MAC Binder Section 1 – Letters From CMS

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DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
61 Forsyth Street S.W. Suite 4T20
Atlanta, Georgia 30303-8909

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Atlanta Regional Operations Group

March 18, 2019

Carol H. Steckel, Commissioner
Department for Medicaid Services
275 East Main Street, 6WA
Frankfort, KY 40621-0001

Dear Ms. Steckel:

In accordance with 42 CFR 438.3(a), the Centers for Medicare & Medicaid Services (CMS) has reviewed and is approving Kentucky's non-emergency medical transportation prepaid ambulatory health plan (NEMT PAHP) contract amendment for the period of July 1, 2018 through June 30, 2020. CMS has also reviewed and approved the capitation rates for the period of July 1, 2018 through December 31, 2018. The contracts and the actuarial certification for the rates were received by the CMS Atlanta Regional Operations Group on July 6, 2018. The actuarial certification was resubmitted by the state on October 10, 2018.

Specifically, the following contract is approved: Non-Emergency Medical Transportation (NEMT) BENEFITS (PON2 748 1800001313).

We have identified provisions in the above-referenced contract that are non-compliant with federal regulatory requirements. In accordance with the January 11, 2019 e-mail communication with your staff, the agreed-upon date of compliance for all non-compliant items is June 30, 2019, for the contracts effective July 1, 2018. Pursuant to this agreement, we anticipate the state will execute and submit a contract to address these deficiencies.

Kentucky's contracts will expire on June 30, 2020. Kentucky's rates expired on December 31, 2018. The contracts and rates are approved for the purpose of federal financial participation effective July 01, 2018. We appreciate the effort and cooperation provided by your staff during our review. If you have questions concerning this letter, please contact Lynda Bennett at (404) 562-7352 or Melanie Benning at (404) 562-7414.

Sincerely,

Shantrina Roberts -S
Digitally signed by Shantrina Roberts -S
Date: 2019.03.18 13:23:02 -04'00'

Shantrina D. Roberts, MSN
Deputy Director
Division of Medicaid Field Operations South

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

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Children and Adults Health Programs Group

APR 1 9 2019

Ms. Carol Steckel
Medicaid Commissioner
Department for Medicaid Services
275 E. Main Street, 6W-D
Frankfort, KY 40621

Dear Ms. Steckel:

Your title XXI Children's Health Insurance Program (CHIP) state plan amendment (SPA) KY-18-0001-CHIP, submitted to the Centers for Medicare & Medicaid Services (CMS) on June 29, 2018 with additional information submitted on April 18, 2019, has been approved. Through this SPA, Kentucky implements mental health parity requirements to ensure that treatment limitations applied to mental health (MH) and substance use disorder (SUD) benefits are no more restrictive than those applied to medical/surgical (M/S) benefits. This SPA has an effective date of October 2, 2017.

Section 2103(c)(7)(A) of the Social Security Act (the Act), as implemented through regulations at 42 CFR 457.496(d)(3)-(5), requires states that provide both M/S and MH/SUD benefits to ensure that financial requirements and treatment limitations applied to MH/SUD benefits covered under the state child health plan are consistent with the mental health parity requirements of 2705(a) of the Public Health Service Act, in the same manner in that such requirements apply to a group health plan. Kentucky demonstrated compliance by providing the necessary assurances and supporting documentation that the state's application of non-quantitative treatment limitations (NQTLs) to MH/SUD benefits are consistent with section 2103(c)(7)(A) of the Act.

This approval relates only to benefits provided under the CHIP state plan; Medicaid benefits will be analyzed separately.

Your title XXI project officer is Ms. Cassie Lagorio. She is available to answer questions concerning this amendment and other CHIP-related issues. Ms. Lagorio's contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
Mail Stop: S2-01-16
7500 Security Boulevard
Baltimore, MD 21244-1850
Telephone: (410) 786-4554
E-mail: Cassandra.Lagorio@cms.hhs.gov

Official communications regarding program matters should be sent simultaneously to Ms. Lagorio and to Ms. Shantrina Roberts, Deputy Director, Division of Medicaid Field Operations South. Ms. Roberts's address is:

Centers for Medicare & Medicaid Services
Division of Medicaid Field Operations South
61 Forsyth Street, SW, Suite 4T20
Atlanta, GA 30303-8909

If you have additional questions, please contact Ms. Amy Lutzky, Director, Division of State Coverage Programs at (410) 786-0721.

We look forward to continuing to work with you and your staff.

Sincerely,

Anne Marie Costello
Director

Enclosure

cc: Ms. Shantrina Roberts, Deputy Director, Division of Medicaid Field Operations South

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
61 Forsyth Street S.W. Suite 4T20
Atlanta, Georgia 30303-8909

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Atlanta Regional Operations Group

April 15, 2019

Carol Steckel, Commissioner
Department for Medicaid Services
275 East Main Street – 6WA
Frankfort, KY 40621-0001

Attention: Sharley J. Hughes

Re: Kentucky State Plan Amendment, Transmittal # 19-0001

Dear Ms. Steckel:

We accept your request, dated April 3, 2019 to withdraw State Plan Amendment 19-0001. We are returning the Form HCFA-179 and the proposed amendment pages.

If you have any questions or need any further assistance, please contact Melanie Benning at 404-562-7414 or Melanie.Benning@cms.hhs.gov

Sincerely,

Trina Roberts

Shantrina D. Roberts, MSN
Deputy Director
Division of Medicaid Field Operations-South

Enclosures

Medicaid Alternative Benefit Plan

Medicaid Alternative Benefit Plan: General Information

State/Territory name: Kentucky

Transmittal Number: KY 19-001

General Information:

Submission Title:

short (under 100 characters) label used to identify this submission in the web application

KY ABP - New Adult Group

Description:

New Adult Group for Medicaid Expansion

☑ Public notice has been conducted prior to SPA submission pursuant to 42 CFR 440.386.

ABP Screening Statements to Indicate Required Forms

Select one of the following options for eligibility group coverage:

- ◉ **The population group for this Alternative Benefit Plan includes only** the adult group under section 1902(a)(10)(A)(i)(VIII) of the Act. *If the state selects this option, the state must complete form ABP2a to indicate agreement to voluntary benefit package selection assurances for the adult group.*
- ○ **The population group for this Alternative Benefit Plan includes the adult group under section 1902(a)(10)(A)(i)(VIII) of the Act, and also includes other groups.** *If the state selects this option, the state must complete forms ABP2a and ABP2b to indicate agreement to voluntary benefit package selection assurances for the adult group and voluntary enrollment assurances for other eligibility groups.*
- ○ **The population for this Alternative Benefit Plan does not include the adult group under section 1902(a)(10)(A)(i)(VIII) of the Act.** *If the state selects this option, the state must complete form ABP2b to indicate agreement to voluntary enrollment assurances for these eligibility groups.*

☑ Enrollment is mandatory for some or all participants. *If selected, the state must complete form ABP2c to indicate agreement to mandatory enrollment assurances.*

Specify the number of **benchmark** benefit packages that will be created or amended with this submission. *The state must submit one version of forms ABP3, ABP4, ABP5, and ABP8 for each benchmark benefit package.* 1

Specify the number of **benchmark-equivalent** benefit packages that will be created or amended with this submission. *The state must submit one version of forms ABP3, ABP4, ABP6, and ABP8 for each benchmark-equivalent benefit package.* 0

Medicaid Alternative Benefit Plan: File Management Summary

State/Territory name: Kentucky

Transmittal Number: KY 19-001

Form Code	Form Name	Uploaded Form Count
ABP1	Alternative Benefit Plan Populations	1
ABP2a	Voluntary Benefit Package Selection Assurances - Eligibility Group under Section 1902(a)(10)(A)(i)(VIII) of the Act	1
ABP2b	Voluntary Enrollment Assurances for Eligibility Groups other than the Adult Group under Section 1902(a)(10)(A)(i)(VIII) of the Act	0
ABP2c	Enrollment Assurances - Mandatory Participants	1
ABP3	Selection of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package	1
ABP4	Alternative Benefit Plan Cost-Sharing	1
ABP5	Benefits Description	1
ABP6	Benchmark-Equivalent Benefit Package	0

Form Code	Form Name	Uploaded Form Count
ABP7	Benefits Assurances	1
ABP8	Service Delivery Systems	1
ABP9	Employer Sponsored Insurance and Payment of Premiums	1
ABP10	General Assurances	1
ABP11	Payment Methodology	1

Medicaid Alternative Benefit Plan: File Management Detail

Form ABP1: Alternative Benefit Plan Populations

ABP1 Forms List

Form
Please provide a short description of this ABP1 form:
Uploaded Form Name: Date Uploaded: 12/06/2013
ABP1 - Alternative Benefit Plan Populations.pdf

Support Documents

Document
Please provide a short description of this support document:
Uploaded Document Name: Date Uploaded: 12/20/2013
Alternative Benefit Plan Notice.docx

Form ABP2a: Voluntary Benefit Package Selection Assurances - Eligibility Group under Section 1902(a)(10)(A)(i)(VIII) of the Act

ABP2a Forms List

Form
Please provide a short description of this ABP2a form:
Uploaded Form Name: Date Uploaded: 12/20/2013
ABP2a - Voluntary Benefit Package Selection Assurances.pdf

Support Documents

Document

Form ABP2b: Voluntary Enrollment Assurances for Eligibility Groups other than the Adult Group under Section 1902(a)(10)(A)(i)(VIII) of the Act

ABP2b Forms List

Form
Please provide a short description of this ABP2b form:
Uploaded Form Name: Date Uploaded:

Support Documents

Document

Form ABP2c: Enrollment Assurances - Mandatory Participants

ABP2c Forms List

Form
Please provide a short description of this ABP2c form:
Uploaded Form Name: Date Uploaded: ABP2c - Enrollment Assurances - Mandatory Participants.pdf

Support Documents

Document
Please provide a short description of this support document:
Uploaded Document Name: Date Uploaded: ABP2c Supporting Document Kentucky Medically Frail Medical Condition Guide Provider v5.docx
Please provide a short description of this support document:
Uploaded Document Name: Date Uploaded: ABP2c Supporting Document Kentucky Medically Frail Medical Condition Guide Provider v5.docx
Please provide a short description of this support document:
Uploaded Document Name: Date Uploaded: ABP2c Support Document Identifying Medically Frail Populations Kentucky Medicaid Case Study..._1
Please provide a short description of this support document:
Uploaded Document Name: Date Uploaded: ABP2c Supporting Document Kentucky Medically Frail Provider Attestation v5 DMS.docx
Please provide a short description of this support document:

Document

Uploaded Document Name: Date Uploaded:

ABP2c Supporting Document n Kentucky Medically Frail MCO Scoring Tool v3.xlsx

Please provide a short description of this support document:

Uploaded Document Name: Date Uploaded:

ABP2c Supporting Document n Kentucky MCO Presentation Medically Frail 2018.06.28.pptx

Form ABP3: Selection of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package

ABP3 Forms List

Form
Please provide a short description of this ABP3 form:

Uploaded Form Name: Date Uploaded: 12/04/2013

ABP3 - Selection of Benchmark Benefit Package or Benchmark Equivalent Package.pdf

Support Documents

Document

Form ABP4: Alternative Benefit Plan Cost-Sharing

ABP4 Forms List

Form
Please provide a short description of this ABP4 form:

Uploaded Form Name: Date Uploaded: 12/12/2013

ABP4 - Alternative Benefit Plan Cost-Sharing.pdf

Support Documents

Document

Form ABP5: Benefits Description

ABP5 Forms List

Form
Please provide a short description of this ABP5 form:

Form
Uploaded Form Name:
Date Uploaded: 12/20/2013
ABP5 - Benefits Description.pdf

Support Documents

Document
Please provide a short description of this support document:
Uploaded Document Name:
Date Uploaded: 10/01/2013
ABP 5 Attachment.xlsx

Form ABP6: Benchmark-Equivalent Benefit Package

ABP6 Forms List

Form

Support Documents

Document

Form ABP7: Benefits Assurances

ABP7 Forms List

Form
Please provide a short description of this ABP7 form:
Uploaded Form Name:
Date Uploaded: 12/04/2013
ABP7 - Benefits Assurances.pdf

Support Documents

Document

Form ABP8: Service Delivery Systems

ABP8 Forms List

Form
Please provide a short description of this ABP8 form:
Uploaded Form Name:
Date Uploaded: 12/04/2013
ABP8 - Service Delivery Systems.pdf

Support Documents

Document

Form ABP9: Employer Sponsored Insurance and Payment of Premiums

ABP9 Forms List

Form
Please provide a short description of this ABP9 form:
Uploaded Form Name: Date Uploaded: 12/04/2013
ABP9 - Employer Sponsored Insurance and Payment of Premiums.pdf

Support Documents

Document

Form ABP10: General Assurances

ABP10 Forms List

Form
Please provide a short description of this ABP10 form:
Uploaded Form Name: Date Uploaded: 12/04/2013
ABP10 - General Assurances.pdf

Support Documents

Document

Form ABP11: Payment Methodology

ABP11 Forms List

Form
Please provide a short description of this ABP11 form:
Uploaded Form Name: Date Uploaded: 12/04/2013
ABP11 - Payment Methodology.pdf

Support Documents

Document

Medicaid Alternative Benefit Plan: Tribal Input

State/Territory name:	**Kentucky**
Transmittal Number:	**KY 19-001**

☐ **One or more Indian Health Programs or Urban Indian Organizations furnish health care services in this State.**

☐ **This State Plan Amendment is likely to have a direct effect on Indians, Indian health programs or Urban Indian Organizations.**

☐ **The State has solicited advice from Indian Health Programs, Urban Indian Organizations, and/or Tribal governments prior to submission of this State Plan Amendment.**

Complete the following information regarding any tribal consultation conducted with respect to this submission:

Tribal consultation was conducted in the following manner. ***States are not required to consult with Indian tribal governments, but if such consultation was conducted voluntarily, provide information about such consultation below:***

☐ **Indian Tribes**

☐ **Indian Health Programs**

☐ **Urban Indian Organization**

The state must upload copies of documents that support the solicitation of advice in accordance with statutory requirements, including any notices sent to Indian Health Programs and/or Urban Indian Organizations, as well as attendee lists if face-to-face meetings were held. Also upload documents with comments received from Indian Health Programs or Urban Indian Organizations and the state's responses to any issues raised. Alternatively indicate the key issues and summarize any comments received below and describe how the state incorporated them into the design of its program.

Indicate the key issues raised in Indian consultative activities:

☐ **Access**

Summarize Comments

Summarize Response

☐ **Quality**

Summarize Comments

Summarize Response

☐ **Cost**

Summarize Comments

Summarize Response

☐ **Payment methodology**

Summarize Comments

Summarize Response

☐ **Eligibility**

Summarize Comments

Summarize Response

☐ **Benefits**

Summarize Comments

Summarize Response

☐ **Service delivery**

Summarize Comments

Summarize Response

☐ **Other Issue**

Medicaid Alternative Benefit Plan: Summary Page (CMS 179)

State/Territory name: **Kentucky**

Transmittal Number:

Please enter the Transmittal Number (TN) in the format ST-YY-0000 where ST= the state abbreviation, YY = the last two digits of the submission year, and 0000 = a four digit number with leading zeros. The dashes must also be entered.

KY 19-001

Proposed Effective Date

04/01/2019 *(mm/dd/yyyy)*

Federal Statute/Regulation Citation

Affordable Care Act

Federal Budget Impact

	Federal Fiscal Year	Amount
First Year	2014	$0.00
Second Year	2015	$0.00

Subject of Amendment

Revising the New Adult Group ABP to align with the Kentucky Health 1115 waiver

Governor's Office Review

○ **Governor's office reported no comment**

○ **Comments of Governor's office received**

Describe:

○ **No reply received within 45 days of submittal**

◉ **Other, as specified**

Describe:

Governor had delegated review to DMS

Signature of State Agency Official

Submitted By:	**Sharley Hughes**
Last Revision Date:	**Feb 27, 2019**
Submit Date:	**Feb 27, 2019**

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
61 Forsyth Street S.W. Suite 4T20
Atlanta, Georgia 30303-8909

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Atlanta Regional Operations Group

March 18, 2019

Carol H. Steckel, Commissioner
Department for Medicaid Services
275 East Main Street, 6WA
Frankfort, KY 40621-0001

Attention: Carol Steckel

RE: State Plan Amendment – KY 18-0004

Ms. Steckel:

We have completed our review of the proposed amendment submitted under transmittal number KY 18-0004. This plan amendment has an effective date of May 1, 2019 and was submitted in order to revise the state's employer sponsored insurance program.

Before we can continue processing this amendment, we need additional or clarifying information.

General Comments/Questions:

1. The current language of Kentucky's cost-effectiveness test does not explicitly state that Kentucky is applying either a "benefits-wrap" or "cost-sharing wrap" as required under section 1906(a)(3) of the Social Security Act ("Act") when determining whether or not paying for premium assistance is cost-effective. In order for premium assistance to be cost-effective, the state needs to determine that the cost of the premium + cost-sharing wrap + benefits wrap + administrative costs are equal to or less than the cost of providing the services directly. The state must provide coverage for any state plan benefits not covered by the commercial plan ("benefits wrap") and the state must cover any cost-sharing amounts that exceed cost-sharing permitted under the state plan ("cost-sharing wrap"). Please confirm that the state provides both a benefits wrap and cost-sharing wrap and that these elements are included in its cost-effectiveness test. If these elements are included in the state's cost-effectiveness test, please revise the SPA accordingly.

2. The state has informed the Centers for Medicare & Medicaid Services (CMS) that its premium assistance enrollees are not charged cost-sharing. However, its regular Medicaid state plan enrollees are charged cost-sharing. This disparity between the premium assistance beneficiaries and state plan beneficiaries is inconsistent with section 1902(a)(17) of the Act, which requires that states apply comparable

eligibility standards and methodologies within eligibility groups. Please confirm that this disparity in the charging of cost-sharing for premium assistance and regular Medicaid state plan enrollees is the state's current practice. If this is accurate, please let CMS know if the state intends to change its policies either by charging its premium assistance enrollees cost-sharing or by foregoing charging its state plan enrollees cost-sharing.

3. In multiple phone calls, the state has informed CMS that if an individual seeks care from a network provider that is outside the Medicaid network, Kentucky instructs the individual to submit provider receipts for reimbursement ("shoebox"). Kentucky then has a process in place to provide full reimbursement to beneficiaries. Requiring beneficiaries to incur out-of-pocket expenses first and then reimburse later is inconsistent with section 1906(a)(3) of the Act. The shoebox policy allows individuals to incur expenses above the nominal limits permitted in the state plan and decreases beneficiaries' access to providers. Please confirm that shoebox reimbursement is Kentucky's current policy for individuals who seek care from non-Medicaid network providers. If this is accurate, please let CMS know if Kentucky will change its policy regarding implementation of the cost-sharing wrap.

4. The SPA discusses that Kentucky disenrolls individuals from its premium assistance program both during a cost-effectiveness redetermination and for failure to report changes in health insurance coverage. Please confirm that prior to disenrolling individuals, Kentucky provides due process rights to these individuals, including proper notice and appeal rights as articulated in 42 CFR 431.206. If these due process rights are provided, please revise the SPA accordingly to note appeal rights.

We are requesting this additional/clarifying information under provisions of section 1915(f) of the Social Security Act (added by PL 97-35). This has the effect of stopping the 90-day clock for CMS to take action on the material, which would have expired on March 21, 2019. 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, and subsequently reiterated in the August 16, 2018 Center for Medicaid and CHIP Services Informational Bulletin, if a response to a formal request for additional information from CMS is not received from the state within 90 days of issuance, CMS will initiate disapproval of the SPA or waiver action. In addition, because this amendment was submitted after January 2, 2001 and is effective after January 1, 2001, please be advised that we will defer federal financial participation (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.

We ask that you respond to this RAI via the Atlanta SPA/Waiver e-mail address at SPA_Waivers_Atlanta_R04@cms.hhs.gov. The original signed response should also be sent to the Atlanta office of the Division of Medicaid Field Operations South.

If you have any questions, please contact Melanie Benning by telephone at (404) 562-7414 or e-mail at Melanie.Benning@cms.hhs.gov.

Sincerely,

Shantrina Roberts -S

Digitally signed by Shantrina Roberts -S
Date: 2019.03.18 10:28:23 -04'00'

Shantrina D. Roberts, MSN
Deputy Director
Division of Medicaid Field Operations South