



Administrator

Washington, DC 20201

OCT 25 2005

Ms. Shannon Turner, J.D.
Commissioner
Cabinet for Health and Family Services
Department for Medicaid Services
275 E. Main Street, 6W-A
Frankfort, KY 40621

Dear Ms. Turner:

We are pleased to inform you that the Centers for Medicare & Medicaid Services (CMS) is approving your extension request for Project No. 11-W-0000-5/4, entitled the "Kentucky Health Care Partnership," for the period November 1, 2005, through October 31, 2008. The extension is granted under the authority of section 1115(f) of the Social Security Act (the Act), which permits the Secretary to grant extensions up to 3 years for existing section 1115 demonstration projects.

Our approval of this extension for the Kentucky Health Care Partnership is subject to the limitations specified in the list of approved waivers and expenditure authorities. The State may deviate from Medicaid State plan requirements to the extent those requirements have been specifically waived. The approval is conditioned upon continued compliance with the enclosed Special Terms and Conditions (STCs), and is subject to our receiving your acknowledgment of the award and acceptance of the STCs within 30 days of the date of this letter.

Consistent with section 1115(f), we have included a budget neutrality trend rate for the extension period. The trend rate is 6.6 percent (see Section X of the enclosed Special Terms and Conditions (STCs)).

Several of the changes that have been made to the STCs are designed to provide a more consolidated set of documents governing the demonstration.

- Updating the list of waivers and expenditure authorities as necessary to ensure that the citations accurately reflect the demonstration;
- Elimination of the requirement for an Operational Protocol and clarification of the process for future amendments to the demonstration;
- Adding an evaluation requirement for the demonstration;
- Revising and/or removing STCs relating to the delivery of services through managed care, because the regulations at CFR Part 438 now govern the provision of Medicaid services through managed care;

- Elimination of initial start-up and implementation requirements; and
- Modification of reporting and monitoring requirements.

CMS has also revised and/or removed waivers and expenditure authorities that are no longer required due to changes in Medicaid law.

Your project officer is Mr. Mark W. Pahl. He is available to answer any questions concerning your section 1115 waiver demonstration. Mr. Pahl's contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and State Operations
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, MD 21244-1850
Telephone: (410) 786-1584
Facsimile: (410) 786-8534
E-mail: Mark.Pahl@cms.hhs.gov

Official communications regarding program matters should be sent simultaneously to Mr. Pahl and to Mr. Renard Murray, Associate Regional Administrator in our Atlanta Regional Office. Mr. Murray's contact information is as follows:

Centers for Medicare & Medicaid Services
Atlanta Regional Office
Atlanta Federal Center, 4th Floor
61 Forsyth Street, SW., Suite 4T20
Atlanta, GA 30303-8909
Telephone: (404) 562-7175
E-mail: Renard.Murray@cms.hhs.gov

If you have questions regarding this correspondence, please contact Ms. Jean Sheil, Director, Family and Children's Health Programs group, Center for Medicaid and State Operations, at (410) 786-5647.

Again, congratulations on the extension of your section 1115(f) demonstration. We look forward to continuing to work with you and your staff.

Sincerely,

A handwritten signature in black ink, appearing to read "Mark B. McClellan", with a long horizontal flourish extending to the right.

Mark B. McClellan, M.D., Ph.D.

Enclosures

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cc: Renard Murray, Associate Regional Administrator, Region IV
Maria Donatto, State Representative, Region IV

**CENTERS FOR MEDICARE & MEDICAID SERVICES
WAIVER LIST**

NUMBER: 11-W-0000-5/4

TITLE: Kentucky Medicaid Section 1115 Health Care Reform Demonstration
(Kentucky Health Care Partnership)

AWARDEE: Cabinet for Health and Family Services
Department for Medicaid Services

All requirements of the Medicaid program expressed in law, regulation and policy statement, not expressly waived or identified as not applicable in this list, shall apply to the State's demonstration project beginning November 1, 2005, through October 31, 2008.

The following waivers shall enable the State to implement the approved Special Terms and Conditions for the Kentucky Health Care Partnership demonstration.

Title XIX Waivers

1. Statewideness/Uniformity **Section 1902(a)(1)**

To enable Kentucky to provide managed-care plans, or certain types of managed care plans, only in certain geographical areas of the State.

2. Amount, Duration, and Scope of Services **Section 1902(a)(10)(B)**

To enable Kentucky to offer a different benefit package to demonstration participants than is being offered to the traditional Medicaid population.

3. Freedom of Choice **Section 1902(a)(23)**

To enable Kentucky to restrict freedom of choice of provider for the demonstration participants including dual eligible beneficiaries. Participants will be restricted to a single plan and may change providers within that plan.

4. Financial Eligibility Standards **Sections 1902(a)(17)
and 1902(r)(2)**

To enable Kentucky to consider the income of certain individuals residing in the household other than the parent of a child or spouse in determining eligibility.

5. Retroactive Coverage

Section 1902(a)(34)

To enable Kentucky to waive the requirement to provide medical assistance for up to 3 months prior to the date that an application for assistance is made.

6. Payment of Federally Qualified Health Centers (FQHCs) And Rural Health Clinics.

**Section 1902(bb)
Section 1902 (a)(15)**

To enable Kentucky to not be required to pay Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) in the Partnership under a prospective payment system, and to enable the State to not be subject to supplemental payments to FQHCs and RHCs.

7. Eligibility

Section 1902(e)(2)

To enable Kentucky to guarantee managed care program members, regardless of the type of health plan, will be eligible for all Medicaid benefits for a 6-month period from the date of their initial eligibility. This 6-month guaranteed period will be granted only once per eligible.

**CENTERS FOR MEDICARE & MEDICAID SERVICES
COSTS NOT OTHERWISE MATCHABLE AUTHORITIES**

NUMBER: 11-W-0000-5/4

TITLE: Kentucky Medicaid Section 1115 Health Care Reform Demonstration
(Kentucky Health Care Partnership)

AWARDEE: Cabinet for Health and Family Services
Department for Medicaid Services

Medicaid Costs Not Otherwise Matchable (CNOM)

All requirements of the Medicaid Program not identified and not applicable in this list, shall apply to the demonstration expenditures listed below for the period beginning November 1, 2005, through October 31, 2008.

Under the authority of section 1115(a)(2) of the Act, expenditures made by the State for the items identified below (which are not otherwise included as expenditures under section 1903) shall, for the period of this extension, be regarded as matchable expenditures under the State's Medicaid State plan:

1. Expenditures for capitation payments provided to a managed care organization which restrict enrollees' rights to disenroll within 90-days of enrollment into a new managed care organization, as designated under section 1903(m)(2)(A)(vi) and section 1932(a)(4).
2. Expenditures for capitation payments made to a managed care organization which do not comply with Section 1903(m)(2)(A)(xi) requiring beneficiary choice of managed care entities as required by Section 1932(a)(3) on choice of a managed care entity. This CNOM is granted only for expenditures made to the Partnership entity operating in the City of Louisville and the 15 surrounding counties.

**CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS**

NUMBER: 11-W-0000-5/4

TITLE: Kentucky Partnership Plan

AWARDEE: Kentucky Cabinet for Health and Family Services

I. PREFACE

The following are the Special Terms and Conditions (STCs) for the Kentucky Partnership Plan section 1115(f) Medicaid demonstration (hereinafter "Demonstration"). The parties to this agreement are the Kentucky Cabinet for Health and Family Services (State) and the Centers for Medicare & Medicaid Services (CMS). These STCs set forth below and the lists of waivers and expenditure authorities, are incorporated in their entirety into the letter approving the Demonstration. The STCs set forth in detail the nature, character, and extent of Federal involvement in the Demonstration and the State's obligations to CMS during the life of the Demonstration extension. This Demonstration is approved for the 3-year period, from November 1, 2005, through October 31, 2008.

The STCs have been arranged into the following subject areas: General Program Requirements; General Reporting Requirements; Eligibility and Enrollment; Benefits and Coverage; Cost Sharing; Delivery Systems; Evaluation; General Financial Requirements; and Monitoring Budget Neutrality.

II. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Statutes.** The State agrees that it shall comply with all applicable Federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.
2. **Compliance with Medicaid Law, Regulation, and Policy.** All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in the award letter of which these terms and conditions are part, shall apply to the Demonstration.
3. **Changes in Law.** The State shall, within the time frame specified in law, come into compliance with any changes in Federal law affecting the Medicaid program that occur after the approval date of this Demonstration
4. **Impact on Demonstration of Changes in Federal Law, Regulation and Policy Statements.** To the extent that a change in Federal law impacts State Medicaid spending

on program components included in the Demonstration, CMS shall incorporate these changes into a modified budget neutrality expenditure cap for the demonstration. The modified budget neutrality expenditure cap would be effective upon implementation of the change in the Federal law. The growth rates for the budget neutrality baseline are not subject to this STC. If mandated changes in the Federal law require State legislation, the changes shall take effect on the day such State legislation becomes effective, or on the last day such legislation was required to be in effect under the law.

5. **State Plan Amendments.** The State shall not be required to submit Title XIX State plan amendments for changes to any populations covered under this Demonstration (as referenced in Section IV, number 23). If a population covered through the State plan is affected by a change to the Demonstration, a conforming amendment to the State plan may be required as well as an amendment to the Demonstration.
6. **Changes Subject to the Amendment Process.** Changes related to eligibility, enrollment, benefits, enrollee rights, delivery systems, cost sharing, evaluation design, sources of non-Federal share of funding, budget and allotment neutrality, and other comparable program elements must be submitted to CMS as amendments to the Demonstration. The state shall not implement changes to these elements without prior approval by CMS. CMS and the State shall develop a comprehensive list within 60 days of the approval of the Demonstration that shall contain all elements of the Demonstration that are subject to the amendment process. Amendments to the Demonstration are not retroactive and FFP may not be available for changes to the Demonstration that have not been approved through the amendment process set forth in paragraph 7 below.
7. **Amendment Process.** Amendment requests must be submitted to CMS for approval no later than 120 days prior to the date of implementation and may not be implemented until approved. Utilizing the standard review process CMS will consult with the federal review team. Amendment requests shall include but not be limited to the following:
 - a) An explanation of the public process used by the State to reach a decision regarding the requested amendment;
 - b) A current assessment of the impact the requested amendment shall have on budget neutrality;
 - c) A detailed description of the amendment, with sufficient supporting documentation; a
 - d) A description of how the evaluation design shall be modified to incorporate this amendment request; and
 - e) Approval of an amendment is at the sole discretion of the Secretary.
8. **Continuation of the Demonstration.** If the State intends to continue with the demonstration beyond this extension period CMS must receive written notice of intent which should include any proposed changes to the demonstration at least one year prior to the expiration date on the current section 1115(f) extension period. In addition, the State must submit to CMS a complete application at least 6 months prior to the expiration of the current section 1115 (f) extension period.

9. **Demonstration Phase-Out.** The State may suspend or terminate this Demonstration in whole or in part at any time prior to the date of expiration. The State must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date. In the event the State elects to phase-out the Demonstration, the State and CMS will collaborate on the phase out plan. The State shall submit a phase-out plan to CMS at least 6 months prior to initiating phase-out activities. The State may also submit an extension plan on a timely basis to prevent disenrollment of Demonstration enrollees. Nothing herein shall be construed as preventing the State from submitting a phase-out plan with an implementation deadline shorter than 6 months when such action is necessitated by emergent circumstances. The phase-out plan and extension plan are subject to CMS approval. If the project is terminated or any relevant waivers suspended by the State, FFP shall be available for only normal closeout costs associated with terminating the demonstration including services and administrative costs of disenrolling participants.
10. **Finding of Non-Compliance.** The State waives none of its rights to challenge CMS' finding that the State materially failed to comply.
11. **Withdrawal of Waiver Authority.** CMS reserves the right to withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest. If a waiver or expenditure authority is withdrawn, FFP shall be available for only normal closeout costs associated with terminating the demonstration including services and administrative costs of disenrolling participants.
12. **Adequacy of Infrastructure.** The State shall ensure the availability of adequate resources for implementation and monitoring of the Demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing; and reporting on financial and other Demonstration components.
13. **Public Notice and Consultation with Interested Parties.** The State shall continue to comply with the State Notice Procedures set forth in 59 *Fed. Reg.* 49249 (1994) when any program changes to the Demonstration are proposed by the State.
14. **Managed Care Requirements.** The State must comply with the managed care regulations published at 42 CFR 438.

III. GENERAL REPORTING REQUIREMENTS AND MILESTONES

15. **General Financial Requirements.** The State shall comply with all general financial requirements under Title XIX set forth in Section IX, General Financial Requirements under Title XIX.
16. **Reporting Requirements Relating to Budget Neutrality.** The State shall comply with all reporting requirements for monitoring budget neutrality set forth in Section X.

17. **Encounter Data.** All managed care organizations (MCOs) contracted with the State under the Demonstration shall be responsible for the collection of all data on services furnished to enrollees through encounter data or other methods as specified by the State, and the maintenance of these data at the plan level. The State shall, in addition, develop mechanisms for the collection, reporting, and analysis of these data (which should at least include all inpatient hospital and physician services), as well as a process to validate that each plan's encounter data are timely, complete and accurate. The State shall have contractual provisions in place to impose financial penalties if accurate data are not submitted in a timely fashion.
18. **Submission of Encounter Data.** The State shall submit encounter data for services provided under this Demonstration to the MSIS system as is consistent with Federal law and Section IX of this document. The State must assure that encounter data maintained at the MCO and provider level can be linked with eligibility files maintained at the State.
19. **Monthly Calls.** CMS shall schedule monthly conference calls with the State. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the Demonstration. Areas to be addressed include, but are not limited to, MCO operations (such as contract amendments and rate certifications), health care delivery, enrollment, quality of care, access, the benefit package, audits, lawsuits, financial reporting and budget neutrality issues, health plan financial performance that is relevant to the Demonstration, progress on evaluations, State legislative developments, and any Demonstration amendments, concept papers or State plan amendments the State is considering submitting. The State and CMS shall discuss quarterly expenditure reports submitted by the State for purposes of monitoring budget neutrality. CMS shall update the State on any amendments or concept papers under review as well as Federal policies and issues that may affect any aspect of the Demonstration. The State and CMS (both the Project Officer and the Regional Office) shall jointly develop the agenda for the calls.
20. **Quarterly Reports.** The State shall submit progress reports 60 days following the end of each quarter.

The intent of these reports is to present the State's analysis and the status of the various operational areas under the demonstration. These quarterly reports shall include:

- a) A discussion of events occurring during the quarter or anticipated to occur in the near future that affect health care delivery, enrollment, quality of care, access, health plan financial performance that is relevant to the Demonstration, the benefit package, and other operational issues.
- b) Action plans for addressing any policy and administrative issues identified.
- c) A separate discussion of the State efforts related to the collection and verification of encounter data.
- d) The quarterly reports will include enrollment data, member month data, budget neutrality monitoring tables in the attached format, as well as an update on the budget plan, etc.

e) The State shall report Demonstration program enrollment on a quarterly basis. The format of the report shall be specified by CMS. Average monthly enrollment will be reported for each of the eligibility groups.

21. **Annual Report.** The State shall submit a draft annual report documenting accomplishments, project status, quantitative and case study findings, utilization data, and policy and administrative difficulties in the operation of the Demonstration. The State shall submit the draft annual report no later than 120 days after the end of each operational year. Within 30 days of receipt of comments from CMS, a final annual report shall be submitted.

IV. ELIGIBILITY AND ENROLLMENT

22. **Demonstration Populations.** The following populations are included in the demonstration. Each new member shall have an initial 6 months guaranteed eligibility to receive Partnership services regardless of loss of eligibility for Medicaid during the 6-month period, provided the member resides in the Partnership region, is not incarcerated or deceased, and is not disenrolled from the Partnership by the state.

Demonstration Population	Income Level	Benefit Package
1. State Plan Children		
Infants under 1	Up to 185 % FPL	Medicaid State plan
Children 1-5	Up to 133% FPL	Medicaid State plan
Children 6-18	Up to 100% FPL	Medicaid State plan
Children under the age of 21 and in a psychiatric residential treatment facility.	Up to 300% of the SSI benefit limit	Medicaid State plan
Children under the age of 18, placed in foster care as defined in State eligibility regulations.	Up to 100% FPL	Medicaid State plan
Children under the age of 18, adopted and having special needs.	Up to 100% FPL	Medicaid State plan
Blind/Disabled Children	Up to the Medically Needy scale	Medicaid State Plan
2. State Plan Adults		
Pregnant women	Up to 185% FPL	Medicaid State plan
Section 1931 adults	Up to AFDC Income Level	Medicaid State plan
Kentucky Transitional Assistance Program (K-Tap)	Up to AFDC Income Level	Medicaid State plan
Blind/Disabled Adults Without SSI	Up to State Supplementation Standards, SSI limit, or Medically Needy scale	Medicaid State plan
Aged and Related Populations	Up to State Supplementation Standards, SSI limit, or Medically Needy scale	Medicaid State plan

Medicare Dual Eligibles (QMB Plus, SLMB Plus, and Medicaid Only)	100% FPL, 120% FPL, or up to 300% of the SSI benefit amount	Medicaid State plan
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V. BENEFITS AND COVERAGE

23. Benefits and Eligibility Determination. Demonstration enrollees receive benefits as listed in the following schedule.

Benefits

COVERED SERVICES
Alternative Birthing Center Services
Ambulatory Surgical Center Services
Chiropractic Services
Dental Services, including Oral Surgery, Orthodontics and Prosthodontics
Durable Medical Equipment, including Prosthetic and Orthotic Devices, and Disposable Medical Supplies
Early and Periodic Screening, Diagnosis & Treatment (EPSDT) screening and special services (including Mental/Behavioral Health Services)
End Stage Renal Dialysis Services
Family Planning Clinic Services in accordance with federal and state law and judicial opinion
Hearing Services, including Hearing Aids for Members Under age 21
Home Health Services
Hospice Services
Independent Laboratory Services
Inpatient Hospital Services with or without Psychiatric Services and/or Rehabilitation Services Distinct Part Units
Meals and Lodging for Appropriate Escort of Members
Medical Detoxification as defined in 907 KAR 1:705
Medical Services, including those provided by Physicians, Advanced Practice Registered Nurses, Physicians Assistants and FQHCs, Primary Care Centers and Rural Health Clinics
Organ Transplant Services not Considered Investigational by FDA
Other Laboratory and X-ray Services
Outpatient Hospital Services
Pharmacy and Limited Over-the-Counter Drugs including Mental/Behavioral Health Drugs
Podiatry Services
Preventive Health Services, including those currently provided in Public Health Departments, FQHCs/Primary Care Centers, and Rural Health Clinics
Specialized Case Management Services for Members with Complex Chronic Illnesses
Therapeutic Evaluation and Treatment, including Physical Therapy, Speech Therapy,

Occupational Therapy
Transportation to Covered Services, including Emergency and Non emergency Ambulance and other Stretcher Services
Urgent and Emergency Care Services
Vision Care, including Vision Examinations, Services of Opticians, Optometrists and Ophthalmologists, including eyeglasses for Members Under age 21
Mental/Behavioral Health Visits
Psychiatric Hospital Services
Psychiatric Residential Treatment Facility
Impact Plus
Targeted Case Management for Adults with Chronic Mental Illness
Targeted Case Management for Children with a Severe Emotional Disability
Services Provided by a Clinical Social Worker
Services Provided by a Psychologist
Community Mental Health Centers
Services Provided by a Physician
Any other cost-effective Mental Health Services Medically Necessary

Eligibility Determination

To reflect a policy of family responsibility, the State considers each member of the family unit (including any Medicaid eligible members) for purposes of determining countable income. Countable income therefore includes the income of the applicant as well as that of the following family members who reside in the household:

- Individuals for whom the applicant has financial responsibility;
- Individuals who have financial responsibility for the applicant; and
- Any other individual for whom such individual in the second bullet above has financial responsibility. Note: the income of a step-parent who has financial responsibility is also included when determining eligibility for an applicant child.

24. **Enrollment Process.** The state agrees to notify demonstration participants regarding eligibility changes. The notification to participants must meet the provisions of 42 CFR 431.210.

VI. COST SHARING

25. **Cost Sharing.** The State agrees to maintain the State Plan co-payments and premium provisions for the mandatory population. Should premiums and co-payments be instituted and or modified for the optional populations the State shall submit an amendment pursuant to items six and seven under Section II, General Program Requirements. Approved premiums and co-payments will be included in the annual report.

Listed below are the approved premium and co-payment limits for all populations with the exception of children under age 19 and pregnant women.

Co-Payments	
<p><u>Prescription Drug Co-Payments</u></p> <ul style="list-style-type: none"> • \$1 generic drug • \$1 atypical anti-psychotic drug if no generic exists • \$2 for preferred brand name drug (brand name drug with supplemental rebate) • \$3 for non-preferred brand name drug. 	<p><u>Service Co-Payments</u></p> <ul style="list-style-type: none"> • \$2 for visit to physician’s office, advanced registered nurse practitioner’s office, physician assistant office, primary care center, federally qualified health center or rural health clinic • \$3 for non-emergency service received via a hospital emergency room • \$3 outpatient hospital visit • \$50 for inpatient hospital admission

VII. DELIVERY SYSTEMS

- 26. Limitation of Freedom of Choice.** Freedom of choice for provider may be restricted to one managed care organization (MCO) for the populations covered under the Demonstration.
- 27. Geographic Limitation.** The State agrees not to expand the Partnership Plan demonstration beyond the geographic boundaries served by the Plan operating in the city of Louisville in Jefferson County and the fifteen surrounding counties.
- 28. Provider Access.** The State agrees to allow any willing provider to participate in the Partnership Plan. Providers must meet licensure and regulatory requirements as established by the State.
- 29. Contracts.** All contracts and modifications of existing contracts between the State and MCOs must be approved by CMS prior to the effective date of the contract or modification of an existing contract. The State will provide CMS with a minimum of 30 days to review and approve changes. The Kentucky Cabinet for Health and Family Services will be responsible for ensuring MCO compliance with state and Federal statutes, regulations, special terms and conditions, and waiver and cost not otherwise matchable authority.
- 30. Contracting with Federally Qualified Health Centers (FQHCs).** The State shall require health plans to contract with FQHCs. If an MCO can demonstrate to the United States Department of Health and Human Services and to the Kentucky Cabinet for Health and Family Services that both adequate capacity and an appropriate range of services for

vulnerable populations exist to serve the expected enrollment in all service areas without contracting with FQHCs, the plan may, with CMS approval, be relieved of this requirement. For any Partnership that requests an exemption from the requirement that it contract with FQHCs, the state shall submit to CMS a report with the following information at least 60 days prior to submission of the final managed care contract for CMS approval.

- a.) The FQHCs in the Partnership's service area, and a description of the demonstration populations served and the services provided by the FQHCs prior to the demonstration.
- b.) An analysis that the Partnership has sufficient provider capacity to serve the demonstration populations currently receiving services at the FQHC. The analysis should include, but not be limited to, a listing of providers signed with the Partnership, capacity of each provider to take on additional Medicaid patients, geographic location of providers and description of accessibility for Medicaid patients to these providers. The Partnership must inform the state if any of this information or data changes over the course of the demonstration.
- c.) An analysis that the Partnership will provide a comparable level of Medicaid services as the FQHC (as covered in the approved State Medicaid plan), including covered outreach, social support services, and the availability of culturally sensitive services, such as translators and training for medical and administrative staff. The analysis should describe the proximity of providers, and range of services as it relates to FQHC patients, to the extent these services are currently available through FQHCs in the service area.
- d.) The Partnership will pay the FQHC(s) on either a capitated (risk) basis (with appropriate adjustments for risk factors) or on a cost-related basis. A description of the payment methodology shall be provided by the state. If during the demonstration, the Partnership changes its payment methodology to an FQHC, the changes must be submitted by the state to CMS for review and approval.

VIII. EVALUATION

31. Submission of Draft Evaluation Design. The State shall submit to CMS for approval within 120 days from the award of the Demonstration a draft evaluation design. At a minimum, the draft design shall include a discussion of the goals, objectives and specific hypotheses that are being tested, including those that focus specifically on the target population for the Demonstration. The draft design shall discuss the outcome measures that shall be used in evaluating the impact of the demonstration during the period of approval, particularly among the target population. It shall discuss the data sources and sampling methodology for assessing these outcomes. The draft evaluation design must include a detailed analysis plan that describes how the effects of the Demonstration shall be isolated from other initiatives occurring in the State. The draft design shall identify

whether the State shall conduct the evaluation, or select an outside contractor for the evaluation.

32. Final Evaluation Design and Implementation. CMS shall provide comments on the draft design within 60 days of receipt, and the State shall submit a final design within 60 days of receipt of CMS comments. The State shall implement the evaluation design, and submit to CMS a draft of the evaluation report 90 days after the expiration of the current demonstration period. CMS shall provide comments within 60 days of receipt of the report. The State shall submit the final report no later than 60 days after receipt of the comments from CMS.

33. Cooperation with Federal Evaluators. Should CMS undertake an evaluation of the Demonstration, the State must fully cooperate with Federal evaluators and their contractors' efforts to conduct an independent federally funded evaluation of the Demonstration.

IX. GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XIX

34. Capitation Rates. The State must submit to CMS for review and approval all capitation rates. Capitation rates shall be developed and certified as actuarially sound in accordance with 42 CFR 438.6. The certification shall identify historic utilization of State Plan services used in the rate development process. Also, the State must submit to CMS the actuarial certification of the capitation rates in accordance with 42 CFR 438.6(c).

35. Quarterly Expenditure Reports. The State shall provide quarterly expenditure reports using the form CMS-64 to report total expenditures for services provided under the Medicaid program, including those provided through the Demonstration under section 1115 authority. This project is approved for expenditures applicable to services rendered during the Demonstration period. CMS shall provide FFP for allowable Demonstration expenditures only as long as they do not exceed the pre-defined limits on the costs incurred as specified in Section X (Monitoring Budget Neutrality for the Demonstration).

36. Budget Neutrality Reporting. The following describes the reporting of expenditures subject to the budget neutrality cap:

- a) In order to track expenditures under this Demonstration, Kentucky shall report Demonstration expenditures through the Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in Section 2500 of the State Medicaid Manual. All expenditures subject to the budget neutrality cap shall be reported on separate Forms CMS-64.9 Waiver and/or 64.9P Waiver, identified by the demonstration project number assigned by CMS (including the project number extension, which indicates the demonstration year in which services were rendered or for which capitation payments were made). Corrections for any incorrectly reported demonstration expenditures for previous demonstration years must be input within 3 months of the beginning of the Demonstration. For monitoring purposes, cost

settlements must be recorded on Line 10.b, in lieu of Lines 9 or 10.C. For any other cost settlements (i.e., those not attributable to this Demonstration), the adjustments should be reported on lines 9 or 10.C, as instructed in the State Medicaid Manual. The term, "expenditures subject to the budget neutrality cap," is defined below in item 36c.

- b) For each Demonstration year, separate Forms CMS-64.9 Waiver and/or 64.9P Waiver shall be submitted reporting expenditures for individuals enrolled in the Demonstration, subject to the budget neutrality cap. The State must complete separate forms for each demonstration population.
- c) The sum of the quarterly expenditures for waiver categories for all Demonstration years shall represent the expenditures subject to the budget neutrality cap.
- d) For purposes of this section, the term "expenditures subject to the budget neutrality cap" shall include all Medicaid expenditures on behalf of the individuals who are enrolled in this Demonstration and who are receiving the services subject to the budget neutrality cap. All expenditures that are subject to the budget neutrality cap are considered Demonstration expenditures and shall be reported on Forms CMS-64.9 Waiver and/or 64.9P Waiver.
- e) Premiums and other applicable cost-sharing contributions from enrollees that are collected by the State from enrollees under the Demonstration shall be reported to CMS on Form CMS-64. In order to assure that the Demonstration is properly credited with premium collections, all premium collections from demonstration participants must be separated from other collections in the State's Medicaid program and reported in the narrative portion of the CMS-64 report as well as reported on line 9.D of the CMS-64 Summary Sheet.
- f) Administrative costs shall not be included in the budget neutrality limit, but the State must separately track and report additional administrative costs that are directly attributable to the Demonstration. All administrative costs shall be identified on the Forms CMS-64.10 Waiver and/or 64.10P Waiver.

- g) All claims for expenditures subject to the budget neutrality cap (including any cost settlements) must be made within two years after the calendar quarter in which the State made the expenditures. Furthermore, all claims for services during the Demonstration period (including any cost settlements) must be made within two years after the conclusion or termination of the Demonstration. During the latter two-year period, the State must continue to identify separately net expenditures related to dates of service during the operation of the section 1115 Demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.

37. Member Months. The following describes the reporting of member months subject to the budget neutrality cap:

- a) For the purpose of calculating the budget neutrality expenditure cap described in Section X, the State shall provide to CMS on a quarterly basis the actual number of eligible member/months for of the Medicaid Eligibility Groups (MEGs). This information shall be provided to CMS 30 days after the end of each quarter as part of the CMS-64 submission, either under the narrative section of the MBES/CBES or as a stand-alone report. To permit full recognition of “in-process” eligibility, reported counts of member months shall be subject to minor revisions for an additional 180 days after the end of each quarter. For example, the counts for the quarter ending September 30, 1999, due to be reported by November 30, 1999, are permitted to be revised until June 30, 2000.
- b) The term “eligible member/months” refers to the number of months in which persons are eligible to receive services under this Demonstration. For example, a person who is eligible for 3 months contributes 3 eligible member/months to the total. Two individuals who are eligible for 2 months each contribute 2 eligible member months to the total, for a total of 4 eligible member/months.
- c) The term “Demonstration eligibles” refers to the categories of Kentucky Partnership Plan enrollees as identified in Section V, number 24.
- d) The term “Demonstration eligibles” excludes unqualified aliens.
- e) The standard Medicaid funding process shall be used during the Demonstration. Kentucky must estimate matchable Medicaid expenditures on the quarterly Form CMS-37. In addition, the estimate of matchable Demonstration expenditures (total computable and Federal share) subject to the budget neutrality cap must be separately reported by quarter for each Federal fiscal year on the Form CMS-37.12 for both the Medical Assistance Program and Administrative Costs. CMS shall make Federal funds available based upon the State’s estimate, as approved by CMS. Within 30 days after the end of each quarter, the State must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. CMS shall reconcile expenditures reported on the Form CMS-64 with Federal funding previously made available to the State, and include the reconciling adjustment in the finalization of the grant award to the State.

Subject to CMS approval of the source(s) of the non-Federal share of funding, CMS shall provide FFP at the applicable Federal matching rates for the following, subject to the limits described in Section X:

- a) Administrative costs, including those associated with the administration of the Demonstration;
- b) Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved State plan;
- c) Net medical assistance expenditures made with dates of service during the operation of the Demonstration.
- d) Net premium and cost-sharing payments paid by Kentucky Partnership Plan eligibles.

38. Matching Funds. The State shall certify State/local monies used as matching funds for the Demonstration and shall further certify that such funds shall not be used as matching funds for any other Federal grant or contract, except as permitted by law. All sources of the non-Federal share of funding and distribution of monies involving Federal match are subject to CMS approval. Upon review of the sources of the non-Federal share of funding and distribution methodologies of funds under the Demonstration, all funding sources and distribution methodologies deemed unacceptable by CMS shall be addressed within the time frames set by CMS. Any amendments that impact the financial status of the program shall require the State to provide information to CMS regarding all sources of the non-Federal share of funding.

39. MSIS Data Submission. The State shall submit its MSIS data electronically to CMS in accordance with CMS requirements and timeliness standards. The State shall ensure, within 120 days of the approval of the Demonstration, that all prior reports are accurate and timely.

X. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

40. Budget Neutrality Limit. Kentucky shall be subject to a limit on the amount of Federal title XIX funding that the State may receive on selected Medicaid expenditures during the period of approval of the Demonstration. The limit is determined by using a per capita cost method, and budget targets are set on a yearly basis with a cumulative budget limit for the length of the entire Demonstration.

41. Risk under Per Capita Cost Method. Kentucky shall be at risk for the per capita cost (as determined by the method described below) for Demonstration eligibles in the MEG under this budget neutrality agreement, but not at risk for the number of current eligibles. By providing FFP for all current eligibles, Kentucky will not be at risk for changing economic conditions. However, by placing Kentucky at risk for the per capita costs for current eligibles, CMS assures that the Federal demonstration expenditures do not exceed the level of expenditures had there been no demonstration.

42. Projected PMPM Cost. Under this budget neutrality agreement the State will report using a single combined MEG.

- a) The budget neutrality limit is the sum of the annual estimates for the Demonstration period, less the amount of premiums paid by the Demonstration eligibles. The Federal share of the budget neutrality limit represents the maximum amount of FFP that the State may receive for expenditures on behalf of eligibles.
- b) The following are the ceiling per member/per month (PMPM) costs for the calculation of the budget neutrality expenditure ceiling for the Demonstration enrollees under this section 1115(f) Demonstration. An annual trend rate not to exceed 6.6% for demonstration years 9, 10 and 11, will be used to project PMPM costs throughout the demonstration period. The PMPM costs below should be net of premiums paid by Kentucky Partnership Plan eligibles. The ceiling PMPM limits are effective November 1, 2005.

Demonstration Year	PMPM Allowed
9 11/05 – 10/06	\$417.22
10 11/06 – 10/07	\$444.76
11 11/07 – 10/08	\$474.11

43. Calculating Budget Neutrality. For the purpose of calculating the budget neutrality limit for this Demonstration the State shall provide to CMS, on a quarterly basis, the actual number of eligible member months for the combined MEG. This information should be provided to CMS within 30 days after the end of each quarter as part of the CMS-64 submission, either under the narrative section of the MBES/CBES or as a stand-alone report.

44. Monitoring Budget Neutrality. For the purpose of monitoring budget neutrality, within 60 days after the end of each quarter, the State shall provide a report to CMS, in the format provided by CMS, identifying the State’s actual member months subject to budget neutrality as set forth in Paragraph 36 for the combined MEG and corresponding actual expenditures for the combined MEG, less the amount of premiums paid by Demonstration eligibles.

45. Future Budget Neutrality Adjustment: The State is required to report budget neutrality using a single combined MEG. At the time of the next extension of this demonstration or submission of a comprehensive section 1115 demonstration, whichever comes first, the State will calculate budget neutrality based on multiple MEGs.

46. Exceeding the Budget Neutrality Limit. If at the end of this Demonstration period the budget neutrality limit has been exceeded, the excess Federal funds shall be returned to CMS. If the Demonstration is terminated prior to the end of the budget neutrality

agreement, the budget neutrality test shall be based on the time elapsed through the termination date.