

MAC Binder Section 1 – Letters from CMS

Table of Contents with Document Summary

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

1-CMS-SPA 15-006 -Ltr to SM from KF-051416:

CMS found that the proposed changes in payment methodology comply with applicable requirements and therefor have approved them with an effective date of October 1, 2015.

2-CMS-Request to Renew 1915 (c) -Ltr to SM from KF-053116:

CMS has approved DMS' request to renew it's 1915(c) Human Service Transportation Delivery Program Waiver. Waiver is approved from July 1, 2016 – June 30, 2018.

3-CMS-Approval of STP in compliance with HCBS-Ltr to SM from KF-060216:

CMS is granting DMS initial approval of it Statewide Transition Plan (STP) to bring settings into compliance with federal home and community based services (HCBS) regulations.

4-CMS-Approval of EQRO -Ltr to SM from KF-060316:

CMS has approved the KY External Quality Review Organization (EQRO) Contract on June 3, 2016.

5-CMS-Letter of Guidance -Ltr to SM from KF-061416:

CMS has issued a letter of guidance on Medicaid Family Planning Services provided under both fee-for-service and managed care delivery systems.

6-CMS- Technical Correction to EQRO Contract -Ltr to SM from KF-061516:

CMS has issued a technical correction to Approval Letter of KY External Quality Review Organization (EQRO) Contract dated June 3, 2016.

7-CMS- NEMT Contract -Ltr to SM from KF-062016:

CMS has reviewed and approved DMS' Non-Emergency Medical Transportation (NEMT) contracts and rates for the periods of July 1, 2012 – June 30, 2016.

8-CMS- HCBS Waiver Long Term Care Acquired Brain Injury -Ltr to SM from KF-062116:

CMS is grating a temporary extension for the waiver renewal submission in order for the state to comport with the public notice requirements.

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9-CMS- HCBS Waiver Home and Community Based -Ltr to SM from KF-062116:

CMS is granting a temporary extension for the waiver renewal submission in order for the state to comport with the public notice requirements.

10-CMS- HCBS Waiver Support and Community Living -Ltr to SM from KF-062116:

CMS is granting a temporary extension for the waiver renewal submission in order for the state to comport with the public notice requirements.

11-CMS-ANIAPD -Ltr to SM from JG-062716:

CMS has approved the As Needed Implementation Planning Document (ANIAPD); specifically one six-month contract extension from May 7, 2016 – November 6, 2016.

12-CMS- Letter of Guidance -Ltr to SM from VW-062716:

CMS has issued a letter of guidance on Medicaid Family Planning Services provided under both fee-for-service and managed care delivery systems.

13-CMS- Open Payments Program -Ltr 063016:

Notice that CMS has published 2015 Open Payments data, along with newly submitted and updated payment records for the 2013 and 2014 reporting periods.

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

MAY 04 2016

Mr. Stephen P. Miller
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) 15-006

Dear Mr. Miller:

We have reviewed the proposed amendment to Attachments 4.19-A of your Medicaid state plan submitted under transmittal number (TN) 15-006. Effective October 1, 2015 this amendment modifies the state's reimbursement methodology for setting payment rates for hospital services. Specifically, this amendment will revise the state's current prospective DRG method to the Medicare DRG methodology including the use of the base rate for both operating and capital and the MS DRG grouper.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a), 1902(a)(13), 1902(a)(30), 1903(a) and 1923 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 blue ink is located below the word "Sincerely,". The signature appears to read "Kristin Fan" and is written in a cursive, flowing style.

Kristin Fan
Director

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

1. TRANSMITTAL NUMBER:
15-006

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:
October 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 \$2 million 81,764,894
b. FFY 2017 \$2 million 81,764,894

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

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

Att. 4.19-A, Page 1 – Page 39
Att. 4.19-A, Exhibit A, Page 1 – 7
Att. 4.19-A, Exhibit B, Page 1 – 3
Att. 4.19-A, Exhibit D – Page 1 - 3

10. SUBJECT OF AMENDMENT:

The purpose of this SPA is to revise KY's hospital reimbursement.

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:

Lisa D. Lee

13. TYPED NAME: Lisa D. Lee

14. TITLE: Commissioner, Department for Medicaid Services

15. DATE SUBMITTED: 9/30/15

16. RETURN TO:

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

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED: MAY 04 2016

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

OCT 01 2015

20. SIGNATURE OF REGIONAL OFFICIAL:

Kristin Fan

21. TYPED NAME:

Kristin FAN

22. TITLE:

Director, FMO

23. REMARKS:

Pen x slub Change to block #7 to include
\$1,764,894 for FFY 2016 and 2017

I General Overview

- A. Effective for discharges on or after October 1, 2015, the Department will pay for acute care inpatient hospital services provided to a Medicaid recipient who is not enrolled with a managed care organization under a diagnosis related group (DRG) based methodology using the CMS Medicare Severity Diagnosis Related Grouper (MS-DRG) grouper. The methodology will be the Medicare Inpatient Prospective Payment System as described in this State Plan. The revised system will utilize the hospital specific Medicare operating and capital base rates, and the Medicare-established relative weights. Hospital services not paid for using the DRG-based methodology will be paid for using per diem rates or as otherwise stated in this plan.

The following will be excluded from the DRG methodology:

- 1) Services provided in Critical access hospitals. Reimbursement procedures are described in section 4, beginning on page 22 of this document;
- 2) Services provided in Free-standing rehabilitation hospitals. Reimbursement procedures are described in section 3, beginning on page 20 of this document;
- 3) Services provided in Long-term acute care hospitals. Reimbursement procedures are described in section 3, beginning on page 20 of this document;
- 4) Psychiatric services, including substance abuse, in Acute care hospitals. Reimbursement procedures are described in section 2(Z), beginning on page 18 of this document;
- 5) Services provided in Free-standing psychiatric hospitals. Reimbursement procedures are described in section 3, beginning on page 20 of this document;
- 6) Rehabilitation services in Acute care hospitals. Reimbursement procedures are described in section 2(Z), beginning on page 18 of this document; and

B. Appeals and Review Process.

- 1) Matters Subject to an Appeal. A hospital may appeal whether the Medicare data specific to the hospital that was extracted by the Department in establishing the hospital's reimbursement was the correct data.
- 2) Appeal Process.
 - a. An appeal shall comply with the requirements and provisions established in this section.
 - b. (1) A request for a review of an appealable issue shall be received by the department within sixty (60) calendar days of the date of receipt by the provider of the department's notice of rates set under Regulation 907 KAR 10:830, revised 9/4/2015.
(2) The request referenced in paragraph (1) of this subsection shall:
 - (a) Be sent to the Office of the Commissioner, Department for Medicaid Services, Cabinet for Health and Family Services, 275 East Main Street, 6th Floor, Frankfort, Kentucky 40621-0002; and
 - (b) Contain the specific issues to be reviewed with all supporting documentation necessary for the departmental review.
 - c. (1) The department shall review the material referenced in subsection (b) of this section and notify the provider of the review results within 30 days of its receipt except as established in paragraph (2) of this subsection.

I Overview (continued)

B. Appeals and Review Process (continued)

- (2) If the provider requests a review of a non-appealable issue under 907 KAR 10:830 (revised 9/4/2015), the department shall:
 - (a) Not review the request; and
 - (b) Notify the provider that the review is outside of the scope of 907 KAR 10:830 (revised 9/4/2015).
- d. (1) A provider may appeal the result of the department's review, except for a notification that the review is outside the scope of 907 KAR 10:830 (revised 9/4/2015), by sending a request for an administrative hearing to the Division for Administrative Hearings (DAH) within thirty (30) days of receipt of the department's notification of its review decision.
 - (2) A provider shall not appeal a notification that a review is outside of the scope of 907 KAR 10:830 (revised 9/4/2015).
- e. (1) An administrative hearing shall be conducted in accordance with KRS Chapter 13B.
 - (2) Pursuant to KRS 13B.030, the Secretary of the Cabinet for Health and Family Services delegates to the Cabinet for Health and Family Services, Division for Administrative Hearings (DAH) the authority to conduct administrative hearings under 907 KAR 10:830 (revised 9/4/2015).
 - (3) A notice of the administrative hearing shall comply with KRS 13B.050.
 - (4) The administrative hearing shall be held in Frankfort, Kentucky no later than ninety (90) calendar days from the date the request for the administrative hearing is received by the DAH.
 - (5) The administrative hearing date may be extended beyond the ninety (90) calendar days by:
 - (a) A mutual agreement by the provider and the department; or
 - (b) A continuance granted by the hearing officer.
 - (6) (a) If the prehearing conference is requested, it shall be held at least thirty (30) calendar days in advance of the hearing date.
 - (b) Conduct of the prehearing conference shall comply with KRS 13B.070.
 - (7) If a provider does not appear at the hearing on the scheduled date, the hearing officer may find the provider in default pursuant to KRS 13B.050(3)(h).
 - (8) A hearing request shall be withdrawn only under the following circumstances:
 - (a) The hearing officer receives a written statement from a provider stating that the request is withdrawn; or
 - (b) A provider makes a statement on the record at the hearing that the provider is withdrawing the request for the hearing.
 - (9) Documentary evidence to be used at the hearing shall be made available in accordance with KRS 13B.090.
 - (10) The hearing officer shall:
 - (a) Preside over the hearing; and
 - (b) Conduct the hearing in accordance with KRS 13B.080 and 13B.090.
 - (11) The provider shall have the burden of proof concerning the appealable issues under 907 KAR 10:830 (revised 9/4/2015).

I Overview (continued)

B. Appeals and Review Process (continued)

- (12) (a) The hearing officer shall issue a recommended order in accordance with KRS 13B.110.
- (b) An extension of time for completing the recommended order shall comply with the requirements of KRS 13B.110 (2) and (3).
- (13) (a) A final order shall be entered in accordance with KRS 13B.120.
- (b) The cabinet shall maintain an official record of the hearing in compliance with KRS 13B.130.
- (c) In the correspondence transmitting the final order, clear reference shall be made to the availability of judicial review pursuant to KRS 13B.140, 13B.150, and KRS 13B.160.

C. Adjustment of rates.

- 1) Final rates are not adjusted except for correction of errors, to make changes resulting from the dispute resolution or appeals process, if the decision determines that rates were not established in accordance with the approved State Plan, Attachment 4.19-A, or to make changes resulting from Federal Court orders including to the extent necessary action to expand the effect of a Federal Court order to similarly situated facilities. .
- 2) New rates shall be set for each universal rate year, and at any point in the rate year when necessitated by a change in the applicable statute or regulation subject to a state plan amendment approved by the Centers for Medicare and Medicaid Services (CMS), if applicable.

D. Use of a Universal Rate Year

- 1) A universal rate year shall be established for rates in this attachment as follows:
 - a. For DRG rates, excluding non-distinct part unit (non-DPU) psychiatric and rehabilitation hospital rates, the universal rate year shall be October 1 through September 30 of the following year.
 - b. For Psychiatric Residential Treatment Facility (PRTF) rates, the universal rate year shall be November 1 through October 31 of the following year.
 - c. For all other hospital rates referenced in this attachment, the universal rate year shall be July 1 through June 30 of the following year, or as specifically stated throughout this attachment.
- 2) A hospital shall not be required to change its fiscal year to conform with a universal rate year.

E. Cost Reporting Requirements.

- 1) The department follows the Medicare Principles of reimbursement found in 42 CFR 413 and the CMS Publication 15 to determine allowable cost. Additional cost report requirements are as follows:

I Overview (continued)

E. Cost Reporting Requirements (continued)

- 2) An in-state hospital participating in the Medicaid program shall submit to the department a copy of a Medicare cost report form CMS 2552-10 it submits to CMS, an electronic cost report file (ECR), the Supplemental Medicaid Schedule KMAP-1, the Supplemental Medicaid Schedule KMAP-4, and the Supplemental Medicaid Schedule KMAP-6 as follows:
 - a. A cost report shall be submitted:
 - (1) For the fiscal year used by the hospital; and
 - (2) Within five (5) months after the close of the hospital's fiscal year; and
 - b. Except as follows, the department shall not grant a cost report submittal extension:
 - (1) If an extension has been granted by Medicare, the cost report shall be submitted simultaneously with the submittal of the Medicare cost report; or
 - (2) If a catastrophic circumstance exists, for example flood, fire, or other equivalent occurrence, the department shall grant a thirty (30) day extension.
- 3) If a cost report submittal date lapses and no extension has been granted, the department shall immediately suspend all payment to the hospital until a complete cost report is received.
- 4) A cost report submitted by a hospital to the department shall be subject to audit and review.
- 5) An in-state hospital shall submit to the department a final Medicare-audited cost report upon completion by the Medicare intermediary along with an electronic cost report file (ECR).

F. Unallowable Costs

- 1) The following shall not be allowable cost for Medicaid reimbursement unless otherwise noted:
 - a. A cost associated with a political contribution;
 - b. The allowability of legal fees is determined in accordance with the following:
 - (1) A cost associated with a legal fee for an unsuccessful lawsuit against the Cabinet for Health and Family Services is not allowable;
 - (2) A legal fee relating to a lawsuit against the Cabinet for Health and Family Services shall only be included as a reimbursable cost in the period in which the suit is settled after a final decision has been made that the lawsuit is successful or if otherwise agreed to by the parties involved or ordered by the court; and
 - c. Cost associated with travel and related expenses must take into consideration the following:

I Overview (continued)

F. Unallowable Costs (continued)

- (1) A cost for travel and associated expenses outside the Commonwealth of Kentucky for the purpose of a convention, meeting, assembly, conference, or a related activity is not allowable.
 - (2) A cost for a training or educational purpose outside the Commonwealth of Kentucky shall be allowable.
 - (3) If a meeting is not solely educational, the cost, excluding transportation, shall be allowable if an educational or training component is included.
- 2) A hospital shall identify an unallowable cost on the Supplemental Medicaid Schedule KMAP-1.
 - 3) The Supplemental Medicaid Schedule KMAP-1 shall be completed and submitted with the annual cost report.

G. Trending of an In-state Hospital's Cost Report Used for Non-DRG Rate Setting Purposes.

- 1) An allowable Medicaid cost, excluding a capital cost, as shown in a cost report on file in the department, either audited or un-audited, shall be trended from the midpoint of the cost report year to the beginning of the universal rate year to update an in-state hospital's Medicaid cost. This methodology applies for all rate setting throughout this attachment.
- 2) The trending factor to be used shall be the inflation factor prepared by GII (Global Insight, Incorporated), a market basket data indexing and forecasting firm referred to as GII) for the period being trended.

H. Indexing for Inflation of an In-state Hospital's Cost Report Used for Rate Setting Purposes.

- 1) After an allowable Medicaid cost has been trended to the beginning of a universal rate year, an indexing factor shall be applied to project inflationary cost to the midpoint in the universal rate year. This methodology applies for all rate setting throughout this attachment.
- 2) The department shall use the inflation factor prepared by GII (Global Insight, Incorporated) as the indexing factor for the universal rate year.

I. Cost Basis.

- 1) An allowable Medicaid cost shall:
 - a. Be a cost allowed after a Medicaid or Medicare audit;
 - b. Be in accordance with 42 C.F.R. Part 413;
 - c. Include an in-state hospital's provider tax; and
 - d. Not include a cost in the Unallowable Costs listed in Section (1)F of this attachment.
- 2) A prospective rate shall include both routine and ancillary costs.

1 Overview (continued)

I. Cost Basis. (continued)

- 3) A prospective rate shall not be subject to retroactive adjustment, except for:
 - a. A critical access hospital; or
 - b. A facility with a rate based on un-audited data.
- 4) An overpayment shall be recouped by the department as follows:
 - a. A provider owing an overpayment shall submit the amount of the overpayment to the department; or
 - b. The department shall withhold the overpayment amount from a future Medicaid payment due the provider.

J. Access to Subcontractor's Records. If a hospital has a contract with a subcontractor for services costing or valued at \$10,000 or more over a twelve (12) month period:

- 1) The contract shall contain a provision granting the department access:
 - a. To the subcontractor's financial information; and
 - b. In accordance with 907 KAR 1:672, published on January 4, 2008, Provider enrollment, disclosure, and documentation for Medicaid participation; and
- 2) Access shall be granted to the department for a subcontract between the subcontractor and an organization related to the subcontractor.

K. New Provider, Change of Owner or Merged Facility

- 1) The Department shall reimburse a new acute care hospital based on the Medicare IPPS Final Rule Data Files and Tables inputs in effect at the time of the hospital's enrollment with the Medicaid program as described in section (2) of this attachment. Final Rule Data Files and Tables can be found at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html>
- 2) If no applicable rate information exists in the Medicare IPPS Final Rule Data Files and Tables for a given period for an in-state acute care hospital, the Department shall use, for the in-state acute care hospital, the average of all in-state acute care hospitals for the operating rate, capital rate, and outlier cost-to-charge ratio, excluding any adjustments made for sole community hospitals or Medicare dependent hospitals.
- 3) If a hospital undergoes a change of ownership, the new owner shall be reimbursed at the rate in place at the time of the ownership change.

I Overview (continued)

K. New Provider, Change of Owner or Merged Facility (continued)

4) A merged facility of two or more entities.

a. The merger of two per diem facilities shall:

- (1) Merge the latest available data used for rate setting.
- (2) Combine bed utilization statistics, creating a new occupancy ratio.
- (3) Combine costs using the trending and indexing figures applicable to each entity in order to arrive at correctly trended and indexed costs.
- (4) If one (1) of the entities merging has disproportionate status and the other does not, retain for the merged entity the status of the entity which reported the highest number of Medicaid days paid.
- (5) Recognize an appeal of the merged per diem rate on Conditions of Medicaid provider participation, withholding overpayments, administrative appeal process, and sanctions.

5) Cost report submission

- a. Require each provider to submit a Medicaid cost report for the period ended as of the day before the merger within five (5) months of the end of the hospital's fiscal year end.
- b. A Medicaid cost report for the period starting with the day of the merger and ending on the fiscal year end for the merged entity shall also be filed with the department in accordance with this attachment.

L. Payment Not to Exceed Charges or the Upper Payment Limits.

- 1) The total of the overall payments to an individual hospital from all sources during the period of the state fiscal year may not exceed allowable charges plus disproportionate share payments, in aggregate, for inpatient hospital services provided to Medicaid recipients. The state fiscal year is July 1 through June 30. If an individual hospital's overall payments for the period exceed charges, the state will recoup payments in excess of allowable charges plus disproportionate share payments.
- 2) The state agency will pay no more in the aggregate for inpatient hospital services than the amount it is estimated would be paid for the services under the Medicare principles of reimbursement. Medicare upper payment limits as required by 42 CFR 447.272 will be determined in advance of the fiscal year from cost report and other applicable data from the most recent rate setting as compared to reimbursement for the same period. Cost data and reimbursement shall be trended forward to reflect current year upper payment limits. See Exhibit A for detail description and formula for UPL demonstration.

M. Public Process for Determining Rates for Inpatient Hospitals. The State has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

N. The Hospital Provider Tax is described in Kentucky Revised Statute 142.303, revised June 26, 2007.

1 Overview (continued)

- O. As required by Section 1923(j) of the Social Security Act related to auditing and reporting of disproportionate share hospital payments, the Department for Medicaid Services will implement procedures to comply with the Disproportionate Share Hospital Payments final rule issued in the December 19, 2008, Federal Register, with effective date of January 19, 2009, to ensure that the hospital specific DSH limits have not been exceeded.

Beginning with the Medicaid State Plan year 2011 DSH audit, DSH payments made to hospitals may be adjusted based on the results of the federally-mandated DSH audits as follows:

- 1) DSH payments found in the DSH audit process for a given state fiscal year that exceed the hospital specific uncompensated care cost (UCC) DSH limits will be recouped from hospitals to reduce their payments to their limit. Any payments that are recouped from hospitals as a result of the DSH audit will be redistributed to hospitals that are shown to have been paid less than their hospital-specific DSH limits. Redistributions will occur proportionately to the original distribution of DSH funds not to exceed each hospital's specific UCC DSH limit. If DSH funds cannot be fully redistributed within the original distribution pool, due to the hospital specific limits, the excess funds will be redistributed to the other distribution pools in proportion to the original DSH payments made by the state.
- 2) If the Medicaid program's original DSH payments did not fully expend the federal DSH allotment for any state fiscal year, the remaining DSH allotment will be retroactively paid to hospitals that are under their hospital-specific DSH limit reflecting the potential redistributions in #1 above. These additional DSH payments will be made in proportion to the original DSH payments, and will be limited to each hospital's specific DSH limit.

2. Acute Care Hospital Services
- A. DRG-Based Methodology
- 1) An eligible in-state acute care hospital shall be paid for all covered inpatient acute care services on a fully-prospective per discharge basis.
- B. Effective for discharges on or after October 1, 2015, the department's reimbursement shall equal ninety-five (95) percent of a hospital's Medicare DRG payment excluding the following Medicare reimbursement components:
- 1) A Medicare low-volume hospital payment;
 - 2) A Medicare end stage renal disease payment;
 - 3) A Medicare new technology add-on payment;
 - 4) A Medicare routine pass-through payment;
 - 5) A Medicare ancillary pass-through payment;
 - 6) A Medicare value-based purchasing payment or penalty;
 - 7) A Medicare readmission penalty in accordance with Item "M" below;
 - 8) A Medicare hospital-acquired condition penalty in accordance with Item "M" below;
 - 9) Any type of Medicare payment implemented by Medicare after October 1, 2015; or
 - 10) Any type of Medicare payment not described below.
- C.
- 1) For covered inpatient acute care services, in an in-state acute care hospital, the total hospital-specific per discharge payment shall be the sum of:
 - a. A DRG base payment; and
 - b. If applicable, a cost outlier payment.
 - 2) The resulting payment shall be limited to ninety-five (95) percent of the calculated value.
 - 3) If applicable, a transplant acquisition fee payment shall be added pursuant to Item "L" below.
- D.
- 1) The department shall assign a DRG classification to each unique discharge billed by an acute care hospital.
 - 2)
 - a. The DRG assignment shall be based on the most recent Medicare Severity DRG (MS-DRG) grouping software released by the Centers for Medicare and Medicaid Services beginning with version 32 on October 1, 2015 unless CMS releases version 33 on October 1, 2015.
 - b. If CMS releases version 33 on October 1, 2015, the department shall make interim payments for dates of service beginning October 1, 2015 based on version 32 and then retroactively adjust claims for dates of service beginning October 1, 2015 using version 33.
 - c. The grouper version shall be updated in accordance with the Reimbursement Updating Procedures outlined below in Item R.

2. Acute Care Hospital Services

- 3) In assigning a DRG for a claim, the department shall exclude from consideration any secondary diagnosis code associated with a never event.
- E.
- 1) A DRG base payment shall be the sum of the Medicare operating base payment and the capital base payment calculated as described in paragraphs 3) and 4) below.
 - 2) All calculations in this subsection shall be subject to special rate-setting provisions for sole community hospitals found in Item O and Medicare dependent hospitals found in Item P.
 - 3)
 - a. The Medicare operating base payment shall be determined by multiplying the hospital-specific operating rate by the DRG relative weight.
 - b. If applicable, the resulting product of subparagraph "a." of this paragraph shall be multiplied by the sum of one (1) and a hospital-specific operating indirect medical education (IME) factor determined in accordance with subparagraph "g." below.
 - c. Beginning October 1, 2015, the hospital-specific operating rate referenced in subparagraph "a." above shall be calculated using inputs from the Federal Fiscal Year 2016 Medicare IPPS Final Rule Data Files and Tables published by CMS as described in subparagraphs "d." through "g." below. Final Rule Data Files and Tables can be found at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html>
 - d. The Medicare IPPS standard amount established for operating labor costs from Table 1 shall be multiplied by the wage index from Table 3 associated with the final Core Based Statistical Area (CBSA) assigned to the hospital by Medicare, inclusive of any Section 505 adjustments applied by Medicare, as reported in the IPPS impact file.
 - e. The resulting product of subparagraph "d." shall be added to the Medicare IPPS standard amount for non-labor operating costs.
 - f. The operating rate shall be updated in accordance with Item "R" below.
 - g.
 - (1) Beginning October 1, 2015, the hospital-specific operating IME factor shall be taken from the Federal Fiscal Year 2016 Medicare Inpatient Prospective Payment System (IPPS) Final Rule Data Files and Tables published by CMS.
 - (2) The operating IME factor shall be updated in accordance with Item "R" below.
 - 4)
 - a. The capital base payment shall be determined by multiplying the hospital-specific capital rate by the DRG relative weight.
 - b. If applicable, the resulting product of subparagraph "a." above shall be multiplied by the sum of one (1) and a hospital-specific capital indirect medical education factor determined in accordance with subparagraph "g." below.
 - c. Beginning October 1, 2015, the hospital-specific capital rate referenced in subparagraph "a." above shall be calculated using inputs from the Federal Fiscal Year 2016 Medicare IPPS Final Rule Data Files and Tables published by CMS as described in subparagraphs "d" through "g" below. Final Rule Data Files and Tables can be found at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html>
 - d. The Medicare IPPS standard amount established for capital costs shall be multiplied by the geographic adjustment factor (GAF) associated with the final CBSA assigned to the hospital by Medicare.
 - e. The capital rate shall be updated in accordance with Item "R" below.

2. Acute Care Hospital Services

- f. Effective October 1, 2015, the hospital-specific capital IME factor shall be taken from the Medicare Inpatient Prospective Payment System (IPPS) Final Rule Data Files and Tables published by CMS.
- g. The capital IME factor shall be updated in accordance with Item "R." below.
- F.
 - 1) The department shall make a cost outlier payment for an approved discharge meeting the Medicaid criteria for a cost outlier for each DRG as established as follows.
 - 2) A cost outlier shall be subject to QIO review and approval.
 - 3) A discharge shall qualify for a cost outlier payment if its estimated cost, as calculated in Item "F" (4) below, exceeds the DRG's outlier threshold, as calculated in Item "F" (5) below.
 - 4)
 - a. The department shall calculate the estimated cost of a discharge:
 - (1) For purposes of comparing the discharge cost to the outlier threshold; and
 - (2) By multiplying the sum of the hospital-specific Medicare operating and capital-related cost-to-charge ratios by the Medicaid allowed charges.
 - b.
 - (1) A Medicare operating and capital-related cost-to-charge ratio shall be extracted from the Federal Fiscal Year 2016 Medicare IPPS Final Rule Data Files and Tables published by CMS. Final Rule Data Files and Tables can be found at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html>
 - (2) The Medicare operating and capital cost-to-charge ratios shall be updated in accordance with Item "R." below.
 - 5)
 - a. The department shall calculate an outlier threshold as the sum of a hospital's DRG base payment or transfer payment and the fixed loss cost threshold.
 - b.
 - (1) Beginning October 1, 2015, the fixed loss cost threshold shall equal the Medicare fixed loss cost threshold established for Federal Fiscal Year 2016.
 - (2) The fixed loss cost threshold shall be updated in accordance with Item "R." below.
 - 6)
 - a. For specialized burn DRGs as established by Medicare, a cost outlier payment shall equal ninety (90) percent of the amount by which estimated costs exceed a discharge's outlier threshold.
 - b. For all other DRGs, a cost outlier payment shall equal eighty (80) percent of the amount by which estimated costs exceed a discharge's outlier threshold.
- G.
 - 1) The department shall establish DRG relative weights obtained from the Medicare IPPS Final Rule Data Files and Tables corresponding to the grouper version in effect under Item "D." above. Final Rule Data Files and Tables can be found at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html>
 - 2) Relative weights shall be revised to match the grouping software version for updates in accordance with Item "R." below.
- H. The department shall separately reimburse for a mother's stay and a newborn's stay based on the DRGs assigned to the mother's stay and the newborn's stay.
- I.
 - 1) If a patient is transferred to or from another hospital, the department shall make a transfer payment to the transferring hospital if the initial admission and the transfer are determined to be medically necessary.
 - 2) For a service reimbursed on a prospective discharge basis, the department shall calculate the transfer payment amount based on the average daily rate of the transferring hospital's payment for each covered day the patient remains in that hospital, plus one (1) day, up to 100 percent of the allowable per discharge reimbursement amount.

2. Acute Care Hospital Services

- 3)
 - a. The department shall calculate an average daily discharge rate by dividing the DRG base payment by the Medicare geometric mean length-of-stay for a patient's DRG classification.
 - b. The Medicare geometric length-of-stay shall be obtained from the Medicare IPPS Final Rule Data Files and Tables corresponding to the grouper version in effect under subparagraph "c." below.
 - c. The geometric length-of-stay values shall be revised to match the grouping software version for updates in accordance with Item "R." below.
 - 4) Total reimbursement to the transferring hospital shall be the transfer payment amount and, if applicable, a cost outlier payment amount, limited to ninety-five (95) percent of the amount calculated for each.
 - 5) For a hospital receiving a transferred patient, the department shall reimburse the standard DRG payment established in Item "D." above.
- J.
- 1) The department shall reimburse a transferring hospital for a transfer from an acute care hospital to a qualifying post-acute care facility for selected DRGs as a post-acute care transfer.
 - 2) The following shall qualify as a post-acute care setting:
 - a. A skilled nursing facility;
 - b. A cancer or children's hospital;
 - c. A home health agency;
 - d. A rehabilitation hospital or rehabilitation distinct part unit located within an acute care hospital;
 - e. A long-term acute care hospital; or
 - f. A psychiatric hospital or psychiatric distinct part unit located within an acute care hospital.
 - 3) A DRG eligible for a post-acute care transfer payment shall be in accordance with 42 U.S.C. 1395ww(d)(4)(J).
 - 4)
 - a. The department shall pay each transferring hospital an average daily rate for each day of a stay.
 - b. A transfer-related payment shall not exceed the full DRG payment that would have been made if the patient had been discharged without being transferred.
 - c. A DRG identified by CMS as being eligible for special transfer payment in the Medicare IPPS Final Rule Data Files and Tables, shall receive fifty (50) percent of the full DRG payment plus the average daily rate for the first day of the stay and fifty (50) percent of the average daily rate for the remaining days of the stay up to the full DRG base payment. The Medicare IPPS release is found at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html>. DRG special transfer payment indicators will be updated in accordance with Item "R" below.
 - d. A DRG that is referenced in paragraph 3) of this subsection and not referenced in subparagraph "c." above shall receive twice the average daily rate for the first day of the stay and the average daily rate for each following day of the stay prior to the transfer.
 - e. Total reimbursement to the transferring hospital shall be the transfer payment amount and, if applicable, a cost outlier payment amount, limited to ninety-five (95) percent of the amount calculated for each.
 - 5)
 - a. The average daily rate shall be the base DRG payment allowed divided by the Medicare geometric mean length-of-stay for a patient's DRG classification.
 - b. The Medicare geometric mean length-of-stay shall be determined and updated in accordance with Item "I(3)" above.

2. Acute Care Hospital Services

- K. The department shall reimburse a receiving hospital for a transfer to a rehabilitation or psychiatric distinct part unit the facility-specific distinct part unit per diem rate, in accordance with 907 KAR 10:815 (published 5/3/11), for each day the patient remains in the distinct part unit.
- L. 1) The department shall reimburse for an organ transplant on a prospective per discharge method according to the recipient's DRG classification.
- 2) a. The department's organ transplant reimbursement shall include an interim reimbursement followed by a final reimbursement.
- b. The final reimbursement shall:
- (1) Include a cost settlement process based on the Medicare 2552 cost report form; and
 - (2) Be designed to reimburse hospitals for ninety-five (95) percent of organ acquisition costs.
- c. (1) An interim organ acquisition payment shall be made using a fixed-rate add-on to the standard DRG payment using the rates below:
- (a) Kidney Acquisition - \$65,000;
 - (b) Liver Acquisition - \$55,000;
 - (c) Heart Acquisition - \$70,000;
 - (d) Lung Acquisition - \$65,000; or
 - (e) Pancreas Acquisition - \$40,000.
- (2) Upon receipt of a hospital's as-filed Medicare cost report, the department shall calculate a tentative settlement at ninety-five (95) percent of costs for organ acquisition costs utilizing worksheet D-4 of the CMS 2552 cost report for each organ specified above.
- (3) Upon receipt of a hospital's finalized Medicare cost report, the department shall calculate a final reimbursement which shall be a cost settlement at ninety-five (95) percent of costs for organ acquisition costs utilizing worksheet D-4 of the CMS 2552 cost report for each organ specified above.
- (4) The final cost settlement shall reflect any cost report adjustments made by CMS.

M. Payment Adjustment for Provider Preventable Conditions

Effective June 1, 2012, and in accordance with Title XIX of the Social Security Act – Sections 1902, 1903 and 42 CFR 434, 438 and 447, Medicaid will make no payment to providers for services related to Provider Preventable Conditions (PPC) which includes Never Events (NE), Other Provider Preventable Conditions (OPPCs) and Additional Other Provider Preventable Conditions (AOPPC).

Payments for Health Care Acquired Conditions (HCACs) shall be adjusted in the following manner:

For DRG cases, the DRG payable shall exclude the diagnoses not present on admission for any HAC.

For per diem payments or cost-based reimbursement, the number of covered days shall be reduced by the number of days associated with the diagnoses not present on admission for any HCAC. The number of reduced days shall be based on the average length of stay (ALOS) on the diagnosis tables published by the ICD vendor used by the Medicaid agency. For example, an inpatient claims with 45 covered days identified with an HCAC diagnosis having an ALOS of 3.4, shall be reduced to 42 covered days.

2. Acute Care Hospital Services

Also, consistent with the requirement of 42 CFR 447.26(c):

- (c)(2) No reduction in payment for a provider preventable condition will be imposed on a provider when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by that provider.
- (c)(3) Reductions in provider payment may be limited to the extent that the following apply:
- i. The identified provider preventable conditions would otherwise result in an increase in payment.
 - ii. The state can reasonably isolate for nonpayment the portion of the payment directly related to treatment for, and related to, the provider preventable conditions.
- (c)(5) Non-payment of provider preventable conditions shall not prevent access to services for Medicaid beneficiaries.

Health Care-Acquired Conditions

The state identifies the following Health Care-Acquired Conditions for non-payment under Section 4.19-A:

- Hospital-Acquired Conditions as identified by Medicare other than Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) following total knee replacement or hip replacement surgery in pediatric and obstetric patients.

Other Provider-Preventable Conditions

The State identifies the following Other Provider-Preventable Conditions for non-payment under Section 4.19-A

- Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

N. Preadmission Services for an Inpatient Acute Care Service.

A preadmission service provided within three (3) calendar days immediately preceding an inpatient admission reimbursable under the prospective per discharge reimbursement methodology shall:

- 1) Be included with the related inpatient billing and shall not be billed separately as an outpatient service; and
- 2) Exclude a service furnished by a home health agency, a skilled nursing facility, or hospice, unless it is a diagnostic service related to an inpatient admission or an outpatient maintenance dialysis service.

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O. Reimbursement for Sole Community Hospitals.

An operating rate for sole community hospitals shall be calculated as described below:

- 1) a. For each sole community hospital, the department shall utilize the hospital's hospital-specific (HSP) rate calculated by Medicare.
- b. The HSP rate shall be extracted from the Federal Fiscal Year 2016 Medicare IPPS Final Rule Data Files and Tables, located at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html>.
- c. Effective October 1, 2016 and for subsequent years on October 1, the HSP rate shall be updated in accordance with Item "R." below.
- 2) a. The department shall compare the rate referenced in paragraph 1) above with the operating rate calculated in Item "E(3)" above.
- b. The higher of the two rates compared in "2) a." above shall be utilized as the operating rate for sole community hospitals.

P. Reimbursement for Medicare Dependent Hospitals.

- 1) a. For a Medicare-dependent hospital, the department shall utilize the hospital's hospital-specific (HSP) rate calculated by Medicare.
- b. The HSP rate shall be extracted from the Federal Fiscal Year 2016 Medicare IPPS Final Rule Data Files and Tables. Final Rule Data Files and Tables can be found at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html>
- c. Effective October 1, 2016 and for subsequent years on October 1, the HSP rate shall be updated in accordance with the reimbursement updating procedures in Item "R." below.
- 2) a. The department shall compare the Medicare-dependent hospital rate referenced in paragraph 1) above with the operating rate calculated in Item "E(3)" above.
- b. If the Item "E(3)" operating rate is higher, it shall be utilized as the hospital's operating rate for the period.
- 3) a. If the rate referenced in paragraph (1) is higher, the department shall calculate the arithmetic difference between the two (2) rates.
- b. The difference shall be multiplied by seventy-five (75) percent.
- c. The resulting product shall be added to the Item "E(3)" operating rate to determine the hospital's operating rate for the period.
- 4) If CMS terminates the Medicare-dependent hospital program, a hospital that is a Medicare-dependent hospital at the time that CMS terminates the program shall receive operating rates as calculated in Item "E(3)" above.

Q. Direct Graduate Medical Education Costs at In-state Hospitals with Medicare-approved Graduate Medical Education Programs.

- 1) The department shall reimburse for the direct costs of a graduate medical education program approved by Medicare as established below.
 - a. A payment shall be made:
 - (1) Separately from the per discharge and per diem payment methodologies; and
 - (2) On an annual basis corresponding to the hospital's fiscal year.

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- b. The department shall determine an annual payment amount for a hospital:
- (1) Total direct graduate medical education costs shall be obtained from a facility's as-filed CMS 2552 cost report, worksheet E-4, line 25.
 - (2)
 - (a) The facility's Medicaid utilization shall be calculated by dividing Medicaid fee-for-service covered days during the cost report period, as reported by the Medicaid Management Information System, by total inpatient hospital days, as reported on worksheet E-4, line 27 of the CMS 2552 cost report.
 - (b) The resulting Medicaid utilization factor shall be rounded to six (6) decimals.
 - (3) The total graduate medical education costs shall be multiplied by the Medicaid utilization factor to determine the total graduate medical education costs related to the fee-for-service Medicaid program.
 - (4) Medicaid program graduate medical education costs shall then be multiplied by ninety-five (95) percent to determine the annual payment amount.

R. Reimbursement Updating Procedures.

- 1)
 - a. The department shall annually update the Medicare grouper software to the most current version used by the Medicare program. The annual update shall be effective October 1 of each year, except as provided below.
 - b. If Medicare does not release a new grouper version effective October 1 of a given year
 - (1) The current grouper effective prior to October 1 shall remain in effect until a new grouper is released; and
 - (2) When the new grouper is released by Medicare, the department shall update the Medicare grouper software to the most current version used by the Medicare program.
 - c. The department shall not update the Medicare grouper software more than once per federal fiscal year which shall be October 1 through September 30 of the following year.
- 2) At the time of the grouper update, all DRG relative weights and geometric length-of-stay values shall be updated to match the most recent relative weights and geometric length-of-stay values effective for the Medicare program.
- 3)
 - a. Annually, on October 1, all values obtained from the Medicare IPPS Final Rule Data Files and Tables shall be updated to reflect the most current Medicare IPPS final rule in effect. Final Rule Data Files and Tables can be found at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html>
 - b.
 - (1) Within thirty (30) days after the Centers for Medicare and Medicaid Services publishes the Medicare IPPS Final Rule Data Files and Tables for a given year, the department shall send a notice to each hospital containing the hospital's data from the Medicare IPPS Final Rule Data Files and Tables to be used by the department to establish diagnosis related group rates on October 1.

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- (2) The notice referenced above shall request that the hospital:
 - (a) Review the information; and
 - (b) If the hospital discovers that the data in the notice sent by the department does not match the data published by the Centers for Medicare and Medicaid Services, notify the department of the discrepancy prior to October 1.
- 4) All Medicare IPPS final rule values utilized shall be updated to reflect any correction notices issued by CMS, if applicable.
- 5) Other than an adjustment resulting from an appeals decision requiring an amendment, the department shall make no other adjustment.

S. Readmissions.

- 1) An unplanned inpatient admission within fourteen (14) calendar days of discharge for the same diagnosis shall be considered a readmission and reviewed by the QIO.
- 2) Reimbursement for an unplanned readmission with the same diagnosis shall be included in an initial admission payment and shall not be billed separately.

T. Reimbursement for Out-of-State Hospitals.

- 1) The department shall reimburse an acute care out-of-state hospital for inpatient care on a fully prospective per discharge basis except for the following hospitals:
 - a. A children's hospital located in a Metropolitan Statistical Area as defined by the United States Office of Management and Budget whose boundaries overlap Kentucky and a bordering state; and
 - b. Vanderbilt Medical Center.
- 2) For eligible inpatient acute care service in an out-of-state acute care hospital the total hospital-specific per discharge payment shall be calculated in the same manner as an in-state hospital with modifications to rates used as described below.
- 3) The DRG payment parameters listed below shall be modified for out-of-state hospitals not specifically excluded in paragraph 1).
 - a. The operating rate used in the calculation of the operating base payment described in Item "E(3)(a)" shall equal the average of all in-state acute care hospital operating rates calculated in accordance with Item "E(3)" multiplied by eighty (80) percent, excluding any adjustments made for:
 - (1) Sole community hospitals; or
 - (2) Medicare-dependent hospitals.
 - b. The capital rate used in the calculation of the capital base payment described in Item "E(4)(a)" shall equal the average of all in-state acute care hospital capital rates calculated in accordance with Item "E(4)" multiplied by eighty (80) percent.
 - c. The DRG relative weights used in the calculation of the operating base payment described in Item "E(3)(a)" and the calculation of the capital base payment described in Item "E(4)(a)" shall be reduced by twenty (20) percent.

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- d. The following provisions shall not be applied:
 - (1) Medicare indirect medical education cost or reimbursement;
 - (2) Organ acquisition cost settlements;
 - (3) Disproportionate share hospital distributions; and
 - (4) Any adjustment mandated for in-state hospitals pursuant to KRS 205.638.
 - e. The Medicare operating and capital cost-to-charge ratios used to estimate the cost of each discharge, for purposes of comparing the estimated cost of each discharge to the outlier threshold, shall be determined by calculating the arithmetic mean of all in-state cost-to-charge ratios established in accordance with Item "F(4)" above.
- 4) The department shall reimburse for inpatient acute care provided by an out-of-state children's hospital located in a Metropolitan Statistical Area as defined by the United States Office of Management and Budget and whose boundaries overlap Kentucky and a bordering state, and except for Vanderbilt Medical Center, the average operating rate and average capital rate paid to in-state children's hospitals.
 - 5) The department shall reimburse for inpatient care provided by Vanderbilt Medical Center using the hospital-specific Medicare base rate extracted from the CMS IPPS Pricer Program in effect at the time that the care was provided multiplied by eighty-five (85) percent.
 - 6) The out-of-state hospitals referenced in paragraphs 4) and 5) shall not be eligible to receive indirect medical education reimbursement, organ acquisition cost settlements, or disproportionate share hospital payments.
 - 7)
 - a. The department shall reimburse a hospital referenced in subsection 4) or 5) of this section a cost outlier payment for an approved discharge meeting Medicaid criteria for a cost outlier for each Medicare DRG.
 - b. A cost outlier shall be subject to quality improvement organization review and approval.
 - c. The department shall determine the cost outlier threshold for an out-of-state claim regarding a hospital using the same method used to determine the cost outlier threshold for an in-state claim as described in Item F above.
- U. Certified Public Expenditures.
- 1)
 - a. The department shall reimburse an in-state public government-owned or operated hospital the full cost of a Medicaid fee-for-service inpatient service provided during a given state fiscal year via a certified public expenditure (CPE).
 - b. A payment shall be limited to the federal match portion of the hospital's uncompensated care cost for inpatient Medicaid fee-for-service recipients.
 - 2) To determine the amount of costs eligible for a CPE, a hospital's allowed days shall be multiplied by routine cost per diems found on worksheet D-1 Part II, lines 38 and 42-47 of the CMS 2552-10 cost report. Allowed ancillary charges shall be multiplied by cost-center specific cost-to-charge ratios from the hospital's 2552-10 cost report found on worksheet C part I, column 9.
 - 3) The department shall verify whether or not a given CPE is allowable as a Medicaid cost.

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- 4) a. An interim CPE reconciliation settlement shall be processed upon receipt of a facility's as-filed 2552-10 cost report.
- b. Subsequent to a final cost report being submitted to the department, a final CPE settlement shall be reconciled with the actual costs reported to determine the final CPE for the period.
- c. If any difference between actual cost and submitted costs remains, the department shall reconcile any difference with the provider.

V. Intensity Operating Allowance Inpatient Supplement Payments.

- 1) A State owned or operated University Teaching Hospital, including a hospital operated by a related party organization as defined at 42 CFR 413.17, which is operated as part of an approved School of Medicine, shall be based on the upper payment limits as required by 42 CFR 447.272 and will be determined prospectively each year based on the difference between the total payments made by Medicaid, excluding DSH, and the estimated Medicare payments for the same services. The Medicare payments will be determined based on the Medicare Principles of Reimbursement in accordance with 42 CFR 412 and 413.
- 2) The detailed formula to determine the supplemental payments is described in Exhibit B incorporated as part of this attachment.
- 3) The prospective supplemental payments will be reconciled annually to the final cost report filed for the rate year or prospective payment period.
- 4) Any payments made under this section are subject to the payment limitations as specified in 42 CFR 447.271, whereby the total overall payments to an individual hospital during the rate year may not exceed the hospital's total charges for the covered services.
- 5) Payments made under this section shall be prospectively determined quarterly amounts, subject to a year-end reconciliation.
- 6) In the event that any payment made under this section is subsequently determined to be ineligible for federal financial participation (FFP) by CMS, the Department shall adjust the payments made to any hospitals as necessary to qualify for FFP.
- 7) Pediatric Teaching Hospital

A state designated pediatric teaching hospital that is not state-owned or operated shall receive a quarterly pediatric teaching supplement in an amount:

- a. Calculated by determining the difference between Medicaid costs as stated on the audited Medicare 2552-10 cost report filed as of June 1 each year and payments received for the Medicaid recipients (i.e., Medicare, KMAP, TPL, and Medical Education); and including,
- b. An additional quarterly payment of \$250,000 (\$1 million annually).

(Medicaid recipients shall not include recipients receiving services reimbursed through a Medicaid managed care contract.)

W. Supplemental Payments for DRG Psychiatric Access Hospitals

- 1) For services provided on and after April 2, 2001 the Department shall provide supplemental payments to certain hospitals to assure access to psychiatric services for patients in rural areas of the Commonwealth. To qualify for psychiatric access payments a hospital must meet the following criteria:

2. Acute Care Hospital Services

- a. The hospital is not located in a Metropolitan Statistical Area (MSA);
 - b. The hospital provides at least 65,000 days of inpatient care as reflected in the Department's Hospital Rate data for Fiscal Year 1998-99;
 - c. The hospital provides at least 20% of inpatient care to Medicaid eligible recipients as reflected in the Department's Hospital Rate data for State Fiscal Year 1998-99; and
 - d. The hospital provides at least 5,000 days of inpatient psychiatric care to Medicaid recipients in a fiscal year.
- 2) Each qualifying hospital will receive a psychiatric access payment amount based on its proportion of the hospital's Medicaid psychiatric days to the total Medicaid psychiatric days for all qualifying hospitals applied to the total funds for these payments. Payments will be made on a quarterly basis in according with the following:

$$\frac{\text{Medicaid patient days}}{\text{Total Medicaid patient days}} \times \text{Fund} = \text{Payment}$$

- 3) Total Medicaid payments to a hospital from all sources shall not exceed Medicaid charges plus disproportionate share payments. A hospital's disproportionate share payment shall not exceed the sum of the payment shortfall for Medicaid services and the costs of the uninsured. The fund shall be an amount not to exceed \$6 million annually.

X. Appalachian Regional Hospital System supplemental payments.

All DRG hospitals operating in the Commonwealth of Kentucky that belong to the Appalachian Regional Hospital System will receive an adjusted payment equal to the difference between what Medicaid pays for inpatient services and what Medicare would pay for those same services to Medicaid eligible individuals or its proportionate share of \$7.5 million, whichever is lower. The Upper Payment Limit as defined in 42 CFR 447.272 will be applied on a facility-specific basis as described in Exhibit A. These payments will be made on a quarterly basis within 30 days of the end of the quarter.

Y. Supplemental DRG Payments

- 1) The Department will pay no more in the aggregate for inpatient hospital services than the inpatient Upper Payment Limit, as set forth in 42 CFR 447.253(b)(2) and 42 CFR 447.272. The Department will determine the inpatient Upper Payment Limit by estimating what would be paid for inpatient hospital services under the Medicare principles of reimbursement. The methodology used by the Department to calculate the inpatient Upper Payment Limits can be found in Attachment 4.19-A Exhibit A.
- 2) An overpayment made to a facility under this section shall be recovered by subtracting the overpayment amount from a succeeding year's payment to be made to the facility in accordance with applicable federal regulations.
 - a. For the purpose of this attachment, Medicaid patient days shall not include enrollee days which means a day of an inpatient hospital stay of a Medicaid recipient who is enrolled with a managed care organization.
 - b. A payment made under the Supplemental DRG payments shall not duplicate a payment made via Disproportionate share hospital distributions.

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Z. Per Diem Methodology: Payment for Rehabilitation or Psychiatric or Substance Abuse Care in an In-State Acute Care Hospital.

1) Distinct Part Unit (DPU)

The department shall reimburse for rehabilitation or psychiatric care in an in-state acute care hospital that has a Medicare-designated rehabilitation or psychiatric distinct part unit on a per diem basis as follows:

- a. On a facility-specific per diem basis equivalent to the per diem cost reported for Medicare distinct part unit patients on the most recently received Medicare cost report prior to the rate year. Routine costs for the distinct part unit will be determined by multiplying allowed days by worksheet D-1 Part I, Title XIX - Subprovider, line 38. Ancillary costs will be determined by multiplying allowed charges by the cost center specific cost-to-charge ratio found on worksheet C part I, column 9 of the 2552-10 cost report.
- b. Reimbursement for an inpatient rehabilitation or psychiatric service shall be determined by multiplying a hospital's rehabilitation or psychiatric per diem rate by the number of allowed patient days.
- c. A rehabilitation or psychiatric per diem rate shall be the sum of a rehabilitation or psychiatric operating per diem rate and a rehabilitation or psychiatric capital per diem rate, as appropriate.
 - (1) The rehabilitation or psychiatric operating cost-per-day amounts used to determine the rehabilitation or psychiatric operating per diem rate shall be calculated for each hospital by dividing its Medicaid rehabilitation or psychiatric cost basis (as appropriate), excluding capital costs and medical education costs, by the number of Medicaid rehabilitation or psychiatric patient days in the base year.
 - (2) The Medicaid rehabilitation or psychiatric cost basis and patient days shall be based on Medicaid claims for patients with a rehabilitation or psychiatric diagnosis (as appropriate) with dates of service in the base year. The rehabilitation or psychiatric operating per diem rate shall be adjusted for inflation in accordance with Section (5)(A)(1) of this attachment.
- d. Computation of rates.
 - (1) A rehabilitation or psychiatric capital per diem rate shall be facility-specific and shall be calculated for each hospital by dividing its Medicaid rehabilitation or psychiatric capital cost basis by the number of Medicaid rehabilitation or psychiatric patient days (as appropriate) in the base year.
 - (2) The Medicaid rehabilitation or psychiatric capital cost basis and patient days shall be based on Medicaid claims for patients with rehabilitation or psychiatric diagnoses (as appropriate) with dates of service in the base year.
 - (3) The rehabilitation or psychiatric capital per diem rate shall not be adjusted for inflation.

2) Non Distinct Part Unit (Non-DPU)

The department shall reimburse for rehabilitation or psychiatric care provided in an in-state hospital that does not have a Medicare-designated distinct part unit:

- a. On a projected payment basis using:
 - (1) A facility specific per diem basis equivalent to its aggregate projected payments for DRG services divided by its aggregate projected Medicaid paid days.
 - (2) Aggregate projected payments and projected Medicaid paid days shall be the sum of:
 - (a) Aggregate projected payments and aggregate projected Medicaid paid days for non-per diem DRG services as calculated by the model established in section (2)A;
 - (b) Actual prior year payments inflated by the inflation factor provided by GII; and
 - (c) Per diem DRG service Medicaid days; and
 - b. In compliance with provisions for the use of a universal rate year and taking into consideration Medicaid policy with regard to unallowable costs as shown in (1)D and F of this attachment.
3. Payment for Long-term Acute Care Hospital Care, In-State Freestanding Psychiatric or Substance Abuse Hospital Care, and In-State Freestanding Rehabilitation Hospital Care.
- A. The department shall reimburse for inpatient care provided to eligible Medicaid recipients in an in-state freestanding psychiatric hospital, in-state freestanding rehabilitation hospital, or LTAC hospital on a per diem basis including both psychiatric or substance abuse care where applicable.
 - B. The department shall calculate a per diem rate by:
 - 1) For rates effective July 1, 2015 through June 30, 2019, using a hospital's fiscal year 2014 Medicare cost report, allowable cost and paid days to calculate a base cost per day for the hospital. Routine costs will be determined by multiplying allowed days by worksheet D-1 Part I, Title XIX, line 38. Ancillary costs will be determined by multiplying allowed charges by the cost center specific cost-to-charge ratio found on worksheet C part I, column 9 of the 2552-10 cost report. Rates will be re-based every four years with adjustments for inflation in non-rebase years, in accordance with section 5 of this attachment. For future rebasing periods beginning July 1, 2019, using the most recently received hospital fiscal year Medicare cost report at the time of rate-setting;
 - 2) Trending and indexing a hospital's specific cost, excluding capital cost, per day to the current state fiscal year;
 - 3) Calculating an average base cost per day for hospitals within similar categories, for example rehabilitation hospitals, using the indexed and trended base cost per day;
 - 4) Assigning no hospital a base cost per day equaling less than ninety-five (95) percent of the weighted average trended and indexed base cost per day of hospitals within the corresponding category;

3. Payment for Long-term Acute Care Hospital Care, In-State Freestanding Psychiatric or Substance Abuse Hospital Care, and In-State Freestanding Rehabilitation Hospital Care.
 - 5) Applying a parity factor equivalent to aggregate cost coverage established by the DRG reimbursement methodology described in the diagnostic related group hospital reimbursement portion of the state plan; and
 - 6) Applying available provider tax funds on a pro-rata basis to the pre-provider tax per diem calculated in paragraphs 1 through 5 of this subsection.
- C. In-State Hospital Minimum Occupancy Factor.
- 1) If an in-state hospital's minimum occupancy is not met, allowable Medicaid capital costs shall be reduced by:
 - a. Increasing the occupancy factor to the minimum factor; and
 - b. Calculating the capital costs using the calculated minimum occupancy factor.
 - 2) The following minimum occupancy factors shall apply:
 - a. A sixty (60) percent minimum occupancy factor shall apply to a hospital with 100 or fewer total licensed beds;
 - b. A seventy-five (75) percent minimum occupancy factor shall apply to a hospital with 101 or more total licensed beds; and
 - c. A newly-constructed in-state hospital shall be allowed one (1) full universal rate year before a minimum occupancy factor shall be applied.
- D. Reduced Depreciation Allowance. The allowable amount for depreciation on a hospital building and fixtures, excluding major movable equipment, shall be sixty-five (65) percent of the reported depreciation amount as shown in the hospital's cost reports.
- E. Payment to a Newly-participating In-State Freestanding Psychiatric Hospital, Freestanding Rehabilitation Hospital or a Long Term Acute Care Hospital.
- 1) The department shall reimburse a newly-participating in-state freestanding psychiatric hospital, freestanding rehabilitation hospital or long term acute care hospital the minimum per diem rate paid to hospitals in their category until the first fiscal year cost report is submitted by the hospital.
 - 2) Upon submission of the first fiscal year cost report for a facility, the department shall reimburse the facility a per diem rate in accordance with Section (3)B of this attachment.

4. Payment for Critical Access Hospital Care.

- A. The department shall pay a per diem rate to a critical access hospital equal to the hospital's Medicare rate.
- B. A critical access hospital's final reimbursement for a fiscal year shall reflect any adjustment made by CMS.
- C. Cost Report Requirements.
 - 1) A critical access hospital shall comply with the cost reporting requirements established in the In-State Hospital Cost Reporting Requirements section.
 - 2) A cost report submitted by a critical access hospital to the department shall be subject to audit and review.
- D. An out-of-state critical access hospital shall be reimbursed under the same methodology as an in-state critical access hospital.
- E. The department shall reimburse for care in a federally defined swing bed in a critical access hospital at the same rate as established by the Centers for Medicare and Medicaid Services for Medicare.
- F. Reimbursement Limit. Total reimbursement to a hospital, other than to a critical access hospital, shall be subject to the limitation established in 42 C.F.R. 447.271.

5. In-State Psychiatric, Rehabilitation, and Long-term Acute Care Hospitals Reimbursement Updating Procedures including psychiatric or substance abuse care, where applicable.
- A. The department shall adjust an in-state hospital's per diem rate annually according to the following:
- 1) The Healthcare Cost Review, a publication prepared by IHS Global Insight (GI) is used to obtain to update trending and indexing factors. The most recently received first-quarter publication is used for rate-setting. For trending and indexing factors the Total %MOVAVG line from Table 6.1CY, Hospital Prospective Reimbursement Market Basket, is used. The second quarter column of the respective year being trended/indexed to is used.
 - 2) A capital per diem rate shall not be adjusted for inflation.
- B. The department shall, except for a critical access hospital, rebase an in-state psychiatric, rehabilitation, and long-term acute care hospital's per diem rate every four (4) years.
- C. Except for an adjustment resulting from an audited cost report, the department shall make no other adjustment, except for correction of error, as a result of a change resulting from a dispute resolution or appeal to the extent rates were not set in accordance with the State Plan or Federal Court decision; or as a result of a properly promulgated policy change and approved by CMS through a State Plan amendment.

6. Reimbursement for Out-of-state Hospitals for Critical Access Care, Long Term Acute Care, Rehabilitation Care and Psychiatric Care including psychiatric or substance abuse care, where applicable.
- A. For inpatient psychiatric or rehabilitation care provided by an acute out-of-state hospital, the department shall reimburse a per diem rate comprised of an operating per diem rate and a capital per diem rate.
- 1) The psychiatric or rehabilitation operating per diem rate shall be the median psychiatric or rehabilitation operating per diem rate paid for all in-state acute care hospitals that have licensed psychiatric or rehabilitation beds, as appropriate.
 - 2) The psychiatric or rehabilitation capital per diem rate shall be the median psychiatric or rehabilitation capital per diem rate paid for all in-state acute care hospitals that have licensed psychiatric or rehabilitation beds, as appropriate.
 - 3) An out-of-state hospital's per diem rate shall not include:
 - a. A provider tax adjustment; or
 - b. Graduate medical education costs.
- B. For care provided by an out-of-state freestanding long term acute care, critical access, or freestanding psychiatric hospital, the department shall reimburse a per diem rate comprised of an operating per diem rate and a capital per diem rate for each type of facility as appropriate.
- 1) The long term acute care or critical access operating per diem rate shall equal the median operating rate, excluding graduate medical education cost or any provider tax cost, per day for all in-state freestanding hospitals of the same type. The psychiatric operating per diem rate shall equal seventy (70) percent of the median operating rate, excluding graduate medical education cost or any provider tax cost, per day for all in-state freestanding psychiatric hospitals.
 - 2) The long term acute care or critical access capital per diem rate shall be the median capital per diem rate for all in-state freestanding hospitals of the same type. The psychiatric capital per diem rate shall equal seventy (70) percent of the median capital rate, excluding graduate medical education cost or any provider tax cost, per day for all in-state freestanding psychiatric hospitals.
 - 3) An out-of-state hospital's per diem rate shall not include:
 - a. A provider tax adjustment; or
 - b. Graduate medical education costs.
- C. For care in an out-of-state rehabilitation hospital, the department shall reimburse a per diem rate equal to the median rehabilitation per diem rate for all in-state rehabilitation hospitals except that an out-of-state hospital's per diem rate shall not include:
 - 1) A provider tax adjustment; or
 - 2) Graduate medical education costs.
- D. The department shall apply the requirements of 42 C.F.R. 447.271 to payments made pursuant to the plan provisions shown in this section of this attachment.

7. Supplemental Payments for a Free-standing In-state Rehabilitation Hospital:

A state designated rehabilitation teaching hospital that is not state-owned or operated shall receive an annual rehabilitation teaching supplement payment, determined on a per diem basis, in an amount calculated by determining the difference between Medicaid costs as stated on the most recently received cost report each year, and payments received for the Medicaid patients (i.e., Medicare, KMAP, TPL, and Medical Education.)

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

May 31, 2016

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



Dear Mr. Miller:

The Centers for Medicare & Medicaid Services (CMS) is approving Kentucky's request to renew its 1915(b) Human Service Transportation Delivery (HSTD) Program waiver (Control# KY-06.R02). This waiver program authorizes the state to provide non-emergency transportation services to Medicaid beneficiaries. This waiver also allows Kentucky to mandatorily enroll Medicaid beneficiaries into a Prepaid Ambulatory Health Plan (PAHP). This waiver was approved on May 31, 2016

This waiver is approved from July 1, 2016 - June 30, 2018.

The decision to approve this waiver renewal is based on the evidence submitted to CMS demonstrating that the state's waiver program is consistent with the purpose of the Medicaid program, and has met all the statutory and regulatory requirements for access to care and quality of service.

The Human Service Transportation Delivery (HSTD) Program waiver is authorized under sections 1915(b)(1) and 1915(b)(4) of the Social Security Act (the Act) and provides for waivers of the following sections of Title XIX:

- Section 1902(a)(4) Mandatory Enrollment into a Single PIHP or PAHP
- Section 1902(a)(23) Freedom of Choice

As specified in the 1915(b) waiver application, Kentucky agrees to comply with the Special Terms and Conditions (STCs) attached to this approval letter to ensure compliance with statutory and regulatory compliance.

If you wish to renew this waiver at the end of the two year term, you must submit a renewal application no later than April 30, 2018. If a renewal is not received, the CMS will request a phase down plan from the state for the termination of the waiver program.

Mr. Stephen P. Miller, Commissioner
Page 2

We wish you continued success in the operation of the 1915(b) HSTD waiver. Thank you for your cooperation during the waiver review process. If you have any further questions, please contact Melanie Benning in the Atlanta Regional Office at (404) 562-7414 or Lovie Davis, CMS Central Office at (410) 786-1533.

Sincerely,



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

Attachment

**Kentucky 1915(b)(4) Waiver Special Terms and Conditions
Waiver Control # KY-06**

Approval Period: July 1, 2016 to August 31, 2018

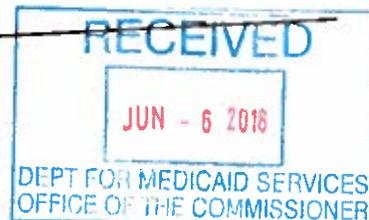
The following are Special Terms and Conditions (STCs) for Kentucky's 1915(b)(1) and 1915(b)(4) Human Service Transportation Delivery (HSTD) Program waiver. These STCs will enable the Centers for Medicare & Medicaid Services (CMS) to evaluate and monitor the state's provision of transportation for beneficiaries to pharmacy providers.

1. The state shall submit a Corrective Action Plan (CAP) to CMS for review and approval that includes the following:
 - a. A detailed plan to demonstrate how the state will comply with 42 CFR 431.53 to ensure necessary transportation for beneficiaries to and from pharmacy providers;
 - b. Key metrics and time frames with compliance achieved no later than December 31, 2017; and,
 - c. A justification for each proposed metric and timeframe identified in the CAP.
2. The state shall submit the CAP to CMS within ninety (90) days of the date of this letter.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-14-26
Baltimore, Maryland 21244-1850



Disabled & Elderly Health Programs Group



June 2, 2016

Stephen P. Miller
Commissioner, Department for Medicaid Services
Commonwealth of Kentucky, Cabinet for Health and Family Services
275 East Main Street, 6 West A
Frankfort, KY 40621

Dear Commissioner Miller:

I am writing to inform you that CMS is granting the state of Kentucky **initial approval** of its Statewide Transition Plan (STP) to bring settings into compliance with the federal home and community-based services (HCBS) regulations found at 42 CFR Section 441.301(c)(4)(5) and Section 441.710(a)(1)(2). Approval is granted because the state completed its systemic assessment, included the outcomes of this assessment in the STP, and clearly outlined remediation strategies to rectify issues that the systemic assessment uncovered, such as legislative changes and changes to contracts, and is actively working on those remediation strategies. Additionally, the state submitted the March 2016 draft of the STP for a 30-day public comment period, made sure information regarding the public comment period was widely disseminated, and responded to and summarized the comments in the STP submitted to CMS.

After reviewing the March 2016 draft submitted by the state, CMS provided additional feedback on May 5, requesting that the state make several technical corrections in order to receive initial approval. These changes did not necessitate another public comment period. The state subsequently addressed all issues, and resubmitted an updated version on May 17, 2016. These changes are summarized in Attachment I of this letter. The state's responsiveness in addressing CMS' remaining concerns related to the state's systemic assessment and remediation expedited the initial approval of its STP.

In order to receive final approval of Kentucky's STP, the state will need to complete the following remaining steps and submit an updated STP with this information included:

- Complete a thorough, comprehensive site-specific assessment of all HCBS settings, implement necessary strategies for validating the assessment results, and include the outcomes of this assessment within the STP;

- Draft remediation strategies and a corresponding timeline that will resolve issues that the site-specific settings assessment process and subsequent validation strategies uncovered by the end of the HCBS rule transition period (March 17, 2019);
- Outline a detailed plan for identifying settings that are presumed to have institutional characteristics including qualities that isolate HCBS beneficiaries, as well as the proposed process for evaluating these settings and preparing for submission to CMS for review under heightened scrutiny;
- Develop a process for communicating with beneficiaries that are currently receiving services in settings that the state has determined cannot or will not come into compliance with the HCBS settings rule by March 17, 2019; and
- Establish ongoing monitoring and quality assurance processes that will ensure all settings providing HCBS continue to remain fully compliant with the rule in the future.

While the state of Kentucky has made much progress toward completing each of these remaining components, there are several technical issues that have been outlined in the attachment to this letter that must be resolved to CMS' satisfaction before the state can receive final approval of its STP. Upon review of this detailed feedback, CMS requests that the state please contact George Failla at 410-786-7561 or George.Failla@cms.hhs.gov or Michelle Beasley at 312-353-3746 or Michelle.Beasley@cms.hhs.gov at your earliest convenience to confirm the date that Kentucky plans to resubmit an updated STP for CMS review and consideration of final approval.

It is important to note that CMS' initial or final approval of a STP solely addresses the state's compliance with the applicable Medicaid authorities. CMS' approval does not address the state's independent and separate obligations under the Americans with Disabilities Act, Section 504 of the Rehabilitation Act or the Supreme Court's Olmstead decision. Guidance from the Department of Justice concerning compliance with the Americans with Disabilities Act and the Olmstead decision is available at http://www.ada.gov/olmstead/q&a_olmstead.htm.

I want to personally thank the state for its efforts thus far on the HCBS statewide transition plan. CMS appreciates the state's completion of the systemic review and corresponding remediation plan with fidelity, and looks forward to the next iteration of the STP that addresses the remaining technical feedback provided in the attachment.

Sincerely,



Ralph F. Lollar, Director
Division of Long Term Services and Supports

ATTACHMENT I

SUMMARY OF TECHNICAL CHANGES MADE BY STATE OF KENTUCKY TO ITS SYSTEMIC ASSESSMENT & REMEDIATION STRATEGY AT REQUEST OF CMS IN UPDATED HCBS STATEWIDE TRANSITION PLAN DATED 5-17-2016

- **Documentation of Systemic Remediation Actions Already Completed:** CMS requested that the state update its STP to indicate which regulatory changes had already been completed within its proposed systemic remediation plan. Additionally, among the first round of regulatory changes that have been already been completed by the state, CMS requested the state provide links to the revised regulations, as well as the state's summary document that describes the language added to each regulation and update the STP to indicate which regulatory changes have already been completed.

State's Response: The state provided the following links to the revised regulations:

- **Acquired Brain Injury (ABI):** <http://www.lrc.ky.gov/kar/907/003/090.htm> – regulation is in effect.
- **Acquired Brain Injury-Long Term Care (ABI-LTC):** <http://www.lrc.ky.gov/kar/907/003/210.htm> – regulation is in effect.
- **Home and Community Based (HCB):** <http://www.lrc.state.ky.us/kar/907/007/010.htm> - please note, this regulation is anticipated to become effective in July (pending waiver renewal application approval from CMS). Please note, the citation of this waiver regulation was formerly 907 KAR 1:160 but is now 907 KAR 7:010.
- **Michelle P. (MPW):** <http://www.lrc.state.ky.us/kar/907/001/835reg.htm> - please note, this regulation will take effect on June 3, 2016.
- **Supports for Community Living:** <http://www.lrc.ky.gov/kar/907/012/010reg.htm> - please note, this regulation is anticipated to become effective in July (pending waiver renewal application approval from CMS).

A streamlined summary table of the inclusion of the HCBS Final Rules setting requirements into Kentucky state waiver regulations was also added on pages 7-12 of the STP. Outdated information was deleted. Additionally, the state included a new attachment to the STP entitled, "HCBS Rules Definitions 2015-02-20", which laid out all language included in each of the waiver regulations to address existing gaps or inconsistencies with the federal settings rule in existing state standards.

- **Additional Details Regarding State's Systemic Remediation:** CMS requested that Kentucky provide more detail to the descriptions of the changes the state will make to its regulations to bring them into full compliance with the federal requirements in the systemic remediation table (pages 23-29).
 - For example, on pages 23-24, one of the proposed remedial actions was to "clarify indicators of integration into the greater community and incorporate into the regulation." CMS requested the state include more precise language regarding the planned revision and what type of language would be added to the regulation.

State's Response: In response to CMS' request, Kentucky added the exact language to this table that was included in our revised waiver regulations. For the four requirements of the HCBS Final

Rules that are not yet in state regulations, Kentucky included the exact language the state is planning to include in the second round of regulations to be revised and filed.

- **Stakeholder Engagement:** CMS recommended that the state include highlights of its efforts to solicit feedback from stakeholders throughout the systemic assessment and remediation process, including meetings and discussions with stakeholders, in the STP.

State's Response: A list of meetings with stakeholders was inserted on pages 23-24.

- **State Standards Already in Full Compliance with HCBS Settings Rule:** CMS requested Kentucky provide a list of the state regulations along with citations that the state found to already be fully compliant with the federal requirements during its systemic assessment process, i.e., those that fell into "group one" (p. 6-7) and did not need any changes to come into compliance. Additionally, CMS asked the state to provide an explanation of how it determined each of these state regulations were compliant with one or more specific elements of the HCBS rule.

State's Response: The state responded that none of the existing state HCBS waiver regulations were originally in full compliance with the HCBS settings rule. There were some requirements within the state's waiver regulations that were similar to the federal requirements, but all state waiver regulations were updated to fully comply with the HCBS settings rule. This information was further clarified by the state on page 7 of the most recent STP submission.

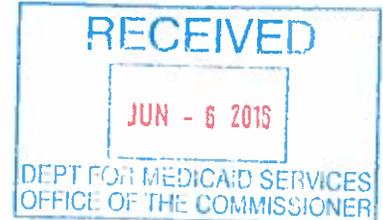
DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
61 Forsyth Street, SW, Suite 4120
Atlanta, Georgia 30303-8909



DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

June 3, 2016

Stephen P. Miller, Commissioner
Cabinet for Health and Family Services
Department for Medicaid Services
275 East Main Street, 6W-A
Frankfort, KY 40621



RE: Approval of KY External Quality Review Organization (EQRO) contract - Island Peer Review Organization (IPRO) #1400002577

Dear Mr. Miller:

The Centers for Medicare & Medicaid Services (CMS) Atlanta Regional Office has reviewed the External Quality Review contract and related amendments (746 1400002577-1, 746 1400002577-2, 746 1400002577-3) submitted July 20, 2015. The contract and amendments were executed between the Kentucky Department for Medical Services (DMS) and IPRO. IPRO evaluates Kentucky's Medicaid Managed Care program. The EQRO contract effective dates are July 1, 2014 through June 30, 2016. The total amount paid by DMS to IPRO is \$2,010,440.00 and includes services provided under and funded through the 1915(b) federal waiver authority.

Federal requirements outlined in 42 CFR 438.370 indicate Federal Financial Participation (FFP) at the 75 percent rate is available for EQR and EQR-related activities conducted by the EQRO. Federal Financial Participation at the 50 percent rate is available for EQR-related activities conducted by any entity that does not qualify as an EQRO.

The IPRO EQR activities included in the contract that are eligible for the enhanced 75 percent rate are:

- Compliance Review
- Validation of Performance Measures
- Validation of Performance Improvement Projects (PIPs)

Mr. Stephen P. Miller, Commissioner
Page 2

The IPRO EQR activities included in the contract that are not eligible for enhanced 75 percent rate, and only eligible for 50 percent FFP are:

- Project Launch Work Plan
- Annual Business Plan
- Individual Case Review
- Managed Care Program Progress Reports
- Monitoring of EPSDT Services
- Technical Assistance for DMS and MCOs and Presentation on EQR Results
- Comprehensive Evaluation Summary of the Medicaid Managed Care Program
- Validation of Patient Level Claims
- Quality of Care Focus Studies
- Access and Availability Surveys
- Validation of Managed Care Provider Network Submissions
- Pharmacy Program Reviews
- EQR Final Technical Report Results
- Follow-up Activities
- Final Draft Evaluation report for the KY Health Care Partnership 1115 Waiver
- Transition Requirements.

Based on the information provided, CMS approved the contract actions on June 3, 2016.

We appreciate the effort and cooperation provided by your staff during our review. If you have any questions or need further assistance, please contact Kia Carter-Anderson at (404) 562-7431.

Sincerely,



Jackie Glaze

Associate Regional Administrator

Division of Medicaid & Children's Health Operations



SHO # 16-008

**Re: Medicaid Family Planning Services
and Supplies**

June 14, 2016

Dear State Health Official:

The purpose of this letter is to clarify previous guidance on the delivery of family planning services and supplies to all Medicaid beneficiaries, as well as to highlight approaches states may take to ensure timely access to this benefit. Specifically, this letter provides guidance on family planning services provided under both fee-for-service and managed care delivery systems; clarifies the purpose of the family planning visit; offers strategies to reduce barriers to receiving family planning services and supplies; and suggests ways to increase access to contraceptive methods. The guidance in this letter is effective immediately.

Background

Under section 1905(a)(4)(C) of the Social Security Act (the Act), family planning services and supplies must be included in the standard Medicaid benefit package and in alternative benefit plans (ABPs). The mandatory family planning benefit provides coverage for services and supplies to prevent or delay pregnancy and may include: education and counseling in the method of contraception desired or currently in use by the individual, a medical visit to change the method of contraception, and (at the state's option) infertility treatment. For expenditures for family planning services and supplies, states receive an enhanced Federal Financial Participation (FFP) of 90 percent.

In addition, section 1902(a)(10)(G) of the Act, as amended by section 2303(a)(3) of the Affordable Care Act, added an optional family planning eligibility group. While full benefit Medicaid eligible individuals receive a wide array of care under other Medicaid coverage categories, individuals in this optional eligibility group are covered only for family planning services and family planning *related* services. Family planning *related* services are medical, diagnostic, and treatment services provided pursuant to a family planning visit that address an individual's medical condition and may be provided for a variety of reasons including, but not limited to: treatment of medical conditions routinely diagnosed during a family planning visit, such as treatment for urinary tract infections or sexually transmitted infection; preventive services routinely provided during a family planning visit, such as the HPV vaccine; or treatment of a major medical complication resulting from a family planning visit. Expenditures for family planning *related* services are matched at the states' regular Federal Medical Assistance Percentage (FMAP). The clarifications in this letter supplement all earlier guidance.

The Centers for Medicare & Medicaid Services (CMS) issued a State Medicaid Directors letter on July 2, 2010 (SMDL #10-013), which provided guidance on the new optional family planning state plan eligibility group created by section 2303 of the Affordable Care Act. In a subsequent

letter issued on April 16, 2014 (SMDL #14-003), CMS provided additional clarification on coverage of family planning-related services provided to individuals eligible under the new optional family planning state plan group.

Applying Family Planning Policy to Fee-for-Service and Managed Care

In accordance with section 1902(a)(23)(B) of the Act, an individual has free choice of a family planning provider regardless of the state's delivery system (i.e., fee-for-service or managed care) and cannot be required to obtain a referral prior to choosing a provider for family planning services. In managed care, enrollees can select any qualified family planning provider from in-network or out-of-network without referral.

In addition to a beneficiary's free choice of provider, beneficiaries are free to choose the method of family planning as provided for in 42 C.F.R. § 441.20. States must provide that individuals are free from coercion or mental pressure and free to choose the method of family planning to be used. States cannot have requirements that would place an undue burden, coercion, or mental pressure that would impinge on access to family planning services.

While states and managed care plans have the ability to apply medical necessity or utilization control criteria for a beneficiary's request for family planning services, such processes cannot interfere with a beneficiary's freedom to choose the method of family planning or the services or counseling associated with choosing the method. For example, a state or managed care plan cannot require that a particular method be used first (e.g., step therapy) or have in place policies that restrict a change in method (which may involve removal of an implanted or inserted method). The only permissible prior authorization requirement would be the determination that the method is medically necessary and appropriate for the individual, using criteria that may include considerations such as severity of side effects, clinical effectiveness, differences in permanence and reversibility of contraceptives, and ability to adhere to the appropriate use of the item or service. States and managed care plans should avoid practices that delay the provision of a preferred method or that impose medically inappropriate quantity limits, such as allowing only one long acting reversible contraceptive (LARC) insertion every five years, even when an earlier LARC was expelled or removed. To the extent that states elect to employ utilization practices, they should pursue only those practices that ensure beneficiaries choice in family planning providers and method of contraception.

Clarification of the Purpose of the Family Planning Visit

CMS is clarifying that, when family planning services and supplies are delivered during a medical visit in which family planning and non-family planning services are furnished, expenditures for such family planning services and supplies are eligible for 90 percent FFP. Therefore, if an individual presents at a medical visit for any reason, such as an annual physical exam, and obtains a family planning service or supply for a family planning purpose during that visit, an expenditure for the family planning service or supply, if properly identified on the claim, is eligible for the 90 percent FFP. The family planning purpose must be for the purpose of preventing or delaying pregnancy (or at the state's option, for treating infertility). In order for the state to claim the 90 percent FFP for that family planning service, states must ensure that

provider claims are appropriately documented to reflect the provision of family planning services and supplies.

Assuring Access to Family Planning Services and Supplies

Coverage of specific family planning services and supplies is one key to ensuring access to family planning for Medicaid beneficiaries. However, family planning benefit requirements differ depending on whether a beneficiary has coverage under the traditional state plan benefit package or under an Alternative Benefit Plan (ABP.)¹ In general, ABPs allow states flexibility in defining benefit packages that are different from the Medicaid state plan. ABPs must include all Essential Health Benefits (EHBs). Under the Preventive Services EHB category, coverage must include all U.S. Food and Drug Administration (FDA) approved methods of contraception prescribed for women by a health care practitioner. ABPs must cover at least one form of contraception within each method approved by the FDA. For a list of approved methods, see FDA Office of Women’s Health Birth Control Guide available at <http://www.fda.gov/downloads/ForConsumers/ByAudience/ForWomen/FreePublications/UCM356451.pdf>.

For Medicaid beneficiaries whose coverage is governed by the state plan rather than the ABP’s, states may determine the specific services and supplies that will be covered as Medicaid family planning services and supplies so long as those services are sufficient in amount, duration, and scope to reasonably achieve the purpose of preventing or delaying pregnancy and permit beneficiary choice of the method of family planning. Although it is not required, CMS recommends that states cover all FDA-identified contraceptive methods for beneficiaries, including both prescription and non-prescription methods. Because not all forms of contraception are appropriate for all beneficiaries, in the absence of contraindications, patient choice and efficacy should be the principal factors used in choosing one method of contraception over another. One pathway for states to accomplish this would be to align ABP and state plan coverage for these services.

Under both ABP and state plan coverage, whether provided through a fee-for-service or a managed care delivery system, family planning services and supplies, including contraceptives and pharmaceuticals, must be provided without cost sharing pursuant to 42 C.F.R. §447.56(a)(2)(ii) and 42 C.F.R. §438.108. Additionally, existing timely claims payment provisions specified in 42 C.F.R. §447.45 and §447.46 apply to claims for family planning services and supplies. For managed care plans, these provisions apply to claims from in-network and out-of-network providers, unless a mutually agreed to alternative payment schedule is in place.

Other confidentiality requirements protect individuals seeking family planning services. State Medicaid programs and managed care plans are “covered entities” under the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule. Under 45 C.F.R. §164.522(b)(ii), the

¹ States are required to provide Medicaid benefits through an ABP for the Medicaid expansion population. The state has the option of providing benefits through an ABP for other populations, otherwise individuals receive traditional state plan benefits.

state Medicaid program and managed care plans must accommodate a beneficiary's reasonable request to receive communications, including explanation of benefits, by alternative means or at an alternative location when the individual clearly states that disclosure could endanger the individual. For example, a beneficiary may request that a plan communicate with her/him via cell phone instead of paper mail. States and managed care plans are responsible for ensuring that beneficiaries are informed of this option. In addition, under 45 C.F.R. §164.522(b)(i), health care providers must accommodate an individual's reasonable request for alternative means of communication in all circumstances. All states and Medicaid managed care plans (and health care providers) should already be ensuring confidentiality as part of their compliance with the HIPAA Privacy Rule.

Strategies for Improving Access to Long Acting Reversible Contraceptives (LARCs)

LARCs, including IUDs and contraceptive implants, are an extremely effective form of contraception. LARCs are administered by physicians and other providers who may administer them within their scope of practice. LARCs may also be cost effective (and when expenditures are federally matched at the 90 percent rate, the costs to states are extremely low). For Medicaid eligible individuals, reimbursement to providers for LARCs should be reasonable and must include not only the insertion and removal of the LARC, but also the LARC itself, even if the service and device are billed and paid separately. CMS issued an informational bulletin on April 8, 2016, highlighting emerging payment approaches that several state Medicaid agencies have used to optimize access to and use of LARCs.²

States may cover LARCs through their pharmacy benefit. Covering LARCs through the pharmacy benefit means that dispensing pharmacies bill the state for the LARCs and applicable dispensing fees, then deliver the LARCs to providers for insertion or administration. The provider then bills the state for the furnished insertion or implantation service. These steps may present barriers to access since this process requires the woman to see the provider twice: once to obtain the LARC prescription and then again for insertion or administration. Another challenge is that, absent permissible state policies or prior manufacturer arrangements, providers may not return un-inserted or un-administered LARCs, resulting in waste and financial loss for the state.

Issues have also arisen when states cover LARCs through the medical benefit. In these states, providers can stock the array of LARCs and implant or administer the most appropriate one during the patient's visit, which helps improve access by reducing the need for a second visit. It could also reduce the waste from unused LARCs. High upfront costs required to maintain a stock of LARCs, however, may deter providers from implementing this approach, resulting in barriers to access due to a potential unwillingness of providers to furnish LARCs.

CMS encourages states to explore and pursue the following models, some of which are already being used by states, to overcome administrative and logistical barriers to the provision of LARCs:

² State Medicaid Payment Approaches to Improve Access to Long-Acting Reversible Contraception. April 8, 2016. <https://medicaid.gov/federal-policy-guidance/downloads/CIB040816.pdf>

First, states are encouraged to implement measures that facilitate immediate postpartum LARC insertion, when a woman chooses this option. As a result of the global or bundled pregnancy and delivery payment arrangements, some states have established policies of not covering additional services provided immediately following delivery. These policies have the effect of deterring providers from inserting LARCs immediately after delivery. In addition, when multiple procedures are performed during a single hospital stay and submitted as a single inpatient claim, if those costs attributable to family planning services are separately identified, the state can receive federal matching funds at the 90 percent rate. To the extent that there are shared costs between family planning services and other services, the state should develop a methodology for allocating these costs. CMS strongly recommends that states establish payment policies that, when a woman chooses, permit and encourage insertion of LARCs immediately following a vaginal delivery or surgical procedure as a separately identified service that is eligible for the 90 percent FFP. CMS also recommends similar policies with respect to coverage of free standing birth center services, which are generally reimbursed at the state's regular FMAP unless the free standing birth center provides family planning services. These services would then be eligible for the 90 percent FFP.

Another approach to ensure same-day access, to the extent permissible, is for publicly funded providers of family planning services who also serve Medicaid patients to pre-purchase and stock their inventories with LARC methods and bill Medicaid or the pertinent third-party payer for the LARC when it is used.

Additionally, states are encouraged to direct pharmacies and providers to utilize programs already established by manufacturers that facilitate stocking providers with LARCs for medical benefit coverage, as well as those that facilitate the return of, and reimbursement by manufacturers to states for unused LARCs dispensed under the pharmacy benefit. Or states can seek to establish new arrangements with LARC manufacturers to increase Medicaid beneficiary access to their LARCs. In one such arrangement piloted in a number of states, the LARC manufacturer proactively furnishes providers with its LARCs without upfront costs. At a reasonable time post-implantation or administration, the manufacturer bills the provider for the cost of the LARC to ensure providers have had the time to be reimbursed by third party payers, including state Medicaid programs. With this approach, providers can be stocked with a supply of LARCs without incurring upfront costs. Providers' funds which would otherwise be invested in inventory could be used in other ways to improve the range and quality of services provided. Beneficiaries would also receive LARCs in a more timely and efficient manner. Lastly, providers may be able to focus more on the provision of healthcare and not the administrative duties related to stocking and being reimbursed for LARCs. This approach is consistent with existing Medicaid policy, including the availability of manufacturer rebates on the drugs.

CMS is also interested in exploring with states the use of section 1115(a) demonstration authority to make available administrative funding at the 90 percent federal matching (authorized by section 1903(a)(5) of the Social Security Act) for states to maintain an inventory of LARCs for providers who furnish covered medical assistance for eligible individuals. The 90 percent federal matching is available for costs related to the state's administration of family planning services and supplies. CMS envisions that, under a section 1115(a) demonstration, the state would incur an administrative expense to purchase a stock for a Medicaid provider for use by

Medicaid beneficiaries. Once the entire stock is used, the state Medicaid agency would re-stock the provider with the same number of LARCs. To be a reasonable administrative cost, the stock would be expected to be used in the course of a period of time, such as a month, and would be replenished as a stock consisting of the same number of items. To account for the costs, states would claim the cost of the stock as a family planning administrative cost, make the stock available without cost to providers, prohibit any further claim by the provider for the cost of LARCs taken from stock for Medicaid use (the provider would bill for insertion or removal of the LARC, but not for the LARC itself), and provide for replenishment of the stock when LARCs are used. CMS will consider other state ideas like this, related to all types of family planning services, subject to the regular process for review, approval, and evaluation of section 1115(a) demonstrations.

Clarifying Policies Regarding Sterilization and Delivery

Federal funds are available for sterilizations as a family planning service, including when the sterilization is provided immediately following delivery with the informed consent of the patient as an add-on procedure. When provided with the informed consent of the patient, postpartum sterilization is an effective form of contraception that provides convenience for the woman, reduces costs, and reduces unplanned pregnancies. All sterilization services require informed consent in accordance with 42 C.F.R., Part 441, Subpart F. The Federally required consent form, without alteration, must be used and consent must be obtained at least 30 days before the sterilization, but not more than 180 days before the date of the sterilization. The only exception is in the case of procedures performed post-premature delivery or following emergency abdominal surgery. Under those exceptions, the informed consent must be given no less than 72 hours prior to the sterilization and, in the case of premature delivery, the informed consent must have been given at least 30 days before the expected date of delivery.

CMS encourages states to develop appropriate policies and procedures that eliminate barriers to requested postpartum sterilization while ensuring informed consent. Providers should be encouraged to discuss postpartum sterilization with interested patients early in the course of treatment to ensure that the requirements for informed consent and for completion of the consent form are met pursuant to 42 C.F.R., Part 441, Subpart F, to avoid payment disallowances. When a postpartum sterilization is performed that does not comply with the requirements for informed consent described in 42 C.F.R., Part 441, Subpart F, FFP is not available for costs related to the sterilization.

CMS is committed to assuring that all Medicaid beneficiaries have access to and receive vital family planning services and supplies without limitations on their choice of provider or their choice of contraception method. CMS hopes that states find the information and clarifications provided within this letter useful in administering the Medicaid family planning benefit. If you have any questions regarding this information, please contact, Kirsten Jensen, Director, Division of Benefits and Coverage, at 410-786-8146.

Sincerely,
/s/

Vikki Wachino
Director

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

AcademyHealth

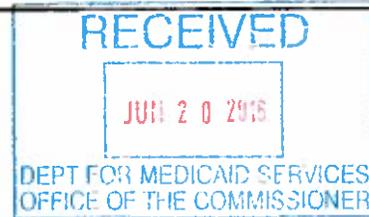
DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Atlanta Regional Office
61 Forsyth Street, Suite 4T20
Atlanta, Georgia 30303



DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

June 15, 2016

Stephen P. Miller, Commissioner
Cabinet for Health and Family Services
Department for Medicaid Services
275 East Main Street, 6W-A
Frankfort, KY 40621



Re: Technical Correction to Approval Letter of KY External Quality Review Organization (EQRO) contract – Island Peer Review Organization (IPRO) #1400002577

Dear Mr. Miller:

This is a technical correction to the recent approval letter for KY EQRO contract with IPRO dated June 3, 2016.

Kentucky is in compliance with 42 CFR 438.358, in that an EQRO may perform the mandatory and optional EQR-related activities included in that section. Federal Financial Participation at the 75 percent rate is available in expenditures for EQR (including the production of EQR results) and EQR-related activities.

The following list of IPRO EQR activities provide the technical correction to the June 3, 2016 approval letter. This list of EQR activities is eligible for the enhanced 75 percent rate:

- Compliance Review
- Validation of Performance Measures
- Validation of Performance Improvement Projects (PIPs)
- Monitoring of EPSDT Services
- Technical Assistance for DMS and MCOs and Presentation on EQR Results
- Validation of Patient Level Claims
- Quality of Care Focus Studies
- Access and Availability Surveys
- Validation of Managed Care Provider Network Submissions
- EQR Final Technical Report Results

Mr. Stephen P. Miller, Commissioner
Page 2

If you have any questions, please contact Kia Carter-Anderson at (404) 562-7431 or
Kia.Carter-Anderson@cms.hhs.gov.

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

June 20, 2016

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



RE: Non-Emergency Medical Transportation Contract and Rate Approvals

Dear Mr. Miller:

In accordance with 42 CFR 438.6, the Centers for Medicare & Medicaid Services (CMS) has reviewed and is approving Kentucky's non-emergency medical transportation (NEMT) contracts and rates for the periods of July 1, 2012 - June 30, 2014 (contract number PON2 748 12 00001605 1) and July 1, 2014 - June 30, 2016 (contract number PON2 748 1400001697 4).

The state has committed to address those areas assessed as non-compliant in its Fiscal Year (FY) 2017 contract. Specifically, the FY 2017 contract will include the following elements: (1) a definition of "service authorization," in a manner that at least includes a managed care enrollee's request for the provision of service, (2) a prohibition from the managed care entity (MCE) knowingly having a person with ownership of more than 5% of the MCE's equity who is (or is affiliated with a person/entity that is) debarred, suspended, or excluded from participation in federal healthcare programs, (3) a statement that if the state learns an MCE has a prohibited relationship with a person or entity who is debarred, suspended, or excluded from participation in federal healthcare programs, the state will notify the Secretary via CMS; and, (4) a provision that the state agency has in effect procedures for monitoring the MCE's operations, including, at a minimum, operations related to violations subject to intermediate sanctions, as set for in Subpart I of 42 CFR 438 and violations of the conditions for receiving federal financial participation, as set forth in Subpart J of 42 CFR 438.

We appreciate the effort and cooperation provided by your staff during our review. If you have questions concerning this letter, please contact Lynda Bennett at (404) 562-7352 or Melanic Benning at (404) 562-7414.

Sincerely,

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

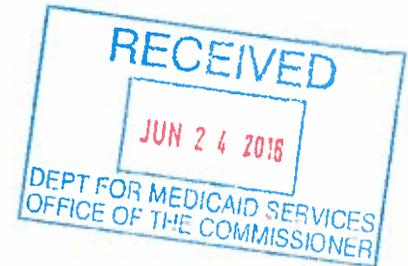
Jackie Glaze
Associate Regional Administrator
Division of Medicaid & Children's Health
Operations



Disabled and Elderly Health Programs Group

June 21, 2016

Stephen P. Miller
Commissioner
Department for Medicaid Services
275 E. Main Street, 6W-B
Frankfort, KY 40621



Dear Mr. Miller:

In response to the June 13, 2016 request from the Kentucky Department for Medicaid Services, the Centers for Medicare & Medicaid Services (CMS) is granting a 90 day temporary extension of Kentucky's Home and Community-Based Services (HCBS) waiver program for individuals who have a diagnosis of brain injury. The current waiver is scheduled to expire June 30, 2016. The extension allows the Acquired Brain Injury, Long Term Care, CMS control number 0447.R01.00, to continue operating through, September 28, 2016, at cost and utilization levels approved for the fifth year of the waiver program with Federal financial participation.

CMS is granting this temporary extension in order to allow for a full 90 day review period and to give the state time to work with CMS to resolve issues identified during the review of the waiver renewal, which was submitted on April 28, 2016. The waiver renewal submission was delayed in order for the state to comport with the public notice requirements at 42 CFR 441.304(f).

If you have any questions regarding this temporary extension or need any assistance, please contact Catherine Cartwright, in the CMS Atlanta Regional Office at (404) 562-7414 and by email at Catherine.Cartwright@cms.hhs.gov or Amanda Hill, in the CMS Baltimore Central Office at (410) 786-2456 and by email at Amanda.Hill@cms.hhs.gov.

Sincerely,

A handwritten signature in black ink is located below the "Sincerely," text. The signature reads "Alissa Mooney DeBoy" in a cursive, flowing script.

Alissa Mooney DeBoy
Deputy Group Director
Disabled and Elderly Health Programs Group

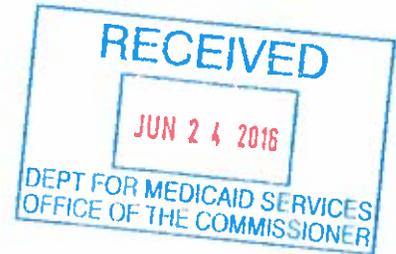
cc: Jackie Glaze, Region IV ARA
cc: Leslie Hoffmann, Director DCA



Disabled and Elderly Health Programs Group

June 21, 2016

Stephen P. Miller
Commissioner
Department for Medicaid Services
275 E. Main Street, 6W-B
Frankfort, KY 40621



Dear Mr. Miller:

In response to the June 13, 2016 request from the Kentucky Department for Medicaid Services, the Centers for Medicare & Medicaid Services (CMS) is granting a 90 day temporary extension of Kentucky's Home and Community-Based Services (HCBS) waiver program for individuals who are aged or disabled, which is currently scheduled to expire July 1, 2016. The seventh extension allows the Home and Community-Based Waiver, CMS control number 0144.R05, to continue operating through September 29, 2016, at cost and utilization levels approved for the fifth year of the waiver program with Federal financial participation.

CMS is granting this temporary extension in order to give the state time to transition waiver participants to the Occupational Therapy Services, Physical Therapy Services, and Speech Therapy Services in the state plan, and make additional revisions to the waiver application. During this TE period, we expect the state to finish addressing the issues in the waiver renewal and complete the transition of participants. CMS is requesting the state submit the updated waiver renewal application no later than August 1, 2016.

If you have any questions regarding this temporary extension or need any assistance, please contact Catherine Cartwright, in the CMS Atlanta Regional Office at (404) 562-7414 and by email at Catherine.Cartwright@cms.hhs.gov or Amanda Hill, in the CMS Baltimore Central Office at (410) 786-2456 and by email at Amanda.Hill@cms.hhs.gov.

Sincerely,

A handwritten signature in black ink, reading "Alissa Mooney DeBoy", is located below the "Sincerely," text.

Alissa Mooney DeBoy
Deputy Group Director
Disabled and Elderly Health Programs Group

cc: Jackie Glaze, Region IV ARA
cc: Leslie Hoffmann, Director DCA

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

June 21, 2016

Stephen P. Miller
Commissioner
Department for Medicaid Services
275 E. Main Street, 6W-B
Frankfort, KY 40621



Dear Mr. Miller:

In response to the June 13, 2016 request from the Kentucky Department for Medicaid Services, the Centers for Medicare & Medicaid Services (CMS) is granting a 90 day temporary extension of Kentucky's Home and Community-Based Services (HCBS) waiver program for individuals who have intellectual and developmental disabilities, which is currently scheduled to expire July 1, 2016. The sixth extension allows the Supports for Community Living Waiver, CMS control number 0314.R03, to continue operating through September 29, 2016, at cost and utilization levels approved for the fifth year of the waiver program with Federal financial participation.

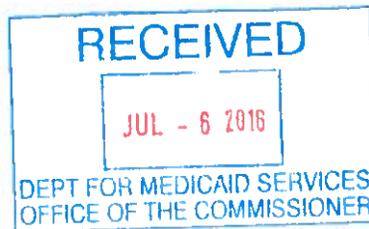
CMS is granting this temporary extension in order to give the state time to transition waiver participants to the Occupational Therapy Services, Physical Therapy Services, and Speech Therapy Services in the state plan. It will also allow time for CMS to work with the state to resolve the remaining issues in the waiver renewal and for the state to make the necessary changes to the waiver application. During this TE period, we expect the state to finish addressing the issues in the waiver renewal and make the necessary changes to the waiver. In addition, we expect the state to complete the transition of participants to the state plan. CMS is requesting the state to submit responses to the formal request for additional information no later than August 1, 2016.

If you have any questions regarding this temporary extension or need any assistance, please contact Catherine Cartwright, in the CMS Atlanta Regional Office at (404) 562-7414 and by email at Catherine.Cartwright@cms.hhs.gov or Amanda Hill, in the CMS Baltimore Central Office at (410) 786-2456 and by email at Amanda.Hill@cms.hhs.gov.

Sincerely,

Alissa Mooney DeBoy
Deputy Group Director
Disabled and Elderly Health Programs Group

cc: Jackie Glaze, Region IV ARA
cc: Leslie Hoffmann, Director DCA



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

June 27, 2016

KY-16-007

Mr. Stephen Miller, Commissioner
Department for Medicaid Services
275 East Main Street, 6W-A
Frankfort, KY 40621-0001

Dear Mr. Miller:

The Centers for Medicare & Medicaid Services (CMS) approves the As Needed Implementation Planning Document (ANIAPD) submitted by the Kentucky Cabinet for Health and Family Services (CHFS) to execute the contract option period with Hewlett Packard to produce Identification Cards for Medicaid beneficiaries. Specifically, one six-month contract extension from May 7, 2016 - November 6, 2016 is approved in order to complete a competitive procurement of a replacement contract. If required, the Commonwealth must submit a new APD to request authorization for the proposed second six-month extension from November 7, 2016 until May 6, 2017.

Kentucky is authorized to use previously approved funding under KY-14-004, dated August 26, 2014, for the KY Health Card Contract in the amount of \$508,998 (\$319,627 federal share and \$189,371 Commonwealth share) to continue the manufacture and issuance of KY Health Cards to the Commonwealth's Managed Care Organization (MCO) and fee-for-service (FFS) populations. No new funding is being requested under this ANIAPD.

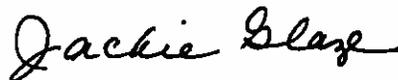
The ANIAPD is approved in accordance with Section 1903(a)(3) of the Social Security Act, 42 CFR Part 433, subpart C, 45 CFR Part 95, subpart F, and the State Medicaid Manual, Part 11. No new funding is approved for this project under this approval. Onsite reviews may be conducted to assure that the intentions 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 APD will require CMS prior written approval to qualify for FFP.

Mr. Stephen Miller
Page 2

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 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,

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

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



SMD # 16-009

**Re: Mechanized Claims Processing
and Information Retrieval Systems –
APD Requirements**

June 27, 2016

Dear State Medicaid Director:

This letter provides guidance concerning Advance Planning Document (APD) requirements, specifically around the conditions and standards required for receipt of enhanced funding for Mechanized Claims Processing and Information Retrieval Systems, including both Medicaid eligibility and enrollment (E&E) systems and Medicaid Management Information Systems (MMIS).

On December 4, 2015 the Centers for Medicare & Medicaid Services (CMS) published a final rule, "Mechanized Claims Processing and Information Retrieval Systems (90/10)," which became effective January 1, 2016. This final rule extended enhanced federal funding for Medicaid E&E systems and revised the conditions and standards state Medicaid IT systems must meet to qualify for enhanced federal funding to better support Medicaid eligibility, enrollment, and delivery systems. This final rule also supported existing requirements for modular systems development. This guidance reflects input from commenters in the rulemaking process, our state partners and other stakeholders.

Background

The recently issued final rule made permanent the applicability of enhanced federal matching rates under section 1903(a)(3) of the Social Security Act (Act) to support the design, development and installation (DDI) and maintenance and operations (M&O) of E&E systems that are streamlined, interoperable with other systems and that provide a consumer-friendly experience. The enhanced federal matching rate is applicable under section 1903(a)(3) to "mechanized claims processing and information retrieval systems." The final rule amended the regulatory definition of such systems at 42 CFR 433.111(b) to include E&E systems. The broadened definition of such systems, and additional changes made in the applicable requirements for such systems, supported an enterprise approach where individual processes, modules, sub-systems, and systems are interoperable and work together seamlessly to support a unified enterprise.

The final rule modified § 433.112(b) to establish new conditions that states must meet in order to receive approval for enhanced federal funding of E&E and MMIS information technology (IT) projects. The final rule also expanded two of the Medicaid Information Technology Architecture (MITA) conditions and standards that were established with the April 19, 2011 final rule (Refer to Appendix A). States must meet these conditions in order to receive approval for enhanced funding for DDI and M&O activities relating to Medicaid IT systems.

CMS expects that states will continue to submit APDs to support improvement of their Medicaid E&E systems now that enhanced federal matching funds are available on a permanent basis. Going forward, any APD that requests enhanced federal matching funds for Medicaid IT systems must describe how the proposed systems will meet these conditions. Unless otherwise noted, the new conditions apply to both MMIS and Medicaid E&E systems.

Expanded Conditions

This final rule expands on two of the MITA conditions and standards originally established in the April 19, 2011 final rule. For the industry standards condition, the final rule revises 42 CFR 433.112(b)(12) to include industry standards adopted by the Office of the National Coordinator for Health Information Technology (ONC) in accordance with 45 CFR Part 170, Subpart B. These industry standards relate to electronic health records (EHRs) and the creation, storage, and exchange of electronic health information.

States and CMS are increasingly investing in health IT infrastructure. These investments are leading to new opportunities to improve program operations, care coordination, and cost efficiency. The MITA framework specifically addresses and supports the use of clinical data, in Medicaid business processes. We expect that states will continue to pursue systems that integrate with health information exchanges and take advantage of available clinical data to improve care coordination. This condition will promote a standardized, interoperable Medicaid IT landscape that will leverage other federal and state investments. States can reference the ONC document, “2016 Interoperability Standards Advisory¹” as a resource for considering the standards contained in 45 CFR Part 170, Subpart B, as well as other standards and implementation specifications that help meet specific interoperability needs including the use of more promising standards such as those regarding provider directories, segmentation of sensitive data, or unique device identification.

CMS expects that states will describe how their plans comply with the 2016 Interoperability Standards Advisory (ISA) both in their APD and in relevant artifacts submitted to the Collaborative Application Lifecycle Tool (CALT), or a successor system, throughout the system lifecycle. System development that does not include plans to include clinical data need not reference the ONC standards.

For the interoperability condition and Medicaid E&E systems, the final rule revises 42 CFR 433.112(b)(16) to specify that the system must support seamless coordination and integration with the Marketplace, whether the Federally-facilitated Marketplace (FFM) or a State-based Marketplace (SBM), as well as the Federal Data Services Hub (FDSH).

Interoperability with the FDSH requires that states develop systems and technology that will efficiently exchange data with the FDSH to enable electronic verifications, exchange electronic accounts (FFM states only) and a better overall application process for consumers. CMS expects that states will develop systems with the appropriate architecture and standards that will communicate with the FDSH on an ongoing basis and in conformance with published Business Service Descriptions (BSDs). States must ensure the security and privacy of sensitive data, which includes meeting the requirements of the respective federal agency (e.g., the Internal

¹ <https://www.healthit.gov/sites/default/files/2016-interoperability-standards-advisory-final-508.pdf>

Revenue Service (IRS)) as well as MARS-E 2.0 (required for E&E systems only but a best practice for MMIS).

CMS expects that when states are requesting additional enhanced match for relevant, new activities, they will describe their interoperability approach in Medicaid E&E systems APDs as well as in relevant artifacts submitted to CMS along the system lifecycle, as they have in the past for MITA conditions and standards.

New Condition - Modified Adjusted Gross Income (MAGI)-based System Functionality

The condition described at § 433.112(b)(17) requires that Medicaid E&E systems be able to adequately process MAGI-based Medicaid applications with limited mitigations and workarounds. This condition requires that states demonstrate MAGI-based functionality by meeting critical success factors (CSFs) that we outlined in the final rule at 80 FR 75819. CMS will require states to use CSFs to document system development progress on an ongoing basis, where items remain incomplete and workarounds are still in place (e.g., an online, fillable PDF instead of a dynamic online application). When evaluating state submissions under this condition, CMS will consider the frequency and length of the proposed mitigation, the degree of manual intervention required, and the impact on beneficiaries' access to benefits.

The MAGI-based system functionality condition primarily applies to states' Medicaid E&E systems. This condition would seldom impact states' MMIS, and is therefore generally not applicable to those systems. MAGI-based system functionality could be relevant to an MMIS, for interoperability with the Medicaid E&E system for certain functions, for example, to carry out cost sharing requirements, or changes related to Medicaid expansion. CMS expects that states will demonstrate their satisfaction of this condition in the APD as well as in relevant artifacts submitted to CMS along the system lifecycle.

New Condition – Mitigation Plan

The condition described at § 433.112(b)(18) requires that states submit mitigation plans addressing strategies to reduce the consequences of failure for all major milestones and functionality. Maintaining a mitigation plan is an industry standard best practice for any major IT build; CMS expects that states will identify potential risks and develop strategies to address those risks throughout the system lifecycle.

Mitigation plans for major Medicaid E&E system or MMIS projects should address minimum expected functionality, critical success factors, and risk factors as tied to major milestones identified in the APD. The mitigation plans should also reflect key events and dates that would trigger the mitigation, and projected timeframe for the mitigation sunset. States should consider strategies to address risks for the M&O phase of the project, such as staffing issues and software upgrades.

CMS expects states to revise and resubmit their plans to CMS as risks and mitigations change along the system lifecycle. States' proposed mitigations should be commensurate with the nature and scope of the identified risks. We also expect that states will submit their mitigation plans with the APDs to demonstrate compliance with this condition.

New Condition – Key Personnel

The condition described at § 433.112(b)(19) requires that states identify their key state personnel assigned to each major project by name, role, and time commitment. Before we approve a state to launch a major IT initiative, CMS wants to ensure that the state team is adequately resourced. States do not need to provide key vendor personnel for this requirement.

As stated in the provision, this information must be included in the APD. For changes to key personnel that occur after an APD is approved, states should notify their CMS points of contact in writing (including by email) and formally reflect the change in the next planned APD update.

This condition refines and strengthens the existing APD requirements regarding personnel resource statements as required under 45 CFR 95.610. For Medicaid E&E APDs, states should include this information in the “Medicaid Eligibility and Enrollment (EE) Implementation Advance Planning Document (IAPD) Template” (OMB Approval Number: 0938-1268). Although there is currently no APD template for MMIS APDs, states must include this information in all MMIS APDs for major IT initiatives.

New Condition – Documentation

The condition described at § 433.112(b)(20) requires that states maintain documentation for certain software such that the software could be operated by contractors and other users. This condition is limited to software that is developed using federal funds; it does not apply to Commercial Off-the-Shelf (COTS) software, Software-as-a-Service, or Business-Solutions-as-a-Service. Adequate documentation means that other users could operate the software with reasonable alterations for a specific hardware or operating system. CMS is neutral as to the specific hardware or operating system that the software uses. Documentation must follow industry standards and best practices, and must include components, procedures, layouts, interfaces, inputs, outputs, and other necessary information so that the systems could be installed and operated by a variety of contractors or other users.

While the APD should address how the state plans to maintain documentation, such documentation is not required to be submitted along with the APD. It is the state’s responsibility to make the documentation available upon request and to upload documentation to CALT or successor systems as needed for gate reviews or for reuse. Submission to other repositories may be required as CMS explores other options.

New Condition – Minimization of Cost for Operation on an Alternate System

The condition described at § 433.112(b)(21) requires that states consider strategies to minimize the costs and difficulty of operating the software on alternate hardware or operating systems. This condition recognizes the significant federal and state investments that are involved with major Medicaid IT projects and requires that states consider options beyond software that will reduce costs or promote reuse.

States should describe in the APD the strategies that were considered when deciding which solution was the most economical and efficient. States are not required to adopt a particular

strategy, but CMS must have sufficient description to evaluate the extent to which the state looked at other solutions. States should consider, at a minimum, the options that offer more opportunities for reuse, lower development costs, lower long-term operating costs, and shorter development time as well as the extent to which the solutions can be readily implemented with alternate hardware and operating systems.

States should consider this new condition in conjunction with existing APD requirements regarding cost benefit analyses required at 45 CFR 95.605 or § 95.610.

Formal Process for Determining New Conditions

The final rule at § 433.112(b)(22) allows the Secretary to establish other conditions to implement statutory and regulatory systems requirements in the future, subject to certain limitations. This flexibility will allow CMS to evaluate states' progress as well as evolving business processes on an ongoing basis and add additional conditions as necessary. Importantly, any new conditions established under this provision will be limited to ensuring that states properly develop their systems in accordance with the existing statutory and regulatory framework. New conditions that go beyond the scope of existing statutory and regulatory systems requirements would be established through formal rulemaking.

New conditions established under this provision would be formally issued in a State Medicaid Director Letter (SMDL). Furthermore, CMS will consult states and other stakeholders for input on any proposed conditions prior to implementing any new conditions. This process will ensure that any new conditions are fully vetted prior to publication and that states will be properly notified before any new conditions take effect.

Acquisition Threshold for Prior Approval

The final rule amends the prior written approval requirements at 45 CFR 95.611(a)(2) by adding an acquisition threshold for requests for federal financial participation (FFP) at the enhanced matching rate authorized by 42 CFR part 433, subpart C. States will now be required to submit acquisition documents (such as requests for proposals (RFPs) or contracts) for prior approval only if the total cost is anticipated to or will exceed \$500,000. This change aligns the prior approval requirements for Medicaid E&E system acquisitions with the existing policy for MMIS.

We still expect APDs to include all relevant information about planned acquisitions in order to justify the funding. This threshold applies only to RFP and contract requests, not prior funding approval. We strongly encourage states to still share the URLs for any open RFPs for Medicaid IT development or services with their CMS point of contact so that we can add them to the Medicaid.gov site on state IT procurements: <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/data-and-systems/procurement-opportunities.html>

We have provided a chart at Appendix C that outlines the approval requirements for requests for FFP at the enhanced matching rate, including the changes made in the final rule.

APD Template

CMS published an Implementation APD template that states are required to use when requesting prior approval for Medicaid E&E system activities. The template, “Medicaid Eligibility and Enrollment (EE) Implementation Advance Planning Document (IAPD) Template” (OMB Approval Number: 0938-1268), covers the requirements of 45 CFR 95.610 and can be found at <https://www.medicaid.gov/affordablecareact/provisions/downloads/medicaid-eligibility-and-enrollment-iapd-template.pdf>. While the template is not required for other APDs, we recommend that states use it to help standardize their APD submissions.

In accordance with the regulations at 45 CFR Part 95 Subpart F, states must submit APDs to CMS for review and prior approval to receive FFP at the enhanced matching rate for MMIS and Medicaid E&E systems. With this final rule, CMS did not change the APD requirements described at 45 CFR 95.610. A chart outlining the elements for all APD types is included for your convenience at Appendix D. The state must include information regarding how the system(s) meet the MITA conditions and standards at 42 CFR §433.112(b)(10)-(16) and the new conditions at § 433.112(b)(17)-(22). Please see Appendix B for frequently asked questions on other APD topics.

This SMDL supersedes and takes precedence over previous guidance in the State Medicaid Manual (SMM) 11100 through 11281 (<https://www.cms.gov/Regulations-and-Guidance/guidance/Manuals/Paper-Based-Manuals-Items/CMS021927.html>) with respect to Medicaid systems and certain other reimbursement rules. The appendices to this letter include additional detail on these topics.

If you have additional questions, please contact Martin Rice at 410-786-2417 or at martin.rice1@cms.hhs.gov. Additional SMDLs will be issued in the coming months to address other aspects of this final rule. We look forward to working with states to facilitate state system builds, to ensure compliance with this regulation, and to provide assistance implementing these requirements.

Sincerely,

/s/

Vikki Wachino
Director

cc:

Jessica Kahn, Director of the Data and Systems Group, CMS

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

AcademyHealth

This message serves as the formal notification to states that state-specific information is available as required by the final rule. For the 2015 data publication year, we are taking advantage of the [Data Explorer](#) interface where states can aggregate and filter their data, as well as create visualizations with the data. Further instructions on how to create and download your states report can be found on the [Reports to States](#) page.

DEPARTMENT OF HEALTH & HUMAN SERVICES

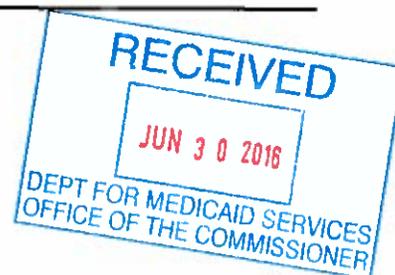
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CMS' Open Payments Program Posts 2015 Financial Data

Health care industry manufacturers reported \$7.52 billion in payments and ownership and investment interests to physicians and teaching hospitals in 2015

Today, the Centers for Medicare & Medicaid Services (CMS) published 2015 Open Payments data, along with newly submitted and updated payment records for the 2013 and 2014 reporting periods, at <https://openpaymentsdata.cms.gov/>. The Open Payments program (sometimes called the "Sunshine Act") requires that transfers of value by drug, device, biological, and medical supply manufacturers paid to physicians and teaching hospitals be published on a public website.

For Open Payments program year 2015, health care industry manufacturers reported \$7.52 billion in payments and ownership and investment interests to physicians and teaching hospitals. This amount is comprised of 11.90 million total records attributable to 618,931 physicians and 1,116 teaching hospitals.

Payments in the three major reporting categories are:

- \$2.60 billion in general (i.e., non-research related) payments
- \$3.89 billion in research payments
- \$1.03 billion of ownership or investment interests held by physicians or their immediate family members

Over the course of the Open Payments program since 2014, we have published 28.22 million records, accounting for \$16.77 billion in payments and ownership and investment interests. The Open Payments 2015 program year data set is the second full year of data available on the CMS Open Payments website. The availability of consecutive, full-year data allows the public the opportunity to explore trends in the health care industry manufacturers' payments to physicians and teaching hospitals for items and services such as food and beverage, travel, education, honoraria, and research. We are also able to analyze payments related to covered drugs, devices, biologicals, and supplies. For example, CMS has determined that for program year 2015, 2.26 percent (637,131 records) of all financial transactions between physicians and pharmaceutical companies was related to opioid medications.

“Transparency is empowering physicians to be purposeful about their financial relationships with companies, and there is a notable shift towards charitable contributions and away from other interactions such as honoraria and gifts,” said Dr. Shantanu Agrawal, a CMS deputy administrator and director of the Center for Program Integrity (CPI).

The amount and distribution of payments and ownership and investment interest categories remained consistent between the 2014 and 2015 reporting periods.

For more information, please visit: <https://openpaymentsdata.cms.gov/>.

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