

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



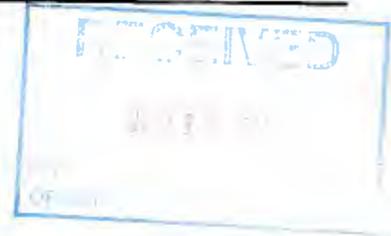
**DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS**

June 20, 2014

Lawrence Kissner, Commissioner  
Department for Medicaid Services  
275 East Main Street, 6WA  
Frankfort, KY 40621-0001

COPIES TO  
LISA NEVILLE,  
SHANEY JEFF,  
LYNNE.

FYI  
Lm 6/20/14



RE: Title XIX State Plan Amendment, KY 14-002B

Dear Mr. Kissner:

Kentucky submitted State Plan Amendment (SPA) 14-002B that was received by the Centers for Medicare & Medicaid Services (CMS) on March 26, 2014, with a proposed effective date of July 1, 2014. As submitted, KY SPA 14-002B updates plan language for two existing TCM groups - (1) at-risk pregnant women and children, and first-time fathers, and (2) children with special health care needs. During our review, we noted that (1) reimbursement for the existing at-risk pregnant women and children, and first-time fathers was based on cost, and (2) that the state does not currently have reimbursement methodology for children with special health care needs, which is also based on cost.

As previously discussed with the state, we have completed our review of KY SPA 14-002B. However, before we can continue processing this amendment, we need additional or clarifying information. We are requesting the below additional information pursuant to Section 1915(f)(2) of the Social Security Act (the Act).

**Statutory and Regulatory Requirements**

Section 1902(a) of the Act requires that states have a state plan for medical assistance that meets certain federal requirements that set out a framework for the state program.

Section 1902(a)(30)(A) of the Act requires that states have methods and procedures in place to assure that payments to providers are consistent with efficiency, economy, and quality of care. To be comprehensive, payment methodologies should be understandable, clear, and unambiguous. In addition, because the plan is the basis for federal financial participation (FFP), it is important that the plan language provide an auditable basis for determining whether payment is appropriate.

42 CFR 430.10 requires that the state plan be a comprehensive written statement that describes the nature and scope of the state's Medicaid program and that it contain all information necessary for CMS to determine whether the plan can be approved to serve as the basis for FFP in the state program.

**Comments/Questions**

1. Attachment 4.19-B, Page 21
  - A. In response to informal questions to the state during the review, the state indicated that the reimbursement methodology for At-risk pregnant women and children and first-time fathers can be found on Attachment 4.19-B, Page 21, and is labeled “Targeted case management services for at risk parents during the prenatal period and until the child’s third birthday”. Based on this response, please change the label to read, “Targeted case management services for at-risk pregnant women and children and first-time fathers”.
  - B. Throughout this page, the state indicates that interim rates are based on projected costs. Please explain the methodology that the state is using to determine the projected costs.
  - C. In the 3<sup>rd</sup> paragraph (Interim rates shall be established in the following manner), items 1), 2), and 3), the state says that “This will include a cost based on the average amount of time required to provide the service”. Please explain how the state is determining “average amount of time”.
  - D. In the 4<sup>th</sup> paragraph (Cost will be accounted for...”, item 1), the state says that “Case management staff directly related to the targeted case management program will code all direct time using categories designated for case management functions in 15 minute increments.” Please provide a list of the designated categories.
  - E. In the same paragraph as D, above, item 2), the state says that “Any contract costs (i.e., for contracted services) will be based on the actual cost of acquisition of the service”. Please provide copies of all contracts relating to this service.
  - F. In the same paragraph as D, above, item 3), the state says that “Any indirect costs of any public state agency will be determined using the appropriate cost allocation plan.” Please provide a list of all public state agencies that are providing these services. Additionally, please provide copies of related cost allocation plans.
  - G. In the last paragraph, the state says that providers will submit cost reports no later than 180 days after the end of the state fiscal year. However, the methodology for targeted case management services for children w/special health care needs indicates that the providers will submit cost reports no later than 90 days after the end of the state fiscal year. Please explain this difference.
  - H. Additionally, in the last paragraph, the state indicates that payments will be adjusted to actual cost based upon review and acceptance of these cost reports in accordance with usual agency procedures. Please provide a copy of the agency procedures.

2. Attachment 4.19-B, Pages 21 and 20.23(a)

A. As it appears as if the state is reimbursing the two target groups (Children w/special health care needs and At-risk pregnant women and children and first-time fathers) based on reconciled cost, the state must develop a cost identification process. In developing a cost identification process, CMS must approve the cost report, line item costs, allocation methodology and, in most instances, the time study used to identify Medicaid cost. When actual cost is paid, an interim rate may be used; however, the interim payments must be reconciled on an annual basis to actual cost at the level of the provider identified through the CMS-approved methodology. The provider must have a cost-accounting system in place to appropriately identify, out of the total pool of costs incurred in providing services to all of its clients, only those that represent expenditures made on behalf of Medicaid beneficiaries. The state must provide all of the components below for CMS' review and approval (including cost reports and instructions).

- (1) Identification of the specific direct costs (salaries and fringes of the direct medical personnel and non-personnel direct medical supplies and equipment),
- (2) The indirect cost rate used or identification of the specific indirect costs,
- (3) Use of a CMS-approved statistically valid time study to identify the time spent providing medical services (if required),
- (4) An allocation methodology to Medicaid,
- (5) The methodology used to determine the interim payment amount,
- (6) The reconciliation procedures between interim payments and the actual costs at the provider level on an annual basis, and
- (7) The cost settlement process.

B. CMS requests the state to submit its cost report and cost report instructions.

C. Are all providers required to submit cost reports?

D. If these services are provided by sister state agencies, please provide a list of those agencies.

E. Please confirm that all providers (governmental and non-governmental) are reimbursed using the same methodology.

3. State's responses to funding questions

The state indicated, in its response to the funding questions, that the source of the state share is not derived from IGTs or CPEs. Please confirm that the source of the state share is state appropriations. If not, please explain.

We are requesting this additional/clarifying information under provisions of section 1915(f)(2) of the Act. This has the effect of stopping the 90-day clock for CMS to take action on the material,

Mr. Lawrence Kissner  
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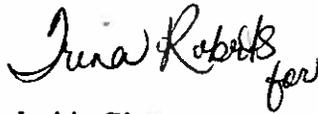
which would have expired on 6/24/14. A new 90-day clock will not begin until we receive your response to this request.

In accordance with our guidelines to all state Medicaid directors dated January 2, 2001, if we have not received the state's response to our request for additional information within 90 days from the date of this letter, we will initiate disapproval action on the amendment.

We ask that you respond to this request for additional information via the Atlanta Regional Office SPA/Waiver mailbox at CMS [SPA\\_Waivers\\_Atlanta\\_R04@cms.hhs.gov](mailto:SPA_Waivers_Atlanta_R04@cms.hhs.gov). In addition, please send hard copies to the Atlanta Regional Office and to me at the above address.

If you have any questions, please contact Darlene Noonan at 404-562-2707 or [Darlene.Noonan@cms.hhs.gov](mailto:Darlene.Noonan@cms.hhs.gov).

Sincerely,

A handwritten signature in black ink that reads "Jackie Glaze" with a small "for" written below the name.

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