

MAC Binder Section 1 – Letters from CMS

Part A

Table of Contents with Document Summary

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

1-CMS-KY Medicaid Review-Ltr to SM from LB-031316:

CMS will be conducting an audit of the Kentucky State Medicaid. Audit will be conducted by a team from the Investigations and Audits Group led by Donald Carr.

2-CMS-NEMT-Ltr to SM from AMD-031316:

CMS is approving the requested extension of the KY-06.R01 waiver to operate the NEMT program. The temporary extension will expire June 30, 2016.

3-CMS-SPA 15-006-Ltr to SM from KF-050416:

CMS approved amendment modifying the state's reimbursement methodology for setting 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.

4-CMS-EHR HITECH-Ltr to SM from JG-032816:

CMS will be conducting their periodic review of the State's progress with the Medicaid HER Incentive Program and related HITECH activities and programs. CMS will be on site in KY June 8 and June 9th 2016.

5-CMS-SMD-MMIS E&E-Ltr to SM from VW-033116:

CMS provides guidance concerning the enhanced federal match rate, and other federal match rates, for various activities related to Medicaid Information Technology in both MMIS and E&E systems, including the use of COTS software.

6-CMS-CHIP-Waiver-Ltr to SM from AMC-040616:

CMS approved KY request for a waiver to delay Medicaid and CHIP renewals due to significant system challenges resulting from the recent deployment of benefind. Renewals scheduled for April 2016 will be completed by July 31, 2016 and those scheduled for May 2016 will be completed by August 31, 2016.

7-CMS-HCBSW-0477-Ltr to SM from JG-040816:

CMS has completed the review of KY CMSV372 annual report for the ABI Long term Care HCBS Waiver. CMS-approved estimates indicate estimated costs were not exceeded.

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8-CMS-DSH Audits & Reports Acknowledgement-Ltr to SM from JG-041216:

Response letter to December 30, 2015 submission of KY state plan rate (SPRY) 2012 Disproportionate Share Hospital audit and report. CMS has determined that the submission does not comport with section 19239j) of the Social Security Act.

9-CMS-HCBSW-Aged-Disabled-Ltr to SM from AMD-041516:

CMS approved the April 11, 2016 request for KY's 67 day temporary extension of HCBS waiver program for individuals who are aged or disabled, extension through July 1, 2016.

10-CMS-HCBSW-IDD-Ltr to SM from AMD-041516:

CMS approved the April 11, 2016 request for KY's 65 day temporary extension of HCBS waiver program for individuals who have intellectual and developmental disabilities, extension through July 1, 2016.

11-CMS-SMD-CHIP-Free Choice of Providers-041916:

CMS provides guidance to clarify "Free Choice of Provider" requirements in conjunction with state authority to take action against Medicaid providers.

DEPARTMENT OF HEALTH & HUMAN SERVICES
CENTERS for MEDICARE & MEDICAID SERVICES
7500 Security Boulevard, Mail Stop AR-21-55
Baltimore, Maryland 21244-1850



Investigations and Audits Group

March 13, 2016

Mr. Stephen Miller, Medicaid Director
Cabinet for Health & Family Services
Department of Medicaid Services
275 E. Main Street, 6 West - A
Frankfort, KY 40621



Dear Mr. Miller:

This letter is to inform you that we plan to conduct a focused review of the Kentucky Medicaid program during the week of June 13, 2016, at your offices in Frankfort. A team from the Investigations and Audits Group, led by Donald Carr from our Baltimore office, will conduct the review. You are welcome to attend the review entrance conference which has been scheduled for 9:00 AM on Tuesday, June 14, 2016.

The purpose of this focused review is to evaluate the effectiveness of Kentucky's program integrity activities in managed care. We have enclosed a copy of our Managed Care (MC) Review Guide Module along with our Managed Care Entity (MCE) Questionnaire for fiscal year (FY) 2016. The information and materials requested in the MC Review Guide Module and the MCE Questionnaire will assist us in completing the review as efficiently as possible. Several questions in the MC Review Guide Module may need to be addressed by program integrity or managed care program staff. Please provide responses to the enclosed FY16 MC Review Guide Module to Mr. Carr as soon as possible, but not later than May 13, 2016.

The FY16 MCE Questionnaire should be sent to all MCEs providing Medicaid services under contract or other agreement with the State Medicaid agency. Please have your PI review representative forward all responses to the FY16 MCE Questionnaire to Mr. Carr by March 27, 2016. Once the FY16 MCE Questionnaires are returned, we will ask the selected MCEs to complete additional information in a separate MCE Review Guide Module that will also be requested by May 13, 2016.

We request that program integrity, managed care, claims processing, and other appropriate managers be present for the entrance conference. We would also appreciate it if attendees would briefly discuss their functional responsibilities as they relate to managed care operations and oversight.

Please ensure that other appropriate staff related to the state's managed care and program integrity operations are available during the week of the review and that workspace is made available for

the review team. The review team may want to visit or interview contractors and MCEs as part of our review.

Approximately 30 days after the last day of the review, the review team will hold an exit conference (via conference call) with state Medicaid management to go over the observations of the review. The state will be afforded the opportunity to provide informal comments to the draft report prior to the issuance of the final report. The state will also be afforded the opportunity to provide formal comments to the final report.

We appreciate your cooperation and assistance and look forward to working with your staff on this review. If you have any questions regarding how to prepare for our visit, please contact Donald Carr at 410-786-0503 or Donald.Carr@cms.hhs.gov.

Sincerely,



Laurie Battaglia, JD
Acting Director - Division of State Program Integrity
Investigations and Audits Group
Center for Program Integrity

Enclosures:

FY 16 Managed Care Review Guide Module
FY 16 Managed Care Entity Questionnaire
Kentucky Comprehensive PI Review Final Report FY13

cc: Robert Long, Program Integrity Manager

Managed Care Entity Questionnaire

State Medicaid Agency: Please send this questionnaire to each managed care entity (MCE) providing Medicaid services under contract or other agreement with the state. Please return all completed questionnaires to the Review Team Leader no later than 2 weeks from the date of the letter.

Managed Care Entity: Please provide written responses to the questions below and return this questionnaire to the State Medicaid Agency.

Based on the questionnaire responses, the CMS review team will choose the MCEs to be interviewed during the onsite review and will send the state the Managed Care Entity review module for each selected MCE to complete and return within a specified timeframe prior to the onsite review.

MCE Name:

Contact Person:

Address:

Telephone:

City, State, Zip:

Email:

Date Completed:

1. Does the MCE have commercial, Medicare, and/or Medicaid lines of business?

2. What is the total number of beneficiaries/enrollees for each line of business?
 - a. Medicaid? _____
 - b. Medicare? _____
 - c. Commercial? _____

3. Identify all of the managed care programs under which the MCE provides services in the state. Please provide this information for each line of business.

4. How many providers are currently under contract or credentialed with the MCE? Please provide this information for each line of business.

5. What are the MCE's total Medicaid expenditures for each of the past 3 FYs?

6. Is there a contract requirement or policy that Medicaid providers enrolling with the MCE must also be enrolled by the State Medicaid Agency? If not, how many MCE providers are also enrolled in FFS Medicaid?

7. Does the MCE have a Special Investigations Unit (SIU) or other unit responsible for program integrity activities? Is the SIU or other unit located at the address listed

above or elsewhere? If it is at another location, please provide the address where the SIU or other unit is located.

8. What is the size of the MCE's SIU staff or other unit for state Medicaid fraud or abuse investigations?
9. Is there a separate unit responsible for conducting Medicaid audits? What unit is identifying and/or collecting overpayments associated with their activities?
10. What are the staff positions that make up the MCEs SIU or other unit and what percent of time does each type of staff (i.e., auditor, investigator, analyst or nurse) devote to Medicaid fraud or abuse?
11. In regards to all provider investigations: For all provider cases opened, closed and actively worked, where are the case files located? Can complete copies of the case files be provided electronically to CMS upon request?
12. What subcontractors do the MCE contract with for any fraud/abuse or other Medicaid audits or reviews?
13. To whom (specific contact information) does the MCE refer cases of suspected Medicaid provider fraud or abuse (i.e., the state agency, the state's Medicaid Fraud Control Unit, or other law enforcement agencies)? Please identify all agencies where the MCE would refer a case pertaining to provider fraud or abuse.
14. How often do you meet with the MFCU or the State's Program Integrity Unit concerning provider fraud or abuse activities?
15. How and why has the MCE's Medicaid enrollment expanded? What is planned for the near future?

State Program Integrity in Managed Care

Kentucky for review on June 13, 2016

Note: CMS expects the managed care Medicaid program to provide the same program safeguards that we expect to see in the fee for service Medicaid Program. Questions in this module will need to be addressed by managed care program/policy and program integrity (PI) staff. In many instances, CMS will request an electronic copy of contracts, policy and/or process documents that should support the response i.e. MC-1 through MC-10. Please ensure to capture the corresponding question number (and attachment, if applicable) with each appropriate response.

The review guide module responses and associated documents are due no later than thirty (30) days in advance of the review or May 13, 2016. Early submissions are highly appreciated.

Area of Assessment: Program Integrity in Managed Care

State Oversight of MCE SIU and Other MCE Program Integrity Activities

Please provide an electronic copy of each of the following documents:

MC-1.	A brief description of the state's managed care delivery system structure. Please include an organizational chart showing the State Medicaid Agency divisions or units with programmatic oversight, fraud and abuse related oversight, and/or contract oversight over each MCE. Include the commensurate number of FTEs.	Please refer to http://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/managed-care-site.html for a complete description of a delivery system, as defined by CMS.
MC-2.	All operational guidelines, policies and procedures, MOUs, or interagency agreements that govern the interaction between the state's PI efforts and programmatic oversight for each managed care program.	
MC-3.	Each MCE contract (or a link to the master contract) for each of the state's managed care delivery systems. This should also include any External Quality Review Organization (EQRO), MCEs (managed care organization [MCO], prepaid inpatient health plan [PIHP], prepaid ambulatory health plan [PAHP], health insuring organization [HIO]) contracts.	
MC-4.	In addition to the contract or link to master contract provided in MC-3, please provide any reports issued under the current contract that relate to managed care fraud and abuse.	
MC-5.	Provide (total expenditures) how much the state paid each MCE, in each of the past 4 FFYs (chart or table).	

MC-6.	Any statute, regulation, policy, procedure or MCE contract clause that requires MCEs to return to the state overpayments recovered from providers as a result of MCE fraud and abuse investigations or audits.	
MC-7.	The 4 most recent reports provided to the state by each MCE notifying the state of suspected provider fraud and abuse.	
MC-8.	Any policies and procedures, review guide, review protocol or checklist used by the state to monitor MCE program integrity/SIU operations.	
Program Integrity Investigations of Network providers relative to 42 CFR 455.13,14,15, 16, and 17.		
MC-9.	A list of MCE network provider investigations that the state conducted in the past 4 FFYs, including the source of each investigation. <i>The CMS review team will select a sample of these cases to review.</i>	
Program Integrity Investigations of MCEs relative to 42 CFR 455.13,14,15,16, and 17.		
MC-10.	A list of state conducted investigations concerning MCEs in the past 4 FFYs. Please specify the MCE investigated and describe the source of such investigations. <i>The CMS review team will select a sample of these cases to review.</i>	
Area of Assessment: Program Integrity in Managed Care		
Section II – Program Integrity and Oversight of Fraud/Waste/Abuse (includes SIU and Training) relative to 42 CFR 438.608; 42 CFR 455.20.		
Question:		Response/Documentation:
MC-11.	Does the state review the MCE's compliance plan required by 42 CFR 438.608 and discuss with the MCEs? Please fully describe the state's compliance plan review process.	If applicable, please provide the policy and procedure.
MC-12.	Who is responsible for managed care contract monitoring?	
MC-13.	Which division, unit or contractor is responsible for managed care programmatic oversight for any External Quality Review Organization (EQRO), prepaid inpatient health plan [PIHP], prepaid ambulatory health plan [PAHP], health insuring organization [HIO]? b. Does this include fraud and abuse-related	

	activities? Does this include PI provisions of the contract?	
MC-14.	Is the PI unit involved in writing managed care contract language on fraud and abuse?	
MC-15.	Does the state communicate information about high risk providers across plans to prevent additional fraud or abuse? Does the state share this information with the program integrity unit / FFS?	
Meetings and trainings		
MC-16.	Do the PI unit and the state managed care staff meet regularly on PI issues? b. Please describe, including the date of the most recent meeting and provide report of last meeting.	
MC-17.	Does the PI unit conduct trainings for the state managed care staff on PI issues? b. If yes, please describe how often and the subject matter of the most recent training. If no, describe why not?	
MC-18.	Has the state and/or the MFCU conducted training to MCEs on PI during the past FFY? b. If available, please provide document or report of last training.	
MC-19.	Was any training offered to SIU personnel? b. If yes, please describe the most recent training, including the MCEs receiving the training, who from the MCE received the training, and the subject matter of the training.	
Contract compliance and MCE performance		
MC-20.	Does the state conduct on-site reviews at the MCEs to verify compliance with its fraud and abuse contract requirements and by what unit? Please fully describe including who is involved and the date of the most recent reviews.	
MC-21.	Relative to 42 CFR 455.20, Does the state ensure that beneficiary services are verified in the Managed Care program? b. Briefly explain the beneficiary verifications,	If applicable, please provide the verification policy and procedure.

	Explanations of Medical Benefits (EOMB), questionnaires, or other methods used by the state to verify receipt of services with managed care beneficiaries (Please specify if this is performed individually by the MCEs)?	
MC-22.	Does the state's external quality review organization (EQRO) or other contractor validate MCEs' compliance with Medicaid fraud and abuse-related contract provisions? Please describe.	
MC-23.	If the EQRO or another contractor validates MCEs' compliance with Medicaid fraud and abuse-related contract provisions, does the state follow up with each MCE on its performance of fraud and abuse-related contract requirements?	
MC-24.	What does the state do if an MCE's performance is less than adequate?	
Tracking and Referrals		
MC-25.	For the MCEs that track activities regarding suspected network provider fraud or abuse, please describe the type of tracking system used. Does the MCE provide all tracking information to the state? <i>The CMS review team may request evidence of the tracking information provided by the MCEs.</i>	
MC-26.	Do the MCEs refer suspected network provider fraud or abuse to the state or the MFCU? Please describe referral process and report whether the state is copied on referrals directly from the MCE to MFCU.	
MC-27.	For MCEs that refer suspected MCE provider fraud to the MFCU, do the MCEs enter into MOUs with the MFCU? If yes, does the state have a copy of each MOU?	
MC-28.	How many cases of suspected network provider fraud or abuse have the MCEs referred to the state in each of the past 4 FFYs? Please provide a list broken down by MCE.	

MC-29.	Does the state consider the cases referred by MCEs to be of adequate quality and quantity? Please fully describe.	
MC-30.	Are the cases opened and/or referred distributed evenly across the provider network? What provider types, if any, predominate in MCE case investigations?	
MC-31.	Do the MCEs typically close cases without a referral? How would the state know if this happened?	
Reporting Requirements		
MC-32.	What reporting requirements must MCEs follow in terms of reporting cases of suspected fraud and abuse to the state? b. Are these reporting requirements outlined in the contract?	
MC-33.	How many MCEs actively conduct investigations of suspected provider fraud or abuse? How often do the MCEs report on their investigations to the state?	
MC-34.	What action does the state take based upon MCE reports of suspected MCE network provider fraud or abuse? Please fully describe.	
42 CFR 1002.3 & 1002.203 - Terminations and 42 CFR 455.436 Federal Database Checks (Exclusion checking)		
MC-35.	Do the MCEs terminate providers?	
MC-36.	Describe under what circumstances might an MCE terminate a provider? Does the MCE report this information to the state?	
MC-37.	Are terminated providers being uploaded by the state or the MCE on the TIBCO MFT portal?	
MC-38.	Who collects the disclosures for network providers required at 42 CFR 455.104, 105, and 106?	
MC-39.	Does the MCEs or state have a database that stores the collected disclosure information on	

	network providers?	
MC-40.	Describe how the MCEs or state maintains compliance with 42 CFR 438.610 and 42 CFR 455.436 and ensures debarred and excluded parties and individuals are not participating in the Medicaid program. Please list all federal databases that are checked and frequency.	
MC-41.	How many excluded individuals or entities causing improper payments to providers have the MCEs or state identified in the past 4 FFYs? What improper payments have been identified and/or collected in each of those years?	
MC-42.	Does the state provide the MCE with any FFS algorithms or scenarios for analysis?	
Overpayments - Determine if the MC contract allows for the collection of overpayments, or improper payments.		
MC-43.	Does the State's contract with the MCEs describe the process for identifying, collecting and reporting overpayments by the MCE and the effect of those dollars on future rates and/or return of the overpayment dollars to the state? Are there any circumstances when the state can collect overpayments from network providers? For example: If the state conducts the review or identifies an excluded provider that receives the improper payment, what happens to the dollars?	
MC-44.	Has any MCE identified and/or returned overpayments (including fraud or abuse) to the state during the past 4 FFYs? If yes, please identify which MCE(s), the amounts broken out by FFY, when the overpayments were identified, and when the MCE returned the overpayments to the state.	
MC-45.	Is overpayment recovery information verified and by whom?	
MC-46.	For MCEs that returned overpayment to the state, did the state return the federal share to CMS? If yes, please identify the amounts broken out by FFY, when the overpayments were identified,	

	and when the state returned the federal share of the overpayments to CMS.	
MC-47.	Do the MCE's financials reflect provider overpayments to offset future capitation payments?	
42 CFR 455.23 - Payment Suspensions		
MC-48.	Does the MCE contract require the MCEs to suspend payments once the state has determined a credible allegation of fraud situation exists? If so, describe the state's process for ensuring the MCEs suspend payments to providers? If not, describe why not?	
MC-49.	Does the state contract allow the MCE to suspend payments to providers directly when the MCE suspects a credible allegation of fraud situation exists?	
MC-50.	How many network provider payment suspensions has the state requested in the past FY for each MCE?	
MC-51.	How many good cause exceptions were granted to by the state in the past? List the reasons for the exception in each case.	
MC-52.	Is the state annually reporting its payment suspensions?	If not, why not?
Other Program Integrity Activities - Determine if the state investigates reports of complaints of fraud and abuse by MCEs. Determine if the state automatically assigns beneficiaries to a MCO.		
MC-53.	Has the state ever investigated an MCE for suspected fraud or abuse? If so, describe the state's process for conducting investigations of suspected MCE fraud or abuse, what was the outcome of the most recent investigation?	
MC-54.	Does the State automatically assign new and current beneficiaries to managed care plans? Please fully describe.	
Technical Assistance		
MC-55.	What technical assistance that the CMS	Organizational structure review and

	<p>Investigations and Audit Group (IAG) could provide would the State agency find helpful?</p>	<p>recommendations (please describe):</p> <p>_____ Priorities for PI efforts (please describe):</p> <p>_____ Assistance with areas of weakness in compliance with Federal statutory and regulatory requirements (please describe):</p> <p>_____ Special Projects</p> <p>_____ Other (please describe):</p>
<p>MC-56.</p>	<p>Has State agency PI staff attended any Medicaid Integrity Institute courses?</p>	<p>If yes: Which course did State agency staff attend?</p> <p>If no: Please describe why the State agency staffs have not taken advantage of available course offerings.</p>
<p>MC-57.</p>	<p>Does the State agency have suggestions for future Medicaid Integrity Institute courses that might benefit State staff?</p>	<p>If yes: Please describe, including which State staff might benefit from each suggested course offering.</p>

**Department of Health and Human Services
Centers for Medicare & Medicaid Services**

**Medicaid Integrity Program
Kentucky Comprehensive Program Integrity Review
Final Report**

May 2013

**Reviewers:
Gretchen Kane, Review Team Leader
Theodore Jackson
Elizabeth Lindner
Debra Tubbs
Bonnie Harris, Review Manager**

INTRODUCTION

The Centers for Medicare & Medicaid Services' (CMS) Medicaid Integrity Group (MIG) conducted a comprehensive program integrity review of the Kentucky Medicaid Program. The MIG review team conducted the onsite portion of the review at the offices of the Department of Medicaid Services (DMS). The review team also conducted a telephone interview with the Medicaid Fraud Control Unit (MFCU).

This review focused on the activities of the Cabinet for Health and Family Services' DMS Division of Program Integrity (DMS-PI) and the Office of Inspector General (OIG), which are responsible for Medicaid program integrity in Kentucky. This report describes two noteworthy practices, three effective practices, seven regulatory compliance issues, and one vulnerability in the State's program integrity operations.

The CMS is concerned that the review identified two uncorrected partial repeat and one uncorrected repeat findings from its 2009 review of Kentucky. The CMS plans on working closely with the State to ensure that all issues, particularly those that remain from the previous review, are resolved as soon as possible.

THE REVIEW

Objectives of the Review

1. Determine compliance with federal program integrity laws and regulations;
2. Identify program vulnerabilities and effective practices;
3. Help Kentucky improve its overall program integrity efforts; and
4. Consider opportunities for future technical assistance.

Overview of Kentucky's Medicaid Program

The DMS administers the Kentucky Medicaid program. As of January 1, 2012, the program served 863,751 beneficiaries, 64 percent of whom were enrolled in four managed care entities (MCEs). Kentucky requires all fee-for-service (FFS) and managed care Medicaid providers to enroll through the State Medicaid agency. As of January 1, 2011, Kentucky had 37,667 enrolled providers. Of those enrolled providers, 21,921 are providing services in MCEs. Medicaid net expenditures in Kentucky for the State fiscal year (SFY) 2011 totaled \$5,695,941,830.

Medicaid Program Integrity Division

In Kentucky, the DMS-PI is the organizational component primarily dedicated to fraud and abuse activities. At the time of the review, DMS-PI had 45 full-time equivalent positions, which includes the Provider Enrollment Branch. In order to manage with limited staff, DMS-PI contracts with the Kentucky OIG for certain types of investigations. Although DMS-PI conducts some preliminary investigations, the majority of suspected provider fraud cases are investigated by the OIG. OIG is the agency responsible for determining and referring cases of credible

**Kentucky Comprehensive PI Review Final Report
May 2013**

allegation of fraud to the MFCU. The OIG has its own fraud hotline and initiates investigations on its own. The table below represents the total number of investigations and overpayment amounts identified and collected in the last four SFYs because of program integrity activities.

SFY	Number of Preliminary Investigations*	Number of Full Investigations**	Amount of Overpayments Identified	Amount of Overpayments Collected
2009	21	14	\$1,956,877.84	\$1,956,877.84
2010	15	11	\$3,951,339.15	\$3,951,339.15
2011	12	17	\$2,649,629.54	\$2,649,629.54
2012	19	10	\$20,443,220.21	\$20,443,220.21***

* Preliminary investigations of fraud or abuse complaints determine if there is sufficient basis to warrant a full investigation.

** Full investigations are conducted when preliminary investigations provide reason to believe fraud or abuse has occurred. They are resolved through a referral to the MFCU, administrative, or legal disposition.

*** The State attributes this significant increase to its emphasis on increasing program integrity efforts and the Recovery Audit Contractor's (RAC) program integrity efforts.

Methodology of the Review

In advance of the onsite visit, the review team requested that Kentucky complete a comprehensive review guide and supply documentation in support of its answers. The review guide included such areas as program integrity, provider enrollment/disclosures, managed care and the MFCU. A four-person team reviewed the responses and materials that the State provided in advance of the onsite visit.

During the week of July 24, 2012, the MIG review team visited the DMS office. The team conducted interviews with numerous DMS-PI and OIG officials. To determine whether MCEs were complying with the contract provisions and other federal regulations relating to program integrity, the MIG team reviewed the State's managed care contracts. The team met separately with DMS staff to discuss managed care oversight and monitoring. In addition, the team conducted sampling of provider enrollment applications, program integrity cases, and other primary data to validate Kentucky's program integrity practices.

Scope and Limitations of the Review

This review focused on the activities of the DMS-PI, but also considered the work of other components and contractors responsible for a range of program integrity functions, including provider enrollment and contract management. Kentucky operates both a stand-alone Children's Health Insurance Program (CHIP) and a Title XIX expansion program. The expansion program operates under the same billing and provider enrollment policies as Kentucky's Title XIX program. The same effective practices, findings and vulnerabilities discussed in relation to the Medicaid program also apply to the expansion of CHIP. The stand-alone program operates under the authority of Title XXI and is beyond the scope of this review.

Unless otherwise noted, Kentucky provided the program integrity-related staffing and financial information cited in this report. For purposes of this review, the review team did not independently verify any staffing or financial information provided.

RESULTS OF THE REVIEW

Noteworthy Practices

As part of its comprehensive review process, the CMS review team identified two practices that merit consideration as noteworthy or "best" practices. The CMS recommends that other States consider emulating these activities.

Increased focus on program integrity

Although the State program integrity unit has several vacant positions and is currently under a hiring freeze, it reports that additional emphasis has been placed on program integrity efforts. Since the last CMS review, DMS-PI has hired a Medicaid Specialist who, through courses at the Medicaid Integrity Institute, has obtained her coder certification. The State has also engaged a RAC. Since the implementation of the RAC contract, from July 1, 2011 through June 30, 2012 DMS-PI has issued over 1,500 demand letters and collected \$13,479,711 in improper payments. Prior to the implementation of the RAC, collections for the past four SFYs ranged from \$11,666 to \$401,922.

Mandatory enrollment of all FFS providers, managed care network providers, personal care services (PCS) agencies, and transportation brokers into the State Medicaid program

The State enrolls all FFS providers, managed care network providers, PCS agencies, and non-emergency medical transportation (NEMT) brokers. By having one focal point of enrollment, the Medicaid agency ensures that all provider types are subject to the same enrollment processes in which required disclosures are made, license verifications conducted and exclusion searches performed. In the 2009 MIG review, it was noted that for providers who were once deactivated or excluded from the program, the State further checks CMS' Fraud Investigation Database, the OIG fraud tracking database, the Kentucky Secretary of State's website, and the State Bureau of Prisons database when such providers seek to re-enroll in Medicaid. This standardization has eliminated essential discrepancies found in many other states, especially for providers participating in managed care networks who may be subject to different credentialing standards.

Notwithstanding the value of the centralized provider enrollment, the CMS team found issues with Kentucky's provider enrollment process during the 2012 review, which are detailed later in the report. When the identified findings are corrected, Kentucky's provider enrollment process will be strengthened.

Effective Practices

As part of its comprehensive review process, the CMS invites each State to self-report practices that it believes are effective and demonstrate its commitment to program integrity. The CMS does not conduct a detailed assessment of each State-reported effective practice. Kentucky reported innovative methods of checking and collecting outstanding Medicaid debt, access to the controlled substance database, and quarterly managed care meetings with State agencies involved in program integrity as effective program integrity tools.

Innovative methods of checking and collecting outstanding debt

In the 2009 MIG review, it was noted that the State agency had developed innovative techniques of checking for providers with outstanding Medicaid debt. One technique is the Application Collection process. When providers submit their annual disclosure information or try to re-enroll in Medicaid after being terminated or inactivated due to non-billing for two years, they are reviewed first for outstanding Medicaid debt. Not all accounts collected through this process are set up initially by DMS-PI. Another tool is the 270 Day Report on active providers which allows staff to review the accounts receivable database for debts which are over 270 days old in order to collect the outstanding debt. During the past three SFYs, the continued use of the Application Collection process has resulted in collections of \$557,493 in SFY 2010, \$532,694 in SFY 2011, and \$95,470 in SFY 2012.

Additionally, Kentucky has instituted a process called the Non Court Ordered Member Collections, where they attempt to collect member Medicaid overpayments that were declined for prosecution by the courts for a variety of reasons, such as overpayments that did not meet the monetary threshold for prosecution and large caseloads. The cases in which a Medicaid overpayment is established against beneficiaries and the courts decline to prosecute, the beneficiaries are referred by the OIG to DMS-PI for administrative collection. During this process DMS-PI sends the beneficiary a Medicaid Program Violation letter stating the reason for ineligibility and the amount of the overpayment. The letter asks the beneficiary to voluntarily repay the Medicaid overpayment in full or agree to enter into a payment plan to eliminate the overpayment debt. Since SFY 2009, the administrative collections from beneficiaries totaled \$49,518.

DMS access to the Prescription Drug Monitoring Program (PDMP) database

The DMS-PI has access to the Kentucky PDMP database that tracks controlled substance prescriptions dispensed within the state. The PDMP, which began in 1999, is housed within the OIG's Drug Enforcement & Professional Practices Branch (OIG-DEPP). This is a reporting system designed to be a source of information for practitioners and pharmacists as well as an investigative tool for law enforcement.

The DMS-PI sends requests to OIG-DEPP to assist with reviews for Medicaid member or provider history and prescribing or utilization patterns for a specific amount of time. The DMS-PI also uses PDMP reports for surveillance and utilization reviews. If it appears that there is an enabling provider, the provider is referred to the OIG for investigation. Based upon the final outcome of the case, a provider could be terminated.

Quarterly MCE meetings with State agencies involved in program integrity

The DMS-PI, OIG, and the MFCU staff meet quarterly with Kentucky's managed care chief compliance officers, the program integrity coordinator for the MCEs' administrative contractor, and when warranted, the Medicaid financial management and medical management staff. The meetings enable the State to monitor MCE activities closely and offer the State the opportunity to provide ongoing education and guidance to the MCEs.

Despite these meetings, the CMS review team did find a vulnerability related to the State's

oversight of the MCE program integrity activities, which is detailed later in the report.

Regulatory Compliance Issues

The CMS review team found seven regulatory compliance issues related to program integrity in Kentucky. These issues are significant and represent risk to the Kentucky Medicaid program. Ranked in order of risk to the program, these compliance issues include: not suspending Medicaid payments in cases of credible allegations of fraud, not conducting complete exclusion searches, not capturing provider disclosures, not reporting adverse actions to the U.S. Department of Health and Human Services-Office of Inspector General (HHS-OIG), and not providing adequate notice of exclusions.

The State does not suspend payments in cases of credible allegations of fraud and is not conforming to the regulatory performance standards.

The federal regulation at 42 CFR 455.23(a) requires that upon the State Medicaid agency determining that an allegation of fraud is credible, the State Medicaid agency must suspend all Medicaid payments to a provider, unless the agency has good cause not to suspend payments or to suspend payment only in part. Under 42 CFR 455.23(d) the State Medicaid agency must make a referral to either a MFCU or to an appropriate law enforcement agency in States with no certified MFCU. The referral to the MFCU must be made in writing and conform to the fraud referral performance standards issued by the Secretary.

Kentucky's State statute that addresses referrals to the MFCU requires raw complaints to be sent to from the Kentucky OIG to the MFCU for informational purposes at the time they are received. The MFCU made this request to ensure that it did not already have an open criminal case related to a raw complaint. During case sampling by the MIG review team, it was noted that when the MFCU recognized and accepted a raw complaint as a credible allegation of fraud, the State did not suspend payments to the provider nor was the case documented with a good cause exception not to suspend payments to a provider.

Additionally, on October 28, 2011, the DMS revised its policy for instances when OIG conducts a preliminary investigation and determines there is a credible allegation of fraud. The DMS, OIG, and MFCU are required to meet informally to discuss cases prior to making a formal referral to the MFCU. During the meetings, in cases where the MFCU determines there is a credible allegation of fraud that warrants a suspension of payments to the provider, the MFCU will issue a verbal law enforcement exception and follow up with a written notice once further investigation is done on the referral. The review team noted during sampling that cases were not documented to reflect a verbal law enforcement exception nor did they have a written notice from the MFCU. The State also failed to suspend provider payments prior to sending the referral to the MFCU. Although DMS, OIG, and MFCU are making progress with communications, the OIG was still sending cases directly to the MFCU without giving DMS the opportunity to suspend provider payments or document a good cause exception not to suspend payments when there was a credible allegation of fraud.

Furthermore, the State uses an investigative checklist which meets the CMS minimum standards for referring cases to the MFCU. However, the checklist was not always consistently used in

**Kentucky Comprehensive PI Review Final Report
May 2013**

cases sampled by the review team. For instance, some referrals were missing addresses, payments to the provider made in the past three years, communication between the State agency and the provider, and Medicaid statutes.

Recommendations: Adhere to DMS' policies to conduct meetings with OIG and the MFCU to discuss cases prior to making a referral to the MFCU to determine if payments to the provider should be suspended or document the reason for the good cause exception for not suspending payments. Consistently implement the *CMS-MIG Performance Standard For Referrals Of Suspected Fraud From A Single State Agency To A Medicaid Fraud Control Unit* in documenting all MFCU referrals as required at 42 CFR 455.23(d).

The State does not conduct complete searches for individuals and entities excluded from participating in Medicaid. (Uncorrected Partial Repeat Finding)

The federal regulation at 42 CFR 455.436 requires that the State Medicaid agency must check the exclusion status of the provider, persons with an ownership or control interest in the provider, and agents and managing employees of the provider on the List of Excluded Individuals/Entities (LEIE) and the General Services Administration's Excluded Parties List System (EPLS)¹ no less frequently than monthly.

The State is conducting exclusion searches of all FFS providers, PCS providers, managed care network providers, MCEs, and NEMT brokers, and persons with an ownership or control interest in the provider, agents, and managing employees of the provider against the LEIE and EPLS upon enrollment and annually, and against the LEIE on a monthly basis. However, the EPLS checks are not conducted on a monthly basis. The State has submitted a change order for the Medicaid Management Information System to include automatic exclusion checks of the EPLS.

Recommendations: Search the EPLS upon enrollment, reenrollment, and at least monthly thereafter, by the names of the above persons and entities, to ensure that the State does not pay federal funds to excluded persons or entities.

The State does not capture all required ownership and control disclosures from disclosing entities. (Uncorrected Partial Repeat Finding)

Under 42 CFR 455.104(b)(1), a provider (or "disclosing entity"), fiscal agent, or MCE, must disclose to the State Medicaid agency the name, address, date of birth (DOB), and Social Security Number (SSN) of each person or entity with an ownership or controlling interest in the disclosing entity or in any subcontractor in which the disclosing entity has a direct or indirect ownership interest of 5 percent or more. The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address.

Additionally, under 455.104(b)(2), a disclosing entity, fiscal agent, or MCE must disclose whether any of the named persons is related to another disclosing entity, fiscal agent, or MCE as

¹ On July 30, 2012, the EPLS was migrated into the new System for Award Management (SAM). State Medicaid agencies should begin using the SAM database. See the guidance at <http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-08-01-12.pdf> for assistance in accessing the database at its new location.

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May 2013**

spouse, parent, child, or sibling. Moreover, under 455.104(b)(3), there must be disclosure of the name of any other disclosing entity, fiscal agent, or MCE in which a person with an ownership or controlling interest in the disclosing entity, fiscal agent, or MCE has an ownership or controlling interest. In addition, under 455.104(b)(4), the disclosing entity must provide the name, address, DOB, and SSN of any managing employee of the disclosing entity, fiscal agent, or MCE. As set forth under 455.104(c), the State agency must collect the disclosures from disclosing entities, fiscal agents, and MCEs prior to entering into the provider agreement or contract with such disclosing entity, fiscal agent, or MCE.

In the 2009 MIG review, the team found that Kentucky's provider enrollment application included instructions to providers not to provide a list of the board of directors if no one on the board has ownership and control interest of 5 percent or more. During the 2012 review, the team found that the provider agreement instructions had been amended to instruct providers to disclose information about officers and board members.

Kentucky's Disclosure of Ownership and Control Interest form in the provider agreement used for FFS, PCS, managed care network providers, and NEMT brokers and the Annual Disclosure of Ownership form used for MCEs do not solicit the primary business address, every business location, and P.O. Box address for corporate entities. The forms only solicit a P.O. Box number or address. In addition, both disclosure forms do not capture relationship information from persons with an ownership or controlling interest in the disclosing entity as required by the regulation. The forms only ask the applicant to list the names of any other disclosing entity in which person(s) listed on the application have ownership of other Medicare or Medicaid facilities. This limits the applicant to disclosing information only about Medicare or Medicaid facilities.

Additionally, the State has not updated the fiscal agent disclosures for persons with an ownership or controlling interest in the disclosing entity as of March 25, 2011.

Recommendations: Modify disclosure forms to capture enhanced addresses of disclosing corporate entities and the names of any other disclosing entity in which person(s) listed on the application have ownership in any other disclosing entity, not limited to Medicare or Medicaid facilities. Update the disclosures from the fiscal agent.

The State does not adequately address business transaction disclosure requirements in its provider agreements or contracts. (Uncorrected Repeat Finding)

The regulation at 42 CFR 455.105(b) requires that, upon request, providers furnish to the State or U.S. Department of Health and Human Services information about certain business transactions with wholly owned suppliers or any subcontractors.

Kentucky's provider agreement and the Annual Disclosure of Ownership form obligate providers and MCEs to report changes in name, ownership, and address within a 35-day timeframe. However, there is no reference that providers furnish business transaction information within 35 days of the date of a request by the Secretary or the Medicaid agency. This issue remains uncorrected from the 2009 MIG review.

The managed care contracts do require, within 35 days of the date of the request, the MCEs to provide information for any subcontractors or suppliers with whom the contractor has had business transactions totaling more than \$250,000 during the immediately preceding twelve month period. However, the contract incorrectly cites the regulation at 42 CFR 455.104 as the regulatory basis for this requirement.

Recommendations: Revise the provider agreement and the Annual Disclosure of Ownership form to include the business transaction information as required in 42 CFR 455.105(b). Modify the MCE contract to cite the correct regulation for this requirement. The MIG made the same recommendation in the 2009 review report.

The State does not capture criminal conviction disclosures from providers or contractors.

The regulation at 42 CFR 455.106 stipulates that providers must disclose to Medicaid agencies any criminal convictions related to Medicare, Medicaid, or Title XX programs at the time they apply or renew their applications for Medicaid participation or at any time on request. The regulation further requires that the Medicaid agency notify HHS-OIG whenever such disclosures are made. In addition, pursuant to 42 CFR 455.106(b)(1), States must report criminal conviction information to HHS-OIG within 20 working days.

Kentucky's disclosure forms and the provider agreement instructions ask for individuals or organizations with a direct or indirect ownership or controlling interest in the provider and the name of any agent or managing employee who has been convicted of a criminal offense related to any program established under Title XVIII, XIX, XX of the Social Security Act or any criminal offense in this state or any other state. However, the forms failed to ask these parties to disclose criminal convictions that they have ever had or since the inception of the State's Medicaid program as specified by the regulation. Since the State is not collecting this information, such disclosures cannot be reported to the HHS-OIG, as required by the regulation.

Recommendations: Modify disclosure forms to capture the regulatory language "since the inception of the program" or add the qualifier of "ever" as required under the regulation.

The State does not report any adverse actions taken on provider applications to HHS-OIG.

The regulation at 42 CFR 1002.3(b)(3) requires reporting to HHS-OIG any adverse actions a State takes on provider applications for participation in the program.

The State is notifying HHS-OIG of terminations of providers for fraud, integrity, or quality reasons. However, the State is not notifying HHS-OIG of other adverse actions such as denials or situations where an individual or entity voluntarily withdraws from the program to avoid a formal sanction in accordance with the regulation.

Recommendation: Develop procedures to notify HHS-OIG of all program integrity-related adverse actions taken on a provider's participation in the Medicaid program including denials and voluntary withdrawals to avoid a formal sanction.

The State does not provide notice of exclusion consistent with the regulation.

Under the regulation at 42 CFR 1002.212, if a State agency initiates exclusion pursuant to the regulation at 42 CFR 1002.210, it must provide notice to the individual or entity subject to the exclusion, as well as other State agencies; the State medical licensing board, as applicable; the public; beneficiaries; and others as provided in 1001.2005 and 1001.2006.

When initiating permissive exclusions, Kentucky does not provide notice to the State medical licensing board and the public as required by the regulation. The State maintains a list of excluded² providers on its website for notifying the public, beneficiaries, other providers, and other State agencies of its State-initiated excluded providers. However, the website does not inform the user of the scope or the effect of the provider exclusion as required by the regulation.

Recommendations: Develop and implement policies and procedures to ensure that the applicable medical licensure board is notified of a State-initiated exclusion. Modify the public notice on the website to include the reason for and the time frame of the exclusion so the public is aware that no Medicaid monies will be paid for services provided by excluded provider.

Vulnerabilities

The review team identified one area of vulnerability in the State's practices regarding not having adequate written policies and procedures for oversight of managed care.

Not having adequate written policies and procedures for the oversight of managed care.

Under the regulation at 42 CFR 455.13, the State Medicaid agency must have methods and criteria for identifying and investigating suspected fraud cases. The regulations prescribe additional requirements for the effective functioning of the States' Medicaid program integrity operations. Kentucky does not have written policies and procedures for program integrity functions for managed care. The shortage of written policies and procedures leaves the State vulnerable to inconsistent operations and ineffective functioning in the event the State loses experienced program integrity or provider enrollment staff.

Kentucky's managed care program expanded as of November 1, 2011. The State now offers managed care services on a statewide basis. With the expansion, a new branch within DMS was created to provide oversight of the MCEs. During the review, the State was unable to provide the review team with operational policies and procedures related to oversight of managed care program integrity activities.

Recommendations: Develop and implement policies and procedures to ensure coordination and communication across the Medicaid program. Protocols addressing provider enrollment, fraud and abuse detection, investigations and law enforcement referrals should include mechanisms for tracking and reporting program integrity activities.

² For reporting purposes, CMS refers to State actions in accordance with this regulation as "terminations" whether the State calls them "terminations" or "exclusions."

CONCLUSION

The identification of seven areas of non-compliance with federal regulations is of concern and should be addressed immediately. In addition, one area of vulnerability was identified. The CMS is particularly concerned over the two uncorrected partial repeat findings and one uncorrected repeat finding. The CMS expects the State to correct them as soon as possible.

To that end, we will require Kentucky to provide a corrective action plan for each area of non-compliance within 30 calendar days from the date of the final report letter. Further, we will request the State include in that plan a description of how it will address the vulnerability identified in this report.

The corrective action plan should address how the State of Kentucky will ensure that the deficiencies will not recur. It should include the timeframes for each correction along with the specific steps the State expects will occur. Please provide an explanation if correcting any of the regulatory compliance issues or vulnerabilities will take more than 90 calendar days from the date of the letter. If Kentucky has already taken action to correct compliance deficiencies or vulnerabilities, the plan should identify those corrections as well.

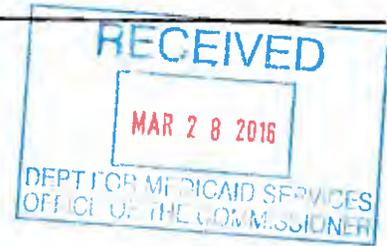
The State of Kentucky applies some noteworthy and effective practices that demonstrate program strengths and the State's commitment to program integrity. The CMS supports the State's efforts and encourages it to look for additional opportunities to improve overall program integrity. The MIG looks forward to working with the State of Kentucky on correcting its areas of non-compliance, eliminating its area of vulnerability, and building on its effective practices.

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

MAR 13 2016



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

Dear Commissioner Miller:

The Centers for Medicare & Medicaid Services (CMS) received your request, dated March 11, 2016, for a temporary extension of Kentucky's Non-Emergency Medical Transportation (NEMT) 1915(b) waiver program under CMS control number KY-06.R01. The current temporary waiver authority expires on March 31, 2016.

You have requested this extension to ensure CMS has adequate time to review the state's responses to the Request for Additional Information (RAI), revised waiver renewal application and cost effectiveness spreadsheets, submitted on March 8, 2016.

The CMS is granting an extension of the KY-06.R01 waiver to operate the NEMT program under section 1915(b) of the Social Security Act (the Act). This temporary extension will expire on June 30, 2016.

The CMS will continue to work with your staff during the extension period. If you have any questions, please contact Melanie Benning, in the Atlanta Regional Office, at (404)562-7414 or Lovie Davis, of my staff, at (410) 786-1533.

Sincerely,

Alissa Mooney DeBoy
Deputy Director

cc: Melanie Benning, Atlanta Regional Office
Melanie Johnson, Atlanta Regional Office
Jackie Glaze, Atlanta Regional Office

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 that reads 'Kristin Fan'.

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.

2. Acute Care Hospital Services

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.

2. Acute Care Hospital Services

- 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.

2. Acute Care Hospital Services

- (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.

2. Acute Care Hospital Services

- 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.

2. Acute Care Hospital Services

- 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.

2. Acute Care Hospital Services

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.)

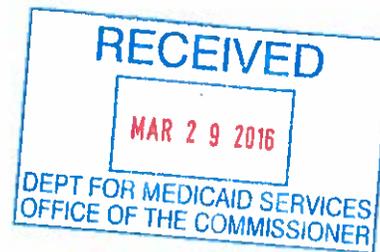
DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Chicago Regional Office
233 North Iowa Avenue, Suite 600
Chicago, Illinois 60601



Consortium for Medicaid and Children's Health Operations

March 28, 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:

Per 42 CFR § 495.364, CMS is charged with conducting periodic reviews of states' progress with their Medicaid EHR Incentive Program and related HITECH activities and programs. This letter is to inform you that CMS plans to conduct an in-person onsite visit with your state on June 8, 2016 through June 9, 2016.

The purpose of the review is threefold:

1. To determine if the state is meeting the requirements of the HITECH regulation and ensure that all requirements have been met for any and all periods for which the state may claim 90 percent enhanced Federal Financial Participation (FFP).
2. To assist and provide in-depth technical assistance in implementing the program, including identification of areas of improvement and best practices.
3. To provide CMS and the state with a global perspective and targeted feedback on how the program is being operated at the state level and how it can be improved.

The onsite review will last approximately 2 days, starting with an entrance conference on the morning of day one and ending with a debrief to the state on preliminary findings on the afternoon of day two.

Generally, the site visit will consist of the following elements:

- Evaluation of the EHR Incentive Program to verify that the federal and state requirements are satisfied
 - Demonstration of the provider attestation system (EP and EH)
 - Demonstration of the internal workflow/payment systems
 - Walkthrough of the audit process

- Review state-specific workflow and initiatives
- Meetings with key stakeholders
- CMS team shares specific findings that identify resolutions for areas of improvement
- State staff meet with CMS staff for Q&A
- CMS conducts meetings with State Medicaid Director, HIT Coordinator, HIE Director and lead EHR staff to discuss the future of the HIT program in the state.
- Discussion on opportunities and challenges of future versions of Meaningful Use
- CMS debriefs state on preliminary findings

The following CMS HITECH Team representatives will participate in the site visit:

Alejandra Johnson, Atlanta Regional Office
 Enitan Oduneye, Atlanta Regional Office
 Amy Osborne, CMS - Contracted Medicaid EHR Team
 Bob Nowell, CMS - Contracted Medicaid EHR Team

To ensure that both CMS and the state are working from the most up-to-date documentation for review and preparation purposes, prior to the visit, please send your Regional HITECH Coordinator your state's most recent:

- Approved SMHP
- Approved IAPD
- Approved Audit plan
- RO Quarterly Data Tool report
- Annual Data Reporting Tool

In addition, we will be sending you a Pre-visit Checklist to be completed and returned to CMS at least two weeks in advance. That checklist will help CMS assess the status of the following program areas:

- SMHP
- IAPD
- Contracts
- Audit Strategy
- EHR Operations
- Implementation
- Payments
- HIE Status
- Public Health Status
- Security & Privacy

During the onsite visit, we would like to conduct interviews with many of your key HIT stakeholders. Please include the following individuals or organizations in your state's visit.

- Medicaid Director
- Medicaid EP
- Medicaid EH
- EP/EH Association
- Vendors engaged in conducting any EHR activities
- Regional Extension Center

CMS sent your staff a draft agenda on March 23, 2016 with proposed times to meet with pertinent stakeholders and to review your EHR Incentive Program system, workflows and processes. We would also like to conduct a pre-site visit conference call to ensure that the site visit is most productive. This call will be scheduled with the state team up to 2 weeks in advance of the site visit and is tentatively scheduled for May 25, 2016 at 9:00 AM EDT.

Thanks in advance for your participation. If you or your staff members have any questions, please contact Alejandra Johnson at (404) 562-1736, or via e-mail at alejandra.johnson@cms.hhs.gov.

Sincerely,



Jackie Garner
Consortium Administrator

cc:

Jessica P. Kahn, Director, Division of State Systems
Jackie Glaze, Associate Regional Administrator, CMCHO, Atlanta Regional Office
Dzung Hoang, CMS HITECH Program Manager
Sam Schaffzin, CMS HITECH Technical Director
Enitan Oduneye, CMS HITECH Team
Stacy Fish, KY Director of Medicaid Systems
Carla Y. Cooper, KY EHR Incentive Program Project Manager
Polly Mullins-Bentley, KY State HIT Coordinator
Ed Walden, KY Technical Contact

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



SMD# 16-004

**RE: Mechanized Claims Processing and
Information Retrieval Systems-Enhanced
Funding**

March 31, 2016

Dear State Medicaid Director:

This letter provides guidance concerning the enhanced federal match rate, and other federal match rates, for various activities related to Medicaid Information Technology (IT) in both Medicaid Management Information Systems (MMIS) and Medicaid Eligibility and Enrollment (E&E) Systems, including the use of Commercial Off-the-Shelf (COTS) software. This guidance is set out in the letter itself and the appendices, which include answers to frequently asked questions.

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 eligibility and enrollment 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 enhanced federal financial participation (FFP) for E&E systems will ensure that states have the resources necessary to complete and maintain updated IT systems. We anticipate states will use these resources to further integrate with Marketplace systems and human service program systems, while retiring outdated legacy systems. CMS expects that up-front investments in the newly developed systems will reduce long-term costs due to the technological efficiencies that will provide an enhanced consumer experience.

This final rule provides for an FFP rate of 90 percent for state expenditures for DDI of Medicaid solutions that include COTS, subject to review and approval by CMS. We believe that the use of modular development provides the most efficient and cost-effective long-term solution for states' business needs. Modular development may include COTS products or Software-as-a-Service (SaaS) solutions as well as other modular approaches.

Conditions for Receipt of Enhanced Rate of FFP for Medicaid E&E Systems

The conditions specified in § 433.112(b) apply to Medicaid E&E systems. Medicaid E&E systems are also subject to the Medicaid Information Technology Architecture (MITA) conditions and standards, and must meet Critical Success Factors (CSFs) and other performance standards to qualify for the enhanced match rate. See: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/Downloads/EFR-Seven-Conditions-and-Standards.pdf>.

Reimbursable Activities and FFP Rates for Medicaid E&E Systems

The federal matching rates for Medicaid E&E systems are the same rates applicable to the other component of mechanized claims processing and information retrieval systems, the MMIS. Those matching rates are 90 percent for DDI and 75 percent for M&O. Below are examples of activities that would qualify for each enhanced match rate. These examples are meant to clarify the final rule and provide guidance to states.

Examples of activities that qualify for 90 percent enhanced rate of FFP include:

- Planning activities, including impact assessments, gap analyses, proof of concepts, requirements analyses (functional/business and technical), and any preparation activities necessary for the implementation/administration/operations;
- Performing a MITA State Self-Assessment (SS-A);
- Interfaces and establishing connectivity (e.g., system to web-based portal);
- Integration and configuration activities to interact with software solutions or applications;
- Preparation and development or enhancement of contingency plans, business continuity plans, disaster recovery plans and security plans;
- Initial software leasing/licensing (including SaaS and COTS); and
- Configuration and minimal customization of COTS software.

Examples of activities that qualify for the 75 percent enhanced rate of FFP include:

- System and/or software maintenance (in-house and/or contract);
- Web-based portal and technology maintenance (in-house and/or contract);
- System(s) and web-based portal operation (in-house and/or contract);
- On-going software leasing or licensing;
- On-going proprietary software leasing or licensing; and
- Training of personnel directly engaged in the operation of a system, including workers processing claims or determining eligibility.

Please refer to Appendix A- *List of Reimbursable Activities and Eligible Federal Financial Participation Rates* for an updated list of activities and corresponding match rates. Refer to Appendix B- *M&O Rates for Medicaid E&E Systems* for more detailed information specific to FFP rates for Medicaid E&E systems activities.

Enhanced FFP for COTS Software and Commercially Available Hosted Solutions

States are encouraged to use existing software, such as COTS and commercially-available hosted solutions (e.g., SaaS) in their Medicaid IT solutions where such use can be shown to be efficient and economical in comparison to other alternatives. “COTS software” means specialized software (which could be a system, subsystem or module) designed for specific applications that is available for sale or lease to other users in the commercial marketplace, and that can be used with little or no modification.

The Medicaid Information Technology Architecture (MITA) model encourages states to move to standardized, service-oriented COTS products and away from the kind of heavily-customized solutions that were common in the past. COTS software, if not overly-customized, supports modularity and enables other states to leverage successful solutions. A modular, flexible approach to systems development, including the use of open interfaces and exposed application programming interfaces (APIs) facilitates the separation of business rules from core programming. We are encouraging states to make their business rules available in both human and machine-readable formats to further facilitate sharing. MITA requires state solutions to promote sharing, leverage, and reuse of Medicaid technologies and systems within and among states.

While preference will not be given to COTS software over other MITA-compliant solutions (such as open source technologies or cloud-based services), CMS promotes consideration of COTS products and SaaS solutions as options for states pursuing development of Medicaid IT systems leading to more efficient, economical, and effective State Medicaid Plan administration.

CMS will review APDs that propose use of the enhanced FFP match for COTS products and commercially-available hosted solutions to determine whether the proposed solutions are more efficient and economical than other available alternatives. These solutions may be employed for full systems or for specific modules or components within a system (e.g., business rules engine,

notices subsystem). The costs of COTS software implementation which are eligible for enhanced funding include:

- At the 90 percent federal matching rate -- the initial licensing fees, and minimum necessary costs to analyze the suitability of COTS or hosted software, installation, configuration and integration of the COTS or hosted software solution, and modification of existing state software to ensure interoperability and coordination of operations.
- At the 75 percent federal matching rate -- ongoing licensing fees during M&O, including usual and customary charges for routine software updates or upgrades, and any associated modifications to customization that might be required.

Use of COTS or SaaS as Efficient and Economical

To document that the use of COTS or a commercially available hosted software solution is efficient and economical, the APD should explain the benefits to the project in terms of minimizing time and costs to implement and make improvements to operations, as well as lower long-term maintenance and operations costs. The APD analysis of these benefits should include a comparative analysis of alternatives. The purpose of the alternatives analysis is to show why the proposed solution results in the most efficient and economical choice for the Medicaid program, compared to other potential solutions. This analysis should be sufficiently clear to support an audit or other oversight review. The analysis should contain data relative to “cost of ownership” and “return on investment” considerations and also include long-term costs to be incurred during M&O. The state should also discuss their decision whether the use of a particular solution will result in any dependencies that create a “lock in” for future procurements. Such dependencies are in conflict with imperatives for modularity and interoperability.

The benefit of COTS or SaaS is that it provides sufficient capabilities so that modification for the intended use is straightforward. Software and hardware solutions must be selected based upon the capabilities and requirements identified during the DDI phase of the project. In instances where multiple solutions exist, only those modules which address defined requirements should be selected. The software which meets the highest number of technical function points without modification of the commercial code is typically the optimal technical solution, although the total cost of ownership must be taken into account. A gap analysis is useful to understand the extent to which a given COTS or SaaS product meets functional and technical requirements.

Configuration and Customization of COTS Software

Regulations at 42 CFR § 433.112(c)(2) provide that COTS-related development costs at the enhanced match rate may only include the initial licensing fee and the minimum necessary to install, configure, and customize the COTS software and ensure that other state systems coordinate with the COTS software solution. When responding to a request for the 90 percent FFP rate for a COTS product, CMS will consider whether the configuration and customization of the product would be kept to minimal levels to achieve full functionality in the most cost-effective manner.

Configuration and testing may be required as part of the DDI phase of systems development to ensure the COTS software performs correctly within the state's Medicaid environment. Configuration pertains only to the functionality included in the core software or complimentary software or applications designed specifically to work with that solution. It does not require modification of any of the underlying source code for the COTS software itself. Examples include population of reference data, setting of parameters, definition of business rules, and work flow settings. COTS software configuration costs are matched at 90 percent.

A condition for enhanced funding of COTS software is that customization of the product is minimal. Examples of minimal customization include modification of database interactions to include additional required data elements, processing of state specific but necessary business rules, and modification of interfaces to allow interoperability with existing systems or modules. If a COTS product is heavily customized, then the solution may become so unique to that state that other states are unable to reuse it, or that newer releases of that software cannot be easily integrated into the state's system, resulting in a solution that no longer meets the MITA conditions.

For each project incorporating COTS software the APD should include the following:

- Clearly delineated costs for configuration and customization;
- Detailed description of the configuration of the COTS product for the proposed installation;
- An outline of customization for the COTS solution, including high-level activities and their associated costs; and
- Description of cost allocations of COTS products between DDI and M&O. Significant enhancements or new functionality may be considered DDI subsequent to release of a system to M&O, only if adequate justification is provided.

Ownership and Royalty-Free Licensing

COTS products and SaaS solutions are designed, developed, and licensed by the vendor, so the state is not entitled to ownership rights to the core program. When the enhanced match is used for COTS configuration or customization, those elements become subject to existing regulation at 45 CFR § 95.617 regarding state and federal ownership and royalty-free licensing. The requirement for a royalty-free, non-exclusive and irrevocable license to software referenced in 45 CFR § 95.617(b) applies only to the software related to the customization and configuration of a COTS product for state use and does not apply to the core product. This means that states could freely share and reuse the resulting COTS software configuration and customization, subject to licensing of the core COTS software products. Contract documents submitted pursuant to an approved APD must clearly specify what is being reused or shared.

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 E&E systems and certain other reimbursement rules, until such time as the SMM is updated. 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:

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

Appendix A

List of Reimbursable Activities and Eligible Federal Financial Participation (FFP) Rates

Related Activity, Scope, Content and/or Definition	FFP Rate	
Section 1: Planning		
Contractor services	90%	
Facility and equipment (i.e., work spaces, software tools, etc.)		
Meetings directly tied to system planning		
Participation in workgroups directly tied to system planning		
Planning, including impact assessments, gap analyses, proof of concept activities, requirements analyses (functional/business and technical), and any preparation activities necessary for the implementation/administration/operations		
Preparation and development of the APD, RFP, and other related procurement instrument(s) for the implementation, enhancement, and/or operation phase		
Preparation and development of the related planning Request for Proposal (RFP) for vendor and consulting services		
Procurement and acquisition (i.e., solicitation, evaluation, negotiation, contract selection, etc.)		
RFP-related services contract		
State personnel directly engaged in planning activities		
Travel directly tied to planning		
Section 2: Implementation		
User Acceptance testing		90%
Contractor Services for DDI		
DDI activities		
Data conversion when transitioning from one system to another		
Hardware, equipment and supplies for DDI (prorated between DDI and M&O)		
Facility for DDI (prorated between DDI and M&O)		
Initial software leasing/licensing		
Integration/configuration activities including business process engineering to install a COTS and/or SaaS and/or hosted solution		
Procurement of new releases of COTS products that were matched at 90%		
Interfaces and connectivity		
Development and/or update of state-owned database and/or software to facilitate conversion of data format		
System integration/interfaces with Medicaid E&E system and/or MMIS		

Section 2: Implementation, continued	
Independent Verification and Validation (IV&V) services contract	90%
Installation, reconfigurations and/or modifications of transfer systems necessary to meet state specific requirements, including testing, data conversion, system stabilization (see above for other implementation activities eligible for 90/75/50 rates)	
Approved customization of COTS software	
Participation in workgroups directly tied to system implementation	
Preparation and development of the implementation APD, RFP, and other related procurement instrument(s) if applicable (i.e., no planning phase APD performed)	
Preparation and development/enhancement of contingency/business continuity/disaster recovery/security plans.	
Procurement and acquisition (i.e., solicitation, evaluation, negotiation, contract selection, etc.)	
Project Management/Quality Assurance services contract	
Site preparation	
Software tool(s) for DDI	
State personnel directly engaged in DDI	
DDI on Asset Verification Systems (AVS)	
Travel directly tied to system implementation	
Documentation and publications (i.e., creation of training for users and business partners)	
Ongoing software leasing/licensing only for system integration and configuration activities.	
Ongoing hosted solution costs only for system integration and configuration.	
Configuration and/or update of cloud-hosted database	
System User Training (directly tied to system usage)	

Section 3: Maintenance & Operations (M&O)	
Call center, i.e., customer/provider relation functions (in-house and/or contract) directly related to systems operation (issues related to eligibility determination/maintenance and claims processing).	75%
Costs of the Operations environment	
Facility and equipment (direct non-personnel costs, i.e., work spaces, software tools, etc.)	
Hardware update purchase/lease for operations	
Ongoing proprietary software leasing or licensing including COTS/SaaS	
Ongoing repetitive cyclic conversion of data	
Production of notices, reports, including MARS and SURS documents, or Medicaid/CHIP ID cards, including eligibility letters, EOBs, Form 1095Bs, 1099s, Remittance Advices etc.	
Provider outreach and training related to systems operation (for example, training on claims submissions, claims processing, and eligibility inquiries).	
Publications necessary for the operation of the system, i.e., paper application, user manual, etc.	
System and/or software maintenance (in-house and/or contract)	
System(s)/Web-based Portal operation (in-house and/or contract)	
Training of personnel directly engaged in the operation of an approved system, including workers processing claims or determining eligibility	
Salary, fringe and other direct costs for personnel engaged in determining eligibility, as specified in Appendix B.	
Regular Program Administrative Costs (i.e., audit)	
End-user/Business User training for personnel NOT directly engaged in eligibility determinations	
Facility and equipment (indirect non-personnel costs, i.e., work spaces, software tools, etc.)	
Indirect personnel costs	
Postage	
Section 4: MITA	
In-house and/or contractor to perform a Medicaid enterprise MITA SS-A	90%

Appendix B

M&O Rates for Medicaid E&E Systems

E&E Activities Matched at 75% FFP

Application, On-going Case Maintenance, and Renewal activities including line staff, supervisory staff and support staff for the following:

- **Intake-** Application/data receipt and activities related to receipt of the application or data related to applications.
- **Acceptance** - Edits, verification and resolution of inconsistencies- Manual and automated edits and verification of data.
- **Eligibility determinations** - Activities related to utilizing the automated eligibility determination system in the evaluation of the edited, verified data to make an eligibility determination.
- **Outputs** - Issuance of eligibility notices to the customer, file updates and transactions to partners, such as the Federally-Facilitated Marketplace (FFM), State Based Marketplaces (SBMs), Managed Care Organizations (MCOs), Point of Sale (POS) vendors, etc. Mailing of notices is matched at 50 percent.
- **On-going case maintenance** - Includes intake activities related to renewals and receipt of data related to the ongoing-eligibility and maintenance of a beneficiary's eligibility, such as address changes, income changes, and household composition changes. Does not include verification activities that occur after enrollment.
- **Customer service** - Call center activities related to receipt of data required for an initial eligibility determination and the ongoing-eligibility and maintenance of a beneficiary's eligibility, but not verification activities, as described above. Costs of call center staff are eligible at the 75 percent rate only for activities related to eligibility determination or on-going case maintenance.

Those call center functions related to benefits, general beneficiary education, plan choice and enrollment are eligible at the 50 percent FFP level. Costs of call center staff should be allocated based on the portion of staff time spent performing functions eligible at the 75 percent rate versus those eligible at the 50 percent FFP levels.

- **Maintenance and Routine Updates** - Routine system maintenance, security updates, automated re-running of eligibility based on updates of standards and program rules, and other routine maintenance activities related to the Eligibility Determination System.

E&E Activities Matched at 50% FFP

Activities which precede the eligibility determination such as outreach, application assistance, etc. and activities subsequent to the eligibility determination such as appeals, reports, etc.:

- **Outreach and Marketing** - Includes general public outreach, beneficiary education and outreach, explanations of eligibility policies, programs and benefits, plan choice counseling and plan enrollment.
- **Policy research and development** - Even if related to the eligibility determination standards and methodologies.
- **Staff development and training** - Even if related to eligibility determination, except for Operational Readiness training for new systems.
- **Community-based application assistance** - Such as assisting with application completion and navigation, etc.
- **Program integrity** - Includes audits and investigations, PERM, MEQC, and any other quality assurance activities.
- **Eligibility verification and validation functions unrelated to the operation of electronic systems** – Includes citizenship/immigration and income verification activities other than electronic data matching operations, and any other administrative verification activities that occur after the individual is enrolled and do not involve any electronic operations.
- **Formal appeals of eligibility decisions** - Includes accepting and processing appeals, and hearings, and decisions if rendered by the State Medicaid Agency.
- **Customer service** - Includes call center activities and out-stationed eligibility worker activities related to areas such as beneficiary education, benefits, plan choice and enrollment, civil rights complaints, appeals.

Appendix C
Frequently Asked Questions and Answers

Q1: How should states report 75 percent Medicaid Eligibility and Enrollment (E&E) system maintenance and operations (M&O) activity expenditures on the CMS-64-10 and CMS-37-10?

- A1:** The CMS-64-10 and CMS-37-10 forms capture Medicaid E&E systems M&O expenditures. Such expenditures are tracked separately as follows:
- M&O expenditures for Medicaid E&E systems, excluding eligibility workers, are reported on the CMS-64.10 and CMS-37.10 on Line 28C – Operation of an approved Medicaid Eligibility Determination System/Cost of In-house Activities and Line 28D – Operation of an approved Medicaid Eligibility Determination System/Cost of Private Sector Contractors.
 - Expenditures for Eligibility Determination Workers eligible for enhanced match are reported on the CMS-64-10 and CMS-37-10 on Line 28E - Eligibility Determination Staff– Cost of In-house Activities and Line 28F- Eligibility Determination Staff– Cost of Private Sector Contractors.
 - Expenditures for Eligibility workers eligible at the standard administrative match of 50 percent are reported on the CMS-64.10 and CMS-37.10 on line 28G – Eligibility Determination Staff – Cost of In-house Activities and Line 28 H – Cost of Private Sector Contractors.
 - As with all expenditures, federal match must be properly claimed and is subject to review and approval. CMS will work closely with each state to review and approve costs and confirm specific implementation details before states submit claims.

Q2: When can the 75 percent Federal Financial Participation (FFP) rate for M&O for Medicaid E&E systems begin? When does it end?

- A2:** Eligibility for the enhanced 75 percent FFP rate will be based on state systems being compliant with the Seven Conditions and Standards and meeting minimum CSFs. The enhanced 75 percent FFP rate will be available when the approved system becomes operational but not earlier than October 1, 2013. In order to begin claiming, states must submit an Operational APD Update to CMS that clearly identifies the functions, staff and costs to be charged at the 75 percent FFP level. The Operational APD Update must be approved by CMS before a state can begin claiming the enhanced match. The availability 75 percent FFP rate does not expire.

Q3: Does the 75 percent FFP rate apply to program integrity activities associated with eligibility and enrollment?

A3: No, program integrity activities are matched at the standard administrative match of 50 percent, including activities performed post-eligibility and normally initiated as part of a sampling approach, including audits, Payment Error Rate Measurement (PERM) or Medicaid Eligibility Quality Control (MEQC) activities. Such costs are usually indirect costs, including the staff costs associated with agency-wide functions such as accounting, budgeting, and general administration. The Operational APD Update must include an allocation or distribution plan showing the breakout of direct and indirect costs for equipment, supplies, and non-personnel resources it intends to claim, along with justifications.

Q4: What aspects of the COTS solution will be subject to the requirements regarding royalty-free licensing?

A4: COTS products developed by the vendor will continue to be owned by the vendor since they developed the software without federal funding. Configuration and any customization related to the COTS product installation will be owned by the state as it will have been developed with enhanced DDI funds (90 percent FFP rate). The state and federal government will have a royalty-free license, per 45 CFR 95.617, that allow the sharing of the configuration and customization of the COTS product with other state Medicaid programs. Other states are still responsible for any license fees for the core COTS software product.

Q5: Are lump sum licensing costs eligible for the 90 percent FFP rate?

A5: The initial licensing cost required for installation of the COTS product is eligible for 90 percent FFP. However, such costs may only include licensing for the product during the DDI phase. Licensing costs for use during the M&O phase are matched at 75 percent. Lump sum licensing costs should be allocated over the entire licensing period, and only the portion that is attributable to the DDI phase would be eligible for 90 percent FFP. The remaining costs would be eligible for 75 percent FFP.

The subscription model calls for periodic payments instead of a lump sum payment. It may be preferable when a state does not want to deploy the COTS software within its E&E or MMIS environment, as in a software as a service (SaaS) arrangement. Federal match rates of 90 percent for DDI and 75 percent for M&O will apply equally to COTS and all commercially available software including SaaS.

Q6: What is the definition of “minimal customization”?

A6: The regulation does not include a definition of “minimal customization.” Accordingly, CMS will consider each request for the 90 percent FFP rate for COTS solutions individually. When evaluating if the proposed customization is minimal, CMS will consider the cost, size, nature, and scope of the product. It is incumbent upon the state to fully describe and justify the required configuration and customization in the APD to receive approval for the 90 percent FFP rate.

Q7: Does the information in this letter apply to CHIP programs?

A7: The funding described in this letter applies to all Medicaid systems including those that are fully integrated with and support CHIP programs. The enhanced funding does NOT apply to stand-alone CHIP programs that are not fully integrated with Medicaid.

Q8: Is the exception to the cost allocation requirements set forth in the Office of Management and Budget (OMB) Circular A-87, Section C.3 and 2 CFR 200.405 of the superseding “Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards” going to be continued permanently, similar to the 90/10 funding?

A8: No, the exception to the cost allocation requirement is not permanent. This exception has been extended only through December 31, 2018. The July 20, 2015 Tri-Agency letter provides details on the extension and can be found at <https://www.medicaid.gov/federal-policy-guidance/downloads/SMD072015.pdf>.

CMS expects that this extension of the exception to certain OMB cost allocation requirements, along with the permanent extension of enhanced Federal funding for Medicaid systems, will provide states additional time needed to integrate the additional human service programs. However, states must consider the expiration of the A-87 exception on January 1, 2019, and plan future activities and funding accordingly.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, Maryland 21244-1850



Children and Adults Health Programs Group

APR 06 2016

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



Dear Mr. Miller:

This letter is in response to Kentucky's request for a waiver, under section 1902(e)(14)(A) of the Social Security Act (the Act) that will assist the state as it implements provisions of the Affordable Care Act. The state's request was further clarified through teleconferences and email correspondence with the Centers for Medicare and Medicaid Services (CMS). Your request is approved, as described and subject to the conditions described below.

This letter authorizes the state, under section 1902(e)(14)(A) of the Act, to delay Medicaid and CHIP renewals scheduled for April 1, 2016, through May 31, 2016, for 90 days, such that renewals scheduled for April 2016 will be completed by July 31, 2016, and those scheduled for May 2016 will be completed by August 31, 2016. Beneficiaries determined eligible at renewal will be renewed until their next originally-scheduled renewal date, in April or May 2017.

Kentucky is experiencing significant system challenges resulting from the state's recent deployment of its new integrated eligibility and enrollment system for human services, *benefind*. As noted in your request, these unanticipated systems issues have prevented the state from processing Medicaid and CHIP applications and renewals in a timely manner, as required by Medicaid and CHIP regulations. In addition, system defects identified in the state's eligibility and enrollment system have resulted in a large volume of cases requiring manual processing, ultimately impacting the state's timely processing.

The CMS has determined that the authority granted in this letter is necessary to protect Medicaid and CHIP beneficiaries in light of the significant systems challenges resulting from the implementation of *benefind*. As such, the authority is granted only to the extent to which the state requires additional time to resolve critical defects in its eligibility and enrollment systems and complete processing of the current backlog of Medicaid and CHIP applications and renewals. The CMS systems analyst for Kentucky will monitor the state's progress toward resolution of these critical system issues as part of the Systems Development Life Cycle Process.

The authority provided in this letter is subject to the conditions described above and CMS receiving your written acknowledgement of this approval and acceptance of these new authorities within 30 days of the date of this letter.

Page 2 – Stephen P. Miller

If you have questions regarding this approval, please contact Ms. Judith Cash, Director, Division of Eligibility and Enrollment, Children and Adults Health Programs Group, Center for Medicaid & CHIP Services, at (410) 786-4473 or judith.cash@cms.hhs.gov.

Sincerely,

A handwritten signature in black ink, appearing to read "Anne Marie Costello". The signature is fluid and cursive, with the first name "Anne" being the most prominent.

Anne Marie Costello
Acting Director

cc: Jackie Glaze, Associate Regional Administrator, Region IV
Jessica Kahn, Director, Data and Systems Group

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

April 8, 2016

Mr. Stephan P. Miller, Commissioner
Department for Medicaid Services
Attn: Leslie Hoffman
275 East Main Street, 6WA
Frankfort, KY 40621-0001



RE: 372 Acceptance letter

Dear Mr. Miller,

We have completed our review of your CMS 372 annual report for the Home and Community-Based Services (HCBS) Waiver listed below. Based on our analysis of the expenditure and recipient data submitted in this report, we find the data acceptable, subject to any future data validation reviews. A comparison of the actual data reported to the most recent CMS-approved estimates indicates that the estimated costs without the waiver were not exceeded.

- **KY 0477 R01 ABI Long Term Care HCBS Waiver**
(Waiver Year 3 – 07/01/2013 – 06/30/2014)

If you have any questions, please contact Catherine Cartwright at 404-562-7465.

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

cc: Amanda Hill, CMS/CO

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

April 12, 2016

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



Re: Disproportionate Share Hospital Audits and Reports Acknowledgement

Dear Mr. Miller:

This letter is in response to your December 30, 2015 submission of Kentucky's state plan rate year (SPRY) 2012 Disproportionate Share Hospital (DSH) audit and report. We appreciate the expeditious manner in which you have submitted your materials. After a cursory screening to assure basic submission standards, it appears that the minimum elements required by the DSH rule have not been included in your submission.

As you know, CMS promulgated CMS-2198-F on December 19, 2008, with an effective date of January 19, 2009. The final rule implements Section 1001 of the Medicare Drug, Improvement and Modernization Act of 2003, requiring State reports and audits to ensure the appropriate use of Medicaid DSH payments and compliance with the statutorily imposed hospital-specific limits. Statute requires that States submit an annual report and an independent certified audit in order to receive Federal Financial Participation (FFP). Additionally, CMS promulgated CMS-2315-F on December 3, 2014, which applies to audits beginning with SPRY 2011. The rule modified the definition of uninsured for purposes of Medicaid DSH from an individual-specific basis to a service-specific basis.

To facilitate the audit and reporting process, CMS issued to states the following guidance relating to the final rule (these materials are available on the CMS website at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Financing-and-Reimbursement/Financing-and-Reimbursement.html>):

- General DSH Audit and Reporting Protocol
- DSH Report Format
- Operational Guidance Letter dated July 27, 2009

- Additional Information on the DSH Reporting and Audit Requirements
- Additional Information on the DSH Reporting and Audit Requirements – Part 2

In the spirit of this cooperative relationship, CMS has conducted a cursory screening of the state's initial December 30, 2015 submission and acknowledges receipt of the following:

- Independent Accountant's Report from Myers and Stauffer LC for SPRY 2012;
- Findings related to the Six Verifications of the Disproportionate Share Hospital Payments Final Rule for the Medicaid SPRY 2012; and
- Disproportionate Share Hospital Data Reporting Form for SPRY 2012.

Upon review of the state's current submission, CMS has determined that the submission does not 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. This acknowledgement of receipt and cursory screening, however, does not constitute notice of a completed review or approval of the content of the State's submission. The specific area(s) of concern is/are as follows:

- Providers did not report accurate charges of uninsured patients.

Some hospitals were unable to provide any payments or only provided a partial year of payments. These payment issues may result in a misstated uncompensated care cost calculation. One hospital was able to estimate the uninsured services provided and payments received using hospital records; however, no detail data is available. Due to lack of detailed data, the Auditors were unable to fully test the reasonableness of the hospital's estimates

The cursory screening was conducted based only on the submitted materials listed above. CMS recognizes that the state may have included in its initial submission only materials that it determined relevant. CMS encourages the state to submit any additional material or supporting documentation that was not originally included with the initial submission.

In order to receive FFP for DSH expenditures, Kentucky must submit an annual report and an independent certified audit to CMS for SPRY 2012 that meets federal statutory, regulatory, and policy requirements. Once CMS has determined that the minimum elements required by the DSH rule have been submitted, CMS will complete its preliminary review of the state's submission. Upon completion of its preliminary review, CMS will conduct an in-depth review of audits and reports. CMS may have additional questions that will be addressed to states at that time, including requests for additional documentation to support the audits and reports and the use of the General DSH Audit and Reporting Protocol.

Please note that to the extent that audit findings demonstrate the DSH payments exceed the documented hospital-specific limits, these payments will be treated as overpayments to providers that, pursuant to 42 CFR Part 433, Subpart F, trigger the return of the federal share to the federal government. Any portion of overpayments not returned to CMS within one year of discovery are subject to disallowance per 42 CFR 430.42 and imputed interest per 42 CFR 433.320(a)(4). However, if the excess DSH payments are redistributed by the state to other qualifying hospitals

as an integral part of the audit process, and in accordance with a federally approved Medicaid state plan provision, the federal share is not required to be returned.

The federal portion of overpayments not subject to redistribution must be returned in accordance with 42 CFR Part 433 Subpart F. 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 year in which the original DSH payments were distributed, which would be fiscal year 2012 in the case of the audits for SPRY 2012. Finally, the state must specify if the redistribution was reflected on the SPRY 2012 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.

CMS remains committed to engaging in open dialogue with the state to discuss this preliminary review and provide technical guidance, as necessary, in an effort to ensure that any adverse financial impact on the Kentucky Medicaid program and its hospitals is averted. Consistent with this effort, CMS would like to coordinate a conference call with the State to further discuss the above guidance and provide any other assistance necessary. In the interim, we welcome any additional information that you or your staff wish to offer. Should the state have any questions regarding the DSH rule requirements or the review process itself, please feel free to contact Stanley Fields at (502) 223-5332.

Thank you in advance for your willingness to continue working with us.

Sincerely,



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

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

April 15, 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 April 11, 2016 request from the Kentucky Department for Medicaid Services, the Centers for Medicare & Medicaid Services (CMS) is granting a 67 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 April 25, 2016. The sixth extension allows the Home and Community-Based Waiver, CMS control number 0144.R05, to continue operating through July 1, 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 make modifications to their Occupational Therapy Services, Physical Therapy Services, and Speech Therapy Services in the state plan, and transition waiver participants to those services. 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 submit the State Plan Amendment to make the changes for the physical therapy, occupational and speech therapy services in the state plan.

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

Sincerely,

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

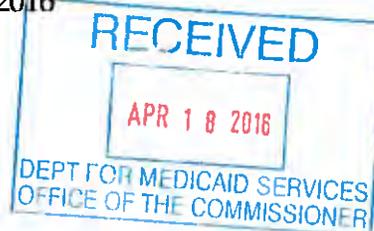
Alissa Mooney DeBoy, Deputy Group Director
Disabled and Elderly Health Programs Group

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

Disabled and Elderly Health Programs Group

April 15, 2016

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



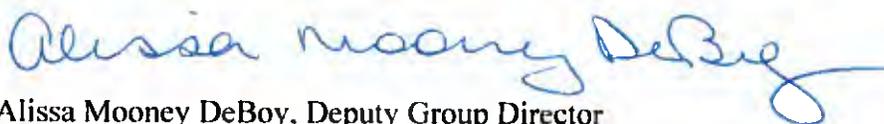
Dear Mr. Miller:

In response to the April 11, 2016 request from the Kentucky Department for Medicaid Services, the Centers for Medicare & Medicaid Services (CMS) is granting a 65 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 April 27, 2016. The fifth extension allows the Supports for Community Living Waiver, CMS control number 0314.R03, to continue operating through July 1, 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 make modifications to their Occupational Therapy Services, Physical Therapy Services, and Speech Therapy Services in the state plan, and transition waiver participants to those services. 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 submit the State Plan Amendment to make the changes for the physical therapy, occupational and speech therapy services in the state plan.

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

Sincerely,



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

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



SMD # 16-005

Re: Clarifying “Free Choice of Provider”
Requirement in Conjunction with State
Authority to Take Action against Medicaid
Providers

April 19, 2016

Dear State Medicaid Director:

The Center for Medicaid and CHIP Services (CMCS) and Center for Program Integrity (CPI) are issuing this State Medicaid Director Letter to provide guidance to state Medicaid agencies on protecting the right of Medicaid beneficiaries to receive covered services from any qualified provider willing to furnish such services when the state exercises its authority to take action against providers that affects beneficiary access to those providers, including but not limited to the denial or termination of provider enrollment, or the exclusion of providers from program participation.

Background

Under section 1902(a)(23) of the Social Security Act, Medicaid beneficiaries generally have the right to obtain medical services “from any institution, agency, community pharmacy, or person, qualified to perform the service or services required . . . who undertakes to provide . . . such services.” This provision is often referred to as the “any willing provider” or “free choice of provider” provision. Implementing regulations at 42 C.F.R. § 431.51(b)(1) require a state plan to allow a beneficiary to obtain Medicaid services from any institution, agency, pharmacy, person, or organization that is (i) qualified to furnish services and (ii) willing to furnish them to that particular beneficiary. There is an exception for beneficiaries enrolled in certain managed care plans (to permit such plans to restrict beneficiaries to providers in the managed care plan network), except that such plans cannot restrict free choice of family planning providers. See section 1902(a)(23)(B); 42 C.F.R. § 431.51(b)(1); 42 C.F.R. Part 438.

State Authority to Establish Provider Qualifications

The “free choice of provider” provision does not infringe on states’ traditional role of setting “reasonable standards relating to the qualifications of providers.” 42 C.F.R. § 431.51(c)(2). States must propose any standards relating to the qualifications of providers during the

Medicaid state plan approval process, as specified in section 1902(a)(22) of the Act. Because the “free choice of provider” provision guarantees Medicaid beneficiaries the right to see any willing and “qualified” provider of their choice, this provision limits a state’s authority to establish qualification standards, or take certain actions against a provider, unless those standards or actions are related to the fitness of the provider to perform covered medical services—*i.e.*, its capability to perform the required services in a professionally competent, safe, legal, and ethical manner—or the ability of the provider to appropriately bill for those services. Such reasons may *not* include a desire to target a provider or set of providers for reasons unrelated to their fitness to perform covered services or the adequacy of their billing practices. The failure of a state to apply otherwise reasonable standards in an evenhanded manner may suggest such targeting. For instance, if a state were to take certain actions against one provider or set of providers, but not other similarly situated providers, it would raise questions as to whether the state is impermissibly targeting disfavored providers.

Moreover, when invoking standards that are validly related to a provider’s “qualifications,” the “free choice of provider” provision ensures that a state may not deny Medicaid beneficiaries the right to see the provider of their choice unless there is a sufficient basis. A state’s action against a provider affecting beneficiary access to the provider must be supported by evidence of fraud or criminal action, material non-compliance with relevant requirements, or material issues concerning the fitness of the provider to perform covered services or appropriately bill for them. Taking such action against a provider without such evidence would not be in compliance with the free choice of provider requirement. If a state does not have evidence supporting its finding that a provider failed to meet a state standard, that provider remains “qualified to furnish” Medicaid services. 42 C.F.R. § 431.51(b)(1)(i).

The “free choice of provider” provision is specific with respect to the free choice of family planning providers. Consistent with the reasonable standards guidance above, states may not deny qualification to family planning providers, or take other action against qualified family planning providers, that affects beneficiary access to those providers—whether individual providers, physician groups, outpatient clinics or hospitals—solely because they separately provide family planning services or the full range of legally permissible gynecological and obstetric care, including abortion services¹ (not funded by federal Medicaid dollars, consistent with the federal prohibition), as part of their scope of practice.

Conclusion

¹ Federal Medicaid funding of abortion services is not permitted under federal law except in certain extraordinary circumstances (in cases of rape, incest, or when the life of the woman would be in danger).

Pursuant to § 431.51(b)(1)(i), states may establish provider standards or take action against Medicaid providers that affects beneficiary access to those providers only (1) based on reasons relating to the fitness of the provider to perform covered medical services or to appropriately bill for those services, and (2) with supporting evidence of the provider's failure to meet the state's reasonable provider standards. This is consistent with longstanding CMS policy that Medicaid beneficiaries are provided with competent care by qualified providers and have the same ability to choose among available providers as those with private coverage.

Providing the full range of women's health services neither disqualifies a provider from participating in the Medicaid program, nor is the provision of such services inconsistent with the best interests of the beneficiary, and shall not be grounds for a state's action against a provider in the Medicaid program.

CMS is available to work closely with each state to ensure compliance with Medicaid's "free choice of provider" provision while at the same time preserving states' authority to take appropriate actions against providers in their Medicaid programs. If you have any questions regarding this information, please contact Kirsten Jensen, CMCS Director Division of Benefits and Coverage, 410-786-8146.

Sincerely,

/s/

Vikki Wachino
Director

cc:

National Association of Medicaid Directors

National Academy for State Health Policy

National Governors Association

American Public Human Services Association

Association of State Territorial Health Officials

Council of State Governments

National Conference of State Legislatures