

## MAC Binder Section 1 – Letters from CMS

### Table of Contents with Document Summary

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

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#### **1- CMS-IPAD-TMIS funding-Ltr to SM from JG-082616:**

CMS has approved the Implementation Advance Planning Document (IAPD) submitted by CHFS for the Transformed Medicaid Statistical Information System (T-MSIS).

#### **2-CMS-MCO Rate Amendment Approval -Ltr to SM from JG-082916:**

CMS has reviewed and approved the MCO Rate Amendment; effective retroactively to July 1, 2015 and through June 30, 2016.

#### **3-CMS-SPA 16-0003-Ltr to SM from JG-091516-to SH:**

CMS is requesting more information on the Kentucky State Plan Amendment (SPA) 16-003. This amendment is to request updates to the current reimbursement methodology for Community Mental Health Centers (CMHC) and expand the services that a CMHC can provide.

#### **4-CMS-HCBS SCL MPW ABI-Ltr to SM from JG RL re extension-100616:**

CMS has denied to Home and Community Based Services waiver programs request for a 90 temporary extension to allow the state for additional time for a systemic review.

#### **5-CMS-KY HEALTH-Ltr to SM from EF re app posting-101916:**

CMS cannot extend the federal comment period, however they will carefully review the 1,800 comments on the states application.

#### **6-CMS-ANAPD-Ltr to SM from JG-approval-102616:**

CMS approves the As Needed Advanced Planning Document (ANAPD) #5. The ANAPD for the Medicaid Enterprise Management System (MEMS) updated project deliverables, and requested line item funding changes within the existing budget.

#### **7-CMCS State Phasedown-CY2017Q123:**

This letter is to notify states of the phased-down State contribution full dual-eligible per capita Medicaid drug payment amount for January – September 2017 as required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA)

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**

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August 26, 2016

KY-16-009

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



Dear Mr. Miller:

The Centers for Medicare & Medicaid Services (CMS) approves the Implementation Advance Planning Document (IAPD) update submitted by the Kentucky Cabinet for Health and Family Services (CHFS) for the Transformed Medicaid Statistical Information System (T-MSIS) project. The total additional funding requested in this IAPD update in the amount of \$762,622 (\$686,360 at 90 percent federal financial participation [FFP]), in addition to a revised project status and Detailed Schedule of Deliverables (DSD) is approved.

The additional funding in the amount of \$672,415 (\$605,174 FFP) will be used to execute a new Statement Of Work (SOW) with Hewlett Packard Enterprise Services (HPES) to accomplish the implementation into T-MSIS 2.0 and for work performed during the current contract year leading up to T-MSIS 1.0 Pre-Operational Readiness Testing (PORT). The additional funding in the amount of \$90,207 (\$81,186 FFP) for Commonwealth business and technical staff needed to continue the Design, Development, and Implementation (DDI) of the T-MSIS project.

The IAPD update is approved in accordance with Section 1903(a)(3) of the Social Security Act, 42 CFR Part 433, subpart C, 45 CFR Part 95, subpart F, and the State Medicaid Manual, Part 11. Onsite reviews may be conducted to assure that the intentions for which FFP was approved are being accomplished. Specifically, the objective is to validate that automated data processing (ADP) equipment or services are being efficiently and effectively utilized to support the approved programs or projects as provided under 45 CFR § 95.621 and the State Medicaid Manual. As provided by the State Medicaid Manual Section 11200 and by 45 CFR § 95.611, all subsequent revisions and amendments to the IAPD update will require CMS prior written approval to qualify for FFP.

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

Sincerely,

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

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

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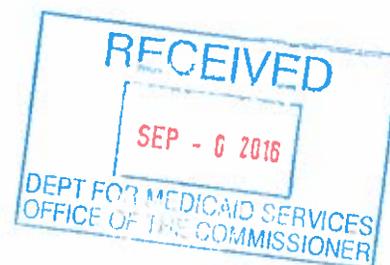


**DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS**

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August 29, 2016

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



Dear Mr. Miller:

The Centers for Medicare & Medicaid Services (CMS) has reviewed and is approving Kentucky's submission of the Managed Care Organization (MCO) rate amendment, subject to Kentucky operating managed care consistently with the State Plan or any waiver of the State Plan. CMS received the actuarial report and rates on June 28, 2016. The rates are for the period July 1, 2015 through June 30, 2016.

Specifically, rate amendments for the following contracts are approved:

- Anthem
- Coventry
- Humana
- Passport
- Wellcare

CMS based its decision to approve these rates based on an actuarial review of the rates performed by our Office of the Actuary. Through the actuarial review, we determine the rates are consistent with federal regulations found at 42 CFR Section 438.6(c), the 2015 Medicaid Managed Care Rate Consultation Guide, and all applicable Actuarial Standards of Practice developed by the Actuarial Standards Board, and that they fell within the actuarially certified rate range. Since the revised rate ranges did not result in a change to the final capitation rates, no associated contract action is necessary. However, if the State chooses to adjust the final capitation rates within the actuarially sound rate range, then a contract amendment is needed.

Stephen P. Miller, Commissioner  
Page 2

The rates noted above are approved for the purpose of federal financial participation, effective retroactively to July 1, 2015 and through June 30, 2016, subject to Kentucky operating managed care consistently with the State Plan or any waiver of the State Plan. If you have any questions concerning this letter, feel free to contact Lynda Bennett of my staff at 404-562-7352 or email her at [lynda.bennett@cms.hhs.gov](mailto:lynda.bennett@cms.hhs.gov).

Sincerely,



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

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



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

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September 15, 2016

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



Re: Kentucky State Plan Amendment 16-0003

Dear Mr. Miller:

Kentucky submitted state plan amendment (SPA) 16-0003, which was received by the Centers for Medicare & Medicaid Services (CMS) on June 22, 2016, with a proposed effective date of October 1, 2016. As submitted, this amendment updates the current reimbursement methodology for Community Mental Health Centers (CMHC) in Kentucky and expands the services that a CMHC may provide. Expanded services are primary care services, physical therapy services, occupational therapy services, and speech therapy services. In addition, reimbursement to the CMHC will be at cost.

We have completed our review of the proposed plan pages, the proposed cost report and the cost report instructions. However, before we can continue processing this amendment, we need additional or clarifying information. We are requesting the below additional information pursuant to Section 1915(f)(2) of the Social Security Act (the Act).

**Statutory and Regulatory Requirements**

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

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

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

42 CFR 447.205 requires public notice of significant proposed changes in methods and standards for setting payment rates for services.

### **Public Notice**

1. 42 CFR 447.205(c) (4) requires the state to identify in the public notice a local agency in each county where copies of the proposed changes are available for public review. Based on our review of the public notice for this amendment we determined the state did not include this information. Please reissue the public notice and identify the local agencies where the proposed changes are available for public review.

### **Comments/Questions**

#### 2. Attachment 4.19-B, Pages 20.15 thru 20.15(1)(a)(viii) – CMHC Reimbursement

##### A. Page 20.15

- (1) Please change APRN to read, “Advanced Practice Registered Nurse (APRN).”
- (2) Please change footer to show that 16-003 supersedes 16-004.

##### B. Page 20.15(1)(a)

- (1) Paragraph A.18.q – Should this be “Substance Use Peer Support Specialist?”
- (2) Please change footer to show that 16-003 supersedes 16-004.

##### C. Page 20.15(1)(a)(i), Section B

- (1) Paragraph B.1.a.(2) – Is the state saying that a CMHC that provides 1915(c) waiver services cannot be reimbursed under this methodology or that the 1915(c) waiver services are not covered under this reimbursement methodology? Please clarify.
- (2) Paragraph B.2.b. – This sentence does not provide enough detail. The state should describe the services/costs being reimbursed. For example, the state could say, “A final reimbursement for the state fiscal year that results from a reconciliation of the interim reimbursement amount paid to the CMHC compared to the CMHC’s Medicaid allowable costs by Cost Center for the state fiscal year.”

##### D. Page 20.15(1)(a)(i), Section C

- (1) As Section C relates to various interim reimbursement methodologies, please change the heading to read “Interim Reimbursement for Services Other Than Behavioral Health.”
- (2) As Laboratory services are paid based on the current Kentucky-specific Medicare Laboratory Fee Schedule, please correct both references to the Kentucky-specific Medicare Physician Fee Schedule.
- (3) Please correct this section to match other sections (a. and b.). In this case, the first paragraph would be 3.a. and the second paragraph would be 3.b.

E. Page 20.15(1)(a)(ii)

- (1) The state currently has “B. Community Mental Health Centers In-state Reimbursement”. As this section continues the interim reimbursement methodology for Section C, please change this to read, “C. Interim Reimbursement for Services Other Than Behavioral Health (continued).”
- (2) Paragraph 5.a. – Please change the reference to Attachment 4.19-B, Page 22 to Attachment 4.19-B, Page 27.
- (3) The state did not submit a proposed plan page for Radiological services that includes the reference to the CMHC’s. Please submit for review.

F. Page 20.15(1)(a)(iii)

- (1) As the 1<sup>st</sup> section is a continuation of Section C, please make same change as indicated in #1, above.
- (2) Paragraph B.8. – Please include the page number where the reimbursement methodology for the cost of injectable drugs can be found.
- (3) As the preceding section was “C,” please change “E” to “D.”
- (4) Paragraph E.(1)(a) – Please confirm that the state will pay the rates in effect on July 1, 2015 as the interim rates for dates of service through June 30, 2018.
- (5) Paragraph E.(2)(b)3.a. – Should this read, “Provided to recipients who are not enrollees in managed care?”
- (6) Paragraphs 6.b. and 7.b. – Please change the reference to Attachment 4.19-B, Page 22 to Attachment 4.19-B, Page 27.

G. Page 20.15(1)(a)(iv)

- (1) The state currently has “B. Community Mental Health Centers In-state Reimbursement.” As this section continues the interim reimbursement methodology for Behavioral Health Services, please change this to read, “D. Interim Reimbursement for Behavioral Health Services (continued).”
- (2) Based on previous changes, Section F should now be Section E.
- (3) Paragraph F.(1)(a)3.a. – Please change this to read, “CMHC’s Medicaid allowable direct costs.”
- (4) Please explain why the state is identifying injectable drugs separately.
- (5) Paragraphs F.(1)(a)(3)a.(i) and (ii) should indicate that these are services rendered to eligible recipients.

H. Page 20.15(1)(a)(v)

- (1) Please change “B. Community Mental Health Centers In-state Reimbursement” to read “E. Final Reimbursement (continued).”
- (2) Paragraph (2) which currently reads, “By October 1 following the departments receipt of a CMHC’s completed cost report...” – This will be 15 months after the providers’ fiscal year ends. Can this be reduced?

- (3) Paragraph (2)(b) which currently reads, “Determine the lesser of the amount of Medicaid allowable costs on the cost report or the provider’s aggregate usual and customary charges...” – Is there a regulation that requires this limit?

I. Page 20.15(1)(a)(vi)

- (1) Please change, “B. Community Mental Health Centers In-state Reimbursement,” to read “E. Final Reimbursement (continued).”
- (2) Paragraph B.(c)2. – The state indicates that the department will recoup the amount owed by the CMHC to the department. However, there is no mention of provider appeal rights. Where are these rights discussed?
- (3) Please change “G. New Services” to read “F. New Services.”
- (4) Please change “H. Auditing and Accounting Records” to read “G. Auditing and Accounting Records.”
- (5) There must be a section that discusses the 100% time reporting requirements.
- (6) Paragraph H.(1)(b) indicates that if the department determines that an audit is not necessary, the cost report shall be settled without an audit. Please explain the circumstances when an audit would not be necessary.
- (7) Paragraph H.(2)(a) – The state should include a chart of accounts for providers to follow.

J. Page 20.15(1)(a)(vii)

- (1) Remove “B. Community Mental Health Centers In-State Reimbursement” as this is confusing to the reader.
- (2) Paragraph I.(1)(d) – Cost incurred for research purposes – Please explain what research costs would be included as research costs that are paid through research grants should not be included as allowable costs.
- (3) Paragraph I.(1)(e) – Is the CMHC enrolled as a transportation provider? This is necessary for “incurred for transporting recipients to services” being an allowable cost.
- (4) Paragraph I.(1)(j)(1) – Indirect costs calculated utilizing the approved federal indirect rate – The state needs to include a definition/description of what costs will be included in the direct and indirect categories, which should follow the format and include items as direct or indirect, that the federal agencies have identified. In addition, the state needs to describe what direct cost the indirect rate will be applied to.
- (5) Paragraph I.(1)(k) – This can be deleted as there are no clinic services being provided.
- (6) Paragraph I.(2)(a) – Please include the section of PRM 15-I that applies to the allowable cost for a service or good purchased by a facility from a related organization.
- (7) General Comments:
  - (a) The state should make a distinction between direct and indirect costs and include a list of each.

- (b) The state should also indicate that indirect costs are based on 100% time reporting, unless an approved federal indirect cost rate is available.
- (c) The state should remove all mention of “clinic” as these are not considered clinic services. The state could say “facility” rather than “clinic.”

K. Page 20.15(1)(a)(viii), Paragraph J: Where are the unit of services defined for Behavioral Health services?

3. Attachment 4.19-B, Page 20.13-E – Laboratory Services and Family Planning Clinics

Please confirm that the reimbursement methodology for Physician Clinical Diagnostic Laboratory Services (item XII) and Family Planning Clinics (item XIII) have not changed.

4. Attachment 4.19-B, Page 20.38 – Radiological (X-ray) Services

A. Although this service is included in the CMHC Reimbursement methodology [page 20.15(1)(a)(ii)], the state did not submit a proposed plan page including the language for the CMHCs. Please submit the required plan page.

B. In addition, this paragraph currently reads, “Payment for radiological services covered pursuant to the mandate contained in 42 CFR 440.30 shall be at the usual and customary charges up to sixty (60) percent of the allowable physician fee for the same procedures where the physician is performing both the professional and technical portions of the service.” Phrases such as “up to” or “not to exceed” are not comprehensive in that they allow for a range of payments. Given that, please change this to read, “...shall be the lesser of the usual and customary charges or sixty (60) percent of the allowable physician fee for the same procedures where the physician is performing both the professional and technical portions of the service” and include the effective date fee schedule language.

5. Attachment 4.19-B, Page 27, 1<sup>st</sup> paragraph - Reimbursement for Physical, Occupational and Speech Therapy - Outpatient

A. It is unclear what provider types receive the payment described. Please clarify.

B. The state indicates that this payment is based on 75% of the Medicare rate. However, it does not indicate which Medicare fee schedule the rate is based on (i.e., 2014, current, etc.). Please include the effective date of the fee schedule language. For example, the state could say, “Effective reimbursement for physical, occupational, and speech therapy services provided by (provider type) will be 75% of the current Medicare fee schedule rate (or the Medicare fee schedule rate that was in effect on (date)). Except as otherwise noted in the state plan, state-developed fee schedule rates are the same for both governmental and private providers of Physical, Occupational, and Speech Therapy services. The agency’s fee schedule rate was set

as of \_\_\_\_\_ and is effective for services provided on or after that date. All rates are published at (agency's website)."

6. The following comments/questions relate to the Cost Report Instructions.

A. Introduction to the Community Mental Health Center Cost Report

(1) Page 2, 2<sup>nd</sup> paragraph

- (a) 1<sup>st</sup> sentence – Please remove “whenever possible.” This language is not comprehensive.
- (b) 2<sup>nd</sup> sentence – This sentence currently reads, “...based upon the actual costs to each care component.” Are care components cost centers? The state needs to insert the requirement that personnel cost must be apportioned based on 100% time reporting (see Section 202, page 38 of the CMHC manual).

(2) Page 2, 3<sup>rd</sup> paragraph

- (a) Please remove “in general” in the 1<sup>st</sup> sentence as this is not comprehensive.
- (b) The 2<sup>nd</sup> sentence currently reads, “Schedules are provided to make any necessary accounting adjustments or reclassifications to ensure proper cost finding.” What schedules? Please describe.

(3) Page 2, 4<sup>th</sup> paragraph

Please remove “if possible” and “similar nature” as these are not comprehensive. If the CMHC has an approved indirect rate, direct cost must be grouped the same as the federal agency grouped them to determine the indirect rate.

B. Schedule A – Unit Cost Information

- (1) Page 3, Item A. – Please delete “If applicable,” as this is not comprehensive.
- (2) Page 3, Item A. – Are unit codes the same as cost centers? If they are, please change to cost centers. If not, please explain.
- (3) Page 3, Item C. – Include language regarding 100% time reporting.
- (4) Page 3, Item D. – Include a description of what is included in facility costs.
- (5) Page 4, Item E. – The 2<sup>nd</sup> sentence reads, “If costs are allocated, enter the travel and transportation costs in column 11.” What is the basis of allocation?
- (6) Page 4, Item G. – Describe what is included in other costs.

C. Schedule A-1 – Local Reclassifications and Allocations

- (1) Need a description of all columns 1-13.
- (2) Page 6, Item H. – Need an explanation of what is being removed or allocated. Also need a work paper or reference in column 4 for each entry in column 12.
- (3) Page 6, Item I. – Remove “I” as this is a continuation of Item H.

D. Schedule B – Admin. Stepdown

- (1) Page 7, Item D. – If an approved federal indirect cost rate is used to determine the indirect cost, the categories identified by the federal agency as direct cost must be used to determine the indirect cost.
- (2) Page 7, Item E. – Please see comment for D, above. Provide an example of this calculation.

7. Corresponding Review

Federal statute and regulations require CMS to review and approve SPAs before a state may implement Medicaid program modifications. CMS reviews these SPA pages in the context of the overall state plan for consistency with the requirements of Section 1902(a) of the Social Security Act (the Act). Therefore, CMS must review not only the proposed specific amendment, but also all other provisions contained on the submitted state plan page or pages and any related or corresponding state plan provisions which are contained elsewhere in the state plan but are integral to understanding the pages submitted. Based on that review, we have the below following comments/questions. Please advise how the state would like to address these issues either with this SPA or through the issuance of a companion letter.

A. Physician Services – Attachment 4.19-B, Pages 20.3 thru 20.5(6)

Attachment 4.19-B, Page 20.3(a), Paragraph C.(4) – Please complete the last sentence “...in accordance with Sections A and B and items (1) through.”

B. APRN Services – Attachment 4.19-B, Page 20.24

- (1) Please correct the heading on page 20.24 to read “Advanced Practice Registered Nurse Services.”
- (2) Please change all references of “ARNP” to “APRN.”
- (3) Paragraph (1)b.2. – Please include a reference to the physician services reimbursement page(s).

We are requesting this additional/clarifying information under provisions of section 1915(f)(2) of the Act. This has the effect of stopping the 90-day clock for CMS to take action on the material, which would have expired on September 20, 2016. A new 90-day clock will not begin until we receive your response to this request.

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

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

Stephen P. Miller, Commissioner  
Page 8

If you have any additional questions or need further assistance, please contact either Darlene Noonan at (770) 443-0049 or [Darlene.Noonan@cms.hhs.gov](mailto:Darlene.Noonan@cms.hhs.gov) or Stanley Fields at (502) 223-5332 or [Stanley.Fields@cms.hhs.gov](mailto:Stanley.Fields@cms.hhs.gov)

Sincerely,

A handwritten signature in black ink, appearing to read "Jackie Glaze".

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

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
Atlanta Regional Office  
61 Forsyth Street, Suite 4T20  
Atlanta, Georgia 3030



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

October 6, 2016

Stephen P. Miller  
Commissioner  
Department of Medicaid Services  
275 East Main Street, 6 West A  
Frankfort, KY 40621



Dear Mr. Miller:

The purpose of this letter is to respond to the state's request for approval of a series of 90-day extensions not to exceed one year from September 16, 2016 for its Home and Community Based Services (HCBS) waiver programs to allow the state additional time for a systemic review. The Kentucky (KY) Supports for Community Living (KY.0314), KY Michelle P (KY.0475), and KY Acquired Brain Injury, Long Term Care (KY0477) are currently on temporary extensions (TEs). The KY Acquired Brain Injury (KY.0333) waiver will expire December 31, 2016 and is not on a TE.

The Centers for Medicare and Medicaid Services (CMS) cannot grant the state's request. Specifically, CMS cannot approve TEs for the evaluation of its system and can only consider a request for a 90 day period at any given time. It becomes problematic when states leave waivers on TEs because it locks them into services, waiver slots, rates and rate methodologies from the fifth year of the previous waiver cycle.

However, CMS does consider requests for TEs in order to allow a state time to satisfactorily resolve outstanding issues raised in the formal requests for additional information (RAI) including, but not limited to, overall health and welfare of waiver participants and the Continuous Quality Improvement Program overlaying the waiver. The KY Michelle P (KY.0475) is currently on the first extension which will expire November 29, 2016 so the state should request a TE by October 30, 2016.

CMS has not received the HCBS renewal applications for the KY Acquired Brain Injury (KY.0333), KY Michelle P (KY.0475), KY Acquired Brain Injury, Long Term Care (KY.0477), and the KY Supports for Community Living (KY.0314) and it is necessary that the state submit these promptly. We are also requesting that the state respond to the RAIs currently outstanding so we can assist in resolving these issues. The state may respond in draft until the concerns are addressed. The state cannot amend a waiver that is on a TE. It must submit any amendments after the renewal has been approved. We stand ready to provide technical assistance to the state on its HCBS waiver programs.

Please contact me, Jackie Glaze, at (404) 562-7417 if you have questions or would like to arrange a call for CMS to provide guidance to the state.

Sincerely,



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



Ralph Lollar  
Director  
Division of Long Term Services and Supports  
Disabled and Elderly Health Program Group

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



State Demonstrations Group

OCT 19 2016

Stephen P. Miller  
Commissioner  
Department for Medicaid Services  
275 East Main Street, 6 West A  
Frankfort, KY 40621



Dear Mr. Miller:

Thank you for your recent section 1115 demonstration application entitled, "Kentucky HEALTH: Helping to Engage and Achieve Long Term Health." In accordance with federal requirements, Kentucky's section 1115 demonstration application was posted for public comment on the Medicaid.gov website for a 30-day federal comment period from September 8 through October 8, 2016.

To date, we have received over 1,800 comments on the state's application. This high level of interest was also evident during the state comment period, leading the Kentucky Department for Medicaid Services to extend the public comment period to provide additional time for comments prior to the state submitting the application to the Centers for Medicare & Medicaid Services (CMS). The Department of Health and Human Services (HHS) recently received a request to provide an extension of the comment deadline to give all interested Kentuckians the opportunity to share their views.

While our rules do not provide for formally extending the federal comment period, as a matter of practice CMS has generally reviewed and considered all public comments received prior to rendering a final decision. Moreover, given the large volume of comments already received, we know that we will need time to carefully consider the public input and discuss it with you. Accordingly, we wanted to let you know that we plan to continue considering comments submitted after the original close of the federal comment period. We will share this information with those who have asked us about the comment deadline.

We look forward to working with you on your demonstration proposal and are prepared to continue our dialogue for as long as it takes to find a solution that continues progress for the people of Kentucky.

Sincerely,

A handwritten signature in black ink, which appears to read "Eliot Fishman", is written over a horizontal line.

Eliot Fishman  
Director

Page 2 – Mr. Stephen Miller

cc: Jackie Glaze, Associate Regional Administrator, CMS Atlanta Regional Office

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



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

October 26, 2016

KY-16-010

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



Dear Mr. Miller:

The Centers for Medicare & Medicaid Services (CMS) approves the As Needed Advance Planning Document (ANAPD) #5, dated September 19, 2016, submitted by the Kentucky Cabinet for Health and Family Services (CHFS). The ANAPD for the Medicaid Enterprise Management System (MEMS) updated project deliverables, and requested line item funding changes within the existing budget as outlined below:

Federal Financial Participation (FFP) enhanced match rate of 90/10 line item shifts totaling \$1,439,734 (federal share \$1,295,761 and Commonwealth share \$143,973) from the DDI State Project Resources budget line to the following:

- Call Center for additional staffing required \$631,854 (federal share \$568,669 and Commonwealth share \$63,185) to be shared equally by Partner Portal (\$315,927) and MWMA (Medicaid Waiver Management Application) (\$315,927).
- Partner Portal for the Fingerprint-based Criminal Background Checks (FCBC) software feature to be added to Partner Portal in the amount of \$150,000 (federal share \$135,000 and Commonwealth share \$15,000).
- The Commonwealth will be purchasing "RoboHelp," a COTS product, and receiving training on its use for help text development for a total cost of \$15,000 (federal share \$13,500, Commonwealth share \$1,500).
- Partner Portal Independent Verification and Validation (IV&V) eight-month extension for \$642,880 (federal share \$578,592 and Commonwealth share \$64,288).

Federal Financial Participation enhanced match rate of 75/25 line item shift from the MEMS Operational Cost budget line to the following:

- MWMA Operations budget for the Operations and Maintenance contract \$728,142 (federal share \$546,107 and Commonwealth share \$182,035).

Staffing table adjustments to Key State Personnel for Commonwealth and Contractor personnel needed to comply with the CMS State Medicaid Director's letter #2 for additional staffing.

CMS reminds the Commonwealth that an Implementation Advance Planning Document Update (IAPDU) must be submitted to address budget needs as the project moves forward in the procurement process. Any re-alignment of budget by federal fiscal year ("carry forward" of unspent FFY 2016 funds to FFY 2017) must be included in that document. The corresponding Statements of Work for Deloitte and CSG Government Solutions and the contract amendment with Xerox for the activities outlined in the ANAPD are also approved under this determination.

The ANAPD #5 is approved in accordance with Section 1903(a)(3) of the Social Security Act, 42 CFR Part 433, subpart C, 45 CFR Part 95, subpart F, and the State Medicaid Manual, Part 11. No new funding is approved for this project under this approval. Onsite reviews may be conducted to assure that the intentions for which FFP was approved are being accomplished. Specifically, the objective is to validate that automated data processing (ADP) equipment or services are being efficiently and effectively utilized to support the approved programs or projects as provided under 45 CFR § 95.621 and the State Medicaid Manual. As provided by the State Medicaid Manual Section 11200 and by 45 CFR § 95.611, all subsequent revisions and amendments to the APD Update will require CMS prior written approval to qualify for FFP.

As described in regulation at 45 CFR § 95.611 and the State Medicaid Manual Section 11200, other contracts supported by funding from the approved APD-U must be approved by CMS prior to execution of the contract. Failure to comply with prior approval requirements may result in either ineligibility for the enhanced federal match or disallowance for those activities.

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

Sincerely,



Jackie Glaze  
Associate Regional Administrator  
Division of Medicaid & 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



**Data and Systems Group**

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**RE: Calendar Year (CY) 2017 Jan - Sep Phased-down State Contribution Final Per-Capita Rates**

October 28, 2016

Dear State Medicaid Director:

As you know, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) requires that the Centers for Medicare & Medicaid Services (CMS) notify each State, no later than October 15 of each calendar year (CY), of its annual per capita drug payment expenditure amount for the following year. Payments for the phased-down State contribution are made on a monthly basis. These payments are defined by the MMA to be the product of the annual per capita full dual-eligible drug payment amount and the monthly State enrollment of full dual eligible.

This letter is to notify you of the phased-down State contribution full dual-eligible per capita Medicaid drug payment amount for January – September 2017, as required by the MMA.

Jan - Sep 2017 phased-down State contribution per capita rates are shown in Attachment 1. The per capita drug expenditure amount for Jan - Sep 2017 is based on the value for Oct - Dec 2016 with the following adjustments:

1. The value is adjusted by the annual percentage increase (API) in per capita Part D expenditures for the 2017 contract year (11.75 percent), along with an adjustment to account for revisions to prior year estimates of per capita drug cost growth from 2003 to 2006 (0.16 percent). This results in a total growth rate of 11.93 percent.
2. There is no change in the discount factor for 2017, because the phased-down factor for the previous year and this update year is 75 percent.
3. Based on the effects of the API update and the reduction in the phased-down contribution percentage, the net change in the State phased-down per capita drug payment amount for CY2017 is 11.93 percent. Details are described in Attachment 2, provided by the CMS Office of the Actuary.

Questions regarding these calculations may be directed to Christian Wolfe at 410-786-2266 or [christian.wolfe@cms.hhs.gov](mailto:christian.wolfe@cms.hhs.gov)

Sincerely,

/s/

Jessica Kahn  
Director, Data & Systems Group

**ATTACHMENT 1: Phased-down State Contribution Rates January-September 2017**

<u>STATE</u>	<u>STATE NAME</u>	<u>Jan-Sep 2017</u>
AL	Alabama	75.13
AK	Alaska	182.54
AZ	Arizona	57.66
AR	Arkansas	69.90
CA	California	123.38
CO	Colorado	158.91
CT	Connecticut	195.58
DE	Delaware	143.59
DC	District of Columbia	70.15
FL	Florida	132.75
GA	Georgia	90.82
HI	Hawaii	102.53
ID	Idaho	100.25
IL	Illinois	155.65
IN	Indiana	109.62
IA	Iowa	145.97
KS	Kansas	145.98
KY	Kentucky	93.50
LA	Louisiana	118.06
ME	Maine	99.25
MD	Maryland	167.07
MA	Massachusetts	130.96
MI	Michigan	82.56
MN	Minnesota	161.26
MS	Mississippi	62.31
MO	Missouri	145.16
MT	Montana	110.29
NE	Nebraska	160.91
NV	Nevada	106.92
NH	New Hampshire	185.73
NJ	New Jersey	199.83
NM	New Mexico	62.57
NY	New York	147.34
NC	North Carolina	108.60
ND	North Dakota	140.12
OH	Ohio	149.75
OK	Oklahoma	97.18
OR	Oregon	115.94
PA	Pennsylvania	166.22
RI	Rhode Island	155.64
SC	South Carolina	64.73
SD	South Dakota	146.82
TN	Tennessee	127.99
TX	Texas	109.31
UT	Utah	112.07
VT	Vermont	138.97
VA	Virginia	168.26
WA	Washington	159.29
WV	West Virginia	83.53
WI	Wisconsin	137.17
WY	Wyoming	175.86

**ATTACHMENT 2: Phased-Down State Contribution to Part D Annual Rate Update for 2017**

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) requires CMS to calculate the payment rates for the Phased-Down State Contribution (PDSC) to Part D each year using the latest available National Health Expenditure (NHE) estimates of per capita drug expenditure growth for the period 2003 to 2006, combined with the annual percentage increase (API) in average per capita aggregate Part D expenditures for 2007 and later years, as defined in section 1860D-2(b)(6) of the Social Security Act. As announced on April 4, 2016, the API for 2017 is 11.75%.<sup>1</sup>

The 2017 API includes an adjustment for revisions to the 2007 through 2016 percentage increases, based on subsequent data and projections, as described in the April 4 announcement. Since the MMA requires use of the latest NHE estimates for 2003 through 2006, the 2017 PDSC rates must also be adjusted for updates, if any, to estimates of per capita prescription drug expenditure growth for the period 2003 to 2006 that have occurred since the promulgation of the 2016 rates. The 2016 rates were based on historical NHE estimates from January 2015 and reflected a cumulative per capita prescription drug expenditure growth rate of 23.28% from 2003 to 2006. The current, January 2016, NHE estimates show a cumulative growth rate of 23.48% for the same period.<sup>2</sup> Accordingly, the 2017 PDSC rates include a multiplicative adjustment of 0.16% ( $1.2348/1.2328 - 1$ ) to account for the updated 2003 to 2006 growth estimates. When applied to the 2017 API of 11.75%, this adjustment results in a net per capita prescription drug expenditure increase for 2017 of 11.93% ( $1.1175 \times 1.0016 - 1$ ).

The PDSC payment rates include a discount factor (the “factor for the month” specified in section 1935(c)(5)), which is 75% in 2015 and subsequent years. Consequently, there is no change in the discount factor for 2017, and the net PDSC payment rate will increase by 11.93%. The table below summarizes these calculations.

**2017 Phased-down State Contribution Payment Rate Increase**

Annual Percentage Increase for 2017	11.75%
Adjustment for updated 2003-2006 growth	0.16%
2017 PDSC payment rate increase	11.93%

Note: Percentages in this table are multiplicative, not additive. Calculations based on displayed values may vary from results shown, since values are carried to additional decimal places.

Office of the Actuary  
October 26, 2016

<sup>1</sup> See <http://www.cms.gov/MedicareAdvtgSpecRateStats/Downloads/Announcement2017.pdf>. Details of the API calculation are contained in Section C of Attachment V.

<sup>2</sup> The current per capita estimates are \$609 for 2003 and \$752 for 2006. These can be found in the NHE tables at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/tables.zip>. See Table 02.