

# 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-Waiver-Ltr to LK from BCE re 1915b\_dte102714:**

Temporary extension of the KY-07 waiver to operate the managed care program under section 1915(b) of the Social Security Act.

### **2 – CMS-NEMT-Ltr to LK from JG\_dte103114:**

Kentucky Non-Emergency Transportation Waiver 06-R02; CMS acceptance to withdraw waiver application KY-06.R02.

### **3 – CMS-MPW HCBW-Ltr to LK from JG\_dte111914:**

CMS approval for DMS to amend Kentucky's Michelle P. Home and Community Based Waiver Program to increase the unduplicated number of individuals who may be served in waiver years four and five.

### **4 – CMS-IAPDU-Ltr to LK from JG\_dte112514:**

CMS approval of the Implementation Advance Planning Document Update #4 which requested additional federal funding to complete modifications to the Medicaid Management Information System (MMIS) in order to comply with ICD-10.

### **5 – CMS-MMIS-HP Cont-Ltr to LK from JG\_dte112514:**

CMS approval of DMS' request for emergency authorization to complete the procurement of a new contract with Hewlett Packard.

### **6 – CMS-NEMT-Ltr to LK from BCE\_dte120214:**

CMS grants 90 day extension of Kentucky's Non-Emergency Medical Transportation Waiver to ensure KY has time to submit a complete waiver application.

### **7 – CMS-ABI-Ltr to LK from JG\_dte120414:**

CMS request for information related to ABI as part of a quality review conducted by CMS.

### **8 – CMS-NEMT-Ltr to LK from BCE re NEMT\_dte121814:**

CMS grants extension of Kentucky's Non-Emergency Medical Transportation Waiver to ensure KY has time to submit a complete waiver application and cost effectiveness spreadsheets with documents.

## MAC Binder Section 1 – Letters From CMS

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#### **9 – CMS-Med Dir from JG re Suff of Mand & Opt Serv\_dte121914:**

CMS shares policy that provides further clarification on the sufficiency of mandatory and optional services which will serve as formalization of the current State Plan Amendment review practice.

#### **10 – CMS-IAPDU MEMS-Ltr to LK from JG\_dte122914:**

CMS approval of DMS' annual Implementation Advance Planning Document for the Medicaid Enterprise Management System (MEMS) to carry forward federal financial participation dollars.

#### **11 – CMS-MEMS-Ltr to LK from JG\_dte122914:**

CMS approval of DMS' annual Implementation Advance Planning Document for the Medicaid Enterprise Management System (MEMS) to perform budget adjustments as described.



Disabled & Elderly Health Programs Group

OCT 27 2014



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

Dear Mr. Kissner:

The Centers for Medicare & Medicaid Services (CMS) received your request, dated October 22, 2014, for a temporary extension of Kentucky's Medicaid Managed Care 1915(b) waiver program under CMS control number KY-07. The current temporary waiver authority expires on October 31, 2014. You have requested this extension to ensure the Kentucky Department for Medicaid Services has adequate time to submit contract and actuarial certifications to CMS for review in order to obtain CMS approval of managed care capitation rates.

The CMS is granting an extension of the KY-07 waiver to operate the managed care program under section 1915(b) of the Social Security Act (the Act). This temporary extension will expire on January 31, 2015. Prior to the expiration of the temporary extension, please submit a complete managed care renewal waiver application, including the cost effectiveness spreadsheets, the Section D description of the cost effectiveness test, data from the state's monitoring activities, and incorporate the recommendations for improvement from the Independent Assessment into the waiver application.

The CMS will continue to work with your staff during the extension period. If you have any questions, please contact Cheryl Brimage, in the Atlanta Regional Office, at (404) 562-7116, or Lovie Davis, of my staff, at (410) 786-1533.

Sincerely,

Barbara Coulter Edwards  
Director

cc: Cheryl Brimage, Atlanta Regional Office  
Shantrina Roberts, Atlanta Regional Office  
Jackie Glaze, Atlanta Regional Office

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

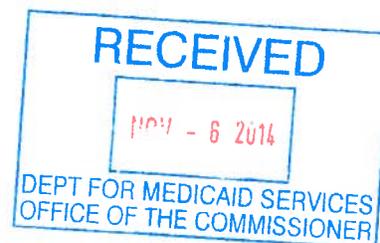


**DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS**

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October 31, 2014

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



Re: Kentucky Non-Emergency Transportation Waiver 06-R02

Dear Mr. Kissner:

We accept your request, dated October 31, 2014, to withdraw the Non-Emergency Transportation Waiver application, KY-06.R02, submitted on September 18, 2014.

If you have any questions or need any further assistance, please contact Cheryl Brimage at (404) 562-7116.

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 St., Suite 4T20  
Atlanta, Georgia 30303-8909



**Division of Medicaid & Children's Health Operations**

November 19, 2014

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



Dear Mr. Kissner:

Your request to amend Kentucky's Michelle P. Home and Community Based Waiver Program for individuals with intellectual and/or developmental disabilities who meet ICF/IID level of care, as authorized under section 1915(c) of the Social Security Act was approved on November 19, 2014. This waiver amendment has been assigned control number KY 0475.R01.01, which should be used in future correspondence. The waiver amendment request is effective September 1, 2014, and complied with transition planning requirements.

This amendment increases the unduplicated number of individuals who may be served in waiver years four and five, with adjustments made to the corresponding J tables.

The following estimates of utilization and cost of waiver services have been approved:

Waiver Year	Unduplicated Recipients	Community Costs	Institutional Costs	Total Waiver Costs
Year 4 (9/1/14 - 8/31/15)	10,500	\$26,046	\$229,897	\$273,483,000
Year 5 (9/1/15 - 8/31/16)	10,500	\$27,859	\$244,661	\$292,519,500

We appreciate the effort and cooperation provided by your staff during our review of this amendment request. If you have any questions, please feel free to contact Kenni Howard at (404) 562-7413.

Sincerely,

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

cc: Michele MacKenzie, Central Office

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



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

November 25, 2014



KY-15-001

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

*Copies for  
MAC  
mg7 team  
SMI & JENNIFER*

Dear Mr. Kissner:

The Implementation Advance Planning Document Update (IAPDU) #4 submitted by Kentucky to the Centers for Medicare & Medicaid Services (CMS) on October 3, 2014, is approved effective on the date of this letter. The IAPDU was submitted by Kentucky to request additional federal funding to complete modifications to the Medicaid Management Information System (MMIS) in order to comply with the national deadline of October 1, 2015 to process claims with International Classification of Diseases version 10.

CMS approves the IAPDU in accordance with Section 1903(a)(3) of the Social Security Act, as well as 42 CFR § 433, subpart C, 45 CFR § 95, subpart F, and Part 11 of the State Medicaid Manual (SMM). As requested in the IAPDU, CMS approves additional funding in the amount of \$1,465,370 for MMIS modifications. This amount includes Federal Financial Participation (FFP) in the amounts and match rates of \$1,193,326 at 90 percent and \$69,726 at 50 percent; Totaling: \$1,263,052 of new funding. CMS also approves moving \$4,186,000 (\$3,767,400 at 90 percent FFP) of prior approved funding to federal fiscal year 2015. The grand total of all funding approved for this project is \$18,549,414 (\$16,205,001 Total FFP; \$15,283,010 at 90 percent; \$413,535 at 75 percent; \$508,456 at 50 percent). Funding approval will expire on September 30, 2015.

As specified in 42 CFR § 433.112, Kentucky must ensure that MMIS modifications incorporate the Seven Conditions and Standards for enhanced funding for Medicaid Information Technology projects. The Seven Conditions and Standards include requirements for MMIS project alignment with the Medicaid Information Technology Architecture (MITA) 3.0 framework for business, technical, and information standards and services, as well as the MITA Maturity Model for measuring business process improvement.

CMS will continue to work closely with Kentucky as the state advances this critically important MMIS project. Project updates will be included as standing agenda items during the regular monthly MMIS calls between CMS and the state. Kentucky is also reminded that onsite reviews will be conducted to determine whether or not the objectives for which FFP was approved are being accomplished, and whether or not the automatic data processing (ADP) equipment or

Mr. Lawrence Kissner  
Page 2

services are being efficiently and effectively utilized in support of approved programs or projects as provided for at 45 CFR Part 95 § 621 and the SMM. As provided by the SMM, Section 11200 and by 45 CFR § 95.611, all subsequent revisions and amendments to the APD will require CMS prior written approval to qualify for FFP. In accordance with 45 CFR § 95.623, state acquisition of ADP equipment and services without prior approval could result in disallowance of FFP.

This approval consolidates and supersedes all other funding approvals for this project. If there are any questions concerning this information, please contact L. David Hinson at (404) 562-7411 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  
Atlanta Regional Office  
61 Forsyth Street, Suite 4T20  
Atlanta, Georgia 30303



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

November 25, 2014



KY-15-005

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

Dear Mr. Kissner:

The request for emergency authorization to complete the procurement of a new contract with Hewlett Packard is approved under 45 CFR, Part 95, Subpart F, para 95.624. Centers for Medicare & Medicaid Services (CMS) recognizes that an emergency exists as the existing contract for operations and maintenance of the Kentucky Medicaid Management Information System (MMIS) will expire on November 30, 2014.

The State is hereby instructed that within 90 days from the date of the State's initial request, the State must submit a formal request for approval which includes the information specified at 45 CFR, Part 95, para 95.611 in order for the advance data processing (ADP) equipment or services acquisition to be considered for the CMS approval. If CMS approves your request federal financial participation (FFP) will be available from the date the State acquires the ADP equipment and services.

If there are any questions concerning this information, please contact L. David Hinson at (404) 562-7411 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

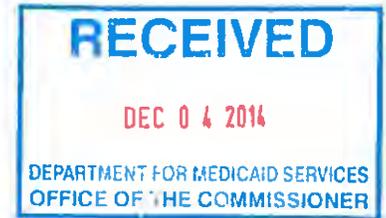
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**Disabled & Elderly Health Programs Group**

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DEC 02 2014



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

Dear Commissioner Kissner:

The Centers for Medicare & Medicaid Services (CMS) received your request, dated November 21, 2014, 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 December 30, 2014.

You have requested this extension to ensure the state has time to submit a complete waiver application and cost effectiveness spreadsheets with documents. CMS is granting a ninety (90) day 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 March 31, 2014.

The CMS will continue to work with your staff during the extension period. If you have any questions, please contact Cheryl Brimage, in the Atlanta Regional Office, at (404)562-7116 or Lovie Davis, of my staff, at (410) 786-1533.

Sincerely,

Barbara Coulter Edwards  
Director

cc: Cheryl Brimage, Atlanta Regional Office  
Shantrina Roberts, Atlanta Regional Office  
Jackie Glaze, Atlanta Regional Office

*COPIES FOR MAC & MGT TEAM*

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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December 4, 2014

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



Dear Mr. Kissner,

The Centers for Medicare & Medicaid Services (CMS) is conducting a quality review of Kentucky's Acquired Brain Injury Waiver for individuals with acquired brain injury who would benefit from intensive rehabilitation services, waiver number 0333.R03. This review will be used to evaluate the overall performance of this waiver program throughout the currently approved period (January 1, 2012 – December 31, 2016) and to identify the need for any modifications or technical assistance necessary to continue successful operation of this waiver program. The results of this review will serve to inform both the state and CMS of the state's compliance with waiver assurances in anticipation of the waiver's renewal. The expiration date of this waiver is December 31, 2016.

The CMS requests states to demonstrate adequate and effective mechanisms for finding and resolving compliance issues on an ongoing basis. Enclosed with this letter is a listing of the types of evidence-based information CMS must review in order to determine the state's implementation of its quality management and improvement strategy – that is discovery, remediation and improvement activities with regard to all of the waiver assurances. We request you submit the information identified in the enclosure to this office within ninety days of receipt of this letter. To expedite the review process, we ask that you provide concise, specific information that demonstrates your state's implementation of your quality management and improvement strategy.

While we recognize the value of state policies and procedures with regard to oversight activities, this evaluation focuses on the extent to which the policies and procedures have been implemented, and the results of the state's oversight activities. That is, how does the state identify quality issues, and how do they address them when they are identified? As you will see in the attachment, we are requesting evidence as to the implementation of oversight activities.

Page 2

Mr. Lawrence Kissner

After reviewing the requested submissions, Melanie Benning will contact your staff to discuss necessary follow-up activities. Please feel free to contact her at (404) 562-7414 with any questions related to this request.

Sincerely,



Jackie Glaze

Associate Regional Administrator

Division of Medicaid & Children's Health Operations

Attachment: HCBS Quality Review Worksheet

cc: Michele MacKenzie, Central Office

# HCBS Quality Review Work Sheet

## I. Level of Care (LOC) Determination

<i>The State demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care consistent with care provided in a hospital, NF, or ICF/MR.</i>		
Sub Assurances	CMS Expectations	Types of Evidence
<p>An evaluation for level of care is provided to all applicants for whom there is reasonable indication that services may be needed in the future.</p>	<p>State submits evidence that it has reviewed applicant files to verify that individual level of care evaluations are conducted.</p>	<p>Summary reports based on a significant sample of any single or combined method or source of evidence as follows:</p> <ul style="list-style-type: none"> <li>✓ Record Reviews, on-site</li> <li>✓ Record reviews, off-site</li> <li>✓ Training verification records</li> <li>✓ On-site observations, interviews, monitoring</li> <li>✓ Analyzed collected data (including surveys, focus group, interviews, etc)</li> <li>✓ Trends, remediation actions proposed / taken</li> <li>✓ Provider performance monitoring</li> <li>✓ Operating agency performance monitoring</li> <li>✓ Staff observation/opinion</li> <li>✓ Participant/family observation/opinion</li> <li>✓ Critical events and incident reports</li> <li>✓ Mortality reviews</li> <li>✓ Program logs</li> <li>✓ Medication administration data reports, logs</li> <li>✓ Financial records (including expenditures)</li> <li>Financial audits</li> <li>Meeting minutes</li> <li>Presentation of policies or procedures</li> <li>Reports to State Medicaid Agency on delegated administrative functions</li> <li>Other</li> </ul>
<p>The level of care of enrolled participants is reevaluated at least annually or as specified in its approved waiver.</p>	<p>State submits evidence that it regularly reviews participant files to verify that reevaluations of level of care are conducted at least annually or as specified in the approved waiver.</p>	
<p>The process and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.</p>	<p>State submits that it regularly reviews participant files to verify that the instrument described in approved waiver is used in all level of care re-determinations, the person(s) who implement level of care determinations are those specified in approved waiver, and the process/instruments are applied appropriately.</p>	

## II. Service Plans

*The State demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.*

Sub Assurances	CMS Expectations	Types of Evidence
<p>Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by waiver services or through other means.</p>	<p>State demonstrates that service plans are reviewed periodically to assure that all of participant needs are addressed and preferences considered.</p>	<p>Summary reports based on a significant sample of any single or combined method or source of evidence as follows:</p> <ul style="list-style-type: none"> <li>✓ Record Reviews, on-site</li> <li>✓ Record reviews, off-site</li> <li>✓ Training verification records</li> <li>✓ On-site observations, interviews, monitoring</li> </ul>
<p>The state monitors service plan development in accordance with its policies and procedures.</p>	<p>State submits evidence of its monitoring process for service plan development and any corrective action taken when service plans were not developed according to policies and procedures.</p>	<ul style="list-style-type: none"> <li>✓ Analyzed collected data (including surveys, focus group, interviews, etc)</li> <li>✓ Trends, remediation actions proposed / taken</li> </ul>
<p>Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.</p>	<p>State submits evidence of its monitoring process for service plan update/revision including service plan updates when a participant's needs changed and corrective actions taken when service plans were not updated/revised according to policies and procedures.</p>	<ul style="list-style-type: none"> <li>✓ Provider performance monitoring</li> <li>✓ Operating agency performance monitoring</li> <li>✓ Staff observation/opinion</li> <li>✓ Participant/family observation/opinion</li> <li>✓ Critical events and incident reports</li> <li>✓ Mortality reviews</li> <li>✓ Program logs</li> <li>✓ Medication administration data reports, logs</li> <li>✓ Financial records (including expenditures)</li> <li>Financial audits</li> <li>Meeting minutes</li> <li>Reports to State Medicaid Agency on delegated administrative functions</li> <li>Presentation of policies or procedures</li> <li>Other</li> </ul>

## Service Plans (Continued)

The State demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

Sub Assurances	CMS Expectations	Types of Evidence
<p>Services are delivered in accordance with the service plan, including in the type, scope, amount, and frequency specified in the service plan.</p>	<p>State submits evidence of the results of its monitoring process for ensuring the services identified in the service plan are implemented.</p>	<p>Summary reports based on a significant sample of any single or combined method or source of evidence as follows:</p> <ul style="list-style-type: none"> <li>✓ Record Reviews, on-site</li> <li>✓ Record reviews, off-site</li> <li>✓ Training verification records</li> <li>✓ On-site observations, interviews, monitoring</li> <li>✓ Analyzed collected data (including surveys, focus group, interviews, etc)</li> <li>✓ Trends, remediation actions proposed / taken</li> <li>✓ Provider performance monitoring</li> <li>✓ Operating agency performance monitoring</li> <li>✓ Staff observation/opinion</li> <li>✓ Participant/family observation/opinion</li> <li>✓ Critical events and incident reports</li> <li>✓ Mortality reviews</li> <li>✓ Program logs</li> <li>✓ Medication administration data reports, logs</li> <li>✓ Financial records (including expenditures)</li> </ul>
<p>Participants are afforded choice:            1) Between waiver services and institutional care; and            2) Between/among waivers services and providers.</p>	<p>State submits evidence of the results of its monitoring process for ensuring the services identified in the service plan are implemented.</p>	<ul style="list-style-type: none"> <li>Financial audits</li> <li>Meeting minutes</li> <li>Reports to State Medicaid Agency on delegated administrative functions</li> <li>Presentation of policies or procedures</li> <li>Other</li> </ul>

### III. Qualified Providers

The State demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

Sub Assurances	CMS Expectations	Types of Evidence
<p>The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other state standards prior to their furnishing waiver services.</p>	<p>State provides documentation of periodic review by licensing/certification entity.</p>	<p>Summary reports based on a significant sample of any single or combined method or source of evidence as follows:</p> <ul style="list-style-type: none"> <li>✓ Record Reviews, on-site</li> <li>✓ Record reviews, off-site</li> <li>✓ Training verification records</li> <li>✓ On-site observations, interviews, monitoring</li> <li>✓ Analyzed collected data (including surveys, focus group, interviews, etc)</li> <li>✓ Trends, remediation actions proposed / taken</li> </ul>
<p>The state monitors non-licensed/non-certified providers to assure adherence to waiver requirements.</p>	<p>State provides documentation that non-licensed/non-certified providers are monitored on a periodic basis sufficient to provide protections to waiver participants.</p>	<ul style="list-style-type: none"> <li>✓ Provider performance monitoring</li> <li>✓ Operating agency performance monitoring</li> <li>✓ Staff observation/opinion</li> <li>✓ Participant/family observation/opinion</li> <li>✓ Critical events and incident reports</li> <li>✓ Mortality reviews</li> <li>✓ Program logs</li> <li>✓ Medication administration data reports, logs</li> <li>✓ Financial records (including expenditures)</li> </ul>
<p>The state implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.</p>	<p>State provides documentation of monitoring of training and actions it has taken when providers have not met requirements (e.g., technical assistance, training).</p>	<ul style="list-style-type: none"> <li>Financial audits</li> <li>Meeting minutes</li> <li>Reports to State Medicaid Agency on delegated administrative functions</li> <li>Presentation of policies or procedures</li> <li>Other</li> </ul>

## IV. Health and Welfare

The State demonstrates, on an ongoing basis that it identifies, addresses, and seeks to prevent instances of abuse, neglect and exploitation.

Sub Assurances	CMS Expectations	Types of Evidence
<p>The state, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.</p>	<p>State demonstrates that, on an ongoing basis, abuse, neglect and exploitation are identified, appropriate actions have been taken when the health or welfare of a participant has not been safeguarded, and an analysis is conducted of abuse, neglect and exploitation trends and strategies it has implemented for prevention.</p>	<p>Summary reports based on a significant sample of any single or combined method or source of evidence as follows:</p> <ul style="list-style-type: none"> <li>✓ Record Reviews, on-site</li> <li>✓ Record reviews, off-site</li> <li>✓ Training verification records</li> <li>✓ On-site observations, interviews, monitoring</li> <li>✓ Analyzed collected data (including surveys, focus group, interviews, etc)</li> <li>✓ Trends, remediation actions proposed / taken</li> <li>✓ Provider performance monitoring</li> <li>✓ Operating agency performance monitoring</li> <li>✓ Staff observation/opinion</li> <li>✓ Participant/family observation/opinion</li> <li>✓ Critical events and incident reports</li> <li>✓ Mortality reviews</li> <li>✓ Program logs</li> <li>✓ Medication administration data reports, logs</li> <li>✓ Financial records (including expenditures)</li> <li>Financial audits</li> <li>Reports to State Medicaid Agency on delegated administrative functions</li> <li>Meeting minutes</li> <li>Presentation of policies or procedures</li> <li>Other</li> </ul>

## V. Administrative Authority

*The State demonstrates that it retains ultimate administrative authority over the waiver program and that its administration of the waiver program is consistent with the approved waiver application.*

Sub Assurances	CMS Expectations	Types of Evidence
<p>The Medicaid agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other State and local/regional non-State agencies (if appropriate) and contracted entities.</p>	<p>State submits evidence of its monitoring of all delegated functions, and implementation of policies/procedures related to its administrative authority over the waiver program, including: memoranda of agreements, description of roles and responsibilities relative to program operations, monitoring, and remediation or system improvements instituted when problems are identified in the operation of the waiver program.</p>	<p>Summary reports based on a significant sample of any single or combined method or source of evidence as follows:</p> <ul style="list-style-type: none"> <li>✓ Record Reviews, on-site</li> <li>✓ Record reviews, off-site</li> <li>✓ Training verification records</li> <li>✓ On-site observations, interviews, monitoring</li> <li>✓ Analyzed collected data (including surveys, focus group, interviews, etc)</li> <li>✓ Trends, remediation actions proposed / taken</li> <li>✓ Provider performance monitoring</li> <li>✓ Operating agency performance monitoring</li> <li>✓ Staff observation/opinion</li> <li>✓ Participant/family observation/opinion</li> <li>✓ Critical events and incident reports</li> <li>✓ Mortality reviews</li> <li>✓ Program logs</li> <li>✓ Medication administration data reports, logs</li> <li>✓ Financial records (including expenditures)</li> <li>Financial audits</li> <li>Meeting minutes</li> <li>Reports to State Medicaid Agency on delegated administrative functions</li> <li>Presentation of policies or procedures</li> <li>Other</li> </ul>

## VI. Financial Accountability

*The State demonstrates that it has designed and implemented an adequate system for assuring financial accountability of the waiver program.*

Sub Assurances	CMS Expectations	Types of Evidence
<p>State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.</p>	<p>State submits results of its financial monitoring process for verifying maintenance of appropriate financial records as specified in approved waiver.</p> <p>State submits results of its review of waiver participant claims to verify that they are coded and paid in accordance with the waiver reimbursement methodology.</p> <p>State demonstrates that interviews with State staff and providers are periodically conducted to verify that any identified financial irregularities are addressed.</p> <p>State demonstrates that site visits are conducted with providers to verify that they maintain financial records according to provider agreements/contracts.</p>	<p>Summary reports based on a significant sample of any single or combined method or source of evidence as follows:</p> <ul style="list-style-type: none"> <li>✓ Record Reviews, on-site</li> <li>✓ Record reviews, off-site</li> <li>✓ Training verification records</li> <li>✓ On-site observations, interviews, monitoring</li> <li>✓ Analyzed collected data (including surveys, focus group, interviews, etc)</li> <li>✓ Trends, remediation actions proposed / taken</li> <li>✓ Provider performance monitoring</li> <li>✓ Operating agency performance monitoring</li> <li>✓ Staff observation/opinion</li> <li>✓ Participant/family observation/opinion</li> <li>✓ Critical events and incident reports</li> <li>✓ Mortality reviews</li> <li>✓ Program logs</li> <li>✓ Medication administration data reports, logs</li> <li>✓ Financial records (including expenditures)</li> </ul> <p>Financial audits Meeting minutes Reports to State Medicaid Agency on delegated administrative functions Presentation of policies or procedures Other</p>

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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December 4, 2014

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

Dear Mr. Kissner,

The Centers for Medicare & Medicaid Services (CMS) is conducting a quality review of Kentucky's Acquired Brain Injury Waiver for individuals with acquired brain injury who would benefit from intensive rehabilitation services, waiver number 0333.R03. This review will be used to evaluate the overall performance of this waiver program throughout the currently approved period (January 1, 2012 – December 31, 2016) and to identify the need for any modifications or technical assistance necessary to continue successful operation of this waiver program. The results of this review will serve to inform both the state and CMS of the state's compliance with waiver assurances in anticipation of the waiver's renewal. The expiration date of this waiver is December 31, 2016.

The CMS requests states to demonstrate adequate and effective mechanisms for finding and resolving compliance issues on an ongoing basis. Enclosed with this letter is a listing of the types of evidence-based information CMS must review in order to determine the state's implementation of its quality management and improvement strategy – that is discovery, remediation and improvement activities with regard to all of the waiver assurances. We request you submit the information identified in the enclosure to this office within ninety days of receipt of this letter. To expedite the review process, we ask that you provide concise, specific information that demonstrates your state's implementation of your quality management and improvement strategy.

While we recognize the value of state policies and procedures with regard to oversight activities, this evaluation focuses on the extent to which the policies and procedures have been implemented, and the results of the state's oversight activities. That is, how does the state identify quality issues, and how do they address them when they are identified? As you will see in the attachment, we are requesting evidence as to the implementation of oversight activities.

Page 2

Mr. Lawrence Kissner

After reviewing the requested submissions, Melanie Benning will contact your staff to discuss necessary follow-up activities. Please feel free to contact her at (404) 562-7414 with any questions related to this request.

Sincerely,



Jackie Glaze

Associate Regional Administrator

Division of Medicaid & Children's Health Operations

Attachment: HCBS Quality Review Worksheet

cc: Michele MacKenzie, Central Office

# HCBS Quality Review Work Sheet

## I. Level of Care (LOC) Determination

<i>The State demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care consistent with care provided in a hospital, NF, or ICF/MR.</i>		
Sub Assurances	CMS Expectations	Types of Evidence
<p>An evaluation for level of care is provided to all applicants for whom there is reasonable indication that services may be needed in the future.</p>	<p>State submits evidence that it has reviewed applicant files to verify that individual level of care evaluations are conducted.</p>	<p>Summary reports based on a significant sample of any single or combined method or source of evidence as follows:</p> <ul style="list-style-type: none"> <li>✓ Record Reviews, on-site</li> <li>✓ Record reviews, off-site</li> <li>✓ Training verification records</li> <li>✓ On-site observations, interviews, monitoring</li> <li>✓ Analyzed collected data (including surveys, focus group, interviews, etc)</li> <li>✓ Trends, remediation actions proposed / taken</li> <li>✓ Provider performance monitoring</li> <li>✓ Operating agency performance monitoring</li> <li>✓ Staff observation/opinion</li> <li>✓ Participant/family observation/opinion</li> <li>✓ Critical events and incident reports</li> <li>✓ Mortality reviews</li> <li>✓ Program logs</li> <li>✓ Medication administration data reports, logs</li> <li>✓ Financial records (including expenditures)</li> <li>Financial audits</li> <li>Meeting minutes</li> <li>Presentation of policies or procedures</li> <li>Reports to State Medicaid Agency on delegated administrative functions</li> <li>Other</li> </ul>
<p>The level of care of enrolled participants is reevaluated at least annually or as specified in its approved waiver.</p>	<p>State submits evidence that it regularly reviews participant files to verify that reevaluations of level of care are conducted at least annually or as specified in the approved waiver.</p>	
<p>The process and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.</p>	<p>State submits that it regularly reviews participant files to verify that the instrument described in approved waiver is used in all level of care re-determinations, the person(s) who implement level of care determinations are those specified in approved waiver, and the process/instruments are applied appropriately.</p>	

## II. Service Plans

*The State demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.*

Sub Assurances	CMS Expectations	Types of Evidence
<p>Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by waiver services or through other means.</p>	<p>State demonstrates that service plans are reviewed periodically to assure that all of participant needs are addressed and preferences considered.</p>	<p>Summary reports based on a significant sample of any single or combined method or source of evidence as follows:</p> <ul style="list-style-type: none"> <li>✓ Record Reviews, on-site</li> <li>✓ Record reviews, off-site</li> <li>✓ Training verification records</li> <li>✓ On-site observations, interviews, monitoring</li> <li>✓ Analyzed collected data (including surveys, focus group, interviews, etc)</li> <li>✓ Trends, remediation actions proposed / taken</li> </ul>
<p>The state monitors service plan development in accordance with its policies and procedures.</p>	<p>State submits evidence of its monitoring process for service plan development and any corrective action taken when service plans were not developed according to policies and procedures.</p>	<ul style="list-style-type: none"> <li>✓ Provider performance monitoring</li> <li>✓ Operating agency performance monitoring</li> <li>✓ Staff observation/opinion</li> <li>✓ Participant/family observation/opinion</li> <li>✓ Critical events and incident reports</li> <li>✓ Mortality reviews</li> <li>✓ Program logs</li> <li>✓ Medication administration data reports, logs</li> </ul>
<p>Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.</p>	<p>State submits evidence of its monitoring process for service plan update/revision including service plan updates when a participant's needs changed and corrective actions taken when service plans were not updated/revised according to policies and procedures.</p>	<ul style="list-style-type: none"> <li>✓ Financial records (including expenditures)</li> <li>Financial audits</li> <li>Meeting minutes</li> <li>Reports to State Medicaid Agency on delegated administrative functions</li> <li>Presentation of policies or procedures</li> <li>Other</li> </ul>

## Service Plans (Continued)

The State demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

Sub Assurances	CMS Expectations	Types of Evidence
<p>Services are delivered in accordance with the service plan, including in the type, scope, amount, and frequency specified in the service plan.</p>	<p>State submits evidence of the results of its monitoring process for ensuring the services identified in the service plan are implemented.</p>	<p>Summary reports based on a significant sample of any single or combined method or source of evidence as follows:</p> <ul style="list-style-type: none"> <li>✓ Record Reviews, on-site</li> <li>✓ Record reviews, off-site</li> <li>✓ Training verification records</li> <li>✓ On-site observations, interviews, monitoring</li> <li>✓ Analyzed collected data (including surveys, focus group, interviews, etc)</li> <li>✓ Trends, remediation actions proposed / taken</li> <li>✓ Provider performance monitoring</li> <li>✓ Operating agency performance monitoring</li> <li>✓ Staff observation/opinion</li> <li>✓ Participant/family observation/opinion</li> <li>✓ Critical events and incident reports</li> <li>✓ Mortality reviews</li> <li>✓ Program logs</li> <li>✓ Medication administration data reports, logs</li> <li>✓ Financial records (including expenditures)</li> </ul>
<p>Participants are afforded choice:</p> <ol style="list-style-type: none"> <li>1) Between waiver services and institutional care; and</li> <li>2) Between/among waivers services and providers.</li> </ol>	<p>State submits evidence of the results of its monitoring process for ensuring the services identified in the service plan are implemented.</p>	<ul style="list-style-type: none"> <li>✓ Financial audits</li> <li>✓ Meeting minutes</li> <li>✓ Reports to State Medicaid Agency on delegated administrative functions</li> <li>✓ Presentation of policies or procedures</li> <li>Other</li> </ul>

### III. Qualified Providers

*The State demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.*

Sub Assurances	CMS Expectations	Types of Evidence
<p>The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other state standards prior to their furnishing waiver services.</p>	<p>State provides documentation of periodic review by licensing/certification entity.</p>	<p>Summary reports based on a significant sample of any single or combined method or source of evidence as follows:</p> <ul style="list-style-type: none"> <li>✓ Record Reviews, on-site</li> <li>✓ Record reviews, off-site</li> <li>✓ Training verification records</li> <li>✓ On-site observations, interviews, monitoring</li> </ul>
<p>The state monitors non-licensed/non-certified providers to assure adherence to waiver requirements.</p>	<p>State provides documentation that non-licensed/non-certified providers are monitored on a periodic basis sufficient to provide protections to waiver participants.</p>	<ul style="list-style-type: none"> <li>✓ Analyzed collected data (including surveys, focus group, interviews, etc)</li> <li>✓ Trends, remediation actions proposed / taken</li> </ul>
<p>The state implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.</p>	<p>State provides documentation of monitoring of training and actions it has taken when providers have not met requirements (e.g., technical assistance, training).</p>	<ul style="list-style-type: none"> <li>✓ Provider performance monitoring</li> <li>✓ Operating agency performance monitoring</li> <li>✓ Staff observation/opinion</li> <li>✓ Participant/family observation/opinion</li> <li>✓ Critical events and incident reports</li> <li>✓ Mortality reviews</li> <li>✓ Program logs</li> <li>✓ Medication administration data reports, logs</li> <li>✓ Financial records (including expenditures)</li> <li>Financial audits</li> <li>Meeting minutes</li> <li>Reports to State Medicaid Agency on delegated administrative functions</li> <li>Presentation of policies or procedures</li> <li>Other</li> </ul>

## IV. Health and Welfare

The State demonstrates, on an ongoing basis that it identifies, addresses, and seeks to prevent instances of abuse, neglect and exploitation.

Sub Assurances	CMS Expectations	Types of Evidence
<p>The state, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.</p>	<p>State demonstrates that, on an ongoing basis, abuse, neglect and exploitation are identified, appropriate actions have been taken when the health or welfare of a participant has not been safeguarded, and an analysis is conducted of abuse, neglect and exploitation trends and strategies it has implemented for prevention.</p>	<p>Summary reports based on a significant sample of any single or combined method or source of evidence as follows:</p> <ul style="list-style-type: none"> <li>✓ Record Reviews, on-site</li> <li>✓ Record reviews, off-site</li> <li>✓ Training verification records</li> <li>✓ On-site observations, interviews, monitoring</li> <li>✓ Analyzed collected data (including surveys, focus group, interviews, etc)</li> <li>✓ Trends, remediation actions proposed / taken</li> <li>✓ Provider performance monitoring</li> <li>✓ Operating agency performance monitoring</li> <li>✓ Staff observation/opinion</li> <li>✓ Participant/family observation/opinion</li> <li>✓ Critical events and incident reports</li> <li>✓ Mortality reviews</li> <li>✓ Program logs</li> <li>✓ Medication administration data reports, logs</li> <li>✓ Financial records (including expenditures)</li> <li>Financial audits</li> <li>Reports to State Medicaid Agency on delegated administrative functions</li> <li>Meeting minutes</li> <li>Presentation of policies or procedures</li> <li>Other</li> </ul>

## V. Administrative Authority

*The State demonstrates that it retains ultimate administrative authority over the waiver program and that its administration of the waiver program is consistent with the approved waiver application.*

Sub Assurances	CMS Expectations	Types of Evidence
<p>The Medicaid agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other State and local/regional non-State agencies (if appropriate) and contracted entities.</p>	<p>State submits evidence of its monitoring of all delegated functions, and implementation of policies/procedures related to its administrative authority over the waiver program, including: memoranda of agreements, description of roles and responsibilities relative to program operations, monitoring, and remediation or system improvements instituted when problems are identified in the operation of the waiver program.</p>	<p>Summary reports based on a significant sample of any single or combined method or source of evidence as follows:</p> <ul style="list-style-type: none"> <li>✓ Record Reviews, on-site</li> <li>✓ Record reviews, off-site</li> <li>✓ Training verification records</li> <li>✓ On-site observations, interviews, monitoring</li> <li>✓ Analyzed collected data (including surveys, focus group, interviews, etc)</li> <li>✓ Trends, remediation actions proposed / taken</li> <li>✓ Provider performance monitoring</li> <li>✓ Operating agency performance monitoring</li> <li>✓ Staff observation/opinion</li> <li>✓ Participant/family observation/opinion</li> <li>✓ Critical events and incident reports</li> <li>✓ Mortality reviews</li> <li>✓ Program logs</li> <li>✓ Medication administration data reports, logs</li> <li>✓ Financial records (including expenditures)</li> <li>Financial audits</li> <li>Meeting minutes</li> <li>Reports to State Medicaid Agency on delegated administrative functions</li> <li>Presentation of policies or procedures</li> <li>Other</li> </ul>

## VI. Financial Accountability

*The State demonstrates that it has designed and implemented an adequate system for assuring financial accountability of the waiver program.*

Sub Assurances	CMS Expectations	Types of Evidence
<p>State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.</p>	<p>State submits results of its financial monitoring process for verifying maintenance of appropriate financial records as specified in approved waiver.</p> <p>State submits results of its review of waiver participant claims to verify that they are coded and paid in accordance with the waiver reimbursement methodology.</p> <p>State demonstrates that interviews with State staff and providers are periodically conducted to verify that any identified financial irregularities are addressed.</p> <p>State demonstrates that site visits are conducted with providers to verify that they maintain financial records according to provider agreements/contracts.</p>	<p>Summary reports based on a significant sample of any single or combined method or source of evidence as follows:</p> <ul style="list-style-type: none"> <li>✓ Record Reviews, on-site</li> <li>✓ Record reviews, off-site</li> <li>✓ Training verification records</li> <li>✓ On-site observations, interviews, monitoring</li> <li>✓ Analyzed collected data (including surveys, focus group, interviews, etc)</li> <li>✓ Trends, remediation actions proposed / taken</li> <li>✓ Provider performance monitoring</li> <li>✓ Operating agency performance monitoring</li> <li>✓ Staff observation/opinion</li> <li>✓ Participant/family observation/opinion</li> <li>✓ Critical events and incident reports</li> <li>✓ Mortality reviews</li> <li>✓ Program logs</li> <li>✓ Medication administration data reports, logs</li> <li>✓ Financial records (including expenditures)</li> </ul> <p>Financial audits Meeting minutes Reports to State Medicaid Agency on delegated administrative functions Presentation of policies or procedures Other</p>

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**

DEC 18 2014

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



Dear Commissioner Kissner,

The Centers for Medicare & Medicaid Services (CMS) received your request dated November 21, 2014 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 December 30, 2014.

You have requested this extension to ensure the state has time to submit a complete waiver application and cost effectiveness spreadsheets with documents. 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 March 31, 2015.

The CMS will continue to work with your staff during the extension period. If you have any questions, please contact Cheryl Brimage in the Atlanta Regional Office at (404)562-7116 or Lovie Davis of my staff at (410) 786-1533.

Sincerely,

A handwritten signature in black ink that reads "Barbara Coulter Edwards". The signature is written in a cursive style.

Barbara Coulter Edwards  
Director

cc: Cheryl Brimage, Atlanta Regional Office  
Shantrina Roberts, Atlanta Regional Office  
Jackie Glaze, 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**

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**DATE:** December 19, 2014  
**TO:** Region IV State Medicaid Directors  
**FROM:** Jackie Glaze, Associate Regional Administrator  
**SUBJECT:** Sufficiency of Mandatory and Optional Services

We are sharing the below policy with you that provides further clarification on the sufficiency of mandatory and optional services and will serve as formalization of the current State Plan Amendment review practice.

We have developed a standard set of questions for evaluating the sufficiency of both mandatory and optional services for individuals 21 years and older. The purpose of these questions is to provide a consistent framework to determine compliance with Federal regulations at 42 CFR 440.230(b) with respect to the requirement that any service provided under the state plan is "sufficient in amount, duration and scope to reasonably achieve its purpose." This document is intended to clarify the circumstances under which these sufficiency questions are, and are not, required to be asked. We note that CMS and states should be familiar with the entirety of 42 CFR 440.230, which has implications beyond the sufficiency of benefits.

Previously, states that proposed an amount, duration or scope limitation on a mandatory service had to demonstrate that the limitation would meet the needs of at least 90% of the Medicaid population as a whole. This analysis does not depict the potential impact of the limitation on individuals with special health care needs such as pregnant women, elders, and individuals with disabilities. More recently we have modified that approach and this document reflects that modification. We are therefore clarifying that the sufficiency of mandatory services should be demonstrated by ensuring that the proposed limitation meets the needs of at least 90% of beneficiaries in each of the following eligibility groups, based on an analysis of claims data of individuals who have utilized the service (children are not listed here because EPSDT provisions ensure that across-the-board hard limits cannot be applied to children):

- Aged, blind and disabled
- Non-dually-eligible adults, unless the proposed limitation applies to a service in which Medicare is not the primary payer, when the analysis would include dually eligible adults
- Pregnant women
- Parents and caretakers
- Adult expansion group, if applicable

States have significant discretion in the provision of optional Medicaid services, including the ability to define the purpose the service is intended to achieve. However, we are clarifying here that optional services also must be provided in an amount, duration and scope that are sufficient to meet the State's defined purpose. Without meeting this threshold, the service could be meaningless, not meeting the needs of beneficiaries, and not cost effective for state or Federal reimbursement. Therefore states need to ensure the sufficiency of proposed amount, duration or scope limitations on optional services by providing the same data analysis as required for mandatory services, but as applied within the context of the state's defined purpose of the service. Based on the state's defined purpose of the service, limitations on optional services must meet the needs of at least 90% of beneficiaries in each of the eligibility groups listed above who have previously utilized the service. For instance, States looking to provide a dental benefit that relieves pain and prevents infection would need to demonstrate that their proposed dental benefit meets those needs of 90% of beneficiaries within each eligibility group who used the dental benefit.

As a general matter, the sufficiency questions apply when a State plan contains hard limitations on the amount, duration or scope of a mandatory or optional service. The questions also recognize situations when a state may not have appropriate or robust data to demonstrate the sufficiency of the limitation. In those cases, states will be asked to submit alternative documentation to support the sufficiency of the proposed service limitation. This may include a description of the state's process that led to the proposed/existing parameters of the benefit. Funding constraints alone do not justify the imposition of a benefit limit. A limit may be prompted by budgetary constraints, but to be approvable it must meet sufficiency standards. Depending on the limitation and information contained elsewhere in the SPA submission, the questions may need to be tailored to recognize the specific provisions in the SPA and some questions may not be appropriate to every SPA.

The sufficiency questions will be asked in the following circumstances when the State plan contains limitations on the amount, duration and scope of a service that cannot be exceeded with prior authorization or based on a determination of medical necessity by the State:

The sufficiency questions must be asked in the following circumstances:

- State is reducing the amount, duration or scope of a service;
- State is adding a new, limited service to a State plan (e.g., adding a limited scope of adult dental services);
- State is increasing existing coverage but that coverage still contains limits.

The sufficiency questions are not required in the following circumstances:

- The state is completely eliminating a service (in which case questions relating to advance notice to beneficiaries and continuity of treatment must be asked in lieu of sufficiency questions);
- The state is amending a service with no limitations noted or with "soft" limits that can be exceeded through prior authorization or some other process. Although sufficiency questions are not asked, other questions may be needed to confirm the service, such as how providers are educated that prior authorization should be pursued in order to provide services above a soft limit, rather than generating a bill to beneficiaries for services provided above the limit.

In addition, any prior authorization process utilized must not serve as a barrier to accessing needed services, and must be publicized to providers and stakeholders.

To ensure the sufficiency of each benefit provided to Medicaid beneficiaries, we are clarifying that hard limitations (i.e., service caps without a possible override based on medical necessity) encompassing more than one benefit category are not permitted. As CMS has communicated to states proposing aggregate limitations in their state plan, such an approach makes it virtually impossible to measure the sufficiency of each impacted benefit.

With respect to “same page” and “corresponding page” review, we will continue to follow the guidance contained in our letter to State Medicaid Directors dated 10/1/2010 as it applies to coverage; however, we will make determinations about whether to apply the new set of sufficiency questions to those SPAs on a case-by-case basis.

<http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD10020.pdf>

If you have any questions about the information contained in this memo, you may contact me at [Jackie.Glaze@cms.hhs.gov](mailto:Jackie.Glaze@cms.hhs.gov) or (404) 562-7417.

Thank you.

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

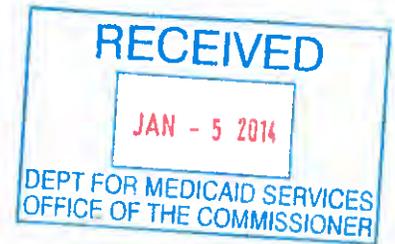


**DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS**

December 29, 2014

KY-15-006

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



Dear Mr. Kissner:

The Centers for Medicare & Medicaid Services has approved your annual Implementation Advance Planning Document Update (IAPDU), dated November 20, 2014, for the Medicaid Enterprise Management System (MEMS) in accordance with 45 CFR Part 95, Subpart F, and the State Medicaid Manual (SMM), Part 11. You are hereby authorized to carry forward \$6,821,829 (\$5,160,380 total federal financial participation; (\$264,045 at 90 percent; \$4,896,335 at 75 percent) previously approved by CMS. The state may use this funding through FFY 2016 for the Pharmacy Benefits Management (PBM) contract.

Please be advised that onsite reviews will be conducted to determine whether or not the objectives for which FFP was approved are being accomplished, and whether or not the automatic data processing equipment or services are being efficiently and effectively utilized in support of approved programs or projects as provided for at 45 CFR Part 95, Subpart F, Section 621 and the SMM. Allowable costs are determined by 45 CFR Part 95, Subpart F, Section 631 and the SMM, Part 11. Only actual costs incurred are reimbursable. The State must provide adequate support for all costs claimed in addition to providing detailed records and proper audit trails.

If you have any questions regarding this notice, please contact L. David Hinson at (404) 562-7411 or via email at [Lawrence.hinson@cms.hhs.gov](mailto:Lawrence.hinson@cms.hhs.gov).

Sincerely,

A handwritten signature in black ink that reads "Melanie Johnson" with "for" written below it.

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**

December 29, 2014

KY-15-007 & 008

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



Dear Mr. Kissner:

The Centers for Medicare & Medicaid Services has approved your annual Implementation Advance Planning Document Update (IAPDU), dated December 3, 2014, for the Medicaid Enterprise Management System (MEMS) in accordance with 45 CFR Part 95, Subpart F, and the State Medicaid Manual (SMM), Part 11. You are hereby authorized to expand the scope of the project to include participation in the creation of an All Payer Claims Database (APDC) and the corresponding contract. Kentucky is authorized to perform the project budget adjustments listed below with no increase to approved total project funding.

1. 90/10: Increase the MEMS Replacement Design, Development and Installation (DDI) line item to \$68,110,338 by shifting \$14,524,595 (\$13,072,136 federal share and \$1,452,459 Commonwealth share) from the state Project Resources DDI line.
2. 90/10: Decrease the Utilization Management line item to \$0.
3. 90/10: Decrease State Resources line item to \$20,065,003 by shifting \$17,787,394 (\$16,008,655 federal share and \$1,778,739 Commonwealth share). This line item also includes travel for Medicaid Management Information System (MMIS) related conferences.
4. 90/10: Increase Medicaid Waiver Management Application (MWMA) to \$6,161,311 by shifting \$1,326,900 (\$1,194,210 federal share and \$132,690 Commonwealth share) from the State Project Resources DDI line.
5. 90/10: Create Partner Portal line item by shifting \$375,000 (\$337,500 federal share and \$37,500 Commonwealth share) from the State Project Resources DDI line.
6. 90/10: Create APCD interface DDI line item by shifting \$1,725,400 (\$1,552,860 federal share and \$172,540 Commonwealth share) from the State Resources line and the Decision Support System/Data Warehouse DDI line.
7. 50/50: Create APCD DDI line item by shifting \$607,109 (\$303,554 federal share and \$303,555 Commonwealth share) from the State Project Resources DDI line.

Mr. Lawrence Kissner

Page 2

The state is reminded that it must submit the proposed contract for CMS prior approval and submit an updated IAPD to reflect actual costs. Please be advised that onsite reviews will be conducted to determine whether or not the objectives for which federal financial participation was approved are being accomplished, and whether or not the automatic data processing equipment or services are being efficiently and effectively utilized in support of approved programs or projects as provided for at 45 CFR Part 95, Subpart F, Section 621 and the SMM. Allowable costs are determined by 45 CFR Part 95, Subpart F, Section 631 and the SMM, Part 11. Only actual costs incurred are reimbursable. The State must provide adequate support for all costs claimed in addition to providing detailed records and proper audit trails.

If you have any questions regarding this notice, please contact L. David Hinson at (334) 791-7826 or via email at [Lawrence.hinson@cms.hhs.gov](mailto:Lawrence.hinson@cms.hhs.gov).

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