or other verifiable means) and relevant information about his or her patient to the non-IHS/Tribal provider;
- (2) The non-IHS/Tribal provider sending information about the care it provides to the patient, including the results of any screening, diagnostic or treatment procedures, to the IHS/Tribal facility practitioner;
- (3) The IHS/Tribal facility practitioner continuing to assume responsibility for the patient’s care by assessing the information and taking appropriate action, including, when necessary, furnishing or requesting additional services; and
- (4) The IHS/Tribal facility incorporating the patient’s information in the medical record through the Health Information Exchange or other agreed-upon means.

Written care coordination agreements under this policy could take various forms, including but not limited to a formal contract, a provider agreement, or a memorandum of understanding and,

⁶ Or as specified in a demonstration project authorized under section 1637 of the Indian Health Care Improvement Act.

to the extent it is consistent with IHS authority, would not be governed by federal procurement rules. The IHS/Tribal facility may decide the form of the written agreement that is executed with the non-IHS/Tribal provider.

Medicaid Billing and Payments to Non-IHS/Tribal Providers

For services provided to Medicaid-eligible AI/AN beneficiaries that are rendered by a non-IHS/Tribal provider in accordance with a written care coordination arrangement, there are several options regarding how those services may be billed to Medicaid.

The first option is for the non-IHS/Tribal provider to bill the Medicaid agency directly. If the non-IHS/Tribal provider bills the state Medicaid program directly, the provider would be reimbursed at the rate authorized under the Medicaid state plan applicable to the provider type and service rendered. To support the application of the 100 percent FMAP, the state should ensure that claims include fields that document that the item or service was “received through” an IHS/Tribal facility. When a non-IHS provider bills a state directly, the state’s payment rate for a covered service furnished by a non-IHS/Tribal provider to an AI/AN Medicaid beneficiary under a written care coordination agreement must be the same as the rate for that service furnished by that provider to a non-AI/AN beneficiary or to an AI/AN beneficiary who self-refers to the provider. Similarly, a state agency cannot establish one rate for services furnished by the facility to AI/AN beneficiaries and another for the same services provided by that facility to non-AI/AN Medicaid beneficiaries.

A second option is for the IHS or Tribal facility to handle all billing. In that case, the IHS/Tribal facility would have to separately identify services provided by non-IHS/Tribal providers under agreement that can be claimed as services of the IHS/Tribal facility (“IHS/Tribal facility services”) from those that cannot. Inpatient services that are furnished by non-IHS providers outside of IHS/Tribal facilities could never be claimed as IHS/Tribal facility services. For IHS, other services provided by non-IHS providers outside of an IHS facility generally cannot be claimed as IHS facility services. Tribal facilities generally may have more flexibility than IHS and should consult with their state to determine the circumstances in which other services provided by non-Tribal providers can be claimed as Tribal facility services. The circumstances under which Tribal facilities may claim services as their own are the same as those that apply for other similar facilities in the state (e.g., inpatient or outpatient hospitals, nursing facilities, Federally Qualified Health Centers, etc.). Services that can properly be claimed as IHS/Tribal facility services may be billed directly by the IHS/Tribal facility and are paid at the applicable Medicaid state plan IHS/Tribal facility rate. For all other services provided by non-IHS/Tribal providers, IHS or the Tribe could bill for these services as an assigned claim by that provider and the payment rate would be the state plan rate applicable to the furnishing provider and the service, not the applicable Medicaid state plan IHS/Tribal facility rate. These services are still eligible for the 100 percent FMAP, provided other requirements have been met.

The billing arrangement should be reflected in the written agreement between the IHS/Tribal facility and the non-IHS/Tribal provider. Payment methodologies for facility services furnished by both the IHS/Tribal facility and rate methodologies paid to non-IHS/Tribal providers must be set forth in an approved state Medicaid plan. Payment rates can reflect the unique access concerns in particular geographic areas, or with respect to certain types of providers. However, rates may not vary based on the applicable FMAP. States should review existing state plans to ensure compliance with the policy articulated in this letter.

Managed Care

The discussion above assumes that the Medicaid-eligible AI/AN has “received [services] through” the IHS/Tribal facility on a fee-for-service basis. In some cases, however, Medicaid-eligible AI/ANs may be enrolled in a risk-based Medicaid managed care organization (MCO), prepaid inpatient health plan (PIHP), or prepaid ambulatory health plan (PAHP), in which case the state Medicaid agency is making monthly capitation payments on behalf of the AI/AN enrollee to the MCO, PIHP, or PAHP. The state may claim 100 percent FMAP for the portion of the capitation payment attributable to the cost of services “received through” an IHS/Tribal facility if the following conditions are met:

- (1) The service is furnished to an AI/AN Medicaid beneficiary who is enrolled in the managed care plan;
- (2) The service meets the same requirements to be considered “received through” an IHS/Tribal facility as would apply in a fee-for-service delivery system and the managed care plan maintains auditable documentation to demonstrate that those requirements are met;
- (3) The non-IHS/Tribal provider is a network provider of the enrollee’s managed care plan;
- (4) The non-IHS/Tribal provider is paid by the managed care plan consistent with the network provider’s contractual agreement with the managed care plan; and
- (5) The state has complied with section 1932(h)(2)(C)(ii) of the Act consistent with CMS guidance.

States would be permitted to claim the 100 percent FMAP for a portion of the capitation payment for AI/ANs who are enrolled in managed care, even though the state itself has made no direct payment for services “received through” an IHS/Tribal facility. The portion of the managed care payment eligible to be claimed at 100 percent FMAP must be based on the cost of services attributable to IHS/Tribal services or encounters received through an IHS/Tribal provider meeting the requirements outlined in this section.

Compliance and Documentation

To ensure accountability for program expenditures, in states where IHS/Tribal facilities elect to implement the policy described in this letter, the Medicaid agency will need to establish a process for documenting claims for expenditures for items or services “received through” an IHS/Tribal facility. The documentation must be sufficient to establish that (1) the item or service was furnished to an AI/AN patient of an IHS/Tribal facility practitioner pursuant to a request for services from the practitioner; (2) the requested service was within the scope of a written care coordination agreement under which the IHS/Tribal facility practitioner maintains responsibility for the patient’s care; (3) the rate of payment is authorized under the state plan and is consistent with the requirements set forth in this letter; and (4) there is no duplicate billing by both the facility and the provider for the same service to the same beneficiary.

Applicability to Section 1115 Demonstrations

State expenditures for services covered under section 1115 demonstration authority are eligible for 100 percent FMAP as long as all of the elements of being “received through” an IHS or Tribal facility that are described in this SHO are present.

Relationship Between 100 Percent FMAP for Tribal Services and Other Federal Matching Rates

The 100 percent FMAP for services “received through” an IHS/Tribal facility is available for services provided to AI/ANs as described in this SHO instead of the regular FMAP rate described in section 1905(b) of the Act, the newly eligible FMAP rate described in section 1905(y) of the Act, the enhanced FMAP rate for breast and cervical cancer, or the enhanced rate for Community First Choice services.

We intend to issue additional guidance materials after the release of this SHO. CMS is available to work closely with each state to implement the policy established in this state health official letter regarding receiving 100 percent FMAP for services “received through” an IHS/Tribal facility. If you have any questions regarding this information, please contact TribalAffairs@cms.hhs.gov or Kirsten Jensen, Director, Division of Benefits and Coverage, 410-786-8146.

Sincerely,

/s/

Vikki Wachino

Director

cc:

National Association of Medicaid Directors

National Academy for State Health Policy

American Public Human Services Association

National Governors Association

Council of State Governments

Association of State and Territorial Health Officials

SMD# 16-003



RE: Availability of HITECH Administrative Matching Funds to Help Professionals and Hospitals Eligible for Medicaid EHR Incentive Payments Connect to Other Medicaid Providers

February 29, 2016

Dear State Medicaid Director:

This letter updates guidance issued by the Centers for Medicare & Medicaid Services (CMS) about the availability of federal funding at the 90 percent matching rate for state expenditures on activities to promote health information exchange (HIE) and encourage the adoption of certified Electronic Health Record (EHR) technology by certain Medicaid providers. CMS previously issued guidance on this topic in State Medicaid Director (SMD) Letter #10-016 (August 17, 2010)¹, SMD Letter #11-004 (May 18, 2011)², and a 2013 guidance document, “CMS Answers to Frequently Asked Questions (9/10/2013)” (2013 guidance).

This updated guidance expands the scope of State expenditures eligible for the 90 percent matching rate, and supports the goals of, “Connecting Health and Care for the Nation: A Shared Nationwide Interoperability Roadmap Version 1.0,”³ published by the Department of Health and Human Services, Office of the National Coordinator (ONC) for Health Information Technology, on October 6, 2015. In this letter, we are expanding our interpretation of the scope of State expenditures eligible for the 90 percent HITECH match, given the greater importance of coordination of care across providers and transitions of care in Meaningful Use modified Stage 2 and Stage 3. This letter supersedes the 2013 guidance but many of the principles of that guidance, as indicated in this letter, remain valid. We intend to issue updated, detailed guidance that integrates those principles with the interpretive changes set forth in this letter.

The Health Information Technology for Economic and Clinical Health (HITECH) Act, enacted as part of the American Recovery and Reinvestment Act of 2009, Pub. L. 111-5, added sections 1903(a)(3)(F) and 1903(t) to the Social Security Act. These provisions make available to States 100 percent Federal matching funding for incentive payments to eligible Medicaid providers to encourage the adoption and use of certified EHR technology through 2021, and 90 percent Federal matching funding (the 90 percent HITECH match) for State administrative expenses related to the program, including State administrative expenses related to pursuing initiatives to encourage the adoption of certified EHR technology to promote health care quality and the exchange of health care information, subject to CMS approval. CMS has implemented these

¹ Available at <http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD10016.pdf>

² Available at <https://www.medicare.gov/Federal-Policy-Guidance/downloads/SMD11004.pdf>

³ Available at <https://www.healthit.gov/sites/default/files/hie-interoperability/nationwide-interoperability-roadmap-final-version-1.0.pdf>

provisions in regulations at 42 CFR Part 495. When attesting to Meaningful Use modified Stage 2 or Stage 3, professionals and hospitals that are eligible for Medicaid EHR Incentive Payments (collectively referred to in this document as Eligible Providers) must demonstrate the ability to electronically coordinate with other providers across care settings under the CMS regulations at 42 CFR Part 495. In order to meet these Meaningful Use objectives, Eligible Providers will often need to electronically coordinate care with other Medicaid providers that are not eligible for Medicaid EHR incentive payments.

SMD Letters #10-016 and #11-004 explained that state costs related to HIE promotion may be matched at the 90 percent HITECH matching rate only if they can be directly correlated to the Medicaid EHR Incentive Program. In the 2013 guidance, we therefore explained that States' costs of facilitating connections for providers to an HIE may be matched at the 90 percent HITECH matching rate only if the providers are Eligible Providers. We now explain that State costs of facilitating connections between Eligible Providers and other Medicaid providers (for example, through an HIE or other interoperable systems), or costs of other activities that promote other Medicaid providers' use of EHR and HIE, can also be matched at the 90 percent HITECH matching rate, but only if State expenditures on these activities help Eligible Providers meet the Meaningful Use objectives. Subject to CMS prior approval, States may thus be able to claim 90 percent HITECH match for expenditures related to connecting Eligible Providers to other Medicaid providers, including behavioral health providers, substance abuse treatment providers, long-term care providers (including nursing facilities), home health providers, pharmacies, laboratories, correctional health providers, emergency medical service providers, public health providers, and other Medicaid providers, including community-based Medicaid providers.

For example, an Eligible Provider might be a physician needing to meet the modified Stage 2 or Stage 3 Meaningful Use objective for health information exchange (*see* 42 CFR 495.22(e)(5)(i) or 495.24(d)(7)(i)(A)) when transitioning patients to another Medicaid provider such as a nursing facility, or a home health care provider. Or an eligible hospital might need to meet the objective for Medication Reconciliation and compare records with other providers to confirm that the information it has on patients' medication is accurate when it admits patients into its care (*see* 42 CFR 495.22(e)(7)(i) or 495.24(d)(7)(ii)(B)(3)(i)). Subject to CMS approval, States can claim 90 percent HITECH match in the costs of developing connectivity between Eligible Providers (whether eligible professionals or eligible hospitals) and other Medicaid providers if this will help the Eligible Providers demonstrate Meaningful Use.

CMS explicitly encourages and welcomes multistate collaboratives partnering on shared solutions for HIE and interoperability, including for the activities discussed in this letter (facilitation of EHR Meaningful Use and related communications through the HIE system). CMS will aggressively support such collaboratives as potentially cost-saving opportunities to increase adoption of interoperability standards and help Eligible Providers demonstrate Meaningful Use. Such collaboratives should promote Medicaid Information Technology Architecture (MITA) principles on scalability, reusability, modularity, and interoperability. We note that ONC is a willing partner in helping States develop open source and open architecture tools for HIE that are consistent with MITA principles.

Cost controls, cost allocations, and other payers

States must ensure that any 90 percent HITECH match claimed under the guidance in this letter supports Eligible Providers' demonstration of Meaningful Use modified Stage 2 and Stage 3, and must therefore report on the extent to which the activities they are funding help Eligible Providers demonstrate Meaningful Use. CMS will require States to describe in advance which specific Meaningful Use measures they intend to support in the Implementation Advance Planning Document (IAPD) as well as to confirm such measures are indeed supported post-implementation. Under no circumstances may States claim 90 percent HITECH match in the costs of actually providing EHR technology to providers or supplementing the functionality of provider EHR systems. This funding is available, subject to CMS approval, as of the date of this letter, and will not be available retroactively.

Additionally, States should claim the 90 percent HITECH match for HIE-related costs relating to Medicaid providers that are not eligible for Medicaid EHR incentive payments only if those HIE-related costs help Eligible Providers demonstrate Meaningful Use. For example, it would not be appropriate for States to claim the 90 percent HITECH match for costs related to an HIE system that did not connect to or include Eligible Providers and therefore would not help Eligible Providers demonstrate Meaningful Use.

States should continue to adhere to the guidance in SMD Letter #11-004 detailing how Medicaid funding should be part of an overall financial plan that leverages multiple public and private funding sources to develop HIEs. Similarly, States are reminded that per SMD Letter #11-004, the 90 percent HITECH match cannot be used for ongoing operations and maintenance costs. This updated guidance makes no changes to the general cost allocation principles and fair share principles States should follow in proposing funding models to CMS for HIEs or interoperable systems, although under this updated guidance, the Medicaid portion of such cost allocations may increase to include costs associated with connecting Eligible Providers to other Medicaid providers. CMS has approved several different cost allocation methodologies for States and those various methodologies will be affected differently by this guidance. CMS will provide technical assistance on the impact of this guidance on specific States. Similarly, States should continue to complete and update the "Health Information Technology Implementation Advance Planning Document (HIT IAPD) Template⁴," developed by CMS and the Office of Management and Budget, in which States detail cost allocation models and other financial considerations. States should meet with CMS to review cost allocation models that carefully consider the extent to which the HIE or other interoperable system benefits Eligible Providers, other Medicaid providers, non-Medicaid providers, and other payers.

Medicaid Information Technology Architecture (MITA) emphasizes the importance of interoperability and industry standards. States should take an aggressive approach to HIE and interoperability governance for purposes of supporting interoperability while focusing on security and standards to keep interface costs to a minimum. The CMS final rule published on December 4, 2015, "Mechanized Claims Processing & Information Retrieval Systems (90/10)"

⁴ https://www.cms.gov/regulations-and-guidance/legislation/ehrincentiveprograms/downloads/medicaid_hit_iapd_template.pdf

requires in 42 CFR 433.112 a new focus on industry standards in MITA that support more efficient, standards-based information exchange as described in 45 CFR Part 170. Specifically, 45 CFR Part 170 defines the Common Clinical Data Set, transport standards, functional standards, content exchange standards and implementation specifications for exchanging electronic health information, and vocabulary standards for representing electronic health information. In implementing these standards, we encourage States to develop partnerships with non-profit collaboratives and other industry participants such as DirectTrust that further support Direct Secure Messaging through trust frameworks that reduce the costs and technical complexities of electronic health information exchange for providers.

The interoperable systems described in this letter are part of the MITA and interfaces to these systems should appropriately follow a Service-Oriented Architecture (SOA) as well as adhere to industry standards. States should aggressively pursue HIE and interoperability solutions for Medicaid providers that either obviate the need for costly interfaces, or utilize open architecture solutions that make such interfaces easily acquired. For example, consistent with the software ownership rights held by the state under 45 CFR § 95.617, States might require that HIE interfaces designed, developed, or installed with Federal financial participation be made available at reduced or no cost to other Medicaid providers connecting to the same HIE. Furthermore, States could require that such interfaces (or the code for such interfaces) be made publicly available. Additionally, CMS and ONC support States in sharing open source tools and interfaces with other States to further drive down the costs of HIEs, interfaces, and other interoperable systems.

States are also reminded that careful alignment and coordination with other funding sources should be thoroughly discussed with CMS and addressed in an Implementation Advance Planning Document Update (IAPD-U), specifically Appendix D. States continue to be encouraged to consult with CMS in advance of formal State Medicaid HIT Plan (SMHP) and IAPD submissions to obtain technical assistance regarding the funding options and boundaries outlined in this and the previous SMD Letters, and additional technical assistance will be provided when we release an update to the 2013 guidance that reflects the new criteria for the 90 percent HITECH match described here. States should reach out to their CMS regional office's Medicaid HIT staff lead as the initial point of contact.

Below are some examples of the types of state costs for which 90 percent HITECH match might be available, subject to CMS approval.

Federal Financial Participation (FFP) for On-boarding Medicaid providers to HIEs or interoperable systems

On-boarding is the technical and administrative process by which a provider joins an HIE or interoperable system and secure communications are established and all appropriate Business Associate Agreements, contracts and consents are put in place. State activities related to on-boarding might include the HIE's activities involved in connecting a provider to the HIE so that the provider is able to successfully exchange data and use the HIE's services. The 90 percent HITECH match is available to cover a state's reasonable costs (e.g., interfaces and testing) to on-board providers to an HIE. Subject to the parameters and cost controls described above, States

may claim 90 percent HITECH match for state costs of supporting the initial on-boarding of Medicaid providers onto an HIE, or onto any interoperable system that connects Eligible Providers to other Medicaid providers. Costs can be claimed both if they are incurred by the state to support the initial on-boarding of Eligible Providers and if they are incurred by the state to support the on-boarding of other Medicaid providers, provided that connecting the other Medicaid providers helps Eligible Providers demonstrate, and meet requirements for, Meaningful Use. States should coordinate with CMS on defining benchmarks and targets for on-boarding providers. States are reminded that, consistent with the principles described in both SMD Letter #10-016 and SMD Letter #11-004, the 90 percent HITECH match is for implementation only, and States should work with CMS on establishing an endpoint to onboarding and always ensure costs are allocated as appropriate across other payers. Also, the scope of the onboarding should be clearly defined and reviewed with CMS prior to IAPD submission to ensure that any costs claimed help Eligible Providers meet Meaningful Use and to ensure that HIE-related costs benefiting providers that are not eligible for Medicaid EHR incentive payments are claimed only if these costs help Eligible Providers demonstrate Meaningful Use. States should generally refer to SMD Letters #10-016 and #11-004 for other information about allowable onboarding costs.

Pharmacies: Similarly, subject to the parameters and cost controls described above, States may claim the 90 percent HITECH match for the costs of supporting the initial on-boarding of pharmacies to HIEs or other interoperable systems, if on-boarding the pharmacies helps Eligible Providers meet Meaningful Use objectives, such as the objectives around sending electronic prescriptions or the objectives around conducting medication reconciliations, both described in 42 CFR 495.22 and 495.24.

Clinical Laboratories: Subject to the parameters and cost controls described above, States may also claim 90 percent HITECH match for the costs of supporting the initial on-boarding of clinical laboratories to HIEs or interoperable systems, if on-boarding these laboratories helps Eligible Providers meet Meaningful Use objectives, such as the objectives for Electronic Reportable Lab Results or laboratory orders in Computerized Provider Order Entry (CPOE) described in 42 CFR 495.22 and 495.24.

Public Health Providers: Similarly, subject to the parameters and cost controls described above, States may also claim 90 percent HITECH match for the costs of on-boarding Medicaid public health providers to interoperable systems and HIEs connected to Eligible Providers so that Eligible Providers are able to meet Meaningful Use measures focused on public health reporting and the exchange of public health data, including activities such as validation and testing for reporting of public health measures described in 42 CFR 495.22 and 495.24.

FFP for interoperability and HIE architecture

As with expenses for on-boarding, States may claim 90 percent HITECH match for their costs of connecting Eligible Providers to other Medicaid providers via HIEs or other interoperable systems, if doing so helps Eligible Providers demonstrate Meaningful Use and the cost controls described above are met.

Specifically, 90 percent HITECH match would be available for States' costs related to the design, development, and implementation of infrastructure for several HIE components and interoperable systems that most directly support Eligible Providers in coordinating care with other Medicaid providers in order to demonstrate Meaningful Use. As described in SMD Letter #11-004, the 90 percent HITECH match cannot be used for ongoing operations and maintenance costs after this technology is established and functional. These components and systems include:

Provider Directories: States may claim the 90 percent HITECH match for costs related to the design, development, and implementation of provider directories that allow for the exchange of secure messages and structured data to coordinate care or calculate clinical quality measures between Eligible Providers and other Medicaid providers, so long as these costs help Eligible Providers meet Meaningful Use and the cost controls described above are met. The 90 percent HITECH match would not be appropriate for costs of developing a separate subdirectory for a class of providers that are not eligible for Medicaid EHR incentive payments and that are unlikely ever to exchange records with an Eligible Provider. CMS emphasizes the importance of dynamic provider directories with, as appropriate, bidirectional communications to public health agencies and public health registries. CMS particularly supports approaches to provider directories that provide solutions for Eligible Providers to connect to other Medicaid providers with lower EHR adoption rates, if doing so helps the Eligible Providers demonstrate Meaningful Use. Secure, web-based provider directories, for example, might help Eligible Providers coordinate care more effectively with long term care providers, behavioral health providers, substance abuse providers, etc. CMS expects that States will consider provider directories as a Medicaid enterprise asset that can also support Medicaid Management Information System (MMIS) functionality, with the reminder that, per SMD Letter #10-016, States should not claim 90 percent HITECH match for costs that could otherwise be matched with MMIS matching funds.

Secure Electronic Messaging: States may claim the 90 percent HITECH match for costs related to the design, development, and implementation of secure messaging solutions that connect Eligible Providers to other Medicaid providers and allow for the exchange of secure messages and structured data, so long as these costs help Eligible Providers meet Meaningful Use and the cost controls described above are met. States are encouraged to utilize Direct Secure Messaging as a transport standard that is secure and scalable. States should refer to the “Medicare and Medicaid Programs; Electronic Health Record Incentive Program – Stage 3 and Modifications to Meaningful Use in 2015 Through 2017” rule for guidance on meeting the Certified Electronic Health Record Technology (CEHRT) requirements for purposes of Meaningful Use⁵. States may also refer to ONC’s 2016 Interoperability Standards Advisory (ISA), a publication that provides the identification, assessment, and determination of the “best available” interoperability standards and implementation specifications for industry use to fulfill specific clinical health IT interoperability needs⁶. States should also be prescriptive in governance requirements to ensure maximal interoperability in the most secure and efficient manner possible. ONC is a willing partner with CMS in helping States deploy Direct Secure Messaging systems and developing

⁵ <https://www.federalregister.gov/articles/2015/10/16/2015-25595/medicare-and-medicaid-programs-electronic-health-record-incentive-program-stage-3-and-modifications>

⁶ <https://www.healthit.gov/sites/default/files/2016-interoperability-standards-advisory-final-508.pdf>

related governance requirements to ensure that Eligible Providers can connect to other Medicaid providers.

Query Exchange: States may claim the 90 percent HITECH match for costs related to the design, development, and implementation of query-based health information exchange, so long as these costs help Eligible Providers meet Meaningful Use, and the cost controls described above are met. States may support coordination of care between Eligible Providers and other Medicaid providers by linking them into a query-based HIE that allows for secure, standards-based information exchange with thorough identity management protocols. A Query Exchange might access a state's Clinical Data Warehouse and similarly be integrated with analytic and reporting functions. These activities may support aggregate queries from providers to support population health activities performed by public health or other entities involved in population health improvement, provided that doing so helps Eligible Providers meet Meaningful Use. Given the unique data and exchange governance challenges of Query Exchange, States are encouraged to reach out to ONC to help formulate governance guidance and best practices.

Care Plan Exchange: States may claim the 90 percent HITECH match for costs related to the design, development, and implementation of interoperable systems and HIEs that facilitate the exchange of electronic care plans between Eligible Providers and other Medicaid providers, so long as these costs help Eligible Providers meet Meaningful Use, and the cost controls described above are met. Medicaid providers coordinating care across multiple care settings may exchange care plans containing treatment plans and goals, as well as problem lists, medication history and other clinical and non-clinical content added and updated as appropriate by members of a patient's care team, including Medicaid social service providers. States are encouraged to consider care plan exchange for patients with multiple chronic conditions who might be coordinating care between many specialists, hospital(s), long term care facilities, rehabilitation centers, home health care providers, or other Medicaid community-based providers. Similarly, children in the foster care system might benefit from care plans shared across Medicaid providers (including Eligible Providers) to facilitate coordination of the children's care. As discussed above, costs related to exchanging care plans between Medicaid providers and other programs, such as foster care programs, may need to be allocated between benefitting programs.

Encounter Alerting: States may claim the 90 percent HITECH match for costs related to the design, development, and implementation of communications within an HIE or interoperable system connecting Eligible Providers and other Medicaid providers about the admission, discharge or transfer of Medicaid patients, so long as these costs help Eligible Providers meet Meaningful Use, and the cost controls described above are met. These communications among Medicaid providers may contain structured data regarding treatment plans, medication history, drug allergies, or other secure content that aids in the coordination of patient care, including coordination of social services as appropriate.

Public Health Systems: States may claim the 90 percent HITECH match for costs related to the design, development, and implementation of public health systems and connections to public health systems, so long as the cost controls described above are met, and so long as these costs help Eligible Providers meet Meaningful Use measures focused on public health reporting and the exchange of public health data described in 42 CFR 495.22 and 495.24. It is worth

emphasizing that state costs eligible for the 90 percent HITECH match might include costs related to developing registry and system architecture for Prescription Drug Monitoring Programs (PDMPs), as per FAQ #13413⁷ PDMPs can be considered a specialized registry to which Eligible Providers may submit data in order to meet Meaningful Use objectives. States should, however, keep in mind that MMIS matching funds might in some circumstances be a more appropriate source of federal funding for costs related to developing a PDMP. Again, States should not claim 90 percent HITECH match for costs that could otherwise be matched with MMIS matching funds.

Health Information Services Provider (HISP) Services: States may claim the 90 percent HITECH match for costs related to the design, development, and implementation of HISP Services that coordinate the technical and administrative work of connecting Eligible Providers to other Medicaid providers, so long as these costs help Eligible Providers meet Meaningful Use, and the cost controls described above are met. HISP Services may coordinate encryption standards across providers, as well as coordinate contracts, Business Associate Agreements or other consents deemed appropriate for the HIEs or interoperable systems. States should be careful to distinguish between on-boarding services and HISP Services, as the scope of HISP activities overlaps with the scope of on-boarding activities, and the state should confirm that activities are only supported with federal funding once. States should clearly define the scope of HISP activities and on-boarding activities as appropriate.

This is not an exhaustive list of the types of state costs for design, development, and implementation of HIE components and interoperable systems for which 90 percent HITECH match might be claimed. Design, development, and implementation costs associated with other HIE components and interoperable systems might be supported by the 90 percent HITECH match as long as these costs help Eligible Providers achieve Meaningful Use and meet the cost controls described above, and will be considered by CMS accordingly.

Under this updated guidance, States remain able, subject to CMS approval, to claim 90 percent HITECH match for design, development, and implementation costs related to personal health records (PHRs), as utilizing a PHR through an HIE will often be the best way for many Eligible Providers to meet the Meaningful Use modified stage 2 Patient Electronic Access objective (*see* 42 CFR 495.22(e)(8)) and/or the Meaningful Use stage 3 Coordination of Care Through Patient Engagement objective (*see* 42 CFR 495.24(d)(6)). The parameters for HITECH administrative funding discussed in SMD Letters #10-016 and #11-004 continue to be relevant to PHR funding requests from States.

Conclusion

With more States utilizing or exploring the possibilities of vehicles for delivery system reform that benefit from coordination of care, such as health homes, primary care case management, managed care, home and community-based service programs, and performance-based incentive payment structures, there is an expectation that the Medicaid Enterprise infrastructure will be designed to support these efforts. These efforts therefore support the MITA principles of

⁷ <https://questions.cms.gov/faq.php?faqId=13413>

reusability, interoperability, and care management in providing a foundation for further delivery system reform.

As States enter the fifth year of the Medicaid EHR Incentive Program, CMS and ONC expect them to leverage available federal funding for tools and guidance to help Eligible Providers demonstrate Meaningful Use, which might include strengthening data exchange between Eligible Providers and other Medicaid providers. States may have questions about the Health Insurance Portability and Accountability Act (HIPAA) considerations applicable to creating more diverse HIEs and interoperable systems, so we have included links to guidance from the U.S. Department of Health and Human Services Office for Civil Rights and the Office of the National Coordinator for Health Information Technology describing uses and disclosures that are permitted under HIPAA⁸. Note that the discussion in the linked guidance only concerns the uses and disclosures that are permitted under HIPAA, and does not address when state costs related to the discussed activities would be eligible for the 90 percent HITECH match. This next phase of infrastructure development and connectivity will best position all Eligible Providers to successfully demonstrate Meaningful Use of Certified EHR Technology while solidifying a broader network of health information exchange among Medicaid providers, writ large.

Sincerely,

/s/

Vikki Wachino
Director

Enclosure

cc:

National Association of Medicaid Directors
National Academy for State Health Policy
National Governors Association
American Public Human Services Association
Association of State Territorial Health Officials
Council of State Governments
National Conference of State Legislatures

⁸ https://www.healthit.gov/sites/default/files/exchange_health_care_ops.pdf and https://www.healthit.gov/sites/default/files/exchange_treatment.pdf