

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-DSH Repost SPRY 2011 -Ltr to SM from JG-071116:

A letter containing the CMS content review results of the Disproportionate Share Hospital (DSH) audit and report for the Kentucky state plan year (SPYR) 2011.

2-CMS-HCBW -Ltr to SM from JG-071316:

CMS has approved DMS' request to renew the Kentucky Home and Community Based Waiver, which serves disabled individuals who meet the nursing facility level of care, as authorized under section 1915(c) of the Social Security Act

3-CMS-SCFPC Rates-Ltr to SM from JK-072116:

Medicare Prescription Drug Improvement and Modernization Act of 2003 requires CMS to notify each state of its per capita drug payment expenditure amount.

4-CMS-ABI -Ltr to SM from JG-072216:

CMS has requested additional information for the state's request to renew Kentucky's Home and Community Based Waiver for Individuals with Acquired Brain Injury (Long Term Care).

5-CMS-SPA-16 -Ltr to SM from JG-072616:

CMS has reviewed and approved the Kentucky state plan amendment KY16-0004. This amendment extends the current sunset date for Community Mental Health Center reimbursements to December 31, 2016.

6-CMS- State Audit SFY 15 -Ltr to SM from MW-072816:

CMS has reviewed the audit for fiscal year ended June 30, 2015. CMS determined if properly implemented DMS' planned action will satisfy the recommendations for which CMS have resolution responsibility.

7-CMS- PBM -Ltr to SM from JG-081116:

CMS has approved CHFS's request for a 75 percent federal financial participation (FFP) costs associated with the operation of the Pharmacy Benefit Manager (PBM) system.

8-CMS-2392-F Mechanized Claims Processing Ltr to SMD from VW-081616:

CMS is issuing the third in a series of Medicaid Directors letters to provide sub-regulatory guidance to supplement CMS-2392-F "Mechanized Claims Processing and Information Retrieval Systems" which became effective January 1, 2016.

MAC Binder Section 1 – Letters from CMS

Table of Contents with Document Summary

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

9-CMS- HCBW-Ltr to SM from AMD-081816:

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- IAPD -Ltr to SM from JG-082516:

CMS has approved the IAPD update in accordance with Section 1903(a)(3) of the Social Security Act, no new funding is approved for this project under this approval.

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



DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

July 11, 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



Dear Mr. Miller:

This letter contains the CMS content review results of the Disproportionate Share Hospital (DSH) audit and report for Kentucky state plan rate year (SPRY) 2011. The content review is designed to complement the results of CMS' initial audit submission screening, which informed the state whether or not its audit met the basic submission standards. This letter also requests information on the status of Medicaid DSH overpayments identified by the audit and provides the state more detailed instructions regarding overpayment and redistribution reporting. Based on the content review, CMS has identified the following issues the state must address to meet federal DSH audit requirements at section 1902(j) of the Social Security Act and implementing regulations:

- 1) For the following issue/issues, the audit identified that some hospital-specific DSH limits were incorrect as a result of missing data, incorrect data, or an incorrect calculation method. Please revise the hospital-specific DSH limit for each affected hospital and submit a revised data elements spreadsheet to CMS. Additionally, please identify any overpayment amounts that may result from the updated hospital-specific DSH limits. If the state audit and report already revised the calculation of affected limits, please confirm.
 - a) Four hospitals were unable to satisfactorily document all of the services they provided to uninsured patients and in most cases the uninsured payments received during the DSH year. These undocumented services were excluded.

- b) Three hospitals were unable to document uninsured patient payments received during the DSH year. These hospitals could not provide the date of collection and/or reported the payments on an accrual basis instead of the required cash basis.
 - c) The majority of hospitals were unable to obtain MMIS out of state paid claim reports to document the out of state services provided and payments received.
- 2) The audit report and data elements spreadsheet identified the following issue/issues with the determination of the hospital-specific limit, but did not include enough information regarding the impact on the determination of the hospital-specific DSH limit. Please provide the requested information and explain any steps taken to ensure that the hospital-specific DSH limit was accurately calculated. If necessary, please revise any affected data elements and submit a revised data elements spreadsheet to CMS. Please also identify any overpayment amounts resulting from modification of the data elements spreadsheet. If the state audit and report already revised the calculation of affected limits, please confirm.
- a) One hospital was unable to document the services they provided to uninsured patients and the uninsured payments received during the DSH year. The hospital was able to estimate the uninsured services provided and payments received using hospital records however, no detail data is available.
 - b) Paid claims data provided by the Department for Medicaid Services, managed care organizations and providers, may include individuals paid by CHIP. For SFY 2011 Title XXI CHIP data is not able to be separated from other Medicaid individuals.
 - c) Prisoners and those meeting the definition of inmates were excluded from the uninsured category. However, 3 state owned and operated psychiatric hospitals included court-ordered patients in the uninsured category which may need to be excluded based on CMS guidance. Please indicate that the included costs and payments for services provided to these individuals is consistent with the guidance provided in SMDL #02-013 published on August 16, 2002 and later clarified in the final rule (CMS-2315-F) published on December 3, 2014. Any payments received or costs incurred on behalf of these individuals which are inconsistent with CMS regulations and guidance should not be included in the calculation of the hospital specific DSH limit.
 - d) Medicare payment data required for dual eligible patients and provided by the state's fiscal intermediary could not be validated to include all Medicare payments such as Medicare Graduate Medical Education. Auditors were able to estimate the Medicare payments using the cost report but these estimates do not consider differences in the case –mix or services provided to dual eligible patients compared to the hospital's entire Medicare patient population.

- e) Final cost settlements related to outpatient payments, as of the date of this report, have not been completed for all hospitals. For incomplete settlements the state was able to
 - f) Provide preliminary settlement amounts based on estimates or other as-filed data. These settlements have been included in the uncompensated care cost calculations.
 - g) One hospital has been accused in lawsuits of submitting bills to Medicare and Medicaid for unnecessary procedures from January 2008 through August 2011. The auditors had no specific claim information related to this \$16.5 million dollar lawsuit.
- 3) For the following items, please indicate the corrective actions taken by the state and/or providers in order to address the identified issues. Please provide a description of these corrective actions, including a status of their resolution.
- a) The hospitals were paid DSH under a CMS approved state plan that did not include the same calculations for UCC as required by the DSH examination in accordance with the Federal Register/Vol. 73, No. 245, dated December 19, 2008. The state needs to update the state plan to be in accordance with the 2008 DSH rule.

The SPRY 2011 audit identified specific overpayments totaling \$7,694,369 in federal financial participation (FFP). Additionally, there are potential total computable overpayments mentioned above that must be promptly addressed. All overpaid related FFP must be refunded as described below. 42 CFR Part 433, Subpart F requires that states return provider overpayments to the federal government within one year from the date of discovery, which is the date of the state's audit submission to CMS. If the state has a DSH overpayment redistribution methodology in its approved state plan, it may redistribute all or a portion of DSH overpayments to qualifying hospitals in accordance with the approved state plan.

Please note that any portion of overpayments not returned to CMS within one year of discovery are subject to disallowance per 42 CFR 430.42. The state is liable for interest for late overpayments as specified in 42 CFR 433.320(a)(4). This interest will be at the Current Value of Funds Rate (CVFR) and will accrue beginning on the day after the end of the one-year period following discovery until the last day of the quarter for which the state submits a CMS-64 report refunding the federal share of the overpayment. Please note that any adjustments to overpayments resulting from the identified issues above must also be redistributed or returned in accordance with federal requirements.

The correct accounting for any redistributed DSH payments requires two separate entries on the CMS-64 Quarterly Expenditure Report, an increasing adjustment on line 7 for DSH payments actually redistributed, and a decreasing adjustment on line 10B to report the federal portion of any identified overpayments redistributed in accordance with the approved state plan. Both the increasing and decreasing prior period adjustments should specify the SPRY which corresponds to the SPRY of the original DSH payments. If the state is only reporting the return of identified overpayments, it should report these overpayments on the CMS-64 Quarterly Expenditure Report by making a decreasing adjustment on line 10B to report the federal portion. Please indicate the specific amounts of redistributions and overpayments reported on each quarterly CMS-64 Report. All adjustments should be made for fiscal year 2011 for purposes of reporting redistributions and the return of overpayments for SPRY 2011 audits. If the state reported overpayments or redistributions using another method, CMS will gladly provide technical assistance to the state to ensure corrections or proper reporting for future periods.

To verify that all redistributions and overpayments are reported properly, the state must specify if the redistribution was reflected on the SPRY data elements spreadsheet submitted as part of the annual audit report submission. If the data element report submitted with the audit report did not reflect the redistribution, states should resubmit the data elements spreadsheet to CMS to reflect final DSH payment amounts made to hospitals after redistribution. The revised data elements spreadsheet should be submitted concurrent with the submission of the CMS-64 Report that reflects the redistribution.

Please provide a response to this letter no later than August 31, 2016 that 1) provides the information requested by the letter, 2) identifies adjustments for overpayment amounts resulting from the audit and content review result, 3) documents the appropriate redistribution or return of identified overpayments, and 4) identifies the status of corrective actions relating to the audit and the content review results specified in this letter. We look forward to continued efforts and commitment on behalf of both our agencies in ensuring that the DSH audits and reports comport with section 1923(j) of the Social Security Act, implementing regulations at 42 CFR 447.299 and 42 CFR 447 Subpart D, and related guidance. Should Kentucky have any questions regarding the DSH rule requirements or the review process itself, please feel free to contact Stanley Fields at (502) 223-5332.

Sincerely,



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

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



DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

July 13, 2016

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



Dear Mr. Miller:

Your request to renew the Kentucky Home and Community Based Waiver, which serves aged or disabled individuals who meet the nursing facility level of care, as authorized under section 1915(c) of the Social Security Act, has been approved. This renewal has been assigned control number KY 0144.R06, which should be used in future correspondence. This waiver was approved on July 13, 2016. The waiver renewal is effective August 1, 2015.

The waiver renewal includes the following estimates of utilization and costs:

Waiver Year	Unduplicated Recipients	Community Costs	Institutional Costs	Total Waiver Costs
1 (8/01/15 - 6/30/16)	17,050	\$13,398.97	\$37,904.13	\$63,373,096.32
2 (8/01/16 - 6/30/17)	17,050	\$13,874.73	\$38,727.72	\$64,386,403.50
3 (8/01/17 - 6/30/18)	17,050	\$14,477.68	\$39,576.59	\$65,785,578.99
4 (8/01/18 - 6/30/19)	17,050	\$15,144.50	\$40,451.11	\$66,716,895.86
5 (8/01/19 - 6/30/20)	17,050	\$15,990.25	\$41,351.75	\$68,939,798.45

As a reminder, for the time period in which this waiver was under a temporary extension (August 1, 2015 through July 8, 2016), this waiver was operating at cost and utilization levels approved for the fifth year of the previous approved waiver (KY 0144.R05) with federal financial participation. The state's data must reflect this in the 372 report that the state submits to CMS for this waiver.

We sincerely appreciate the dedicated effort and cooperation provided by your staff during our review of this request. If you have any questions, please feel free to contact Catherine Cartwright at (404) 562-7465 or via email at catherine.cartwright@cms.hhs.gov.

Sincerely,

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

cc: Amanda Hill, Central Office

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



RE: Calendar Year (CY) 2016 Oct - Dec Phased-down State Contribution Final Per Capita Rates

July 21, 2016

Dear State Medicaid Director:

As you know, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) requires that the Centers for Medicare & Medicaid Services (CMS) notify each State of its per capita drug payment expenditure amount. Payments for the phased-down State contribution are made on a monthly basis. These payments are defined by the MMA to be the product of the annual per capita full dual-eligible drug payment amount and the monthly State enrollment of full dual eligibles.

This letter is to notify you of the phased-down State contribution full dual-eligible per capita Medicaid drug payment amount for October - December 2016, as required by the MMA.

Oct-Dec 2016 phased-down State contribution per capita rates are shown in Attachment 1. The per capita drug expenditure amount for Oct-Dec 2016 is based on the value for Jan-Sep 2016, adjusted for the change in FMAP, if any, between FY 2016 and FY 2017.

Questions regarding these calculations may be directed to Christian Wolfe, at 410-786-2266 or via E-mail at Christian.Wolfe@cms.hhs.gov



Sincerely,

/s/

Jessica Kahn
Director, Data & Systems Group

ATTACHMENT 1: Phased-down State Contribution Rates Oct - Dec 2016

		Oct-Dec 2016
AL	Alabama	67.12
AK	Alaska	163.08
AZ	Arizona	51.51
AR	Arkansas	62.45
CA	California	110.23
CO	Colorado	141.97
CT	Connecticut	174.73
DE	Delaware	128.28
DC	District of Columbia	62.67
FL	Florida	118.60
GA	Georgia	81.14
HI	Hawaii	91.60
ID	Idaho	89.56
IL	Illinois	139.06
IN	Indiana	97.93
IA	Iowa	130.41
KS	Kansas	130.41
KY	Kentucky	83.53
LA	Louisiana	105.47
ME	Maine	88.67
MD	Maryland	149.26
MA	Massachusetts	117.00
MI	Michigan	73.76
MN	Minnesota	144.06
MS	Mississippi	55.67
MO	Missouri	129.68
MT	Montana	98.53
NE	Nebraska	143.76
NV	Nevada	95.52
NH	New Hampshire	165.93
NJ	New Jersey	178.52
NM	New Mexico	55.90
NY	New York	131.63
NC	North Carolina	97.02
ND	North Dakota	125.18
OH	Ohio	133.79
OK	Oklahoma	86.82
OR	Oregon	103.58
PA	Pennsylvania	148.50
RI	Rhode Island	139.05
SC	South Carolina	57.83
SD	South Dakota	131.17
TN	Tennessee	114.34
TX	Texas	97.65
UT	Utah	100.12
VT	Vermont	124.15
VA	Virginia	150.33
WA	Washington	142.30
WV	West Virginia	74.62
WI	Wisconsin	122.55
WY	Wyoming	157.11

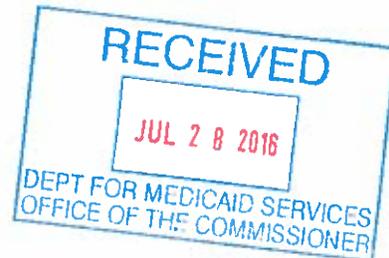
DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Atlanta Regional Office
61 Forsyth Street, Suite 4T20
Atlanta, Georgia 30303



DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

July 22, 2016

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



Dear Mr. Miller:

This formal Request for Additional Information (RAI) is in response to the state's request to renew Kentucky's Home and Community Based Waiver for Individuals with Acquired Brain Injury (Long Term Care) control number 0477.R01. Our review found that the Informal RAI responses did not conform fully to statutory and regulatory requirements. Please note additional information requested includes how the state intends to transition the implementation of occupational, physical, and speech therapy services for waiver participants.

The state's response to the IRAI included a request that the effective date of the waiver renewal be moved from July 1, 2016 to February 1, 2017. Before the renewal can be approved, the state will need to demonstrate completion of the above mentioned transition. In addition, please provide clarification on the following issues:

Main- Attachment #1

1. Please address the transition of those receiving nursing services in the waiver to receiving the services in the state plan.

Appendix A – OIS

2. The updated performance measure has reversed the Numerator and Denominator. The complete universe of the group/data the state is measuring is always in the Denominator; the Numerator can only be equal to or smaller. In this case, the "Number of required reports the QIO provides to DMS" should be the Denominator.

Appendix B-6-i

3. Please update this section in the waiver application to include the information given in the state's response to the IRAI. Specifically, that "there is an MWMA system-generated notice sent to the case manager 40 days prior to the participant's level of care end date. A "Schedule Reassessment" task is automatically generated for the case manager to start the LOC reassessment process."

Appendix B – QIS-a

4. The updated performance measure has reversed the Numerator and Denominator. The complete universe of the group/data the state is measuring is always in the Denominator; the Numerator can only be equal to or smaller. In this case, the “Total number of waiver applicants” should be the Denominator.

Appendix C - Services

5. There are a number of issues related to service definitions, primarily related to Service Type and EPSDT requirements. Some of these issues were created in response to the IRAI, and may have been generated by confusion over those questions and instructions. The state will need to work with CMS personnel to resolve these issues before resubmitting the waiver application.

Appendix D-1-e

6. Please clarify how back-up plans for emergencies and disasters are incorporated into the service plan. Please clarify if other back up plans are developed and incorporated into the service plan such as when staff is unable to make their assigned shift and this absence presents a risk to the participant’s health and welfare.

Appendix D-QIS-a

7. The first sub-assurance for the Service Plans assurance requires that service plans address all participants’ assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means. The current performance measure does not address health and safety risk factors or the participants’ personal goals. The performance measure should be modified to add these elements or additional performance measures should be added to the waiver.

Appendix F-1

8. Please specify where notices of adverse actions and the opportunity to request a Fair Hearing are kept when issued to individual participants.

Appendix I-1

9. Please update the waiver application to include language indicating that waiver providers are not required to secure an independent audit of their financial statements, and add the information provided in response to the IRAI question regarding audits and billing reviews (question 39-c). Verify that DMS is responsible for performing both the certification and post-payment reviews.

Appendix I-2-a

10. Please detail the rate setting methodology for each waiver service, including a summary on how each waiver service rate was determined and set. Update the application to include this rate setting methodology information. This will require listing out the individual services and detailing the methodology for each service. It should also include the following:
 - a. What inputs were used to set the initial waiver service rates?
 - b. What cost assumptions were used?
 - c. How are the rates updated?

11. Please update this section to reflect the information provided by the state in response to IRAI questions 39-g and 39-h.

Appendix J-2-c

12. Please update this section for the Factor D' derivation and the Factor G' derivation with the information provided in the state's response to the IRAI.

Under section 1915(f) of the Social Security Act, a waiver request must be approved, denied or additional information requested within 90 days of receipt or the request will be deemed approved. The 90-day review period of this request ends July 27, 2016. This request for additional information will, however, stop the 90 day clock. Once the additional information is submitted, the 90-day clock will restart at day one.

If you have any questions, please feel free to contact Catherine Cartwright at (404) 562-7465 or via email at catherine.cartwright@cms.hhs.gov.

Sincerely,



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

cc: Amanda Hill, Central Office

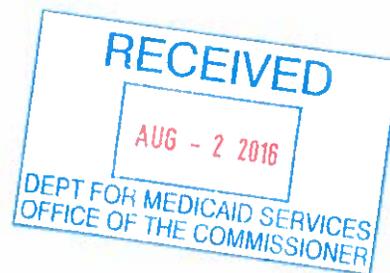
DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Atlanta Regional Office
61 Forsyth Street, Suite 4T20
Atlanta, Georgia 30303



DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

July 26, 2016

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



Re: Kentucky State Plan Amendment 16-0004

Dear Mr. Miller:

We have reviewed the proposed Kentucky state plan amendment, KY 16-0004, which was submitted to the Centers for Medicare & Medicaid Services (CMS) on June 24, 2016. This amendment extends the current sunset date for Community Mental Health Center reimbursement from June 30, 2016 to December 31, 2016.

Based on the information provided, the Medicaid State Plan Amendment KY 16-0004 was approved on July 26, 2016. The effective date of this amendment is July 1, 2016. We are enclosing the approved HCFA-179 and a copy of the new state plan page.

If you have any additional questions or need further assistance, please contact Darlene Noonan at (770) 443-0049 or Darlene.Noonan@cms.hhs.gov.

Sincerely,

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

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

Enclosures

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL	1. TRANSMITTAL NUMBER: 16-004	2. STATE Kentucky
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
FOR: HEALTH CARE FINANCING ADMINISTRATION	4. PROPOSED EFFECTIVE DATE July 1, 2016	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		

5. TYPE OF PLAN MATERIAL (Check One):

NEW STATE PLAN AMENDMENT TO BE CONSIDERED AS NEW PLAN AMENDMENT

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

6. FEDERAL STATUTE/REGULATION CITATION:	7. FEDERAL BUDGET IMPACT: a. FFY 2016 Budget Neutral b. FFY 2016 Budget Neutral
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Att. 4.19-B, Page 20.15(1)(a)	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Same

10. SUBJECT OF AMENDMENT:
The purpose of this SPA is to continue the current reimbursement that was to sunset on June 30, 2016 until January 1, 2017 for the Community Mental Health Centers.

11. GOVERNOR'S REVIEW (Check One):

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

COMMENTS OF GOVERNOR'S OFFICE ENCLOSED

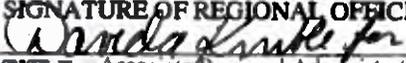
NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

12. SIGNATURE OF STATE AGENCY OFFICIAL: 	16. RETURN TO: Department for Medicaid Services 275 East Main Street 6W-A Frankfort, Kentucky 40621
13. TYPED NAME: Stephen P. Miller	
14. TITLE: Commissioner, Department for Medicaid Services	
15. DATE SUBMITTED: 6/25/15	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 06/24/16	18. DATE APPROVED: 07/26/16
-----------------------------	-----------------------------

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 07/01/16	20. SIGNATURE OF REGIONAL OFFICIAL: 
21. TYPED NAME: Jackie Glaze	22. TITLE: Associate Regional Administrator Division of Medicaid & Children Health Opns

23. REMARKS: Approved with the following changes to block #7 as authorized by state agency on email dated July 25, 2016.
Block # 7a changed to read: FFY2016 Budget Neutral and 7b changed to read: FFY 2017 Budget Neutral

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

- ix. Peer Support Specialist working under the supervision of a physician, a psychiatrist, an APRN, a PA, a LP, a LPP, a LPA, a LCSW, a LMFT, a LPCC, a CSW, a LMFTA, a LPCA, a CADC, a Professional Equivalent, a psychiatric nurse, a LPAT, or a LPATA ;
- x. A certified alcohol and drug counselor (CADC) working under the supervision of a physician, a psychiatrist, an APRN, a PA, a LP, a LPP, a LPA, a LCSW, a LMFT, a LPCC, a CSW, a LMFTA, a LPCA, a LPAT, or a LPATA; and
- xi. A community support associate who is working under the supervision of a physician, a psychiatrist, an APRN, a PA, a LP, a LPP, a LPA, a LCSW, a LMFT, a LPCC, a CSW, a LMFTA, a LPCA, a CADC, a Professional Equivalent, a psychiatric nurse, a LPAT, a LPATA, a LBA, or a LABA.

The current reimbursement methodology, as outlined above, for services provided in CMHCs will end on December 31, 2016.

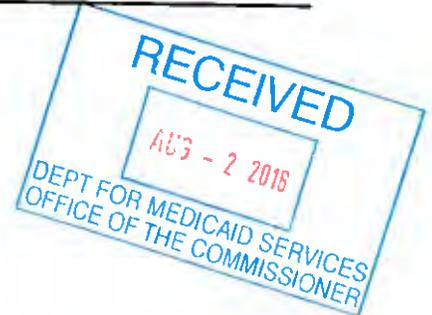
DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
61 Forsyth Street, SW, Room 4T20
Atlanta, Georgia 30303-8909



Division of Medicaid & Children's Health Operations

July 28, 2016

Stephen P. Miller, Commissioner
Department for Medicaid Services
275 E. Main St., 5W
Frankfort, Kentucky 40621



RE: A-04-16-30057, Kentucky Single State Audit SFY 2015

Dear Mr. Miller:

We have reviewed the Department of Health and Human Services' Office of Inspector General (OIG), National External Audit Review Center transmittal letter A-04-16-30057 (dated June 10, 2016) and the related submissions by your organization to comply with the Office of Management and Budget (OMB) Circular A-133 for the fiscal year ended June 30, 2015. The Kentucky State Auditor performed the audit and submitted it to the Federal Audit Clearinghouse on March 30, 2016. CMS has the responsibility to issue a management decision for the Recommendation Code(s) listed on Attachment A of the OIG transmittal letter with a Resolution Agency of HHS/CMS. Any other Recommendation Code(s) are the resolution responsibility of another component(s) of the Department of Health and Human Services. Please respond to this letter within 30 days of the date with a corrective action plan and the progress the State has made on that plan.

We have determined that, if properly implemented, your organization's planned action will satisfy the recommendations for which we have resolution responsibility. This management decision is based upon our review of your organization's responses in the reporting package (e.g., responses in the auditor's findings, the summary schedule of prior audit findings, and the corrective action plan).

The audit finding(s) and the CMS decision(s) are described below.

1. **Recommendation Code:** 299-901-10. 2015-003. The Cabinet for Health and Family Services Did Not Record Medicaid Expenditures To the Correct Contracts.

Recommendation Description: We recommend procedures be implemented to ensure all expenditures are properly charged to the correct contracts.

Response/Corrective Actions: The State agreed with the recommendation. In September 2014, CHFS developed and implemented new procedures to ensure all MCO payments are charged against the correct master agreement contracts. The

Department of Medicaid Services sorts and approves the monthly MCO payments by master agreement contract and the Division of Accounting and Procurement Services pays accordingly.

CMS Decision: The CMS RO concurs with the recommendation and the corrective actions taken/planned.

- 2. Recommendation Code:** 211-922-10. 2015-007. The Cabinet for Health and Family Services Did Not Ensure Encounter Data Submitted to the Kentucky Medicaid Management Information System is Accurate and Complete.

Recommendation Description: We recommend procedures be implemented to ensure encounter data submitted is complete and accurate.

Response/Corrective Actions: The State agreed with the recommendation. Per the recommendation, beginning July 1, 2015 the new contract language (for State Fiscal Year 2016) accurately reflects the penalties being assessed for late or inaccurate encounter data. The Department of Medicaid Services (DMS) began penalizing the MCOs effective July 1, 2015. The MCO's are notified via SharePoint of these penalties on or before the third Thursday of the month.

CMS Decision: The CMS RO concurs with the recommendation and the corrective actions taken/planned.

- 3. Recommendation Code:** 211-901-10. 2015-008. The Cabinet for Health and Family Services Did Not Ensure All System Audits and Edits Were Accurately Configured for the Kentucky Medicaid Management Information System and Were Kept up to Date Within System Documentation.

Recommendation Description: We recommend procedures be implemented to ensure validity of the system controls.

Response/Corrective Actions: The State agreed with the recommendation. The Department agrees that the MMIS audit and Edit manuals were not updated with the above referenced details and since this finding only related to documentation no claims processing errors occurred. The Division of Medicaid Systems created a task and requested the vendor to update the edit and audit manual. This corrective action was completed on September 16, 2015 by the HP Business Analyst. The updated data has been verified by the Systems Monitoring Branch Manager in the Division of Medicaid Systems and an updated copy has been posted for internal users. The edits that were updated are listed within a spreadsheet that was provided to the auditors along with this response.

CMS Decision: The CMS RO concurs with the recommendation and the corrective actions taken/planned. Please send the support for the corrective actions completed for our review.

4. **Recommendation Code:** 306-905-10-2. 2015-053, 2014-057, 13-CHFS-51, 13-CHFS-59. Eligibility.

Recommendation Description: This is a repeat finding. We recommend procedures be strengthened to ensure documentation supporting eligibility is properly maintained.

Response/Corrective Actions: Effective February 29, 2016, a new integrated eligibility system was implemented. This system fully integrates all programs currently remaining on the KAMES legacy system and all health insurance programs onto a new platform using the kynect platform. With this integration, there will only be one case for all programs, as to multiple cases on multiple systems. This one case will be associated with one electronic case file, streamlining workload management and documents received for processing. In addition, various other state and federal interfaces were built into the system. Many of these interfaces are real time and will assist with verifying required information such as social security number, citizenship, etc. If verification cannot be verified through an available interface, the system will automatically pend the case and generate a request for information to the client asking for the required information. If the required information is not received, the system will automatically take action to either deny the application or discontinue benefits depending on the status of the case.

To reinforce the importance of maintaining proper case files, central office management will address this issue in the regularly scheduled monthly meetings with regional management. Additionally, the Division of Family Support (DFS) will issue announcements on a quarterly basis reminding staff of the importance of following policy and procedures in the maintenance of case files beginning with April 2016.

CMS Decision: The CMS RO concurs with the recommendation and the corrective actions taken/planned. Please send the support for the corrective actions completed for our review.

5. **Recommendation Code:** 339-935-10. 2015-054, 2014-058. Activities Allowed or Unallowed and Allowable Costs/Cost Principles – Drug Rebates.

Recommendation Description: This is a repeat finding. We recommend procedures be strengthened to ensure 1) drug rebate balances are collected in a timely manner and 2) adequate oversight over the drug rebate program.

Response/Corrective Actions: DMS implemented the following corrective actions beginning September 2015:

- (1) DMS explored options through the PBM to increase collection attempts on behalf of the Commonwealth; including:
 - a. Sending additional late payment notices to manufacturers (although additional penalties cannot be included):
 - b. Increase the frequency of submitting notice to CMS regarding manufacturers that do not submit payment timely (quarterly);
- (2) DMS reviewed the supplemental agreement contract entered into with manufacturers through the National Medicaid Pooling Initiative (NMPI) to explore the addition of penalties and sanctions against untimely payments from manufacturers for the next contract renewal period. There is some provision for additional interest accrual on unpaid balances. DMS has considered the implication of this provision and uses its discretion to prefer or non-prefer products from manufacturers with a poor payment track record when doing so would not disadvantage recipients or the State.
- (3) In August 2015, DMS explored initiating requests for state hearings as allowed in the National Rebate Agreement. However, DMS must approach hearing proceedings with great caution to avoid causing unwanted complications.
- (4) DMS also instructed the PBM to compile a list of balances for manufacturers that continue to have returned mail due to them being terminated. This report will allow for balances to adjust down to zero in the rebate system since they are not collectable. This project shall begin operation during spring 2016.

CMS Decision: The CMS RO concurs with the recommendation and the corrective actions taken/planned. Please send the support for the corrective actions completed for our review.

6. Recommendation Code: 099-901-10. 2015-055. Allowable Costs/Costs Principles.

Recommendation Description: We recommend procedures be implemented to ensure services provided to participants are properly monitored and are in accordance with State regulations.

Response/Corrective Actions: The State agreed with the recommendation in part. DMS disagrees that the program was not monitored correctly, rather with a different interpretation of the regulation at that time. However, the Division of Community Alternatives has a new Director. A more correct interpretation of the monitoring is being enforced.

In early 2015, DMS notified Michelle P Waiver CDO providers/support broker agencies that effective April 1, 2015, any first time budget requests for the MPW that exceeded 40 hours per week would be denied, and the applicant would receive a right to a fair hearing. The notification included that any consumers currently receiving in excess of 40 hours per week would be required to adjust their plan of care to comply with the regulatory maximums starting April 1, 2016. This will require the consumer to submit a voluntarily reduced support spending plan/plan of care, or the consumer

will have his or her budget denied, due to exceeding regulatory limits, and consumer will receive a right to a fair hearing. This transition period gave each consumer/representative a one year notice to prepare for nay reduction in benefits. In addition, DMS notified the providers that any requests for budget exceptions that were presented in excess of 40 hours per week would also be denied with appeal rights.

DMS has also written multiple change orders for the MMIS system, which when fully implemented, will prohibit any MPW providers from billing for services which, when combined, would exceed the 40 hour limit; anything in excess of this limit would be securitized and require a manual override by DMS.

CMS Decision: The CMS RO concurs with the recommendation and the corrective actions taken/planned.

Please make the appropriate adjustments in accordance with (*42 CFR 433.300, the time limits identified at 42 CFR433.316, 42 CFR 457*) for the monetary amounts referenced above. Findings with amounts to be returned to the Medicaid program, please make a line 10A adjustment to the CMS-64 referencing A-04-16-30057 and for findings with amounts to be returned to the Children Health Insurance Program, please make a Line 3 decreasing adjustment on the CMS-21 referencing A-04-16-30057. If an outstanding refund is not received, CMS may then initiate a disallowance to obtain the recommended refund amount.

As a reminder, your organization is required by OMB Circular A-133 *Audits of States, Local Governments, and Nonprofit Organizations* to follow-up and to take corrective action on audit findings and to report the status of audit findings in the subsequent audit's Summary Schedule of Prior Audit Findings. Also, your auditor is required by OMB Circular A-133 to follow-up on prior audit findings, to perform procedures to assess the reasonableness of the Summary Schedule of Prior Audit Findings, and to report exceptions.

Thank you for your cooperation, if we can be of any further assistance, please contact Lynda Bennett @ 404-562-7352 of my staff.

Sincerely,



Michelle White
Acting Financial Management Branch Manager

Cc: Edgar Ross
Controller, State of Kentucky

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

August 11, 2016

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



Dear Mr. Miller:

The Kentucky Cabinet for Health and Family Services (CHFS) has requested approval of 75 percent federal financial participation (FFP) for costs associated with the operation of the Commonwealth's Pharmacy Benefits Manager (PBM) system, retroactive to July 1, 2014, and ongoing. The Centers for Medicare & Medicaid Services (CMS) approves Kentucky's request.

On August 14, 2015, CMS received the Commonwealth's request for 75 percent FFP for PBM operations, retroactive to July 1, 2014. The PBM system is a component of Kentucky's Medicaid Management Information System (MMIS); it processes non-institutional pharmacy claims as Point of Service (POS) transactions. Kentucky also submitted a copy of a letter to Magellan Medicaid Administration formally accepting all deliverables for the PBM system. The letter states that the PBM system's transition to operations was completed by June 30, 2014.

In support of Kentucky's request for enhanced funding, CHFS assessed the PBM system and subsequent operations using the current version of the Medicaid Enterprise Certification Toolkit (Toolkit) that is available on the CMS website. The Toolkit contains checklists that are aligned to Medicaid business areas. In addition to the documentation previously listed, Kentucky completed and submitted the following checklists, which are organized by Medicaid business area:

- Operations Management Business Area
 - Reference Data Management Checklist
 - Pharmacy Point of Service Checklist
- Program Management Business Area
 - Program Management Reporting Checklist
 - Financial Management Checklist
 - Security and Privacy Checklist
- Program Integrity Business Area
 - Program Integrity Checklist

Kentucky's request letter affirms that the PBM system adjudicates claims and information required for payment of services in accordance with all provisions of 42 CFR Part 447 and the approved state Medicaid Plan. The letter also states that the PBM system meets the requirements of 42 CFR § 433.117 for all periods for which 75 percent FFP is being claimed. We have performed a

Mr. Stephen Miller

Page 2

Preliminary review of CHFS' completed checklists to make sure that all of the criteria derived from federal requirements have been checked "Yes," and that all of the capabilities that Kentucky Planned to develop, as defined in the previously-approved Implementation Advance Planning Document (IAPD) and Request for Proposal (RFP), have been delivered.

Based on Kentucky's attestation that the PBM system provides all expected functionality and operates in accordance with 42 CFR § 433.117, Part 11 of the State Medicaid Manual, the Medicaid Enterprise Certification Toolkit, the Seven Conditions and Standards, Medicaid Information Technology Architecture (MITA) 3.0, the Commonwealth's approved IAPD and RFP, and other federal and state requirements, CMS accepts Kentucky's attestation, retroactive to July 1, 2014, the date the PBM system began operations. Our review of CHFS' completed Toolkit checklists and other submitted documentation supports Kentucky's attestation. In accordance with 42 CFR § 433.117, CHFS can claim 75 percent FFP for PBM system operations on a retroactive adjustment basis (as of July 1, 2014), and ongoing.

However, CMS plans to perform additional evaluation of the PBM system in concert with certification review activities for Kentucky's Medicaid Enterprise Management System (MEMS), and as we continue to refine the MMIS modular certification process, described in our final rule CMS-2392-F, "Medicaid Program; Mechanized Claims Processing and Information Retrieval Systems (90/10)." The schedule for the Commonwealth's MEMS project, which is currently in the design, development, and implementation (DDI) phase, will be considered in future planning for onsite and/or remote assessments of the PBM system. Kentucky anticipates transitioning the MEMS project to the operations phase beginning December 1, 2018.

As Kentucky's PBM system continues operations, CHFS may determine that the previously completed Toolkit checklists are no longer adequate or accurate, based on changing business objectives or technical architecture. The goal is to keep the checklists current, to maintain communication with CMS, and to provide a basis for the State Certification Readiness Protocol, as described in the Toolkit. It is the responsibility of the Commonwealth to make changes and send updated checklists to CMS. Additionally, CMS will work with Kentucky to address new or modified checklist criteria as we continue to modernize the Toolkit and MMIS certification procedures.

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

Sincerely,



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



SMD # 16-010

RE: CMS-2392-F Mechanized Claims Processing and Information Retrieval Systems – Modularity

August 16, 2016

Dear State Medicaid Director:

The Centers for Medicare & Medicaid Services (CMS) is issuing this third in a series of State Medicaid Director letters to provide sub-regulatory guidance to supplement CMS-2392-F, “Mechanized Claims Processing and Information Retrieval Systems (90/10),” which became effective January 1, 2016. This regulation further supports the modular systems development requirement detailed in 42 CFR Part 433, Subpart C - Mechanized Claims Processing and Information Retrieval Systems.

In reviewing the responses to our Request for Comments in our Notice of Proposed Rulemaking (NPRM) (CMS-2392-P) published on April 16, 2015 (80 FR 20455), we determined that there is a need for the development of supporting policy and sub-regulatory guidance. In developing sub-regulatory guidance, CMS is engaging our partners and stakeholders in recognition of their valuable experience and unique perspectives on this final rule.

Each of the letters in this series addresses discrete subject areas impacted by the final rule.¹ This letter addresses modular certification of Medicaid Management Information Systems (MMIS).

Background

On December 4, 2015, CMS published a final rule at 80 FR 75817, “Federal Funding for Medicaid Eligibility Determination and Enrollment Activities.” This final rule provided for a temporary enhancement to the federal financial participation (FFP) rate to support the design, development, and installation (DDI) and maintenance and operations (M&O) of Medicaid Eligibility and Enrollment (E&E) systems that are streamlined and interoperable with other systems and that provide a consumer-friendly experience. To further integrated systems, the final rule modified the definition of Claims Processing and Information Retrieval Systems at 42 CFR 433.111(b) to permanently include E&E systems. The broadened definition was also refined to support an enterprise approach where individual processes, modules, sub-systems, and systems are interoperable and work together seamlessly to support a unified Medicaid enterprise.

¹ Previous letters in this series include State Medicaid Director Letter (SMDL) #16-004 and SMDL #16-009 which can be found at <https://www.medicaid.gov/federal-policy-guidance/federal-policy-guidance.html>.

The Medicaid enterprise includes: (1) An E&E system used to process Medicaid enrollment applications, as well as change in circumstance updates and renewals. The E&E system might be implemented as the core of an integrated eligibility system that also supports eligibility for other human services programs; and (2) An MMIS used to process claims for Medicaid payment from providers of medical care and services furnished to beneficiaries under the medical assistance program, including review of managed care encounter data, and to perform other functions necessary for economic and efficient operations, management, monitoring, and administration of the Medicaid program. To receive enhanced federal matching funding for development, maintenance and operations, the Medicaid E&E systems and the MMIS must meet all applicable standards and conditions, including modularity, along with associated provisions such as the role of independent verification and validation (IV&V).

A module is a packaged, functional business process or set of processes implemented through software, data, and interoperable interfaces that are enabled through design principles in which functions of a complex system are partitioned into discrete, scalable, reusable components. An MMIS module is a discrete piece (component) of software that can be used to implement an MMIS business area as defined in the Medicaid Enterprise Certification Toolkit (MECT). The updated MECT can be found at <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/data-and-systems/mect.html>.

Modules can be added to a system or replaced, as needed, to implement a required functionality. To meet re-use requirements, modules should be made available to be shared and reused by another state or territory, or have been obtained as a result of sharing and reusing software from another state or territory. Modular projects may leverage the use of commercial off-the-shelf (COTS) products or Software-as-a-Service (SaaS) solutions as well as other modular approaches. In the case of proprietary products and SaaS, the same effective module is potentially available to other states subject to a state's contractual arrangement with the vendor.

Under the revised rule, CMS requires states to follow a modular approach that supports timely, cost-effective projects. We believe that a modular approach to the Medicaid Information Technology (IT) enterprise provides the most efficient and cost-effective long-term solution for meeting states' business needs. States will be able to leverage the modular approach to optimize project design for agility, interoperability and other desirable attributes as well as associated acquisition approaches to avoid prolonged development efforts and vendor lock-in. The modular approach is capable of supporting all Medicaid service delivery models, including managed care, fee-for-service, and use of an administrative services organization.

CMS will support projects that address rational, discrete subsets of Medicaid enterprise functionality (modules) that are interoperable with other parts of the Medicaid enterprise and meet all other Standards and Conditions for Medicaid IT. States are required to follow the modularity principles in their development of new or replacement MMIS and E&E modules. The requirement for modular approaches applies to all systems that are eligible for enhanced match within the Medicaid IT enterprise.

Modular Certification of MMIS Modules

Under previous rules, determination that an MMIS meets all applicable requirements (i.e. “certification”), was completed only after implementation of an entire system and an initial period of operational use. States were able to access the enhanced federal match for maintenance and operations only after this determination. Such an approach resulted in replacement or enhancement projects that were often large, lengthy, expensive and high risk, and delayed states’ access to the enhanced match. For these reasons CMS discourages replacement of an entire MMIS as a monolithic activity.

Modular certification will be applied to MMIS systems as new modules are introduced and as existing modules are replaced. CMS may require modular certification of portions of a system when proposed changes or enhancements have been determined to be high risk. Modular certification will result in several benefits to states. With smaller, more incremental projects risk and costs should be reduced for all aspects of the project. Modular MMIS certification will allow the states to access the 75 percent enhanced FFP for M&O of the certified module(s) prior to having completed their total MMIS system replacement, improving the state’s cash flow.

Modular certification is supported by the updated MECT, which supersedes the prior MMIS Certification Toolkit. Modular certification will leverage the MECT as a dynamic methodology that can be applied to projects variously aligned along business process lines and functionality. The MECT has multiple options for certifying modular projects that should suit the variety of approaches being taken by different states, including a custom certification approach suggested by a state, subject to CMS’s review and approval. Project risk will be a major consideration in deciding whether or not to approve enhanced FFP for a modular project.

Although the addition of a new module or changes or enhancements to an existing module or set of modules would call for modular certification, it would not require the recertification of the entire MMIS. Review of a modular implementation would focus on that module’s functions within the MMIS, how it interfaces with other MMIS modules, and how effectively and efficiently it serves its purpose within the MMIS. Successful completion of regression testing must also be verified to ensure that the integration of the new module will not have a negative impact on other parts of the system. CMS requires that the state has accepted the modular solution from their vendor and that there has been at least a six-month period of live operations before it will consider a module for certification. Approval is subject to the conditions in the State Medicaid Manual Chapter 2, Approval of MMIS Systems, sections 11210, 11241, and related sections, found at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021927.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=ascending>, as well as the standards and conditions documented in the MECT.

CMS has organized the requirements in the MECT into checklist sets to be used in certifying MMIS modules. States can use MECT checklists based on 1) the MITA 3.0 business areas, 2) MMIS modules, or 3) a tailored checklist set prepared by the state which the state then submits to CMS for acceptance. Appendix A lists the MITA 3.0 and MMIS business area checklists. Whichever checklist set is used, the MITA 3.0 requirements still apply. In support of a more outcome-based approach, the new MECT also incorporates the concept of critical success factors, further unifying the approaches available to the states for managing MMIS projects.

Recommended Modules

CMS expects that states will take different approaches to identifying the best solutions to meet the needs of the Medicaid IT enterprise. CMS will work with states during the planning stage and provide guidance on the appropriate modules to be incorporated into each project based on the state's concept of operations. The need for modular certification will be identified during the planning stages of a project, including advance planning document (APD) review. Appendix A lists modules that could be constructed based on the two standard checklist sets.

Modular Acquisition

A modular approach to acquisition increases the opportunity to select progressive technology from different vendors, along with the flexibility to swap solutions in and out over time as needed. As the market for modular solutions evolves, states should take advantage of acquisition approaches that will avoid vendor lock-in and other risks of a single, massive solutions. States also should be able to replace individual modules to take advantage of specific innovations without significant integration cost and additional risks.

The modular approach supports states in achieving an optimal balance in the use of open source and proprietary COTS software solutions over the use of custom solutions, thereby reducing the need for custom development, promoting reuse, expanding the availability of open source solutions, and encouraging the use of shared services. Open source projects offer the potential to introduce additional efficiency and innovation. Multiple independent developers contribute best practices and new ideas, reacting to each other's work in a collaborative, open environment. Such projects have been highly successful in other subject domains, in terms of both richness of functionality and economy, and could have similar potential in the Medicaid domain as well. A modular approach to acquisition will lower the barriers to entry for smaller vendors, thereby increasing the availability of modules and shared services in the marketplace.

Conditions for modularity and interoperability require acquisition of loosely coupled modules with open, documented interfaces, including COTS solutions, in order to qualify for enhanced federal funding. A key component of this approach is a well-documented set of open interfaces that allow for vendor-independent integration of modules into an overall business solution. These interfaces may take a number of forms including, but not limited to, application programming interfaces (APIs), open services under a service oriented architecture (SOA), and shared standards-based data stores.

States should carefully craft Requests for Proposals (RFPs) to specify these conditions, and may find it efficient to include excerpts from the certification checklists, particularly the critical success factors. CMS expects that states' RFPs and contracts will contain language requiring publication of open APIs.

System Integrator Role

CMS envisions a discrete role for the system integrator (SI) in each state, with specific focus on ensuring the integrity and interoperability of the Medicaid IT architecture and cohesiveness of the various modules incorporated into the Medicaid enterprise. The target outcome for the SI should be to foster ever evolving solutions for Medicaid business requirements, with the SI responsible for the successful integration of the chosen solutions and infrastructure into a seamless functional system. The scope of the SI role shall include the interoperable integration of the Health Information Exchange activities as described in State Medicaid Directors letter #16-003 into the Medicaid enterprise. More information on the SI role can be found in the MECT, Medicaid Enterprise Certification Life Cycle, part 01 Section 1.7.

States are encouraged to use an acquisition approach that limits the potential for conflict of interest an SI may have in choosing the modular solutions to be incorporated into the system. Such an approach could preclude the SI from bidding on functional modules, but still allow the SI to provide elements of the technical infrastructure such as the enterprise service bus, master data management, etc. As described above, the goal is to avoid lock-in to a single vendor or an otherwise closed set of solutions.

Independent Verification and Validation

Under regulation at 45 CFR 95.626, Independent Verification and Validation (IV&V) may be required for any major Medicaid IT project. The IV&V contractor represents state and CMS interests throughout each project and, as such, provides an independent and unbiased perspective on the progress of MMIS or E&E system development and the integrity and functionality of the system. The scope of IV&V responsibilities are detailed in the MECT and include evaluation of project management and performance, project development and testing processes, and technical reviews of the modules. The IV&V contractor must also verify that adequate regression testing has been performed to confirm that the replaced or enhanced module does not adversely impact the functionality and operation of the MMIS, E&E systems or other related components of the state's Medicaid Enterprise.

In order to allow time for states to align existing contracts and projects to the new IV&V guidelines, CMS will allow states an 18-month period from the date of this letter to comply with new IV&V requirements. This 18-month period is applicable only to contracts in place as of the date of this letter. Contracts entered into after the date of this letter must comply with all IV&V requirements. To aid in adoption of these new requirements the MECT contains model language for states to include in their IV&V contracts.

MITA 3.0 Compliance

Regulation at 42 CFR 433.112(b)(11) requires alignment with MITA for DDI of MMIS and E&E systems that are funded with enhanced federal matching funds. MITA 3.0 compliance requires that systems be designed, developed, and maintained with up-to-date industry best practices, so that the resulting MMIS and E&E systems are modular and technically suitable for sharing and reuse with other states. See <https://www.medicaid.gov/Medicaid-CHIP-Program->

[Information/By-Topics/Data-and-Systems/Medicaid-Information-Technology-Architecture-MITA.html](#).

Module Pre-Certification

CMS will implement a module pre-certification program that will allow vendors to present their Medicaid IT modular solutions to CMS for review, regardless of whether the software has been implemented in a state system or not. Information about the pre-certification criteria and process is available at <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/data-and-systems/modules.html>.

This SMDL supersedes previous guidance in the State Medicaid Manual (SMM) Chapter 11 (<https://www.cms.gov/Regulations-and-Guidance/guidance/Manuals/Paper-Based-Manuals-Items/CMS021927.html>). Supplemental information is available in the MECT and in a series of responses to frequently asked questions (FAQs) maintained at <https://questions.medicaid.gov>.

If you have additional questions, please contact Martin Rice at Martin.Rice1@cms.hhs.gov. 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
Academy Health

Appendix A: List of Modules

Medicaid Management Information System (MMIS) Modules

Below are lists of modules that could be constructed based on the two standard checklist sets available within the Medicaid Enterprise Certification Toolkit (MECT).

I. Medicaid Information Technology Architecture (MITA) Business-Aligned Modules

The following correspond to the set of MITA business-aligned certification checklists of the same names:

- Business Relationship Management
- Care Management
- Contractor Management
- Eligibility & Enrollment
- Financial Management
- Member Management
- Operations Management
- Performance Management
- Plan Management
- Provider Management

II. MMIS System Modules

The following are aligned with MMIS system models:

- Member Enrollment
- FFS Claims & Adjudication
- Pharmacy
- Third Party Liability
- Care Management
- Program Integrity
- Decision Support System
- Reference Data Management
- Provider Management
- Registries

Disabled and Elderly Health Programs Group

August 18, 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 August 11, 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 intellectual and developmental disabilities. The current waiver is scheduled to expire August 31, 2016. The temporary extension allows the Michelle P. Waiver, CMS control number 0475.R01, to continue operating through November 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 allow time for the state to complete public notice requirements at 42 CFR 441.304(f) which was delayed, along with the waiver renewal application which was due May 31, 2016. The delay was due to the state resolving issues related to the timing of the state's budget cycle, budgetary changes, and the addition of individual cost limits in the waiver, before submission. The extension will also be used to complete the 90 day review period and for the state to address concerns regarding the application as a result of that review. CMS is requesting that the state submit the waiver renewal application on or before October 15, 2016.

If you need any assistance, feel free to contact Catherine Cartwright,
Catherine.Cartwright@cms.hhs.gov or via telephone at (404) 562-7414; or Amanda Hill,
Amanda.Hill@cms.hhs.gov or via telephone at (410) 786-2456.

Sincerely,



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

C: Jackie Glaze, Region IV ARA
Deborah Anderson, 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

August 25, 2016

KY-16-008

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 Implementation Advance Planning Document (IAPD) update submitted by the Kentucky Cabinet for Health and Family Services (CHFS) to close the International Classification of Diseases, Version 10 (ICD-10), systems modification project. The budget and approved activity schedule remained under the approved estimates of \$18,549,414 (\$16,205,001 Federal Financial Participation [FFP] and \$2,344,413 state share). CMS congratulates the Commonwealth for returning \$7,004,497 (\$5,827,750 FFP and \$1,176,747 state share) to the Medicaid program.

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

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

Sincerely,

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

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