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

September 11, 2014

Mr. Lawrence Kissner
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) 14-007

Dear Mr. Kissner:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid state plan submitted under transmittal number (TN) 14-007. Effective August 1, 2014 this amendment proposes to revise the nursing facility reimbursement methodology for determining payment rates. Specifically, this revision will allow Veteran's Affairs nursing facilities to include the cost of prescription drugs in the annual cost report as an ancillary service cost.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(13), 1902(a)(30), and 1903(a) of the Social Security Act (the Act) and the implementing federal regulations at 42 CFR 447 Subpart C. Before we can continue processing this amendment, we need additional or clarifying information.

The regulation at 42 CFR 447.252(b) requires that the state plan include a comprehensive description of the methods and standards used to set payment rates. Section 6002 of the State Medicaid Manual explains further that the state plan must be comprehensive enough to determine the required level of federal financial participation (FFP) and to allow interested parties to understand the rate setting process and the items and services that are paid through these rates. Further, since the plan is the basis for FFP, it is important that the plan's language be clear and unambiguous. Therefore, we have the following questions regarding TN 14-007.

GENERAL

1. CMS Form 179 - Box 7. The state estimates a federal budget impact of $0 for FY 2014 and $0 FY 2015. Please provide a detailed analysis showing how the state determined the federal budget impact.

2. Public Process. Please provide information demonstrating that the changes proposed in SPA 14-007 comport with public process requirements at section 1902(a)(13)(A) of the Act.

3. Please provide an analysis of what would be paid for prescription drugs for these nursing home residents through the state's pharmacy fee for services system versus cost through the annual cost report.

4. Please provide any information the providers submitted regarding the purchasing program used by the veterans hospitals and nursing homes that satisfied the state the cost would be less if reimbursed through the cost reports.

STANDARD FUNDING QUESTIONS

The following questions are being asked and should be answered in relation to all payments made to all providers under Attachment 4.19-D of your state plan.

5. Section 1903(a)(1) provides that federal matching funds are only available for expenditures made by states for services under the approved state plan. Do providers receive and retain the total Medicaid expenditures claimed by the state (includes normal per diem, supplemental, enhanced payments, other) or is any portion of the payments returned to the state, local governmental entity, or any other intermediary organization? If providers are required to return any portion of payments, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the payments, a complete listing of providers that return a portion of their payments, the amount or percentage of payments that are returned and the disposition and use of the funds once they are returned to the state (i.e., general fund, medical services account, etc.).

6. Section 1902(a)(2) provides that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan. Please describe how the state share of each type of Medicaid payment (normal per diem, supplemental, enhanced, other) is funded. Please describe whether the state share is from appropriations from the legislature to the Medicaid agency, through intergovernmental transfer agreements (IGTs), certified public expenditures (CPEs), provider taxes, or any other mechanism used by the state to provide state share. Note that, if the appropriation is not to the Medicaid agency, the source of the state share would necessarily be derived through either an IGT or CPE. In this case, please identify the agency to which the funds are appropriated. Please provide an estimate of total expenditure and state share amounts for each type of Medicaid payment. If any of the

non-federal share is being provided using IGTs or CPEs, please fully describe the matching arrangement including when the state agency receives the transferred amounts from the local government entity transferring the funds. If CPEs are used, please describe the methodology used by the state to verify that the total expenditures being certified are eligible for federal matching funds in accordance with 42 CFR 433.51(b). For any payment funded by CPEs or IGTs, please provide the following:

(i) a complete list of the names of entities transferring or certifying funds;
(ii) the operational nature of the entity (state, county, city, other);
(iii) the total amounts transferred or certified by each entity;
(iv) clarify whether the certifying or transferring entity has general taxing authority; and,
(v) whether the certifying or transferring entity received appropriations (identify level of appropriations).

7. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for federal financial participation to states for expenditures for services under an approved state plan. If supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to each provider type.

8. Does any governmental provider receive payments that in the aggregate (normal per diem, supplemental, enhanced, other) exceed their reasonable costs of providing services? If payments exceed the cost of services, do you recoup the excess and return the federal share of the excess to CMS on the quarterly expenditure report?

Maintenance of Effort (MOE)

9. Under section 1902(gg) of the Act, as amended by the Affordable Care Act, as a condition of receiving any federal payments under the Medicaid program during the MOE period indicated below, the state shall not have in effect any eligibility standards, methodologies, or procedures in its Medicaid program which are more restrictive than such eligibility provisions as in effect in its Medicaid program on March 10, 2010.

MOE Period.

- Begins on: March 10, 2010, and
- Ends on: The date the Secretary of the Federal Department of Health and Human Services determines an Exchange established by a state under the provisions of section 1311 of the Affordable Care Act is fully operational.

Is Kentucky in compliance with the conditions of the MOE provision of section 1902(gg) of the Act for continued funding under the Medicaid program?

10. Section 1905(y) and (z) of the Act provides for increased federal medical assistance percentages (FMAP) for expenditures made on or after January 1, 2014 for individuals determined eligible under section 1902(a)(10)(A)(i)(VIII) of the Act. Under section 1905(cc) of the Act, the increased FMAP under sections 1905(y) and (z) would not be available for states that require local political subdivisions to contribute amounts toward the non-federal share of the state's expenditures at a greater percentage than would have been required on December 31, 2009.

    Prior to January 1, 2014 states may potentially require contributions by local political subdivisions toward the non-federal share of the states' expenditures at percentages greater than were required on December 31, 2009. However, because of the provisions of section 1905(cc) of the Act, it is important to determine and document/flag any SPAs/state plans which have such greater percentages prior to the January 1, 2014 date in order to anticipate potential violations and/or appropriate corrective actions by the states and the federal government.

    This SPA would [ ] / would not [ ] violate these provisions, if they remained in effect on or after January 1, 2014.

11. Section 1905(aa) of the Act provides for a "disaster-recovery FMAP" increase effective no earlier than January 1, 2011. Under section 1905(cc) of the Act, the increased FMAP under section 1905(aa) of the Act is not available for states that require local political subdivisions to contribute amounts toward the non-federal share of the state's expenditures at a greater percentage than would have been required on December 31, 2009.

    This SPA would [ ] / would not [ ] qualify for such increased FFP and is not in violation of this requirement.

12. Does TN 14-007 comply with the requirements of section 1902(a)(37) of the Act regarding prompt payment of claims?

We are requesting this additional/clarifying information under provisions of section 1915(f) of the Act (added by PL 97-35). This has the effect of stopping the 90-day clock for CMS to take action on the material. A new 90-day clock will not begin until we receive your response to this request.

In accordance with our guidelines to all state Medicaid directors dated January 2, 2001, if we have not received the state's response to our request for additional information within 90 days from the date of this letter, we will initiate disapproval action on the amendment. In addition, because this amendment was submitted after January 2, 2001 and is effective after January 1, 2001, please be advised that we will continue to defer FFP for state payments made in accordance with this amendment until it is approved. Upon approval, FFP will be available for the period beginning with the effective date through the date of approval.

Please submit your response to:

National Institutional Reimbursement Team
Attention: Stanley Fields
SPA_Waivers_Atlanta_R04@cms.hhs.gov

If you have any questions or would like to discuss our comments and questions, please contact Stanley Fields at 502-223-5332.

Sincerely,

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

Cc: Maria Sotirelis, CMCS
Tim Weidler, NIRT
Davida Kimble, ROIV
Darlene Noonan, ROIV
Stanley Fields, ROIV NIRT
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