

MAC Binder Section 1 – Letters From CMS

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

1 – CMS-HCBS-Ltr to LL & LH from JG re 1915b_dte091515:

CMS request for additional information (RAI) in response to the State’s request to renew Kentucky’s Home and Community Based Waiver for individuals who are technology (ventilator) dependent who meet the NF level of care.

2 – CMS-MCO-Ltr to LL from JG re _MCO Contracts dte100815:

CMS has reviewed and is approving Kentucky’s submission of MCO contracts and rates, subject to Kentucky operating managed care consistently with the State Plan or and Waiver of the State Plan.

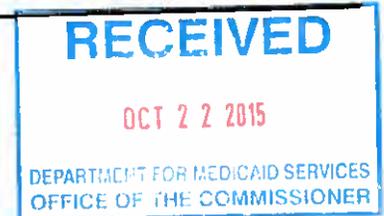
3 – CMS-MCW -Ltr to LL from JG_dte101615:

CMS is approving Kentucky’s request to renew its 1915(b) Managed Care Waiver Program (KY-07.R01). The waiver allows Kentucky to mandatorily enroll all Medicaid populations enrolled in the waiver.

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



October 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) is approving Kentucky's request to renew its 1915(b) Managed Care waiver program (Control # KY-07.R01). The waiver allows Kentucky to mandatorily enroll all Medicaid populations enrolled in the waiver.

CMS has reviewed the state's waiver renewal application, which includes a cost-effectiveness analysis, a description of program monitoring and operations, and an independent assessment of the existing managed care program. We approve this waiver renewal based on the evidence Kentucky provided in its initial renewal application and subsequently in its responses to CMS's informal requests for further information. This evidence demonstrated that the state's waiver program is consistent with the purposes of the Medicaid program, that the waiver program meets all the statutory, regulatory, and CMS policy requirements for assuring beneficiaries access to quality care, and that it will be a cost-effective and efficient means of providing services to Medicaid recipients in Kentucky.

This managed care waiver program is authorized under section 1915(b)(1) of the Social Security Act and provides for waivers of the following sections of Title XIX:

- Section 1902(a)(10)(B) - Comparability of Services
- Section 1902(a)(23) - Freedom of Choice

This waiver is approved from November 1, 2015 to October 31, 2017.

If you wish to renew this waiver at the end of the two year term, you must submit a renewal application no later than July 31, 2017. If we do not receive a renewal application by this date, CMS will seek a phase down plan from the state to terminate the waiver program.

We wish you continued success in operating the Kentucky 1915(b)(1) managed care program. Thank you for your cooperation during the waiver renewal review process. If you have any further

Ms. Lisa D. Lee
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questions, please contact Cheryl L. Brimage, Atlanta Regional Office, at (404) 562-7116 or Lovie Davis, CMS Central Office, at (410) 786-1533.

Sincerely,

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

October 8, 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:

In accordance with 42 CFR § 438.6, the Centers for Medicare & Medicaid Services (CMS) has reviewed and is approving Kentucky's submission of Managed Care Organization contracts and rates, subject to Kentucky operating managed care consistently with the State Plan or any waiver of the State Plan. CMS received the contracts on July 16, 2015. We received the rates for these contracts in three parts: the initial certification dated January 29, 2015; a risk adjustment amendment to the rates dated June 9, 2015; and an amendment to these rates dated July 28, 2015. The contracts and rates are for the period July 1, 2015 through June 30, 2016.

Specifically, the following contracts are approved:

- Anthem
- Coventry
- Humana
- Passport
- Wellcare

CMS based its decision to approve these contracts and rates based on our formal review of the contracts considering federal regulation and policy, as well as an actuarial review of the rates performed by our Office of the Actuary. Through the actuarial review, we determined the rates are consistent with federal regulations found at 42 CFR § 438.6(c), the 2015 Medicaid Managed Care Rate Consultation Guide, and all applicable Actuarial Standards of Practice developed by the Actuarial Standards Board, and that they fell within the actuarially certified rate range.

Although the rates met all federal regulations, actuarial standards and practices, and are consistent with Medicaid managed care policy, there are some areas in your rate development that we believe the state could improve in future years that would further refine the accuracy and predictability of the rates, and improve oversight of the Medicaid managed care program. These areas include: reducing the number of rate cells in order to improve credibility and to reduce the

need to use smoothing techniques; improving encounter data collection efforts at the state level, which will allow the state and actuaries to use state-collected encounter data as compared to ad hoc data requests from the MCOs; and revising the methodology in which the state includes payments to hospitals and other provider groups that would be considered supplemental payments in a Medicaid fee-for-service arrangement. CMS is able to work with the state and provide technical assistance if you have any questions about these areas suggested for improvement.

Kentucky's prior MCO contracts expired on June 30, 2015. The contracts and rates noted above are approved for the purpose of federal financial participation, effective October 7, 2015, subject to Kentucky operating managed care consistently with the State Plan or any waiver of the State Plan. If you have any questions concerning this letter, feel free to contact Cheryl L. Brimage, of my staff, at 404-562-7116 or email her at cheryl.brimage@cms.hhs.gov.

Sincerely,

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

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

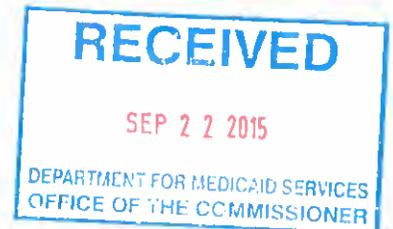
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DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

September 15, 2015

Ms. Lisa Lee, Commissioner
Department for Medicaid Services
Attn: Leslie Hoffman
275 East Main Street, 6WA
Frankfort, KY 40621-0001



Re: Renewal of Kentucky's HCBS Waiver # 40146

Dear Ms. Lee:

This formal Request for Additional Information (RAI) is in response to the state's request to renew Kentucky's Home and Community Based Waiver for individuals who are technology (ventilator) dependent who meet the nursing facility level of care. Our review of the request (control # 40146.R06) found that it did not conform fully to statutory and regulatory requirements. Please provide necessary clarification on the following issues:

Main Module

1. Request for Information, H. Dual Eligibility for Medicaid and Medicare: Please specify whether this waiver provides services to dual eligible individuals.
2. Attachment #1, Transition Plan: The language provided in this section is in reference to the Statewide Transition Plan. This language only needs to be stated in Attachment #2 as Attachment #1 addresses a different type of transition. Please remove this language and assure it is found in Attachment #2 and not in #1.
3. Attachment #2, Home and Community-Based Settings Waiver Transition Plan: Please ensure the information contained in Attachment #2 aligns with the Statewide Transition plan as it references the Model II Waiver. This should include a timeline that includes the non-residential provider survey, public input and comment as it relates to the waiver, and any additional portions of the Statewide Transition Plan that addressed the Model II Waiver.
4. Public Input, 6-I:
 - Please provide the URL for the waiver renewal that was posted for public comment.
 - Please include the actual e-mail address and physical address to where submission of the comments was indicated.

- Please indicate that no changes were made to the waiver renewal as a result of the public comment if this statement is, in fact, accurate.

Appendix B

5. Quality Improvement, Level of Care, Sub-assurance (a): The proposed performance measure (PM) does not measure the sub-assurance's requirement of evaluating for Level of Care (LOC) all "applicants" who may qualify for waiver services. Please amend or replace the proposed PM with a PM that measures whether all reasonably qualified "applicants" are timely evaluated for LOC.
6. Quality Improvement, Level of Care, Sub-assurance (c):
 - Please update and clarify the following language: "DMS will meet with the Fiscal Agent to develop reports that meet the performance measure by March 30th, 2011. The responsible parties will be the fiscal agent and DMS."
 - Please clarify whether the PM is measuring whether all (and not just most or some) forms/instruments were completed as required for each participant. We suggest the PM be clarified to indicate that all forms and instruments must be properly and timely completed.
 - Please clarify whether the numerator would measure the completeness of forms before or after any corrections are made.
 - Please clarify whether, in cases where one or more errors are discovered by the party monitoring performance, the case will be counted in the numerator. Will certain types of errors be disregarded for purposes of including the case in the numerator? If yes, please explain.

Appendix C

7. Please indicate if there are any limits on amount, frequency or duration of each service.
8. Please be more specific regarding what the provider qualifications are for each provider. For instance, please explain what the 902 KAR license and standards and program service manual entails, and what trainings are mandatory.
9. What mechanism is in place to prevent duplicate billing of the two skilled nursing services?
10. C-2-a, Criminal History/Background Investigations: Please specify the state process to ensure that mandatory investigations have been conducted.
11. C-2-b, Abuse Registry Screening: Please specify the state process to ensure that mandatory screenings have been conducted.
12. C-2-f: Please specify the timeframes established for providers when qualifying for and enrolling in the program.

13. Quality Improvement, Qualified Providers, Sub-assurance (a):
- Regarding the first proposed PM (percentage of Provider Agencies whose staff have completed background investigations prior to rendering services): The state does not indicate what percentage of a Provider Agency's staff must have completed background investigations. If the state's intent is that 100% of the agency's staff have successfully completed background investigations, the proposed PM should be revised to so indicate.
 - Regarding the second proposed PM (percentage of Provider Agency staff whose licensure is current prior to rendering services): Please confirm that the numerator counts the number of Agency staff members who provide waiver services and whose licensure is current prior to rendering waiver services, and that the denominator counts all agency staff who are required to be licensed before rendering waiver services.
 - Regarding the third proposed PM (percentage of Provider Agencies' staff who continue to meet licensure requirements): Please clarify how the state will determine each staff person continues to meet his or her particular licensure requirements.
 - Please clarify why none of the PMs refer to certification requirements for providers (e.g., Does the waiver not use providers who must be certified? Or is the term "licensed" meant to include the concept of certified, in which case, please replace "licensed" with "licensed/certified" and "licensure" with "licensure/certification.").
14. Quality Improvement, Qualified Providers, Sub-assurance (c): Please clarify whether the phrase "(i.e. CPR, HIPAA, Abuse and neglect training)" was meant to indicate that CPR, HIPAA, and abuse and neglect training are the only three required trainings (in which case "i.e." is appropriate), or whether the three listed trainings are merely examples of required trainings (in which case "e.g." would be used instead).
15. To the extent the Office of Inspector General's (OIG) licensing process includes training and/or certifications an individual provider must obtain, what role, if any, does the State Medicaid Agency play in providing that information to the state's OIG?

Appendix D

16. D-1-b: Please provide more detail on the safeguards to assure that the service provider's influence on the planning process (i.e., exercising free choice of providers, controlling the content of the plan, including assessment of risk, services, frequency and duration, and informing the participant of their rights) is fully disclosed to the participant and procedures are in place to mitigate that influence?
17. D-1-c: Please describe the meaningful information and supports that are available to the participant or his/her designee to actively engage in and direct the process.

18. D-1-d:
- Please specify in this section how the process ensures that the service plan addresses participant desired outcomes, needs and preferences.
 - Please include information pertaining to the timing of the plan as well as how the planning meetings are scheduled at times and locations convenient to the individual.
 - Please include how information about participant strengths, capacities, needs, preferences, and desired outcomes are secured as part of the service plan development process.
19. D-1-f:
- Please clarify how, on an ongoing basis, participants have ready access to accessible information (in a manner consistent with their needs) about choice of qualified providers and available service providers.
 - Please also clarify how they are supported in selecting providers.
20. D-1-g: Please specify the basis for the sample size of plans reviewed, the frequency of these retroactive reviews, review methodology, and persons/entities who conduct the review.
21. D-2-a:
- Please specify the monitoring frequency including the frequency of direct, in-person contact with the participant.
 - Please specify how the effectiveness of back-up plans are monitored.
 - Please specify how methods for systematic collection of information about monitoring results are compiled, including how problems identified during monitoring, are reported to the state.
 - Please specify the prompt follow-up and remediation of identified problems.
22. D-2-b: Please note that Case Management must comport with conflict of interest requirements at 42 CFR 441.301(1)(vi). Please include this information or indicate where this information can be found in the waiver renewal.
23. Quality Improvement, Service Plan, Sub-assurance (a): Regarding the first PM:
- Please explain in detail how a service plan is determined to be “adequate and appropriate.”
 - We suggest that the state modify its first PM by changing the parenthetical to read: “including health and safety risk factors.”
24. Quality Improvement, Service Plan, Sub-assurance (b):
- Please clarify what is meant by “service plan development activities.”
 - Please confirm that “as described in the waiver application” means that adherence to deadlines is also measured by this PM, such that if a development activity is performed after the due date specified in state or waiver requirements, that service plan will not be counted in the numerator.
 - Please clarify how and when this PM will be evaluated when the state indicates the frequency is: “Monthly, continuously, and ongoing.”

25. Quality Improvement, Service Plan, Sub-assurance (c):
- Please confirm that the term “as needed” includes all service plans that are updated or revised at least annually.
 - Please clarify whether the service plan update will be completed by the participant's anniversary date, and that any service plan that is not 100% complete by the participant's anniversary date will not be counted in the numerator.
 - How will the state identify service plans that were revised during the year?
26. Quality Improvement, Service Plan, Sub-assurance (d): We recommend the state develop a different PM to demonstrate that services are delivered according to the service plan, including the type, scope, amount, duration and frequency specified in the service plan. Surveys of aged and disabled persons are inherently unreliable and often imprecise for measuring the sub-assurance.
27. Quality Improvement, Service Plan, Sub-assurance (e): It appears that the state is addressing the old version of the sub-assurance. The current sub-assurance does not require the state to measure whether participants are given a choice between institutional and waiver services. The state should revise its proposed PM to measure that participants are afforded choices between (or among) various waiver services and between (or among) waiver providers.

Appendix F

28. F-1:
- Please address when/how a notice is made to an individual in the instance of an adverse action regarding choice of home and community based services versus institutional services, and choice of provider or service.
 - Please specify where notices of adverse actions and the opportunity to request a Fair Hearing are kept.
 - Please specify the entity or entities responsible for issuing the notice.
 - Please clarify whether a cabinet level administrative hearing is the same as a Fair Hearing.
29. F-2-b:
- Please describe how/when a participant elects to make use of the dispute mechanism, the state informs the participant that the dispute resolution mechanism is not a prerequisite or substitute for a Fair Hearing.
 - Please describe the types of disputes that can be addressed.
 - Please clarify that an Administrative Hearing is the same as a Fair Hearing.
30. F-3: Please clarify how a participant is informed that filing a grievance or making a complaint is not a prerequisite or substitute for a Fair Hearing.

Appendix G

31. G-2-a: Please provide specific methods to detect unauthorized use of restraints, and specify the state agency (or agencies) responsible for conducting this oversight.
32. G-2-b: The state indicated the use of restrictive interventions is permitted if it is agreed upon during the participant plan of care meeting by the participant and the team members. Please select, "The use of restrictive interventions is permitted during the course of the delivery of waiver services," and complete items G-2-b-i and G-2-b-ii.
33. G-2-c: Please provide specific methods to detect unauthorized use of seclusion, and specify the state agency (or agencies) responsible for conducting this oversight.
34. Quality Improvement, Health and Welfare, Sub-assurance (a):
 - For the performance measure, "Number and percent of satisfaction survey respondents who reported that staff yell or scream at them," please consider strengthening this performance measure by including other forms of abuse, neglect, and exploitation.
 - A satisfaction survey is not a reliable or precise method of assessing whether the state demonstrates, on an ongoing basis, that it identifies and seeks to prevent instances of abuse, neglect, exploitation or unexplained death. We recommend the state develop one or more new PMs that more accurately and appropriately measure the state's performance for this sub-assurance.
 - We recommend the state develop a separate PM to measure how it will address instances of abuse, neglect, exploitation and unexplained death.
 - Regarding the second proposed PM, how will the state monitor whether the participant (and/or family or legal guardian) has received information/education about how to report abuse, neglect, exploitation, and other critical incidents?
35. Quality Improvement, Health and Welfare, Sub-assurances (b), (c), and (d): The state must add at least one performance measure to address each of these sub-assurances.

Appendix H

36. How are the results of the Quality Improvement Strategy communicated, and with what frequency, to agencies, waiver providers, participants, families and other interested parties, and the public?
37. Please clarify the process and frequency for evaluating and updating the QIS.
38. The state indicates that the DMS is currently working with the fiscal agent to upgrade the utilization report to include provider number, member number and changes in the LOC date, which will affect the waiver segment in the Medicaid Waiver Management Application (MWMA) Portal. Please describe the state's timeline for this process.

Appendix I

39. 1-1:

- Does the state require an independent audit of provider agencies? If so:
 - What, specifically, are the types of findings and discrepancies that the auditors of public accounts report?
 - What, specifically, do the auditors of public accounts review? Please describe in detail the items that they review and explain the processes they perform to determine the provider agencies' waiver compliance.
 - Are all providers subject to annual audits?
 - If not, how many providers are audited on an annual basis (both in terms of numbers and percentages)?
 - Please describe how providers are chosen for an audit:
 - i. Are providers chosen by random sample?
 - ii. How often are all providers audited?
 - iii. Are some providers audited more frequently than others? Why?
- Please update the waiver to clarify the process by which DMS directly conducts post payment annual billing reviews.
 - What are the processes and methods DMS performs to complete its reviews?
 - Does the 100% review of active waiver providers include all payments, or does the 100% only indicate that all active providers are reviewed?
- How does the state confirm that only services actually rendered and prescribed by the service plan are paid and that only the providers authorized by the service plan to deliver the services prescribed by the service plan are paid?
- How frequently are on-site monitoring reviews conducted by DMS?
- What, if any, are the penalties imposed on providers who have payments with inappropriate documentation? Please describe the method the DMS uses to recoup these payments.

40. 1-2-a:

- Please specify the entity or entities responsibility for rate determination and how oversight of the rate determination process is conducted.
- Please describe how information about payment rates is made available to waiver participants.
- Please clarify the methods used to trend the claims data forward.
- How often is the fee-for-service rate schedule updated, and when was the last time the rates were updated? When was the last time the rates were re-based?

- Please describe if there is a schedule for annual cost of living increase (or other reason for increase) for the rates. If so, please provide the annual schedule for increase and describe how it is determined. If there is no COLA or similar schedule for periodic rate adjustments, please describe why a cost increase is not built into the rates.
- Please describe how public comments are solicited during promulgation.
- Please describe how and when information about payment rates is made available to waiver participants.
- Was there any change in rate methodology used for any of the services between the rate development in the approved waiver and this waiver renewal submission? Please describe all changes and the rationale behind those changes in the methodology.

41. 1-2-d:

- Please describe the process used to ensure that the service billed is in the recipient's approved service plan.
- What checks are in place to assure that the service plan-authorized services were actually provided?

42. Quality Improvement, Financial Accountability, Sub-assurance (a):

- Please explain how this performance measure ensures claims are paid for in accordance with the reimbursement methodology and only for services rendered.
- The proposed PM does not address how the state will confirm that the services rendered were provided consistent with each participant's service plan. The state should either develop an additional PM to cover this, or revise its proposed PM.

43. Quality Improvement, Financial Accountability, Sub-assurance (b): The state must add at least one performance measure to address this sub-assurance.

44. Methods for Remediation/Fixing Individual Problems: We suggest that the state develop a more detailed and robust set of remediation methods for correcting each incident of non-compliance by an individual or organization. We suggest the state set forth separate methods for each PM, which includes the following: (i) who specifically is accountable for identifying non-compliance, (ii) who is responsible for issuing the remediation requirements, (iii) the remediation requirements for each instance of non-compliance, (iv) who is responsible for monitoring that the remediation has been completed within the time specified; and (v) the consequences (or range of consequences) for non-compliance that is not addressed within the specified timeframe.

Appendix J

45. J-2-a and J-2-b:

- The state indicated that the estimated Average Length of Stay (ALOS) for the renewal waiver is based on data from the CMS 372 Lag Report for the period 10/01/2008 through 09/30/2009. Please explain why ALOS was not based on a more recent CMS 372 Lag Report.
- The ALOS in each year of the renewal waiver as reported in Appendix J, is 10. The most recent CMS 372 lag report, 10/01/2012 through 09/30/2013, shows 18,884 total enrollment days and 62 unduplicated participants, resulting in an ALOS of 304.58. Conversion of the ALOS from days to months using this CMS 372 lag report would result in an ALOS of 10 months. Please clarify whether the ALOS is expressed in months, and if so, please correct it to be expressed in days.

46. J-2-c:

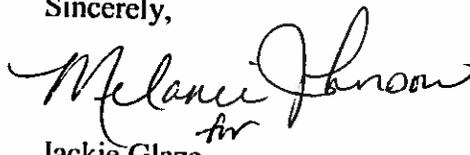
- When stated that the factor "held static," please specify through which time period this refers. Please update the factors where this is outdated (e.g., Factor D is based on 2009 numbers).
- From where are the factor estimates for D', G, G' derived?
- Please ensure your explanation for the Factor G estimate is fully documented, is evidence based, and is appropriately justified.
- Please ensure your explanation for the Factor G' estimate is fully documented, is evidence based, and is appropriately justified.
- Please clarify the state has accounted for and removed the cost of prescription drugs from its estimates in Factor D'.
- Regarding the development of Factor D, please explain why waiver year 2009 CMS 372 expenditures were used, rather than more recent data.
- Regarding the development of Factor D':
 - Please explain why the downward trend of an average 13.71% seen in waiver years 2007-2009 was used.
 - Please explain why this trend was applied to waiver year 2010-2011 and then held static.
- Regarding the development of Factors G and G':
 - Please explain why waiver year 2009 expenditures were used instead of more recent years' expenditures.
 - How was the 3% annual trend developed?
 - Please explain why this trend was applied to waiver years 2010 and 2011, and then held static.

Ms. Lisa Lee
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Under section 1915(f) of the Social Security Act, a waiver request must be approved, denied or additional information requested within 90 days of receipt or the request will be deemed approved. The 90-day review period of this request ends December 13, 2015. This request for additional information will, however, stop the 90 day clock. Once the additional information is submitted, the 90-day clock will restart at day one.

If you have questions related to this request, or would like to schedule a time to discuss these questions, please contact Melanie Benning at (404) 562-7414 at melanie.benning@cms.hhs.gov.

Sincerely,

A handwritten signature in cursive script that reads "Melanie Johnson" with a small "for" written below it.

Jackie Glaze

Associate Regional Administrator

Division of Medicaid & Children's Health Operations

cc: Amanda Hill, Central Office

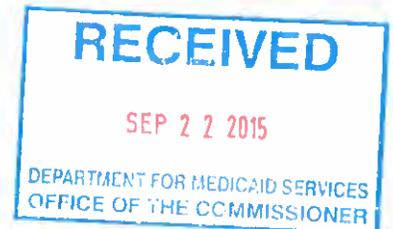
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DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

September 15, 2015

Ms. Lisa Lee, Commissioner
Department for Medicaid Services
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275 East Main Street, 6WA
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Re: Renewal of Kentucky's HCBS Waiver # 40146

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Main Module

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15. To the extent the Office of Inspector General's (OIG) licensing process includes training and/or certifications an individual provider must obtain, what role, if any, does the State Medicaid Agency play in providing that information to the state's OIG?

Appendix D

16. D-1-b: Please provide more detail on the safeguards to assure that the service provider's influence on the planning process (i.e., exercising free choice of providers, controlling the content of the plan, including assessment of risk, services, frequency and duration, and informing the participant of their rights) is fully disclosed to the participant and procedures are in place to mitigate that influence?
17. D-1-c: Please describe the meaningful information and supports that are available to the participant or his/her designee to actively engage in and direct the process.

18. D-1-d:
- Please specify in this section how the process ensures that the service plan addresses participant desired outcomes, needs and preferences.
 - Please include information pertaining to the timing of the plan as well as how the planning meetings are scheduled at times and locations convenient to the individual.
 - Please include how information about participant strengths, capacities, needs, preferences, and desired outcomes are secured as part of the service plan development process.
19. D-1-f:
- Please clarify how, on an ongoing basis, participants have ready access to accessible information (in a manner consistent with their needs) about choice of qualified providers and available service providers.
 - Please also clarify how they are supported in selecting providers.
20. D-1-g: Please specify the basis for the sample size of plans reviewed, the frequency of these retroactive reviews, review methodology, and persons/entities who conduct the review.
21. D-2-a:
- Please specify the monitoring frequency including the frequency of direct, in-person contact with the participant.
 - Please specify how the effectiveness of back-up plans are monitored.
 - Please specify how methods for systematic collection of information about monitoring results are compiled, including how problems identified during monitoring, are reported to the state.
 - Please specify the prompt follow-up and remediation of identified problems.
22. D-2-b: Please note that Case Management must comport with conflict of interest requirements at 42 CFR 441.301(1)(vi). Please include this information or indicate where this information can be found in the waiver renewal.
23. Quality Improvement, Service Plan, Sub-assurance (a): Regarding the first PM:
- Please explain in detail how a service plan is determined to be “adequate and appropriate.”
 - We suggest that the state modify its first PM by changing the parenthetical to read: “including health and safety risk factors.”
24. Quality Improvement, Service Plan, Sub-assurance (b):
- Please clarify what is meant by “service plan development activities.”
 - Please confirm that “as described in the waiver application” means that adherence to deadlines is also measured by this PM, such that if a development activity is performed after the due date specified in state or waiver requirements, that service plan will not be counted in the numerator.
 - Please clarify how and when this PM will be evaluated when the state indicates the frequency is: “Monthly, continuously, and ongoing.”

25. Quality Improvement, Service Plan, Sub-assurance (c):
- Please confirm that the term “as needed” includes all service plans that are updated or revised at least annually.
 - Please clarify whether the service plan update will be completed by the participant's anniversary date, and that any service plan that is not 100% complete by the participant's anniversary date will not be counted in the numerator.
 - How will the state identify service plans that were revised during the year?
26. Quality Improvement, Service Plan, Sub-assurance (d): We recommend the state develop a different PM to demonstrate that services are delivered according to the service plan, including the type, scope, amount, duration and frequency specified in the service plan. Surveys of aged and disabled persons are inherently unreliable and often imprecise for measuring the sub-assurance.
27. Quality Improvement, Service Plan, Sub-assurance (e): It appears that the state is addressing the old version of the sub-assurance. The current sub-assurance does not require the state to measure whether participants are given a choice between institutional and waiver services. The state should revise its proposed PM to measure that participants are afforded choices between (or among) various waiver services and between (or among) waiver providers.

Appendix F

28. F-1:
- Please address when/how a notice is made to an individual in the instance of an adverse action regarding choice of home and community based services versus institutional services, and choice of provider or service.
 - Please specify where notices of adverse actions and the opportunity to request a Fair Hearing are kept.
 - Please specify the entity or entities responsible for issuing the notice.
 - Please clarify whether a cabinet level administrative hearing is the same as a Fair Hearing.
29. F-2-b:
- Please describe how/when a participant elects to make use of the dispute mechanism, the state informs the participant that the dispute resolution mechanism is not a prerequisite or substitute for a Fair Hearing.
 - Please describe the types of disputes that can be addressed.
 - Please clarify that an Administrative Hearing is the same as a Fair Hearing.
30. F-3: Please clarify how a participant is informed that filing a grievance or making a complaint is not a prerequisite or substitute for a Fair Hearing.

Appendix G

31. G-2-a: Please provide specific methods to detect unauthorized use of restraints, and specify the state agency (or agencies) responsible for conducting this oversight.
32. G-2-b: The state indicated the use of restrictive interventions is permitted if it is agreed upon during the participant plan of care meeting by the participant and the team members. Please select, "The use of restrictive interventions is permitted during the course of the delivery of waiver services," and complete items G-2-b-i and G-2-b-ii.
33. G-2-c: Please provide specific methods to detect unauthorized use of seclusion, and specify the state agency (or agencies) responsible for conducting this oversight.
34. Quality Improvement, Health and Welfare, Sub-assurance (a):
 - For the performance measure, "Number and percent of satisfaction survey respondents who reported that staff yell or scream at them," please consider strengthening this performance measure by including other forms of abuse, neglect, and exploitation.
 - A satisfaction survey is not a reliable or precise method of assessing whether the state demonstrates, on an ongoing basis, that it identifies and seeks to prevent instances of abuse, neglect, exploitation or unexplained death. We recommend the state develop one or more new PMs that more accurately and appropriately measure the state's performance for this sub-assurance.
 - We recommend the state develop a separate PM to measure how it will address instances of abuse, neglect, exploitation and unexplained death.
 - Regarding the second proposed PM, how will the state monitor whether the participant (and/or family or legal guardian) has received information/education about how to report abuse, neglect, exploitation, and other critical incidents?
35. Quality Improvement, Health and Welfare, Sub-assurances (b), (c), and (d): The state must add at least one performance measure to address each of these sub-assurances.

Appendix H

36. How are the results of the Quality Improvement Strategy communicated, and with what frequency, to agencies, waiver providers, participants, families and other interested parties, and the public?
37. Please clarify the process and frequency for evaluating and updating the QIS.
38. The state indicates that the DMS is currently working with the fiscal agent to upgrade the utilization report to include provider number, member number and changes in the LOC date, which will affect the waiver segment in the Medicaid Waiver Management Application (MWMA) Portal. Please describe the state's timeline for this process.

Appendix I

39. 1-1:

- Does the state require an independent audit of provider agencies? If so:
 - What, specifically, are the types of findings and discrepancies that the auditors of public accounts report?
 - What, specifically, do the auditors of public accounts review? Please describe in detail the items that they review and explain the processes they perform to determine the provider agencies' waiver compliance.
 - Are all providers subject to annual audits?
 - If not, how many providers are audited on an annual basis (both in terms of numbers and percentages)?
 - Please describe how providers are chosen for an audit:
 - i. Are providers chosen by random sample?
 - ii. How often are all providers audited?
 - iii. Are some providers audited more frequently than others? Why?
- Please update the waiver to clarify the process by which DMS directly conducts post payment annual billing reviews.
 - What are the processes and methods DMS performs to complete its reviews?
 - Does the 100% review of active waiver providers include all payments, or does the 100% only indicate that all active providers are reviewed?
- How does the state confirm that only services actually rendered and prescribed by the service plan are paid and that only the providers authorized by the service plan to deliver the services prescribed by the service plan are paid?
- How frequently are on-site monitoring reviews conducted by DMS?
- What, if any, are the penalties imposed on providers who have payments with inappropriate documentation? Please describe the method the DMS uses to recoup these payments.

40. 1-2-a:

- Please specify the entity or entities responsibility for rate determination and how oversight of the rate determination process is conducted.
- Please describe how information about payment rates is made available to waiver participants.
- Please clarify the methods used to trend the claims data forward.
- How often is the fee-for-service rate schedule updated, and when was the last time the rates were updated? When was the last time the rates were re-based?

- Please describe if there is a schedule for annual cost of living increase (or other reason for increase) for the rates. If so, please provide the annual schedule for increase and describe how it is determined. If there is no COLA or similar schedule for periodic rate adjustments, please describe why a cost increase is not built into the rates.
- Please describe how public comments are solicited during promulgation.
- Please describe how and when information about payment rates is made available to waiver participants.
- Was there any change in rate methodology used for any of the services between the rate development in the approved waiver and this waiver renewal submission? Please describe all changes and the rationale behind those changes in the methodology.

41. 1-2-d:

- Please describe the process used to ensure that the service billed is in the recipient's approved service plan.
- What checks are in place to assure that the service plan-authorized services were actually provided?

42. Quality Improvement, Financial Accountability, Sub-assurance (a):

- Please explain how this performance measure ensures claims are paid for in accordance with the reimbursement methodology and only for services rendered.
- The proposed PM does not address how the state will confirm that the services rendered were provided consistent with each participant's service plan. The state should either develop an additional PM to cover this, or revise its proposed PM.

43. Quality Improvement, Financial Accountability, Sub-assurance (b): The state must add at least one performance measure to address this sub-assurance.

44. Methods for Remediation/Fixing Individual Problems: We suggest that the state develop a more detailed and robust set of remediation methods for correcting each incident of non-compliance by an individual or organization. We suggest the state set forth separate methods for each PM, which includes the following: (i) who specifically is accountable for identifying non-compliance, (ii) who is responsible for issuing the remediation requirements, (iii) the remediation requirements for each instance of non-compliance, (iv) who is responsible for monitoring that the remediation has been completed within the time specified; and (v) the consequences (or range of consequences) for non-compliance that is not addressed within the specified timeframe.

Appendix J

45. J-2-a and J-2-b:

- The state indicated that the estimated Average Length of Stay (ALOS) for the renewal waiver is based on data from the CMS 372 Lag Report for the period 10/01/2008 through 09/30/2009. Please explain why ALOS was not based on a more recent CMS 372 Lag Report.
- The ALOS in each year of the renewal waiver as reported in Appendix J, is 10. The most recent CMS 372 lag report, 10/01/2012 through 09/30/2013, shows 18,884 total enrollment days and 62 unduplicated participants, resulting in an ALOS of 304.58. Conversion of the ALOS from days to months using this CMS 372 lag report would result in an ALOS of 10 months. Please clarify whether the ALOS is expressed in months, and if so, please correct it to be expressed in days.

46. J-2-c:

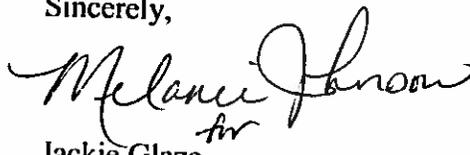
- When stated that the factor "held static," please specify through which time period this refers. Please update the factors where this is outdated (e.g., Factor D is based on 2009 numbers).
- From where are the factor estimates for D', G, G' derived?
- Please ensure your explanation for the Factor G estimate is fully documented, is evidence based, and is appropriately justified.
- Please ensure your explanation for the Factor G' estimate is fully documented, is evidence based, and is appropriately justified.
- Please clarify the state has accounted for and removed the cost of prescription drugs from its estimates in Factor D'.
- Regarding the development of Factor D, please explain why waiver year 2009 CMS 372 expenditures were used, rather than more recent data.
- Regarding the development of Factor D':
 - Please explain why the downward trend of an average 13.71% seen in waiver years 2007-2009 was used.
 - Please explain why this trend was applied to waiver year 2010-2011 and then held static.
- Regarding the development of Factors G and G':
 - Please explain why waiver year 2009 expenditures were used instead of more recent years' expenditures.
 - How was the 3% annual trend developed?
 - Please explain why this trend was applied to waiver years 2010 and 2011, and then held static.

Ms. Lisa Lee
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Under section 1915(f) of the Social Security Act, a waiver request must be approved, denied or additional information requested within 90 days of receipt or the request will be deemed approved. The 90-day review period of this request ends December 13, 2015. This request for additional information will, however, stop the 90 day clock. Once the additional information is submitted, the 90-day clock will restart at day one.

If you have questions related to this request, or would like to schedule a time to discuss these questions, please contact Melanie Benning at (404) 562-7414 at melanie.benning@cms.hhs.gov.

Sincerely,

A handwritten signature in cursive script that reads "Melanie Johnson" with a small "for" written below it.

Jackie Glaze

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

cc: Amanda Hill, Central 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

October 8, 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:

In accordance with 42 CFR § 438.6, the Centers for Medicare & Medicaid Services (CMS) has reviewed and is approving Kentucky's submission of Managed Care Organization contracts and rates, subject to Kentucky operating managed care consistently with the State Plan or any waiver of the State Plan. CMS received the contracts on July 16, 2015. We received the rates for these contracts in three parts: the initial certification dated January 29, 2015; a risk adjustment amendment to the rates dated June 9, 2015; and an amendment to these rates dated July 28, 2015. The contracts and rates are for the period July 1, 2015 through June 30, 2016.

Specifically, the following contracts are approved:

- Anthem
- Coventry
- Humana
- Passport
- Wellcare

CMS based its decision to approve these contracts and rates based on our formal review of the contracts considering federal regulation and policy, as well as an actuarial review of the rates performed by our Office of the Actuary. Through the actuarial review, we determined the rates are consistent with federal regulations found at 42 CFR § 438.6(c), the 2015 Medicaid Managed Care Rate Consultation Guide, and all applicable Actuarial Standards of Practice developed by the Actuarial Standards Board, and that they fell within the actuarially certified rate range.

Although the rates met all federal regulations, actuarial standards and practices, and are consistent with Medicaid managed care policy, there are some areas in your rate development that we believe the state could improve in future years that would further refine the accuracy and predictability of the rates, and improve oversight of the Medicaid managed care program. These areas include: reducing the number of rate cells in order to improve credibility and to reduce the

need to use smoothing techniques; improving encounter data collection efforts at the state level, which will allow the state and actuaries to use state-collected encounter data as compared to ad hoc data requests from the MCOs; and revising the methodology in which the state includes payments to hospitals and other provider groups that would be considered supplemental payments in a Medicaid fee-for-service arrangement. CMS is able to work with the state and provide technical assistance if you have any questions about these areas suggested for improvement.

Kentucky's prior MCO contracts expired on June 30, 2015. The contracts and rates noted above are approved for the purpose of federal financial participation, effective October 7, 2015, subject to Kentucky operating managed care consistently with the State Plan or any waiver of the State Plan. If you have any questions concerning this letter, feel free to contact Cheryl L. Brimage, of my staff, at 404-562-7116 or email her at cheryl.brimage@cms.hhs.gov.

Sincerely,

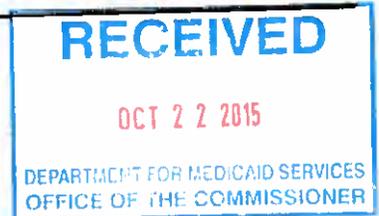
A handwritten signature in cursive script that reads "Jackie Glaze".

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



October 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) is approving Kentucky's request to renew its 1915(b) Managed Care waiver program (Control # KY-07.R01). The waiver allows Kentucky to mandatorily enroll all Medicaid populations enrolled in the waiver.

CMS has reviewed the state's waiver renewal application, which includes a cost-effectiveness analysis, a description of program monitoring and operations, and an independent assessment of the existing managed care program. We approve this waiver renewal based on the evidence Kentucky provided in its initial renewal application and subsequently in its responses to CMS's informal requests for further information. This evidence demonstrated that the state's waiver program is consistent with the purposes of the Medicaid program, that the waiver program meets all the statutory, regulatory, and CMS policy requirements for assuring beneficiaries access to quality care, and that it will be a cost-effective and efficient means of providing services to Medicaid recipients in Kentucky.

This managed care waiver program is authorized under section 1915(b)(1) of the Social Security Act and provides for waivers of the following sections of Title XIX:

- Section 1902(a)(10)(B) - Comparability of Services
- Section 1902(a)(23) - Freedom of Choice

This waiver is approved from November 1, 2015 to October 31, 2017.

If you wish to renew this waiver at the end of the two year term, you must submit a renewal application no later than July 31, 2017. If we do not receive a renewal application by this date, CMS will seek a phase down plan from the state to terminate the waiver program.

We wish you continued success in operating the Kentucky 1915(b)(1) managed care program. Thank you for your cooperation during the waiver renewal review process. If you have any further

Ms. Lisa D. Lee
Page 2

questions, please contact Cheryl L. Brimage, Atlanta Regional Office, at (404) 562-7116 or Lovie Davis, CMS Central Office, at (410) 786-1533.

Sincerely,

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

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