MAC Binder Section 2 – Letters to CMS

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CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES

Matthew G. Bevin
Governor

275 East Main Street, 6W-A
Frankfort, KY 40621
www.chfs.ky.gov

Adam M. Meier
Secretary

Carol H. Steckel, MPH
Commissioner

April 3, 2019

Shantrina Roberts
Acting Associate Regional Director
Centers for Medicare and Medicaid Services
61 Forsyth Street, SW, Suite 4T20
Atlanta, Georgia 30303-8909

RE: State Plan Amendment 19-001
Kentucky HEALTH SPA

Dear Ms. Roberts:

Due to the recent court ruling regarding Kentucky's 1115 waiver for Kentucky HEALTH, the state would like to withdraw SPA 19-001.

If you have any questions, please contact Sharley Hughes.

Sincerely,

Carol H. Steckel
Commissioner

CHS/sjh

Enclosure

CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES

Matthew G. Bevin
Governor

275 East Main Street, 6W-A
Frankfort, KY 40621
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Commissioner

April 5, 2019

Shantrina Roberts
Acting Associate Regional Director
Centers for Medicare and Medicaid Services
61 Forsyth Street, SW, Suite 4T20
Atlanta, Georgia 30303-8909

RE: State Plan Amendment 19-002
Substance Use Disorder

Dear Ms. Roberts:

Enclosed for your review and approval is Kentucky Title XIX State Plan Amendment No. 19-002. This amendment will change Kentucky's Substance Use Disorder benefits and add Medication Assisted Treatment. The Public Notice for this SPA was issued on March 22, 2019, and a copy of the notice is included in this SPA submittal package.

Because we are adding a new benefit with reimbursement, we are including the state's responses to CMS General Funding Questions.

1. Section 1903(a)(1) provides that federal matching funds are only available for expenditures made by states for services under the approved plan. Do providers receive and retain the Medicaid expenditures claimed by the state (includes normal per diem, supplemental, enhanced payment, 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 the response a full description of the repayment process. Include in the 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.)

DMS Response – Providers retain the full Medicaid reimbursement for all eligible claims.

2. 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 and IGT or CPE. In this case, please identify the agency to which the funds are appropriated. Please provide an estimate of total expenditure and the 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 governmental 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 entity;
iv. clarify whether the transferring or certifying entity has general taxing authority; and,
v. whether the certifying or transferring entity received appropriations (identify the level of appropriations).

DMS Response – State funds are from appropriations from the legislature to the Medicaid agency.

3. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1902(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.

DMS Response – Not applicable.as no supplemental payments will be processed under this SPA.

4. For clinic or outpatient hospital services, please provide a detailed description of the methodology used by the state to estimate the upper payment limit (UPL) for each class of providers (state owned or operated, non-state government owned or operated, and privately owned or operated). Please provide a current (i.e., applicable to the current rate year) UPL demonstration.

   DMS Response – Not applicable

5. 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?

   DMS Response – any funds that are paid inappropriately or in excess of the cost of services are recouped and the federal share is returned to CMS.

All correspondence relating to the Medicaid Program should be sent to my office.

If you have any questions, please contact Sharley Hughes.

Sincerely,

Carol H. Steckel
Commissioner

CHS/sjh

Enclosure

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 19-002

2. STATE: Kentucky

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2019

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN X AMENDMENT

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

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 430.12(b)

7. FEDERAL BUDGET IMPACT:
a. FFY 2018 $34,628,255
b. FFY 2019 $155,007,581

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Att 3.1-A, Page 7.6.1 (c) – Page 7.6.1 (tt)
Att 3.1-B, Page 31.5(c) – Page 31.5 (tt)
Att. 4.19-B, Page 20.15(1)(d) – Page 20.15(1)(d)1

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Same

10. SUBJECT OF AMENDMENT: The purpose of this SPA is to revise Kentucky's SUD benefits and to include Medication Assisted Treatment.

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
X OTHER, AS SPECIFIED: Review delegated to Commissioner, Department for Medicaid Services

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME: Carol H. Steckel

14. TITLE: Commissioner, Department for Medicaid Services

15. DATE SUBMITTED: 4/5/19

16. RETURN TO:

Department for Medicaid Services
275 East Main Street 6W-A
Frankfort, Kentucky 40621

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED:

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:

22. TITLE:

23. REMARKS: