

State of Kentucky

ATTORNEY GENERAL'S CERTIFICATION

I certify that:

The Department for Medicaid Services is the single State agency responsible for:

administering the plan.

The legal authority under which the agency administers the plan on a Statewide basis is

KRS 194.030 and Executive Order 85-967 issued pursuant to KRS 12.028
(statutory citation)

supervising the administration of the plan by local political subdivisions.

The legal authority under which the agency supervises the administration of the plan on a Statewide basis is contained in

(statutory citation)

The agency's legal authority to make rules and regulations that are binding on the political subdivisions administering the plan is

(statutory citation)

March 27, 1986
DATE

David Armstrong
Signature (See original document for signature)

Attorney General
Title

ORGANIZATION AND FUNCTION OF THE STATE AGENCY

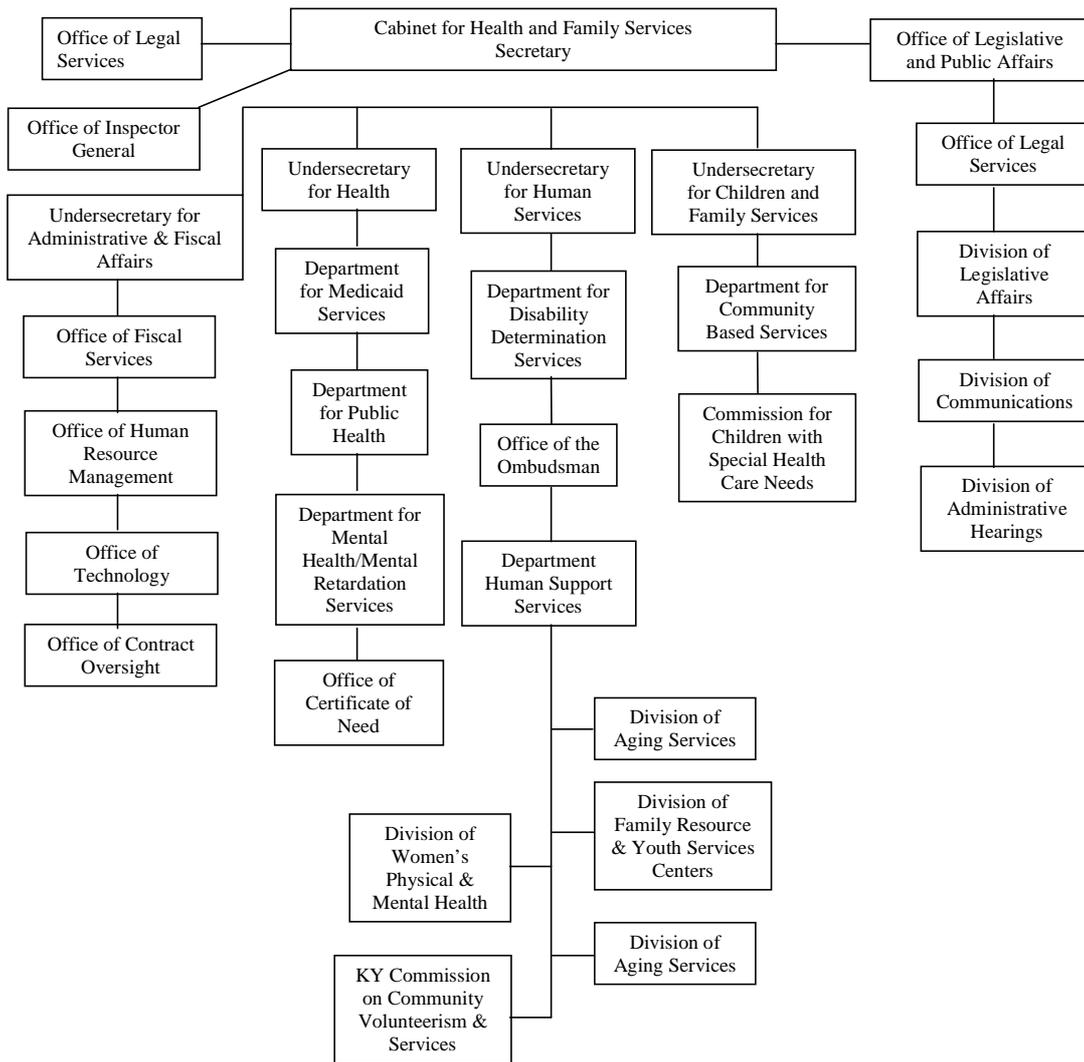
The Cabinet for Health and Family Services is the primary agency in state government responsible for the development and operation of health programs, including all federal programs in which the Commonwealth elects to participate. The Secretary of the Cabinet is the chief executive and administrative officer of the Cabinet for Health and Family Services.

The Secretary of the Cabinet for Health and Family Services has supervisory authority over the Department for Medicaid Services, which is the Single State Agency. The Commissioner for Medicaid Services directs the operation of all Divisions and functions within the Department, and has the authority to exercise administrative discretion in the administration or supervision of the Medicaid program, including the issuance of policies, rules, and regulations on program matters. The Cabinet Secretary is responsible for determining that the Commissioner's exercise of authority is in compliance with general state executive policy.

The Department for Community Based Services, within the Cabinet for Health and Family Services, makes eligibility determinations as shown in Attachment 1.2-D.

The following chart illustrates the organizational structure and functional relationships of the Cabinet for Health and Family Services.

Cabinet for Health and Family Services

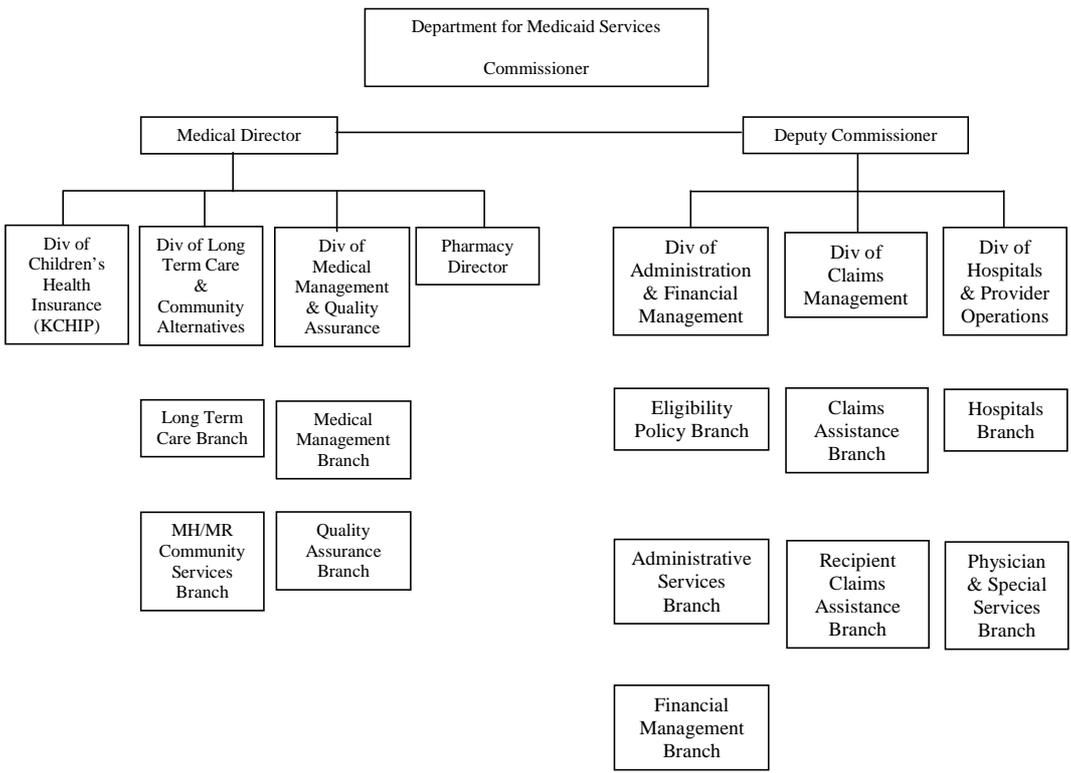


ORGANIZATION AND FUNCTION OF THE STATE AGENCY

The Department for Medicaid Services is the Single State Agency in the Commonwealth to administer Title XIX of the federal Social Security Act. The Commissioner for Medicaid Services exercises authority over the Department under the direction of the Secretary of the Cabinet for Health and Family Services and performs those functions delegated by the Secretary.

The Secretary of the Cabinet has delegated to the Department for Medicaid Services, line organizational responsibilities as the medical assistance unit within the government of the Commonwealth of Kentucky. Accordingly, it is the organizational unit responsible for administration of Medicaid programs and payments for vendor services provided to eligible recipients in the program under the direct supervision of the Secretary of the Cabinet for Health and Family Services.

The following chart illustrates the organizational structure and functional relationships of the Department for Medicaid Services.



ORGANIZATION AND FUNCTION OF THE STATE AGENCY

ORGANIZATIONAL DESCRIPTION

The organizational structure of the Department for Medicaid Services consists of a commissioner, deputy commissioner, medical director, pharmacy director, and six (6) divisions. Each division director assumes specific responsibility in one of the following divisions: Children's Health Insurance (KCHIP), Long Term Care and Community Alternatives, Medical Management and Quality Assurance, Administration and Financial Management, Claims Management, and Hospitals and Provider Relations.

Each director utilizes professional and clerical staff specializing in specific program areas.

FUNCTIONS OF THE UNIT

The Department for Medicaid Services is directly concerned with administration of all aspects of the Program (excluding the eligibility determinations function) and with attaining its objectives. It is responsible for promoting and administering the provision of a continuum of high quality comprehensive services to indigent citizens of the Commonwealth of Kentucky so as to improve their health care. There is a further responsibility for the Department to promote efficiency in assuring the availability and accessibility of facilities and resources, particularly in rural and urban poverty areas where shortages of health resources prevail. To be effective in these respects, it is essential for the Department to have a unified philosophy, clearly defined goals, and sufficient authority to carry out its responsibilities. As the organizational unit administering the Medicaid program, the Department is responsible for developing, recommending, and implementing policies, standards, and procedures relating to benefit elements.

A. Functions and responsibilities of the Department include, but are not limited to, the following:

1. Certifying the need of recipients for Medicaid;
2. Issuing authorizations for provision of Medicaid;
3. Certifying the provision of medical care in accordance with quality and quantity standards as established;
4. Developing bases and methods of payment for the medical services provided;
5. Certifying vendor billings for compliance with established base of payments;

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6. Developing and implementing a managed care program for the delivery of physical and behavioral health services through Health Care Partnerships and KenPAC;
 7. Redirecting the emphasis of services through managed care toward primary care and prevention while improving accessibility, availability and quality of care for individuals served by Medicaid;
 8. Developing and implementing a capitated non-emergency medical transportation delivery system, excluding ambulance stretcher services; and
 9. All other activities agreed upon jointly by the Advisory Council for Medical Assistance, the Cabinet for Health and Family Services, and the Department for Medicaid Services.
- B. In the course of carrying out the above specifically designated functions and in providing staff assistance to the Advisory Council for Medical Assistance, the Department for Medicaid Services performs other functions, including but not limited to:
1. Developing, implementing, and disseminating policy and procedure material relevant to service benefits;
 2. Preparing and managing the Program budget;
 3. Conducting research analysis and evaluation, and preparing special reports on the findings thereof;
 4. Conducting provider and recipient utilization review for use as a control technique in the enforcement of quality and quantity standards;
 5. Establishing and maintaining a data base for the generation of statistics necessary for the operation and management of the program;
 6. Maintaining a complete system of claims processing;
 7. Determining recipient qualifications for specific service benefits;
 8. Verifying recipient eligibility and certifying provider payments;
 9. Providing oversight of the managed care program for the delivery of physical and behavioral health services;
 10. Providing oversight of the capitated non-emergency medical transportation delivery system;
 11. Assisting the Advisory Council, the Technical Advisory Committees, and other special committees as they carry out their assignments; and
 12. Administering a quality improvement program to monitor and evaluate the health and health outcomes of members.

ORGANIZATION AND FUNCTION OF THE STATE AGENCY

III. MISSION STATEMENTS FOR DIVISIONS AND SUBORDINATE UNITS

A. OFFICE OF THE COMMISSIONER

The Office of the Commissioner, Department for Medicaid Services, subject to the supervision and approval of the Secretary of the Cabinet for Health and Family Services, carries the responsibility for overall administration and direction of the Kentucky Medicaid Program. This office provides the principal liaison between the Office of the Secretary and Divisions within the Department. It is also responsible for directing the coordination of program activities with those of related programs of other state and federal agencies. The Office of the Commissioner is directly responsible for overseeing the Advisory Council for Medical Assistance.

B. DIVISION OF CHILDREN'S HEALTH INSURANCE (KCHIP)

This division is responsible for the program development and reimbursement and oversight functions of the Title XXI Kentucky Children's Health Insurance Program (KCHIP). This division monitors participating providers for compliance with state and federal regulations and their achievement of service access and quality targets and goals, and provides necessary program technical assistance and training to participating providers. In conjunction with the Division of Claims Management, this division ensures that automated provider payment and reporting systems are appropriately updated and revised so as to enforce and support program policies.

C. DIVISION OF LONG TERM CARE AND COMMUNITY ALTERNATIVES

This division is responsible for program development and reimbursement functions of the long term care programs for the Commonwealth of Kentucky. Administration and monitoring of the contract with the Peer Review Organization (PRO) is the responsibility of this division. Coordination of programmatic functions will be conducted through two (2) branches. This division is also responsible for providing program specific technical assistance and expert testimony to and on behalf of the Cabinet and other state agencies (e.g., hearings, legislative testimony, court actions, new program development, remaining abreast of state of the art of the various assigned service areas of responsibility (e.g., Federal

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regulatory changes, marketplace dynamics, service and reimbursement innovations) and recommended program policy, negotiating and monitor assigned provider and department agent contracts, managing the internal operations and administrative functions of the division, and serving as liaison to assigned TACs, committees, councils and citizen's groups.

1. Long Term Care Branch: This branch is responsible for continuing departmental compliance with all applicable federal, state, and local laws and regulations related to long term care facilities. These responsibilities include: continued research and data compilation regarding long term care facilities; amendments to current regulations; amendments to the state plan; reimbursement function of long term care facilities; monitoring of long term care facilities to ensure compliance with program requirements as well as recipient safety and welfare; and any other support necessary for the continuing operation of long term care facilities. Nursing, ventilator, brain injury, and swing beds are the facilities included in the operations of the Long Term Care Branch, as are Home Health services and Hospice.
2. MH/MR Community Services Branch: This branch is responsible for continuing departmental compliance with all applicable federal, state, and local laws and regulations related to long term care programs. These responsibilities include: research and compilation of data related to existing and potential long term care programs; development, amendment, and renewal of waiver programs; drafting and submitting state plan amendments and administrative regulations; drafting and issuing long term care program manuals; reimbursement functions of long term care programs; monitoring of long term care providers to ensure compliance with program requirements as well as recipient safety and welfare; and any other support necessary for the implementation and operation of long term care programs. Programs operated under this branch include: Home and Community Based Waiver, Model II Waiver, Adult Day Care, Community Mental Health Centers, SCL Waivers and contract oversight, Targeted Case Management for Adults, Targeted Case Management for Children, Impact Plus, ICF-MR, and Acquired Brain Injury Waiver.

D. DIVISION OF MEDICAL MANAGEMENT AND QUALITY ASSURANCE

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This division will identify recipients who need medical management of their illnesses and assist providers in improving clinical outcomes, improving quality standards and providing the best care in an cost effective manner. There are two branches in this division.

1. Medical Management Branch: This branch will focus on activities for managing the health care needs of the Medicaid population by implementing disease management, case management and effective utilization management.
2. Quality Assurance Branch: This branch will focus on quality of care and quality outcomes, improving care and service for Medicaid recipients

E. DIVISION OF ADMINISTRATION AND FINANCIAL MANAGEMENT

This division is the Department's financial analysis and budget office, and has responsibility for formulation and monitoring of the Medicaid budget, preparation and distribution of statistical data and activities.

1. Administrative Services Branch: This branch is responsible for the state plan and regulation system. This branch coordinates and maintains the Title XIX State Plan, provides administrative regulation coordination, legislation coordination, monitors the development of the intranet and the resource library, and processes all open records requests. This branch also reviews appropriate media to identify federal or state policy changes and program actions and refers issues to appropriate program divisions.
2. Eligibility Policy Branch: This branch is primarily responsible for eligibility policy monitoring systems. This branch coordinates and maintains policy analysis, program research, program development regarding eligibility, establishes Medicaid third party liability policy as related to eligibility processes, provides technical assistance to the department and external agencies pertaining to eligibility criteria and systems, and ensures that internet resources related to eligibility are updated as needed.
3. Financial Management Branch: This branch oversees the Department's administrative and benefit budgets, as well as all financial transactions of the Department. Contract development

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and negotiations are coordinated through this branch. All Federal budget and statistical reports are prepared and submitted by this branch. In conjunction with the Division of Claims Management, this branch ensures that the Department's automated systems are appropriately updated to provide accurate and timely finance- related information. This branch is primarily responsible for audit coordination, rate coordination/IGT coordination, and expenditure analysis and forecasting. With appropriate program staff input, this branch performs long and short term revenue and expenditure forecasting for the Department, performs financial impact analysis for newly proposed programs, proposed legislation, service or eligibility revisions for expansion, and conducts or sponsors actuarial studies of Medicaid of MCE service and demographic experience. In addition, they evaluate Managed Care Entities rate proposals in light of actuarial information, and maintain expertise necessary to provide technical assistance to program staff in support of their rate modeling and development responsibilities.

F. DIVISION OF CLAIMS MANAGEMENT

This division has the oversight responsibility for the contract with MMIS/Fiscal Agent. Division staff are responsible for provision of technical assistance to the Commissioner and Deputy Commissioner. This division is also responsible for policy development regarding eligibility, for resolving all recipient eligibility concerns, Utilization Review, and program integrity issues. This Division provides technical assistance to the Department in all areas of Information System development and management.

1. Recipient Claims Assistance Branch: This branch maintains a general Medicaid information help desk to field inquiries from the public and provides assistance to Medicaid recipients.
2. Claims Assistance Branch: This branch develops and coordinates the procurement, maintenance and monitoring of the MMIS contract. In addition, this Branch serves as the Department liaison and monitors the performance of all external "feeder" Information Systems (KAMES, SDX, PAS, etc.), prepares and verifies the accuracy and completeness of all routine and special management information reports, and serves as the Department liaison to

ORGANIZATION AND FUNCTION OF THE STATE AGENCY

external information management agencies. They also assist program staff in the interpretation of data.

G. DIVISION OF HOSPITALS AND PROVIDER OPERATIONS

This division has direct responsibility for all hospital, physician, and specialty services. Providers include physicians, dentists, nurse practitioners, podiatrists, nurse anesthetists, chiropractors, and optometrists. Specialty services include vision services, hearing services, independent labs, durable medical equipment suppliers, and emergency transportation providers. The Director of this division has direct responsibility for the Physician Services, Dental Care, Podiatric Care, Nursing Services, Optometric Care, Primary Care, and Hospital Care Technical Advisory Committees.

1. Hospitals Branch: This branch is primarily responsible for services in Inpatient Hospitals, Outpatient Hospitals, Renal Dialysis Centers, Ambulatory Surgical Centers, Rehab Hospitals/Facilities, Psychiatric Hospitals, Psychiatric Residential Treatment Facilities (PRTF), Comprehensive Outpatient Rehab Facilities, Critical Access Hospitals, DSH policy, and transplants.
2. Physician and Specialty Services Branch: This branch includes the following programs: dentists, vision services, hearing services, podiatrists, chiropractors, family planning, durable medical equipment (DME), emergency transportation and ambulance service, independent lab, other lab, X-ray, optometrists, services to physicians, Primary Care Centers, Rural Health Centers, nurse practitioners, midwife services, nurse anesthetists, and preventative care (LHD). This branch is also responsible for policy/regulation development and analysis, rate setting and analysis, and provider enrollment.

PROFESSIONAL MEDICAL, DIRECT SUPPORT STAFF AND PERSONNEL
ENGAGED DIRECTLY IN THE OPERATION OF MECHANIZED CLAIMS
PROCESSING AND INFORMATION RETRIEVAL SYSTEMS

Following is a description of the kinds and numbers of personnel engaged directly in the operation of mechanized claims processing and information retrieval systems, professional medical personnel and their supporting staff, used in the administration of the Program and their responsibilities.

Medical Director - (1) Office of the Commissioner

Physician responsible for medical oversight of the Division of Children's Health Insurance, Division of Long Term Care and Community Alternatives and the Division of Medical Management and Quality Assurance.

Pharmacy Director - (1) Office of the Commissioner

Acts as support staff to the Drug Management Review Advisory Board. Interfaces with fiscal agent on prior authorization (drugs) issues. Manages pharmacy program.

Nurse Consultant/Inspector — (1) Division of Hospitals & Provider Operations

Provides administration and monitoring for psychiatric hospitals. Conducts random sampling reviews of admissions and continued stays for psychiatric hospitals, PRTF's and acute care hospitals. Provides clinical technical assistance regarding valid codes and claims.

Nurse Consultant/Inspector — (1) Division of Hospitals & Provider Operations

Provides administration and monitoring of physician, physician assistant, chiropractic, and podiatry services. Reviews claim issues and recommends systems audits and edits for resolution. Researches claims and medical records as appropriate to resolve questionable practice or coverage issues. Reviews and updates reimbursement system codes. Provides technical assistance to providers based on Medicaid guidelines.

Nurse Consultant/Inspector — (1) Division of Hospitals & Provider Operations

Provides administration and monitoring of durable medical equipment (DME). Provides technical assistance for providers, including research and resolution for claims issues. Provides prior authorization entry and other changes as needed for DME.

Nurse Consultant/Inspector — (3) Division of Hospitals & Provider Operations

Provides administration and monitoring of physician and specialty services. Provides technical assistance for providers, including research and resolution for claims issues. Performs other technical assistance functions as required.

Nurse Consultant/Inspector - (1) Division of Long Term Care & Community Alternatives
Responsible for Community Mental Health Center and Abuse services and the Supports for Community Living Program.

Nurse Consultant/Inspector - (1) Division of Long Term Care & Community Alternatives
Responsible for the Acquired Brain Injury Waiver Program and the Supports for Community Living Waiver Program.

Nurse Consultant/Inspector - (1) Division of Long Term Care & Community Alternatives
Responsible for Targeted Case Management Programs and the ICF/MR Program.

Nurse Consultant/Inspector - (3) Division of Long Term Care & Community Alternatives
Responsible for nurse aide training and review, free standing nursing facilities, Home Health, Hospice, appeals, MDS validation, and training for MDS. Works with the PRO and related associations.

Nurse Consultant/Inspector - (4) Division of Long Term Care & Community Alternatives
Responsible for monitoring, clinical, and appeals for Home & Community Based Waiver, Adult Day Care, and Model Waiver II.

Director- (1) Division of Medical Management & Quality Assurance
A medical professional responsible for directing the policies and activities related to medical management and quality assurance.

Assistant Director - (1) Division of Medical Management & Quality Assurance
Assists in managing the health care needs of the Medicaid population for the division and the department. Maintains a general knowledge of changing directions within health care and keeps the Director apprised of new legislation affecting the division. Serves as a backup to the Director.

Nurse Administrator - (2) Division of Medical Management & Quality Assurance
Manages Division programs, services, and personnel. Develops Division policies and procedures. Assists with strategic planning and develops operating budgets. Supervises in-house and field Nurse Consultant/inspectors and other support staff.

Nurse Consultant/Inspector- (1) Division of Medical Management & Quality Assurance

Responsible for oversight and quality performance of Passport Healthcare. Reviews quality reports and monitors contractual requirements of Passport and review outcomes and benchmarks. Reviews quality initiative for Medicaid fee-for-service and compares quality indicators and benchmarks of both Passport and fee-for-service.

Nurse Consultant/Inspector - (1) Division of Medical Management & Quality Assurance Requests, reviews and analyzes reports for the Medicaid fee-for-service programs. Identifies members or providers who are over utilizing resources and refers them to appropriate staff (care coordination, disease management, and educational needs if appropriate).

Nurse Consultant/Inspector - (1) Division of Medical Management & Quality Assurance Performs oversight and quality performance of National Health Services (NHS), the Department's peer review organization. Responsible for reviewing quality issues and monitoring contractual requirements of NHS, as well as review outcomes and benchmarks.

Nurse Consultant/Inspector - (1) Division of Medical Management & Quality Assurance Performs oversight of Medicaid fee-for-service programs. Reviews quality standards, outcomes and benchmarks as it relates to Medicaid programs. Reviews policies and procedures and makes recommendations accordingly.

Nurse Consultant/Inspector - (1) Division of Medical Management & Quality Assurance Acts as transplant coordinator and disease management coordinator in this division. Responsible for research regarding management of specific diseases and activity coordination in accordance with that research.

Nurse Consultant/Inspector - (1) Division of Medical Management & Quality Assurance Nurse coordinator of the EPSDT program. Researches and develops EPADT policies and procedures. Researches CMS mandates regarding children's programs. Performs overview compliance and reports of an ASO entity. Oversees and reports on appropriate treatment, national standards and quality reviews.

Nurse Consultant/Inspector - (1) Division of Medical Management & Quality Assurance Reviews all medical management documentation, utilization reports, quality reports and makes recommendations to the medical director regarding all aspects of care coordination, disease management, lock-in and quality initiatives of the division.

Nurse Consultant/Inspector - (1) Division of Medical Management & Quality Assurance

Performs case management and care coordination for adult and pediatric catastrophic cases and for those Medicaid recipients referred to the Medicaid Lock-in Program.

Nurse Consultant/Inspector - (11) Division of Medical Management & Quality Assurance

Responsible for regional care coordination program and technical consultative services. Participates in the development, revision, evaluation, and interpretation of agency policies, procedures and guidelines.

Graduate Accountant IV - (1) Division of Administration and Financial Management Establishes escrow accounts on MMIS. Maintains a daily check log for the Department. Places stop payments on reimbursement checks and reissues returned checks as appropriate. Reviews account receivable reports.

Assistant Director - (1) Division of Claims Management

Assists in monitoring the fiscal agent contract in order to assure compliance with contract requirements. Assists in direction of system and design change and discrepancy request forms and other correspondence between information systems and fiscal agent, department divisions, and others. Assists in developing solutions for MMIS problems and in helping in the design of enhancements for the division and the department. Assists in the coordination of changes mandated by CMS as they relate to the information system of the division and as required by the department. Maintains a general knowledge of changing directions within health care and keeps the Director apprised of new legislation affecting the division. Serves as a backup to the Director.

Administrative Branch Manager - (1) Division of Claims Management

Manages the employees and activities of an information technology branch. Responsible for the development, installation and operation of Medicaid-related data processing computer systems. Manages the data processing training activities and programs for the department.

Administrative Secretary I - (1) Division of Claims Management

Provides administrative support for functions of an information technology branch.

Resource Management Analyst II - (3) Division of Claims Management

Monitors and makes recommendations concerning contracts or operations, problems and issues in the systems or web/Internet environment. Under general direction, analyzes user requests for the development or modification of technology requests, researches and makes recommendations for solutions. Reviews specifications and testing for all phases of systems development.

Provides technical assistance to staff implementing new systems or modifications to existing systems. Communicates programmatic needs and facilitates problem resolution between agency and contract staff. Identifies and evaluates problems or issues in the systems or web/Internet environment.

Resource Management Analyst III - (3) Division of Claims Management

Coordinates user input and monitors the work of systems analysts or programmer analysts in the development, implementation and modification of computer systems. Reviews state and federal legislative and regulatory changes and technology alternatives and develops plans, procedures and recommendations accordingly. Approves specifications and testing for all phases of systems development. Monitors and makes recommendations concerning operations, problems or issues in the systems or web/Internet environment. Serves as technical resource to Department management during evaluation of technology initiatives, conducting or preparing presentations for the Department and Cabinet leadership as required. Contributes to the creation of and conducts reviews of RFIs, RFAs, and RFPs.

Systems Consultant IT - (1) Division of Claims Management

Coordinates user input and monitors the work of systems analysts or programmer analysts in the development, implementation and modification of computer systems. Approves specifications and testing for all phases of systems development. Contributes to the creation of and conducts reviews of RFIs, RFAs, and RFPs. Facilitates MMIS training for DMS staff and other stakeholders.

Systems Consultant IT - (1) Division of Claims Management

Coordinates problem resolution and future planning between DMS systems and program staff. Contacts Unisys (the Medicaid fiscal agent) program staff, analysts and administrative staff daily regarding system issues or contractual duties daily. Coordinates all activities related to EFT implementation. Assists ad hoc reporting staff so queries can accurately be completed. Assists contractors with criteria needed to correctly compile data on recipients, services, and providers.

Medicaid Specialist I - (1) Division of Claims Management

Research and recommend solutions to billing issues. Track and monitor claims sent for reprocessing. Monitor claims from out-of-state nursing facilities. Act as technical consultant for proposed payment systems updates and enhancements.

Medicaid Specialist II - (1) Division of Claims Management

Researches and recommends solutions to billing issues, Tracks and monitors claims sent for reprocessing. Assists providers in resolving billing issues. Develops systems change requests to improve hospital claim processing.

Conducts retrospective claim reviews. Assists with pricing hospital transplant claims. Accepts ad hoc system requests and distributes the completed reports.

Medicaid Specialist III - (1) Division of Claims Management

Provides technical assistance to providers regarding the billing process, prior authorization process, procedure codes, pricing, and claims denial. Responsible for claims overrides and approvals. Educates providers regarding EPSDT special services and regular Medicaid services. Determines which providers may enroll as EPSDT providers and explains the enrollment process. Interacts with NHS regarding coverage, pricing, coding, and prior authorization issues.

State: Kentucky

ELIGIBILITY DETERMINATIONS

The Department for Medicaid Services has by interagency agreement provided that the Department for Community Based Services will be responsible for all eligibility determinations and certification functions for individuals eligible for Medicaid, except that pursuant to agreement with the Social Security Administration, that agency determines Medicaid eligibility for Supplemental Security Income recipients.

The Department for Community Based Services is the single State agency for financial assistance under Title IV-A. Within the Department for Community Based Services, the Director of the Division of Family Support is responsible for supervising and directing the eligibility-related activities of staff located in each of Kentucky's 120 counties. Staff assigned to each local county make the eligibility determinations, with the appropriate eligibility rolls maintained at the central office level.

The interagency agreement shall include the following:

1. All of the Department for Community Based Services office in each of the 120 counties will accept applications face-to-face or by mail-in application as approved by the Department for Medicaid Services:
2. If a recertification form is returned within 30 days after the date of discontinuance and contains documentation necessary to process the re-determination, the case will be re-determined based on the information received and the family will not need to complete a new application for benefits.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kentucky

GROUPS COVERED AND AGENCIES RESPONSIBLE FOR ELIGIBILITY DETERMINATION

Agency*	Citation(s)	Groups Covered
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The following groups are covered under this plan.

A. Mandatory Coverage - Categorically Needy and Other Required Special Groups

42 CFR 435.110

1. Recipients of AFDC

IV-A

The approved State AFDC plan includes:

- Families with an unemployed parent for the mandatory 6-month period and an optional extension of 6 months.
- Pregnant women with no other eligible children.
- AFDC children age 18 who are full-time students in a secondary school or in the equivalent level of vocational or technical training.

The standards for AFDC payments are listed in Supplement 1 of ATTACHMENT 2.6-A.

42 CFR 435.115

2. Deemed Recipients of AFDC

IV-A

a. Individuals denied a title IV-A cash payment solely because the amount would be less than \$10.

* Agency that determines eligibility for coverage.

State: Kentucky

Agency*	Citation(s)	Groups Covered
		A. <u>Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)</u>
		2. Deemed Recipients of AFDC.
1902 (a) (10) (A) (i) (I) of the Act IV-A		b. Effective October 1, 1990, participants in a work supplementation program under title IV-A and any child or relative of such individual (or other individual living in the same household as such individuals) who would be eligible for AFDC if there were no work supplementation program, in accordance with section 482(e) (6) of the Act.
(a) (22) (A) the Act IV-A		c. Individuals whose AFDC payments are reduced to zero by reason of recovery of overpayment of AFDC funds.
406(h) and 1902 (a) (10) (A) (i)(I) of the Act IV-A		d. An assistance unit deemed to be receiving AFDC for a period of four calendar months because the family becomes ineligible for AFDC as a result of collection or increased collection of support and meets the requirements of section 406(h) of the Act.
1902(a) of the Act IV-E		e. Individuals deemed to be receiving AFDC who meet the requirements of section 473(b) (1) or (2) for whom an adoption assistance agreement is in effect or foster care maintenance payments are being made under title IV—E of the Act.

* Agency that determines eligibility for coverage.

State: Kentucky

Agency*	Citation(s)	Groups Covered
	A.	<u>Mandatory Coverage - Categorically Needy and Other Required Special Groups</u> (Continued)
407(b), 1902 (a) (10) (A) (i) and 1905(m) (1) of the Act	3.	Qualified Family Members (Medicaid Only) See Item A.10, pg 4b. <i>P&I HCFA 11-14-94</i>
1902 (a) (52) and 1925 of the Act IV-A	4.	Families terminated from AFDC solely because of earnings, hours of employment, or loss of earned income disregards entitled up to twelve months of extended benefits in accordance with section 1925 of the Act. (This provision expires on September 30, 1998.)

* Agency that determines eligibility for coverage.

State: Kentucky

Agency*	Citation(s)	Groups Covered
IV-A		A. <u>Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)</u>
42 CFR 435.113		5. Individuals who are ineligible for AFDC solely because of eligibility requirements that are specifically prohibited under Medicaid. Included are: <ul style="list-style-type: none">a. Families denied AFDC solely because of income and resources deemed to be available from--<ul style="list-style-type: none">(1) Stepparents who are not legally liable for support of stepchildren under a State law of general applicability;(2) Grandparents;(3) Legal guardians; and(4) Individual alien sponsors (who are not spouses of the individual or the individual's parent);b. Families denied AFDC solely because of the involuntary inclusion of siblings who have income and resources of their own in the filing unit.c. Families denied AFDC because the family transferred a resource without receiving adequate compensation.

* Agency that determines eligibility for coverage.

State: Kentucky

Agency*	Citation(s)	Groups Covered
	A.	<u>Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)</u>
42 CFR 435.114 IV-A	6.	Individuals who would be eligible for AFDC except for IV-A the increase in OASDI benefits under Pub. L. 92-336 (July 1, 1972), who were entitled to OASDI in August 1972, and who were receiving cash assistance in August 1972. <input type="checkbox"/> Includes persons who would have been eligible for cash assistance but had not applied in August 1972 (this group was included in this State's August 1972 plan). <input checked="" type="checkbox"/> Includes persons who would have been eligible for cash assistance in August 1972 if not in a medical institution or intermediate care facility (this group was included in this State's August 1972 plan). <input type="checkbox"/> Not applicable with respect to intermediate care facilities; State did or does not cover this service.
1902(a) (10) (A) (i) (III) and 1905(n) of the Act IV-A	7.	Qualified Pregnant Women and Children. a. A pregnant woman whose pregnancy has been medically verified who-- (1) Would be eligible for an AFDC cash payment if the child had been born and was living with her;

* Agency that determines eligibility for coverage.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: Kentucky

COVERAGE AND CONDITIONS OF ELIGIBILITY

Citation(s)	Groups Covered
	A. <u>Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)</u>
	(2) Is a member of a family that would be eligible for aid to families with dependent children of unemployed parents if the State had an AFDC-unemployed parents program; or
	(3) Would be eligible for an AFDC cash payment on the basis of the income and resource requirements of the State's approved AFDC plan.
1902 (a) (10) (A) (i)(III) and 1905(n) of the Act IV-A	b. Children born after September 30, 1983 who are under age 19 and who would be eligible for an AFDC cash payment on the basis of the income and resource requirements of the State's approved AFDC plan. <input type="checkbox"/> Children born after _____ (specify optional earlier date) who are under age 19 and who would be eligible for an AFDC cash payment on the basis of the income and resource requirements of the State's approved AFDC plan.

* Agency that determines eligibility for coverage.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

COVERAGE AND CONDITIONS OF ELIGIBILITY

Citation(s)

Groups Covered

A. Mandatory Coverage - Categorically Needy and Other Required Special Groups
(Continued)

1902(a)(10)(A)
(I)(IV) and
1902(1)(1)(A)
and (B) of the
Act (

8. Pregnant women and infants under 1 year of age with family incomes up to 133 percent of the Federal poverty level who are described in section 1902(a)(10)(A)(I)(IV) and 1902 1)(1)(A) and (B) of the Act. The income level for this group J specified in Supplement 1 to ATTACHMENT 2.6-A.

The State uses a percentage greater than 133 but not more than 185 percent of the Federal poverty level, as established in its State plan, State legislation, or State appropriations as of December 19, 1989.

1902(a)(10)(A)
(I)(VI)
1902(1)(1)(C)
of the Act

9. Children:
- a. who have attained 1 year of age but have not attained 6 years of age, with family incomes at or below 133 percent of the Federal poverty levels.
- b. born after September 30, 1983, who have attained 6 years of age but have not attained 19 years of age, with family incomes at or below 100 percent of the Federal poverty levels.

Children born after

September 30, 1979
(Specify optional earlier date)

who have attained 6 years of age but have not attained 19 years of age, with family incomes at or below 100 percent of the Federal poverty levels.

Income levels for these groups are specified in Supplement 1 to ATTACHMENT I6A

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kentucky

COVERAGE AND CONDITIONS OF ELIGIBILITY

Citation(s)	Groups Covered
	A. <u>Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)</u>
1902(a)(10) (A)(i)(v) and 1905(m) of the Act IV-A	10. Individuals other than qualified pregnant women and children under item A.7. above who are members of a family that would be receiving AFDC under section 407 of the Act if the State had not exercised the option under section 407(b)(2)(B)(i) of the Act to limit the number of months for which a family may receive AFDC.
1902(e)(5) of the Act IV-A	11. a. A woman who, while pregnant, was eligible for, applied for, and receives Medicaid under the approved State plan on the day her pregnancy ends. The woman continues to be eligible, as though she were pregnant, for all pregnancy-related and postpartum medical assistance under the plan for a 60-day period (beginning on the last day of her pregnancy) and for any remaining days in the month in which the 60th day falls.
1902(e)(6) of the Act	b. A pregnant woman who would otherwise lose eligibility because of an increase in income (of the family in which she is a member) during the pregnancy or the postpartum period which extends through the end of the month in which the 60-day period (beginning on the last day of pregnancy) ends.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kentucky

COVERAGE AND CONDITIONS OF ELIGIBILITY

Citation(s)	Groups Covered
	A. <u>Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)</u>
1902(e) (4) of the Act	12. A child born to a woman who is eligible for and receiving Medicaid as categorically needy on the date of the child's birth. The child is deemed eligible for one year from birth as long as the mother remains eligible or would remain eligible if still pregnant and the child remains in the same household as the mother.
IV-A	
42 CFR 435.120	13. Aged, Blind and Disabled Individuals Receiving Cash Assistance
SSI	<input checked="" type="checkbox"/> a. Individuals receiving SSI. This includes beneficiaries' eligible spouses and persons receiving SSI benefits pending a final determination of blindness or disability or pending disposal of excess resources under an agreement with the Social Security Administration; and beginning January 1, 1981 persons receiving SSI under section 1619(a) of the Act or considered to be receiving SSI under section 1619(b) of the Act. <input checked="" type="checkbox"/> Aged <input checked="" type="checkbox"/> Blind <input checked="" type="checkbox"/> Disabled

State: Kentucky

COVERAGE AND CONDITIONS OF ELIGIBILITY

Citation(s)	Groups Covered
	A. <u>Mandatory Coverage - Categorically Needy and Other Required Special Groups</u> (Continued)
435.121	13. <input type="checkbox"/> b. Individuals who meet more restrictive requirements for Medicaid than the SSI requirements. (This includes persons who qualify for benefits under section 1619(a) of the Act or who meet the requirements for SSI status under section 1619(b) (1) of the 1619(b) (1) Act and who met the State's more of the Act restrictive requirements for Medicaid in the month before the month they qualified for SSI under section 1619(a) or met the requirements under section 1619(b) (1) of the Act. Medicaid eligibility for these individuals continues as long as they continue to meet the 1619(a) eligibility standard or the requirements of section 1619(b) of the Act.) <input type="checkbox"/> Aged <input type="checkbox"/> Blind <input type="checkbox"/> Disabled

The more restrictive categorical eligibility criteria are described below:

(Financial criteria are described in ATTACHMENT 2.6-A).

* Agency that determines eligibility for coverage.

State: Kentucky

COVERAGE AND CONDITIONS OF ELIGIBILITY

Citation(s)	Groups Covered
SSI 1902 (a) (10) (A) (i) (II) and 1905 (q) of the Act	A. <u>Mandatory Coverage - Categorically Needy and Other Required Special Groups</u> (Continued) 14. Qualified severely impaired blind and disabled individuals who-- a. For the month preceding the first month of eligibility under the requirements of section 1905(q) (2) of the Act, received SSI, a State supplemental payment under section 1616 of the Act or under section 212 of P.L. 93-66 or benefits under section 1619(a) of the Act and were eligible for Medicaid; or b. For the month of June 1987, were considered to be receiving SSI under section 1619(b) of the Act and were eligible for Medicaid. These individuals must-- (1) Continue to meet the criteria for blindness or have the disabling physical or mental impairment under which the individual was found to be disabled; (2) Except for earnings, continue to meet all nondisability-related requirements for eligibility for SSI benefits; (3) Have unearned income in amounts that would not cause them to be ineligible for a payment under section 1611(b) of the Act;

*Agency that determines eligibility for coverage.

State: Kentucky

COVERAGE AND CONDITIONS OF ELIGIBILITY

Citation(s)	Groups Covered
A. <u>Mandatory Coverage - Categorically Needy and Other Required Special Groups</u> (Continued)	<p>(4) Be seriously inhibited by the lack of Medicaid coverage in their ability to continue to work or obtain employment; and</p> <p>(5) Have earnings that are not sufficient to provide for himself or herself a reasonable equivalent of the Medicaid, SSI (including any Federally administered SSP), or public funded attendant care services that would be available if he or she did have such earnings.</p> <p><input type="checkbox"/> Not applicable with respect to individuals receiving only SSP because the State either does not make SSP payments or does not provide Medicaid to SSP-only recipients.</p>

*Agency that determines eligibility for coverage.

State: Kentucky

COVERAGE AND CONDITIONS OF ELIGIBILITY

Citation(s) Groups Covered

A. Mandatory Coverage - Categorically Needy and Other Required Special Groups
(Continued)

1619(b) (3)
of the Act

- The State applies more restrictive eligibility requirements for Medicaid than under SSI and under 42 CFR 435.121. Individuals who qualify for benefits under section 1619(a) of the Act or individuals described above who meet the eligibility requirements for SSI benefits under section 1619(b) (1) of the Act and who met the States more restrictive requirements in the month before the month they qualified for SSI under section 1619(a) or met the requirements of section 1619(b) (1) of the Act are covered. Eligibility for these individuals continues as long as they continue to qualify for benefits under section 1619(a) of the Act or meet the SSI requirements under section 1619(b) (1) of the Act.

*Agency that determines eligibility for coverage.

State: Kentucky

COVERAGE AND CONDITIONS OF ELIGIBILITY

Citation(s)	Groups Covered
	A. <u>Mandatory Coverage - Categorically Needy and Other Required Special Groups</u> (Continued)
1634(c) of the Act SSI	15. Except in States that apply more restrictive eligibility requirements for Medicaid than under SSI, blind or disabled individuals who— a. Are at least 18 years of age; b. Lose SSI eligibility because they become entitled to OASDI child's benefits under section 202(d) of the Act or an increase in these benefits based on their disability. Medicaid eligibility for these individuals continues for as long as they would be eligible for SSI, absent their OASDI eligibility. <input type="checkbox"/> c. The State applies more restrictive eligibility requirements than those under SSI, and part or all of the amount of the OASDI benefit that caused SSI/SSP ineligibility and subsequent increases are deducted when determining the amount of countable income for categorically needy eligibility. <input type="checkbox"/> d. The State applies more restrictive requirements than those under SSI, and none of the OASDI benefit is deducted in determining the amount of countable income for categorically needy eligibility.
42 CFR 435.122 IV-A	16. Except in States that apply more restrictive eligibility requirements for Medicaid than under SSI, individuals who are ineligible for SSI or optional State supplements (if the agency provides Medicaid under §435.230), because of requirements that do not apply under title XIX of the Act.

*Agency that determines eligibility for coverage.

State: Kentucky

COVERAGE AND CONDITIONS OF ELIGIBILITY

Citation(s)	Groups Covered
42 CFR 435.130 IV-A	A. <u>Mandatory Coverage - Categorically Needy and Other Required Special Groups</u> (Continued) 17. Individuals receiving mandatory State supplements.

*Agency that determines eligibility for coverage.

State: Kentucky

COVERAGE AND CONDITIONS OF ELIGIBILITY

Agency*	Citation(s)	Groups Covered
	A.	<u>Mandatory Coverage - Categorically Needy and Other Required Special Groups</u> (Continued)
42 CFR 435.131 SSI	18.	Individuals who in December 1973 were eligible for Medicaid as an essential spouse and who have continued, as spouse, to live with and be essential to the well-being of a recipient of cash assistance. The recipient with whom the essential spouse is living continues to meet the December 1973 eligibility requirements of the State's approved plan for OAA, AB, APTD, or AABD and the spouse continues to meet the December 1973 requirements for having his or her needs included in computing the cash payment. <input checked="" type="checkbox"/> In December 1973, Medicaid coverage of the essential spouse was limited to the following group(s): <input checked="" type="checkbox"/> Aged <input checked="" type="checkbox"/> Blind <input checked="" type="checkbox"/> Disabled <input type="checkbox"/> Not applicable. In December 1973, the essential spouse was not eligible for Medicaid.

* Agency that determines eligibility for coverage.

State: Kentucky

COVERAGE AND CONDITIONS OF ELIGIBILITY

Agency*	Citation(s)	Groups Covered
	A.	<u>Mandatory Coverage - Categorically Needy and Other Required Special Groups</u> (Continued)
42 CFR 435.132 IV-A	19.	Institutionalized individuals who were eligible for Medicaid in December 1973 as inpatients of title XIX medical institutions or residents of title XIX intermediate care facilities, if, for each consecutive month after December 1973, they-- a. Continue to meet the December 1973 Medicaid State plan eligibility requirements; and b. Remain institutionalized; and c. Continue to need institutional care.
42 CFR 435.133 I V-A	20.	Blind and disabled individuals who-- a. Meet all current requirements for Medicaid eligibility except the blindness or disability criteria; and b. Were eligible for Medicaid in December 1973 as blind or disabled; and c. For each consecutive month after- December 1973 continue to meet December 1973 eligibility criteria.

* Agency that determines eligibility for coverage.

State: Kentucky

COVERAGE AND CONDITIONS OF ELIGIBILITY

Agency*	Citation(s)	Groups Covered
	A.	<u>Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)</u>
42 CFR 435.134 IV-A	21.	Individuals who would be SSI/SSP eligible except for the increase in OASDI benefits under Pub. L. 92-336 (July 1, 1972), who were entitled to OASDI in August 1972, and who were receiving cash assistance in August 1972. <input type="checkbox"/> Includes persons who would have been eligible for cash assistance but had not applied in August 1972 (this group was included in this State's August 1972 plan). <input checked="" type="checkbox"/> Includes persons who would have been eligible for cash assistance in August 1972 if not in a medical institution or a nursing facility (this group was included in this State's August 1972 plan). <input type="checkbox"/> Not applicable with respect to nursing facilities; the State did or does not cover this service.

* Agency that determines eligibility for coverage.

State: Kentucky

COVERAGE AND CONDITIONS OF ELIGIBILITY

Agency*	Citation(s)	Groups Covered
	A.	<u>Mandatory Coverage - Categorically Needy and Other Required Special Groups</u> (Continued)
42 CFR 435.135	22.	Individuals who --
IV-A	a.	Are receiving OASDI and were receiving SSI/SSP but became ineligible for SSI/SSP after April 1977; and
	b.	Would still be eligible for SSI or SSP if cost-of-living increases in OASDI paid under section 215(i) of the Act received after the last month for which the individual was eligible for and received SSI/SSP and OASDI, concurrently, were deducted from income.
	<input type="checkbox"/>	Not applicable with respect to individuals receiving only SSP because the State either does not make such payments or does not provide Medicaid to SSP-only recipients.
	<input type="checkbox"/>	Not applicable because the State applies more restrictive eligibility requirements than those under SSI.
	<input type="checkbox"/>	The State applies more restrictive eligibility requirements than those under SSI and the amount of increase that caused SSI/SSP ineligibility and subsequent increases are deducted when determining the amount of countable income for categorically needy eligibility.

* Agency that determines eligibility for coverage.

State: Kentucky

COVERAGE AND CONDITIONS OF ELIGIBILITY

Agency*	Citation(s)	Groups Covered
	A.	<u>Mandatory Coverage - Categorically Needy and Other Required Special Groups</u> (Continued)
1634 of the Act IV-A	23.	Disabled widows and widowers who would be eligible for SSI or SSP except for the increase in their OASDI benefits as a result of the elimination of the reduction factor required by section 134 of Pub. L. 98-21 and who are deemed, for purposes of title XIX, to be SSI beneficiaries or SSP beneficiaries for individuals who would be eligible for SSP only, under section 1634(b) of the Act. <input type="checkbox"/> Not applicable with respect to individuals receiving only SSP because the State either does not make these payments or does not provide Medicaid to SSP-only recipients. <input type="checkbox"/> The State applies more restrictive eligibility standards than those under SSI and considers these individuals to have income equalling the SSI Federal benefit rate, or the SSP benefit rate for individuals who would be eligible for SSP only, when determining countable income for Medicaid categorically needy eligibility.

* Agency that determines eligibility for coverage.

State/Territory: Kentucky

COVERAGE AND CONDITIONS OF ELIGIBILITY

Agency*	Citation(s)	Groups Covered
	A.	<u>Mandatory Coverage - Categorically Needy and Other Required Special Groups</u> (Continued)
1634(d)(2) of the Act IV-A	24.	Disabled widows, disabled widowers, and disabled surviving divorced spouses who had been married to the insured individual for a period of at least ten years before the divorce became effective, who have attained the age of 50, who are receiving title II payments, and who because of the receipt of title II income lost eligibility for SSI or SSP which they received in the month prior to the month in which they began to receive title II payments, who would be eligible for SSI or SSP if the amount of the title II benefit were not counted as income, and who are not entitled to Medicare Part A. <input type="checkbox"/> The State applies more restrictive eligibility requirements for its blind or disabled than those of the SSI program. <input checked="" type="checkbox"/> In determining eligibility as categorically needy, the State disregards the amount of the title II benefits identified in 1634(d)(1)(A) in determining the income of the individual, but does not disregard any more of this income than would reduce the individual's income to the SSI income standard. <input type="checkbox"/> In determining eligibility as categorically needy, the State disregards only part of the amount of the benefits identified in 1634(d)(1)(A) in determining the income of the individual, which amount would not reduce the individual's income below the SSI income standard. The amount of these benefits to disregarded is specified in Supplement 4 to Attachment 2.6—A. <input type="checkbox"/> In determining eligibility as categorically needy, the State chooses not to deduct any of the benefit identified in S 1634(d)(1)(A) in determining the income of the individual.

* Agency that determines eligibility for coverage.

State: Kentucky

COVERAGE AND CONDITIONS OF ELIGIBILITY

Agency*	Citation(s)	Groups Covered
OBRA 90, Sec. 5103, Sec. 1634 (d) (2) of the Act IV-A	24a.	Disabled widows and widowers and disabled surviving divorced spouses who would be eligible for SSI except for entitlement to an OASDI benefit resulting from a change in the definition of disability, effective 1/1/91, and who are deemed, for the purposes of title XIX, to be SSI recipients under 1634 of the Act.

* Agency that determines eligibility for coverage.

TN No. 92-1
Supersedes
TN No. None

Approval Date: NOV 14 1994

Effective Date: 1-1-92

HCFA ID: 7983E

State: Kentucky

COVERAGE AND CONDITIONS OF ELIGIBILITY

Agency*	Citation(s)	Groups Covered
	A.	<u>Mandatory Coverage - Categorically Needy and Other Required Special Groups</u> (Continued)
1902(a) (10)(E) (i) 1905(s) and 1905(p)(3)(A)(i) of the Act	25.	Qualified Medicare beneficiaries a. Who are entitled to hospital insurance benefits under Medicare Part A (but not pursuant to an enrollment under Section 1818A of the Act); b. Whose income does not exceed 100 percent of the Federal poverty level; and c. Whose resources do not exceed three times the SSI resource limit, adjusted annually by the increase in the consumer price index. Whose resources do not exceed twice the maximum standard under SSI. (Medical assistance for this group is limited to Medicare cost-sharing as defined in item 3.2 of this plan.)
1902(a)(10)(E)(ii) 1905(s) and 1905(p)(3)(A)(i) of the Act	26.	Qualified disabled and working individuals a. Who are entitled to hospital insurance benefits under Medicare Part A under section 1818A of the Act. b. Whose income does not exceed 200 percent of the Federal poverty level; and c. Whose resources do not exceed twice the maximum standard under SSI. d. Who are not otherwise eligible for medical assistance under Title XIX of the Act. (Medical assistance for this group is limited to Medicare Part A premiums under section 1B1BA of the Act.)

* Agency that determines eligibility for coverage.

State: Kentucky

COVERAGE AND CONDITIONS OF ELIGIBILITY

Agency*	Citation(s)	Groups Covered
	A.	<u>Mandatory Coverage - Categorically Needy and Other Required Special Groups</u> (Continued)
1902(a)(10)(E)(iii) and 1905(p)(#)(A)(ii) of the Act	27.	Specified low-income Medicare beneficiaries- a. Who are entitled to hospital insurance benefits under Medicare Part A (but not pursuant to an enrollment under Section 1818A of the Act); b. Whose income is greater than 100 percent but less than 120 percent of the federal poverty level; and c. Whose resources do not exceed three times the SSI resource limit, adjusted annually by the increase in the consumer price index. (Medical assistance for this group is limited to Medicare Part B premiums under section 1839 of the Act).
1902(a)(10)(E)(iv) and 1905(p)(3)(A)(ii) and 1860D-14(a)(3)(D) of the Act	28.	Qualifying Individuals— a. Who are entitled to hospital insurance benefits under Medicare Part A (but not pursuant to an enrollment under section 1818A of the Act); b. Whose income is at least 120 percent but less than 135 percent of the Federal poverty level; c. Whose resources do not exceed three times the SSI resource limit, adjusted annually by the increase in the consumer price index.

* Agency that determines eligibility for coverage.

State: Kentucky

COVERAGE AND CONDITIONS OF ELIGIBILITY

Agency*	Citation(s)	Groups Covered
	A.	<u>Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)</u>
1634(e) of the Act	29.	a. Each person to whom SSI benefits by reason of disability are not payable <i>for</i> any month solely by reason of clause (i) or (v) of Section 1611(e)(3)(A) shall be treated, for purposes of title XIX, as receiving SSI benefits for the month.
		b. The State applies more restrictive eligibility standards than those under SSI. Individuals whose eligibility for SSI benefits are based solely on disability who are not payable for any months solely by reason of clause (i) or (v) of Section 1611(e)(3)(A), and who continue to meet the more restrictive requirements for Medicaid eligibility under the State plan, are eligible for Medicaid as categorically needy.

* Agency that determines eligibility for coverage.

State: Kentucky

COVERAGE AND CONDITIONS OF ELIGIBILITY

Agency*	Citation(s)	Groups Covered
		B. <u>Optional Groups Other Than the Medically Needy</u>
42 CFR 435.210 1902 (a) (10) (A) (ii) and 1905(a) of the Act IV-A	<input checked="" type="checkbox"/> 1.	Individuals described below who meet the income and resource requirements of AFDC, SSI, or an optional State supplement as specified in 42 CFR 435.230, but who do not receive cash assistance. <input type="checkbox"/> The plan covers all individuals as described above. <input checked="" type="checkbox"/> The plan covers only the following group or groups of individuals: <input type="checkbox"/> Aged <input type="checkbox"/> Blind <input type="checkbox"/> Disabled <input checked="" type="checkbox"/> Caretaker relatives <input checked="" type="checkbox"/> Pregnant women <input checked="" type="checkbox"/> Individuals under the age of <input type="checkbox"/> 18 <input checked="" type="checkbox"/> 19 ** <input type="checkbox"/> 20 <input type="checkbox"/> 21
42CFR 423.211 IV-A	<input checked="" type="checkbox"/> 2.	Individuals who would be eligible for AFDC, SSI or an optional State supplement as specified in 42 CFR 435.230, if they were not in a medical institution.

** Includes individuals under age 18 and individuals age 18 but who have not reached age 19, are in an accredited program of secondary education as a full-time student, and are reasonably expected to graduate by their 19th birthday.

* Agency that determines eligibility for coverage.

State: Kentucky

COVERAGE AND CONDITIONS OF ELIGIBILITY

Agency*	Citation(s)	Groups Covered
	B.	<u>Optional Groups Other Than the Medically Needy</u>
42CFR435.212 & [] 1902(e)(2) of the Act, P.L. 99-272 (section 9517), P.L. 101-508 (section 4732)	3.	The State deems as eligible those individuals who became otherwise ineligible for Medicaid while enrolled in an HMO qualified under Title XIII of the Public Health Service Act, or a managed care organization (MCO), or a primary care case management (PCCM) program, but who have been enrolled in the entity for less than the minimum enrollment period listed below. Coverage under this section is limited to MCO or PCCM services and family planning services described in section 1905(a)(4)(C) of the Act. <input checked="" type="checkbox"/> The State elects not to guarantee eligibility. <input type="checkbox"/> The State elects to guarantee eligibility. The minimum enrollment period is _____ months (not to exceed six). The State measures the minimum enrollment period from: <input type="checkbox"/> The date beginning the period of enrollment in the MCO or PCCM, without any intervening disenrollment, regardless of Medicaid eligibility. <input type="checkbox"/> The date beginning the period of enrollment in the MCO or PCCM as a Medicaid patient (including periods when payment is made under this section). without any intervening disenrollment. <input type="checkbox"/> The date beginning the last period of enrollment in the MCO or PCCM as a Medicaid patient (not including periods when payment is made under this section) without any intervening disenrollment or periods of enrollment as a privately paying patient. (A new minimum enrollment period begins each time the individual becomes Medicaid eligible other than under this section).

* Agency that determines eligibility for coverage.

Revision: HCFA-PM-91-1-4 (BPD)
DECEMBER 1991

State: Kentucky

COVERAGE AND CONDITIONS OF ELIGIBILITY

Agency*	Citation(s)	Groups Covered
	B.	<u>Optional Groups Other Than the Medically Needy</u>
1932(a)(4) of the Act		<p>The Medicaid Agency may elect to restrict the disenrollment of Medicaid enrollees of MCOs, PIHPs, PAHPs, and PCCMs in accordance with the regulations at 42 CFR 438.56. This requirement applies unless a recipient can demonstrate good cause for disenrollment or if he/she moves out of the entity's service area or becomes ineligible.</p> <p><input type="checkbox"/> Disenrollment rights are restricted for a period of _____ months (not to exceed 12 months).</p> <p>During the first three months of each enrollment period the recipient may disenroll without cause. The State will provide notification, at least once per year, to recipients enrolled with such organization of their right to and restrictions of terminating such enrollment.</p> <p><input type="checkbox"/> No restrictions upon disenrollment rights.</p>
1903(m)(2)(H) 1902(a)(52) of the Act		<p>In the case of individuals who have become ineligible for Medicaid for the brief period described in section 1903(m)(2)(H) and who were enrolled with an MCO, PIHP, PAHP, or PCCM when they became ineligible, the Medicaid agency may elect to reenroll those individuals in the same entity if that entity still has a contract.</p> <p><input checked="" type="checkbox"/> The agency elects to reenroll the above individuals who are eligible in a month but in the succeeding two months become eligible, into the same entity in which they were enrolled at the time eligibility was lost.</p> <p><input type="checkbox"/> The agency elects not to reenroll above individuals into the same entity in which they were previously enrolled.</p>

* Agency that determines eligibility for coverage.

TN # 03-10
Supersedes
TN # 92-2

Approval Date: NOV 18 2003

Effective Date: 8/13/03

State/Territory: Kentucky

COVERAGE AND CONDITIONS OF ELIGIBILITY

Agency*	Citation(s)	Groups Covered
	B.	<u>Optional Groups Other Than the Medically Needy</u>
42 CFR 435.217	<input checked="" type="checkbox"/>	4. A group or groups of individuals who would be eligible for Medicaid under the plan if they were in a NF or an ICF/MR, who but for the provision of home and community-based services under a waiver granted under 42 CFR Part 441, Subpart G would require institutionalization, and who will receive home and community-based services under the waiver. The group or groups covered are listed in the waiver request. This option is effective on the effective date of the State's section 1915(c) waiver under which this group(s) is covered. In the event an existing 1915(c) waiver is amended to cover this group(s), this option is effective on the effective date of the amendment.

* Agency that determines eligibility for coverage.

State: Kentucky

COVERAGE AND CONDITIONS OF ELIGIBILITY

Agency*	Citation(s)	Groups Covered
	B.	<u>Optional Groups Other Than the Medically Needy</u>
1902(a) (10) (A) (ii) (VII) of the Act	<input checked="" type="checkbox"/> 5.	Individuals who would be eligible for Medicaid under the plan if they were in a medical institution, who are terminally ill, and who receive hospice care in accordance with a voluntary election described in section 1905(o) of the Act.
IV-A	<input checked="" type="checkbox"/>	The State covers all individuals as described above.
	<input type="checkbox"/>	The State covers only the following group or groups of individuals:
	<input type="checkbox"/>	Aged
	<input type="checkbox"/>	Blind
	<input type="checkbox"/>	Disabled -
	<input type="checkbox"/>	Individuals under the age of--
	<input type="checkbox"/>	21
	<input type="checkbox"/>	20
	<input type="checkbox"/>	19
	<input type="checkbox"/>	18
	<input type="checkbox"/>	Caretaker relatives
	<input type="checkbox"/>	Pregnant women

* Agency that determines eligibility for coverage.

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State: Kentucky

COVERAGE AND CONDITIONS OF ELIGIBILITY

Agency*	Citation(s)	Groups Covered
		B. <u>Optional Groups Other Than the Medically Needy</u>
42 CFR 435.220	<input type="checkbox"/>	6. Individuals who would be eligible for AFDC if their work-related child care costs were paid from earnings rather than by a State agency as a service expenditure. The State's AFDC plan deducts work-related child care costs from income to determine the amount of AFDC. <input type="checkbox"/> The State covers all individuals as described above.
1902 (a) (10) (A) (ii) and 1905(a) of the Act	<input type="checkbox"/>	The State covers only the following group or groups of individuals: <input type="checkbox"/> Individuals under the age of-- <input type="checkbox"/> 21 <input type="checkbox"/> 20 <input type="checkbox"/> 19 <input type="checkbox"/> 18 <input type="checkbox"/> Caretaker relatives <input type="checkbox"/> Pregnant women
42 CFR 435.222 1902 (a) (10) (A)(ii) and 1905(a)(i) of the Act	<input checked="" type="checkbox"/>	7. a. All individuals who are-not described in section 1902(a) (10) (A) (i) of the Act, who meet the income and resource requirements of the AFDC State plan, and who are under the age of: <input type="checkbox"/> 21 <input type="checkbox"/> 20 <input checked="" type="checkbox"/> 19** <input type="checkbox"/> 18
IV-A		

** Includes individuals under age 18 and individuals age 18 but who have not reached age 19, are in an accredited program of secondary education as a full-time student, and are reasonably expected to graduate by their 19th birthday.

* Agency that determines eligibility for coverage.

State: Kentucky

COVERAGE AND CONDITIONS OF ELIGIBILITY

Agency*	Citation(s)	Groups Covered
	B.	<u>Optional Groups Other Than the Medically Needy</u>
42 CFR 435.222	<input type="checkbox"/>	b. Reasonable classifications of individuals described in (a) above, as follows: <ul style="list-style-type: none"><input type="checkbox"/> (1) Individuals for whom public agencies are assuming full or partial financial responsibility and who are:<ul style="list-style-type: none"><input type="checkbox"/> (a) In foster homes (and are under the age of ____).<input type="checkbox"/> (b) In private institutions (and are under the age of ____)<input type="checkbox"/> (c) In addition to the group under b.(1) (a) and (b), individuals placed in foster homes or private institutions by private, nonprofit agencies (and are under the age of _____)<input type="checkbox"/> (2) Individuals in adoptions subsidized in full or part by a public agency (who are under the age of _____)<input type="checkbox"/> (3) Individuals in NFs (who are under the age of ____). NF services are provided under this plan.<input type="checkbox"/> (4) In addition to the group under (b) (3), individuals in ICFs/MR (who are under the age of _____)

* Agency that determines eligibility for coverage.

State: Kentucky

COVERAGE AND CONDITIONS OF ELIGIBILITY

Agency*	Citation(s)	Groups Covered
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B. Optional Groups Other Than the Medically Needy (Continued)

- (5) Individuals receiving active treatment as inpatients in psychiatric facilities or programs (who are under the age of _____. Inpatient psychiatric services for individuals under age 21 are provided under this plan.
- (6) Other defined groups (and ages), as specified in Supplement 1 of ATTACHMENT 2.2-A.

* Agency that determines eligibility for coverage.

State: Kentucky

COVERAGE AND CONDITIONS OF ELIGIBILITY

Agency*	Citation(s)	Groups Covered
		B. <u>Optional Groups Other Than the Medically Needy</u> (Continued)
1902(a) (10) (A) (ii) (VIII) of the Act	<input checked="" type="checkbox"/>	8. A child for whom there is in effect a State adoption assistance agreement (other than under title IV-E of the Act), who, as determined by the State adoption agency, cannot be placed or adoption without medical assistance because the child has special needs for medical or rehabilitative care, and who before execution of the agreement— a. Was eligible for Medicaid under the State's approved Medicaid plan; or b. Would have been eligible for Medicaid if the standards and methodologies of the title IV-E foster care program were applied rather than the AFDC standards and methodologies. The State covers individuals under the age of-- <input type="checkbox"/> 21 <input type="checkbox"/> 20 <input checked="" type="checkbox"/> 19** <input type="checkbox"/> 18
IV-E		

** Includes individuals under age 18 and individuals age 18 but who have not reached age 19, are in an accredited program of secondary education as a full-time student, and are reasonably expected to graduate by their 19th birthday.

* Agency that determines eligibility for coverage.

State: Kentucky

COVERAGE AND CONDITIONS OF ELIGIBILITY

Agency*	Citation(s)	Groups Covered
		B. <u>Optional Groups Other Than the Medically Needy</u> (Continued)
42 CFR 435.223	<input type="checkbox"/>	9. Individuals described below who would be eligible for AFDC if coverage under the State's AFDC plan were as broad as allowed under title IV-A:
1902 (a) (10) (A) (ii) and 1905(a) of the Act	<input type="checkbox"/>	Individuals under the age of--
		<input type="checkbox"/> 21
		<input type="checkbox"/> 20
		<input type="checkbox"/> 19
		<input type="checkbox"/> 18
	<input type="checkbox"/>	Caretaker relatives
	<input type="checkbox"/>	Pregnant women

* Agency that determines eligibility for coverage.

State: Kentucky

COVERAGE AND CONDITIONS OF ELIGIBILITY

Agency*	Citation(s)	Groups Covered
		B. <u>Optional Groups Other Than the Medically Need</u> (Continued)
42 CFR 435.230	<input checked="" type="checkbox"/> 10.	<u>States using SSI criteria with agreements under IV-A sections 1616 and 1634 of the Act.</u> The following groups of individuals who receive only a State supplementary payment (but no SSI payment) under an approved optional State supplementary payment program that meets the following conditions. The supplement is-- a. Based on need and paid in cash on a regular basis. b. Equal to the difference between the individual's countable income and the income standard used to determine eligibility for the supplement. c. Available to all individuals in the State. d. Paid to one or more of the classifications of individuals listed below, who would be eligible for SSI except for the level of their income. - <input type="checkbox"/> (1) All aged individuals. <input type="checkbox"/> (2) All blind individuals. <input type="checkbox"/> (3) All disabled individuals.

* Agency that determines eligibility for coverage.

State: Kentucky

Agency*	Citation(s)	Groups Covered
		B. <u>Optional Groups Other Than the Medically Needy</u> (Continued)
		<input checked="" type="checkbox"/> (4) Aged individuals in domiciliary facilities or other group living arrangements as defined under SSI.
42 CFR 435.230		<input checked="" type="checkbox"/> (5) Blind individuals in domiciliary facilities or other group living arrangements as defined under SSI.
		<input checked="" type="checkbox"/> (6) Disabled individuals in domiciliary facilities or other group living arrangements as defined under SSI.
		<input type="checkbox"/> (7) Individuals receiving a Federally administered optional State supplement that meets the conditions specified in 42 CFR 435.230.
		<input checked="" type="checkbox"/> (8) Individuals receiving a State administered optional State supplement that meets the conditions specified in 42 CFR 435.230.
		<input type="checkbox"/> (9) Individuals in additional classifications approved by the Secretary as follows:

* Agency that determines eligibility for coverage.

State: Kentucky

Agency*	Citation(s)	Groups Covered
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B. Optional Groups Other Than the Medically Needy (Continued)

The supplement varies in income standard by political subdivisions according to cost-of-living differences.

- Yes.
 No.

The standards for optional State supplementary payments are listed in Supplement 6 of ATTACHMENT 2.6-A.

* Agency that determines eligibility for coverage.

State: Kentucky

Agency*	Citation(s)	Groups Covered
	B.	<u>Optional Groups Other Than the Medically Needy (Continued)</u>
42 CFR 435.230 435.121 1902(a)(10) (A)(ii)(XI) of the Act	<input type="checkbox"/> 11.	<u>Section 1902(f) States and SSI criteria States without agreements under section 1616 or 1634 of the Act.</u> The following groups of individuals who receive a State supplementary payment under an approved optional State supplementary payment program that meets the following conditions. The supplement is-- a. Based on need and paid in cash on a regular basis. b. Equal to the difference between the individual's countable income and the income standard used to determine eligibility for the supplement. c. Available to all individuals in each classification and available on a Statewide basis. d. Paid to one or more of the classifications of individuals listed below: <input type="checkbox"/> (1) All aged individuals. <input type="checkbox"/> (2) All blind individuals. <input type="checkbox"/> (3) All disabled individuals.

* Agency that determines eligibility for coverage.

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TN No. 87-15

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HCFA ID: 7984E

State: Kentucky

Agency*	Citation(s)	Groups Covered
		B. <u>Optional Groups Other Than the Medically Needy</u> (Continued)
		<input type="checkbox"/> (4) Aged individuals in domiciliary facilities or other group living arrangements as defined under SSI.
		<input type="checkbox"/> (5) Blind individuals in domiciliary facilities or other group living arrangements as defined under SSI.
		<input type="checkbox"/> (6) Disabled individuals in domiciliary facilities or other group living arrangements as defined under SSI.
		<input type="checkbox"/> (7) Individuals receiving federally administered optional State supplement that meets the conditions specified in 42 CFR 435.230.
		<input type="checkbox"/> (8) Individuals receiving a State administered optional State supplement that meets the conditions specified in 42 CFR 435.230.
		<input type="checkbox"/> (9) Individuals in additional classifications approved by the Secretary as follows:

* Agency that determines eligibility for coverage.

State: Kentucky

Agency*	Citation(s)	Groups Covered
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B. Optional Groups Other Than the Medically Needy (Continued)

The supplement varies in income standard by political subdivisions according to cost-of-living differences.

Yes

No

The standards for optional State supplementary payments are listed in Supplement 6 of ATTACHMENT 2.6-A.

* Agency that determines eligibility for coverage.

State: Kentucky

Agency*	Citation(s)	Groups Covered
	B.	<u>Optional Groups Other Than the Medically Needy (Continued)</u>
42 CFR 435.231 1902 (a) (10) (A) (ii) (V) of the Act	<input checked="" type="checkbox"/> 12.	Individuals who are in institutions for at least 30 consecutive days and who are eligible under a special income level. Eligibility begins on the first day of the 30-day period. These individuals meet the income standards specified in Supplement 1, page 9a. to <u>ATTACHMENT 2.6-A</u> .
IV—A	<input checked="" type="checkbox"/>	The State covers all individuals as described above.
1902 (a) (10) (A) (ii) and 1905(a) of the Act	<input type="checkbox"/>	The State covers only the following group or groups of individuals: <ul style="list-style-type: none"><input type="checkbox"/> Aged<input type="checkbox"/> Blind<input type="checkbox"/> Disabled<input type="checkbox"/> Individuals under the age of--<ul style="list-style-type: none"><input type="checkbox"/> 21<input type="checkbox"/> 20<input type="checkbox"/> 19<input type="checkbox"/> 18<input type="checkbox"/> Caretaker relatives<input type="checkbox"/> Pregnant women

* Agency that determines eligibility for coverage.

State: Kentucky

Agency*	Citation(s)	Groups Covered
		B. <u>Optional Groups Other Than the Medically Needy</u> (Continued)
1902(e) (3) of the Act	<input type="checkbox"/>	13. Certain disabled children age 18 or under who are living at home, who would be eligible for Medicaid under the plan if they were in a medical institution, and for whom the State has made a determination as required under section 1902(e) (3) (B) of the Act. <u>Supplement 3 to ATTACHMENT 2.2-A</u> describes the method that is used to determine the cost effectiveness of caring for this group of disabled children at home.
1902(a) (10) (A) (ii) (IX) and 1902(1) of the Act	<input checked="" type="checkbox"/>	14. The following individuals who are not mandatory categorically needy whose income does not exceed the income level (established at an amount above the mandatory level and not more than 185 percent of the Federal poverty income level) specified in <u>Supplement 1 to ATTACHMENT 2.6-A</u> -for a family of the same size, including the woman and unborn child or infant and who meet the resource standards specified in <u>Supplement 2 to ATTACHMENT 2.6-A</u> : a. Women during pregnancy (and during the 60-day period beginning on the last day of pregnancy); and b. Infants under one year of age.
IV-A		

* Agency that determines eligibility for coverage.

Revision: HCFA-PM-91-4 (BPD)
1991

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State: Kentucky

Agency*	Citation(s)	Groups Covered
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1991

Revised
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Page 22
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State: Kentucky

Agency*	Citation(s)	Groups Covered
		B. <u>Optional Groups Other Than the Medically Needy</u> (Continued)
1902(a) (ii) (X) and 1902(m) (1) and (3) of the Act	<input type="checkbox"/>	16. Individuals--(for 209b states only) a. Who are 65 years of age or older or are disabled, as determined under section 1614(a)(3) of the Act. Both aged and disabled individuals are covered under this eligibility group. b. Whose income does not exceed the income level (established at an amount up to 100 percent of the Federal income poverty level) specified in Supplement 1 to <u>Attachment 2.6-A</u> for a family of the same size; and c. Whose resources do not exceed the maximum amount allowed under SSI; or under the State's medically needy program as specified in <u>Attachment 2.6-A</u> . Supplement 2, page. 6.

* Agency that determines eligibility for coverage.

TN No. 92-1
Supersedes
TN No. None

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Effective Date: 1-1-92

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
COVERAGE AND CONDITIONS OF ELIGIBILITY

Agency*	Citation(s)	Groups Covered
1902(a)(47) and 1920 of the Act	<input checked="" type="checkbox"/>	B. <u>Optional Groups Other Than the Medically Needy</u> (Continued) 17. Pregnant women who are determined by a "qualified provider" (as defined in Section 1920 (b)(2) of the Act) based on preliminary information, to meet the highest applicable income criteria specified in this plan under <u>Attachment 2.6-A</u> and are therefore determined to be presumptively eligible during a presumptive eligibility period in accordance with Section 1920 of the Act.

* Agency that determines eligibility for coverage.

State/Territory: Kentucky

Agency*	Citation(s)	Groups Covered
	B.	<u>Optional Groups Other Than the Medically Needy</u> (Continued)
1906 of the Act	18.	Individuals required to enroll in cost-effective employer-based group health plans remain eligible for a minimum enrollment period of <u> 2 </u> months.
1902(a)(10)(F) and 1902(u)(1) of the Act	19.	Individuals entitled to elect COBRA continuation coverage and whose income as determined under Section 1612 of the Act for purposes of the SSI program, is no more than 100 percent of the Federal poverty level, whose resources are no more than twice the SSI resource limit for an Individual, and for whom the State determines that the cost of COBRA premiums is likely to be less than the Medicaid expenditures for an equivalent set of services. See Supplement 11 to Attachment 2.6-A.

* Agency that determines eligibility for coverage.

Agency*	Citation(s)	Groups Covered
	B. <u>Optional Groups Other Than the Medically Needy (Continued)</u>	
1902 (a) (10) (A)	<input type="checkbox"/>	19. Optional Targeted Low Income Children who: <ul style="list-style-type: none"><li data-bbox="504 427 1173 501">a. are not eligible for Medicaid under any other optional or mandatory eligibility group or eligible as medically needy (without spenddown liability);<li data-bbox="504 528 1173 602">b. would not be eligible for Medicaid under the policies in the State's Medicaid plan as in effect on April 15, 1997 (other than because of the age expansion provided for in §1902(1) (2) (D));<li data-bbox="504 629 1173 752">c. are not covered under a group health plan or other group health insurance (as such terms are defined in §2791 of the Public Health Service Act coverage) other than under a health insurance program in operation before July 1, 1997 offered by a State which receives no Federal funds for the program;<li data-bbox="504 779 1173 981">d. have family income at or below: 200 percent of the Federal poverty level for the size family involved, as revised annually in the Federal Register; or A percentage of the Federal poverty level, which is in excess of the "Medicaid applicable income level" (as defined in §2110(b) (4) of the Act) but by no more than 50 percentage points. <input checked="" type="checkbox"/> The State covers: All children described above who are under age 19 with family income at or below 150 percent of the Federal poverty level.

Agency*	Citation(s)	Groups Covered
1920(E) (12) of the Act	<input type="checkbox"/>	<p data-bbox="504 322 1165 427"><input type="checkbox"/> The following reasonable classifications of children described above who are under age ____ (18, 19) with family income at or below the percent of the Federal poverty level specified for the classification:</p> <p data-bbox="427 450 1165 555">20. A child under age ____ (not to exceed age (19) who has been determined eligible is deemed to be eligible for a total of ____ months (not to exceed 12 months) regardless of changes in circumstances other than attainment of the maximum age state above.</p> <p data-bbox="427 577 1165 651">21. Children under age 19 who are determined by a 'qualified entity' (as defined in §1920A(b) (3) (A)) based on preliminary information, to meet the highest applicable income criteria specified in this plan.</p> <p data-bbox="504 674 1165 880">The presumptive period begins on the day that the determination is made. If an application for Medicaid is filed on the child's behalf by the last day of the month following the month in which the determination of presumptive eligibility was made, the presumptive period ends on the day that the State agency makes a determination of eligibility based on that application. If an application is not filed on the child's behalf by the last day of the month following the month the determination of presumptive eligibility was made, the presumptive period ends on that last day.</p>

State: Kentucky

Agency*	Citation(s)	Groups Covered
1902(a)(1O)(A) (ii)(X VIII) of the Act	B.	Optional Groups Other Than the Medically Needy (Continued)
	<input checked="" type="checkbox"/>	22. Women who: <ul style="list-style-type: none"> a. have been screened for breast or cervical cancer under Centers for Disease Control and Prevention Breast and Cervical Cancer Early Detection Program established under Title XV of the Public Health Service Act in accordance with the requirements of section 1504 of that Act and need treatment for breast or cervical cancer, including a pre cancerous condition of the breast or cervix; b. are not otherwise covered under creditable coverage, as defined in section 2701(c) of the Public Health Service Act; c. are not eligible for Medicaid under any mandatory categorically needy eligibility group; and d. have not attained age 65.
	<input type="checkbox"/>	23. Women who are determined by a “qualified entity” (as defined in 1920(B)(b)) based on preliminary information, to be a woman described in 1902(aa) of the Act related to certain breast and cervical cancer patients. <p>The presumptive period begins on the day that the determination is made. The period ends on the date that the State makes a determination with respect to the woman’s eligibility for Medicaid, or if the woman does not apply for Medicaid (or a Medicaid application was not made on her behalf) the last day of the month following the month in which the determination of presumptive eligibility was made, the presumptive period ends on that last day.</p>
	1920(B) of the Act	

State/Territory: Kentucky

Agency*	Citation(s)	Groups Covered
B. <u>Optional Groups Other Than the Medically Needy (Continued)</u>		
1902(a)(10)(A) (ii)(XIII) of the Act	<input type="checkbox"/>	24. BBA Work Incentives Eligibility Group - Individuals with a disability whose net family income is below 250 percent of the Federal poverty level for a family of the size involved and who, except for earned income, meet all criteria for receiving benefits under the SSI program. See page 12c of Attachment 2.6 A.
1902(a)(10)(A) (ii)(XV) of the Act	<input checked="" type="checkbox"/>	25. TWWIIA Basic Coverage Group – Individuals with a disability at least 16 but less than 65 years of age whose income and resources do not exceed a standard established by the State. See page 12d of Attachment 2.6 A.
1902(a)(10)(A) (ii)(XVI) of the Act	<input type="checkbox"/>	26. TWWIIA Medical Improvement Group - Employed individuals at least 16 but less than 65 years of age with a medically improved disability whose income and resources do not exceed a standard established by the State. See page 12h of Attachment 2.6A.
NOTE: If the State elects cover this group, it MUST also cover the eligibility group described in No. 25 above.		

State Kentucky

Agency*	Citation(s)	Groups Covered
	C. <u>Optional Coverage of the Medically Needy</u>	
42 CFR 435.301		This plan includes the medically needy.
IV-A	<input type="checkbox"/> No. <input checked="" type="checkbox"/> Yes. This plan covers:	
	1.	Pregnant women who, except for income and/or resources, would be eligible as categorically needy under title XIX of the Act.
1902(e) of the Act	2.	Women who, while pregnant, were eligible for and have applied for Medicaid and receive Medicaid as medically needy under the approved State plan on the date the pregnancy ends. These women continue to be eligible, as though they were pregnant, for all pregnancy-related and postpartum services under the plan for a 60-day period, beginning with the date the pregnancy ends, and any remaining days in the month in which the 60th day falls.
IV-A		
1902(a) (10) (C) (ii) (I) of the Act	3.	Individuals under age 18 who, but for income and/or resources, would be eligible under section 1902 (a)(10)(A)(i) of the Act.
IV-A		

State: Kentucky

Agency*	Citation(s)	Groups Covered
	C.	<u>Optional Coverage of the Medically Needy (Continued)</u>
1902(e) (4) of the Act		4. Newborn children born on or after October 1, 1984 to a woman who is eligible IV-A as medically needy and is receiving Medicaid on the date of the child's birth. The child is deemed to have applied and been found eligible for Medicaid on the date of birth and remains eligible for one year so long as the woman remains eligible or would remain eligible if she were pregnant and the child is a member of the woman's household.
42 CFR 435.308 IV-A	<input checked="" type="checkbox"/>	5. a. Financially eligible individuals who are not described in section C.3 above and who are under the age of-- <input type="checkbox"/> 21 <input type="checkbox"/> 20 <input checked="" type="checkbox"/> 19** <input type="checkbox"/> 18 or under age 19 who are full-time students in a secondary school or in the equivalent level of vocational or technical training
	<input type="checkbox"/>	b. Reasonable classifications of financially eligible individuals under the ages of 21, 20, 19, or 18 as specified below: - <input type="checkbox"/> (1) Individuals for whom public agencies are assuming full or partial financial responsibility and who are: <input type="checkbox"/> (a) In foster homes (and are under the age of ____) <input type="checkbox"/> (b) In private institutions (and are under the age of ____)

** Includes individuals under age 18 and individuals age 18 but who have not reached age 19, are in an accredited program of secondary education as a full-time student, and are reasonably expected to graduate by their 19th birthday.

State: Kentucky

Agency*	Citation(s)	Groups Covered
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C. Optional Coverage of the Medically Needy (Continued)

- (c) In addition to the group under b. (1) (a) and (b), individuals placed in foster homes or private institutions by private, nonprofit agencies (and are under the age of ____)
- (2) Individuals in adoptions subsidized in full or part by a public agency (who are under the age of ____).
- (3) Individuals in NFS (who are under the age of ____). NF services are provided under this plan.
- (4) In addition to the group under (b)(3), individuals in ICFs/MR (who are under the age of ____)
- (5) Individuals receiving active treatment as inpatients in psychiatric facilities or programs (who are under the age of ____). Inpatient psychiatric services for individuals under age 21 are provided under this plan.
- (6) Other defined groups (and ages), as specified in Supplement 1 of ATTACHMENT 2.2-A.

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State: Kentucky

Agency* Citation(s)	Groups Covered
IV-A	C. <u>Optional Coverage of the Medically Needy</u> (Continued)
42 CFR 435.310	<input checked="" type="checkbox"/> 6. Caretaker relatives.
42 CFR 435.320 and 435.330 IV-A	<input checked="" type="checkbox"/> 7. Aged individuals.
42 CFR 435.322 and 435.330 IV-A	<input checked="" type="checkbox"/> 8. Blind individuals.
42 CFR 435.324 and 435.330 IV-A	<input checked="" type="checkbox"/> 9. Disabled individuals.
42 CFR 435.326	<input type="checkbox"/> 10. Individuals who would be ineligible if they were not enrolled in an HMO. Categorically needy individuals are covered under 42 CFR 435.212 and the same rules apply to medically needy individuals.
435.340 IV-A	<input type="checkbox"/> 11. Blind and disabled individuals who: a. Meet all current requirements for Medicaid eligibility except the blindness or disability criteria; b. Were eligible as medically needy- in December 1973 as blind or disabled; and c. For each consecutive month after December 1973 continue to meet the December 1973 eligibility criteria.

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State: Kentucky

Agency*	Citation(s)	Groups Covered
1906 of the Act	C. <u>Optional Coverage of the Medically Needy</u> (Continued)	12. Individuals required to enroll in cost effective employer-based group health plans remain eligible for a minimum enrollment period of <u>2</u> months.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kentucky

REQUIREMENTS RELATING TO DETERMINING ELIGIBILITY FOR MEDICARE
PRESCRIPTION DRUG LOW-INCOME SUBSIDIES

Agency*	Citation(s)	Groups Covered
	C.	<u>Optional Coverage of the Medically Needy(Continued)</u>
1935(a) and 1902(a)(66)		The agency provides for making Medicare prescription drug Low Income Subsidy determinations under Section 1935(a) of the Social Security Act.
42 CFR 423.774 and 423.904	1.	The agency makes determinations of eligibility for premium and cost-sharing subsidies under and in accordance with section 1860D-14 of the Social Security Act;
	2.	The agency provides for informing the Secretary of such determinations in cases in which such eligibility is established or redetermined;
	3.	The agency provides for screening of individuals for Medicare cost-sharing described in Section 1905(p)(3) of the Act and offering enrollment to eligible individuals under the State plan or under a waiver of the State plan.

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1991

SUPPLEMENT 1 TO ATTACHMENT 2.2-A
Page 1
OMB NO.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kentucky

REASONABLE CLASSIFICATIONS OF INDIVIDUALS UNDER
THE AGE OF 21, 20, 19, AND 18

TN No. 92-1
Supersedes
TN No. None

Approval Date: NOV 14 1994

Effective Date: 1-1-92

HCFA ID: 7984E

Revision: HCFA-PM-91-4 (BPD)
1991

SUPPLEMENT 3 TO ATTACHMENT 2.2-A
Page 1
OMB NO.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kentucky

Method for Determining Cost Effectiveness of Caring for
Certain Disabled Children At Home

TN No. 92-1
Supersedes
TN No. None

Approval Date NOV 14 1994

Effective Date 1-1-92

HCFA ID: 7984E

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kentucky

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
	A. <u>General Conditions of Eligibility</u>
	Each individual covered under the plan:
42 CFR Part 435, Subpart G	1. Is financially eligible (using the methods and standards described in Parts B and C of this Attachment) to receive services.
42 CFR Part 435 Subpart F	2. Meets the applicable non-financial eligibility conditions. a. For the categorically needy: (i) Except as specified under items A.2.a.(ii) and (iii) below, for AFDC—related individuals, meets the non—financial eligibility conditions of the AFDC program. (ii) For SSI-related individuals, meets the non-financial criteria of the SSI program or more restrictive SSI-related categorically needy criteria.
1902(1) of the Act	(iii) For financially eligible pregnant women, infant ⁸ or children covered under sections 1902(a) (10) (A) (i) (IV), 1902(a)(10) (A)(i)(VI), 1902(a)(10)(A)(i)(VII), and 1902(a)(10)(A)(ii)(IX) of the Act, meets the non-financial criteria of section 1902(1) of the Act.
1902(m) of the Act	(iv) For financially eligible aged and disabled individuals covered under section 1902(a) (10) (A) (ii) (X) of the Act, meets the non-financial criteria of section 1902(m) of the Act.

State: Kentucky

-
- 1905(p) of the Act
- 1905(s) of the Act
- P.L. 102-585
Section 402
- 1902(a) and 1903(v)
of the Act and
Section
401(b)(I)(A) of P.L.
104-193
- b. For the medically needy, meets the non-financial eligibility conditions of 42 CFR Part 435.
 - c. For financially eligible qualified Medicare beneficiaries covered under section 1902(a)(10)(E)(i) of the Act, meets the non financial criteria of section 1905(p) of the Act.
 - d. For financially eligible qualified disabled and working individuals covered under section 1902(a)(10)(E)(ii) of the Act, meets the non-financial criteria of section 1905(s).
3. Is residing in the United States and--
- a. Is a citizen.
 - b. Is a qualified alien, as identified in section 431(b) of P.L. 104-193, whose coverage is mandatory under sections 402 and 403 of P.L. 104-193, including those who entered the U. S. prior to August 22, 1996, and those who entered on or after August 22, 1996.
 - Is a qualified alien, as defined in section 431(b) of P.L. 104-193, whose coverage is optional under section 402 and 403 of P.L. 104-1 93, including those who entered the U. S. Prior to August 22,1996 and those who entered on or after August 22, 1996.
 - c. Is an alien who is not a qualified alien as defined in section 431(b) of P.L. 104-193, or who is a qualified alien but is not eligible under the provision of (b) above. (Coverage is restricted to certain emergency services).
 - d. Limited Coverage for Certain Aliens
- Is an alien who is not a qualified alien or who is a - qualified alien, as defined in section 431(b) of P.L. 104- 193, but is not eligible for Medicaid based on alien status, and who would otherwise qualify for Medicaid is provided Medicaid only for the treatment of an emergency medical condition (including emergency labor and delivery) as defined in section 1903(v)(3) of the Act.

State: Kentucky

42 CFR 435.403
1902(b) of the Act

4. Is a resident of the State, regardless of whether or not the individual maintains the residence permanently or maintains it at a fixed address.

State has interstate residency agreement with the following States:

Iowa	New Jersey
West Virginia	New Mexico
California	North Dakota
Georgia	South Dakota
Tennessee	Maryland
Alabama	Ohio
Arkansas	Pennsylvania
Florida	Wisconsin
Kansas	Indiana (for individual cases)
Mississippi	Idaho

State has open agreement(s).

Not applicable; no residency requirement

State: Kentucky

Citation(s)	Condition or Requirement
435.1008	5. a. Is not an inmate of a public institution. Public institutions do not include medical institutions, nursing facilities, intermediate care/mentally retarded facilities, or publicly operated community residences that serve no more than 16 residents, or certain child care institutions.
42 CFR 435.1008 1905(a) of the Act	b. Is not a patient under age 65 in an institution for mental diseases except as an inpatient under age 22 receiving active treatment in an accredited psychiatric facility or program. <input type="checkbox"/> Not applicable with respect to individuals under age 22 in psychiatric facilities or programs. Such services are not provided under the plan.
433.145 ??604 ??2 of the Act	6. Is required, as a condition of eligibility, to assign rights to medical support and to payments for medical care from any third party, to cooperate in obtaining such support and payments, and to cooperate in identifying and providing information to assist in pursuing any liable third party. The assignment of rights obtained from an applicant or recipient is effective only for services that are reimbursed by Medicaid. The requirements of 42 CFR 433.146 through 433.148 are met. <input checked="" type="checkbox"/> Assignment of rights is automatic because of State law.
42 CFR 435.910	7. Is required, as a condition of eligibility, to furnish his/her social security account number (or numbers, if he/she has more than one number), except for aliens seeking medical assistance for the treatment of an emergency medical condition under Section 1903(v) (2) of the Social Security Act and newborn children who are eligible under Section 1902 (e) 4.

TN No. - 92-1
Supersedes
TN No. None

Approval Date: NOV 14 1994

Effective Date: 1-1-92

HCFA ID: 7985E

State: Kentucky

Citation(s)	Condition or Requirement
1902(e) (2)	8. Is not required to apply for AFDC benefits under title IV-A as a condition of applying for, or receiving, Medicaid if the individual is a pregnant woman, infant, or child that the State elects to cover under sections 1902(a) (10) (A) (i) (IV) and 1902(a) (10) (A) (ii) (IX) of the Act.
1902(e) (10) (A) and (B) of the Act	9. Is not required, as an individual child or pregnant woman, to meet requirements under section 402(a) (43) of the Act to be in certain living arrangements. (Prior to terminating AFDC individuals who do not meet such requirements under a State's AFDC plan, the agency determines if they are otherwise eligible under the State's Medicaid plan.)

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October 1991

ATTACHMENT 2.6-A
Page 3c
OMB No.: 0938-

State/Territory: Kentucky

Citation(s)	Condition or Requirement
1906 of the Act	10. Is required to apply for enrollment in an employer- based cost-effective group health plan, if such plan is available to the individual. Enrollment is a condition of eligibility except for the individual who is unable to enroll on his/her own behalf (failure of a parent to enroll a child does not affect a child's eligibility).

TN No. 92-22
Supersedes
TN No. None

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Effective Date 2-1-93

HCFA ID: 7985E

Citation(s)	Condition or Requirement
	B. <u>Posteligibility Treatment of Institutionalized Individuals' Incomes</u>
	1. The following items are not considered in the posteligibility process:
1902(o) of the Act	a. SSI and SSP benefits paid under § 1611(e)(1)(E) and (G) of the Act to individuals who receive care in a hospital, nursing home, SNF, or ICF.
Bondi v Sullivan (SSI)	b. Austrian Reparation Payments (pension (reparation) payments made under § 500 - 506 of the Austrian General Social Insurance Act). Applies only if State follows SSI program rules with respect to the payments.
1902(r)(1) of the Act	c. German Reparations Payments (reparation payments made by the Federal Republic of Germany).
105/ 206 of P. L. 100-383	d. Japanese and Aleutian Restitution Payments.
1. (a) of P. L. 103-286	e. Netherlands Reparation Payments based on Nazi, but not Japanese, persecution (during World War II).
10405 of P. L. 101-239	f. Payments from the Agent Orange Settlement Fund or any other fund established pursuant to the settlement in the In re Agent Orange product liability litigation, M.D.L. no. 381 (E.D.N.Y.)
6(h)(2) of P. L. 101-426	g. Radiation Exposure Compensation.
12005 of P. L. 103-66	h. VA pensions limited to \$90 per month under 38 U.S.C. 5503.

Citation(s)	Condition or Requirement
1924 of the Act 435.725 435.733 435.832	<p>2. The following monthly amounts for personal needs are deducted from total monthly income in the application of an institutionalized individual's or couple's income to the cost of institutionalized care:</p> <p>Personal Needs Allowance (PNA) of not less than \$30 for Individuals and \$60 for Couples for all institutionalized persons.</p> <p>a. Aged, blind, disabled: Individuals <u>\$40.00</u> plus mandatory nondiscretionary deductions Couples <u>\$80.00</u> plus mandatory nondiscretionary deductions</p> <p>For the following persons with greater need: Supplement 12a to <u>Attachment 2.6-A</u> describes the greater need; describes the basis or formula for determining the deductible amount when a specific amount is not listed above; lists the criteria to be met; and where appropriate, identifies the organizational unit which determines that a criterion is met.</p> <p>b. AFDC Related:</p> <p>Children <u>\$40.00</u> plus mandatory nondiscretionary deductions Adults <u>\$40.00</u> plus mandatory nondiscretionary deductions</p> <p>For the following persons with greater need: Supplement 12a to <u>Attachment 2.6-A</u> describes the greater need; describes the basis or formula for determining the deductible amount when a specific amount is not listed above; lists the criteria to be met; and where appropriate, identifies the organizational unit which determines that a criterion is met.</p> <p>c. Individual under age 21 covered in the plan as specified in Item B.7 of Attachment 2.2-A. <u>\$40.00</u> plus mandatory nondiscretionary deductions.</p>

Citation(s)	Condition or Requirement
1924 of the Act	<p data-bbox="576 327 970 349">For the following persons with greater need:</p> <p data-bbox="576 376 1161 501">Supplement 12a to <u>Attachment 2.6-A</u> describes the greater need; describes the basis or formula for determining the deductible amount when a specific amount is not listed above; lists the criteria to be met; and where appropriate; identifies the organizational unit which determines that a criterion is met.</p> <p data-bbox="432 528 1161 600">3. In addition to the amounts under item 2., the following monthly amounts are deducted from the remaining income of an institutionalized individual with a community spouse:</p> <p data-bbox="504 629 1161 801">a. The monthly income allowance for the community spouse, calculated using the formula in §1 924(d)(2), is the amount by which the maintenance needs standard exceeds the community spouse's income. The maintenance needs standard cannot exceed the maximum prescribed in §1924(d)(3)(C). The maintenance needs standard consists of a poverty level component plus an excess shelter allowance.</p> <p data-bbox="576 831 1161 902"><input checked="" type="checkbox"/> The poverty level component is calculated using the applicable percentage (set out §1924(d)(3)(B) of the Act) of the official poverty level.</p> <p data-bbox="576 931 1161 1025"><input type="checkbox"/> The poverty level component is calculated using a percentage greater than the applicable percentage, equal to ___%, of the official poverty level (still subject to maximum maintenance needs standard).</p> <p data-bbox="576 1055 1161 1126"><input type="checkbox"/> The maintenance needs standard for all community spouses is set at the maximum permitted by §1924(d)(3)(C).</p> <p data-bbox="647 1155 1161 1305">Except that, when applicable, the State will set the community spouse's monthly income allowance at the amount by which exceptional maintenance needs, established at a fair hearing, exceed the community spouse's income, or at the amount of any court ordered support.</p>

Citation(s)	Condition or Requirement
	<p>In determining any excess shelter allowance, utility expenses are calculated using:</p> <p><input type="checkbox"/> the standard utility allowance under §5(e) of the Food Stamp Act of 1977; or</p> <p><input checked="" type="checkbox"/> the actual unreimbursable amount of the community spouse's utility expenses less any portion of such amount included in condominium or cooperative charges.</p>
	<p>b. The monthly income allowance for other dependent family members living with the community spouse is:</p> <p><input checked="" type="checkbox"/> one-third of the amount by which the poverty level component (calculated under §1924(d)(3)(A)(i) of the Act, using the applicable percentage specified in §1924(d)(3)(B)) exceeds the dependent family member's monthly income.</p> <p><input type="checkbox"/> a greater amount calculated as follows:</p> <p>The standards described above are used for individuals receiving home and community based waiver services in lieu of services provided in a medical and remedial care institution.</p> <p>The following definition is used in lieu of the definition provided by the Secretary to determine the dependency of family members under §1924(d)(1):</p> <p style="text-align: center;">The Definition of Dependency:</p> <p style="text-align: center;">For the purpose of deducting allowances under Section 1924, a dependent means a child, parent, or sibling who lives with the community spouse and is claimed as a dependent by either spouse under the Internal Revenue Services Code.</p>
	<p>c. Amounts for health care expenses described below that are incurred by and for the institutionalized individual and are not subject to payments by a third party:</p>

Citation(s)	Condition or Requirement
(i)	Medicaid, Medicare and other health insurance premiums, deductibles, or coinsurance charges, or copayments.
(ii)	Necessary medical or remedial care recognized under State law but not covered under the State plan. (Reasonable limits on amounts are described in Supplement 3 to <u>ATTACHMENT 2.6-A</u>)

Citation(s)	Condition or Requirement
435.725 435.733 435.832	<p>4. In addition to any amounts deductible under the items above, the following monthly amounts are deducted from the remaining monthly income of an institutionalized individual or an institutionalized couple:</p> <p>a. An amount for the maintenance needs of each member of a family living in the institutionalized individual's home with no community spouse living in the home. The amount must be based on a reasonable assessment of need but must not exceed the higher of the:</p> <ul style="list-style-type: none">o AFDC level; oro Medically needy level: <p>(Check one)</p> <ul style="list-style-type: none"><input type="checkbox"/> AFDC levels in Supplement I<input checked="" type="checkbox"/> Medically needy level in Supplement I<input type="checkbox"/> Other: \$ _____ <p>b. Amounts for health care expenses described below that have not been deducted under 3.c. above (i.e., for an institutionalized individual with a community spouse), are incurred by and for the institutionalized individual or institutionalized couple, and are not subject to the payment by a third party:</p> <ul style="list-style-type: none">(i) Medicaid,, Medicare, and other health insurance premiums, deductibles, or coinsurance charges, or copayments.(ii) Necessary medical or remedial care recognized under State law but not covered under the State plan. (Reasonable limits on amount are described in Supplement 3 to <u>ATTACHMENT 2.6-A.</u>)
435.725 435.733 435.832	<p>5. At the option of the State, as specified below, the following is deducted from any remaining monthly income of an institutionalized individual or an institutionalized couple:</p> <p>A monthly amount for the maintenance of the home of the individual or couple for not longer than 6 months if a physician has certified that the individual, or one member of the institutionalized couple, is likely to return to the home within that period:</p> <ul style="list-style-type: none"><input checked="" type="checkbox"/> No.<input type="checkbox"/> Yes (the applicable amount is shown on page 5a.)

Citation(s)	Condition or Requirement
	<input type="checkbox"/> Amount for maintenance of home is \$_____:
	<input type="checkbox"/> Amount for maintenance of home is the actual maintenance costs not to exceed \$_____
	<input type="checkbox"/> Amount for maintenance of home is deductible when countable income is determined under §1924(d)(1) of the Act only if the individuals home and the community spouse's home are different.
	<input type="checkbox"/> Amount for maintenance of home is not deductible when countable income is determined under § 1924(d)(1) of the Act.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kentucky

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
42 CFR 435.711 435.721, 435.831	<p data-bbox="360 477 612 499">C. <u>Financial Eligibility</u></p> <p data-bbox="432 528 1165 651">For individuals who are AFDC or SSI recipients, the income and resource levels and methods for determining countable income and resources of the AFDC and SSI program apply, unless the plan provides for more restrictive levels and methods than SSI for SSI recipients under section 1902(f) of the Act, or more liberal methods under section 1902(r) (2) of the Act, as specified below.</p> <p data-bbox="432 680 1165 752">For individuals who are not AFDC or SSI recipients in a non-section 1902(f) State and those who are deemed to be cash assistance recipients, the financial eligibility requirements specified in this section C apply.</p> <p data-bbox="432 781 1165 981"><u>Supplement 1 to ATTACHMENT 2.6-A</u> specifies the income levels for mandatory and optional categorically needy groups of individuals, including individuals with incomes related to the Federal income poverty level--pregnant women and infants or children covered under sections 1902(a)(10)(A)(i)(IV), 1902(a)(10)(A)(i) (VI), 1902(a) (10) (A) (i) (VII), end 1902(a)(10)(A)(ii)(1X) of the Act and aged and disabled individuals covered under section 1902(a)(10)(A)(ii)(X) of the Act--and for mandatory groups of qualified Medicare beneficiaries covered under section 1902(a) (10) (E)(i) of the Act.</p>

Citation(s)	Condition or Requirement
<input checked="" type="checkbox"/>	<u>Supplement 2 to ATTACHMENT 2.6-A</u> specifies the resource levels for mandatory and optional categorically needy poverty level related groups, and for medically needy groups.
<input type="checkbox"/>	<u>Supplement 7 to ATTACHMENT 2.6-A</u> specifies the income levels for categorically needy aged, blind and disabled persons who are covered under requirements more restrictive than SSI.
<input type="checkbox"/>	<u>Supplement 4 to ATTACHMENT 2.6-A</u> specifies the methods for determining income eligibility used by States that have more restrictive methods than SSI, permitted under section 1902(f) of the Act.
<input type="checkbox"/>	<u>Supplement 5 to ATTACHMENT 2.6-A</u> specifies the methods for determining resource eligibility used by States that have more restrictive methods than SSI, permitted under section 1902(f) of the Act.
<input checked="" type="checkbox"/>	<u>Supplement 8a to ATTACHMENT 2.6-A</u> specifies the methods for determining income eligibility used by States that are more liberal than the methods of the cash assistance programs, permitted under section 1902(r) (2) of the Act.
<input checked="" type="checkbox"/>	<u>Supplement 8b to ATTACHMENT 2.6-A</u> specifies the methods for determining resource eligibility used by States that are more liberal than the methods of the cash assistance programs, permitted under section 1902(r) (2) of the Act.
<input checked="" type="checkbox"/>	<u>Supplement 8c to ATTACHMENT 2.6-A</u> specifies the methods for determining resource eligibility used by State that are more liberal than the method of the cash assistance permitted under sections 1902(r)(2) and 1917(b)(1)(C) of the Act.
<input checked="" type="checkbox"/>	<u>Supplement 9b to ATTACHMENT 2.6-A</u> specifies the criteria used for transfer of assets under section 1917(c) of the Act, which affects the eligibility of institutionalized individuals on or after February 8, 2006.
<input checked="" type="checkbox"/>	<u>Supplement 10 to ATTACHMENT 2.6-A</u> specifies the criteria used to exclude the assets transferred into a Medicaid trust because of undue hardship for categorically needy individuals, as permitted under section 1902(d)(4) of the Act.
<input type="checkbox"/>	<u>Supplement 11 to ATTACHMENT 2.6-A</u> specifies cost effectiveness methodology for COBRA continuation beneficiaries.
<input checked="" type="checkbox"/>	<u>Supplement 12 to ATTACHMENT 2.6-A</u> specifies the variations from the basic personal needs allowance under section 1902(a)(50) of the Act. It also specifies the AFDC covered groups and the income and resource eligibility criteria for low-income families under section 1931 of the Act.
<input checked="" type="checkbox"/>	<u>Supplement 13 to ATTACHMENT 2.6-A</u> specifies the treatment of available income and resources for certain institutionalized spouses with a community spouse under section 1924 of the Act.

State: Kentucky

Citation(s)	Condition or Requirement
<input type="checkbox"/>	<u>Supplement 14 to ATTACHMENT 2.6-A</u> specifies the income and resources requirements used by States for determining eligibility of Tuberculosis-infected individuals whose eligibility is determined under section 1902(z)(1) of the Act.
<input checked="" type="checkbox"/>	<u>Supplement 15 to ATTACHMENT 2.6-A</u> specifies disqualification for long term care assistance for individuals with substantial home equity.

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Supersedes
TN No. None

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kentucky

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
1902(r) (2) of the Act	<p>1. <u>Methods of Determining Income</u></p> <p>a. <u>AFDC-related individuals (except for poverty level related pregnant women, infants, and children).</u></p> <p>(1) In determining countable income for AFDC-related individuals, the following methods are used:</p> <p><input checked="" type="checkbox"/> (a) The methods under the State's approved AFDC plan only; or</p> <p><input type="checkbox"/> (b) The methods under the State's approved AFDC plan and/or any more liberal methods described in Supplement 8a to ATTACHMENT 2.6—A.</p> <p>(2) In determining relative financial responsibility, the agency considers only the income of spouses living in the same household as available to spouses and the income of parents as available to children living with parents until the children become 21.</p>
1902(e)(6) the Act	<p>(3) Agency continues to treat women eligible under the provisions of sections 1902(a)(10) of the Act as eligible, without regard to any changes in income of the family of which she is a member, for the 60-day period after her pregnancy ends and any remaining days in the month in which the 60th day falls.</p>

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY AC

State: Kentucky

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
42 CFR 435.721 435.832, and 1902(m) (1) (B) (m) (4) and 1902(r) (2) of the Act	b. <u>Aged individuals.</u> In determining countable income for aged individuals, including aged individuals with incomes up to the Federal poverty level described in section 1902(m)(') of the Act, the following methods are used: <input type="checkbox"/> The methods of the SSI program only. <input checked="" type="checkbox"/> The methods of the SSI program and/or any more liberal methods described in <u>Supplement 8a to ATTACHMENT 2.6-A.</u>

State: Kentucky

Citation(s)	Condition or Requirement
	<input type="checkbox"/> For individuals other than optional State supplement recipients, more restrictive methods than SSI, applied under the provisions of section 1902(f) of the Act, as specified in <u>Supplement 4 to ATTACHMENT 2.6-A</u> and any more liberal methods described in <u>Supplement 8a to ATTACHMENT 2.6-A</u> .
	<input type="checkbox"/> For institutional couples, the methods specified under section 1611(e) (5) of the Act.
	<input type="checkbox"/> For optional State supplement recipients under §435.230, income methods more liberal than SSI, as specified in <u>Supplement 4 to ATTACHMENT 2.6-A</u> .
	<input type="checkbox"/> For optional State supplement recipients in section 1902(f) States and SSI criteria States without section 1616 or 1634 agreements-- (SSA administered OSS) <ul style="list-style-type: none"><input type="checkbox"/> SSI methods only.<input type="checkbox"/> SSI methods and/or any more liberal methods than SSI described in <u>Supplement 8a to ATTACHMENT 2.6-A</u>.<input type="checkbox"/> Methods more restrictive and/or more liberal than SSI. More restrictive methods are described in <u>Supplement 4 to ATTACHMENT 2.6-A</u> and more liberal methods are described in <u>Supplement 8a to ATTACHMENT 2.6-A</u>.
	In determining relative financial responsibility, the agency considers only the income of spouses living in the same household as available to spouses.

State: Kentucky

Citation(s)	Condition or Requirement
42 CFR 435.721 and 435.831 1902(m) (1) (B), (m)(4), and 1902(r) (2) of the Act	<p>c. <u>Blind individuals</u>. In determining countable income for blind individuals, the following methods are used:</p> <ul style="list-style-type: none"><input type="checkbox"/> The methods of the SSI program only.<input checked="" type="checkbox"/> SSI methods and/or any more liberal methods described in <u>Supplement 8a to ATTACHMENT 2A</u>.<input type="checkbox"/> For individuals other than optional State supplement recipients, more restrictive methods than SSI, applied under the provisions of section 1902(f) of the Act, as specified in <u>Supplement 4 to ATTACHMENT 2.6-A</u>, and any more liberal methods described in <u>Supplement 8a to ATTACHMENT 2.6-A</u>.<input type="checkbox"/> For institutional couples, the methods specified under section 1611(e) (5) of the Act.<input type="checkbox"/> For optional State supplement recipients under §435.230, income methods more liberal than SSI, as specified in <u>Supplement 4 to ATTACHMENT 2.6-A</u>.<input type="checkbox"/> For optional State supplement recipients in section 1902(f) States and SSI criteria States without section 1616 or 1634 agreements--<ul style="list-style-type: none"><input type="checkbox"/> SSI methods only. -<input type="checkbox"/> SSI methods and/or any more liberal methods than SSI described in <u>Supplement 8a to ATTACHMENT 2.6-A</u>.<input type="checkbox"/> Methods more restrictive and/or more liberal than SSI. More restrictive methods are described in <u>Supplement 4 to ATTACHMENT 2.6-A</u> and more liberal methods are described in <u>Supplement 8a to Attachment 2.6-A</u>.

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HCFA ID: 7985E

State: Kentucky

Citation(s)	Condition or Requirement
42 CFR 435.721, and 435.831 1902(m) (1) (B), (m)(4), and 1902(r) (2) of the Act	<p>In determining relative responsibility, the agency considers only the income of spouses living in the same household as available to spouses and the income of parents as available to children living with parents until the children become 21.</p> <p>d. <u>Disabled individuals.</u> In-determining countable income of disabled individuals, including individuals with incomes up to the Federal poverty level described in section 1902(m) of the Act the following methods are used:</p> <ul style="list-style-type: none"><input type="checkbox"/> The methods of the SSI program.<input checked="" type="checkbox"/> SSI methods and/or any more liberal methods described in <u>Supplement 8a to ATTACHMENT 2.6-A.</u><input type="checkbox"/> For institutional couples: the methods specified under section 1611(e) (5) of the Act.<input type="checkbox"/> For optional State supplement recipients under §435.230: income methods more liberal than SSI, as specified in <u>Supplement 4 to ATTACHMENT 2.6-A.</u><input type="checkbox"/> For individuals other than optional State supplement recipients (except aged and disabled individuals described in section 1903(m)(1) of the Act): more restrictive methods than SSI, applied under the provisions of section 1902(f) of the Act, as specified in <u>Supplement 4 to ATTACHMENT 2.6-A</u> and any more liberal methods described in <u>Supplement 8a to ATTACHMENT 2.6-A.</u>

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Citation(s)	Condition or Requirement
	<p><input type="checkbox"/> For optional State supplement recipients in section 1902(f) States and SSI criteria States without section 1616 or 1634 agreements--</p> <p><input type="checkbox"/> SSI methods only.</p> <p><input type="checkbox"/> SSI methods and/or any more liberal methods than SSI described in <u>Supplement 8a to ATTACHMENT 2.6-A.</u></p> <p><input type="checkbox"/> Methods more restrictive and/or more liberal than SSI, except for aged and disabled individuals described in section 1902(m) (1) of the Act. More restrictive methods are described in <u>Supplement 4 to ATTACHMENT 2.6-A</u> and more liberal methods are specified in <u>Supplement 8a to-ATTACHMENT 2.6-A.</u></p> <p>In determining relative financial responsibility, the agency considers only the income of spouses living in the same household as available to spouses and the income of parents as available to children living with parents until the children become 21.</p>

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kentucky

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
1902(1)(3)(E) and 1902(r) (2) of the Act	<p>e. <u>Poverty level pregnant women, infants, and children.</u> For pregnant women and infants or children covered under the provisions of sections 1902(a)(10)(A)(i)(IV), (VI), and (VII), and 1902(a)(10)(A)(ii)(IX) of the Act--</p> <p>(1) The following methods are used in determining countable income:</p> <ul style="list-style-type: none"><input checked="" type="checkbox"/> The methods of the State's approved AFDC plan.<input checked="" type="checkbox"/> The methods of the approved title IV-E plan.<input type="checkbox"/> The methods of the approved AFDC State plan and/or any more liberal methods described in <u>Supplement 8a to ATTACHMENT 2.6-A.</u><input type="checkbox"/> The methods of the approved title IV-E plan and/or any more liberal methods described in <u>Supplement 8a to ATTACHMENT 2.6-A.</u>

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kentucky

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
1902(e)(6) of the Act	(2) In determining relative financial responsibility, the agency considers only the income of spouses living in the same household as available to spouses and the income of parents as available to children living with parents until the children become 21. (3) The agency continues to treat women eligible under the provisions of sections 1902(a) (10) of the Act as eligible, without regard to any changes in income of the family of which she is a member, for the 60-day period after her pregnancy ends and any remaining days in the month in which the 60th day falls.
1905(p) (1), 1902 (m) (4), and 1902(r) (2) of the Act	f. <u>Qualified Medicare beneficiaries.</u> In determining countable income for qualified Medicare beneficiaries covered under section 1902(a)(10)(E)(i) of the Act, the following methods are used: <input type="checkbox"/> The methods of the SSI program only. <input checked="" type="checkbox"/> SSI methods and/or any more liberal methods than SSI described in <u>Supplement 8a to ATTACHMENT 2.6-A.</u> <input type="checkbox"/> For institutional couples, the methods specified under section 1611(e)(5) of the Act.

State: Kentucky

Citation(s)	Condition or Requirement
1905(s) of the Act	<p>If an individual receives a title II benefit, any amounts attributable to the most recent increase in the monthly insurance benefit as a result of a title IX COLA is not counted as income during a "transition period" beginning with January, when the title II benefit for December is received, and ending with the last day of the month following the month of publication of the revised annual Federal poverty level.</p> <p>For individuals with title II income, the revised poverty levels are not effective until the first day of the month following the end of the transition period.</p> <p>For individuals not receiving title II income, the revised poverty levels are effective no later than the date of publication.</p> <p>g. (1) <u>Qualified disabled and working individuals.</u></p> <p>In determining countable income for qualified disabled and working individuals covered under 1902(a)(10)(E)(ii) of the Act, the methods of the SSI program are used.</p>
1905(p) of the Act	<p>(2) <u>Specified low-income Medicare beneficiaries.</u></p> <p>In determining countable income for specified low-income Medicare beneficiaries covered under 1902(a)(10)(E)(iii) of the Act, the same method as in f. is used.</p>

State: Kentucky

Citation(s)	Condition or Requirement
1902(u) of the Act	<p data-bbox="504 376 898 400">h. <u>COBRA Continuation Beneficiaries</u></p> <p data-bbox="576 427 1163 474">In determining countable income for COBRA continuation beneficiaries, the following disregards are applied:</p> <ul data-bbox="576 501 1163 651" style="list-style-type: none"><li data-bbox="576 501 959 526"><input type="checkbox"/> The disregards of the SSI program;<li data-bbox="576 553 1163 651"><input type="checkbox"/> The agency uses methodologies for treatment of income more restrictive than the SSI program. These more restrictive methodologies are described in Supplement 4 to Attachment 2.6—A. <p data-bbox="576 678 1163 804">NOTE: For COBRA continuation beneficiaries specified at 1902(u) (4), costs incurred from medical care or for any other type of remedial care shall not be taken into account in determining income, except as provided in section 1612(b) (4) (B) (ii).</p>

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State/Territory: Kentucky

Citation(s)	Condition or Requirement
1902(a)(10)(A)(ii) (XIII) of the Act	<p data-bbox="504 403 975 427">(i) <u>Working Individuals With Disabilities BBA</u></p> <p data-bbox="576 450 1163 528">In determining countable income and resources for working individuals with disabilities under BBA, the following methodologies are applied:</p> <ul style="list-style-type: none"> <li data-bbox="576 551 999 577"><input type="checkbox"/> The methodologies of the SSI program. <li data-bbox="576 600 1163 725"><input type="checkbox"/> The agency uses methodologies for treatment of income and resources more restrictive than the SSI program. These more restrictive methodologies are described in Supplement 4(income) and Supplement 5 (resources) to Attachment 2.6-A. <li data-bbox="576 748 1163 880"><input type="checkbox"/> The agency uses more liberal income and/or resource than the SSI program. More liberal methodologies are described in Supplement 8a to attachment 2.6-A. More liberal resource methodologies are described in Supplement 8b to Attachment 2.6-A.

TN No: 08-004

Supersedes

TN No: NoneApproval Date: 05/13/08Effective Date: 01/01/2008

State/Territory: Kentucky

Citation(s)	Condition or Requirement
1902(a)(10)(A) (ii)(XV) of the Act	<p>(ii) <u>Working Individuals with Disabilities - Basic Coverage Group - TWWIA</u></p> <p>In determining financial eligibility for working individuals with disabilities under this provision, The following standards and methodologies are applied:</p> <p><input type="checkbox"/> The agency does not apply any income or resource standard.</p> <p>NOTE: If the above option is chosen, no further eligibility-related options should be elected.</p> <p><input checked="" type="checkbox"/> The agency applies the following income and/or resource standard(s):</p> <p>The resource limit is \$5,000 for individual and \$10,000 for a couple. Unearned income combined with earned income after deductions shall not exceed 250% FPL.</p>

State/Territory: Kentucky

Citation(s)	Condition or Requirement
1902(a)(10)(A) (ii)(XV) of the Act (cont.)	<p data-bbox="572 403 783 430"><u>Income Methodologies</u></p> <p data-bbox="572 452 1165 504">In determining whether an individual meets the income standard described above, the agency uses the following methodologies.</p> <ul style="list-style-type: none"> <li data-bbox="572 526 1070 553"><input checked="" type="checkbox"/> The income methodologies of the SSI program. <li data-bbox="572 602 1165 703"><input type="checkbox"/> The agency uses methodologies for treatment of income that are more restrictive than the SSI program. These more restrictive methodologies are described in Supplement 4 to Attachment 2.6 – A. <li data-bbox="572 728 1165 806"><input type="checkbox"/> The agency uses more liberal income methodologies than the SSI program. More liberal income methodologies are described in Supplement 8a to Attachment 2.6-A.

State/Territory: Kentucky

Citation(s)	Condition or Requirement
1902(a)(10)(A) (ii)(XV) of the Act (cont.)	<p data-bbox="576 403 799 427"><u>Resource Methodologies</u></p> <p data-bbox="576 452 1163 504">In determining whether the individual meets the resource standard described above, the agency uses the following methodologies.</p> <p data-bbox="576 528 1163 725">Unless one of the following items is checked, the agency, under the authority of 1902(r)(2) of the Act, disregards all funds held in retirement funds and accounts, including private retirement accounts such as IRAs and other individual accounts, and employer-sponsored retirement plans such as 401(k) plans, Keogh plans, and employer pension plans. Any disregard involving retirement accounts is separately described in Supplement 8b to Attachment 2.6-A.</p> <ul style="list-style-type: none"> <li data-bbox="576 752 1163 804"><input type="checkbox"/> The agency disregards funds held in employer-sponsored retirement plans, but not private retirement plans. <li data-bbox="576 831 1163 927"><input type="checkbox"/> The agency disregards funds in retirement accounts in a manner other than those described above. The agency's disregards are specified in Supplement 8b to Attachment 2.6-A.

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Supersedes

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State/Territory: Kentucky

Citation(s)	Condition or Requirement
1902(a)(10)(A) (ii)(XV) of the Act (cont.)	<input type="checkbox"/> The agency does not disregard funds in retirement accounts. <input type="checkbox"/> The agency uses resource methodologies in addition to any indicated above that are more liberal than those used by the SSI program. More liberal resource methodologies are described in Supplement 8b to Attachment 2.6-A. <input checked="" type="checkbox"/> The agency uses the resource methodologies of the SSI Program. <input type="checkbox"/> The agency uses methodologies for treatment of resources that are more restrictive than the SSI program. These more restrictive methodologies are described in Supplement 5 to Attachment 2.6-A.

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State/Territory: Kentucky

Citation(s)	Condition or Requirement
1902(a)(10)(A) (ii)(XVI) of the Act	<p>(ii) <u>Working Individuals with Disabilities - Employed Medically Improved Individuals - TWWIA</u></p> <p>In determining financial eligibility for employed medically improved individuals under this provision, the following standards and methodologies are applied:</p> <p><input type="checkbox"/> The agency does not apply any income or resource standard.</p> <p>NOTE: If the above option is chosen, no further eligibility-related options should be elected.</p> <p><input type="checkbox"/> The agency applies the following income and/or resource standard(s):</p>

State/Territory: Kentucky

Citation(s)	Condition or Requirement
1902(a)(10)(A) (ii)(XVI) of the Act (cont.)	<p data-bbox="576 400 783 423"><u>Income Methodologies</u></p> <p data-bbox="576 450 1161 499">In determining whether an individual meets the income standard described above, the agency uses the following methodologies.</p> <ul data-bbox="576 526 1161 801" style="list-style-type: none"><li data-bbox="576 526 1070 548"><input type="checkbox"/> The income methodologies of the SSI program.<li data-bbox="576 602 1161 701"><input type="checkbox"/> The agency uses methodologies for treatment of income that are more restrictive than the SSI program. These more restrictive methodologies are described in Supplement 4to Attachment 2.6-A.<li data-bbox="576 728 1161 801"><input type="checkbox"/> The agency uses more liberal income methodologies than the SSI program. More liberal income methodologies are described in Supplement 8a to Attachment 2.6-A.

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Effective Date: 01/01/2008

State/Territory: Kentucky

Citation(s)	Condition or Requirement
1902(a)(10)(A) (ii)(XV) of the Act (cont.)	<p data-bbox="576 403 799 425"><u>Resource Methodologies</u></p> <p data-bbox="576 454 1163 501">In determining whether the individual meets the resource standard described above, the agency uses the following methodologies.</p> <p data-bbox="576 530 1163 725">Unless one of the following items are checked, the agency, under the authority of 1902(r)(2) of the Act, disregards all funds held in retirement funds and accounts, including private retirement accounts such as IRAs and other individual accounts, and employer-sponsored retirement plans such as 401(k) plans, Keogh plans, and employer pension plans. Any disregard involving retirement accounts is separately described in Supplement 8b to Attachment 2.6-A.</p> <ul style="list-style-type: none"> <li data-bbox="576 754 1163 801"><input type="checkbox"/> The agency disregards funds held in employer-sponsored retirement plans, but not private retirement plans. <li data-bbox="576 831 1163 927"><input type="checkbox"/> The agency disregards funds in retirement accounts in a manner other than those described above. The agency's disregards are specified in Supplement 8b to Attachment 2.6-A.

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State/Territory: Kentucky

Citation(s)	Condition or Requirement
1902(a)(10)(A) (ii)(XVI) of the Act (cont.)	<input type="checkbox"/> The agency does not disregard funds_in retirement accounts. <input type="checkbox"/> The agency uses resource methodologies in addition to any indicated above that are more liberal than those used by the SSI program. More liberal resource methodologies are described in Supplement 8b to Attachment 2.6-A. <input type="checkbox"/> The agency uses the resource methodologies of the SSI Program. <input type="checkbox"/> The agency uses methodologies for treatment of resources that are more restrictive than the SSI program. These more restrictive methodologies are described in Supplement 5 to Attachment 2.6-A.

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State/Territory: Kentucky

Citation(s)	Condition or Requirement
1902(a)(10)(A) (ii)(XVI) and 1905(v)(2) of the Act.	<p data-bbox="576 400 1163 450"><u>Definition of Employed – Employed Medically Improved Individuals – TWWIA</u></p> <ul style="list-style-type: none"> <li data-bbox="576 477 1163 553"><input type="checkbox"/> The agency uses the statutory definition of “employed”, i.e., earning at least the minimum wage, and working at least 40 hours per month. <li data-bbox="576 577 1163 678"><input type="checkbox"/> The agency uses an alternative definition of “employed” that provides for substantial and reasonable threshold criteria for hours of work, wages, or other measures. The agency’s threshold criteria is described below:

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State/Territory: Kentucky

Citation(s)	Condition or Requirement
1902(a)(10)(A)(ii)(XIII) (XV), (XVI), and 1916(g) of the Act	<p data-bbox="576 403 1050 425"><u>Payment of Premiums or Other Cost Sharing Charges</u></p> <p data-bbox="576 450 1161 501">For individuals eligible under the BBA eligibility group described in No. 24 on page 23e of Attachment 2.2 A:</p> <p data-bbox="576 526 1161 629"><input type="checkbox"/> The agency requires payment of premiums or other cost sharing charges on a sliding scale based on income. The premiums or other cost-sharing charges, and how they are applied are described below:</p>

State/Territory: Kentucky

Citation(s)	Condition or Requirement
1902(a)(10)(A)(ii) (XIII), (XV), (XVI), and 1916(g) of the Act (cont.)	<p>For individuals eligible under the Basic Coverage Group described in No. 25 on page 23e of Attachment 2.2-A, and the Medical Improvement Group described in No. 26 on page 23e of Attachment 2.2-A:</p> <p>NOTE: Regardless of the option selected below, the agency MUST require that individuals whose annual adjusted gross income, as defined under IRS statute, exceeds \$75,000 pay 100 percent of premiums.</p> <p><input checked="" type="checkbox"/> The agency requires individuals to pay premiums or other cost sharing charges on a sliding scale based on income. For individuals with net annual income below 250 percent of the Federal poverty level for a family of the size involved, the amount of premiums cannot exceed 7.5 percent of the individual's income.</p> <p>The premiums or other cost-sharing charges, and how they are applied are described on page 12o.</p>

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State/Territory: Kentucky

Citation(s)	Condition or Requirement								
Sections 1902(a)(10)(A)(ii)(XV), (XVI), and 1916(g) of the Act (cont.)	<p data-bbox="576 403 959 425"><u>Premiums and Other Cost Sharing Charges</u></p> <p data-bbox="576 450 1161 519">For the Basic Coverage Group, the agency's premium and other cost sharing charges, and how they are applied, are described below.</p> <p data-bbox="576 551 1161 620">Medicaid Works individuals with income from 101-250% of the FPL will be required to pay a premium in accordance with the following:</p> <table data-bbox="632 651 1082 804"> <thead> <tr> <th data-bbox="632 651 826 674">Federal Poverty Level</th> <th data-bbox="866 651 1082 721">Monthly Premium per Medicaid Works Individual</th> </tr> </thead> <tbody> <tr> <td data-bbox="632 728 722 750">101-150%</td> <td data-bbox="866 728 903 750">\$35</td> </tr> <tr> <td data-bbox="632 754 722 777">151-200%</td> <td data-bbox="866 754 903 777">\$45</td> </tr> <tr> <td data-bbox="632 781 722 804">201-250%</td> <td data-bbox="866 781 903 804">\$55</td> </tr> </tbody> </table>	Federal Poverty Level	Monthly Premium per Medicaid Works Individual	101-150%	\$35	151-200%	\$45	201-250%	\$55
Federal Poverty Level	Monthly Premium per Medicaid Works Individual								
101-150%	\$35								
151-200%	\$45								
201-250%	\$55								

TN No: 08-004
Supersedes
TN No: None

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Effective Date: 01/01/2008

State Kentucky

Citation(s)	Condition or Requirement
1902(k) of the Act	2. Medicaid Qualifying Trusts In the case of a Medicaid qualifying trust described in section 1902(k)(2) of the Act, the amount from the trust that is deemed available to the individual who established the trust (or whose spouse established the trust) is the maximum amount that the trustee(s) is permitted under the trust to distribute to the individual This amount is deemed available to the individual, whether or not the distribution is actually made. This provision does not apply to any trust or initial trust decree established before April 7, 1986, solely for the benefit of a mentally retarded individual who resides in an intermediate care facility for the mentally retarded. <input checked="" type="checkbox"/> The agency does not count the funds in a trust as described above in any instance where the State determines that it would work an undue hardship as determined on the basis of criteria established by the Secretary of the Department of Health and Human Services.
1917(d) of the Act	Effective October 1, 1993 the agency complies with the provisions of 1917(d) of the Social Security Act as amended.
1902(a)(10) the Act	3. Medically needy income levels (MNILs) are based on of family size. <u>Supplement 1 to ATTACHMENT 2.6-A</u> specifies the MNILs for all covered medically needy groups. If the agency chooses more restrictive levels under section 1902(f) of the Act, <u>Supplement 1</u> so indicates.

State: Kentucky

Citation(s)	Condition or Requirement
42 CFR 435.732, 435.831	<p>4. Handling of excess income – Spend-down for the Medically Needy in all States and the Categorically Needy in 1902(f) States Only</p> <p>a. <u>Medically Needy</u></p> <p>(1) Income in excess of the MNIL is considered as available for payment of medical care and services. The Medicaid agency measures available income for periods of <u>3*</u> months(s) (not to exceed 6 months) to determine the amount of excess countable income applicable to the cost of medical care and services.</p> <p>(2) If countable income exceeds the MNIL standard, the agency deducts the following incurred expenses in the following order:</p> <p>(a) Health insurance premiums, deductibles and coinsurance charges.</p> <p>(b) Expenses for necessary medical and remedial care not included in the plan.</p> <p>(c) Expenses for necessary medical and remedial care included in the plan.</p> <p><input type="checkbox"/> Reasonable limits on amounts of expenses deducted from income under a.(2)(a) and (b) above are listed below:</p> <p>Incurred expenses that are subject to payment by a third party are not deducted unless the expenses are subject to payment by a third party that is a publicly funded program (other than Medicaid) of a State or local government, and is financed by the State or local government</p>
1902(a)(17) of the Act	
*	The retroactive spenddown period uses available income for one month with eligibility for each month determined individually.

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October 1991

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State: Kentucky

Citation(s)	Condition or Requirement
1903(f) (2) of	a. <u>Medically Needy (Continued)</u> <input type="checkbox"/> (3) If countable income exceeds the MNIL standard, the agency deducts spenddown payments made to the State by the individual.

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TN No. None

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Effective Date 1-1-92

HCFA ID: 7985E

State: Kentucky

Citation(s)	Condition or Requirement
42 CFR 435.732	<p data-bbox="432 376 906 398">b. <u>Categorically Needy - Section 1902 (f) States</u></p> <p data-bbox="504 427 1165 501">The agency applies the following policy under the provisions of section 1902(f) of the Act. The following amounts are deducted from income to determine the individual's countable income:</p> <ol data-bbox="504 528 1165 927" style="list-style-type: none"><li data-bbox="504 528 804 551">(1) Any SSI benefit received.<li data-bbox="504 577 1165 680">(2) Any State supplement received that is within the scope of an agreement described in sections 1616 or 1634 of the Act, or a State supplement within the scope of section 1902(a)(10)(A)(ii)(XI) of the Act.<li data-bbox="504 707 1165 781">(3) Increases in OASDI that are deducted under 435.134 and 435.135 for individuals specified in that section, in the manner elected by the State under that section.<li data-bbox="504 808 1165 860">(4) Other deductions from income described in this plan at <u>Attachment 2.6-A, Supplement 4</u>.<li data-bbox="504 887 1165 927">(5) Incurred expenses for necessary medical and remedial services recognized under State law.
1902(a) (17) of the Act, P.L. 100-203	Incurred expenses that are subject to payment by a third party are not deducted unless the expenses are subject to payment by a third party that is a publicly funded program (other than Medicaid) of a State or local government.

State: Kentucky

Citation(s)	Condition or Requirement
1903(f) (2) of	4. b. <u>Categorically Needy - Section 1902(f) States</u> Continued <input type="checkbox"/> (6) Spenddown payments made to the State by the individual. NOTE: FFP will be reduced to the extent a State is paid a spenddown payment by the individual.

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Supersedes
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Approval Date NOV 14 1994

Effective Date 1-1-92

HCFA ID: 7985E

State: Kentucky

Citation(s)	Condition or Requirement
5. <u>Methods for Determining Resources</u>	
a. <u>AFDC-related individuals (except for poverty level related pregnant women, infants, and children).</u>	
	(1) In determining countable resources for AFDC-related individuals, the following methods are used:
	(a) The methods under the State's approved AFDC plan; and
	<input checked="" type="checkbox"/> (b) The methods under the State's approved AFDC plan and/or any more liberal methods described in <u>Supplement 8b to ATTACHMENT 2.6-A.</u>
	(2) In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with parents until the children become 21.

State: Kentucky

Citation(s)	Condition or Requirement
1902 (a) (10) (A), 1902(a) (10) (C), 1902(m) (1) (B) and (C), and 1902(r) of the Act	<p data-bbox="359 403 756 425">5. <u>Methods for Determining Resources</u></p> <p data-bbox="432 450 1163 524">b <u>Aged individuals</u>. For aged individuals, including individuals covered under section 1902(a) (10) (A) (ii) (X) of the Act, the agency used the following methods for treatment of resources:</p> <ul style="list-style-type: none"><li data-bbox="505 553 871 575"><input type="checkbox"/> The methods of the SSI program.<li data-bbox="505 602 1163 651"><input checked="" type="checkbox"/> SSI methods and/or any more liberal methods described in <u>Supplement 8b to ATTACHMENT 2.6-A</u>.<li data-bbox="505 678 1163 804"><input type="checkbox"/> Methods that are more restrictive (except for individuals described in section 1902(m)(1) of the Act) and/or more liberal than those of the SSI program. <u>Supplement 5 to ATTACHMENT 2.6-A</u> describes the more restrictive methods and <u>Supplement 8b to ATTACHMENT 2.6-A</u> specifies the more liberal methods.

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Supersedes
TN No. None

Approval Date: NOV 14 1994

Effective Date: 1-1-92

HCFA ID: 7985E

State: Kentucky

Citation(s)	Condition or Requirement
1902(a) (10) (A), 1902(a) (10) (C), 1902(m) (1) (B), and 1902(r) of the Act	<p>In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses.</p> <p>c. <u>Blind individuals</u>. For blind individuals the agency uses the following methods for treatment of resources:</p> <ul style="list-style-type: none"><input type="checkbox"/> The methods of the SSI program.<input checked="" type="checkbox"/> SSI methods and/or any more liberal methods described in <u>Supplement 8b to ATTACHMENT 2.6-A</u>.<input type="checkbox"/> Methods that are more restrictive and/or more liberal than those of the SSI program. <u>Supplement 5 to ATTACHMENT 2.6-A</u> describe the more restrictive methods and <u>Supplement 8b to ATTACHMENT 2.6-A</u> specify the more liberal methods. <p>In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with parents until the children become 21.</p>

State: Kentucky

Citation(s)	Condition or Requirement
1902 (a) (10) (A), 1902 (a) (10) (C), 1902(m) (1) (B) and (C), and 1902(r) (2) of the Act	<p>d. <u>Disabled individuals, including individuals covered under section 1902(a)(10)(A)(ii)(X) of the Act.</u> The agency uses the following methods for the treatment of resources:</p> <ul style="list-style-type: none"><input type="checkbox"/> The methods of the SSI program.<input checked="" type="checkbox"/> SSI methods and/or any more liberal methods described in <u>Supplement 8b to ATTACHMENT 2.6-A.</u><input type="checkbox"/> Methods that are more restrictive (except for individuals described in section 1902(m)(1) of the Act) and/or more liberal than those under the SSI program. More restrictive methods are described in <u>Supplement 5 to ATTACHMENT 2.6-A</u> and more liberal methods are specified in <u>Supplement 8b to ATTACHMENT 2.6-A.</u> <p>In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with parents until the children become 21.</p>
1902 (1) (3) and 1902(r) (2) of the Act	<p>e. <u>Poverty level pregnant women covered under sections 1902(a)(10)(A)(i)(IV) and 1902(a) (10) (A) (ii) (IX) (A) of the Act.</u></p> <p>The agency uses the following methods in the treatment of resources.</p> <ul style="list-style-type: none"><input type="checkbox"/> The methods of the SSI program only.<input type="checkbox"/> The methods of the SSI program and/or any more liberal methods described in <u>Supplement 5a or Supplement 8b to ATTACHMENT 2.6-A.</u>

State: Kentucky

Citation(s)	Condition or Requirement
	<p><input type="checkbox"/> Methods that are more liberal than those of SSI. The more liberal methods are specified in <u>Supplement 5a or Supplement 8b to ATTACHMENT 2.6-A.</u></p> <p><input checked="" type="checkbox"/> Not applicable. The agency does not consider resources in determining eligibility.</p> <p>In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with parents until the children become 21.</p>
1902(1) (3) and 1902(r) (2) of the Act	f. <u>Poverty Level infants covered under section 1902(a) (10) (A) (i)(IV) of the Act.</u> The agency uses the following methods for the treatment of resources:
1902(1)(3)(C) of the Act	<input type="checkbox"/> The methods of the State's approved AFDC plan. <input type="checkbox"/> Methods more liberal than those in the State's approved AFDC plan (but not more restrictive), in accordance with section 1902(1) (3)(C) of the Act, as specified in <u>Supplement 5a of ATTACHMENT 2.6-A.</u>
1902(r) (2) of the Act	<input type="checkbox"/> Methods more liberal than those in the States approved AFDC plan (but not more restrictive), as described in Supplement 5a or <u>Supplement 8b to ATTACHMENT 2.6-A.</u> <input checked="" type="checkbox"/> Not applicable. The agency does not consider resources in determining eligibility.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kentucky

ELIGIBILITY' CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
1902(l)(3) and 1902(r)(2) of the Act	<p>g. 1. <u>Poverty level children covered under section 1902(a) (10) (A) (i) (VI) of the Act.</u></p> <p>The agency uses the following methods for the treatment of resources:</p> <p><input type="checkbox"/> The methods of the State's approved AFDC plan.</p>
1902(l)(3)(C) of the Act	<p><input type="checkbox"/> Methods more liberal than those in the State's approved AFDC plan (but not more restrictive), in accordance with section 1902(l) (3)(C) of the Act, as specified in <u>Supplement 5a of ATTACHMENT 2.6-A.</u></p>
1902(r) (2) of the Act	<p><input type="checkbox"/> Methods more liberal than those in the State's approved AFDC plan (but not more restrictive), as described in <u>Supplement 8b to ATTACHMENT 2.6-A.</u></p> <p><input checked="" type="checkbox"/> Not applicable. The agency does not consider resources in determining eligibility.</p> <p>In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with parents until the children become 21.</p>

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kentucky

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)		Condition or Requirement
1902(1) (3) and 1902(r)(2) of the Act	g. 2.	<u>Poverty level children under section 1902(a) (10) (A) (i)(VII)</u> The agency uses the following methods for the treatment of resources: <input type="checkbox"/> The methods of the State's approved AFDC plan.
1902(1)(3)(C) the Act		<input type="checkbox"/> Methods more liberal than those in the State's approved AFDC plan (but not more restrictive) as specified in <u>Supplement 5a of ATTACHMENT 2.6-A.</u>
1902(r) (2) of the Act		<input type="checkbox"/> Methods more liberal than those in the State's approved AFDC plan (but not more restrictive), as described in <u>Supplement 8a to ATTACHMENT 2.6-A.</u> <input checked="" type="checkbox"/> Not applicable. The agency does not consider resources in determining eligibility. In determining relative responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with parents until the children become 21.

State: Kentucky

Citation(s)		Condition or Requirement	
1905(p) (1) (C) and (D) and 1902(r) (2) of the Act	5. h.	<p><u>For qualified Medicare beneficiaries covered under section 1902 (a) (10) (E) (i) of the Act--</u></p> <p>The agency used the following methods for treatment of resources:</p> <p><input type="checkbox"/> The methods of the SSI program only.</p> <p><input checked="" type="checkbox"/> The methods of the SSI program and/or more liberal methods as described in <u>Supplement 8b to .ATTACHMENT 2.6-A.</u></p>	
1905(s) of the Act	i.	For qualified disabled and working individuals covered under section 1902(a) (10) (E) (ii) of the Act, the agency uses SSI program methods for the treatment of resources.	
1905 (u) of the Act	j.	For COBRA continuation beneficiaries, the agency uses the following methods for treatment of resources:	<p><input type="checkbox"/> The methods of the SSI program only.</p> <p><input type="checkbox"/> More restrictive methods applied under section 1902(f) of the Act as described in <u>Supplement 5 to Attachment 2.6-A.</u></p>

State: Kentucky

Citation(s)	Condition or Requirement
6.	Resource Standard - Categorically Needy
a.	1902(f) States (except as specified under items 6.c. and d. below) for aged, blind and disabled individuals:
	<input type="checkbox"/> Same as SSI resource standards.
	<input type="checkbox"/> More restrictive.
	The resource standards for other individuals are the same as those in the related cash assistance program.
b.	Non-1902(f) States (except as specified under items 6.c. and d. below)
	The resource standards are the same as those in the related cash assistance program.
	<u>Supplement 8 to ATTACHMENT 2.6-A</u> specifies for 1902(f) States the categorically needy resource levels for all covered categorically needy groups.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Kentucky

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
1902(1)(3)(A), (B) and (C) of the Act	<p>c. For pregnant women and infants covered under the provisions of section 1902 (a) (10)(A)(i)(IV) and 1902(a)(10)(A)(ii) (IX) of the Act, the agency applies a resource standard.</p> <p><input type="checkbox"/> Yes. <u>Supplement 2 to Attachment 2.6-A</u> specifies the standard which, for pregnant women, is no more restrictive than the standard under the SSI program; and for infants is no more restrictive than the standard applied in the State's approved AFDC plan.</p> <p><input checked="" type="checkbox"/> No. The agency does not apply a resource standard to these individuals.</p>
1902(1)(3)(A) and (C) of the Act.	<p>d. For children covered under the provisions of section 1902(a) (10) (A) (i) (VI) of the Act, the agency applies a resource standard.</p> <p><input type="checkbox"/> Yes. <u>Supplement 2 to Attachment 2.6-A</u> specifies the standard which is no more restrictive than the standard applied in the State's approved AFDC plan.</p> <p><input checked="" type="checkbox"/> No. The agency does not apply a resource standard to these individuals.</p>
1902(1)(3)(A) and (D) of the Act.	<p>e. For children covered under the provisions of section 1902(a) (10) (A) (i) (VII) of the Act, the agency applies a resource standard.</p> <p><input type="checkbox"/> Yes. <u>Supplement 2 to Attachment 2.6-A</u> specifies the standard which is no more restrictive than the standard applied in the State's approved AFDC plan.</p> <p><input checked="" type="checkbox"/> No. The agency does not apply a resource standard to these individuals.</p>

State Kentucky

Citation(s)	Condition or Requirement
1902(m)(1)(C) and (m)(2)(B) of the Act	f. For aged and disabled individuals described in section 1902(m)(l) of the Act who are covered under Section 1902(a)(10)(A)(ii)(X) of the Act, the resource standard is: <input type="checkbox"/> Same as SSI resource standards. <input type="checkbox"/> Same as the medically needy resource standards, which are higher than the SSI resource standards (if the State covers the medically needy). <u>Supplement 2 to Attachment 2.6-A</u> specifies the resource levels for these individuals.

State: Kentucky

Citation(s)	Condition or Requirement
1902(a)(10)(C)(i) of the Act	<p>7. Resource Standard - Medically Needy</p> <p>a. Resource standards are based on family size.</p> <p>b. A single standard is employed in determining resource resource eligibility for all groups.</p> <p>c. In 1902(f) States, the resource standards are more restrictive than in 7.b. above for--</p> <p><input type="checkbox"/> Aged</p> <p><input type="checkbox"/> Blind</p> <p><input type="checkbox"/> Disabled</p> <p><u>Supplement 2 to ATTACHMENT 2.6-A</u> specifies the resource standards for all covered medically needy groups. If the agency chooses more restrictive levels under 7.c., <u>Supplement 2 to ATTACHMENT 2.6-A</u> so indicates.</p>
1902(a)(10)(E), 1905(p)(1)(D), 1905(p)(2)(B) and 1860D- 14(a)(3)(D) of the Act	<p>8. Resource Standard - Qualified Medicare Beneficiaries, Specified Low-Income Medicare Beneficiaries and Qualifying Individuals</p> <p>For Qualified Medicare Beneficiaries covered under section 1902(a)(10)(E)(i) of the Act, Specified Low-Income Medicare Beneficiaries covered under section 1902(a)(10)(E)(iii) of the Act, and Qualifying Individuals covered under 1902(a)(10)(E)(iv) of the Act, the resource standard is three times the SSI resource limit, adjusted annually since 1996 by the increase in the consumer price index.</p>

State: Kentucky

Citation(s)	Condition or Requirement
1902(a)(10)(E)(ii), 1905(s) and 1860D-14(a)(3)(D) of the Act	9. Resource Standard - Qualified Disabled and Working Individuals For qualified disabled and working individuals covered under section 1902(a)(10)(E)(ii) of the Act, the resource standard for an individual or a couple (in the case of an individual with a spouse) is two times the SSI resource limit.
1902(u) of the Act	10. For COBRA continuation beneficiaries, the resource standard is: <input type="checkbox"/> Twice the SSI resource standard for an individual. <input type="checkbox"/> More restrictive standard as applied under section 1902(f) of the Act as described in <u>Supplement 8 to Attachment 2.6-A</u> .

State: Kentucky

Citation(s)	Condition or Requirement
11. Excess Resources	
a. Categorically Needy, Qualified Medicare Beneficiaries, and Qualified Disabled, Working Individuals, and Qualified Individuals	
	Any excess resources make the individual ineligible.
b. Categorically Needy Only	
	<input checked="" type="checkbox"/> This State has a section 1634 agreement with SSI. Receipt of SSI is provided for individuals while disposing of excess resources.
c. Medically Needy	
	Any excess resources make the individual ineligible.

State: Kentucky

Citation(s)	Condition or Requirement
42 CFR 435.914	<p>11. Effective Date of Eligibility</p> <p>a. Groups Other Than Qualified Medicare Beneficiaries</p> <p>(1) For the prospective period.</p> <p>Coverage is available for the full month if the following individuals are eligible at any time during the month.</p> <p><input checked="" type="checkbox"/> Aged, blind, disabled. *</p> <p><input checked="" type="checkbox"/> AFDC-related. *</p> <p>Coverage is available only for the period during the month for which the following individuals meet the eligibility requirements.</p> <p><input type="checkbox"/> Aged, blind, disabled.</p> <p><input type="checkbox"/> AFDC-related.</p> <p>(2) For the retroactive period.</p> <p>Coverage is available for three months before the date of application if the following individuals would have been eligible had they applied:</p> <p><input type="checkbox"/> Aged, blind, disabled.</p> <p><input type="checkbox"/> AFDC-related.</p> <p>Coverage is available beginning the first day of the third month before the date of application if the following individuals would have been eligible at any time during that month, had they applied.</p> <p><input checked="" type="checkbox"/> Aged, blind, disabled. *</p> <p><input checked="" type="checkbox"/> AFDC-related. *</p>

* For medically needy spenddown cases, coverage begins on the day the spenddown liability met.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kentucky

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)		Condition or Requirement
1920 (b)(1) of the Act	<input checked="" type="checkbox"/> (3)	For a presumptive eligibility period for pregnant women only. Coverage is available for ambulatory prenatal care for the period that begins on the day a qualified provider determines that a woman meets any of the income and eligibility levels specified in Attachment 2.6-A of this approved plan. If the woman files an application for Medicaid by the last day of the month following the month in which the qualified provider made the determination of presumptive eligibility, the period ends on the day that the State agency makes the determination of eligibility based on that application. If the woman does not file an application for Medicaid by the last day of the month following the month in which the qualified provider made the determination, the period ends on that last day.
1902 (e)(8) and 1905 (a) of the Act	<input checked="" type="checkbox"/> b.	For qualified Medicare beneficiaries defined in section 1905 (p)(1) of the Act coverage is available beginning with the first day of the month after the month in which the individual is first determined to be a qualified Medicare beneficiary under section 1905 (p)(1). The eligibility determination is valid for-- <input checked="" type="checkbox"/> 12 months <input type="checkbox"/> 6 months <input type="checkbox"/> ___ months (no less than 6 months and no more than 12 months)

Citation(s)	Condition or Requirement
1902(a)(18) and 1902(f) of the Act	<p>12. Pre-OBRA 93 Transfer of Resources - Categorically and Medically Needy, Qualified Medicare Beneficiaries, and Qualified Disabled and Working Individuals</p> <p>The agency complies with the provisions of section 1917 of the Act with respect to the transfer of resources.</p> <p>Disposal of resources at less than fair market value affects eligibility for certain services as detailed in <u>Supplement 9 to Attachment 2.6-A</u>.</p>
1917(c)	<p>13. Transfer of Assets - All eligibility groups</p> <p>The agency complies with the provisions of section 1917(c) of the Act, as enacted by OBRA 93, with regard to the transfer of assets.</p> <p>Disposal of assets at less than fair market value affects eligibility for certain services as detailed in <u>Supplement 9 to Attachment 2.6-A</u>, except in instances where the agency determines that the transfer rules would work an undue hardship.</p>
1917(d)	<p>14. Treatment of Trusts - All eligibility groups</p> <p>The agency complies with the provisions of section 1917(d) of the Act, as amended by OBRA 93, with regard to trusts.</p> <p><input type="checkbox"/> The agency uses more restrictive methodologies under section 1902(f) of the Act, and applies those methodologies in dealing with trusts.</p> <p><input checked="" type="checkbox"/> The agency meets the requirements in section 191 7(d)(f)(B) of the Act for use of Miller trusts.</p> <p>The agency does not count the funds in a trust in any instance where the agency determines that the transfer would work an undue hardship, as described in <u>Supplement 10 to Attachment 2.6-A</u>.</p>

Citation(s)	Condition or Requirement
1924 of the Act	15. The agency complies with the provisions of §1924 with respect to income and resource eligibility and posteligibility determinations for individuals who are expected to be institutionalized for at least 30 consecutive days and who have a spouse living in the community. When applying the formula used to determine the amount of resources initial eligibility determinations, the State standard for community spouses is: <input type="checkbox"/> the maximum standard permitted by law; <input type="checkbox"/> the minimum standard permitted by law; or <u>\$20,000</u> a standard that is an amount between the minimum and the maximum.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kentucky

INCOME ELIGIBILITY LEVELS

A. MANDATORY CATEGORICALLY NEEDY

1. AFDC-Related Groups Other Than Poverty Level Pregnant Women and Infants:

<u>Family Size</u>	<u>Need Standard</u>	<u>Payment Standard</u>	<u>Maximum Payment Amounts</u>
1	\$394		\$186
2	\$460		\$225
3	\$526		\$262
4	\$592		\$328
5	\$658		\$383
6	\$724		\$432
7 or more	\$790		\$482

2. Pregnant Women and Infants under Section 1902 (a) (10) (A) (i) (IV) of the Act:

Effective July 1, 1990, for pregnant women and infants under Section 1902 (a) (10) (A) (i) (IV) of the Act, the income eligibility level is 185 percent of the Federal poverty level (as revised annually in the Federal Register) for the family size involved.

STATE PLAN UNDER TITLE XX OF THE SOCIAL SECURITY ACT

State: Kentucky

INCOME ELIGIBILITY LEVELS

A. MANDATORY CATEGORICALLY NEEDY (Continued)

3. For children under Section 1902(a)(10)(A)(i)(VI) of the Act (children who have attained age 1 but have not attained age 6), the income eligibility level is 133 percent of the Federal poverty level (as revised annually in the Federal Register) for the size family involved.
4. For children under Section 1902(a)(10)(A)(i)(VII) of the Act (children who were born after September 30, 1983 and have attained age 6 but have not attained age 19), the income eligibility level is 100 percent of the Federal poverty level (as revised annually in the Federal Register) for the size family involved.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kentucky

INCOME ELIGIBILITY LEVELS (Continued)

B. OPTIONAL CATEGORICALLY NEEDY GROUPS WITH INCOMES RELATED TO FEDERAL POVERTY LEVEL

1. Pregnant Women and Infants

The levels for determining income eligibility for optional groups of pregnant women and infants under the provisions of sections 1902(a) (10)(A)(ii)(IX) and 1902(1)(2) of the Act are as follows:

Based on 185 percent of the official Federal income poverty level (more than 133 percent and no more than 185 percent).

<u>Family Size</u>	<u>Income Level</u>
<u> 1 </u>	<u> \$ </u>
<u> 2 </u>	<u> \$ </u>
<u> 3 </u>	<u> \$ </u>
<u> 4 </u>	<u> \$ </u>
<u> 5 </u>	<u> \$ </u>

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kentucky

INCOME ELIGIBILITY LEVELS (Continued)

B. CATEGORICALLY NEEDY GROUPS WITH INCOMES RELATED TO FEDERAL POVERTY LEVEL

2. Children under age 19

The levels for determining income eligibility for groups of children who are born after September 30, 1983 and who have attained 6 years of age but are under 19 years of age under the provisions of section 1902(1)(2) of the Act are as follows:

Based on 100 percent (no more than 100 percent) of the official Federal income poverty line.

<u>Family Size</u>	<u>Income Level</u>
<u>1</u>	<u>\$</u>
<u>2</u>	<u>\$</u>
<u>3</u>	<u>\$</u>
<u>4</u>	<u>\$</u>
<u>5</u>	<u>\$</u>
<u>6</u>	<u>\$</u>
<u>7</u>	<u>\$</u>
<u>8</u>	<u>\$</u>
<u>9</u>	<u>\$</u>
<u>10</u>	<u>\$</u>

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kentucky

INCOME ELIGIBILITY LEVELS (Continued)

3. Aged and Disabled Individuals

The levels for determining income eligibility for groups of aged and disabled individuals under the provisions of section 1902(m) (4) of the Act are as follows:

Based on _____ percent of the official Federal income poverty line.

<u>Family Size</u>	<u>Income Level</u>
<u>1</u>	<u>\$</u>
<u>2</u>	<u>\$</u>
<u>3</u>	<u>\$</u>
<u>4</u>	<u>\$</u>
<u>5</u>	<u>\$</u>

If an individual receives a title II benefit any amount attributable to the most recent increase in the monthly insurance benefit as a result of a title II COLA is not counted as income during a "transition period" beginning with January, when the title II benefit for December is received, and ending with the last day of the month following the month of publication of the revised annual Federal poverty level.

For individuals with title II income, the revised poverty levels are not effective until the first day of the month following the end of the transition period.

For individuals not receiving title II income, the revised poverty levels are effective no later than the beginning of the month following the date of publication.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kentucky

INCOME ELIGIBILITY LEVELS (Continued)

C. QUALIFIED MEDICARE BENEFICIARIES WITH INCOMES RELATED TO FEDERAL POVERTY LEVEL

The levels for determining income eligibility for groups of qualified Medicare beneficiaries under the provisions of section 1905(p) (2) (A) of the Act are as follows:

1. NON-SECTION 1902(f) STATES

a. Based on the following percent of the official Federal income poverty level:

Eff. Jan. 1, 1989: 85 percent _____ percent (no more than 100)

Eff. Jan. 1, 1990: 100 percent 90 percent (no more than 100)

Eff. Jan. 1, 1991: 100 percent

Eff. Jan. 1, 1992: 100 percent

b. Levels:

<u>Family Size</u>	<u>Income Level</u>
<u>1</u>	<u>\$</u>
<u>2</u>	<u>\$</u>

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kentucky

INCOME ELIGIBILITY LEVELS (Continued)

C. QUALIFIED MEDICARE BENEFICIARIES WITH INCOMES RELATED TO FEDERAL POVERTY LEVEL

2. SECTION 1902(f) STATES WHICH AS OF JANUARY 1, 1987 USED INCOME STANDARDS MORE RESTRICTIVE THAN SSI

a. Based on the following percent of the official Federal income poverty level:

- Eff. Jan. 1, 1989: 80 percent _____ percent (no more than 100)
- Eff. Jan. 1, 1990: 85 percent _____ percent (no more than 100)
- Eff. Jan. 1, 1991: 90 percent _____ percent (no more than 100)
- Eff. Jan. 1, 1992: 100 percent

b. Levels:

<u>Family Size</u>	<u>Income Level</u>
1	\$ _____
2	\$ _____

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kentucky

INCOME LEVELS (Continued)

D. MEDICALLY NEEDY

- Applicable to all groups. Applicable to all groups except those specified below. Excepted group income levels are also listed on an attached page 3.

(1)	(2)	(3)	(4)	(5)
Family Size	Net income level protected for maintenance for _____ months	Amount by which Column (2) exceeds limits specified in 42 CFR 423.1007*	Net income level for persons living in rural areas for _____ months	Amount by which Column (4) exceeds limits specified in 42 CFR 435.1007*
<input type="checkbox"/> Urban only				
<input type="checkbox"/> Urban & Rural				
1	\$2,600	\$	\$	\$
2	\$3,200	\$	\$	\$
3	\$3,700	\$	\$	\$
4	\$4,600	\$	\$	\$

* The agency has methods for excluding from its claim for FFP payments made on behalf of individuals whose income exceeds these limits.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kentucky

INCOME LEVELS (Continued)

D. MEDICALLY NEEDY

(1)	(2)	(3)	(4)	(5)
Family Size	Net income level protected for maintenance for _____ months	Amount by which Column (2) exceeds limits specified in 42 CFR 423.1007*	Net income level for persons living in rural areas for _____ months	Amount by which Column (4) exceeds limits specified in 42 CFR 435.1007*
<input type="checkbox"/> Urban only				
<input type="checkbox"/> Urban & Rural				
5	\$5,400	\$	\$	\$
6	\$6,100	\$	\$	\$
7	\$6,800	\$	\$	\$
8	\$7,520	\$	\$	\$
9	\$8,240	\$	\$	\$
10	\$8,960	\$	\$	\$
For each additional person, add:	\$700	\$	\$	\$

* The agency has methods for excluding from its claim for FFP payments made on behalf of individuals whose income exceeds these limits.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kentucky

INCOME LEVELS (Continued)

E. Optional Groups Other Than the Medically Needy

1. Institutionalized Individuals Under Special Income Levels as follows:

For individuals covered under 42 CFR 435.231, the special income level shall be 300% of the Supplemental Security Income (SSI) Program federal benefit rate.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kentucky

RESOURCE LEVELS

A. CATEGORICALLY NEEDY GROUPS WITH INCOMES RELATED TO FEDERAL POVERTY LEVEL

1. Pregnant Women

a. Mandatory Groups

- Same as SSI resources levels.
 Less restrictive than SSI resource levels and is as follows:

<u>Family Size</u>	<u>Resource Level</u>
<u>1</u>	<u>N/A*</u>
<u>2</u>	<u>N/A*</u>

b. Optional Groups

- Same as SSI resources levels.
 Less restrictive than SSI resource levels and is as follows:

<u>Family Size</u>	<u>Resource Level</u>
<u>1</u>	<u>N/A*</u>
<u>2</u>	<u>N/A*</u>

* All Resources are disregarded.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kentucky

2. Infants

a. Mandatory Group of Infants

- Same as resource levels in the State's approved AFDC plan.
 Less restrictive than the AFDC levels and are as follows:

<u>Family Size</u>	<u>Resource Level</u>
<u>1</u>	<u>N/A*</u>
<u>2</u>	<u>N/A*</u>
<u>3</u>	<u>N/A*</u>
<u>4</u>	<u>N/A*</u>
<u>5</u>	<u>N/A*</u>
<u>6</u>	<u>N/A*</u>
<u>7</u>	<u>N/A*</u>
<u>8</u>	<u>N/A*</u>
<u>9</u>	<u>N/A*</u>
<u>10</u>	<u>N/A*</u>

* All resources are disregarded

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kentucky

b. Optional Group of Infants

- Same as resource levels in the State's approved AFDC plan.
 Less restrictive than the AFDC levels and are as follows:

<u>Family Size</u>	<u>Resource Level</u>
<u>1</u>	<u>N/A*</u>
<u>2</u>	<u>N/A*</u>
<u>3</u>	<u>N/A*</u>
<u>4</u>	<u>N/A*</u>
<u>5</u>	<u>N/A*</u>
<u>6</u>	<u>N/A*</u>
<u>7</u>	<u>N/A*</u>
<u>8</u>	<u>N/A*</u>
<u>9</u>	<u>N/A*</u>
<u>10</u>	<u>N/A*</u>

* All resources are disregarded

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kentucky

3. Children

a. Mandatory Group of Children under Section 1902(a)(10)(A)(i)(VI) of the Act. (Children who have attained age 1 but have not attained age 6.)

Same as resource levels in the State's approved AFDC plan.

Less restrictive than the AFDC levels and are as follows:

<u>Family Size</u>	<u>Resource Level</u>
<u>1</u>	<u>N/A*</u>
<u>2</u>	<u>N/A*</u>
<u>3</u>	<u>N/A*</u>
<u>4</u>	<u>N/A*</u>
<u>5</u>	<u>N/A*</u>
<u>6</u>	<u>N/A*</u>
<u>7</u>	<u>N/A*</u>
<u>8</u>	<u>N/A*</u>
<u>9</u>	<u>N/A*</u>
<u>10</u>	<u>N/A*</u>

* All resources are disregarded

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kentucky

b. Optional Group of Child

- Same as resource levels in the State's approved AFDC plan.
 Less restrictive than the AFDC levels and are as follows:

<u>Family Size</u>	<u>Resource Level</u>
<u>1</u>	<u>N/A*</u>
<u>2</u>	<u>N/A*</u>
<u>3</u>	<u>N/A*</u>
<u>4</u>	<u>N/A*</u>
<u>5</u>	<u>N/A*</u>
<u>6</u>	<u>N/A*</u>
<u>7</u>	<u>N/A*</u>
<u>8</u>	<u>N/A*</u>
<u>9</u>	<u>N/A*</u>
<u>10</u>	<u>N/A*</u>

* All resources are disregarded

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kentucky

RESOURCE LEVELS (Continued)

B. MEDICALLY NEEDY

Applicable to all groups —

Except those specified below under the provisions of section 1902(f) of the Act.

<u>Family Size</u>	<u>Resource Level</u>
<u>1</u>	<u>2,000</u>
<u>2</u>	<u>4,000</u>
<u>3</u>	<u>4,050</u>
<u>4</u>	<u>4,100</u>
<u>5</u>	<u>4,150</u>
<u>6</u>	<u>4,200</u>
<u>7</u>	<u>4,250</u>
<u>8</u>	<u>4,300</u>
<u>9</u>	<u>4,350</u>
<u>10</u>	<u>4,400</u>
<u>For each additional person</u>	<u>\$50</u>

State: Kentucky

SUPPLEMENT 3 to
ATTACHMENT 2.6-A
Page 1
OMB No.: 0938-0193

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
REASONABLE LIMITS ON AMOUNTS FOR NECESSARY MEDICAL
OR REMEDIAL CARE NOT COVERED UNDER MEDICAID

The deduction for medical and remedial care expenses that were incurred as the result of imposition of a transfer of assets penalty period is limited to zero.

TN No. 06-009
Supersedes
TN No. 85-2

Approval Date: 5/11/06

Effective Date: 4/1/06

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kentucky

METHODS FOR TREATMENT OF INCOME THAT DIFFER FROM
THOSE OF THE SSI PROGRAM

(Section 1902(f) more restrictive methods and criteria and State supplement criteria in SSI criteria. States without section 1634 agreements and in section 1902(f) States. Use to reflect more liberal methods only if you limit to State supplement recipients. DO NOT USE this supplement to reflect more liberal policies that you elect under the authority of section 1902(r) (2) of the Act. Use Supplement 8a for section 1902(r) (2) methods.)

Not applicable

TN No. 92-1
Supersedes
TN No. None

Approval Date: NOV 14 1994

Effective Date: 1-1-92

HCFA ID: 7985E

Revision: HCFA-PM-91-4 (BPD)
August 1991

SUPPLEMENT 5 TO ATTACHMENT 2.6-A
Page 1
OMB No.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kentucky

**MORE RESTRICTIVE METHODS OF TREATING RESOURCES
THAN THOSE OF THE SSI PROGRAM — Section 1902(f) States only**

Not applicable

TN No. 92-1
Supersedes
TN No. 87-15

Approval Date: NOV 14 1994

Effective Date: 1-1-92

HCFA ID: 7985E

Revision: HCFA-PM-91-4 (BPD)
August 1991

SUPPLEMENT 5a TO ATTACHMENT 2.6-A
Page 1
OMB No.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kentucky

METHODS FOR TREATMENT OF RESOURCES FOR INDIVIDUALS
WITH INCOMES RELATED TO FEDERAL POVERTY LEVELS

(Do not complete if you are electing more liberal methods under the authority of section 1902(r) (2) of the Act instead of the authority specific to Federal poverty levels. Use Supplement 8b for section 1902(r) (2) methods.)

Not applicable

TN No. 92-1
Supersedes
TN No. None

Approval Date: NOV 14 1994

Effective Date: 1-1-92

HCFA ID: 7985E

State: Kentucky

Standards for Optional State Supplementary Payments

Payment Category (Reasonable Classification) (1)	Administered by		Income Level				Income Disregards Employed (5)
	Federal (2)	State	Gross		Net		
			1 person (3)	Couple	1 person (4)	Couple	
Living independently with caretaker in the home:							Not Applicable
Single individual			300% of SSI SPA	-	\$343	-	
Eligible couple, one requiring care			-	600% of SSI SPA	-	\$496	
Eligible couple, both requiring care			-	600% of SSI SPA	-	\$534	
Living in family care home			300% of SSI SPA	-	\$389	-	Not Applicable
Living in home for the aged or infirm			300% of SSI SPA	-	\$476	-	Not Applicable

TN #: 84-9
Supersedes
TN # 83-20

Approval Date: 10/12/84

Effective Date: 7-1-84

Revision: HCFA-PM-91-4 (BPD)
August 1991

SUPPLEMENT 7 TO ATTACHMENT 2.6-A
Page 1
OMB No.: 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kentucky

INCOME LEVELS FOR 1902(F) STATES – CATEGORICALLY NEEDY
WHO ARE COVERED UNDER REQUIREMENTS MORE RESTRICTIVE THAN SSI

Not applicable

TN No. 92-1
Supersedes
TN No. 85-2

Approval Date: NOV 14 1994

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Revision: HCFA-PM-91-4 (BPD)
August 1991

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kentucky

RESOURCE STANDARDS FOR 1902(f) STATES – CATEGORICALLY NEEDY

Not applicable

TN No. 92-1
Supersedes
TN No. 85-2

Approval Date: NOV 14 1994

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kentucky

MORE LIBERAL METHODS OF TREATING INCOME
UNDER SECTION 1902 (r) (2) OF THE ACT*

Section 1902(f) State Non-Section 1902(f) State

Income Disregards - Categorically and Medically Needy, Non-Cash Recipients

With regard to the aged, blind, and disabled, (excluding pass-through and protected groups), the state agency uses the same methodologies as SSI with minor variations specified below.

Method of averaging and/or considering income received on an irregular basis:

- ** a. Income from wages (including spot labor, part time labor and agricultural employment) is averaged based on the last available month's income.
- ** b. Commission income (e.g., from real estate sales) is averaged based on the last available three months' income.
- ** c. Lease income (e.g., oil and gas leases) is averaged over the lease span (usually a year) even though the lease payment may be at intervals other than monthly (e.g., semi-annual or annual). Note: Changes of circumstances are taken into consideration in determining availability of income.
- ** In currently approved state plan.

*More liberal methods may not result in exceeding gross income limitations under section 1903(f).

Revision: HCFA-PM-00-1
February 2000

Revised
Supplement 8A to
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State: Kentucky

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

LESS RESTRICTIVE METHODS OF TREATING INCOME
UNDER SECTION 1902 (r)(2) OF THE ACT

- For all eligibility groups subject to Section 1902 (r)(2) of the Act except State supplementation recipients described in Section 1902 (a)(10)(A)(ii)(IV) and the special income group described in Section 1902(a)(10)(A)(ii)(V): exclude all wages paid by the Census Bureau for temporary employment related to Census 2000 activities.
- For all eligibility groups subject to Section 1902 (r)(2) of the Act except State supplementation recipients described in Section 1902 (a)(10)(A)(ii)(IV) and the special income group described in Section 1902 (a)(10)(A)(ii)(V): exclude all income paid to individuals from the Tobacco Settlement between states and tobacco manufacturers.
- For AFDC related eligibility groups subject to Section 1902 (r)(2) of the Act, exclude all interest and dividend income.

TN No. 01-10
Supersedes
TN No. 00-03

Approval Date: AUG 24 2001

Effective Date: 6/1/01

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

LESS RESTRICTIVE METHODS OF TREATING INCOME
UNDER SECTION 1902(r)(2) OF THE ACT

- When the annual Social Security and Railroad Retirement COLAs and Federal Poverty Level COLA adjustments cause ineligibility for Medicaid, disregard the most recent Social Security/Railroad Retirement COLA increase. The disregard is for eligibility groups subject to Sections 1902(a)(10)(E)(i) & 1905(p), 1902(a)(10)(E)(iv) and 1902(a)(10)(E)(iii).

This disregard continues until the individual loses Medicaid coverage for any other reason for three (3) consecutive months.

State: Kentucky

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

MORE LIBERAL METHODS OF TREATING RESOURCES
UNDER SECTION 1902(r)(2) OF THE ACT

Section 1902(f) Non-Section 1902(f) State

Resource Exemptions – Categorically and Medically Needy, Non-Cash Recipients

With regard to the groups listed in 1902(a)(10)(A)(i)(III), 1902(a)(10)(A)(i)(IV), 1902(A)(10)(A)(ii), and 1902(a)(10)(C)(I)(III) of the Social Security Act, the state agency disregards the following resources.

- (1) (Reserved)
- (2) The value of household goods and personal effects, as defined under SSI policy which SSI counts
- (3) Interest accruing to a burial reserve and burial spaces are disregarded in determining resources. Burial reserves are defined as prepaid burial agreements, burial trust funds, life insurance policies which accrue cash surrender value, and other identifiable funds of resources designated as set aside for the individual's burial expense. Burial spaces are defined as conventional grave sites, crypts, mausoleums, urns, vaults, caskets, opening and closing of the grave, headstone, etc., used for the remains of deceased persons. (This policy is to apply to all the above noted groups. Even though this is AFDC and SSI policy, the state plans to protect the exclusion under the authority of Section 1902(r)(2) to the extent that any part of such interest is or becomes countable as a resource.)

More Liberal Resource Methodologies Protected

- * (4) One automobile is excluded regardless of value if it is used for employment, to obtain medical treatment, or if specifically equipped for the handicapped \$4,500 is then excluded from the total equity value of any non-excluded automobiles.
- (5) Equity in income introducing non-homestead real estate is exempted even when the SSI test of "income producing" is not met.

NOTE: The value of non-homestead real estate is that as determined by the county property valuation administrator (PVA) for tax purposes, or the market value if less. If the PVA valuation is within the limit, no determination of market value is made.

Effective with regard to determination of eligibility made on or after May 1, 1990, the value of property (including the tools of a tradesperson and the machinery and livestock of a farmer) that is essential for self-support for the individual or spouse, or family group in the instance of families with children, and which is used in a trade or business or some other manner, or by the individual or member of the family group as an employee is excluded from consideration as a resource.

- * (6) Burial reserves (whether in the form of a prepaid burial, trust fund or life insurance policy) are exempt from consideration up to a value of \$1,500 per individual. If the value of the burial reserve exceeds \$1,500, the excess is added to the total of liquid assets

* In currently approved state plan.

More Liberal Resource Methodologies Protected

in determining eligibility. When a life insurance policy considered as a burial reserve has a face value in excess of \$1,500 (per individual), the cash surrender value in excess of the disregard amount is considered a liquid asset.

- * (7) The state agency does not consider the value of life interests in real estate or other property as an available resource.
- * (8) If resources are equal to or less than the limits when an application or reinvestigation is processed at any time during the month, the case is considered to be resource eligible for the full month.
- * (9) IRAs, Keogh Plan Funds, 401(k) retirement funds, and other deferred tax protected assets are considered as an unavailable resource until accessed by the owner. When accessed, the available amount is the amount actually withdrawn minus any penalty amounts resulting from the withdrawal.

* In currently approved state plan

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kentucky

STATE LONG-TERM CARE INSURANCE PARTNERSHIP

1902(r)(2)
1917(b)(1)(C)

The following more liberal methodology applies to individuals who are eligible for medical assistance under one of the following eligibility groups:

Section 1902(a)(10)(A)(ii)(V) of the Act.

An individual who is a beneficiary under a long-term care insurance policy that meets the requirements of a "qualified State long-term care insurance partnership" policy (partnership policy) as set forth below, is given a resource disregard as described in this amendment. The amount of the disregard is equal to the amount of the insurance benefit payments made to or on behalf of the individual. The term "long-term care insurance policy" includes a certificate issued under a group insurance contract.

- The State Medicaid Agency (Agency) stipulates that the following requirements will be satisfied in order for a long-term care policy to qualify for a disregard. Where appropriate, the Agency relies on attestations by the State Insurance Commissioner (Commissioner) or other State official charged with regulation and oversight of insurance policies sold in the state, regarding information within the expertise of the State's Insurance Department.
- The policy is a qualified long-term care insurance policy as defined in section 7702B(b) of the Internal Revenue Code of 1986.
 - The policy meets the requirements of the long-term care insurance model regulation and long-term care insurance model Act promulgated by the National Association of Insurance Commissioners (as adopted as of October 2000) as those requirements are set forth in section 1917(b)(5)(A) of the Social Security Act.

TN No. 08-009
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TN No.: None

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kentucky

STATE LONG-TERM CARE INSURANCE PARTNERSHIP

- The policy was issued no earlier than the effective date of this State plan amendment.
- The insured individual was a resident of a Partnership State when coverage first became effective under the policy. If the policy is later exchanged for a different long-term care policy, the individual was a resident of a Partnership State when coverage under the earliest policy became effective.
- The policy meets the inflation protection requirements set forth in section 1917(b)(1)(C)(iii)(IV) of the Social Security Act.
- The Commissioner requires the issuer of the policy to make regular reports to the Secretary that include notification regarding when benefits provided under the policy have been paid and the amount of such benefits paid, notification regarding when the policy otherwise terminates, and such other information as the Secretary determines may be appropriate to the administration of such partnerships.
- The State does not impose any requirement affecting the terms or benefits of a partnership policy that the state does not also impose on non-partnership policies.
- The State Insurance Department assures that any individual who sells a partnership policy receives training, and demonstrates evidence of an understanding of such policies and how they relate to other public and private coverage of long-term care.
- The Agency provides information and technical assistance to the Insurance Department regarding the training described above.

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TN No: None

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kentucky

* In currently approved state plan.

TN No. 92-1
Supersedes
TN No. 89-5

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kentucky

* In currently approved state plan.

TN No. 92-1
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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kentucky

* In currently approved state plan.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kentucky

* In currently approved state plan.

TN No. 92-1
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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kentucky

* In currently approved state plan.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kentucky

* In currently approved state plan.

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State: Kentucky

* In currently approved state plan.

TN No. 92-1
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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kentucky

TRANSFER OF ASSETS

1917(c) The agency provides for the denial of certain Medicaid services by reason of disposal of assets for less than fair market value.

1. Institutionalized individual. may be denied certain Medicaid services upon disposing of assets for less than fair market value on or after the look-back date.

The agency withholds payment to institutionalized individual a for the following services:

Payments based on a level of care in a nursing facility;

Payments based on a nursing facility level of care in a medical institution;

Home and community-based services under a 1915 waiver.

2. Non-institutionalized individuals:

- The agency applies these provisions to the following non- institutionalized eligibility groups. These groups can be no more restrictive than those set forth in section 1905 (a) of the Social Security Act:

The agency withholds payment to non-institutionalized individuals for the following services:

Home health services (section 1905(a) (7));

Home and community care for functionally disabled and elderly adults (section 1905 (a) (22))

Personal care services furnished to individuals who are not inpatients in certain medical institutions, as recognized under agency law and specified in .section 1905(a)(24).

- The following other long-term care services for which medical assistance is otherwise under the agency plan:

State: Kentucky

TRANSFER OF ASSETS

3. Penalty Date--The beginning date of each penalty period imposed for an uncompensated transfer of assets is:
- the first day of the month in which the asset was transferred;
 - the first day of the following the month of transfer.
4. Penalty Period – Institutionalized Individuals--
- In determining the penalty for an institutionalized individual, the agency uses:
- the average monthly cost to a private patient of nursing facility services in the agency;
 - the average monthly cost to a private patient of nursing facility services in the community in which the individual is institutionalized.
5. Penalty Period – Non-institutionalized Individuals--
- The agency imposes a penalty period determined by using the same method as is used for an institutionalized individual including the use of the average monthly cost of nursing facility services;
- imposes a shorter penalty period than would be imposed for institutionalized individuals, as outlined below:

State: Kentucky

TRANSFER OF ASSETS

6. Penalty period for amounts of transfer less than cost of nursing facility care—
- a. Where the amount of the transfer is less than the monthly cost of nursing facility care, the agency:
- does not impose a penalty;
 - imposes a penalty for less than a full month based on the proportion of the agency's private nursing facility rate that was transferred.
- b. Where an individual makes a series of transfers, each less than the private nursing facility rate for a month, the agency:
- does not impose a penalty;*
 - imposes a series of penalties, each for less than a full month.
7. Transfers made so that penalty periods would overlap--
- The agency:
- totals the value of all assets transferred to produce a single penalty period;
 - calculates the individual penalty periods and imposes them sequentially.
8. Transfers made so that penalty periods would not overlap- -.
- The agency:
- assigns each transfer its own penalty period;
 - uses the method outlined below:

* Transfers within a month would be totaled for this purpose.

State: Kentucky

Transfer of Assets

9. Penalty periods - Transfer by a spouse that results in a penalty period for the individual -

- a) The agency apportions any existing penalty period between the spouses using the method outlined below, provided the spouse is eligible for Medicaid. A penalty can be assessed against the spouse, and some portion of the penalty against the individual remains. The penalty period apportioned equally between institutionalized spouses. (A penalty is not applied against a non- institutionalized spouse).
- b) If one spouse is no longer subject to a penalty, the remaining penalty period must be served by the remaining spouse.

10. Treatment of income as an asset --

When income has been transferred as a lump sum, the agency will calculate the penalty period on the lump sum value.

- The agency will impose partial month penalty periods.

When a stream of income or the right to a stream of income has been transferred, the agency will impose a penalty period for each income payment

- For transfers of individual income payments, the agency will impose partial month penalty periods.
- For transfers of the right to an income stream, the agency will use the actuarial value of all payments transferred.
- The agency uses an alternate method to calculate penalty periods, as described below: The agency does not recognize transfer of a stream of income or their right to a stream of income. Any such transfer will result in the income continuing to be considered available to the recipient for eligibility determinations

State: Kentucky

Transfer of Assets

11. Imposition of a penalty would work an undue hardship -

The agency does not apply the transfer of assets provisions in any case in which the agency determines that such an application would work an undue hardship. The agency will use the following procedures in making undue hardship determination:

At the time it is determined that a transfer of assets has occurred, the recipient is notified of the action to be taken. The notice advises the recipient that an undue hardship exemption may be requested, the procedure for making the request and the appeal process if the decision adversely affects eligibility.

The request for undue hardship exemption will be forwarded in writing to the Department for Medicaid Services (DMS) from the Department for Social Insurance (DSI) (or other agency making the eligibility determination for DMS). The request receives immediate attention and a decision provided in the shortest time period possible.

The following criteria will be used to determine whether the agency will not count assets transferred because the penalty would work an undue hardship:

When the agency determines the transferred funds are not recoverable, that the transfer was not intended by the original owner(s) to result in Medicaid coverage or was made in circumstances not under the control of the original owner(s), and the applicant or recipient would be unable to receive necessary medical care unless an undue hardship exemption is granted.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kentucky

TRANSFER OF ASSETS

1917(c) FOR TRANSFERS OF ASSETS FOR LESS THAN FAIR MARKET VALUE MADE ON OR AFTER FEBRUARY 8, 2006, the agency provides for the denial of certain Medicaid services.

1. Institutionalized Individuals are denied coverage of certain Medicaid services upon disposing of assets for less than fair market value on or after the look-back date.

The agency does not provide medical assistance coverage for vendor payment recipients for the following services:

Nursing facility services;

Nursing facility level of care provided in a medical institution;

Intermediate Care Facility for the Mentally Retarded and Developmentally Disabled

Home and community-based services under a 1915(c) or (d) waiver.

2. Non-institutionalized individuals:

The agency applies these provisions to the following non-institutionalized eligibility groups. These groups can be no more restrictive

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kentucky

TRANSFER OF ASSETS

than those set forth in section 1905(a) of the Social Security Act:

The agency withholds payment to non-institutionalized individuals for the following services:

Home health services (section 1905(a)(7));

Home and community care for functionally disabled elderly adults (section 1905(a)(22));

Personal care services furnished to individuals who are not inpatients in certain medical institutions, as recognized under agency law and specified in section 1905(a)(24).

The following other long-term care services for which payment for medical assistance is otherwise made under the agency plan:

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State: Kentucky

TRANSFER OF ASSETS

3. Penalty Date--The beginning date of each penalty period imposed for an uncompensated transfer of assets is the later of:
- the first day of a month during or after which assets have been transferred for less than fair market value;
 - The State uses the first day of the month in which the assets were transferred
 - The State uses the first day of the month after the month in which the assets were transferred
- or
- the date on which the individual is eligible for medical assistance under the State plan and is receiving institutional level care services described in paragraphs 1 and 2 that, were it not for the imposition of the penalty period, would be covered by Medicaid;

AND

which does not occur during any other period of ineligibility for services by reason of a transfer of assets penalty.

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State: Kentucky

TRANSFER OF ASSETS

4. Penalty Period - Institutionalized Individuals--

In determining the penalty for an institutionalized individual, the agency uses:

- the average monthly cost to a private patient of nursing facility services in the State at the time of application;
- the average monthly cost to a private patient of nursing facility services in the community in which the individual is institutionalized at the time of application.

5. Penalty Period – Non-institutionalized Individuals—

The agency imposes a penalty period determined by using the same method as is used for an institutionalized individual, including the use of the average monthly cost of nursing facility services;

- imposes a shorter penalty period than would be imposed for institutionalized individuals, as outlined below:

6. Penalty period for amounts of transfer less than cost of nursing facility care--

- Where the amount of the transfer is less than the monthly cost of nursing facility care, the agency imposes a penalty for less than a full month, based on the option selected in item 4.
- The state adds together all transfers for less than fair market value made during the look-back period in more than one month and calculates a

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kentucky

TRANSFER OF ASSETS

single period of ineligibility, that begins on the earliest date that would otherwise apply if the transfer had been made in a single lump sum.

7. Penalty periods - transfer by a spouse that results in a penalty period for the individual--

- (a) The agency apportions any existing penalty period between the spouses using the method outlined below, provided the spouse is eligible for Medicaid. A penalty can be assessed against the spouse, and some portion of the penalty against the individual remains.
- (b) If one spouse is no longer subject to a penalty, the remaining penalty period must be served by the remaining spouse.

8. Treatment of a transfer of income-

When income has been transferred as a lump sum, the agency will calculate the penalty period on the lump sum value.

When a stream of income or the right to a stream of income has been transferred, the agency will impose a penalty period for each income payment.

- For transfers of individual income payments, the agency will impose partial month penalty periods using the methodology selected in 6. above.
- For transfers of the right to an income stream, the agency will base the penalty period on the combined actuarial value of all payments transferred.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kentucky

TRANSFER OF ASSETS

9. Imposition of a penalty would work an undue hardship--

The agency does not impose a penalty for transferring assets for less than fair market value in any case in which the agency determines that such imposition would work an undue hardship. The agency will use the following criteria in making undue hardship determinations:

Application of a transfer of assets penalty would deprive the individual:

- (a) Of medical care such that the individual's health or life would be endangered; or
- (b) Of food, clothing, shelter, or other necessities of life.

10. Procedures for Undue Hardship Waivers

The agency has established a process under which hardship waivers may be requested that provides for:

- (a) Notice to a recipient subject to a penalty that an undue hardship exception exists;
- (b) A timely process for determining whether an undue hardship waiver will be granted; and
- (c) A process, which is described in the notice, under

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kentucky

TRANSFER OF ASSETS

which an adverse determination can be appealed.

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March 1995

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State: Kentucky

The agency does not apply the trust provisions in any case in which the agency determines that such application would work an undue hardship.

The following criteria will be used to determine whether the agency will not count assets transferred because doing so would work an undue hardship:

When the agency determines the transferred funds are not recoverable, that the transfer was not intended by the original owner(s) to result in Medicaid coverage or was made in circumstances not under the control of the original owner(s), and the applicant or recipient would be unable to receive necessary medical care unless an undue hardship exemption is granted.

At the time it is determined that a transfer of assets has occurred, the recipient is notified of the action to be taken. The notice advises the recipient that an undue hardship exemption may be requested, the procedure for making the request and the appeal process if the decision adversely affects eligibility.

The request for undue hardship exemption will be forwarded in writing to the Department for Medicaid Services (DM5) from the Department for Social Insurance (DSI) (or other agency making the eligibility determination for DM5). The request receives immediate attention and a decision provided in the shortest time period possible.

Under the agency's undue hardship provisions, the agency exempts the funds in an irrevocable burial trust.

The maximum value of the exemption for an irrevocable burial trust is: Not Limited.

TN No. 95-6
Supersedes
TN No. None

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Effective Date: 4/1/95

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kentucky

COST EFFECTIVENESS METHODOLOGY FOR COBRA CONTINUATION BENEFICIARIES

1902(u) of the Act Premium payments are made by the agency only if such payments are likely to be cost-effective. The agency specifies the guidelines used in determining cost effectiveness by selecting one of the following methods:

- The methodology as described in SMM section 3598
- Another cost-effective methodology as described below.

A. Cost Effectiveness

- (1) Enrollment in a group health insurance plan shall be considered cost effective when the cost of paying the premiums, coinsurance, deductibles and other cost-sharing obligations, and additional administrative costs is estimated to be less than the amount paid for an equivalent set of Medicaid services.
- (2) When determining cost effectiveness of a group health insurance plan, the department shall consider the following information:
 - a. The cost of the insurance premium, coinsurance, and deductible;
 - b. The scope of services covered under the insurance plan, including exclusions for pre-existing conditions, exclusions to enrollment, and lifetime maximum benefits imposed;
 - c. The average anticipated Medicaid utilization:
 1. By age, sex, and coverage group for persons covered under the insurance plan; and
 2. Using a statewide average for the geographic component;
 - d. The specific health-related circumstances of the persons covered under the insurance plan; and
 - e. Annual administrative expenditures of an amount determined by the department per Medicaid participant covered under the group health insurance plan.

B. Cost Effectiveness Review.

- (1) The department shall complete a cost effectiveness review:
 - a. At least once every six (6) months for an employer-related group health insurance plan; or
 - b. Annually for a non-employer-related group health insurance plan.
- (2) The department shall perform a cost effectiveness re-determination if:
 - a. A predetermined premium rate, deductible, or coinsurance increases;
 - b. Any of the individuals covered under the group health plan lose full Medicaid eligibility; or

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State/Territory: Kentucky

COST EFFECTIVENESS METHODOLOGY FOR COBRA CONTINUATION BENEFICIARIES

- c. There is a:
 - 1. Change in Medicaid eligibility;
 - 2. Loss of employment when the insurance is through an employer;
or
 - 3. A decrease in the services covered under the policy.
 - (3) Changes in enrollment
 - a. A health insurance premium payment program participant, who is a Medicaid enrollee, or a person on that individual's behalf, shall report all changes concerning health insurance coverage to the participant's local Department for Community Based Services (DCBS), Division of Family Support within ten (10) days of the change.
 - b. Except as allowed in section (4) below, if a Medicaid enrollee who is a health insurance premium payment program participant fails to comply with paragraph (a) of this subsection, the department shall disenroll the HIPP program participating Medicaid enrollee, and any family member enrolled in the HIPP program directly through the individual if applicable, from the HIPP program.
 - (4) The department shall not disenroll an individual from HIPP program participation if the individual demonstrates to the department, within thirty (30) days of notice of HIPP program disenrollment, good cause for failing to comply with subsection (3) of this section.
 - (5) Good cause for failing to comply with subsection (3) of this section shall exist if:
 - a. There was a serious illness or death of the individual, parent, guardian, or caretaker or a member of the individual's, parent's guardian's, or caretaker's family;
 - b. There was a family emergency or household disaster – for example a fire, flood, tornado, or similar;
 - c. The individual, parent, guardian, or caretaker offers a good cause beyond the individual's, parent's, guardian's, or caretaker's control; or
 - d. There was a failure to receive the department's request for information or notification for a reason not attributable to the individual, parent, guardian, or caretaker or lack of a forwarding address shall be attributable to the individual, parent, guardian, or caretaker.
- C Coverage of Non-Medicaid Family Members.
- (1) If determined to be cost effective, the department shall enroll a family member who is not a Medicaid enrollee into the HIPP program if the family member has group health insurance plan coverage through which the department can obtain health insurance coverage for a Medicaid-enrollee in the family.
 - (2) The needs of a family member who is not a Medicaid enrollee shall not be taken into consideration when determining cost effectiveness of a group health insurance plan.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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- (3) The department shall:
- a. Pay a HIPP program premium on behalf of a HIPP program participating family member who is not a Medicaid enrollee; and
 - b. Not pay a deductible, coinsurance, or other cost-sharing obligation on behalf of a HIPP program-participating family member who is not a Medicaid enrollee.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

ELIGIBILITY UNDER SECTION 1931 OF THE ACT

The State covers low-income families and children under section 1931 of the Act.

The following groups were included in the AFDC State plan effective July 16, 1996:

- Pregnant women with no other eligible children.
- AFDC children age 18 who are full-time students in a secondary school or in the equivalent level of vocational or technical training.
- In determining eligibility for Medicaid, the agency uses the AFDC standards and methodologies in effect as of July 16, 1996 without modifications.
- In determining eligibility for Medicaid, the agency uses the AFDC standards and methodologies in effect as of July 16, 1996, with the following modifications.
 - The agency applies lower income standards which are lower than the AFDC standards in effect on May 1, 1988, as follows:
 - The agency applies higher income standards than those in effect as of July 16, 1996, increased by no more than the percentage increases in the CPI-U since July 16, 1996, as follows:
 - The agency applies higher resource standards than those in effect as of July 16, 1996, increased by no more than the percentage increases in the CPI-U since July 16, 1996, as follows:
 - The agency uses less restrictive income and/or resource methodologies than those in effect as of July 16, 1996, as follows:

All wages paid by the Census Bureau for temporary employment related to Census 2000 or related to a census in the following decades activities are excluded. Temporary employment for interim Census Reports is not excluded.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

All income paid to individuals from the Tobacco Settlement between the states and tobacco manufacturers is excluded.

Family Alternatives Diversion payments are excluded as income.

Earnings of an individual attending school who is a child or parent under age 19 or a child under age 18 who is a high school graduate are disregarded.

A recipient shall have the option to receive a one-time exclusion of 2 months earned income for new employment or increased wages acquired after approved and reported timely.

Interest and dividend income shall be excluded.

\$1,000 in resources shall be excluded.

All non-liquid resources shall be exempted. Non-liquid resources are defined as items other than cash, checking accounts, savings accounts, money market accounts, certificates of deposit, bonds, or stocks.

The income and/or resource methodologies that the less restrictive methodologies replace are as follows:

Earnings of a dependent child who is attending school shall be disregarded for 6 months per calendar year.

All income is considered with no option to exclude 2 months of wages.

Total resources could not exceed \$1000.

Interest and dividend income was considered.

All non-liquid resources were considered unless specifically excluded.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

- The agency terminates medical assistance (except for certain pregnant women and children) for individuals who fail to meet TANF work requirements.
- The agency continues to apply the following waivers of provisions of Part A of Title IV in effect as of July 16, 1996, or submitted prior to August 22, 1996 and approved by the Secretary on or before July 1, 1997.

Revision: HCFA-PM-97-2
December 1997
State: Kentucky

SUPPLEMENT 12A TO
ATTACHMENT 2.6-A
Page 1
QMB No.:0938-0673

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
VARIATIONS FROM THE BASIC PERSONAL NEEDS ALLOWANCE

“Personal Needs Allowance - Individuals with Greater Needs”

Aged, blind, disabled; AFDC Related; and individuals under age 21 covered in this plan as specified in Item B.7 of Attachment 2.2-A.

1. For ICF/MR patients in therapeutic placements designed to rehabilitate the individuals the first \$65 plus 1/2 of the remainder of earned income (as an addition to the \$40 personal needs allowance) with the total amount disregarded not to exceed the SSI standard for an individual.
2. For institutionalized individuals, amounts excluded under a plan to achieve self-support (PASS), as an income related work expense (IRWE), or blind work expense (BWE) shall be added to the individual's usual PNA.

TN No. 98-03
Supersedes
TN No. None

Approval Date 4/20/98

Effective Date 1/1/98

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: KENTUCKY

SECTION 1924 PROVISIONS

- A. Income and resource eligibility policies used to determine eligibility for institutionalized individuals who have spouses living in the community are consistent with Section 1924.
- B. In the determination of resource eligibility for the community spouse, the state resource standard is \$20,000.
- C. The definition of undue hardship for purposes of determining if institutionalized spouses receive Medicaid in spite of having excess countable resources is described below:

“Undue hardship” exists when Medicaid eligibility of the institutionalized spouse cannot be established on the basis of assigned support rights and institutionalized spouse is subject to discharge from the medical institution, nursing facility, or HCBS waiver program due to inability to pay.

Citation	Condition or Requirement
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“Personal Needs Allowance - Individuals with Greater Needs”

Aged, blind, disabled; AFDC Related; and individuals under a 21 covered in this plan as specified in Item B.7 of Attachment 2.2-A.

1. For ICF/MR patients in therapeutic placements designed to rehabilitate the individuals the first \$65 plus 1/2 of the remainder of earned income (as an addition to the \$40 personal needs allowance) with the total amount disregarded not to exceed the SSI standard for an individual.
2. For institutionalized individuals, amounts excluded under a plan to achieve self-support (PASS), as an income related work expense (IRWE), or blind work expense (BWE) shall be added to the individual's usual PNA.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kentucky

DISQUALIFICATION FOR LONG-TERM CARE ASSISTANCE FOR INDIVIDUALS WITH
SUBSTANTIAL HOME EQUITY

1917(f) The State agency denies reimbursement for nursing facility services and other long-term care services covered under the State plan for an individual who does not have a spouse, child under 21 or adult disabled child residing in the individual's home, when the individual's equity interest in the home exceeds the following amount:

- \$500,000 (increased by the annual percentage increase in the urban component of the consumer price index beginning with 2011, rounded to the nearest \$1,000).
- An amount that exceeds \$500,000 but does not exceed \$750,000 (increased by the annual percentage increase in the urban component of the consumer price index beginning with 2011, rounded to the nearest \$1,000).

The amount chosen by the State is _____

- This higher standard applies statewide.
- This higher standard does not apply statewide. It only applies in the following areas of the State:
- This higher standard applies to all eligibility groups.
- This higher standard only applies to the following eligibility groups:

The State has a process under which this limitation will be waived in cases of undue hardship. Good cause is determined when the denial of a benefit results in the loss of :

- a. Medical care which shall result in an endangerment to the individual's health or life; or
- b. Food, clothing, shelter, or other necessities of life;

TN No: 08-009
Supersedes
TN No: None

Approval Date: 10/17/08

Effective Date: 7/14/2008

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kentucky

ASSET VERIFICATION SYSTEM

- 1940(a) 1. of the Act
1. The agency will provide for the verification of assets for purposes of determining or redetermining Medicaid eligibility for aged, blind and disabled Medicaid applicants and recipients using an Asset Verification System (AVS) that meets the following minimum requirements.
 - A. The request and response system must be electronic:
 - (1) Verification inquiries must be sent electronically via the internet or similar means from the agency to the financial institution (FI).
 - (2) The system cannot be based on mailing paper-based requests.
 - (3) The system must have the capability to accept responses electronically.
 - B. The system must be secure, based on a recognized industry standard of security (e.g., as defined by the U.S. Commerce Department's National Institute of Standards and Technology, or NIST).
 - C. The system must establish and maintain a database of FIs that participate in the agency's AVS.
 - D. Verification requests also must be sent to FIs other than those identified by applicants and recipients, based on some logic such as geographic proximity to the applicant's home address, or other reasonable factors whenever the agency determines that such requests are needed to determine or redetermine the individual's eligibility.
 - E. The verification requests must include a request for information on both open and closed accounts, going back up to 5 years as determined by the State.

TN No.: 10-001
Supersedes
TN No.: New

Approval Date: 06-25-10

Effective Date: 01/01/2010

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kentucky

ASSET VERIFICATION SYSTEM

2. System Development

- A. The agency itself will develop an AVS.
In 3 below, provide any additional information the agency wants to include.
- B. The agency will hire a contractor to develop an AVS.
In 3 below provide any additional information the agency wants to include.
- C. The agency will be joining a consortium to develop an AVS.
In 3 below, identify the States participating in the consortium. Also, provide any other information the agency wants to include pertaining to how the consortium will implement the AVS requirements.
- D. The agency already has a system in place that meets the requirements for an acceptable AVS.
In 3 below, describe how the existing system meets the requirements in Section I.
- E. Other alternative not included in A. - D. above.
In 3 below, describe this alternative approach and how it will meet the requirements in Section 1.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kentucky

ASSET VERIFICATION SYSTEM

3. Provide the AVS implementation information requested for the implementation approach checked in Section 2, and any other information the agency may want to include.

In order to implement the requirements of an asset verification system, the Kentucky Department for Medicaid Services will select a contractor through a Request for Proposal (REP) process. The contractor will meet the Commonwealth's regulatory criteria and qualifications. The contractor will be responsible for utilizing the required authorizations from applicants and recipients to carry out the asset verification program aforementioned in Section I and consistent with the program utilized by the Commissioner of Social Security under section 1631(e)(1)(B)(ii) of the Social Security Act. The Commonwealth will provide guidance to the contractor in the development of the program and monitor the program's implementation.. The contractor shall be responsible for compilation of data for the Commonwealth to comply with federally required AVS report submissions. The contracted entity shall be subject to the same requirement on use and disclosure of information as would be applicable if the Commonwealth were to directly perform the AVS activities.

State/Territory: Kentucky

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

1. Inpatient hospital services other than those provided in an Institution for mental diseases.
Provided: No limitations With limitations*
- 2.a. Outpatient hospital services.
Provided: No limitations With limitations*
- b. Rural health clinic services and other ambulatory services furnished by a rural health clinic (which are otherwise included in the State plan).
 Provided: No limitations With limitations* Not provided.
- c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with Section 4231 of the State Medicaid Manual (HCFA- Pub. 45-4).
 Provided: No limitations With limitations*
3. Other laboratory and x-ray services.
 Provided: No limitations With limitations*

*Description provided on attachment.

State/Territory: Kentucky

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

- 4.a. Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.
 Provided: No limitations With limitations*
- 4.b. Early and periodic screening, diagnostic and treatment services for individuals under 21 years of age, and treatment of conditions found.*
- 4.c. Family planning services and supplies for individuals of child-bearing age.
4. d Face-to-Face Tobacco Cessation Counseling Services for Pregnant Women
 Provided: No limitations With limitations*
- 5.a. Physicians' services whether furnished in the office, the patient's home, a hospital, a nursing facility or elsewhere.
 Provided: No limitations With limitations*
- b. Medical and surgical services furnished by a dentist (in accordance with section 1905(a)(5)(B) of the Act).
 Provided: No limitations With limitations*
6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.
- a. Podiatrists' services.
 Provided: No limitations With limitations*

*Description provided on attachment.

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND
REMEDIAL CARE AND SERVICES PROVIDED TO THE
CATEGORICALLY NEEDY

Commonwealth Global Choices

b. Optometrists' services.

Provided: No limitations With limitations* Not Provided.

c. Chiropractors' services.

Provided: No limitations With limitations* Not provided.

d. Other Practitioners' Services

Provided: No limitations With limitations* Not provided.

7. Home Health Services

a. Intermittent or part-time nursing services provided by a home health agency or by a registered nurse when no home health agency exists in area.

Provided: No limitations With limitations* Not provided.

b. Home health aide services provided by a home health agency.

Provided: No limitations With limitations* Not provided.

c. Medical supplies suitable for use in the home.

Provided: No limitations With limitations* Not provided.

*Description provided on attachment

State/Territory: Kentucky

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

- d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility.
- Provided: No limitations With limitations* Not Provided.
8. Private duty nursing services.
- Provided: No limitations With limitations* Not Provided.

*Description provided on attachment.

AMOUNT, DURATION, SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

9. Clinic Services.

Provided: No limitations With limitations* Not Provided.

10. Dental Services.

Provided: No limitations With limitations* Not Provided.

11. Physical therapy and related services.

a. Physical therapy.

Provided: No limitations With limitations* Not Provided.

b. Occupational therapy.

Provided: No limitations With limitations* Not Provided.

c. Services for individuals with speech, hearing, and language disorders (provided by or under the supervision of a speech pathologist or audiologist).

Provided: No limitations With limitations* Not Provided.

*Description provided on attachment.

AMOUNT, DURATION, SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORIACLLY NEEDY

12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.
- a. Prescribed drugs.
 Provided: No limitations With limitations* Not Provided.
- b. Dentures
 Provided: No limitations With limitations* Not provided.
- c. prosthetic devices.
 Provided: No limitations With limitations* Not Provided.
- d. Eyeglasses
 Provided: No limitations With limitations* Not Provided.
13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.
- a. Diagnostic services.
 Provided: No limitations With limitations* Not Provided.

*Description provided on attachment.

AMOUNT, DURATION, SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

- b. Screening Services
 Provided: No limitations With limitations* Not Provided.
- c. Preventive Services
 Provided: No limitations With limitations* Not Provided.
- d. Rehabilitative services
 Provided: No limitations With limitations* Not Provided.
14. Services for individuals age 65 or older in institutions for mental diseases.
- a. Inpatient hospital services
 Provided: No limitations With limitations* Not Provided.
- b. Nursing facility services.
 Provided: No limitations With limitations* Not Provided.

*Description provided on attachment.

AMOUNT, DURATION, SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORIACLLY NEEDY

15. a. Services in an Intermediate Care Facility for the Mentally Retarded (other than in an institution for mental diseases) for individuals who are determined, in accordance with Section 1902(a)(31)(A), to be in need of such care.
- Provided: No limitations With limitations* Not Provided.
16. Inpatient psychiatric facility services for individuals under 22 years of age.
- Provided: No limitations With limitations* Not Provided.
17. Nurse-midwife services.
- Provided: No limitations With limitations* Not Provided.
18. Hospice care (in accordance with Section 1905(o) of the Act).
- Provided: No limitations Provided in accordance with Section 2302 of the Affordable Care Act
- With limitations* Not Provided.

*Description provided on attachment.

TELEHEALTH

The Kentucky Department for Medicaid Services program (DMS) reimburses for medically necessary health services furnished to eligible DMS members. To assist DMS' eligible members receive medically necessary services, DMS includes coverage for selected telehealth services. The department's definition of telehealth services is:

TELEHEALTH MEDICAL SERVICES: The originating-site or spoke site is the location of the eligible Kentucky Medicaid recipient at the time the telehealth service is being furnished via an interactive telehealth service communications system. The distant or hub site is the location of the provider and is considered the place of service. An interactive telehealth service communication system includes interactive audio and video equipment permitting two-way real time interactive communication between the patient and the practitioner at the originating and distant-sites. Coverage for services rendered through telehealth service, provided at the originating-site, are covered to the same extent the service and the provider are covered when not furnished through telehealth service and are considered an alternative way of providing covered services that are typically provided face-to-face and thus do not constitute a change in Medicaid coverage.

ELIGIBLE PROVIDERS: Providers of telehealth services shall be initially approved by the Kentucky e-Health Network Board. The e-Health board will oversee the operation of the statewide electronic health network. Telehealth providers must be an approved member of the Kentucky telehealth network and comply with the standards and protocols established by the Kentucky Telehealth Board.

Upon subsequent approval or verification of a DMS medical assistance provider participation agreement by DMS or its designee, OIG recognized licensed providers that meet applicable telehealth services requirements are eligible to be reimbursed for furnishing covered telehealth services to eligible DMS members.

Providers are enrolled in Medicaid before submitting a telehealth services claim for payment to the DMS claims processing contractors. DMS makes available on the CHFS/DMS website, or other program-specific websites or in hard copy format, information necessary to participate in health care programs administered by DMS or its authorized agents, including telehealth services program policies, billing instructions, utilization review instructions, and other pertinent materials. Reimbursement for services provided through an interactive, telehealth services telecommunication system can be made when the service is rendered at an allowed originating telehealth services site.

PROVIDER RESPONSIBILITIES: A provider who furnishes services to Kentucky Medicaid members via telehealth services agrees to comply with all federal and state laws and regulations relevant to the provision of medical services as specified in the DMS provider participation agreement. A provider also agrees to conform to DMS program policies and instructions as specified in this state plan amendment and its appendices, and program directions and billing instructions, as updated. A provider is also responsible for following coding manual guidelines and CMS correct coding initiatives.

COVERED SERVICES: DMS covers telehealth services and procedures that are Medicaid State Plan services and medically necessary for the diagnosis and treatment of an illness or injury as indicated by the eligible recipient's condition. All telehealth services must be furnished within the limits of provider program policies and within the scope and practice of the provider's professional standards.

The distant-site is the location where the provider agent/practitioner is physically located at time of the telehealth service. Coverage of services furnished through telehealth at the distant-site is limited to:

1. Consultations;
2. Mental health evaluation and management services;
3. Individual and group psychotherapy;
4. Pharmacologic management;
5. Psychiatric/psychological/mental health diagnostic interview examinations;
6. Individual medical nutrition services;

*All services are covered to the same extent the service and the provider are covered when not provided through telehealth.

PRIOR AUTHORIZATION AND UTILIZATION REVIEW: All telehealth services are subject to utilization review for medical necessity and program compliance. Reviews can be performed before services are furnished, before payment is made, or after payment is made. Once enrolled, the provider receives instructions on how to access provider program policies, billing instructions, utilization review instructions, and other pertinent material and to obtain answers to questions on or not covered by these materials. It is the provider's responsibility to access these instructions or ask for paper copies to be provided, to understand the information provided and to comply with the requirements.

Certain telehealth procedures or services can require prior approval from DMS or its authorized agents. Services for which prior authorization was obtained remain subject to utilization review at any point in the payment process. A service provided through telehealth is subject to the same prior authorization and utilization review requirements which exist for the service when not provided through telehealth.

NON-COVERED SERVICES: If a service is not covered in a face-to-face setting, it is also not covered if provided through telehealth. A service provided through telehealth is subject to the same program restrictions, limitations and coverage which exist for the service when not provided through telehealth.

TELEHEALTH AUTHORIZED PRACTITIONERS OR THOSE FUNCTIONING AS AGENTS OF AN AUTHORIZED PROVIDER FOR SERVICES NOT PROVIDED IN A COMMUNITY MENTAL HEALTH CENTER:

1. A psychiatrist;
2. A licensed clinical social worker directly employed by a psychiatrist if the psychiatrist also interacts with the recipient during the encounter;
3. A psychologist with a license in accordance with KRS 319.010(5) and a doctorate degree in psychology directly employed by a psychiatrist if the psychiatrist also interacts with the recipient during the encounter;
4. A licensed professional clinical counselor directly employed by a psychiatrist if the psychiatrist also interacts with the recipient during the encounter;
5. A licensed marriage and family therapist directly employed by a psychiatrist if the psychiatrist also interacts with the recipient during the encounter;
6. A physician*;
7. An ARNP*;

-
8. Speech-language pathologist*;
 9. Occupational therapist*;
 10. Physical therapist*;
 11. Licensed dietitian or certified nutritionist*; or
 12. Registered nurse or dietician*

*Certain restrictions apply for these providers and are outlined in the Kentucky Administrative Regulation, which can be found at: <http://www.lrc.ky.gov/kar/907/003/170.htm>

TELEHEALTH AUTHORIZED PRACTITIONERS OR THOSE FUNCTIONING AS AGENTS OF AN AUTHORIZED PROVIDER FOR SERVICES PROVIDED IN A COMMUNITY MENTAL HEALTH CENTER:

1. A psychiatrist;
2. A physician;
3. Psychologist with a license in accordance with KRS 319.010(5);
4. A licensed marriage and family therapist;
5. A licensed professional clinical counselor;
6. A psychiatric medical resident;
7. A psychiatric registered nurse;
8. A licensed clinical social worker;
9. An advanced registered nurse practitioner;

1. Inpatient Hospital Services

- a. Payment is made for inpatient hospital care as medically necessary. Each admission must have prior approval of appropriateness by the designated peer review organization in order for the admission to be covered under the Medicaid program, this requirement does not apply to emergency admissions. Weekend stays associated with a Friday or Saturday admission will not be reimbursed unless an emergency exists. Covered admissions are limited to those admissions primarily indicated in the management of acute or chronic illness, injury, or impairment, or for maternity care that could not be rendered on an outpatient basis. Admissions relating to only observation or only diagnostic purposes or for elective cosmetic surgery shall not be covered. Laboratory tests not specifically ordered by a Physician and not done on a preadmission basis, where feasible, will not be covered unless an emergency exists which precludes such preadmission testing

- b. A recipient may transfer from one hospital to another hospital when such transfer is necessary for the patient to receive medical care which is not available in the first hospital. In such situations, the admission resulting from the transfer is an allowable admission.

- c. The following listed surgical procedures are not covered on an inpatient basis, except when a life threatening situation exists, there is another primary purpose for the admission, or the admitting physician certifies a medical necessity requiring admission to a hospital:
 - (a) Biopsy: breast, cervical node, cervix, lesions (skin subcutaneous, submucous), lymph node except high axillary excision, etc.), and muscle.
 - (b) Cauterization or cryotherapy: lesions (skin, subcutaneous, submucous), moles, polyps, warts/condylomas, anterior nose bleeds, and cervix.
 - (c) Circumcision.
 - (d) Dilation: dilatation and curettage (diagnostic or therapeutic nonobstetrical); dilatation/probing of lacrimal duct.
 - (e) Drainage by incision or aspiration: cutaneous, subcutaneous, and joint
 - (f) Exam under anesthesia (pelvic).

- (g) Excision: barthotin cyst, condylomas, foreign body, lesions lipoma, nevi (moles), sebaceous cyst, polyps, and subcutaneous fistulas.
 - (h) Extraction: foreign body, and teeth (per existing policy).
 - (i) Graft, skin (pinch, splint of full thickness up to defect size 3/4 inch diameter).
 - (j) Hymenotomy.
 - (k) Manipulation and/or reduction with or without x-ray; cast change: dislocations depending upon the joint and indication for procedure, and fractures.
 - (l) Meatotomy/ urethral dilation, removal calculus and drainage of bladder without incision.
 - (m) Myringotomy with or without tubes, otoplasty.
 - (n) Oscopy with or without biopsy (with or without salpingogram): arthroscopy, bronchoscopy, colonoscopy, culdoscopy, cystoscopy, esophagoscopy, endoscopy, otoscopy, and sigmoidoscopy or proctosidmoidoscopy.
 - (o) Removal: IUD, and fingernail or toenails.
 - (p) Tenotomy hand or foot.
 - (q) Vasectomy.
 - (r) Z-plasty for relaxation of scar/contracture.
- d. Abortion services are reimbursable under the Medical Assistance Program only when the woman suffers from a physical disorder, physical injury or physical illness, including a life endangering physical condition caused or arising from the pregnancy itself that would place the woman in danger of death unless an abortion is performed, or when the pregnancy is the result of an act of rape or incest.

2 Outpatient Hospital Services

- a. Hospital outpatient services are limited to therapeutic and diagnostic services as ordered by a physician or if applicable, a dentist; to emergency room services in emergency situations; and to drugs, biologicals, or injections administered in the outpatient hospital setting (excluding "take home" drugs and those drugs deemed less-than-effective by the Food and Drug Administration).
- b. For recipients in the Lock-In Program, non-emergency services will be covered only in the recipients designated Lock-In hospital.
- c. Abortion services are reimbursable under the Medical Assistance Program only when the woman suffers from a physical disorder, physical injury or physical illness, including a life endangering physical condition caused or arising from the pregnancy itself that would place the woman in danger of death unless an abortion is performed, or when the pregnancy is the result of an act of rape or incest.

documenting that in the physician's opinion the appropriate circumstances, as outlined in sentence one of this paragraph, existed. A copy of the completed certification form and an operative report shall accompany each claim submitted for payment. However, when medical services not routinely related to the uncovered abortion service are required, the utilization of an uncovered abortion service shall not preclude the recipient from receipt of medical services normally available through the Medical Assistance Program.

2 b. Rural Health Clinic Services

Other ambulatory services furnished by a rural health clinic shall have the same limitations when provided by the rural health clinic as when provided by the usual ambulatory care provider as specified in the relevant subsections of Attachment 3.1-A pertaining to those ambulatory services, except that limitations pertaining to qualifications of provider shall not apply. Reimbursement is not made for the service of physician assistants.

With regard to services provided on or after October 1, 1988, rural health clinics will be allowed to secure drugs for specified immunizations from the Department for Public Health free to provide immunizations for Medicaid recipients. The specified immunizations are: diphtheria and tetanus toxoids and pertussis vaccine (DPT); measles, mumps, and rubella virus vaccine, live (MMR); poliovirus vaccine, live, oral (any types(s)) (OPV); and hemophilus B conjugate vaccine (HBCV).

2 c. Federal Qualified Health Center Services

Federal qualified health center (FQHC) services are limited to FQHC services as defined in the Social Security Act including ambulatory services offered by a FQHC and which are included in the state plan.

3. Other Lab and X-Ray Services

Laboratory Services limited to a benefit schedule of covered laboratory procedures when ordered or prescribed by a duly-licensed physician or dentist.

3. Other Lab and X-Ray Services**A. Coverage.**

- (1) The department shall reimburse for a procedure provided by an independent laboratory if the procedure:
 - (a) Is one that the laboratory is certified to provide by Medicare and in accordance with state regulation.
 - (b) Is a covered service within the CPT code range of 80047 – 89356 except as indicated in Section B.
 - (c) Is prescribed in writing or by electronic request by a physician, podiatrist, dentist, oral surgeon, advanced registered nurse practitioner, or optometrist; and
 - (d) Is supervised by a laboratory director; and
 - (e) Is independent of an institutional setting.
- (2) The department shall reimburse for a radiological service if the service:
 - (a) Is provided by a facility that:
 - 1) Is licensed to provide radiological services;
 - 2) Meets the requirements established in 42 CFR 440.30;
 - 3) Is certified by Medicare to provide the given service;
 - 4) Meets the requirements established in 42 CFR 493 regarding laboratory certification, registration, or other accreditation as appropriate; and
 - (b) Is prescribed in writing or by electronic request by a physician, oral surgeon, dentist, podiatrist, optometrist, advanced registered nurse practitioner, or a physician's assistant;
 - (c) Is provided under the direction or supervision of a licensed physician; and
 - (d) Is a covered service within the CPT code range of 70010 – 78999.

B. Exclusions. The department shall not reimburse for an independent laboratory or radiological service for the following services or procedures:

- (1) A procedure or service with a CPT code of 88300 through 88399;
- (2) A procedure or service with a CPT code of 89250 through 89356;
- (3) A service provided to a resident of a nursing facility or an intermediate care facility for individuals with mental retardation or a developmental disability; or
- (4) A court-ordered laboratory or toxicology test. The court-ordered exclusion does not apply when medically necessary and in the scope of the Medicaid program.

C. Provider Participation Conditions.

-
- (1) To be reimbursed by the department for a service provided in accordance with this administrative regulation, a provider of independent laboratory services or radiological services shall:
- (a) Be a Medicaid-enrolled provider;
 - (b) Be a Medicare participating facility;
 - (c) Comply with state regulations on Non-duplication of Payments and Claims processing;
 - (d) Comply with the requirements regarding the confidentiality of personal records pursuant to 42 U.S.C. 1320d-8 and 45 C.F.R. parts 160 and 164; and
 - (e) Annually submit documentation of:
 - 1) Current CLIA certification to the department if the provider is an independent laboratory; and
 - 2) A current radiological license to the department if the provider provides radiological services.
- (2) A provider may bill a recipient for a service not covered by the department if the provider informed the recipient of noncoverage prior to providing the service.

4.a. Nursing Facility Services (Other Than Services in an Institution for Mental Diseases) for Individuals 21 Years of Age or Older

A. Definitions:

- 1 "High intensity nursing care services" means care provided to Medicaid eligible individuals who meet high intensity patient status criteria which shall be equivalent to skilled nursing care standards under Medicare.
- 2 "Low intensity nursing care services" means care provided to Medicaid eligible individuals who meet low intensity patient status criteria which shall be equivalent to the former intermediate care patient status standards.
- 3 "Intermediate care for the mentally retarded and persons with related conditions services" means care provided to Medicaid eligible individuals who meet ICF-MR patient status criteria by ICF-MRs participating in the Medicaid Program.

B. Services:

Program benefits are limited to eligible recipients who require nursing facility care services meeting the above definitions. These services must be preauthorized and must be reevaluated every six (6) months. If the reevaluation of care needs reveals that the patient no longer requires high intensity, low intensity, or intermediate care for the mentally retarded services and payment is no longer appropriate in the facility, payment shall continue for ten (10) days to permit orderly discharge or transfer to an appropriate level of care.

All individuals receiving nursing facility care must be provided care in appropriately certified beds.

The following services are payable by the Medicaid program when they are medically necessary and ordered by the attending physician. The facilities may not charge the Medicaid recipient for these services. (Also see Attachment 4.19- D Exhibit B for a detailed explanation of each service or item.)

- (1) Routine services include a regular room (if the attending physician orders a private room, the facility cannot charge the family or responsible party any difference in private/semi-private room charges; the facility enters their charges for a private room when billing Medicaid), dietary services and supplements, medical social services, respiratory therapy and supplies, nursing services, the use of equipment and facilities, medical and surgical supplies, podiatry services, items which are furnished routinely and relatively uniformly to all patients, prosthetic devices, and laundry services (including laundry services for personal clothing which is the normal wearing apparel in the facility).
- (2) Ancillary services are those for which a separate charge is customarily made. They include physical therapy, occupational therapy, speech therapy, laboratory procedures, x-ray, oxygen and oxygen supplies, and ventilator use.

4.b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age and Treatment of Conditions Found.A. Dental Services

Kentucky will comply with the requirements in Section 1905 of the Social Security Act relating to medically necessary services to EPSDT recipients. For services beyond the stated limitations or not covered under the Title XIX state plan, the state will determine the medical necessity of the EPSDT services on a case by case basis through prior authorization.

A listing of dental services available to recipients under age 21 is maintained at the central office of the single state agency.

Services not listed will be pre-authorized when medically necessary for EPSDT eligible recipients.

(1) Out of Hospital Dental Services

A listing of dental services available to recipients under age 21 is maintained at the central office of the single state agency.

Services not listed will be pre-authorized when medically necessary for EPSDT eligible recipients.

(2) In Hospital Dental Services

A listing of dental services available to recipients under age 21 is maintained at the central office of the single state agency.

Services not listed will be pre-authorized when medically necessary for EPSDT eligible recipients.

(3) Oral Surgery Dental Services

A listing of oral surgery dental services available to recipients under age 21 is maintained at the central office of the single state agency.

Services not listed will be pre-authorized when medically necessary for EPSDT eligible recipients.

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B. Hearing Services

(1) Audiological Benefits

- (a) Coverage is available only for recipients under age 21 and is limited to the following services provided by certified audiologists:
 - i. Complete hearing evaluation one time per year;
 - ii. Hearing aid evaluation one time per year;
 - iii. A maximum of three follow-up visits within the six month period immediately following fitting of a hearing aid such visits to be related to the proper fit and adjustment of that hearing aid; and
 - iv. One follow-up visit six months following fitting of a hearing aid, to assure a patient's successful use of the aid.
- (b) Services not listed above will be provided when medically necessary upon appropriate pre-authorization through the EPSDT Program.

Commonwealth Global Choices

(b) Exception to the above limitations may be made through preauthorization if need is indicated in the individual case.

(2) Hearing Aid Benefits

(a) Coverage is provided only for recipients under age 21 on a pre-authorized basis for any hearing aid model recommended by a certified audiologist so long as that model is available through a participating hearing aid dealer.

(b) If medical necessity is established, these limitations do not apply to EPSDT eligible children in accordance with 1905 (r)(5) of the Social Security Act.

C. Vision Care Services

(1) Optometrists' services are provided to children under 21 years of age. Coverage includes writing of prescriptions, services to frames and lenses, and diagnostic services provided by ophthalmologists and optometrists, to the extent the optometrist is licensed to perform the services and to the extent the services are covered in the ophthalmologist portion of the physician's program.

(2) If medical necessity is established, these limitations do not apply to EPSDT eligible children in accordance with 1905 (r)(5) of the Social Security Act.

4.b EPSDT Services (continued)

- D. Discretionary Services under EPSDT. For neonatal care related to any of the following diagnoses, an infant (i.e., child not more than twelve (12) months of age) EPSDT eligible recipient may transfer from a hospital with a level III neonatal unit to a different hospital with a level II or level I neonatal unit with the transfer considered a new admission. A "level III neonatal unit" means a unit able to provide the full range of resources and expertise required for the management of any complication of the newborn; a nurse/patient ratio of 1:2 is required. A "level II neonatal unit" means a unit able to provide care to the moderately ill infant who requires various support services: a nurse/patient ratio of 1:4 is required. A "level I neonatal unit" means a unit providing care to infants with uncomplicated conditions: normal nursery staffing is required.

Neonatal Related Diagnoses

- (1) Fetus or newborn affected by maternal conditions, which may be unrelated to present pregnancy.
- (2) Fetus or newborn affected by maternal complications of pregnancy.
- (3) Fetus or newborn affected by complications of placenta, cord, and membranes.
- (4) Fetus or newborn affected by other complications of labor and delivery.
- (5) Slow fetal growth and fetal malnutrition.
- (6) Disorders relating to short gestation and unspecified low birth weight.
- (7) Disorders relating to long gestation and high birth weight.
- (8) Birth Trauma
- (9) Intrauterine hypoxia and birth asphyxia.
- (10) Respiratory distress syndrome.
- (11) Other respiratory conditions of fetus and newborn.
- (12) Infections specific to the perinatal period.
- (13) Fetal and neonatal hemorrhage.
- (14) Hemolytic disease of fetus or newborn, due to isoimmunization.
- (15) Other perinatal jaundice.
- (16) Endocrine and metabolic disturbances specific to the fetus and newborn.
- (17) Hematological disorders of fetus and newborn.
- (18) Perinatal disorders of digestive system.
- (19) Conditions involving the integument and temperature regulation of fetus and newborn
- (20) Congenital anomalies and related surgical procedures.
- (21) Other and ill-defined conditions originating in the perinatal period.

4.b. Early and periodic screening and diagnosis of individuals under 21 years of age and treatment of conditions found.

E. Medicaid Services Provided in Schools

Individuals receiving Medicaid Services in schools have freedom of choice of qualified licensed providers as established in 1902(a)(23) of the Act.

(a) Audiology

Services must be medically necessary and appear in the child's Individualized Education Plan. Covered services include:

Assessment services:

Service may include testing and/or clinical observation as appropriate for chronological or developmental age for one or more of the following areas of functioning, and shall yield a written report:

Auditory sensitivity, including pure tone air and bone conduction, speech detection, and speech reception thresholds, auditory discrimination in quiet and noise, impedance audiometry including tympanometry and acoustic reflex, hearing aid evaluation, central auditory function and auditory brainstem evoked response

Treatment services:

Service may include one or more of the following as appropriate:

Auditory training, speech reading and augmentative communication

Qualifications of Providers: Providers must meet the applicable requirements of 42 CFR 440.110. A provider shall have a valid license issued by the Board of Examiners for Speech and Language Pathologists and Audiologists.

(b) Occupational Therapy

Services must be medically necessary and appear in the child's Individualized Education Plan. Covered services include:

Assessment services

Service may include testing and/or clinical observation as appropriate for chronological or developmental age for one or more of the following areas of functioning, and shall yield a written report:

Activities of daily living assessment, sensorimotor assessment, neuromuscular assessment, fine motor assessment, feeding/oral motor assessment, visual perceptual assessment, perceptual motor development assessment, musculo-skeletal assessment, gross motor assessment, and functional mobility assessment.

Treatment services

Service may include one or more of the following as appropriate:

Activities of daily living training, sensory integration, neuromuscular development, muscle strengthening, and endurance training, feeding/oral motor training, adaptive equipment application, visual perceptual training, facilitation of gross motor skills, facilitation of fine motor skills, fabrication and application of splinting and orthotic devices, manual therapy techniques, sensorimotor training, functional mobility training, perceptual motor training.

Qualifications of Providers:

Providers must meet the applicable requirements of 42 CFR 440.110. Occupational therapy assessment services must be provided by a licensed occupational therapist. Occupational therapy treatment services must be provided by a licensed occupational or a licensed occupational therapist assistant under the supervision of a licensed occupational therapist.

(c) Physical Therapy Services

Services must be medically necessary and appear in the child's Individualized Education Plan. Covered services include:

Assessment services

Service may include testing and/or clinical observation as appropriate for chronological or developmental age for one or more of the following areas of functioning, and shall yield a written report:

Neuromotor assessment, range of motion, joint integrity and functional mobility, flexibility assessment, gait, balance, and coordination assessment, posture and body mechanics assessment, soft tissue assessment, pain assessment, cranial nerve assessment, clinical electromyographic assessment, nerve conduction, latency and velocity assessment, manual muscle test, activities of daily living assessment, cardiac assessment, pulmonary assessment, sensory motor assessment and feeding/oral motor assessment

Treatment services

Service may include one or more of the following as appropriate:

Manual therapy techniques, fabrication and application of orthotic devices, therapeutic exercise, functional training, facilitation of motor milestones, sensory motor training, cardiac training, pulmonary enhancement, adaptive equipment application, feeding/oral motor training, activities of daily living training, gait training, posture and body mechanics training, muscle strengthening, gross motor development, modalities, therapeutic procedures, hydrotherapy, manual manipulation

Qualifications of Providers:

Providers must meet the applicable requirements of 42 CFR 440.110. Physical therapy assessment services must be provided by a licensed physical therapist. Physical therapy treatment services must be provided by a licensed physical therapist or a licensed physical therapist assistant under the supervision of a licensed physical therapist.

(d) Behavioral Health Services

Services must be medically necessary and appear in the child's Individualized Education Plan. Covered services include:

Assessment services

Service may include testing and/or clinical observation as appropriate for chronological or developmental age for one or more of the following areas of functioning, and shall yield a written report:

Cognitive, emotional/personality, adaptive behavior, behavior and perceptual or visual motor

Treatment services

Service may include one or more of the following as appropriate:

Cognitive-behavioral therapy, rational-emotive therapy, family therapy, individual interactive psychotherapy using play equipment, physical devices, language interpreter or other mechanisms of non verbal communication and sensory integrative therapy

Qualifications of Providers:

Minimum qualifications for providing services are licensure as follows:

1. An individual currently licensed by the Kentucky Board of Examiners of Psychology as a licensed psychologist, licensed psychological practitioner, certified psychologist with autonomous functioning, certified psychologist, or licensed psychological associate;
2. A licensed clinical social worker currently licensed by the Kentucky Board of Social Work;
3. A licensed social worker currently licensed by the Kentucky Board of Social Work;
4. A certified social worker currently licensed by the Kentucky Board of Social Work;
5. An advanced registered nurse practitioner who has a specialty area in accordance with the American Nurses' Association Statement on Psychiatric Mental Health Clinical Nursing Practice and Standards of Psychiatric Mental Health Clinical Nursing Practice.

(e) Speech

Services must be medically necessary and appear in the child's Individualized Education Plan. Covered services include:

Assessment services

Service may include testing and/or clinical observation as appropriate for chronological or developmental age for all the following areas of functioning and shall yield a written report:

Receptive and expressive language, auditory memory, discrimination, and processing, vocal quality and resonance patterns, phonological development, pragmatic language, rhythm/fluency, oral mechanism, swallowing assessment, augmentative communication and hearing status based on pass/fail criteria

Treatment services

Service includes one or more of the following as appropriate:

Articulation therapy, language therapy; receptive and expressive language, augmentative communication training, auditory processing, discrimination, and training, fluency training, disorders of speech flow, voice therapy, oral motor training; swallowing therapy and speech reading.

Qualifications of Providers

Treatment services may be performed by a Speech/Language Pathologist with the following qualifications:

1. Current Certificate of Clinical Competence from the American Speech Hearing Association (ASHA);
2. Current license as Speech Language Pathologist from KY Board of Speech Language Pathology and Audiology;

As of August 1, 2011, Speech Therapy services will only be performed by individuals meeting applicable requirements of 42 CFR 440.110, including the possession of a Speech/Language Pathologist with a current Certificate of Clinical Competence from the American Speech Hearing Association (ASHA).

(f) Nursing Services:

Services must be medically necessary. The services may be provided in accordance with an Individualized Education Program or an Individual Family Service Plan. Nursing services must be those services that are in a written plan of care based on a physician, physician assistant or nurse practitioner's written order. The plan of care must be developed by a licensed registered nurse. Services include but are not limited to: assessments including referrals based on results, bladder catheterizations, suctioning, medication administration and management including observation for adverse reactions, response or lack of response to medication, informing the student about their medications, oxygen administration via tracheostomy and ventilator care, enteral feedings, emergency interventions, individual health counseling and instructions, and other treatments ordered by the physician and outlined in the plan of care.

Qualifications of Providers:

The Licensed Practical Nurse and Registered Nurse shall be licensed by the State of Kentucky to provide the services and practice within the Kentucky Nursing Practice Act. Nursing services can be provided under 42 CFR 440.60 and on a restorative basis under 42 CFR 440.130 (d) including services delegated in accordance with the Nurse Practice Act and the Kentucky School Health Program Manual to individuals trained to perform delegated acts by a Registered Nurse.

Services provided by a health aide may only be provided under the following conditions:

1. Is under the supervision of an advanced registered nurse practitioner or a registered nurse;
2. Has been trained by an advanced registered nurse practitioner or registered nurse for the specific nursing service provided to a specific recipient; or
3. An advanced registered nurse practitioner or registered nurse has verified in writing that the aide has appropriate training and skills to perform the specific service in a safe, effective manner.

(g) Respiratory Therapy Services:

Respiratory therapy are the procedures employed in the therapy, management, rehabilitation, gathering of assessment information, or other procedures administered to patients with deficiencies or abnormalities which affect their cardiopulmonary system and associated aspects of cardiopulmonary and other systems functions.

Respiratory therapy services are provided by a practitioner certified by the Kentucky Board of Respiratory Care. Incidental interpreter services provided in conjunction with another covered service. These services will be provided based on state law requirements for appropriate specialties. Incidental interpreter services are provided by an interpreter licensed by the Kentucky Board of Interpreters for the Deaf and Hard of Hearing.

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- (h) Orientation and Mobility Services: Orientation and mobility services provide sequential instruction to individuals with visual impairment in the use of their remaining senses to determine their position within the environment and in techniques for safe movement from one place to another. The skills in this instruction include but are not limited to concept development, motor development and sensory development.

Orientation and mobility services are provided by an orientation and mobility specialist certified by the Academy for Certification of Vision Rehabilitation and Education Professionals (ACVREP) or National Blindness Professional Certification Board (NBPCB).

- (j) Specialized Transportation Services: Services must be medically necessary and appear in the child's Individualized Education Plan or an Individual Family Service Plan. Specialized transportation services include transportation to receive Medicaid approved school health services pursuant to an IEP. This service is limited to transportation of covered, prior authorized services.

- 1) The special transportation is Medicaid reimbursable if:
 - (a) It is provided to a Medicaid eligible EPSDT child who is a student in a public school in Kentucky.
 - (b) It is being provided on a day when the child receives a prior authorized covered service;
 - (c) The student's need for specialized transportation service is documented in the child's plan of care; and
 - (d) The driver has a valid driver's license.
- 2) Specialized transportation services are defined as transportation that requires a specially equipped vehicle, or the use of specialized equipment to ensure a child is taken to and from the child's residence to school or to a community provider's office for prior authorized health related services.
 - (a) Transportation provided by or under contract with the school, to and from the student's place of residence, to the school where the student receives one of the health related services covered by Title XIX;
 - (b) Transportation provided by or under contract with the school, to and from the student's place of residence to the office of a medical provider who has a contract with the school to provide one of the health related services covered by Title XIX; or
 - (c) Transportation provided by or under contract with the school from the student's place of residence to the office of a medical provider who has a contract with the school to provide one of the health related services covered by Title XIX and returns to school.
- 3) Specialized transportation services will not be Medicaid reimbursable if the child does not receive a Medicaid covered service on the same day. When claiming these costs as direct services, each school district is responsible for maintaining written documentation, such as a trip log, for individual trips provided. No payment will be made to, or for parents providing transportation.

4.b. EPSDT Services (continued)

- E. The Medicaid program shall provide such other necessary health care, diagnostic services, treatment, and other measures described in Section 1905(a) of the Social Security Act to correct or ameliorate defects and physical and mental illness and conditions discovered by the screening services, whether or not such services are covered under the state plan.

4.c. Family planning services and supplies for individuals of child-bearing age

Family planning services shall include counseling services, medical services, and pharmaceutical supplies and devices to aid those who decide to prevent or delay pregnancy. In-vitro fertilization, artificial insemination, sterilization reversals, sperm banking and related services, hysterectomies, and abortions shall not be considered family planning services.

4.d. Face-to-Face Tobacco Cessation Counseling Services for Pregnant Women

Tobacco Cessation Counseling Services for Pregnant Women shall include counseling services, medical services, and pharmaceutical supplies and devices to aid those who decide to quit tobacco. This shall include four (4) face-to-face counseling sessions per quit attempt, with a minimum of two (2) quit attempts per twelve (12) month period.

Face-to-face counseling services shall be provided:

- (i) By or under supervision of a physician;
- (ii) By any other health care professional who is legally authorized to furnish such services under State law and who is authorized to provide Medicaid coverable services other than tobacco cessation services; or
- (iii) Any other health care professional legally authorized to provide tobacco cessation services under State law and who is specifically designated by the Secretary in regulations.

5. Physicians' Services

All physician services that an optometrist is legally authorized to perform are included in physicians' services under this plan and are reimbursed whether furnished by a physician or an optometrist.

- A. Coverage for certain initial visits is limited to one visit per patient per physician per three (3) year period. This limitation applies to the following procedures:

New patient evaluation and management office or other outpatient services as identified by codes in the most current edition of the Physicians' Current Procedural Terminology.

New patient evaluation and management home or custodial care services as identified by codes in the most current edition of the Physicians' Current Procedural Terminology.

New patient evaluation and management preventive medicine services as identified by codes in the most current edition of the Physicians' Current Procedural Terminology.

- B. Coverage for an evaluation and management service with a corresponding CPT code of 99214 or 99215 shall be limited to two (2) per recipient per year, per physician. If this limit is exceeded, then DMS will reimburse any such claim as a CPT code 99213 evaluation and management visit.
- C. Outpatient psychiatric service procedures rendered by other than board-eligible and board-certified psychiatrists are limited to four (4) such procedures per patient per physician per twelve (12) month period.
- D. Coverage for laboratory procedures performed in the physician's office is limited to those procedures for which the physician's office is CLIA certified with the exception of urinalysis performed by dipstick or reagent tablet only which shall not be payable as a separate service to physician providers. The fee for this, or comparable lab tests performed by reagent strip or tablet, excluding blood glucose, shall be included in the evaluation and management service reimbursement provided on the same date of service for the same provider.

The professional component of laboratory procedures performed by board certified pathologists in a hospital setting or an outpatient surgical clinic are covered so long as the physician has an agreement with the hospital or outpatient surgical clinic for the provision of laboratory procedures.

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- E. The cost of preparations used in injections is not considered a covered benefit, except for the following:
- (1) The Rhogarn injection.
 - (2) Injectable antineoplastic chemotherapy administered to recipients with a malignancy diagnosis contained in the Association of Community Cancer Centers Compendia-Based Drug Bulletin, as adopted by Medicare.
 - (3) Depo Provera provided in the physician office setting.
 - (4) Penicillin G (up to 600,000 I.U.) and Ceftriaxone (250 mg.).
 - (5) Long acting injectable risperidone.
 - (6) An injectable, infused or inhaled drug or biological that is:
 - a. Not typically self-administered;
 - b. Not listed as a noncovered immunization or vaccine; and
 - c. Requires special handling, storage, shipping, dosing or administration.
- F. Coverage for standard treadmill stress test procedures are limited to three (3) per six (6) month period per recipient. If more than three (3) are billed within a six (6) month period, documentation justifying medical necessity shall be required.
- G. Telephone contact between a physician and patient is not a covered service.
- H. Coverage of a physician service is contingent upon direct physician/patient interaction except in the following cases:
- (1) A service furnished by a resident under the medical direction of a teaching physician in accordance with 42 CFR 415.
 - (2) A service furnished by a physician assistant acting as agent of a supervising physician and performed within the physician assistant's scope of certification.

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- J. Reimbursement for induced abortions is provided when the physician certifies that the pregnancy was a result of rape or incest or the woman suffers from a physical disorder, injury or illness, including a life-endangering physical condition cause or arising from the pregnancy itself that would place the woman in danger of death unless an abortion is performed.
- K. Any physician participating in the lock-in program will be paid for providing patient management services for each patient locked-in to him/her during the month.
- L. Regional anesthesia (e.g., epidurals) for post-operative pain management shall be limited to one (1) service per day up to four (4) days maximum for the anesthesiologist.
- M. Epidural injections of substances for control of chronic pain other than anesthetic, Contrast, or neurolytic solutions shall be limited to three (3) injections per six (6) month period per recipient.
- N. Anesthesia Service limits are soft limits which means the service can be covered when medically necessary subject to prior authorization requirements described in material on file in the state agency.
- O. Coverage for an evaluation and assessment service, provided by a physician or physician assistant with a corresponding CPT code of 99407 for tobacco cessation shall be limited to two (2) per recipient per year.
1. The evaluation and assessment service shall be:
 - a. Performed face-to-face with the recipient;
 - b. Be performed over a period of at least ten (10) minutes.
 2. The evaluation and assessment service shall include:
 - a. Asking the recipient about tobacco use;
 - b. Advising the recipient to quit using tobacco;
 - c. Assessing the recipient's readiness to quit using tobacco products
 - d. Compiling a tobacco usage, medical, and psychosocial history of the recipient;
 - e. Incorporating a review of the recipient's coping skills and barriers to quitting; and
 - f. Providers obtaining of a signed and dated Tobacco Cessation Referral Form from the recipient declaring the recipient's intent to quit using tobacco.
- P. Allergy testing, shots and allergy treatment for all Medicaid recipients, when medically necessary.

6. Medical care and any other type of Remedial Care

A. Podiatry services are provided to both the categorically needy and medically needy in accordance with the following limitations.

- (1) Coverage. The Medical Assistance (Medicaid) Program will cover medical and/or surgical services provided to eligible Medicaid recipients by licensed, participating podiatrists when such services fall within the scope of the practice of podiatry except as otherwise provided for herein. The scope of coverage generally parallels the coverage available under the Medicare program with the addition of wart removal.
- (2) Exclusions from Coverage; Exceptions. The following areas of care are not covered except as specified.

Treatment of flatfoot: services directed toward the care or correction of such a service are not covered.

Treatment of subluxations of the foot: surgical or nonsurgical treatments undertaken for the sole purpose of correcting a subluxated structure as an isolated entity within the foot are not covered; this exclusion of coverage does not apply to reasonable and necessary diagnosis and treatment of symptomatic conditions such as osteoarthritis, bursitis (including bunion), tendonitis, etc., that result from or are associated with partial displacement of foot structures, or to surgical correction that is an integral part of the treatment of a foot injury or that is undertaken to improve the function of the foot or to alleviate an induced or associated symptomatic condition.

Orthopedic shoes and other supportive devices for the feet are not covered under this program element.

Routine foot care: services characterized as routine foot care are generally not covered; this includes such services as the cutting or removal of corns or calluses, the trimming of nails) and other hygienic and preventive maintenance care in the realm of self—care such as cleaning and soaking the feet, the use of skin creams to maintain skin tone of both ambulatory and bedfast patients, and any services performed in the absence of localized illness, injury or symptoms involving the foot. Notwithstanding the preceding, payment may be made for routine foot care such as

cutting or removing corns, calluses or nails when the patient has a systemic disease of sufficient severity that unskilled performance of such procedures would be hazardous; the patient's condition must have been the result of severe circulatory embarrassment or because of areas of desensitization in the legs or feet. Although not intended as a comprehensive list, the following metabolic, neurological, and peripheral vascular diseases (with synonyms in parentheses) most commonly represent the underlying systemic conditions contemplated and which would justify coverage; where the patient's condition is one (1) of those designated by an asterisk (*), routine procedures are reimbursable only if the patient is under the active care of a doctor of medicine or osteopathy for such a condition, and this doctor's name must appear on the claim form:

- *Diabetes mellitus;
- Arteriosclerosis obliterans (A.S.O., arteriosclerosis of the extremities, occlusive peripheral arteriosclerosis);
- Buerger's disease (thromboangitis obliterans);
- Chronic thrombophlebitis;
- Peripheral neuropathies involving the feet:
 1. *Associated with malnutrition and vitamin deficiency, such as: malnutrition (general, pellagra); alcoholism; malabsorption (celiac disease, tropical sprue); and pernicious anemia;
 2. *Associated with carcinoma;
 3. *Associated with diabetes mellitus;
 4. *Associated with drugs and toxins;
 5. *Associated with multiple sclerosis;
 6. *Associated with uremia (chronic renal disease);
 7. Associated with traumatic injury;
 8. Associated with leprosy or neurosyphilis; and
 9. Associated with hereditary disorders, such as: hereditary sensory radicular neuropathy, angiokeratoma corporis; and diffusum (Fabry's), amyloid neuropathy.

TN # 84-10
Supersedes
TN # None

Approval
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Services ordinarily considered routine are also covered if are performed as a necessary and integral part of otherwise covered services, such as the diagnosis and treatment of diabetic ulcers, wounds, and infections. Diagnostic and treatment services for foot infections are also covered as they are considered outside the scope of "routine."

- (3) Provision relating to Special Diagnostic Tests. Plethysmography is a recognized tool for the preoperative podiatric evaluation of the diabetic patient or one who has intermittent claudication or other signs or symptoms indicative of peripheral vascular disease which would have a bearing on the patient's candidacy for foot surgery. The method of plethysmography determines program coverage.

Covered methods include:

- Segmental, including regional, differential, recording oscillometer, and pulse volume recorder;
- Electrical impedance; and
- Ultrasonic measure of blood flow (Doppler).

Noncovered methods include:

- Inductance;
- Capacitance;
- Strain gauge;
- Photoelectric; and
- Mechanical oscilometry.

Venous occlusive pneumoplethysmography would be appropriate only in the setting of a hospital vascular laboratory.

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(6) Medical care and Any Other Type of Remedial Care

B. Optometry services are only provided to recipients under age twenty-one (21).

C. Chiropractic services are provided with the following limitations:

- (1) Fifteen (15) chiropractic visits per year for recipients age 21 and older.
- (2) Seven (7) chiropractic visits per year for recipients under 21 years of age.
- (3) If medical necessity is established, these limitations do not apply to EPSDT eligible children in accordance with 1905(r)(5) of the Social Security Act.

6. Medical Care and Any Other Type of Remedial Care

d. Other practitioner's services

Advanced Practice Registered Nurse (APRN) Services

- (1) An APRN covered service shall be a medically necessary service provided within the legal scope of practice of the APRN and furnished through direct practitioner-patient interaction so long as that service is eligible for reimbursement by Kentucky Medicaid.
- (2) APRN's participating as nurse-midwives or nurse anesthetists shall comply with the service requirements of those components for participation and reimbursement, as appropriate.
- (3) An APRN desiring to participate in the Medical Assistance Program shall:
 - (a) Meet all applicable requirements of state laws and conditions for practice as a licensed APRN;
 - (b) Enter into a provider agreement with the Department for Medicaid Services to provide services;
 - (c) Accompany each participation application with a current copy of the APRN's license; and
 - (d) Provide and bill for the services in accordance with the terms and conditions of the provider participation agreement.
- (4) Administration of anesthesia by an APRN is a covered service.
- (5) The cost of the following injectables administered by an APRN in a physician or other independent practitioner's office shall be covered:
 - a. Rho (D) immune globulin injection;
 - b. Injectable anticancer chemotherapy administered to a recipient with a malignancy diagnosis contained in the Association of Community Cancer Centers Compendia-Based Drug Bulletin, as adopted by Medicare;
 - c. Depo- Provera contraceptive injection;
 - d. Penicillin G and ceftriaxone injectable antibiotics; and
 - e. Epidural injections administered for pain control.
- (6) An outpatient laboratory procedure by an APRN who has been certified in accordance with 42 CFR, Part 493 shall be covered.

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- (7) An obstetrical and gynecological service provided by an APRN shall be covered as follows:
- a. An annual gynecological examination;
 - b. An insertion of an intrauterine device (IUD), including the cost of the device, or removal of the IUD;
 - c. The insertion of an implantable contraceptive capsule, including the cost of the contraceptive capsule and related supplies, or removal of the capsule;
 - d. Prenatal care.
 - e. A routine newborn service to an infant born to a Kentucky Medicaid eligible recipient; and
 - f. A delivery service, which shall include:
 1. Admission to the hospital;
 2. Admission history;
 3. Physical examination,
 4. Anesthesia;
 5. Management of uncomplicated labor;
 6. Vaginal delivery; and
 7. Postpartum care.
- (8) An EPSDT screening service provided in compliance with a periodicity schedule developed in conjunction with the American Academy of Pediatrics Recommendations for Preventive Pediatric Health shall be covered.
- (9) A limitation on a service provided by a physician as described in Attachment 3.1- A. pages 7.21, 7.21(a) and 7.21(a)(o) shall also apply if the service is provided by an APRN.
- (10) The same service provided by an APRN and a physician on the same day within a common practice shall be considered as one (1) covered service.
- (11) Coverage for an evaluation and assessment services with a corresponding CPT code of 99407 for tobacco cessation shall be limited to two (2) per recipient per year.
1. The evaluation and assessment service shall be:
 - a. Performed face-to-face with the recipient;
 - b. Be performed over a period of at least thirty (30) minutes.
 2. The evaluation and assessment service shall include:
 - a. Asking the recipient about tobacco use;
 - b. Advising the recipient to quit using tobacco;
 - c. Assessing the recipient's readiness to quit using tobacco products
 - d. Compiling a tobacco usage, medical, and psychosocial history of the recipient;
 - e. Incorporating a review of the recipient's coping skills and barriers to quitting; and
 - f. Providers obtaining of a signed and dated Tobacco Cessation Referral Form from the recipient declaring the recipient's intent to quit using tobacco.

Commonwealth Global Choices

Other Licensed Practitioners' Services (continued)

- (d) Ophthalmic dispensers' services, limited to dispensing service or a repair service (for eyeglasses provided to eligible recipients), are covered. The following limitations are also applicable:
 - (1) Telephone contacts are not covered;
 - (2) Contact lens are not covered;
 - (3) Safety glasses are covered when medically necessary subject to prior authorization requirements described in material on file in the state agency.

- (e) Pharmacist - Administration of the H1N1 vaccine by a pharmacist who is employed by a pharmacy participating in the Kentucky Medicaid Program.

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND
SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

7. Home Health Services

Home health services must be provided by a home health agency that is Medicare and Medicaid certified. The service must be medically necessary, ordered by a physician, prior authorized, provided in accordance with approved plan of care and provided in the individual's residence. A hospital, nursing facility or intermediate care facility for mentally retarded shall not be considered as an individual's place or residence. Prior authorization must be conducted by the Department and is based on medical necessity; physician's orders; the recipient's needs, diagnosis, condition; the plan of care; and cost-effectiveness when compared with other care options.

a. Intermittent or Part-time Nursing Service

Intermittent or part-time nursing services must be ordered by a physician, be prior authorized, provided in accordance with an approved plan of care and provided in the individual's residence. Home health agencies may provide disposable medical supplies necessary for, or related to, the provision of intermittent or part-time nursing service as specified for coverage by the Medicaid Program.

b. Home health Aide Services

Home health aide services must be ordered by a physician, be prior authorized, provided in accordance with an approved plan of care and provided in the individual's residence.

c. Medical Supplies Suitable for Use in the Home.

Each provider desiring to participate as a medical supply provider must be a participating Medicare Provider and sign a provider agreement with the Department for Medicaid Services.

-
1. The provider submits a certificate of medical necessity (CMN) and, if required, a prior authorization form and any other documentation to support medical necessity.
 2. Coverage of medical supplies for use by patients in the home, are based on medical necessity.

Coverage criteria established by the Medicare program will be used as a guide in determining medical necessity but will be subject to a medical necessity override.
 3. The criteria used in the determination of medical necessity Includes an assessment of whether the item is:
 - a. Provided in accordance with 42 CFR 440.230;
 - b. Reasonable and required to identify, diagnose, treat, correct, cure, ameliorate, palliate, or prevent a disease, illness, injury, disability or other medical condition;
 - c. Clinically appropriate in terms of amount, scope, and duration based on generally accepted standards of good medical practice;
 - d. Provided for medical reasons rather than primarily for the convenience of the recipient, caregiver or the provider;
 - e. Provided in the recipient's residence, in accordance with generally accepted standards of good medical practice, where the service may, for practical purposes, be safely and effectively provided;
 - f. Needed, if used in reference to an emergency medical service, to evaluate or stabilize an emergency medical condition that is found to exist using the prudent lay person standard; and,
 - g. Provided in accordance with early and periodic screening, diagnosis, and treatment (EPSDT) requirements for recipients under twenty-one (21) years of age.
 4. Coverage of an item of medical supply shall be in accordance with the following: shall serve a medical purpose; shall not generally be useful to a person in the absence of illness or injury; shall be appropriate for use in the home; and shall be medically necessary and reasonable.

7. D. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility

Physical therapy, occupational therapy, speech pathology services, or speech/hearing/language therapy services provided by a home health agency must be ordered by a physician, physician assistant or advanced registered nurse practitioner, be prior authorized, provided in accordance with an approved plan of treatment, which shall be developed by the appropriate qualified therapist and physician.

Occupational therapy, physical therapy and speech pathology services and speech/hearing/language therapy are limited to twenty visits per calendar year. Rehabilitative and habilitative services have a combined twenty visit limit per type of therapy. Additional visits may be granted based on medical necessity.

Audiology services are not provided under this component. Physical therapy, occupational therapy, speech pathology, or speech/hearing/language therapy services provided by a medical rehabilitation facility are not provided under this component.

Qualification of Providers

Providers performing physical, occupational or speech therapy must meet requirements defined in 42 C.F.R. 484.4. A qualified physical therapist assistant, occupational therapist assistant or speech therapy assistant must be under the direct supervision of a qualified physical, occupational or speech therapist.

8. Private Duty Nursing Services

Medically necessary private duty nursing (PDN) services for up to two thousand (2,000) hours are provided under the direction of the recipient's physician in accordance with 42 CFR 440.80 and with prior approval by the Department for Medicaid Services, or its designee. These limits may be exceeded based on medical necessity with prior authorization.

Recipients in personal care homes are not eligible for this service. In addition, recipients in hospitals, nursing facilities, intermediate care facilities for the intellectually disabled, rehabilitation centers, and other institutional settings are not eligible for this service. PDN services are not covered while an individual is being observed or treated in a hospital emergency room or similar environment.

This service is only approvable based on the need for PDN services in the patient's private residence. An individual with a medical condition that necessitates this service normally is unable to leave the home without being accompanied by a licensed nurse and leaving the home requires considerable and taxing effort. An individual may utilize the approved hours of coverage outside of his/her residence during those hours when the individual's normal life activities take the patient out of the home. The need for nursing care to participate in activities outside of the home is not a basis for authorizing PDN services or expanding the hours needed for PDN services.

Medicaid will not reimburse for Personal Care Services, Skilled Nursing Visits, or Home Health Aide Services provided during the same hours of the day as PDN services.

Medicaid Payments for PDN are made only to agencies enrolled with the Department for Medicaid Services as providers for the service. An enrolled provider must be a State licensed home health or private duty nursing agency within Kentucky that is approved in its license to provide nursing services within the State. PDN services shall be rendered by a licensed registered nurse (RN) or licensed practical nurse (LPN) who is licensed by the Kentucky Board of Nursing and employed by a licensed home care agency.

A member of the patient's immediate family (spouse, child, parent, grandparent, grandchild, or sibling, including corresponding step and in-law relationship) or a legally responsible person who maintains their primary residence with the recipient may not be employed by the provider agency to provide PDN services reimbursed by Medicaid.

9. Clinic Services

Coverage for clinic services is limited to services provided by the following clinics and includes:

1. Mental health centers licensed in accordance with applicable state laws and regulations. However, services rendered by community mental health centers to skilled nursing or intermediate care facility patients/residents are not covered.
2. Family planning clinics.
3. Clinics engaging in screening for the purposes of the early and periodic screening, diagnosis, and treatment component of the Medicaid Program.
4. Out-patient surgical clinics.
5. Other clinics authorized under 42 CFR 440.90.

5a. Abortion services are reimbursable under the Medical Assistance Program only when service to provide an abortion or induce miscarriage is, in the opinion of the physician, necessary for the preservation of the life of the woman seeking such treatment or to comply with federal court order in the case of *Hope vs. Childers*. Any request for program payment for an abortion or induced miscarriage must be justified by a signed physician certification documenting that in the physician's opinion the appropriate circumstances, as outlined in sentence one of this paragraph, existed. A copy of the completed certification form and an operative report shall accompany each claim submitted for payment. However, when medical services not routinely related to the uncovered abortion service are required, the utilization of an uncovered abortion service shall not preclude the recipient from receipt of medical services normally available through the Medical Assistance Program.

5b. Specialized Children's Services Clinics

Specialized Children's Services Clinics provide a comprehensive interdisciplinary evaluation, assessment, and treatment of sexually and physically abused children under the age of 18. A team of professionals representing a variety of medical, social, and legal disciplines and advocates assesses the child and coordinates and/or provides needed services. Sexual abuse examinations are available to children from 18 to 20 years of age through Medicaid providers who deliver and bill for the separate components of the service (physical examination and mental health screening) through the physician and mental health components of the state plan.

Medicaid coverage of services provided by clinics is limited to a sexual abuse medical exam which includes the following components:

1. A physical exam provided by a licensed physician who has received specialized training in providing medical exams of sexually abused children and the use of a colposcope; and
2. A mental health screening provided by a mental health professional under the direct supervision of a physician. Mental health professionals shall include, but not be limited to the following: social workers, psychologists, art therapists, ARNPs and other qualified therapists who are required to have specialized training in the screening and assessment of sexually abused children. Under direct supervision means the physician shall assume professional responsibility for the service provided by the mental health professional.

Providers of clinic services are employed by, under contract, or have a signed affiliation agreement with the clinic.

Reimbursement methodology is described in Attachment 4.19-B, Section XXXII.

13. Dental Services

- A. A listing of dental services available to recipients age 21 and over is maintained at the central office of the single state agency.
- B. Out-of-Hospital Dental Services
A listing of dental services available to Medicaid recipients is maintained at the central office of the single state agency.
- C. In-Hospital Care
A listing of dental services available to Medicaid recipients is maintained at the central office of the single state agency.
- D. Oral Surgery
A listing of oral surgery dental services available to Medicaid recipients is maintained at the central office the single state agency.

11. Physical Therapy and Related Services – Other than Therapy Services Provided by Home Health Agencies for Rehabilitative and Habilitative Services

A. Outpatient Physical, Occupational and Speech Therapy

Physical therapy, occupational therapy, speech pathology services, or speech/hearing/language therapy services provided must be ordered by a physician, physician assistant or advanced registered nurse practitioner, be prior authorized, provided in accordance with an approved plan of treatment, which shall be developed by the appropriate qualified therapist and physician.

Audiology services are not provided under this component. Physical therapy, occupational therapy, speech pathology, or speech/hearing/language therapy services provided by a medical rehabilitation facility are not provided under this component.

Qualification of Providers

Providers performing physical, occupational or speech therapy must meet requirements defined in 42 C.F.R. 484.4. A qualified physical therapist assistant, occupational therapist assistant or speech therapy assistant must be under the direct supervision of a qualified physical, occupational or speech therapist.

B. Inpatient Physical, Occupational and Speech Therapy

Services shall be provided to inpatients of acute participating hospitals and skilled nursing facilities or to residents of intermediate care facilities for individuals with mental retardation or developmental disabilities under the following conditions:

Physical therapy, occupational therapy, speech pathology services, or speech/hearing/language therapy services provided must be ordered by a physician, physician assistant or advanced registered nurse practitioner, be prior authorized, provided in accordance with an approved plan of treatment, which shall be developed by the appropriate qualified therapist and physician.

Qualification of Providers

Providers performing physical, occupational or speech therapy must meet requirements defined in 42 C.F.R. 484.4. A qualified physical therapist assistant, occupational therapist assistant or speech therapy assistant must be under the direct supervision of a qualified physical, occupational or speech therapist.

11. Physical Therapy and Related Services – Other than Therapy Services Provided by Home Health Agencies for Rehabilitative and Habilitative Services

C. Limitations

There is a limit of twenty (20) visits per calendar year combined for inpatient and outpatient physical therapy.

There is a limit of twenty (20) visits per calendar year combined for inpatient and outpatient occupational therapy

There is a limit of twenty (20) visits per calendar year combined for inpatient and outpatient speech therapy.

Rehabilitative and habilitative services have a combined twenty visit limit per type of therapy. If medical necessity requires additional visits, the provider must request additional visits via prior authorization guidelines in effect for recipient.

12. Prescribed Drugs, Dentures, Prosthetic Devices, and Eyeglasses

If medical necessity is established, limitations in this section do not apply to EPSDT eligible children in accordance with 1905 (r)(5) of the Social Security Act.

a. Prescribed Drugs

- (1) Coverage is provided for drugs included in the Medicaid drug lists that are prescribed for outpatient use by a physician, osteopath, dentist, podiatrist, optometrist, physician assistant, or advanced registered nurse practitioner. Drugs added to the Preferred Drug List (PDL) are based on recommendations submitted by the Pharmacy and Therapeutics Advisory Committee to the Commissioner of the Kentucky Department for Medicaid Services for approval. Drugs requiring prior authorization must follow the process listed below. Approval of prior authorization is based on FDA-approved indications or a medically accepted indication documented in official compendia or peer-reviewed medical literature.
- (2) Kentucky will provide reimbursement for covered outpatient drugs when prescribed by an enrolled licensed provider within the scope of their license and practice as allowed by State law and in accordance with Section 1927 of the Social Security Act. This will apply to drugs of any manufacturer that has entered into a rebate agreement with the Centers for Medicare and Medicaid Services (CMS). All drugs covered by the National Drug Rebate Agreements remain available to Medicaid beneficiaries, although some may require prior authorization. The prior authorization process complies with the requirements of Section 1927 of the Social Security Act and provides for a 24-hour turnaround by either telephone or other telecommunications device from receipt of request and provides for a 72- hour supply of drugs in emergency circumstances. The preferred drug list meets the formulary requirements that are specified in Section 1 927(d)(4) of the Social Security Act.
- (3) The drugs or classes of drugs listed in 42 USC 1396r-8(d)(2) are excluded from coverage unless specifically placed, either individually or by drug class, on the Medicaid drug lists or prior authorized based on FDA-approved indications or a medically accepted indication documented in official compendia or peer-reviewed medical literature. The following drugs are excluded from coverage through the Outpatient Pharmacy Program:
 - (a) A drug for which the FDA has issued a "less than effective (LTE)" rating or a drug "identical, related, or similar (IRS)" to an LTE drug;
 - (b) A drug that has reached the termination date established by the drug manufacturer;
 - (c) A drug for which the drug manufacturer has not entered into or has not complied with a rebate agreement in accordance with 42 USC 1396r-8(a) unless there has been a review and determination by the department that it shall be in the best interest of Medicaid recipients for the department to make payment for the non-rebated drug. Note: Because federal financial participation is not generally available for a non-rebated drug, state funds will be used to cover such drugs if necessary to protect the health of a Medicaid recipient and no other appropriate options exist;

- (d) A drug provided to a recipient in an institution in which drugs are considered a part of the reasonable allowable costs under the Kentucky Medicaid Program;
 - (e) A drug or its medical use in one (1) of the following categories unless the drug or its medical use is designated as covered in the drug list:
 - 1. A drug if used for anorexia, weight loss, or weight gain;
 - 2. A drug if used to promote fertility;
 - 3. A drug if used for cosmetic purposes or hair growth;
 - 4. A drug if used for the symptomatic relief of cough and colds;
 - 5. Vitamin or mineral products other than prenatal vitamins and fluoride preparations;
 - 6. An over-the-counter drug provided to a Medicaid nursing facility service recipient if included in the nursing facility's standard price;
 - 7. A drug which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee; or
 - 8. A drug utilized for erectile dysfunction therapy unless the drug is used to treat a condition, other than sexual or erectile dysfunction, for which the drug has been approved by the United States Food and Drug Administration;
 - (f) A drug dispensed as part of, or incident to and in the same setting as, an inpatient hospital service, an outpatient hospital service, or an ambulatory surgical center service. However, a legend drug may be provided through prior authorization to a recipient admitted to an inpatient facility that does not bill patients, Medicaid, or other third-party payers for health care services.
 - (g) A drug for which the department requires prior authorization if prior authorization has not been approved; and
- (4) Except for emergencies, a recipient "locked-in" to one pharmacy due to over-utilization may receive prescriptions:
- (a) Only from his/her designated lock-in pharmacy and prescribed by his/her lock-in provider; or
 - (b) For specified controlled substances prescribed by his/her designated controlled substance lock-in prescriber.
- (5) If authorized by the prescriber, a prescription for a controlled substance in Schedule III-V may be refilled up to five times within a six month period from the date the prescription was written or ordered; a non-controlled substance may be refilled up to 11 times within a 12 month period from the date the prescription was written or ordered. In addition, a prescription fill for a maintenance drug may be dispensed in a 92-day supply if a recipient has demonstrated stability on the maintenance drug. However, a 92-day supply of a maintenance drug shall not be dispensed if a prescribing provider specifies that the quantity should be less. Also, individuals receiving supports for community living services, long term care, and personal care shall not be subject to the 92-day supply requirement.

- (6) A refill of a prescription shall not be covered unless at least 90 percent of the prescription time period has elapsed. However, a refill may be covered before 90 percent of the prescription time period has elapsed if the prescribing provider or dispensing pharmacy submits a prior authorization request by phone, fax, or web submission. Medicaid recipients residing in a long-term care facility or personal care home will be exempt from the 90 percent requirement and remain at the current 80 percent.

(7) Supplemental Rebate Program:

The state is in compliance with Section 1927 of the Social Security Act. The state has the following policies for the Supplemental Rebate Program for the Medicaid population:

- (a) CMS has authorized the Commonwealth of Kentucky to enter into the Michigan multi-state pooling agreement (MMSPA) also referred to as the National Medicaid Pooling Initiative (NMPI) for drugs provided to Medicaid beneficiaries. The NMPI Supplemental Rebate Agreement (SRA) and the Amendment to the SRA submitted to CMS on January 6, 2005 have been authorized for pharmaceutical manufacturers' existing agreements through their current expiration dates. The updated NMPI SRA (submitted to CMS on December 10, 2013) has been authorized for renewal and new agreements with pharmaceutical manufacturers for drugs provided to Medicaid beneficiaries.
- (b) CMS has authorized Kentucky's collection of supplemental rebates through the NMPI.
- (c) Supplemental rebates received by the State in excess of those required under the national drug rebate agreement will be shared with the Federal Government on the same percentage basis as applied under the national drug rebate agreement.
- (d) All drugs covered by the program, irrespective of a supplemental rebate agreement, will comply with the provision of the national drug rebate agreement.
- (e) Any contracts not authorized by CMS will be submitted for CMS approval in the future.
- (f) As specified in Section 1927(b)(3)(D) of the Act, notwithstanding any other provisions of law, rebate information disclosed by a manufacturer shall not be disclosed by the state for purposes other than rebate invoicing and verification.

Commonwealth Global Choices

B. Dentures

Dentures are not covered for adults. Dentures may be covered for children through the Early, Periodic, Screening, Diagnosis and Treatment Program (EPSDT).

C. Prosthetics

Prosthetic devices are covered under durable medical equipment in accordance with Attachment 3.1-A, page 13.

D. Eyeglasses The following limitations are applicable:

- (1) Eyeglasses are provided only to recipients under age twenty-one (21). Coverage for eyeglasses is limited to no more than \$200 per year per member.
- (2) Contact lenses are not covered.
- (3) Telephone contacts are not covered.
- (4) Safety glasses are covered when medically necessary subject to prior authorization requirements described in material on file in the slate agency.
- (5) If medically necessary, prisms shall be added within the cost of the lenses.

If medical necessity is established, these limitations do not apply to EPSDT eligible children in accordance with 1905 (r)(5) of the Social Security Act.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

Diagnostic, screening, preventive, and rehabilitative services are covered when provided by qualified providers, licensed in accordance with applicable state laws and regulations. Reimbursement for services under this authority will not be made when delivered in a long-term care environment as such services are reimbursable as a routine cost to the institution.

13a. Diagnostic Services

Diagnostic Services are described under other sections of this State Plan.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13b. Screening Services

Screening Services are described under other sections of this State Plan.

13. Other diagnostic, screening, preventive and, rehabilitative services, ie. other than those provided elsewhere in this plan.

13c. Preventive Services

- A. Eligible preventive services include all of the preventive services assigned a grade of A or B by the United States Preventive Services Task Force (USPSTF), and all approved adult vaccines and their administration, recommended by the Advisory Committee on Immunization Practices (ACIP). Such services are provided in accordance with Section 4106 of the Affordable Care Act. The state has documentation available to support the claim of the enhanced FMAP for preventive services beginning January 1, 2014. The state assures that it has a method to ensure that, as changes are made to USPSTF or ACIP recommendations, the state will update their coverage and billing codes to comply with those revisions.

In conjunction with the above and in compliance with Section 2713 of the Public Health Service Act, eligible preventive services also include preventive care and screening for infants, children and adults recommended by HRSA's Bright Futures program project, and additional preventive services for women recommended by the Institute of Medicine.

No cost sharing shall be applied to preventive services.

- B. Covered services shall be provided by a:

1. Physician;
2. Physician Assistant;
3. Advanced Registered Nurse Practitioner; or
4. Registered Nurse. A "registered nurse" is defined by state law as a person who is licensed in accordance with state law to engage in registered nursing practice. State law defines "registered nursing practice" as the performance of acts requiring substantial specialized knowledge, judgment, and nursing skill based upon the principles of psychological, biological, physical, and social sciences in the application of the nursing process in:
 - a The care, counsel, and health teaching of the ill, injured, or infirm;
 - b The maintenance of health or prevention of illness of others;
 - c The administration of medication and treatment as prescribed by a physician, physician assistant, dentist, or advanced registered nurse practitioner and as further authorized or limited by the Kentucky Board of Nursing, and which are consistent either with American Nurses' Association Standards of Practice or with Standards of Practice established by nationally accepted organizations of registered nurses. Components of medication administration include but are not limited to:
 - i Preparing and giving medications in the prescribed dosage, route, and frequency, including dispensing medications;
 - ii Observing, recording, and reporting desired effects, untoward reactions, and side effects of drug therapy;
 - iii Intervening when emergency care is required as a result of drug therapy;
 - iv Recognizing accepted prescribing limits and reporting deviations to the prescribing individual;

13. Other diagnostic, screening, preventive and, rehabilitative services, ie. other than those provided elsewhere in this plan.

13c. Preventive Services (cont.)

- v Recognizing drug incompatibilities and reporting interactions or potential interactions to the prescribing individual; and
- vi Instructing an individual regarding medications;
- d The supervision, teaching of, and delegation to other personnel in the performance of activities relating to nursing care; and
- e The performance of other nursing acts which are authorized or limited by the Kentucky Board of Nursing, and which are consistent either with American Nurses' Association Standards of Practice or with Standards of Practice established by nationally accepted organizations of registered nurses.

C. Covered services include:

1. Early and Periodic screening, diagnosis, and treatment (EPSDT):

EPSDT services are described in Attachment 3.1-A, pages 7.1.2 – 7.1.4, 7.1.7, 7.1.8, and Attachment 3.1-B, pages 16-18, 20.1, and 20.2.

2. Pediatric services:

Services include the following:

- a Diagnostic and nursing evaluation and management services;
- b Provision of all childhood immunizations as described by page 9a of this plan included in the Vaccines for Children program. Provision of other immunizations to children as recommended by the CDC;
- c Medications and other treatment procedures; and
- d Follow-up nursing care.

3. Prenatal and related services:

Services provided or arranged in accordance with the standards developed for the prenatal program include the following:

- a Pregnancy testing/confirmation;
- b Contact visit counseling;
- c Initial examination;
- d Subsequent monitoring visits;
- e Laboratory tests, as necessary;
- f Individual counseling;
- g Hands voluntary home visitation program;
- h Initial infant assessment;
- i Postpartum visit; and
- j Family planning visit.

13. Other diagnostic, screening, preventive and, rehabilitative services, ie. other than those provided elsewhere in this plan.

13c. Preventive Services (cont.)

4 Communicable disease services:

Communicable disease services include:

- a Diagnostic evaluation and management services;
- b Laboratory tests, as necessary;
- c Medications and other treatment procedures;
- d Individual counseling; and
- e Adult immunizations as recommended by the CDC.

5 Chronic disease services:

Services are provided for the following:

- a Diabetes;
- b Heart disease and stroke program;
- c Women's Cancer Screening program;
- d Substance abuse prevention program;
- e Tobacco prevention and cessation;
- f Obesity;
- g Arthritis/osteoarthritis;
- h Depression;
- i Oncology;
- j Hemophilia;
- k Sickle Cell;
- l Organ transplants; and
- m Rare disease.

6 Family planning services:

Family planning services are described in Attachment 3.1-A, page 7.1.9 and Attachment 3.1-B, page 20.3.

Services include the following:

- a Complete medical history;
- b Physical examination;
- c Laboratory and clinical test supplies; and
- d Counseling and prescribed birth control methods to best suit the patient's needs.

Services provided within these categories are those defined by procedure code under the Medicare Physician Fee Schedule.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

Rehabilitative substance use and mental health services are medical or remedial services that have been recommended by a physician or other licensed practitioner of the healing arts within the scope of his practice, under Kentucky State Law and consistent with federal regulations at 42 CFR 440.130(d).

Each medical professional is given the choice of whether or not to participate in the Kentucky Medicaid Program. From those professionals who have chosen to participate, the recipient may choose the one from whom he wishes to receive his medical care.

When the Department makes payment for a covered service and the provider accepts the payment made by the Department in accordance with the Department's fee structure, the amounts paid shall be considered payment in full except any applicable co-payment; and no bill for the same service shall be sent to the recipient for any amount above the Medicaid allowed charges (with the exception of any applicable co-payments). The provider may bill the recipient for services not covered by Kentucky Medicaid; however, the provider must make the recipient aware of the non-covered services prior to rendering those services.

Providers of medical service attest by their signatures that the presented claims are valid and in good faith. Fraudulent claims are punishable by fine and /or imprisonment.

Diagnoses shall be recorded in the health record within three visits, in order to receive Medicaid payment. The exception is for crisis services.

A billable unit of service is the actual time spent face-to-face delivering an actual service. Time spent in traveling to and from an off-site visit shall not be billed.

1. Limitations on Amount, Duration or Scope of Services

Unless a diagnosis is made and documented in the medical record within three visits, the service will not be covered. The exception is for crisis services. An appropriate mental health or substance use disorder diagnosis is required for coverage, with the exception for crisis services.

Some rehabilitative services are furnished with limitations on amount, duration, or scope of service. The limitations of these services are indicated in the service description. If there is no limitation noted within the description of the service, there are no limits on the amount, duration or scope of the service. All services, including those without specific limitations, with the exception of crisis services, must meet medical necessity and must be provided in accordance with a documented diagnosis and plan of treatment.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

1. Limitations on Amount, Duration or Scope of Services (continued)

The following services will NOT be covered by Medicaid:

- (a) Services provided to residents of nursing facilities
- (b) Services provided to inmates of local, state or federal jails, detention centers or prisons
- (c) Services to those with developmental and intellectual disabilities, without documentation of an additional psychiatric diagnosis
- (d) Psychiatric or psychological testing for other agencies such as courts or schools, which does not result in the client receiving psychiatric intervention or therapy from the independent provider. If the testing results in behavioral health treatment, then the testing was medically necessary and would be covered. School services included in a child's Individual Education Plan (IEP) may be coverable under the Medicaid School-Based Services Program.
- (e) Consultation or educational services provided to Medicaid recipients or others
- (f) Collateral therapy for ages 21 and over
- (j) Consultation or third party contracts shall be outside the scope of covered benefits. Covered services require direct patient contact except collateral services for children under age twenty-one (21), when a part of the plan of care.
- (k) Telephone calls, emails, texts or other electronic contacts
- (l) Travel time
- (m) Field trips, recreational, social, and physical exercise activity groups

2. Eligible Recipients

Unless otherwise indicated within the description of each service, services for the treatment of substance use and/or mental health are available to all Medicaid beneficiaries who meet the medical necessity criteria for these services. Except where indicated, all services will apply to both children and adults.

3. Categories of Providers

Kentucky defines the following categories of providers:

- (a) Individual Practitioner: An individual practitioner who is licensed by the respective board in the Commonwealth of Kentucky or who is supervised by a licensed practitioner to render health services and/or bill Kentucky Medicaid.
- (b) Provider group: A group of more than one individually licensed practitioner who forms a business entity to render health services and bill Kentucky Medicaid.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

3. Categories of Providers (continued)

- (c) Licensed organization: A business entity that employs licensed and non-licensed health professionals and is licensed to render health services and bill Kentucky Medicaid. This organization must also meet the following criteria:
- a. Be enrolled as a Medicaid provider in the Commonwealth of Kentucky;
 - b. Demonstrate experience serving the population of individuals with behavioral health disorders relevant to the particular services provided;
 - c. Have the administrative capacity to provide quality of services in accordance with state and federal requirements;
 - d. Use a financial management system that provides documentation of services and costs;
 - e. Demonstrate capacity to document and maintain individual case records in accordance with state and federal requirements.

4. Covered Services

Unless indicated within the description of services, all services listed below are eligible services for the treatment of both substance use, mental illness, and co-occurring conditions.

The following services, as defined by the Kentucky Department for Medicaid Services, are considered Medicaid rehabilitative mental health and substance use services:

- (a) Screening
- (b) Assessment
- (c) Psychological Testing
- (d) Crisis Intervention
- (e) Mobile crisis
- (f) Residential Crisis Stabilization
- (g) Day Treatment
- (h) Peer Support
- (i) Parent/Family Peer Support
- (j) Intensive Outpatient Program (IOP)
- (k) Individual Outpatient Therapy
- (l) Group Outpatient Therapy
- (m) Family Outpatient Therapy
- (n) Collateral Outpatient Therapy
- (o) Partial Hospitalization
- (p) Service Planning
- (q) Residential Services for Substance Use Disorders (Substance use only)

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

4. Covered Services (continued)

- (r) SBIRT – Screening, Brief Intervention and Referral to Treatment (Substance use only)
- (s) Medication Assisted Treatment (Substance use only)
- (t) Assertive Community Treatment (Mental health only)
- (u) Comprehensive Community Support Services (Mental health only)
- (v) Therapeutic Rehabilitation Program (TRP) (Mental health only)

(a) Screening

Screening shall be the determination of the likelihood that a person has a mental health, substance use, or co-occurring disorder. The purpose is not to establish the presence or specific type of such a disorder but to establish the need for an in-depth assessment.

Authorized Providers:

Rendering Practitioners practicing as an individual practitioner, a provider group, or as part of a licensed organization

- Licensed Psychologist (LP)
- Licensed Psychological Associate (LPA) working under the supervision of a LP*
- Licensed Psychological Practitioner (LPP)
- Licensed Clinical Social Worker (LCSW)
- Certified Social Worker, Master Level (CSW) working under the supervision of a LCSW*
- Licensed Professional Clinical Counselor (LPCC)
- Licensed Professional Counselor Associate (LPCA) working under the supervision of a LPCC*
- Licensed Marriage and Family Therapist (LMFT) Marriage and Family Therapist Associate (MFTA) working under the supervision of a LMFT*
- Physician
- Psychiatrist
- Advanced Practice Registered Nurse (APRN)
- Physician Assistant (PA) working under the supervision of a Physician*

* Billed through supervisor

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

4. Covered Services (continued)

(a) Screenings (continued)

Billing Providers

- Individual Practitioners
 - LP
 - LPP
 - LCSW
 - LPCC
 - LMFT
 - Physician
 - Psychiatrist
 - APRN
- Provider Groups
 - LP
 - LPP
 - LCSW
 - LPCC
 - LMFT
 - Physician
 - Psychiatrist
 - APRN
- Licensed Organizations

(b) Assessment

Assessment shall include gathering information and engaging in a process with the client that enables the provider to establish the presence or absence of a mental health and/or substance use disorder, determine the client's readiness for change, identify client strengths or problem areas that may affect the processes of treatment and recovery, and engage the client in the development of an appropriate treatment relationship. The purpose of an assessment is to establish (or rule out) the existence of a clinical disorder or service need and to work with the client to develop a treatment and service plan. This does not include psychological or psychiatric evaluations or assessments.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

4. Covered Services (continued)

(b) Assessment (continued)

Authorized Providers:

Rendering Practitioners practicing as an individual practitioner, a provider group, or as part of a licensed organization

- Licensed Psychologist (LP)
- Licensed Psychological Associate (LPA) working under the supervision of a LP*
- Licensed Psychological Practitioner (LPP)
- Licensed Clinical Social Worker (LCSW)
- Certified Social Worker, Master Level (CSW) working under the supervision of a LCSW*
- Licensed Professional Clinical Counselor (LPCC)
- Licensed Professional Counselor Associate (LPCA) working under the supervision of a LPCC*
- Licensed Marriage and Family Therapist (LMFT)
- Marriage and Family Therapist Associate (MFTA) working under the supervision of a LMFT*
- Physician
- Psychiatrist
- Advanced Practice Registered Nurse (APRN)
- Physician Assistant (PA) working under the supervision of a Physician

* Billed through supervisor

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

4. Covered Services (continued)

(b) Assessment (continued)

Billing Providers

- Individual Practitioners
 - LP
 - LPP
 - LCSW
 - LPCC
 - LMFT
 - Physician
 - Psychiatrist
 - APRN
- Provider Groups
 - LP
 - LPP
 - LCSW
 - LPCC
 - LMFT
 - Physician
 - Psychiatrist
 - APRN
- Licensed Organizations

(c) Psychological Testing

Psychological testing for individuals with mental health, substance use, or co-occurring mental health and substance use disorders may include psychodiagnostic assessment of personality, psychopathology, emotionality, and/or intellectual abilities. Also includes interpretation and written report of testing results.

Authorized Providers:

Rendering Practitioners practicing as an individual practitioner, a provider group, or as part of a licensed organization

- Licensed Psychologist (LP)
- Licensed Psychological Associate (LPA) working under the supervision of a LP*
- Licensed Psychological Practitioner (LPP)

* Billed through supervisor

TN No. New

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

4. Covered Services (continued)

(c) Psychological Testing (continued)

Billing Providers

- Individual Practitioners
 - LP
 - LPP
- Provider Groups
 - LP
 - LPP
- Licensed Organizations

(d) Crisis Intervention

Crisis Intervention shall be a therapeutic intervention provided for the purpose of immediately reducing or eliminating risk of physical or emotional harm to the client, or others. This service shall be provided as an immediate relief to the presenting problem or threat. It must be followed by non-crisis service referral as appropriate. It must be provided in a face-to-face, one-on-one encounter between the provider and the client.

Crisis intervention may include further service prevention planning such as lethal means reduction for suicide risk and substance use relapse prevention.

Authorized Providers:

Rendering Practitioners practicing as an individual practitioner, a provider group, or as part of a licensed organization

- Licensed Psychologist (LP)
- Licensed Psychological Associate (LPA) working under the supervision of a LP*
- Licensed Psychological Practitioner (LPP)
- Licensed Clinical Social Worker (LCSW)
- Certified Social Worker, Master Level (CSW) working under the supervision of a LCSW*
- Licensed Professional Clinical Counselor (LPCC)
- Licensed Professional Counselor Associate (LPCA) working under the supervision of a LPCC*
- Licensed Marriage and Family Therapist (LMFT)

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

4. Covered Services (continued)

(d) Crisis Intervention (continued)

- Marriage and Family Therapist Associate (MFTA) working under the supervision of a LMFT*Physician
- Psychiatrist
- Advanced Practice Registered Nurse (APRN)
- Physician Assistant (PA) working under the supervision of a Physician*
- Peer Support Specialist working under the supervision of a physician, a psychiatrist, a LP, a LPP, a LPA working under the supervision of a LP, a LCSW, a CSW with three (3) years of inpatient or outpatient clinical experience in psychiatric social work and currently employed by a hospital or forensic psychiatric facility licensed by the Commonwealth or a psychiatric unit of a general hospital or a private agency or company engaged in the provision of mental health services or a regional community mental health center; a LMFT with three (3) years of inpatient or outpatient clinical experience in psychiatric mental health practice and currently employed by a hospital or forensic facility licensed by the Commonwealth, a psychiatric unit of a general hospital, a private agency or company engaged in providing mental health services, or a regional community mental health center*

* Billed through supervisor

Billing Providers

- Individual Practitioners
 - LP
 - LPP
 - LCSW
 - LPCC
 - LMFT
 - Physician
 - Psychiatrist
 - APRN

TN No. New

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

4. Covered Services (continued)

(d) Crisis Intervention (continued)

- Provider Groups
 - LP
 - LPP
 - LCSW
 - LPCC
 - LMFT
 - Physician
 - Psychiatrist
 - APRN
- Licensed Organizations

(e) Mobile Crisis

Mobile Crisis provides the same services as crisis intervention, except the location for the service is not in the office. Services are available 24 hours a day, seven (7) days a week, 365 days a year. This service is provided in duration of less than 24 hours and is not an overnight service. This service provides crisis response in home or community to provide an immediate evaluation, triage and access to acute behavioral health services including treatment and supports to effect symptom reduction, harm reduction or to safely transition persons in acute crises to appropriate least restrictive level of care.

Authorized Providers

The Mobile Crisis practitioners must be employed by a licensed organization that meets the criteria of a licensed organization and the following additional criteria:

- Capacity to employ required practitioners and coordinate service provision among the rendering practitioners
- Capacity to provide the full range of mobile crisis services on a 24/7/365 basis
- Access to a board-certified or board-eligible psychiatrist on a 24/7/365 basis

13. Other diagnostic, screening, preventive and, rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

4. Covered Services (continued)

(e) Mobile Crisis (continued)

Rendering Practitioners practicing as part of a licensed organization

- Licensed Psychologist (LP)
- Licensed Psychological Associate (LPA) working under the supervision of a LP
- Licensed Psychological Practitioner (LPP)
- Licensed Clinical Social Worker (LCSW)
- Certified Social Worker, Master Level (CSW) working under the supervision of a LCSW
- Licensed Professional Clinical Counselor (LPCC)
- Licensed Professional Counselor Associate (LPCA) working under the supervision of a LPCC
- Licensed Marriage and Family Therapist (LMFT)
- Marriage and Family Therapist Associate (MFTA) working under the supervision of a LMFT
- Physician
- Psychiatrist
- Advanced Practice Registered Nurse (APRN)
- Physician Assistant (PA) working under the supervision of a Physician
- Peer Support Specialist working under the supervision of a physician, a psychiatrist, a LP, a LPP, a LPA working under the supervision of a LP, a LCSW, a CSW with three (3) years of inpatient or outpatient clinical experience in psychiatric social work and currently employed by a hospital or forensic psychiatric facility licensed by the Commonwealth or a psychiatric unit of a general hospital or a private agency or company engaged in the provision of mental health services or a regional community mental health center; a LMFT with three (3) years of inpatient or outpatient clinical experience in psychiatric mental health practice and currently employed by a hospital or forensic facility licensed by the Commonwealth, a psychiatric unit of a general hospital, a private agency or company engaged in providing mental health services, or a regional community mental health center*

Billing Providers

- Licensed Organizations

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

4. Covered Services (continued)

(f) Residential Crisis Stabilization

Residential Crisis Stabilization services are provided in Crisis Stabilization Units. Crisis Stabilization Units are community-based, residential programs that offer an array of services including screening, assessment, treatment planning, individual, group, and family therapy, and peer support in order to stabilize a crisis and divert the individual from a higher level of care. It is not part of a hospital. They are used when individuals in a behavioral health emergency cannot be safely accommodated within the community, are not in need of hospitalization but need overnight care. The purpose is to stabilize the individual, provide treatment for acute withdrawal, when appropriate, and re-integrate them back into the community, or other appropriate treatment setting, in a timely fashion. These units provide a non-hospital residential setting and services 24-hours per day, seven days per week, 365 days a year. The estimated length of stay for children is three to five days. The estimated length of stay for adults is seven to 10 days. The component services of crisis stabilization units are screening, assessment, service planning, psychiatric services, individual therapy, family therapy, group therapy, and peer support.

Residential crisis stabilization does not include, and FFP is not available for, room and board services; educational, vocational and job training services; habilitation services; services to inmates in public institutions as defined in 42 CFR §435.1010; services to individuals residing in institutions for mental diseases as described in 42 CFR§435.1010; recreational and social activities; and services that must be covered elsewhere in the state Medicaid plan.

KY Medicaid will not pay for this service in a unit of more than 16 beds or multiple units operating as one unified facility with more than 16 aggregated beds.

Authorized Providers

The Residential Crisis Stabilization providers must be employed by a licensed organization that meets the criteria of a licensed organization and the following additional criteria:

- Capacity to employ practitioners and coordinate service provision among rendering providers
- Capacity to provide the full range of services included in the Residential Crisis Stabilization service definition
- Ability to provide Residential Crisis Stabilization services on a 24/7/365 basis
- Access to a board-certified or board-eligible psychiatrist on a 24/7/365 basis

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

4. Covered Services (continued)

(f) Residential Crisis Stabilization (continued)

Rendering Practitioners practicing as part of a licensed organization

- Licensed Psychologist (LP)
- Licensed Psychological Associate (LPA) working under the supervision of a LP
- Licensed Psychological Practitioner (LPP)
- Licensed Clinical Social Worker (LCSW)
- Certified Social Worker, Master Level (CSW) working under the supervision of a LCSW
- Licensed Professional Clinical Counselor (LPCC)
- Licensed Professional Counselor Associate (LPCA) working under the supervision of a LPCC
- Licensed Marriage and Family Therapist (LMFT)
- Marriage and Family Therapist Associate (MFTA) working under the supervision of a LMFT
- Physician
- Psychiatrist
- Advanced Practice Registered Nurse (APRN)
- Physician Assistant (PA) working under the supervision of a Physician
- Peer Support Specialist working under the supervision of a physician, a psychiatrist, a LP, a LPP, a LPA working under the supervision of a LP, a LCSW, a CSW with three (3) years of inpatient or outpatient clinical experience in psychiatric social work and currently employed by a hospital or forensic psychiatric facility licensed by the Commonwealth or a psychiatric unit of a general hospital or a private agency or company engaged in the provision of mental health services or a regional community mental health center; a LMFT with three (3) years of inpatient or outpatient clinical experience in psychiatric mental health practice and currently employed by a hospital or forensic facility licensed by the Commonwealth, a psychiatric unit of a general hospital, a private agency or company engaged in providing mental health services, or a regional community mental health center

Billing Providers

- Licensed Organizations

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

4. Covered Services (continued)

(g) Day Treatment

Day Treatment is a non-residential, intensive treatment program designed for children/youth under the age of 21 who have an emotional disability, neurobiological and/or substance use disorders and who are at high risk of out-of-home placement due to behavioral health issues. Intensive coordination/linkage with schools and or other child serving agencies is included.

Intensive coordination is needed in order to successfully transition youth recipients to a lower level of care. See below for basic components of the required linkage agreement between the provider and the local education authority that specifies the responsibility of the authority and the provider for:

- Appropriately licensed teachers and provisions for their professional development;
- Educational supports including classroom aides and textbooks;
- Educational facilities;
- Physical education and recreational therapies;
- Transportation; and
- Transition planning.

Day treatment services do not include services covered in a child's Individualized Education Plan (IEP).

Day treatment services shall be provided:

- In collaboration with the education services of the Local Education Authority (LEA) including those provided through IDEA and/or Section 504;
- On school days and during scheduled breaks;
- In coordination with the recipient's individual educational plan, if the recipient has an individual educational plan;
- With a linkage agreement to other behavioral health services with the LEA that specifies the responsibilities of the LEA and the day treatment provider.

Authorized Providers

Rendering Practitioners practicing as an individual practitioner, a provider group, or as part of a licensed organization

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

4. Covered Services (continued)

(g) Day Treatment (continued)

- Licensed Psychologist (LP)
- Licensed Psychological Associate (LPA) working under the supervision of a LP
- Licensed Psychological Practitioner (LPP)
- Licensed Clinical Social Worker (LCSW)
- Certified Social Worker, Master Level (CSW) working under the supervision of a LCSW
- Licensed Professional Clinical Counselor (LPCC)
- Licensed Professional Counselor Associate (LPCA) working under the supervision of a LPCC
- Licensed Marriage and Family Therapist (LMFT)
- Marriage and Family Therapist Associate (MFTA) working under the supervision of a LMFT
- Physician
- Psychiatrist
- Advanced Practice Registered Nurse (APRN)
- Physician Assistant (PA) working under the supervision of a Physician
- Peer Support Specialist working under the supervision of a physician, a psychiatrist, a LP, a LPP, a LPA working under the supervision of a LP, a LCSW, a CSW with three (3) years of inpatient or outpatient clinical experience in psychiatric social work and currently employed by a hospital or forensic psychiatric facility licensed by the Commonwealth or a psychiatric unit of a general hospital or a private agency or company engaged in the provision of mental health services or a regional community mental health center; a LMFT with three (3) years of inpatient or outpatient clinical experience in psychiatric mental health practice and currently employed by a hospital or forensic facility licensed by the Commonwealth, a psychiatric unit of a general hospital, a private agency or company engaged in providing mental health services, or a regional community mental health center

Billing Providers

- Individual Practitioners
 - LP
 - LPP
 - LCSW
 - LPCC
 - LMFT

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

4. Covered Services (continued)

(g) Day Treatment (continued)

- Physician
- Psychiatrist
- APRN
- Provider Groups
 - LP
 - LPP
 - LCSW
 - LPCC
 - LMFT
 - Physician
 - Psychiatrist
 - APRN
- Licensed Organizations

(h) Peer Support

Peer Support is emotional support that is provided by persons having a mental health, substance use, or co-occurring mental health and substance use disorder to others sharing a similar mental health, substance use, or co-occurring mental health and substance use disorder in order to bring about a desired social or personal change. It is an evidence based practice. Peer Support Services are structured and scheduled non-clinical but therapeutic activities with individual clients or groups provided by a self-identified consumer of mental health, substance use, or co-occurring mental health and substance use disorder services who has been trained and certified in accordance with state regulations. Services should promote socialization, recovery, self-advocacy, preservation and enhancement of community living skills for the client.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

4. Covered Services (continued)

(h) Peer Support (continued)

Peer support services must incorporate the following core components:

- Supervision – Peer support specialists must be supervised regularly by a physician, a psychiatrist, a LP, a LPP, a LPA working under the supervision of a LP, a LCSW, a CSW with three (3) years of inpatient or outpatient clinical experience in psychiatric social work and currently employed by a hospital or forensic psychiatric facility licensed by the Commonwealth or a psychiatric unit of a general hospital or a private agency or company engaged in the provision of mental health services or a regional community mental health center; a LMFT with three (3) years of inpatient or outpatient clinical experience in psychiatric mental health practice and currently employed by a hospital or forensic facility licensed by the Commonwealth, a psychiatric unit of a general hospital, a private agency or company engaged in providing mental health services, or a regional community mental health center, including receiving face-to-face individual supervision no less than once a month.
- Care coordination - Peer support services must be coordinated within the context of a comprehensive, individualized treatment plan which is developed through a person centered planning process. The peer support services must be identified on each client's individual treatment plan, and must be designed to directly contribute to the participant's individualized goals, as specified in the plan.
- Training - Peer Support Specialists have a minimum educational requirement of a high school diploma or a General Educational Development (GED) certificate and must successfully complete training approved by DBHDID. Training includes a minimum 30 hour program based on a nationally-recognized curriculum. The curriculum includes modules on problem solving, creating a wellness recovery action plan, stages in the recovery process, effective listening skills, establishing recovery goals and using support groups to promote and sustain recovery. The peer must take and pass a test (both written and oral components) before being certified as a peer specialist. In addition, Peer Support Specialists must obtain at least 6 hours of related training or continuing education per year.

Authorized Providers

Peer Support – Peer support specialists must be employed by a licensed organization or provider group that meets the criteria of a licensed organization and the following additional criteria:

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

4. Covered Services (continued)

(h) Peer Support (continued)

- Must employ qualified peer support specialists who are certified in accordance with Kentucky Administrative Regulation
- Must provide supervision by a physician, a psychiatrist, a LP, a LPP, a LPA working under the supervision of a LP, a LCSW, a CSW with three (3) years of inpatient or outpatient clinical experience in psychiatric social work and currently employed by a hospital or forensic psychiatric facility licensed by the Commonwealth or a psychiatric unit of a general hospital or a private agency or company engaged in the provision of mental health services or a regional community mental health center; a LMFT with three (3) years of inpatient or outpatient clinical experience in psychiatric mental health practice and currently employed by a hospital or forensic facility licensed by the Commonwealth, a psychiatric unit of a general hospital, a private agency or company engaged in providing mental health services, or a regional community mental health center for peer support specialists
- Capacity to provide on-going continuing education and technical assistance to peer support specialists
- Demonstrated experience serving the behavioral health population (mental health, substance use or co-occurring mental health and substance use disorders) and age range served (youth or adult peers or parent-to-parent)

Rendering Practitioners practicing as part of a provider group or licensed organization

- Peer Support Specialist working under the supervision of a physician, a psychiatrist, a LP, a LPP, a LPA working under the supervision of a LP, a LCSW, a CSW with three (3) years of inpatient or outpatient clinical experience in psychiatric social work and currently employed by a hospital or forensic psychiatric facility licensed by the Commonwealth or a psychiatric unit of a general hospital or a private agency or company engaged in the provision of mental health services or a regional community mental health center; a LMFT with three (3) years of inpatient or outpatient clinical experience in psychiatric mental health practice and currently employed by a hospital or forensic facility licensed by the Commonwealth, a psychiatric unit of a general hospital, a private agency or company engaged in providing mental health services, or a regional community mental health center

13. Other diagnostic, screening, preventive and, rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

4. Covered Services (continued)

(h) Peer Support (continued)

Billing Providers

- Provider Groups
 - LP
 - LPP
 - LCSW
 - LPCC
 - LMFT
 - Physician
 - Psychiatrist
 - APRN
- Licensed Organizations

(i) Parent/Family Peer Support

Parent/Family Peer Support is emotional support that is provided by parents or family members of children having a mental health, substance use, or co-occurring mental health and substance use disorder to parents or family members with a child sharing a similar mental health, substance use, or co-occurring mental health and substance use disorder in order to bring about a desired social or personal change. It is an evidence based practice. Peer Support Services are structured and scheduled non-clinical but therapeutic activities with individuals or groups provided by a self-identified parent /family member of a child/youth consumer of mental health, substance use, or co-occurring mental health and substance use disorder services who has been trained and certified in accordance with state regulations. Services should promote socialization, recovery, self-advocacy, preservation and enhancement of community living skills for the client.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

4. Covered Services (continued)

(i) Parent/Family Peer Support (continued)

Peer support services must incorporate the following core components:

- Supervision – Peer support specialists must be supervised regularly by a physician, a psychiatrist, a LP, a LPP, a LPA working under the supervision of a LP, a LCSW, a CSW with three (3) years of inpatient or outpatient clinical experience in psychiatric social work and currently employed by a hospital or forensic psychiatric facility licensed by the Commonwealth or a psychiatric unit of a general hospital or a private agency or company engaged in the provision of mental health services or a regional community mental health center; a LMFT with three (3) years of inpatient or outpatient clinical experience in psychiatric mental health practice and currently employed by a hospital or forensic facility licensed by the Commonwealth, a psychiatric unit of a general hospital, a private agency or company engaged in providing mental health services, or a regional community mental health center, including receiving face-to-face individual supervision no less than once a month.
- Care coordination - Peer support services must be coordinated within the context of a comprehensive, individualized treatment plan which is developed through a person centered planning process. The peer support services must be identified on each client's individual treatment plan, and must be designed to directly contribute to the participant's individualized goals, as specified in the plan.
- Training - Peer Support Specialists have a minimum educational requirement of a high school diploma or a General Educational Development (GED) certificate and must successfully complete training approved by DBHDID. Training includes a minimum 30 hour program based on a nationally-recognized curriculum. The curriculum includes modules on problem solving, creating a wellness recovery action plan, stages in the recovery process, effective listening skills, establishing recovery goals and using support groups to promote and sustain recovery. The peer must take and pass a test (both written and oral components) before being certified as a peer specialist. In addition, Peer Support Specialists must obtain at least 6 hours of related training or continuing education per year.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

4. Covered Services (continued)

(i) Parent/Family Peer Support (continued)

Authorized Providers

Peer Support – Peer support specialists must be employed by a licensed organization or provider group that meets the criteria of a licensed organization and the following additional criteria:

- Must employ qualified peer support specialists who are certified in accordance with Kentucky Administrative Regulation
- Must provide supervision by a physician, a psychiatrist, a LP, a LPP, a LPA working under the supervision of a LP, a LCSW, a CSW with three (3) years of inpatient or outpatient clinical experience in psychiatric social work and currently employed by a hospital or forensic psychiatric facility licensed by the Commonwealth or a psychiatric unit of a general hospital or a private agency or company engaged in the provision of mental health services or a regional community mental health center; a LMFT with three (3) years of inpatient or outpatient clinical experience in psychiatric mental health practice and currently employed by a hospital or forensic facility licensed by the Commonwealth, a psychiatric unit of a general hospital, a private agency or company engaged in providing mental health services, or a regional community mental health center for peer support specialists
- Capacity to provide on-going continuing education and technical assistance to peer support specialists
- Demonstrated experience serving the behavioral health population (mental health, substance use or co-occurring mental health and substance use disorders) and age range served (youth or adult peers or parent-to-parent)

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

4. Covered Services (continued)

(i) Parent/Family Peer Support (continued)

Rendering Practitioners practicing as part of a provider group or licensed organization

- Peer Support Specialist working under the supervision of a physician, a psychiatrist, a LP, a LPP, a LPA working under the supervision of a LP, a LCSW, a CSW with three (3) years of inpatient or outpatient clinical experience in psychiatric social work and currently employed by a hospital or forensic psychiatric facility licensed by the Commonwealth or a psychiatric unit of a general hospital or a private agency or company engaged in the provision of mental health services or a regional community mental health center; a LMFT with three (3) years of inpatient or outpatient clinical experience in psychiatric mental health practice and currently employed by a hospital or forensic facility licensed by the Commonwealth, a psychiatric unit of a general hospital, a private agency or company engaged in providing mental health services, or a regional community mental health center

Billing Providers

- Provider Group
 - LP
 - LPP
 - LCSW
 - LPCC
 - LMFT
 - Physician
 - Psychiatrist
 - APRN
- Licensed Organizations

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

4. Covered Services (continued)

(j) Intensive Outpatient Program (IOP)

Intensive Outpatient Program is an alternative to inpatient hospitalization or partial hospitalization for mental health and/or substance use disorders. An intensive outpatient program must offer a multi-modal, multi-disciplinary structured outpatient treatment program that is significantly more intensive than individual, group, and family therapies.

IOP services must be provided at least three (3) hours per day and at least three (3) days per week.

Programming must include individual therapy, group therapy, and family therapy unless contraindicated, Crisis Intervention as it would occur in the setting where IOP is being provided, and psychoeducation (Psychoeducation is one component of outpatient therapy for mental health conditions. During psychoeducation, the client and/or their family is provided with knowledge about their diagnosis, the causes of that condition, and the reasons why a particular treatment might be effective for reducing their symptoms. Clients and their families gain empowerment to understand and accept the diagnosis and learn to cope with it in a successful manner).

All treatment plans must be individualized, focusing on stabilization and transition to a lesser level of care.

The State does not claim IOP that is located in a hospital as a rehabilitative service.

Authorized Providers

Intensive Outpatient Services - Practitioners must be employed by a provider group or licensed organization that meets the criteria of a provider group or licensed organization and the following additional criteria:

- Access to a board-certified or board-eligible psychiatrist for consultation
- Access to a psychiatrist, other physician or Advanced Practice Registered Nurse (APRN) for medication management
- Adequate staffing to assure a minimum recipient-to-staff ratio of four clients to one staff member
- Capacity to provide services utilizing a recognized intervention protocol based on Recovery Principles
- Capacity to employ required practitioners and coordinate service provision among rendering practitioners

TN No. New

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

4. Covered Services (continued)

(j) Intensive Outpatient Program (IOP) (continued)

- Capacity to provide the full range of services included in the Intensive Outpatient service definition

Rendering Practitioners practicing as part of a licensed organization

- Licensed Psychologist (LP)
- Licensed Psychological Associate (LPA) working under the supervision of a LP
- Licensed Psychological Practitioner (LPP)
- Licensed Clinical Social Worker (LCSW)
- Certified Social Worker, Master Level (CSW) working under the supervision of a LCSW
- Licensed Professional Clinical Counselor (LPCC)
- Licensed Professional Counselor Associate (LPCA) working under the supervision of a LPCC
- Licensed Marriage and Family Therapist (LMFT)
- Marriage and Family Therapist Associate (MFTA) working under the supervision of a LMFT
- Physician
- Psychiatrist
- Advanced Practice Registered Nurse (APRN)
- Physician Assistant (PA) working under the supervision of a Physician

Billing Providers

- Provider Groups
 - LP
 - LPP
 - LCSW
 - LPCC
 - LMFT
 - Physician
 - Psychiatrist
 - APRN
- Licensed Organizations

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

4. Covered Services (continued)

(k) Individual Outpatient Therapy

Individual Therapy shall consist of a face-to-face therapeutic intervention provided in accordance with a recipient's identified treatment plan and is aimed at the deduction of adverse symptoms and improved functioning. Individual therapy must be provided as a one-on-one encounter between the provider and the client. Individual therapy services shall be limited to a maximum of three (3) hours per day, per client, but can be exceeded based on medical necessity.

Authorized Providers:

Rendering Practitioners practicing as an individual practitioner, a provider group, or as part of a licensed organization

- Licensed Psychologist (LP)
- Licensed Psychological Associate (LPA) working under the supervision of a LP*
- Licensed Psychological Practitioner (LPP)
- Licensed Clinical Social Worker (LCSW)
- Certified Social Worker, Master Level (CSW) working under the supervision of a LCSW*
- Licensed Professional Clinical Counselor (LPCC)
- Licensed Professional Counselor Associate (LPCA) working under the supervision of a LPCC*
- Licensed Marriage and Family Therapist (LMFT)
- Marriage and Family Therapist Associate (MFTA) working under the supervision of a LMFT*
- Physician
- Psychiatrist
- Advanced Practice Registered Nurse (APRN)
- Physician Assistant (PA) working under the supervision of a physician*

* Billed through supervisor

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

4. Covered Services (continued)

(k) Individual Outpatient Therapy (continued)

Billing Providers

- Individual Practitioners
 - LP
 - LPP
 - LCSW
 - LPCC
 - LMFT
 - Physician
 - Psychiatrist
 - APRN
- Provider Groups
 - LP
 - LPP
 - LCSW
 - LPCC
 - LMFT
 - Physician
 - Psychiatrist
 - APRN
- Licensed Organizations

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

4. Covered Services (continued)

(I) Group Outpatient Therapy

Group therapy shall be therapeutic intervention provided to a group of unrelated persons. A group consists of no more than eight persons. It is usually for a limited time period (generally 1 to 1 ½ hours in duration). In group therapy, clients are involved with one another at a cognitive and emotional level. Group therapy focuses on psychological needs of the clients as evidenced in each client's plan of treatment. Group therapy centers on goals such as building and maintaining healthy relationships, personal goal setting, and the exercise of personal judgment. The group shall have a deliberate focus and must have a defined course of treatment. Individual notes must be written for each recipient within the group and be kept in that individual's medical record.

Services shall be limited to a maximum of three (3) hours of group therapy per day, per client, but can be exceeded based on medical necessity.

Authorized Providers:

Rendering Practitioners practicing as an individual practitioner, a provider group, or as part of a licensed organization

- Licensed Psychologist (LP)
- Licensed Psychological Associate (LPA) working under the supervision of a LP*
- Licensed Psychological Practitioner (LPP)
- Licensed Clinical Social Worker (LCSW)
- Certified Social Worker, Master Level (CSW) working under the supervision of a LCSW*
- Licensed Professional Clinical Counselor (LPCC)
- Licensed Professional Counselor Associate (LPCA) working under the supervision of a LPCC*
- Licensed Marriage and Family Therapist (LMFT)
- Marriage and Family Therapist Associate (MFTA) working under the supervision of a LMFT*
- Physician
- Psychiatrist
- Advanced Practice Registered Nurse (APRN)
- Physician Assistant (PA) working under the supervision of a Physician*

* Billed through supervisor

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

4. Covered Services (continued)

(I) Group Outpatient Therapy (continued)

Billing Providers

- Individual Practitioners
 - LP
 - LPP
 - LCSW
 - LPCC
 - LMFT
 - Physician
 - Psychiatrist
 - APRN
- Provider Groups
 - LP
 - LPP
 - LCSW
 - LPCC
 - LMFT
 - Physician
 - Psychiatrist
 - APRN
- Licensed Organizations

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

4. Covered Services (continued)

(m) Family Outpatient Therapy

Family Therapy shall consist of a face to face therapeutic intervention provided through scheduled therapeutic visits between the therapist and the recipient and one or more members of a recipient's family to address issues interfering with the relational functioning of the family and improve interpersonal relationships within the home environment.

The need for family therapy shall be so stated in the client's plan of treatment. Family therapy services shall be for the benefit of the client

Authorized Providers:

Rendering Practitioners practicing as an individual practitioner, a provider group, or as part of a licensed organization

- Licensed Psychologist (LP)
- Licensed Psychological Associate (LPA) working under the supervision of a LP*
- Licensed Psychological Practitioner (LPP)
- Licensed Clinical Social Worker (LCSW)
- Certified Social Worker, Master Level (CSW) working under the supervision of a LCSW*
- Licensed Professional Clinical Counselor (LPCC)
- Licensed Professional Counselor Associate (LPCA) working under the supervision of a LPCC*
- Licensed Marriage and Family Therapist (LMFT)
- Marriage and Family Therapist Associate (MFTA) working under the supervision of a LMFT*
- Physician
- Psychiatrist
- Advanced Practice Registered Nurse (APRN)
- Physician Assistant (PA) working under the supervision of a Physician*

* Billed through supervisor

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

4. Covered Services (continued)

(m) Family Outpatient Therapy (continued)

Billing Providers

- Individual Practitioners
 - LP
 - LPP
 - LCSW
 - LPCC
 - LMFT
 - Physician
 - Psychiatrist
 - APRN
- Provider Groups
 - LP
 - LPP
 - LCSW
 - LPCC
 - LMFT
 - Physician
 - Psychiatrist
 - APRN
- Licensed Organizations

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

4. Covered Services (continued)

(n) Collateral Outpatient Therapy

Collateral services shall be limited to recipients under the age of twenty-one, who are clients of the rendering provider. A collateral service shall be a face-to-face encounter with a parent/caregiver, legal representative/guardian, school personnel or other person in a position of custodial control or supervision of the client, for the purpose of providing counseling or consultation on behalf of a client in accordance with an established plan of treatment. The parent or legal representative in a role of supervision of the client shall give written approval for this service. This written approval shall be kept in the recipient's medical record. This service is only reimbursable for a recipient under age 21.

Authorized Providers:

Rendering Practitioners practicing as an individual practitioner, a provider group, or as part of a licensed organization

- Licensed Psychologist (LP)
- Licensed Psychological Associate (LPA) working under the supervision of a LP*
- Licensed Psychological Practitioner (LPP)
- Licensed Clinical Social Worker (LCSW)
- Certified Social Worker, Master Level (CSW) working under the supervision of a LCSW*
- Licensed Professional Clinical Counselor (LPCC)
- Licensed Professional Counselor Associate (LPCA) working under the supervision of a LPCC*
- Licensed Marriage and Family Therapist (LMFT)
- Marriage and Family Therapist Associate (MFTA) working under the supervision of a LMFT*
- Physician
- Psychiatrist
- Advanced Practice Registered Nurse (APRN)
- Physician Assistant (PA) working under the supervision of a Physician*

* Billed through supervisor

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

4. Covered Services (continued)

(n) Collateral Outpatient Therapy (continued)

Billing Providers

- Individual Practitioners
 - LP
 - LPP
 - LCSW
 - LPCC
 - LMFT
 - Physician
 - Psychiatrist
 - APRN
- Provider Groups
 - LP
 - LPP
 - LCSW
 - LPCC
 - LMFT
 - Physician
 - Psychiatrist
 - APRN
- Licensed Organizations

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

4. Covered Services (continued)

(o) Partial Hospitalization

Partial Hospitalization is a short-term (average of four to six weeks), less than 24-hour, intensive treatment program for individuals experiencing significant impairment to daily functioning due to substance use disorders, mental health disorders, or co-occurring mental health and substance use disorders. Partial Hospitalization may be provided to adults or children. Admission criteria are based on an inability to adequately treat the client through community-based therapies or intensive outpatient services. The program will consist of individual, group, family therapies and medication management. Educational, vocational, or job training services that may be provided as part of Partial Hospitalization are not reimbursed by Medicaid. The program has an agreement with the local educational authority to come into the program to provide all educational components and instruction which are not Medicaid billable or reimbursable. Services in a Medicaid-eligible child's Individual Education Plan (IEP) are coverable under Medicaid.

Partial Hospitalization is typically provided for a lesser number hours per day and days per week than Day Treatment. Partial Hospitalization is typically focused on one primary presenting problem (i.e. Substance use, sexual reactivity, etc.). Day treatment is typically provided for more hours per day for more days per week, requires more treatment components and often lasts for a longer period of time E.g., three months), compared to partial hospitalization. Day treatment may focus on resolving multiple mental health and/or substance use issues and is typically provided as an alternative to a school or other traditional day time setting for children.

Authorized Providers

Partial Hospitalization – Practitioners must be employed by a licensed organization that meets the criteria of a licensed organization and the following additional criteria:

- Programs must provide the following medical coverage: An Advanced Practice Registered Nurse (APRN), Physician Assistant (PA) or Physician available on site and a board-certified or board-eligible psychiatrist available for consultation
- Capacity to provide services utilizing a recognized intervention protocol based on Recovery Principles
- Capacity to employ required practitioners and coordinate service provision among rendering practitioners
- Capacity to provide the full range of services included in the Partial Hospitalization definition

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

4. Covered Services (continued)

(o) Partial Hospitalization (continued)

Rendering Practitioners practicing as part of a licensed organization

- Licensed Psychologist (LP)
- Licensed Psychological Associate (LPA) working under the supervision of a LP
- Licensed Psychological Practitioner (LPP)
- Licensed Clinical Social Worker (LCSW)
- Certified Social Worker, Master Level (CSW) working under the supervision of a LCSW
- Licensed Professional Clinical Counselor (LPCC)
- Licensed Professional Counselor Associate (LPCA) working under the supervision of a LPCC
- Licensed Marriage and Family Therapist (LMFT)
- Marriage and Family Therapist Associate (MFTA) working under the supervision of a LMFT
- Physician
- Psychiatrist
- Advanced Practice Registered Nurse (APRN)
- Physician Assistant (PA) working under the supervision of a Physician

Billing Providers

- Licensed Organizations

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

4. Covered Services (continued)

(p) Service Planning

Service planning involves assisting the recipient in creating an individualized plan for services needed for maximum reduction of mental disability and restoration of a recipient to his best possible functional level. A person centered planning process is required. The plan is directed by the recipient and must include practitioners of the recipient's choosing. The providers include more than licensed professionals – it may include the recipient (and his guardian if applicable), care coordinator, other service providers, family members or other individuals that the recipient chooses.

Authorized Providers:

Rendering Practitioners practicing as an individual practitioner, a provider group, or as part of a licensed organization

- Licensed Psychologist (LP)
- Licensed Psychological Associate (LPA) working under the supervision of a LP*
- Licensed Psychological Practitioner (LPP)
- Licensed Clinical Social Worker (LCSW)
- Certified Social Worker, Master Level (CSW) working under the supervision of a LCSW*
- Licensed Professional Clinical Counselor (LPCC)
- Licensed Professional Counselor Associate (LPCA) working under the supervision of a LPCC*
- Licensed Marriage and Family Therapist (LMFT)
- Marriage and Family Therapist Associate (MFTA) working under the supervision of a LMFT*
- Physician
- Psychiatrist
- Advanced Practice Registered Nurse (APRN)
- Physician Assistant (PA) working under the supervision of a Physician*

* Billed through supervisor

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

4. Covered Services (continued)

(p) Service Planning (continued)

Billing Providers

- Individual Practitioners
 - LP
 - LPP
 - LCSW
 - LPCC
 - LMFT
 - Physician
 - Psychiatrist
 - APRN
- Provider Groups
 - LP
 - LPP
 - LCSW
 - LPCC
 - LMFT
 - Physician
 - Psychiatrist
 - APRN
- Licensed Organizations

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

4. Covered Services (continued)

(q) Residential Services for Substance Use Disorders (SUDS) TREATMENT FOR SUBSTANCE USE ONLY

Residential services for substance use disorders is residential treatment (24 hour/day) that may be short-term or long-term for the purposes of providing intensive treatment and skills building, in a structured and supportive environment, to assist individuals (children and adults) to obtain abstinence and enter into alcohol/drug addiction recovery. This service is provided in a 24 hour live- in facility that offers a planned and structured regimen of care that aims to treat persons with addictions or substance use disorders and assists them in making the necessary changes in their lives that will enable them to live drug or alcohol free lives. Individuals must have been assessed and meet criteria for approval of residential services, utilizing a nationally recognized assessment tool (e.g., American Society of Addiction Medicine (ASAM) as approved by the DBHDID.

Services should have more than eight (8), but less than or equal to 16 patient beds; be under the medical direction of a physician; and provide continuous nursing services.

Residential treatment services shall be based on individual need and may include:

- Screening
- Assessment
- Service Planning
- Individual Therapy
- Group Therapy
- Family Therapy
- Peer Support

Service provision must be in accordance with KY licensure for procedures and standards for persons and agencies operating nonmedical/non-hospital based alcohol and others drug abuse treatment programs and the individually credentialed personnel as outlined in the state law. (908 KAR 1:370)

There are two levels of residential treatment:

- Short term –length of stay-14-28 days
- Long term- length of stay 28- 90 days

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

4. Covered Services (continued)

(q) Residential Services for Substance Use Disorders (SUDS) TREATMENT FOR SUBSTANCE USE ONLY (continued)

Short Term

Short-term services should have a duration of less than thirty (30) days, but can be exceeded based on medical necessity. 24 hour staff as required by licensing regulations. Planned Clinical program activities constituting at least 15 hours per week of structured professionally directed treatment services to stabilize and maintain a person's substance use disorder and to help him or her to develop and apply recovery skills.

Services may include:

- Screening
- Assessment
- Service Planning
- Individual Therapy
- Group Therapy
- Family Therapy
- Peer Support

Long Term

24 hour staff as required by licensing regulations
Planned clinical program activities constituting 40 hours per week of structured professionally directed treatment services to stabilize and maintain a person's substance use and or substance use and mental health disorder and to help him or her to develop and apply recovery skills

Services may include:

- Screening
- Assessment
- Service Planning
- Individual Therapy
- Group Therapy
- Family Therapy
- Peer Support

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

4. Covered Services (continued)

(q) Residential Services for Substance Use Disorders (SUDS) TREATMENT FOR SUBSTANCE USE ONLY (continued)

Residential SUD treatment programs do not include, and FFP is not available for, room and board services; educational, vocational and job training services; habilitation services; services to inmates in public institutions as defined in 42 CFR §435.1010; services to individuals residing in institutions for mental diseases as described in 42 CFR§435.1010; recreational and social activities; and services that must be covered elsewhere in the state Medicaid plan. Services must be provided in a residential unit with 16 or fewer beds or, if provided within multiple units operating as on unified facility, 16 or fewer aggregated beds.

Authorized Providers

Residential Services for Substance Use Disorders (SUDS) – Practitioners must be employed by a licensed organization which meets the criteria of a licensed organization and the following additional criteria:

- Licensure as a non-medical/non-hospital based alcohol and other drug abuse treatment program in accordance with 908 KAR 1:370
- Capacity to employ required practitioners and coordinate service provision among rendering practitioners
- Capacity to provide the full range of services included in the service definition

Rendering Practitioners practicing as part of a licensed organization

- Licensed Psychologist (LP)
- Licensed Psychological Associate (LPA) working under the supervision of a LP
- Licensed Psychological Practitioner (LPP)
- Licensed Clinical Social Worker (LCSW)
- Certified Social Worker, Master Level (CSW) working under the supervision of a LCSW
- Licensed Professional Clinical Counselor (LPCC)
- Licensed Professional Counselor Associate (LPCA) working under the supervision of a LPCC
- Licensed Marriage and Family Therapist (LMFT)
- Marriage and Family Therapist Associate (MFTA) working under the supervision of a LMFT

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

4. Covered Services (continued)

(q) Residential Services for Substance Use Disorders (SUDS) TREATMENT FOR SUBSTANCE USE ONLY (continued)

- Physician
- Psychiatrist
- Advanced Practice Registered Nurse (APRN)
- Physician Assistant (PA) working under the supervision of a physician
- Peer Support Specialist working under the supervision of a physician, a psychiatrist, a LP, a LPP, a LPA working under the supervision of a LP, a LCSW, a CSW with three (3) years of inpatient or outpatient clinical experience in psychiatric social work and currently employed by a hospital or forensic psychiatric facility licensed by the Commonwealth or a psychiatric unit of a general hospital or a private agency or company engaged in the provision of mental health services or a regional community mental health center; a LMFT with three (3) years of inpatient or outpatient clinical experience in psychiatric mental health practice and currently employed by a hospital or forensic facility licensed by the Commonwealth, a psychiatric unit of a general hospital, a private agency or company engaged in providing mental health services, or a regional community mental health center

Billing Providers

- Licensed Organizations

(r) Screening, Brief Intervention, and Referral to Treatment (SBIRT) TREATMENT OF SUBSTANCE USE ONLY

SBIRT is an evidence-based early intervention approach that targets individuals with non-dependent substance use to provide effective strategies for intervention prior to the need for more extensive or specialized treatment. SBIRT consists of three major components:

Screening – Assessing an individual for risky substance use behaviors using standardized screening tools;

Brief Intervention – Engaging a patient showing risky substance use behaviors in a short conversation, providing feedback and advice; and

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

4. Covered Services (continued)

**(r) Screening, Brief Intervention, and Referral to Treatment (SBIRT)
TREATMENT OF SUBSTANCE USE ONLY (continued)**

Referral to Treatment – Provides a referral to additional mental health, substance use, or co-occurring mental health and substance use disorder services to patients who screen in need of additional services to address substance use. The Referral to Treatment is part of the Brief Intervention and thus to a behavioral health rehabilitative service.

Authorized Providers:

Rendering Practitioners practicing as an individual practitioner, a provider group, or as part of a licensed organization

- Licensed Psychologist (LP)
- Licensed Psychological Associate (LPA) working under the supervision of a LP*
- Licensed Psychological Practitioner (LPP)
- Licensed Clinical Social Worker (LCSW)
- Certified Social Worker, Master Level (CSW) working under the supervision of a LCSW*
- Licensed Professional Clinical Counselor (LPCC)
- Licensed Professional Counselor Associate (LPCA) working under the supervision of a LPCC*
- Licensed Marriage and Family Therapist (LMFT)
- Marriage and Family Therapist Associate (MFTA) working under the supervision of a LMFT*
- Physician
- Psychiatrist
- Advanced Practice Registered Nurse (APRN)
- Physician Assistant (PA) working under the supervision of a Physician*

* Billed through supervisor

Billing Providers

- Individual Practitioners
 - LP
 - LPP
 - LCSW

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

4. Covered Services (continued)

**(r) Screening, Brief Intervention, and Referral to Treatment (SBIRT)
TREATMENT OF SUBSTANCE USE ONLY (continued)**

- LPCC
- LMFT
- Physician
- Psychiatrist
- APRN
- Provider Groups
 - LP
 - LPP
 - LCSW
 - LPCC
 - LMFT
 - Physician
 - Psychiatrist
 - APRN
- Licensed Organizations

(s) Medication Assisted Treatment (MAT) TREATMENT FOR SUBSTANCE USE ONLY

Any opioid addiction treatment that includes a U.S. Food and Drug Administration (FDA) approved medication for the detoxification or maintenance treatment of opioid addiction (e.g., methadone, levo-alpha acetyl methadol [LAAM], buprenorphine, buprenorphinenaloxone, naltrexone) along with counseling and other supports, including urine drug screen. Services may be provided in an Opioid Treatment Program (OTP), a medication unit affiliated with an OTP, or, with the exception of Methadone, a physician's office or other community based setting including the recipient's home/residence, homeless shelter, school (only if not an IEP covered service), or other community setting where the recipient may wish/need to receive a service. Providers are instructed through regulations that the confidentiality of the client must be maintained in any setting where a service may occur. MAT increases the likelihood for cessation of illicit opioid use or of prescription opioid abuse. MATs are non-residential and must comply with all state laws.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

4. Covered Services (continued)

(s) Medication Assisted Treatment (MAT) TREATMENT FOR SUBSTANCE USE ONLY (continued)

Opioid Treatment Program or “OTP” means a substance abuse program using approved controlled substances and offering a range of treatment procedures and services for the rehabilitation of persons dependent on opium, morphine, heroin or any derivative or synthetic drug of that group. A “medication unit affiliated with an OTP” means a Medication Station or Dosing Location that obtains its drug supply from the main program site and retains all records (except dosing, urine screens) at the main location. Main program means the location of the MAT program where all administrative and medical information related to the narcotic treatment program is retained for the purpose of on-site reviews by federal agencies or the state narcotic authority or state opioid treatment authority designee. Service components include:

- Individual and Group therapy
- Dosing
- Medication
- Assessment and
- Urine Drug screens

Authorized Providers:

Rendering Practitioners practicing as an individual practitioner, a provider group, or as part of a licensed organization – must obtain specific certification to deliver this service

- Physician
- Psychiatrist

Billing Providers

- Individual Practitioners
 - Physician
 - Psychiatrist
- Provider Groups
 - Physician
 - Psychiatrist
- Licensed Organizations

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

4. Covered Services (continued)

(t) Assertive Community Treatment (ACT) TREATMENT OF MENTAL HEALTH

Assertive community treatment (ACT) is an evidence-based psychiatric rehabilitation practice which provides a comprehensive approach to service delivery for consumers with serious mental illnesses. ACT uses a multidisciplinary team of professionals including psychiatrists, nurses, case managers, therapists and peer support specialists. Component services include assessment, treatment planning, case management, psychiatric services (including evaluation diagnosis and treatment of mental health and/or substance use disorders, case consultation, prescribing, and medication management delivered by a licensed professional), medication management including administration, individual and group therapy, peer support, mobile crisis intervention, mental health consultation, family support and basic living skills. Mental health consultation involves brief, collateral interactions with other treating professionals who may have information for the purposes of treatment planning and service delivery. Family support involves the ACT team working with the recipient's natural support systems to improve family relations in order to reduce conflict and increase recipient autonomy and independent functioning. Basic living skills are rehabilitative services focused on teaching activities of daily living (i.e., taking medications, housekeeping, meal preparation, hygiene, interacting with neighbors) necessary to maintain independent functioning and community living. Psychiatric services as a component of the ACT service includes evaluation, diagnosis and treatment of mental health and or substance use disorders, case consultation, prescribing and medication management delivered by a licensed professional (i.e. psychiatrist, APRN)

Authorized Providers

Assertive Community Treatment (ACT) – Team members must be employed by a licensed organization that meets the criteria of a licensed organization and the following additional criteria:

- Must employ one or more teams led by one of the rendering practitioners listed below and including, at a minimum, four full time equivalents including a nurse and the rendering practitioners listed below.
- Adequate staffing to assure a caseload size no greater than 10 participants per team member
- Capacity to coordinate service provision among team members
- Capacity to provide the full range of services included in the ACT service definition

13. Other diagnostic, screening, preventive and, rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

4. Covered Services (continued)

(t) Assertive Community Treatment (ACT) TREATMENT OF MENTAL HEALTH (continued)

Rendering Practitioners practicing as part of a licensed organization

- Licensed Psychologist (LP)
- Licensed Psychological Associate (LPA) working under the supervision of a LP
- Licensed Psychological Practitioner (LPP)
- Licensed Clinical Social Worker (LCSW)
- Certified Social Worker, Master Level (CSW) working under the supervision of a LCSW
- Licensed Professional Clinical Counselor (LPCC)
- Licensed Professional Counselor Associate (LPCA) working under the supervision of a LPCC
- Licensed Marriage and Family Therapist (LMFT) Marriage and Family Therapist Associate (MFTA) working under the supervision of a LMFT
- Physician
- Psychiatrist
- Advanced Practice Registered Nurse (APRN)
- Physician Assistant (PA) working under the supervision of a MD
- Registered Nurse (RN)
- Licensed Practical Nurse (LPN)
- Peer Support Specialist working under the supervision of a physician, a psychiatrist, a LP, a LPP, a LPA working under the supervision of a LP, a LCSW, a CSW with three (3) years of inpatient or outpatient clinical experience in psychiatric social work and currently employed by a hospital or forensic psychiatric facility licensed by the Commonwealth or a psychiatric unit of a general hospital or a private agency or company engaged in the provision of mental health services or a regional community mental health center; a LMFT with three (3) years of inpatient or outpatient clinical experience in psychiatric mental health practice and currently employed by a hospital or forensic facility licensed by the Commonwealth, a psychiatric unit of a general hospital, a private agency or company engaged in providing mental health services, or a regional community mental health center

Billing Providers

- Licensed Organizations

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

4. Covered Services (continued)

(u) Comprehensive Community Support Services TREATMENT OF MENTAL HEALTH ONLY

Comprehensive Community Support Services covers activities necessary to allow individuals with mental illnesses to live with maximum independence in the community. Activities are intended to assure successful community living through utilization of skills training as identified in the individual service plan. Skills training is designed to reduce mental disability and restore the recipient to his best possible functional level.

Comprehensive community support services consists of using a variety of psychiatric rehabilitation techniques to improve daily living skills (hygiene, meal preparation, medication adherence), self-monitoring of symptoms and side effects, emotional regulation skills, crisis coping skills and developing and enhancing interpersonal skills.

Authorized Providers:

Rendering Practitioners practicing as an individual practitioner, a provider group, or as part of a licensed organization

- Licensed Psychologist (LP)
- Licensed Psychological Associate (LPA) working under the supervision of a LP*
- Licensed Psychological Practitioner (LPP)
- Licensed Clinical Social Worker (LCSW)
- Certified Social Worker, Master Level (CSW) working under the supervision of a LCSW*
- Licensed Professional Clinical Counselor (LPCC)
- Licensed Professional Counselor Associate (LPCA) working under the supervision of a LPCC*
- Licensed Marriage and Family Therapist (LMFT)
- Marriage and Family Therapist Associate (MFTA) working under the supervision of a LMFT*
- Physician
- Psychiatrist
- Physician Assistant (PA) working under the supervision of a Physician*
- Advanced Practice Registered Nurse (APRN)

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

4. Covered Services (continued)

(u) Comprehensive Community Support Services TREATMENT OF MENTAL HEALTH ONLY (continued)

- Peer Support Specialist working under the supervision of a physician, a psychiatrist, a LP, a LPP, a LPA working under the supervision of a LP, a LCSW, a CSW with three (3) years of inpatient or outpatient clinical experience in psychiatric social work and currently employed by a hospital or forensic psychiatric facility licensed by the Commonwealth or a psychiatric unit of a general hospital or a private agency or company engaged in the provision of mental health services or a regional community mental health center; a LMFT with three (3) years of inpatient or outpatient clinical experience in psychiatric mental health practice and currently employed by a hospital or forensic facility licensed by the Commonwealth, a psychiatric unit of a general hospital, a private agency or company engaged in providing mental health services, or a regional community mental health center*

* Billed through supervisor

Billing Providers

- Individual Practitioners
 - LP
 - LPP
 - LCSW
 - LPCC
 - LMFT
 - Physician
 - Psychiatrist
 - APRN
- Provider Groups
 - LP
 - LPP
 - LCSW
 - LPCC
 - LMFT
 - Physician
 - Psychiatrist
 - APRN
- Licensed Organizations

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

4. Covered Services (continued)

(v) Therapeutic Rehabilitation Program TREATMENT OF MENTAL HEALTH

A Therapeutic Rehabilitation Program is a rehabilitative service for adults with serious mental illnesses and children with serious emotional disabilities designed to maximize reduction of mental disability and restoration of the recipient's best possible functional level. Services shall be designed for the reduction in disabilities related to social, personal, and daily living skills, as well as the restoration of these skills. The recipient establishes his own rehabilitation goals within the person centered service plan. Component services are delivered using a variety of psychiatric rehabilitation techniques and focus on improving daily living skills (hygiene, meal preparation, and medication adherence), self-monitoring of symptoms and side effects, emotional regulation skills, crisis coping skills and interpersonal skills. Services may be delivered individually or in a group.

Authorized Providers

Rendering Practitioners practicing as an individual practitioner, a provider group, or as part of a licensed organization

- Licensed Psychologist (LP)
- Licensed Psychological Associate (LPA) working under the supervision of a LP*
- Licensed Psychological Practitioner (LPP)
- Licensed Clinical Social Worker (LCSW)
- Certified Social Worker, Master Level (CSW) working under the supervision of a LCSW*
- Licensed Professional Clinical Counselor (LPCC)
- Licensed Professional Counselor Associate (LPCA) working under the supervision of a LPCC*
- Licensed Marriage and Family Therapist (LMFT)
- Marriage and Family Therapist Associate (MFTA) working under the supervision of a LMFT*
- Physician
- Psychiatrist
- Advanced Practice Registered Nurse (APRN)
- Physician Assistant (PA) working under the supervision of a Physician*

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

4. Covered Services (continued)

(v) Therapeutic Rehabilitation Program TREATMENT OF MENTAL HEALTH (continued)

- Peer Support Specialist working under the supervision of a physician, a psychiatrist, a LP, a LPP, a LPA working under the supervision of a LP, a LCSW, a CSW with three (3) years of inpatient or outpatient clinical experience in psychiatric social work and currently employed by a hospital or forensic psychiatric facility licensed by the Commonwealth or a psychiatric unit of a general hospital or a private agency or company engaged in the provision of mental health services or a regional community mental health center; a LMFT with three (3) years of inpatient or outpatient clinical experience in psychiatric mental health practice and currently employed by a hospital or forensic facility licensed by the Commonwealth, a psychiatric unit of a general hospital, a private agency or company engaged in providing mental health services, or a regional community mental health center*

* Billed through supervisor

Billing Providers

- Individual Practitioners
 - LP
 - LPP
 - LCSW
 - LPCC
 - LMFT
 - Physician
 - Psychiatrist
 - APRN
- Provider Groups
 - LP
 - LPP
 - LCSW
 - LPCC
 - LMFT
 - Physician
 - Psychiatrist
 - APRN
- Licensed Organizations

TN No. New

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

5. Community Mental Health Centers (CMHC)

CMHCs provide a comprehensive range of coordinated mental health and substance use rehabilitation services. Reimbursement is available for all rehabilitation services described above under covered services subject to the following:

1. Medicaid will reimburse for community mental health center rehabilitation services when provided to persons diagnosed with a mental health disorder or substance use or co-occurring disorder when provided by qualified mental health professionals listed below. Service limitations applicable to other provider types are also applicable to CMHCs.
2. Professionals qualified to provide mental health or substance use rehabilitation services in the CMHCs include:
 - Licensed Psychologist (LP)
 - Licensed Psychological Practitioner (LPP)
 - Licensed Clinical Social Worker (LCSW)
 - A psychiatric social worker with a master's degree from an accredited school
 - Licensed Professional Clinical Counselor (LPCC)
 - Licensed Marriage and Family Therapist (LMFT)
 - Psychiatrist
 - Physician
 - A psychiatric nurse licensed in the state of Kentucky with one of the following combination of education and experience:
 - i. Master of Science in Nursing with a specialty in psychiatric or mental health nursing. No experience required.
 - ii. Bachelor of Science in Nursing and 1 year of experience in a mental health setting.
 - iii. A graduate of a three-year educational program with 2 years of experience in a mental health setting.
 - iv. A graduate of a two-year educational program (Associate degree) with 3 years of experience in a mental health setting.
 - A professional equivalent, through education in a mental health field and experience in a mental health setting, qualified to provide mental health services. Professional equivalents may include practitioners obtaining experience to qualify for licensure in their behavioral health profession or individuals with a bachelor's degree or greater, with experience in behavioral health. Education and experience are as follows:
 - i. Bachelor's degree and 3 years of full-time supervised experience.
 - ii. Master's degree and 6 months of full-time supervised experience.
 - ii. Doctoral degree. No experience.

13. Other diagnostic, screening, preventive and, rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

5. Community Mental Health Centers (CMHC) (continued)

- The following professionals may provide services with appropriate supervision:
 - i. A mental health associate with a minimum of a Bachelors degree in psychology, sociology, social work, or human services under supervision of one of the above professionals;
 - ii. A licensed psychological associate working under the supervision of a licensed psychologist;
 - iii. A marriage and professional counselor associate working under the supervision of a licensed professional clinical counselor;
 - iv. A certified social worker, Master Level working under the supervision of a licensed clinical social worker;
 - v. A marriage and family therapy associate working under the supervision of a licensed marriage and family therapist;
 - vi. A physician assistant working under the supervision of a physician;
 - vii. A peer support specialist who meets the qualifications in 908 KAR 2:220, has completed required training, and who is working under the supervision of a physician, a psychiatrist, a LP, a LPP, a LPA working under the supervision of a LP, a LCSW, a CSW with three (3) years of inpatient or outpatient clinical experience in psychiatric social work and currently employed a regional community mental health center; a LMFT with three (3) years of inpatient or outpatient clinical experience in psychiatric mental health practice and currently employed by a regional community mental health center;
 - viii. A certified alcohol and drug counselor (CADC) working under the supervision of a CADC who has at least two (2) years of post-certificate experience and who provides supervision to not more than twelve (12) applicants in an individual or group setting at any one (1) time, and whose certificate is currently in good standing with the (CADC) board;
 - ix. A community support associate who is working under the supervision of a physician, a psychiatrist, a LP, a LPP, a LPA working under the supervision of a LP, a LCSW, a CSW with three (3) years of inpatient or outpatient clinical experience in psychiatric social work and currently employed a regional community mental health center; a LMFT with three (3) years of inpatient or outpatient clinical experience in psychiatric mental health practice and currently employed by a regional community mental health center, or professional equivalent.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

6. Qualifications of Providers

Qualified providers are approved practitioners, licensed or certified under state law, operating within the scope of their licensures (or under the appropriate supervision).

1. APRN – KRS 314.042 states that an applicant for licensure to practice as an advanced practice registered nurse shall:
 - (a) File with the board a written application for licensure and submit evidence, verified by oath, that the applicant has completed an approved organized post basic program of study and clinical experience; has fulfilled the requirements of KRS 214.615(1); is certified by a nationally established organization or agency recognized by the board to certify registered nurses for advanced practice registered nursing; and is able to understandably speak and write the English language and to read the English language with comprehension.
 - (b) The board may issue a license to practice advanced practice registered nursing to an applicant who holds a current active registered nurse license issued by the board or holds the privilege to practice as a registered nurse in this state and meets the qualifications of subsection (1) of this section. An advanced practice registered nurse shall be:
 - i. Designated by the board as a certified nurse anesthetist, certified nurse midwife, certified nurse practitioner, or clinical nurse specialist; and
 - ii. Certified in a least one (1) population focus.
 - (c) An advanced practice registered nurse shall maintain a current active registered nurse license issued by the board or hold the privilege to practice as a registered nurse in this state and maintain current certification by the appropriate national organization or agency recognized by the board.
 - (d) Before an advanced practice registered nurse engages in the prescribing or dispensing of nonscheduled legend drugs as authorized by KRS 314.011(8), the advanced practice registered nurse shall enter into a written "Collaborative Agreement for the Advanced Practice Registered Nurse's Prescriptive Authority for Nonscheduled Legend Drugs" (CAPA-NS) with a physician that defines the scope of the prescriptive authority for nonscheduled legend drugs.
 - (e) Before an advanced practice registered nurse engages in the prescribing of Schedules II through V controlled substances as authorized by KRS 314.011(8), the advanced practice registered nurse shall enter into a written "Collaborative Agreement for the Advanced Practice Registered Nurse's Prescriptive Authority for Controlled Substances" (CAPA-CS) with a physician that defines the scope of the prescriptive authority for controlled substances.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

6. Qualifications of Providers (continued)

2. Certified Social Worker, Master Level – KRS 335.08 states the board shall issue a license as “certified social worker” to an applicant who meets the following requirements:
 - (a) Is at least eighteen years of age;
 - (b) Is a person of good moral character;
 - (c) Has received a master’s degree or doctorate degree in social work from an educational institution approved by the board;
 - (d) Has passed an examination prepared by the board;
 - (e) Has not, within the preceding three months failed to pass an examination given by the board;
 - (f) A Certified Social Worker, Master Level may engage in the practice of clinical social work by contracting, in writing, with a licensed behavioral health professional who meets the requirements of the respective KY Board of Licensure for supervision of the Certified Social Worker, Masters Level. The supervising licensed behavioral health professional shall assume responsibility for and supervise the MFTA’s practice.
3. Licensed Clinical Social Worker (LCSW) – KRS 335.100 states that the LCSW must:
 - (a) Have received a master's degree or doctoral degree in social work from an educational institution approved by the board;
 - (b) Have had a minimum of two (2) years of full time post-master's experience, consisting of at least thirty (30) hours per week, or three (3) years of part time, consisting of at least twenty (20) hours per week, post-master's degree experience acceptable to the board in the use of specialty methods and measures to be employed in clinical social work practice, the experience having been acquired under appropriate supervision as established by the board by promulgation of an administrative regulation;
 - (c) Have paid to the board an examination fee established by the board by promulgation of an administrative regulation;
 - (d) Have passed an examination prepared by the board for this purpose; and
 - (e) Have not, within the preceding three (3) months, failed to pass an examination given by the board;
4. Licensed Marriage and Family Therapist (LMFT) – KRS 335.330 states the LMFT has
 - (a) Completed a master's or doctoral degree program in marriage and family therapy, from a regionally-accredited educational institution, or a master's, post-master's, or doctoral program approved by the Commission on Accreditation for Marriage

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

6. Qualifications of Providers (continued)

and Family Therapy Education or any of its successor organizations, or an equivalent course of study as defined by the board by promulgation of administrative regulations.

- i The degree or equivalent course of study shall contain specific coursework on psychopathology and the Diagnostic and Statistical Manual; and
 - ii In determining equivalency, the board shall use the criteria for marriage and family therapy education and clinical training approved by the United States Department of Education;
- (b) Completed each of the following:
- i At least two (2) years' experience in the practice of marriage and family therapy, acceptable to the board and subsequent to being granted a master's degree; and
 - ii A minimum of two hundred (200) hours of clinical supervision acceptable to the board and subsequent to being granted a master's degree; and
- (c) Passed a written examination prescribed by the board by promulgation of administrative regulations.
5. Marriage and Family Therapist Associate (LMFTA) – KRS 335.332 states the LMFTA has
- (a) Completed a master's or doctoral degree program in marriage and family therapy, from a regionally-accredited educational institution, or a master's, post-master's, or doctoral program approved by the Commission on Accreditation for Marriage and Family Therapy Education or any of its successor organizations, or an equivalent course of study as defined by the board by promulgation of administrative regulations.
 - i The degree or equivalent course of study shall contain specific coursework on psychopathology and the Diagnostic and Statistical Manual; and
 - ii In determining equivalency, the board shall use the criteria for marriage and family therapy education and clinical training approved by the United States Department of Education;
 - (b) A MFTA shall engage in the practice of marriage and family therapy while receiving qualifying experience by contracting, in writing, with a licensed behavioral health professional who meets the requirements of the respective KY Board of Licensure for supervision of the MFTA. The supervising licensed behavioral health professional shall assume responsibility for and supervise the MFTA's practice.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

6. Qualifications of Providers (continued)

6. Licensed Professional Clinical Counselor – KRS 335.525 states that the board shall issue a "professional clinical counselor" license to an applicant who:
 - (a) Has paid the application fee and the appropriate examination fee to the board;
 - (b) Is of good moral character;
 - (c) Has received a master's, specialist, or doctoral degree in counseling or a related field from a regionally accredited institution;
 - (d) Has completed a minimum of sixty (60) graduate semester hours in the following:
 - i The helping relationship, including counseling theory and practice;
 - ii Human growth and development;
 - iii Lifestyle and career development;
 - iv Group dynamics, process, counseling, and consulting;
 - v Assessment, appraisal, and testing of individuals;
 - vi Social and cultural foundations, including multicultural issues;
 - vii Principles of etiology, diagnosis, treatment planning, and prevention of mental and emotional disorders and dysfunctional behavior;
 - viii Research and evaluation; and
 - ix Professional orientation and ethics;
 - (e) Has completed a minimum of four thousand (4,000) hours of experience in the practice of counseling, all of which must have been obtained since obtaining the master's degree and must be under approved supervision and shall include but not be limited to a minimum of one thousand six hundred (1,600) hours of direct counseling with individuals, couples, families, or groups and a minimum of one hundred (100) hours of individual, face-to-face clinical supervision with an approved supervisor. Each applicant is encouraged to include as part of the total hours of experience a minimum of ten (10) hours of direct counseling with individuals in a jail or corrections setting. All applicants shall complete an organized practicum or internship consisting of at least four hundred (400) hours; and
 - (f) Has achieved passing scores on all portions of the examinations required by the board.
7. Licensed Professional Counselor Associate – KRS 335.525 states that the board shall issue a "professional clinical counselor" license to an applicant who:
 - (a) Has completed all requirements under paragraphs (a) to (d) as outlined under Licensed Professional Counselor above;
 - (b) Has not met the requirements of paragraphs (e) or (f) as outlined under Licensed Professional Counselor above; and

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

6. Qualifications of Providers (continued)

- (c) Has obtained a board-approved supervisor of record.
 - (d) A licensed professional counselor associate shall maintain ongoing supervision with a licensed behavioral health professional who meets the requirements of the respective KY Board of Licensure for supervision of the Licensed Professional Counselor Associate. The supervising licensed behavioral health professional shall assume responsibility for and supervise the MFTA's practice. .
8. Licensed Psychological Associate – KRS 319.064 states a licensed psychological associate shall:
- (a) Have received a master's degree in psychology from a regionally accredited educational institution.
 - (b) Have passed an examination procedure in psychology.
 - (c) A licensed psychological associate shall not practice independently, except under the employment and supervision of any board-approved licensed psychologist.
9. Licensed Psychological Practitioner – KRS 319.053 states a person holding a credential as a certified psychologist or as a licensed psychological associate may apply for a license to perform certain functions within the practice of psychology without supervision and use the title of "licensed psychological practitioner" when all of the following conditions are met:
- (a) Submission of three letters of endorsement to the board to sit for the examination:
 - i one of the letters shall be from the applicant's current board approved supervisor of record and shall include a statement describing the scope of practice demonstrated in the clinical experience of the applicant; and
 - ii Two letters shall be from licensed mental health professionals who are acceptable to the board and who are familiar with the clinical work of the applicant.
 - (b) Documentation of at least sixty semester hours of graduate study in psychology or a related field or its equivalent acceptable to the board; and
 - (c) Completion, after credentialing by the board as a certified psychologist, psychological associate, or licensed psychological associate, of the equivalent of five full-time years of professional experience under the supervision of a board-approved licensed psychologist.
 - (d) An applicant for licensure shall be required by the board to pass the national objective examination known as the EPPP, with an equal to or exceeding the score required for the passage for a licensed psychologist candidate at the doctoral level at the time the examination is taken.

13. Other diagnostic, screening, preventive and, rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

6. Qualifications of Providers (continued)

- (e) The board shall require an applicant for licensure under this section to pass an examination of psychological practice, ethical principles and the law.
10. Licensed Psychologist – Per KRS 319.050, a licensed psychologist shall pass an examination in psychology and fulfill all requirements for supervised experience.
- (a) The psychologist shall:
 - i Have received a doctoral degree in psychology that is acceptable to the board from a regionally accredited educational institution; provided, however, the board may grant a license to an individual otherwise qualified under this chapter who has received a doctoral degree in psychology that is acceptable to the board from an educational institution outside the United States, if the educational institution would otherwise be accredited by a regional accrediting body if located in the United States;
 - ii Have passed the national EPPP examination at the doctoral level; and
 - iii Have had at least two (2) years of supervised professional experience satisfactory to the board, one (1) year of which shall be an internship.
 - (b) Upon acceptance of the application to sit for the examination in psychology, the applicant may practice psychology under the supervision of a licensed psychologist under conditions of supervision and temporary licensure established by the board. The board shall establish a grace period not to exceed sixty (60) days to allow for the employment and supervision of the applicant by an agency from the time the applicant's degree requirements are completed to the submission of the complete application. During this period of supervision, the applicant for licensure may not supervise certified psychologists, licensed psychological associates, other applicants for licensure, or temporarily licensed persons, nor shall he engage in an independent practice, except under the employment of his supervising psychologist. Upon certification to the board of completion of the two (2) years of supervision satisfactory to the board, the applicant shall be examined on psychological practice, ethical principles, and the law.
 - (c) Licensed psychologists may function independently without supervision. Licensed psychologists who have the designation "health service provider" may retain that designation and may employ and supervise certified psychologists and licensed psychological associates. Licensed psychologists who have the designation "health service provider" may supervise no more than a total of six (6) certified psychologists, licensed psychological associates, or applicants for licensure at one (1) time.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

6. Qualifications of Providers (continued)

11. Physician – KRS 311.571 states that any applicant who is a graduate of a medical or osteopathic school shall be eligible for a regular license to practice medicine in the Commonwealth if they:
 - (a) Are able to understandably speak, read, and write the English language;
 - (b) Has graduated from an accredited college or university or has satisfactorily completed a collegiate course of study necessary for entry into an approved medical or osteopathic school or college;
 - (c) Has graduated from a prescribed course of instruction in a medical or osteopathic school or college situated in the United States or Canada and approved by the board;
 - (d) Has satisfactorily completed a prescribed course of postgraduate training of a duration to be established by the board in an administrative regulation; and
 - (e) Has successfully completed an examination prescribed by the board;
12. Physician Assistant – Has graduated from a physician assistant or surgeon assistant program accredited by the Accreditation Review Commission on Education for Physician Assistants or its predecessor or successor agencies and has passed the certifying examination administered by the National Commission on Certification of Physician Assistants or its predecessor or successor agencies; or (b) Possesses a current physician assistant certificate issued by the board prior to July 15, 2002;
13. Psychiatrist – Licensed under the laws of Kentucky to practice medicine or osteopathy, or a medical officer of the government of the United States while engaged in the performance of official duties, who is certified or eligible to apply for certification by the American Board of Psychiatry and Neurology, Inc.
14. KY Credentialed Peer Support Specialist – Kentucky regulation states that an applicant shall:
 - (a) Complete and submit an application for training to DBHDID;
 - (b) Complete the DBHDID peer specialist training program;
 - (c) Successfully complete the DBHDID peer specialist examination;
 - (d) Complete and maintain documentation of a minimum of six (6) hours of job related training or education in each subsequent year of employment; and
 - (e) Deliver services working under the supervision of a physician, a psychiatrist, a LP, a LPP, a LPA working under the supervision of a LP, a LCSW, a CSW with three (3) years of inpatient or outpatient clinical experience in psychiatric social work and currently employed by a hospital or forensic psychiatric facility licensed by the Commonwealth or a psychiatric unit of a general hospital or a private agency or company engaged in the provision of mental health services

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

6. Qualifications of Providers (continued)

or a regional community mental health center; a LMFT with three (3) years of inpatient or outpatient clinical experience in psychiatric mental health practice and currently employed by a hospital or forensic facility licensed by the Commonwealth, a psychiatric unit of a general hospital, a private agency or company engaged in providing mental health services, or a regional community mental health center, including regularly scheduled face-to-face supervision.

15. Certified Alcohol and Drug Counselor (CADC): KAR 309.083 states that shall:
- (a) Be at least eighteen (18) years of age;
 - (b) Have obtained a baccalaureate degree;
 - (c) Have completed six thousand (6,000) hours of board-approved experience working with alcohol or drug dependent persons, three hundred (300) hours of which shall have been under the direct supervision of a certified alcohol and drug counselor who has at least two (2) years of post-certification experience; (4) Have completed at least two hundred seventy (270) classroom hours of board-approved curriculum;
 - (d) Have passed a written examination that has been approved by the International Certification Reciprocity Consortium on Alcoholism and Drug Abuse and an oral examination approved by the board;
 - (e) Have signed an agreement to abide by the standards of practice and code of ethics approved by the board;
 - (f) Have completed at least six (6) hours of ethics training and two (2) hours of training in the transmission, control, treatment, and prevention of the human immunodeficiency virus;
 - (g) Have submitted two (2) letters of reference from certified alcohol and drug counselors; and
 - (h) Be supervised by a certified alcohol and drug counselor who has at least two (2) years of post-certificate experience and who provides supervision to not more than twelve (12) applicants in an individual or group setting at any one (1) time, and whose certificate is currently in good standing with the (CADC) board.
 - (e) Work under the supervision of a physician, a psychiatrist, a LP, a LPP, a LPA working under the supervision of a LP, a LCSW, a CSW with three (3) years of inpatient or outpatient clinical experience in psychiatric social work and currently employed by a regional community mental health center; a LMFT with three (3) years of inpatient or outpatient clinical experience in psychiatric mental health practice and currently employed by a regional community mental health center or a professional equivalent.

14.b. Nursing Facility Services for Individuals Age 65 or Older in and Institutions for Mental Diseases.

C.

A. Definitions:

1. "High intensity nursing care services" means care provided to Medicaid eligible individuals who meet high intensity patient status criteria which shall be equivalent to skilled nursing care standards under Medicare.
2. "Low intensity nursing care services" means care provided to Medicaid eligible individuals who meet low intensity patient status criteria which shall be equivalent to the former intermediate care patient status standards.
3. "Intermediate care for the mentally retarded and persons with related conditions services" means care provided to Medicaid eligible individuals who meet ICF-MR patient status criteria by ICF-MRs participating in the Medicaid Program.

B. Services:

Program benefits are limited to eligible recipients who require nursing facility care services meeting the above definitions. These services must be preauthorized and must be reevaluated every six (6) months. If the reevaluation of care needs reveals that the patient no longer requires high intensity, low intensity, or intermediate care for the mentally retarded services and payment is no longer appropriate in the facility, payment shall continue for ten (10) days to permit orderly discharge or transfer to an appropriate level of care.

All individuals receiving nursing facility care must be provided care in appropriately certified beds.

The following services are payable by the Medicaid program when they are medically necessary and ordered by the attending physician. The facilities may not charge the Medicaid recipient for these services. (Also see Attachment 4.19-D Exhibit B for a detailed explanation of each service or item.)

- (1) Routine services include a regular room (if the attending physician orders a private room, the facility cannot charge the family or responsible party any difference in private/semi-private room charges; the facility enters their charges for a private room when billing Medicaid), dietary services and supplements, medical social services, respiratory therapy and supplies, nursing services, the use of equipment and facilities, medical and surgical supplies, podiatry services, items which are furnished routinely and relatively uniformly to all patients, prosthetic devices, and laundry services (including laundry services for personal clothing which is the normal wearing apparel in the facility).
- (2) Ancillary services are those for which a separate charge is customarily made. They include physical therapy, occupational therapy, speech therapy, laboratory procedures, x-ray, oxygen and oxygen supplies, and ventilator use.

15.a. Services in an Intermediate Care Facility for the Mentally Retarded and Developmentally Disabled (Other Than Such Services in an Institution for Mental Diseases) for Persons Determined, in Accordance with Section 1902(a) (31) (A) of the Act, to be in Need of Such Care

Program benefits are limited to eligible recipients who require active treatment. These services must be preauthorized and must be reevaluated every six (6) months. If the reevaluation of care reveals that the patient no longer requires skilled, nursing facility level of care, or intermediate care for the mentally retarded and developmentally-disabled services and payment is no longer appropriate in the facility, payment shall continue for ten (10) days to permit orderly discharge or transfer to an appropriate level of care.

All individuals receiving nursing facility care must be provided care in appropriately certified beds.

The following services are payable by the Medicaid program when they are medically necessary and ordered by the attending physician. The facilities may not charge the Medicaid recipient for these services. (Also see Attachment 4.19- D Exhibit B for a detailed explanation of each service or item.)

- (1) Routine services include a regular room (if the attending physician orders a private room, the facility cannot charge the family or responsible party any difference in private/semi-private room charges; the facility enters their charges for a private room when billing Medicaid), dietary services and supplements, medical social services, respiratory therapy and supplies, nursing services, the use of equipment and facilities, medical and surgical supplies, podiatry services, items which are furnished routinely and relatively uniformly to all patients, prosthetic devices, and laundry services (including laundry services for personal clothing which is the normal wearing apparel in the facility).
- (2) Ancillary services are those for which a separate charge is customarily made. They include physical therapy, occupational therapy, speech therapy, laboratory procedures, x-ray, oxygen and oxygen supplies, and ventilator use.

16. Inpatient Psychiatric Facility Services for Individuals Under 22 Years of Age

The following limitations are applicable for inpatient psychiatric facility services for individuals under 21 years of age (or under 22 years of age if an inpatient in the facility on the individual's 21st birthday):

- (1) Program benefits are limited to eligible recipients who require inpatient psychiatric facility services on a continuous basis as a result of a severe mental or psychiatric illness (including severe emotional disturbances) as shown in ICD-9-CMs Services shall not be covered if appropriate alternative services are available in the community. Services must be preauthorized and reevaluated at thirty day intervals.
- (2) Service may be provided in a psychiatric hospital; or in a licensed psychiatric residential treatment facility which meets the requirements of 42 CFR 441 Subpart D.

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18. Hospice

A. Benefits

The Kentucky Medicaid Hospice Program follows the amount, duration, and scope of services specified in the Medicare Hospice Program.

Any terminally ill Medicaid recipient may elect hospice coverage (where hospice care is provided by a participating hospice program in his service area) Each recipient will be required to make his voluntary selection in writing, and must present a statement from a physician (or such statement must be available) to show that the recipient's illness is terminal and that death is expected to occur within six (6) months. In doing so, the recipient waives rights to other Medicaid services that are related to the treatment of his or her terminal illness(es) with the exception of individuals less than 21 years of age. Individuals less than 21 years of age may receive concurrent hospice and acute care treatment. The recipient has the right to cancel the election at any time without forfeiting additional Medicaid hospice coverage at a later time. The recipient does not waive rights to Medicaid services for conditions not related to the terminal condition.

Medicaid beneficiaries under the age of 21 may receive hospice benefits, including curative treatment without foregoing any other service to which the child is entitled under the Medicaid program, pursuant to Section 2302 of the Patient Protection and Affordable Care Act of 2010.

B. Limitations

Dually eligible (Medicare and Medicaid) recipients must participate in the Medicare and Medicaid hospice programs simultaneously in order to receive Medicaid hospice services.

-
24. Any other medical care and any other type of remedial care recognized under the state law, specified by the Secretary.
- A. Transportation
1. Definitions.
- a. Ambulance transportation includes air and ground transportation provided at advanced life support level or basic life support levels by an appropriately licensed carrier.
- b. Medical service area is made up of the recipient's county of residence or a contiguous county.
2. Ambulance Services.
- a. An emergency ambulance service shall be provided without prior authorization to and from the nearest hospital emergency room. If a hospital emergency room is not available, a statement from an attending physician associated with the facility from which the patient receives services verifying medical necessity of stretcher ambulance services and the nature of the emergency services provided to the patient shall be required.
- b. A non-emergency ambulance service to a hospital, clinic, physician's office or other medical facility for provision of a Medicaid covered service exclusive of a pharmacy service, shall be covered upon referral from a licensed medical professional for a recipient whose medical condition warrants transport by stretcher.
- c. When it is determined by the attending physician that ground ambulance is not appropriate, a referral may be made for air ambulance transport to a medical facility beyond the recipient's county of residence or state boundaries. Medically necessary air travel will be covered within the parameters of the allowed reimbursement amounts specified in Attachment 4.19-B, page 20.11. Special authorization by the Commissioner or his designated representative is required for air transportation provided at a cost in excess of these amounts.
- d. Ground ambulance transport for in-state non-emergency ambulance travel outside the medical service area shall be covered if prescribed by the attending physician.
- e. Ground ambulance transport for out-of-state non-emergency ambulance transport shall only be covered if prior approval is obtained from the Department.
- f. Only the least expensive available transportation suitable for the recipient's needs shall be approved.

3. Specially Authorized Non-emergency Medical Transportation

- a. A specially authorized transportation service is non-emergency transportation necessary under extraordinary circumstances in which the recipient is required to travel out-of-state for medical treatment unavailable in-state.
- b. The Department assures provision of necessary transportation to and from a provider if the recipient has no other transportation resources.
- c. If transportation is not available free of charge, the Department will cover the least expensive means of appropriate transportation.
- d. Prior approval is required for all specially authorized transportation. When the recipient's medical needs cannot be met within the state, the Department will only approve travel to the nearest facility where those needs can be met.
- e. The Department will cover the following specially authorized transportation services:
 - (1) Transportation for a recipient;
 - (2) Lodging for a recipient, and a parent or attendant, if necessary;
 - (3) Meals, when necessary for the recipient to remain away from home and outside a medical facility while receiving treatment;
 - (4) Transportation and meals for one parent or guardian to accompany a dependent child receiving covered medical services, when treatment requires the child to remain away from home; and
 - (5) Transportation and meals for an attendant who accompanies a recipient receiving medical services, when there is a justifiable need for an attendant. The attendant can be a parent.

23.d. Nursing Facility Services for Patients Under 21 Years Age

A. Definitions:

1. "High intensity nursing care services" means care provided to Medicaid eligible individuals who meet high intensity patient status criteria which shall be equivalent to skilled nursing care standards under Medicare.
2. "Low intensity nursing care services" means care provided to Medicaid eligible individuals who meet low intensity patient status criteria which shall be equivalent to the former intermediate care patient status standards.
3. "Intermediate care for the mentally retarded and persons with related conditions services" means care provided to Medicaid eligible individuals who meet ICF-MR patient status criteria by ICF-MRs participating in the Medicaid Program.

B. Services:

Program benefits are limited to eligible recipients who require nursing facility care services meeting the above definitions. These services must be preauthorized and must be reevaluated every six (6) months. If the reevaluation of care needs reveals that the patient no longer requires high intensity, low intensity, or intermediate care for the mentally retarded services and payment is no longer appropriate in the facility, payment shall continue for ten (10) days to permit orderly discharge or transfer to an appropriate level of care.

All individuals receiving nursing facility care must be provided care in appropriately certified beds.

The following services are payable by the Medicaid program when they are medically necessary and ordered by the attending physician. The facilities may not charge the Medicaid recipient for these services. (Also see Attachment 4.19- D Exhibit B for a detailed explanation of each service or item.)

- (1) Routine services include a regular room (if the attending physician orders a private room, the facility cannot charge the family or responsible party any difference in private/semi-private room charges; the facility enters their charges for a private room when billing Medicaid), dietary services and supplements, medical social services, respiratory therapy and supplies, nursing services, the use of equipment and facilities, medical and surgical supplies, podiatry services, items which are furnished routinely and relatively uniformly to all patients, prosthetic devices, and laundry services (including laundry services for personal clothing which is the normal wearing apparel in the facility).
- (2) Ancillary services are those for which a separate charge is customarily made. They include physical therapy, occupational therapy, speech therapy, laboratory procedures, x-ray, oxygen and oxygen supplies, and ventilator use.

23.e. Emergency Hospital Services

Coverage is limited to the provision of emergency services provided in hospitals which have been determined to meet Title XVIII's definition of an emergency hospital.

TN No. 90-36
Supersedes
TN No. None

Approval Date: 11-14-1994

Effective Date 10-1-90

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

19. Case management services as defined in, and to the group specified in, Supplement 1 to ATTACHMENT 3.1-A (in accordance with Section 1905(a)(19) or section 1915(g) of the Act).

Provided: With limitations Not provided.

20. Extended services to pregnant women.

- a. Pregnancy-related and postpartum services for a 60-day period after the pregnancy ends and any remaining days in the month in which the 60th day falls.

Provided: + Additional coverage ++

- b. Services for any other medical conditions that may complicate pregnancy.

Provided: + Additional coverage ++ Not provided.

- c. Services related to pregnancy (including prenatal, delivery, postpartum, and family planning services) and to other conditions that may complicate pregnancy to individuals covered under section 1902(a)(i0)(A)(ii)(IX) of the Act.

Provided: + Additional coverage ++ Not provided.

+ Attached is a list of major categories of services (e.g., inpatient hospital, physician, etc.) and limitations on them, if any, that are available as pregnancy-related services or services for any other medical condition that may complicate pregnancy.

++ Attached is a description of increases in covered services beyond limitations for all groups described in this attachment and/or any additional services provided to pregnant women only.

* Description provided on attachment.

State/Territory: Kentucky

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND
SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

21. Ambulatory prenatal care for pregnant women furnished during a presumptive eligibility period by an eligible provider (in accordance with section 1920 of the Act).
 Provided: No limitations With Limitations* Not provided.
22. Respiratory care services (in accordance with section 1902 (e)(9)(A) through (C) of the Act).
 Provided: No limitations With Limitations* Not provided.
23. Certified pediatric or family nurse practitioners services.
 Provided: No limitations With Limitations* Not provided.

See item 6d for limitations.

* Description provided on attachment.

State/Territory: Kentucky

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND
REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

24. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.
- a. Transportation.
 Provided: No limitations With Limitations* Not provided.
- b. Services provided in Religious Nonmedical Health Care Institutions.
 Provided: No limitations With Limitations* Not provided.
- c. Reserved
- d. Nursing facilities for patients under 21 years of age.
 Provided: No limitations With Limitations* Not provided.
- e. Emergency hospital services.
 Provided: No limitations With Limitations* Not provided.
- f. Personal care services in recipient's home prescribed in accordance with a plan of treatment and provided by a qualified person under supervision of a registered nurse.
 Provided: No limitations With Limitations* Not provided.

* Description provided on attachment

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kentucky

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE
AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

24. Any other medical care and any other type of remedial care recognized under State law and specified by the Secretary.

a 1. Transportation

- No limitations
 With limitations

Transportation is limited to individuals requesting transportation who lack access to free transportation that meets their medical needs. Transportation is only authorized for a Medicaid-covered service that has been determined medically necessary.

a 2. Brokered Transportation

- Provided under section 1902(a)(70)

The State assures it has established a non-emergency medical transportation program in order to more cost-effectively provide transportation, and can document, upon request from CMS, that the transportation broker was procured in compliance with the requirements of 45 CFR 92.36 (b)-(f).

(1) The State will operate the broker program without the requirements of the following paragraphs of section 1902(a);

- (1) statewideness (indicate areas of State that are covered)
 (10)(B) comparability (indicate participating beneficiary groups)
 (23) freedom of choice (indicate mandatory population groups)

All Medicaid recipients covered under Kentucky's State Plan, excluding Qualified Medicare Beneficiaries, are eligible for the non-emergency medical transportation benefit. Recipients are restricted to using the regional broker and the provider assigned by the broker for the recipient's trip.

(2) Transportation services provided will include:

- wheelchair van
 taxi

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kentucky

- stretcher car
- bus passes
- tickets
- secured transportation
- such other transportation as the Secretary determines appropriate (please describe):
Private automobiles, non-profit transit system, specialty carriers for non-emergency ambulatory disoriented persons, and specialty carriers using lift equipped vehicles in compliance with the Americans with Disabilities Act certified to transport non-emergency, non-ambulatory persons.

Private auto providers enroll via the same enrollment and credentialing process as other Medicaid providers and submit additional enrollment documents specific to the transportation program including vehicle registration, vehicle insurance coverage and a valid driver's license. This category of provider is defined in Kentucky Revised Statute 281.873.

Private auto providers are reimbursed the Kentucky State Employee mileage rate in effect for the given time period.

- (3) The State assures that transportation services will be provided under a contract with a broker who:
 - (i) is selected through a competitive bidding process based on the State's evaluation of the broker's experience, performance, references, resources, qualifications, and costs;
 - (ii) has oversight procedures to monitor beneficiary access and complaints and ensures that transport personnel are licensed, qualified, competent, and courteous;
 - (iii) is subject to regular auditing and oversight by the State in order to ensure the quality of the transportation services provided and the adequacy of beneficiary access to medical care and services;
 - (iv) complies with such requirements related to prohibitions on referrals and conflict of interest as the Secretary shall establish (based on prohibitions on physician referrals under section 1877 and such other prohibitions and requirements as the Secretary determines to be appropriate);
- (4) The broker contract will provide transportation to the following categorically needy mandatory populations:
 - Low-income families with children (section 1931)
 - Low-income pregnant women
 - Low-income infants
 - Low-income children 1 through 5
 - Low-income children 6-19

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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- Qualified pregnant women
 - Qualified children
 - IV-E Federal foster care and adoption assistance children
 - TMA recipients (due to employment)
 - TMA recipients (due to child support)
 - SSI recipients
- (5) The broker contract will provide transportation to the following categorically needy optional populations:
- Optional low-income pregnant women
 - Optional low-income in
 - Optional targeted low-income children
 - Individuals under 21 who are under State adoption assistance agreements
 - Individuals under age 21 who were in foster care on their 18th birthday
 - Individuals who meet income and resource requirements of AFDC or SSI
 - Individuals who would meet the income & resource requirements of AFDC if child care costs were paid from earnings rather than by a State agency
 - Individuals who would be eligible for AFDC if State plan had been as broad as allowed under Federal law
 - Individuals who would be eligible for AFDC or SSI if they were not in a medical institution
 - Individuals infected with TB
 - Individuals screened for breast or cervical cancer by CDC program
 - Individuals receiving COBRA continuation benefits
 - Individuals in special income level group, in a medical institution for at least 30 consecutive days, with gross income not exceeding 300% of SSI income standard
 - Individuals receiving home and community based waiver services who would only be eligible under State plan if in a medical institution
 - Individuals terminally ill if in a medical institution and will receive hospice care
 - Individuals aged or disabled with income not above 100% FPL
 - Individuals receiving only an optional State supplement in a 209(b) State
 - Individuals working disabled who buy into Medicaid (BBA working disabled group)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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- Employed medically improved individuals who buy into Medicaid under TWWIA Medical Improvement Group
 - Individuals disabled age 18 or younger who would require an institutional level of care (TEFRA 134 kids)
- (6) The State will pay the contracted broker by the following method:
- (i) risk capitation
 - (ii) non-risk capitation
 - (iii) other (e.g., brokerage fee and direct payment to providers)

Under a brokerage system, Kentucky is divided into fifteen (15) Non-Emergency Medical Transportation Regions which were established based upon regional medical utilization and referral patterns. The broker contract for each region is bid separately; however, a broker may be a successful bidder for more than one region. Each region has a single per member per month (PMPM) capitation rate which is paid to the regional broker for all transportation eligible recipients in that region. A single payment for each broker is made each month on a prospective basis. In the event one broker gains the contract in multiple regions, a blended PMPM rate is paid for all regions served by that broker.

The PMPM rate for each region is established based on historical utilization and cost patterns for the region. The PMPM rate for each region may be updated annually effective July 1st of each year if encounter data trends indicate that a region has experienced an increase in transportation utilization and/or cost which was outside of the control of the broker. PMPM rates may also be adjusted on an as needed basis if programmatic changes (i.e. State Plan or waiver changes) would result in a change in transportation utilization or if transportation cost factors (i.e. gas prices) result in a change in the projected cost of transportation.

If for any reason, a broker's contract is terminated before a replacement broker can be procured, non-emergency transportation reimbursement will revert to the methods applicable to non-emergency transportation described in Attachment 4.19-B, Section VII of the State Plan.

TN No.: 06-008
Supersedes
TN No.: New

Approval Date: 05/03/06

Effective Date: 06/01/06

State: Kentucky

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

25. Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A, and Appendices A-G to Supplement 2 to Attachment 3.1-A.

provided not provided

AMOUNT, DURATION AND SCOPE OF MEDICAL
AND REMEDIAL CARE SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

26. Program of All-Inclusive Care for the Elderly (PACE) services, as described and limited in Supplement 3 to Attachment 3.1-A.

provided not provided

State/Territory: Kentucky

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND
REMEDIAL CARE AND SERVICES PROVIDED TO THE
CATEGORICALLY NEEDY

27. Durable Medical Equipment, Medical Supplies, Prosthetics and Orthotics

Provided: No limitations With limitations* Not provided.

*Description provided on attachment

TN No. 03-06
Supersedes
TN No. None

Approval Date 10/31/2003

Effective Date 01-01-03

State/Territory Kentucky

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND
REMEDIAL CARE AND SERVICES PROVIDED TO THE
MEDICALLY NEEDY

27. Durable Medical Equipment, Medical Supplies, Prosthetics and Orthotics

An item of durable medical equipment, prosthetic, or orthotic shall be durable in nature and able to withstand repeated use. Coverage of an item of durable medical equipment, medical supplies, prosthetics and orthotics shall be in accordance with the following: shall serve a medical purpose; shall not generally be useful to a person in the absence of illness or injury; and shall be medically necessary and reasonable.

- a. A provider must be Medicare and Medicaid certified. Items must be medically necessary and, if required, prior authorized.
- b. All miscellaneous codes require prior authorization. Any item that does not have a designated HCPCS code and is determined by the department to be a covered item will use the designated miscellaneous HCPCS code from the HCPCS Coding Book and require prior authorization.
- c. Any item designated by a covered HCPCS code being reimbursed at \$150.00 or more will require prior authorization.
- d. All items of durable medical equipment, prosthetic, orthotic, or medical supply will require a Certificate of Medical Necessity to be kept on file at the provider's office for five (5) years.
- e. The following general types of durable medical equipment, medical supply, prosthetics or orthotics are excluded from coverage under the durable medical equipment program:
 1. Items which would appropriately be considered for coverage only through other sections of the Medicaid Program, such as frames and lenses, hearing aids, and pacemakers;
 2. Items which are primarily and customarily used for a non-medical purpose, such as air conditioners and room heaters;
 3. Physical fitness equipment, such as exercycles and treadmills;
 4. Items which basically serve a comfort or convenience of the recipient or the person caring for the recipient, such as elevators and stairway elevators;
 5. Items needed as a resident of an inpatient program of a hospital, or nursing facility, and
 6. Items considered educational or recreational.
- f. A cast or splint shall be limited to two (2) per ninety (90) day period for the same injury or condition.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Agency: Kentucky

MEDICAID PROGRAM: REQUIREMENTS RELATING TO
COVERED OUTPATIENT DRUGS FOR THE CATEGORICALLY NEEDY

Citation (s)	Provision (s)
1935(d)(1)	Effective January 1, 2006, the Medicaid agency will not cover any Part D drug for full-benefit dual eligible individuals who are entitled to receive Medicare benefits under Part A or Part B.

TN No.: 05-010
Supersedes
TN No.: NEW

Approval Date: 11/25/05

Effective Date: 01/01/06

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Agency: Kentucky

MEDICAID PROGRAM: REQUIREMENTS RELATING TO PAYMENT FOR COVERED
OUTPATIENT DRUGS FOR THE CATEGORICALLY NEEDY

Citation (s)	Provision (s)
1927(d)(2) and 1935(d)(2)	<p>1. The Medicaid agency provides coverage for the following excluded or otherwise restricted drugs or classes of drugs or their medical uses to all Medicaid recipients, including full benefit dual eligible beneficiaries under the Medicare Prescription Drug Benefit - Part D.</p> <p>— The following excluded drugs are covered:</p> <ul style="list-style-type: none"><input type="checkbox"/> (a) agents when used for anorexia, weight loss, weight gain (see specific drug categories below)<input type="checkbox"/> (b) agents when used to promote fertility (see specific drug categories below)<input type="checkbox"/> (c) agents when used for cosmetic purposes or hair growth (see specific drug categories below)<input type="checkbox"/> (d) agents when used for the symptomatic relief cough and colds (see specific drug categories below)<input type="checkbox"/> (e) prescription vitamins and mineral products, except prenatal vitamins and fluoride (see specific drug categories below)<input checked="" type="checkbox"/> (f) nonprescription drugs (see specific drug categories below)

TN No.: 05-010
Supersedes
TN No.: NEW

Approval Date: 11/25/05

Effective Date: 01/01/06

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Agency: Kentucky

MEDICAID PROGRAM: REQUIREMENTS RELATING TO PAYMENT FOR COVERED
OUTPATIENT DRUGS FOR THE CATEGORICALLY NEEDY

Citation(s)	Provision(s)
1927(d)(2) and 1935(d)(2)	<input type="checkbox"/> (g) covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee (see specific drug categories below) (The Medicaid agency lists specific category of drugs below) Kentucky Medicaid will cover all nonprescription drug categories for full benefit dual eligible beneficiaries, which is consistent with Kentucky's policy of covering all nonprescription drug categories for non-dual recipients. Herbal products are not covered.
	<input type="checkbox"/> No excluded drugs are covered.

TN No. 13-026
Supersedes
TN No.: 11-011

Approval Date 1/23/2014

Effective Date: October 1, 2013

28. (i) **Licensed or Otherwise State-Approved Freestanding Birth Centers**

- Provided No limitations With limitations
 None licensed or approved

28. (ii) **Licensed or Otherwise State-recognized covered professionals providing services in the Freestanding Birth Center.**

- Provided No limitations With limitations
 Not Applicable (there are no licensed or State approved Freestanding Birth Centers)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kentucky

CASE MANAGEMENT SERVICES

- A. Target Groups: By invoking the exception to comparability allowed by 1915 (g)(1) of the Social Security Act, this service will be reimbursed when provided to persons who are:
1. Aged 0-21 and meet the medical eligibility criteria of Commission for Handicapped Children, the state's Title V Crippled Children's Agency, and
 2. Persons of all ages meeting the medical eligibility criteria of the Commission for Handicapped Children and having a diagnosis of hemophilia.
- The individuals in the target groups may not be receiving case management services under an approved waiver program.
- B. Areas of State in which services will be provided:
- Entire State.
- Only in the following geographic areas (authority of Section 1915 (g)(1) of the Act is involved to provide services less than statewide:
- C. Comparability of Services
- Services are provided in accordance with Section 1902(a)(10)(B) of the Act.
- Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.
- D. Definition of Services: Case management is a service instrument by which service agencies assist an individual in accessing needed medical, social, educational and other support services. Consistent with the requirements of Section 1902 a (23) of the Act, the providers will monitor client treatment to assure that clients receive services to which they are referred. One case management unit is the sum of case management activities that occur within a calendar month. These activities include:

(continued on next page)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kentucky

CASE MANAGEMENT SERVICES

D. Definition of Services: (Continued)

1. Assessment of client's medical, social, and functional status and identification of client service needs;
2. Arranging for service delivery from the client's chosen provider to insure access to required services;
3. Insure access to needed services by explaining the need and importance of services in relation to the client's condition;
4. Insure access, quality and delivery of necessary services, and
5. Preparation and maintenance of case record documentation to include service plans, forms, reports, and narratives, as appropriate.

E. Qualification of Providers:

Providers must be certified as a Medicaid provider meeting the following criteria:

1. Demonstrated capacity to provide all core elements of case management
 - (a) assessment
 - (b) care/services plan development
 - (c) linking/coordination of services
 - (d) reassessment/follow up
2. Demonstrated case management experience in coordinating and linking such community resources as required by the target population.
3. Demonstrated experience with the target population.
4. An administrative capacity to insure quality of services in accordance with state and federal requirements.
5. A financial management system that provides documentation of services and costs.
6. Capacity to document and maintain individual case records in accordance with state and federal requirements.
7. Demonstrated ability to assure a referral process consistent with Section 1902a(23), freedom of choice of provider.
8. Demonstrated capacity to meet the case management service needs of the target population.

(Continued on next Page)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kentucky

CASE MANAGEMENT SERVICES

E. Qualifications of Providers (continued)

Qualifications of Case Manager (Only the following can be case managers)

1. Registered Nurse - Must be licensed as a Registered Nurse or possess a valid work permit issued by the Kentucky Board of Nursing.
2. Social Worker - A master's degree in social work supplemented by one year of professional social work experience; or a graduate of a college or university with a bachelor's degree supplemented by two years of professional social work experience.

F. The State that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a) (23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services.
2. Eligible recipients will have free choice of the providers of other medical care under the plan.

G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Targeted Case Management Services for Severely Emotionally Disturbed Children

- A. Target Groups: By involving the exception to comparability allowed by 1915(g)(1) of the Social Security Act, this service will be reimbursed when provided to persons who are:
1. Age 0-21 and meet the state's conditions and circumstances to be defined as a "severely emotionally disturbed child."
- The individuals in the target groups may not be receiving case management services under an approved waiver program.
- B. Areas of State in which services will be provided:
- Entire State.
- Only in the following geographic areas (authority of Section 1915(g)(1) of the Act is involved to provide services less than statewide:
- C. Comparability of Services
- Services are provided in accordance with Section 1902(a)(10)(B) of the Act.
- Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.
- D. Definition of Services: Case management is a service instrument by which service agencies assist an individual in accessing needed medical, social, educational and other support services. Consistent with the requirements of Section 1902 (a) (23) of the Act, the providers will monitor client treatment to assure that clients receive services to which they are referred. One case management unit is the sum of case management activities that occur within a calendar month. These activities include:

- (1) A written comprehensive assessment of the child's needs;
- (2) Arranging for the delivery of the needed services as identified in the assessment;
- (3) Assisting the child and his family in accessing needed services;
- (4) Monitoring the child's progress by making referrals, tracking the child's appointments, performing follow-up on services rendered, and performing periodic reassessments of the child's changing needs;
- (5) Performing advocacy activities on behalf of the child and his family;
- (6) Preparing and maintaining case records documenting contacts, services needed, reports, the child's progress, etc.;
- (7) Providing case consultation (i.e., consulting with the service providers/collateral's in determining child's status and progress); and
- (8) Performing crisis assistance (i.e., intervention on behalf of the child, making arrangements for emergency referrals, and coordinating other needed emergency services).

E. Qualification of Providers:

Provider participation shall be limited to the Kentucky Department for Social Services and the fourteen Regional Mental Health Mental Retardation Centers, licensed in accordance with state regulations.

Qualifications of Case Manager and Supervision Requirement

- (1) Case Manager Qualifications. Each case manager shall be required to meet the following minimum requirements:
 - (a) Have a Bachelor of Arts or Bachelor of Sciences degree in any of the behavioral sciences from an accredited institution; and
 - (b) Have one (1) year of experience working directly with children or performing case management services (except that a master's degree in a human services field may be substituted for the one (1) year of experience); and
 - (c) Have received training within six (6) months designed and provided by each participating provider directed toward the provision of case management services to the targeted population; and

- (d) Have supervision for a minimum of one (1) year by a mental health professional; i.e., psychiatrist, psychologist, master's level social worker (MSW), psychiatric nurse or professional equivalent (a minimum of a bachelor's degree in a human services field, with two (2) years of experience in mental health related children's services). The supervisor shall also complete the required case management or training course.
 - (2) Case Manager Supervision Requirement. For at least one (1) year, each case manager shall have supervision performed at least once a month for each case plan.
- F. The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.
 - (1) Eligible recipients will have free choice of the providers of case management services.
 - (2) Eligible recipients will have free choice of the providers of other medical care under the plan.
- G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purposes.

State Kentucky

Targeted Case Management Services for Children in the Custody of or at Risk of Being in the Custody of the State, and for Children under the Supervision of the State, and for Adults in Need of Protective Services

- A. Target Groups: By invoking the exception to comparability allowed by 1915(g)(1) of the Social Security Act, this service will be reimbursed when provided to persons who are:
1. Age 0-21 and meet the state's conditions and circumstances to be defined as a child in the custody of or at risk of being in the custody of the state, or a child who is under the supervision of the state, and
 2. Adults who meet the state's conditions and circumstances to be defined as an adult in need of protective services.
- B. Areas of State in which services will be provided:
- Entire State.
- Only in the following geographic areas (authority of Section 191 5(g)(1) of the act is invoked to provide services less than statewide):
- C. Comparability of Services
- Services are provided in accordance with Section 1902(a)(10)(B) of the Act.
- Services are not comparable in amount, duration and scope. Authority of Section 191 5(g)(1) of the Act is invoked to provide services without regard to the requirements of Section 1902(a)(10)(B) of the Act.
- D. Definition of Services: Case management is a service that allows providers to assist eligible individuals in accessing needed medical, social, educational and other support services. Consistent with the requirements of Section 1 902(a)(23) of the Act, the providers will monitor client treatment to assure that clients receive services they are referred to. One case management unit is the sum of case management activities that occur within a calendar month. These activities include:

- (1) A written assessment of the child or adults needs;
- (2) Arranging for the delivery of the needed services as identified in the assessment;
- (3) Assisting the child and his family, or the adult, in accessing services needed by the individual child or adult.
- (4) Monitoring the child or adults progress by making referrals, tracking the child or adult's appointments, performing follow-up on services rendered, and performing periodic reassessments of the child or adult's changing needs;
- (5) Performing advocacy activities on behalf of the adult, or the child and his family, to assure that the individual adult or child gains access to the services he or she needs.
- (6) Obtaining, preparing and maintaining case records documenting contacts, services needed, reports, the child or adult's progress, etc following provision of service to the child or the adult on behalf of the child or adult.
- (7) Providing case consultation (i.e., consulting with the service provider/collateral's in determining the child or adult's status and progress); and
- (8) Performing crisis assistance (i.e., intervention on behalf of the child or adult, making arrangements for emergency referrals, and coordinating other needed emergency services).

E. Qualification of Providers:

Providers must be certified as a Medicaid provider meeting the following criteria:

- (1) Demonstrated capacity to provide all core elements of case management including
 - (a) assessment;
 - (b) care/services plan development;
 - (c) linking/coordination of services; and
 - (d) reassessment/follow-up.
- (2) Demonstrated case management experience in coordinating and linking such community resources as required by one of the target populations.

- (3) Demonstrated experience with one of the target populations.
- (4) An administrative capacity to insure quality of services in accordance with state and federal requirements.
- (5) Have a financial management system that provides documentation of services and costs.
- (6) Capacity to document and maintain individual case records in accordance with state and federal requirements.
- (7) Demonstrated ability to assure a referral process consistent with Section 1 902(a)(23) of the Act, freedom of choice of provider.
- (8) Demonstrated capacity to meet the case management service needs of the target population.

Qualifications of Case Manager (Only the following can be case managers)

Each case manager must be employed by an enrolled Medicaid provider or by an approved subcontractor of an enrolled Medicaid provider and must meet the following minimum requirements:

- (1) Have a Bachelor of Arts or Bachelor of Sciences degree in any of the social/behavioral sciences or related fields from an accredited institution; and
 - (2) Have one (1) year of experience working directly with the targeted case management population or performing case management services or have a master's degree in a human service field.
- F. The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of Section 1902(a)(23) of the Act.
- (1) Eligible recipients will have free choice of the providers of case management services.
 - (2) Eligible recipients will have free choice of the providers of other medical care under the plan.
- G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Targeted Case Management Services for children birth to 3 participating in the Kentucky Early Intervention Program

- A. Target Groups: By invoking the exception to comparability allowed by 1915(g)(i) of the Social Security Act, this service will be reimbursed when provided to persons who are:
1. Children birth to three years of age who have developmental disabilities and who meet the eligibility criteria of and are participants in the Kentucky Early Intervention Program.
- The individuals in the target groups may not be receiving case management services under an approved waiver program.
- B. Areas of State in which services will be provided:
- Entire State
 - Only in the following geographic areas (authority of Section 1915(g)(1) of the Act is involved to provided services less than statewide:
- C. Comparability of Services
- Services are provided in accordance with Section 1902(a)(10)(B) of the Act.
 - Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.
- D. Definition of Services: Case management is a service which allows providers to assist eligible individuals in gaining access to needed medical, social, educational, and other services. Consistent with the requirements of Section 1902(a)(23) of the Act, the providers will monitor client treatment to assure that clients receive services to which they are referred.

Case management is an active, ongoing process that involves activities carried out by a case manager to assist and enable a child eligible for services under the Kentucky Early Intervention Program in gaining access to needed medical, social, educational and other services. There are two parts to case management: Initial Service Coordination and Primary Service Coordination. Initial Service Coordination assists the child and child's family, as it relates to the child's needs, from the notice of referral through the initial development of the child's needs-identified Individualized Family Services Plan (IFSP). Primary Service Coordination assists the child and child's family, as it relates to the child's needs, with ongoing service coordination, for the child, provided by the individual service coordinator selected at the time the IFSP is finalized. A child would only have one service coordinator at a time.

These activities include:

- (1) Assessment of child's medical, social and functional status and identification of service needs;
- (2) Initial service coordination from notice of referral through initial IFSP development;
- (3) Assuring that all procedural safeguards are met during intake and IFSP development;
- (4) Arranging for and coordinating the development of the child's IFSP;
- (5) Arranging for the delivery of the needed services as identified in the IFSP;
- (6) Assisting the child and his family, as it relates to the child's needs, in accessing needed services for the child and coordinating services with other programs;
- (7) Monitoring the child's progress by making referrals, tracking the child's appointments, performing follow-up on services rendered, and performing periodic reassessments of the child's changing service needs;
- (8) Performing activities to enable an eligible individual to gain access to needed services;
- (9) Obtaining, preparing and maintaining case records documenting contacts, services needed, reports, the child's progress, etc.;
- (10) Providing case consultation (i.e., with the service providers/collaterals in determining child's status and progress);

-
- (11) Performing crisis assistance (i.e., intervention on behalf of the child, making arrangements for emergency referrals, and coordinating other needed emergency services); and
 - (12) Facilitating and coordinating development of the child's transition plan.

E. Qualifications of Providers:

As provided for in Section 1915 (g)(1) of the Social Security Act, qualified providers shall be the Title V agencies and their subcontractors who meet the following Medicaid criteria in order to ensure that case managers for the children with developmental disabilities target group are capable of ensuring that such individuals receive needed services:

1. Demonstrated capacity to provide all core elements of case management including:
 - a) assessment;
 - b) care/services plan development;
 - c) linking/ coordination of services; and
 - d) reassessment/follow-up
2. Demonstrated case management experience in coordinating and linking such community resources as required by the target population;
3. Demonstrated experience with targeted population;
4. An administrative capacity to insure quality of services in accordance with state and federal requirements; and
5. A financial management system that provides documentation of services End costs.

Qualifications of Case Manager (only the following can be case managers)

Each case manager must be a Kentucky Early Intervention Program certified service provider, and:

- A. Have a Bachelor's degree; and
- (1) 2 years experience in service coordination for children with disabilities up to age 18; or
 - (2) 2 years experience in service provision to children under six years of age; or
- B. Meet one of the following professional criteria:
1. Audiologist - Licensed or Certified,
 2. Family Therapist - M.A. and Certified,
 3. Developmental Interventionist - Certified or working toward an Interdisciplinary Early Childhood Certificate as demonstrated by implementing a professional development plan approved by the Cabinet for Health Services,
 4. Developmental Associate,
 5. Registered Nurse,
 6. Advanced Registered Nurse Practitioner,
 7. Dietitian - Licensed,
 8. Occupational Therapist - Licensed,
 9. Occupational Therapist Assistant - B.S. and Licensed,
 10. Orientation and Mobility Specialist - Certified,
 11. Physical Therapist - Licensed,
 12. Psychologist - Licensed or Certified,
 13. Speech Language Pathologist - Licensed or Certified,
 14. Speech Language Assistance - Licensed,
 15. Social worker - Licensed,
 16. Physician, Licensed,
 17. Nutritionist, Licensed

- F. The State assures that the provision of case management services will not unlawfully restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.
- (1) Eligible recipients will have free choice of the available providers of case management services.
 - (2) Eligible recipients will have free choice of the available providers of other medical care under the plan.
- G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for the same purpose.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

CASE MANAGEMENT SERVICES

- A. Target Group: By invoking the exception to comparability allowed by 1915(g)(1) of the Social Security Act, this service will be reimbursed when provided to persons who are:
1. Pregnant women who have not reached their twentieth birthday and will be first time parents;
 2. Pregnant women who are twenty years of age or older, will be first time parents, and screen positive for the home visitation program which shall be called Health Access Nurturing Development Services (HANDS). High risk screening factors include: first time mothers who are single, separated or divorced; those who had late, sporadic or no prenatal care; those who sought or attempted an unsuccessful abortion; partner unemployed; inadequate income or no source of income; unstable housing; no phone; education less than 12 years; inadequate emergency contacts; treatment of or current substance abuse; treatment of abortion; treatment of psychiatric care; relinquishment for adoption, sought or attempted; marital or family problems; treatment of or current depression;
 3. Infants and toddlers up to their third birthday who are children in families described in A.1 and A.2 of this subsection;
 4. First born infants up to twelve (12) weeks of age whose families were not identified prenatally and who assess into the program.
- B. Areas of State in which services will be provided:
- Entire State
- Only in the following geographic areas (authority of Section 1915(g)(1) of the Act is invoked to provide services less than state wide:
- C. Comparability of Services:
- Services are provided in accordance with 1902(a)(10)(B) of the Act.
- Services are not comparable in amount, duration and scope. Authority of 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of 1902(a)(10)(B).
- D. Definition of Services
- Case management is a service which allows providers to assist eligible individuals in gaining access to needed medical, social, education, and other services. Consistent with the requirement of Section 1902(a)(23) of the Act, the providers will monitor client treatment to

assure that clients receive services to which they are referred.

Case management is an active, ongoing process that involves activities carried out by case managers to assess and enable first time mothers and infants/toddlers who are eligible for services under the Kentucky HANDS (Health Access Nurturing Development Services) Program. There are two phases to case management - assessment and home "visitation. Both phases include assisting the infant/toddler, mother, or family in accessing needed services, developing a treatment plan, coordinating needed services, monitoring progress, preparing and maintaining case records, providing case consultation as specified by the plan, and providing follow-up and evaluation.

The service activities include:

1. Assessment
 - a) Provided by a Registered Nurse, Social Worker or Early Childhood Development Specialist;
 - b) Conducts a face-to-face needs assessment with the child, mother and family. The assessment shall include:
 - 1) parent's childhood experience;
 - 2) lifestyle behaviors and mental health status;
 - 3) parenting experience;
 - 4) stressors, coping skills and support system for the new family;
 - 5) anger management skills;
 - 6) expectations of infant's developmental milestones and behaviors;
 - 7) perception of new infant, and bonding and attachment issues;
 - 8) plans for discipline; and
 - 9) family environment and support system.
 - c) Develops a written report of the findings and a service plan for the family.
 - d) Assigns home visitor and arranges for the delivery of the needed services by other Medicaid and community providers as identified in the treatment plan.

2. Home Visitation

- a) A public health nurse, social worker, or family support worker who is supervised by a public health nurse, social worker or early childhood development specialist may perform a home visit;
- b) Assist the child and family, as it relates to the treatment plan, in accessing needed services and coordinating services with other programs;
- b) Monitor progress by making referrals, tracking the appointments, performing follow-up services, and performing periodic evaluation of the changing needs;
- c) Perform activities to enable the child and family to gain access to needed services;
- d) Prepare and maintain case records documenting contacts, services needed, reports, progress;
- e) Provide case consultation (i.e., with the service providers/collaterals in determining child's status and progress); and
- f) Perform crisis assistance (i.e., intervention on behalf of the child, making arrangement for emergency referrals, and coordinating other needed emergency service).

E. Qualifications of Providers:

1. Providers must be certified as a Medicaid provider meeting the following criteria:

- a) Demonstrated capacity to contract statewide for the case management services for the targeted population;
- b) Demonstrated capacity to ensure all components of case management including:
 - 1) screening,
 - 2) assessment,
 - 3) treatment plan development,
 - 4) home visiting,
 - 5) linking/coordination of services, and
 - 6) follow-up and evaluation;
- c) Demonstrated experience in coordinating and linking such community resources as required by the target population;
- d) Demonstrated experience with the target population;

-
- e) Administrative capacity to insure quality of services in accordance with state and federal requirements;
 - f) Demonstrated capacity to provide certified training and technical assistance to case managers;
 - g) Financial management system that provides documentation of services and costs;
 - h) Capacity to document and maintain individual case records in accordance with state and federal requirements;
 - i) Demonstrated ability to assure a referral process consistent with Section 1902a(23), freedom of choice of provider; and
 - j) Demonstrated capacity to meet the case management service needs of the target population.

2. Qualifications of Case Manager

The case manager shall meet one of the following professional criteria:

- a) Registered Nurse – Must have a valid Kentucky Board of Nursing license as a registered nurse or advanced registered nurse practitioner.
- b) Social Worker – Meet the requirement of KRS Chapter 335 for licensure by the State Board of Examiners of Social Work, have a masters degree in social work, or have a bachelors degree in social work from an accredited institution.
- c) Early Childhood Development Specialist – have a bachelors degree in Family Studies, Early Childhood Education, Early Childhood Special Education, or a related Early Childhood Development Curriculum.
- d) Family Support Worker (FSW) – Have a high school diploma or GED, be 18 years of age or older, and have received core training prior to having family contact on assessment of family strengths and needs, service plan development, home visitor process, home visitor role, supporting growth in families, observing parent-child interactions, knowing indicators of parent-infant attachment, keeping home visit records, conducting service coordination and reassessment. In addition to the core training the family support worker receives continuing training on selected topics including confidentiality, community resources, developmental milestones, family violence, substance abuse, ethical issues, communication skills, HIV/AIDS training, and interviewing techniques. The FSW must be supervised by a registered nurse or social worker.

- F. The state assures that the provision of case management services will not unlawfully restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.
1. Eligible recipients will have free choice of the providers of case management services.
 2. Eligible recipients will have free choice of the available providers of other medical care under the plan.
- G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for the same purpose.

Targeted Case Management services for pregnant women including postpartum women for sixty (60) day period after the pregnancy ends and any remaining days in the month in which the 60th day falls.

- A. By invoking the exception to comparability allowed by 1915(g)(1) of the Social Security Act, this service will be reimbursed when provided to persons who are:
- (1) Women diagnosed as a pregnant woman or postpartum woman up to the end of the month of sixty days following the date of delivery who has applied for or is receiving substance abuse services through Medicaid.
- B. Areas of State in which services will be provided:
- Entire State
- Only in the following geographic areas (authority of Section 191 5(g)(1) of the Act is involved to provided services less than statewide:
- C. Comparability of Services
- Services are provided in accordance with Section 1902(a)(10)(B) of the Act.
- Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.
- D. Definition of Services: Case management is a service which allows providers to assist eligible individuals in gaining access to needed medical, social, education, and other services. Consistent with the requirements of Section 1902(a)(23) of the Act, the providers will monitor client treatment to assure that clients receive services to which they are referred.
- (1) Substance abuse case management services.
 - (a) Case management shall be:
 1. A face-to-face or telephone contact between or on behalf of an individual and a qualified substance abuse professional; and
 2. For the purpose of reducing or eliminating an individual's substance abuse problem by assisting an individual in gaining access to needed medical, social, educational and other support services.
 - (b) Case management services shall include:
 1. The development of a service plan that identifies an individual's case management needs and projected outcomes; and
 2. Activities that support the implementation of an individual's service plan
 - (c) Case management services shall not be connected with a specific type of substance abuse treatment but shall follow an individual across the array of substance abuse treatment services identified in an individual's treatment plan.

(d) Service limitations. The following activities shall not be reimbursed by Medicaid:

1. An outreach or case-finding activity to secure a potential individual for services;
2. Administrative activities associated with Medicaid eligibility determinations; and
3. The actual provision of a service other than a case management service.

A. Qualifications of Providers:

- 1) Services are covered when provided by any mental health center, and their subcontractors, and any other qualified providers, licensed in accordance with applicable state laws and regulations.
- 2) Demonstrated capacity to provide all core elements of case management including: Assessment skills, care/services plan development, linking/coordination of services, reassessment/follow-up, training specific to the target population, an administrative capacity to insure quality of services in accordance with state and federal requirements and a financial system that provides documentation of services and costs.
- 3) The provider shall employ or have a contractual agreement with a physician licensed in Kentucky.
- 4) A provider must have staff available to provide emergency services for the immediate evaluation and care of an individual in a crisis situation on a twenty-four (24) hour a day, seven (7) day a week basis.
- 5) Qualifications for case management services:
 - (a) An alcohol and drug counselor certified by the Kentucky Board of Certification for Alcohol and Drug Counselors;
 - (b) An individual who has a bachelor's degree or greater in any field, from an accredited college or university who meets the training, documentation and supervision requirements;
 - (c) A Kentucky licensed physician.
 - (d) A psychiatrist who is licensed in Kentucky.
 - (e) A psychologist licensed or certified by the Kentucky Board of Examiners of Psychology;
 - (f) A psychological associate certified by the Kentucky Board of Examiners of Psychology;

- (g) A social worker licensed or certified in Kentucky;
 - (h) A Kentucky licensed registered nurse with the following combinations education and work experience:
 - 1. A registered nurse with a masters degree in psychiatric nursing from an accredited college or university;
 - 2. A bachelor of science degree in nursing from an accredited college or university and one year of clinical work experience in the substance abuse or mental health field;
 - 3. A diploma graduate in nursing and two years of clinical work experience in the substance or mental health field; or
 - 4. An associate degree in nursing from an accredited college or university and three years of clinical work experience in the substance abuse or mental health field;
 - (i) A Kentucky licensed advanced registered nurse practitioner;
 - (j) A marriage and family therapist licensed by the Kentucky Board of Licensure of Marriage and Family Therapists;
 - (k) A Kentucky-certified professional counselor; or
 - (l) A Kentucky-certified professional art therapist.
- F. The State assures that the provision of case management services will not unlawfully restrict an individual's free choice of providers in violation of section 1 902(a)(23) of the Act.
- (1) Eligible recipients will have free choice of the available providers of case management services.
 - (2) Eligible recipients will have free choice of the available providers of other medical care under the plan.
- G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for the same purpose.

AMOUNT, DURATION AND SCOPE OF MEDICAL AND
REMEDIAL CARE SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

PACE SERVICES

The State of Kentucky has not entered into any valid program agreements with a PACE provider and the Secretary of the Department of Health and Human Services.

The State of _____ has entered into a valid program agreement(s) with a PACE provider(s) and secretary, as follows:

Name of PACE provider: _____

Service area: _____

Maximum number of individuals to be enrolled: _____

This information should be provided for all PACE providers with which the State Administering Agency for PACE and the Secretary have entered into valid program agreements.)

AMOUNT DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): ALL

The following ambulatory services are provided:

Physician's Services
Rural Health Clinic
Outpatient Hospital
Laboratory and X-Ray
EPSDT
Physical Therapy
Dental
Hearing
Vision
Home Health
Clinic
Emergency Hospital
Transportation
Nurse-midwife Services
Hospice Care
Case Management
Federally Qualified Health Center Services
Chiropractic Services

*Description provided on attachment.

TN No.: 03-017
Supersedes
TN No: 90-11

Approval Date: 2/20/2004

Effective Date: 10/16/2003

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP (5): ALL

1. Inpatient hospital services other than those provided in an institution for mental diseases.
- Provided: No limitations With limitations*
- 2.a. Outpatient hospital services.
- Provided: No limitations With limitations*
- b. Rural health clinic services and other ambulatory services furnished by a rural clinic (which are otherwise covered under the plan).
- Provided: No limitations With limitations*
- c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with section 4231 of the State Medicaid Manual (HCFA-Pub. 45-4).
- Provided: No limitations With limitations*
3. Other laboratory and x-ray services.
- Provided: No limitations With limitations*
- 4.a. Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.
- Provided: No limitations With limitations*
- b. Early and periodic screening, diagnostic and treatment services for individuals under 21 years of age, and treatment of conditions found.
- Provided:
- c. Family planning services and supplies for individuals of childbearing age.
- Provided: No limitations With limitations*
- d 1) Face-to-Face Tobacco Cessation Counseling Services for Pregnant Women
- Provided: No limitations With limitations*

* Description provided on attachment.

State/Territory: Kentucky

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): All

5.a. Physicians' services, whether furnished in the office, the patient's home, a hospital, a nursing facility, or elsewhere.

Provided With limitations*

b. Medical and surgical services furnished by a dentist (in accordance with section 1905(a)(5)(B) of the Act).

Provided: No limitations With limitations:

*Description provided on attachment.

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND
REMEDIAL CARE AND SERVICES PROVIDED TO THE
MEDICALLY NEEDY

Commonwealth Global Choices

6. Medical care and any other type of remedial care recognized under State Law, furnished by licensed practitioners within the scope of their practice as defined by State Law.
- a. Podiatrists services.
- Provided: No limitations With Limitations* Not provided
- b. Optometrists' services.
- Provided: No limitations With Limitations* Not provided
- c. Chiropractics' services.
- Provided: No limitations With Limitations* Not provided
- d. Other Practitioners' Services
- Provided: No limitations With Limitations* Not provided
7. Home Health Services
- a. Intermittent or part-time nursing services provided by a home health agency or by a registered nurse when no home health agency exists in area.
- Provided: No limitations With Limitations* Not provided
- b. Home health aide services provided by a home health agency.
- Provided: No limitations With Limitations* Not provided
- c. Medical supplies suitable for use in the home.
- Provided: No limitations With Limitations* Not provided
- d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility.
- Provided: No limitations With Limitations* Not provided

*Description provided on attachment.

State/Territory: Kentucky

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): All

-
8. Private duty nursing services.
- Provided: No limitations With limitations*
9. Clinic services.
- Provided: No limitations With limitations*
10. Dental services.
- Provided: No limitations With limitations*
11. Physical therapy and related services.
- a. Physical therapy.
- Provided: No limitations With limitations*
- b. Occupational therapy.
- Provided: No limitations With limitations*
- c. Services for individuals with speech, hearing, and language disorders provided by or under supervision of a speech pathologist or audiologist.
- Provided: No limitations With limitations*
12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.
- a. Prescribed drugs.
- Provided: No limitations With limitations*
- b. Dentures.
- Provided: No limitations With limitations*

* Description provided on attachment.

AMOUNT, DURATION AND SCOPE OF SERVICES
PROVIDED MEDICALLY NEEDY GROUP(S): ALL

- c. Prosthetic devices.
 Provided: No limitations With limitations*
- d. Eyeglasses.
 Provided: No limitations With limitations*
13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in this plan.
- a. Diagnostic services.
 Provided: No limitations With limitations*
- b. Screening services.
 Provided: No limitations With limitations*
- c. Preventive services.
 Provided: No limitations With limitations*
- d. Rehabilitative services.
 Provided: No limitations With limitations*
14. Services for individuals age 65 or older in institutions for mental diseases.
- a. Inpatient hospital services.
 Provided: No limitations With limitations*
- b. Nursing facility services.
 Provided: No limitations With limitations*

*Description of limitations provided on attachment.

State/Territory: Kentucky

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S)

- c. Intermediate Care Facility Services.
- Provided: No limitations With limitations*
15. a. Services in an Intermediate Care Facility for the Mentally Retarded (other than such services in an institution for mental disease) for persons determined in accordance with Section 1902(a)(31)(A) of the Act, to be in need of such care.
- Provided: No limitations With limitations*
16. Inpatient psychiatric facility services for individuals under 22 years of age.
- Provided: No limitations With limitations*
17. Nurse-midwife Services
- Provided: No limitations With limitations*
18. Hospice care (in accordance with section 1905(o) of the Act).
- Provided: No limitations Provided in accordance with Section 2302 of the Affordable Care Act
- With limitations*

*Description provided on attachment

State/Territory: Kentucky

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): All

-
19. Case management services as defined in, and to the group specified in, Supplement 1 to Attachment 3.1-A (in accordance with Section 1905(a)(19) or section 1915(g) of the Act).
- Provided: With limitations Not provided
20. Extended services for pregnant women.
- a. Pregnancy-related and postpartum services for a 60-day period after pregnancy ends and for any remaining days in the month in which the 60th day falls.
- Provided+: Additional coverage ++
- b. Services for any other medical conditions that may complicate pregnancy.
- Provided+: Additional coverage ++ Not Provided
21. Certified pediatric or family nurse practitioners' services
- Provided: No Limitations With limitations
P&I HCFA 11-14-94 (handwritten)
See item 6d for limitations
- + Attached is a list of major categories of services (e.g., inpatient hospital, physician, etc.) and limitations on them, if any, that are available as pregnancy-related services or services for any other medical condition that may complicate pregnancy.
- ++ Attached is a description of increases in covered services beyond limitations for all groups described in this attachment and/or any additional services provided to pregnant women only.

*Description provided on attachment.

State/ Territory: Kentucky

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP (S): ALL

22. Respiratory care services (in accordance with section 1902(e)(9)(A) through (C) of the Act).
- Provided: No limitations With limitations* Not provided.
23. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary
- a. Transportation.
- Provided: No limitations With limitations* Not provided.
- b. Services provided in Religious Nonmedical Health Care Institutions.
- Provided: No limitations With limitations* Not provided
- c. Reserved
- d. Nursing facility services for individuals under 21 years of age.
- Provided: No limitations With limitations* Not provided
- e. Emergency hospital services.
- Provided: No limitations With limitations* Not provided.
- f. Personal care services in a recipient's home, prescribed in accordance with a plan of treatment and provided by a qualified person under supervision of a registered nurse.
- Provided: No limitations With limitations* Not provided.

* Description provided on attachment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kentucky

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE
AND SERVICES PROVIDED TO THE MEDICALLY NEEDY

23. Any other medical care and any other type of remedial care recognized under State law and specified by the Secretary.

- a 1. Transportation
 No limitations
 With limitations

Transportation is limited to individuals requesting transportation who lack access to free transportation that meets their medical needs. Transportation is only authorized for a Medicaid-covered service that has been determined medically necessary.

- a 2. Brokered Transportation
 Provided under section 1902(a)(70)

The State assures it has established a non-emergency medical transportation program in order to more cost-effectively provide transportation, and can document, upon request from CMS, the transportation broker was procured in compliance with the requirements of 45 CFR 92.36 (b)-(f).

- (1) The State will operate the broker program without the requirements of the following paragraphs of section 1902(a);
 (1) statewideness (indicate areas of State that are covered)
 (10)(B) comparability (indicate participating beneficiary groups)
 (23) freedom of choice (indicate mandatory population groups)

All Medicaid recipients covered under Kentucky's State Plan, excluding Qualified Medicare Beneficiaries, are eligible for the non-emergency medical transportation benefit. Recipients are restricted to using the regional broker and the provider assigned by the broker for the recipient's trip.

- (2) Transportation services provided will include:
 wheelchair van
 taxi

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kentucky

-
- stretcher car
 - bus passes
 - tickets
 - secured transportation
 - such other transportation as the Secretary determines appropriate (please describe): Private automobiles, non-profit transit system, specialty carriers for non-emergency ambulatory disoriented persons, and specialty carriers using lift equipped vehicles in compliance with the Americans with Disabilities Act certified to transport non-emergency, non-ambulatory persons.

Private auto providers enroll via the same enrollment and credentialing process as other Medicaid providers and submit additional enrollment documents specific to the transportation program including vehicle registration, vehicle insurance coverage and a valid driver's license. This category of provider is defined in Kentucky Revised Statute 281.873. Private auto providers are reimbursed the Kentucky State Employee mileage rate in effect for the given time period.

- (3) The State assures that transportation services will be provided under a contract with a broker who:
 - (i) is selected through a competitive bidding process based on the State's evaluation of the broker's experience, performance, references, resources, qualifications, and costs;
 - (ii) has oversight procedures to monitor beneficiary access and complaints and ensures that transport personnel are licensed, qualified, competent, and courteous;
 - (iii) is subject to regular auditing and oversight by the State in order to ensure the quality of the transportation services provided and the adequacy of beneficiary access to medical care and services;
 - (iv) complies with such requirements related to prohibitions on referrals and conflict of interest as the Secretary shall establish (based on prohibitions on physician referrals under section 1877 and such other prohibitions and requirements as the Secretary determines to be appropriate);
- (4) The broker contract will provide transportation to the following medically needy populations under section 1905(a)(i) – (xiii):
 - Under age 21, or under age 21, 19, or 18 as the State may choose
 - Relatives specified in section 406(b)(1) with whom a child is living if child is a dependent child under part A of title IV
 - Aged (65 years of age or older)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kentucky

-
- Blind with respect to States eligible to participate, under title XVI
 - Permanently or totally disabled individuals 18 or older, under title XVI
 - Persons essential to recipients under title I, X, XIV, or XVI
 - Blind or disabled as defined in section 1614 with respect to States not eligible to participate in the State plan program under title XVI
 - Pregnant women
 - Individuals provided extended benefits under section 1925
 - Individuals described in section 1902(u)(1)
 - Employed individuals with a medically improved disability (as defined in section V)
 - Individuals described in section 1902(aa)
 - Individuals screened for breast or cervical cancer by CDC program
 - Individuals receiving COBRA continuation benefits.

(5) The State will pay the contracted broker by the following method:

- (i) risk capitation
- (ii) non-risk capitation
- (iii) other (e.g., brokerage fee and direct payment to providers)

Under a brokerage system, Kentucky is divided into fifteen (15) Non-Emergency Medical Transportation Regions which were established based upon regional medical utilization and referral patterns. The broker contract for each region is bid separately; however, a broker may be a successful bidder for more than one region. Each region has a single per member per month (PMPM) capitation rate which is paid to the regional broker for all transportation eligible recipients in that region. A single payment for each broker is made each month on a prospective basis. In the event one broker gains the contract in multiple regions, a blended PMPM rate is paid for all regions served by that broker.

The PMPM rate for each region is established based on historical utilization and cost patterns for the region. The PMPM rate for each region may be updated annually effective July 1st of each year if encounter data trends indicate that a region has experienced an increase in transportation utilization and/or cost which was outside of the control of the broker. PMPM rates may also be adjusted on an as needed basis if programmatic changes (i.e. State Plan or waiver changes) would result in a change in transportation utilization or if transportation cost factors (i.e. gas prices) result in a change in the projected cost of transportation.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kentucky

If for any reason, a broker's contract is terminated before a replacement broker can be procured, non-emergency transportation reimbursement will revert to the methods applicable to non-emergency transportation described in Attachment 4.19-B, Section VII of the State Plan.

TN No.: 06-008
Supersedes
TN No.: New

Approval Date: 05/03/06

Effective Date: 06/01/06

State/Territory: Kentucky

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): All

24. Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A, and Appendices A-G to Supplement 2 to Attachment 3.1-A.

Provided Not Provided

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE MEDICALLY
NEEDY GROUP(S):

25. Ambulatory prenatal care for pregnant women furnished during a presumptive eligibility period by an eligible provider (in accordance with section 1920 of the Act).
- Provided No limitations With limitations Not provided
26. Program of All-inclusive Care for the Elderly (PACE) services, as described and limited in Supplement 3 to Attachment 3.1-A.
- Provided Not provided
28. (i) Licensed or Otherwise State-Approved Freestanding Birth Centers
- Provided No limitations With limitations
- None licensed or approved
28. (ii) Licensed or Otherwise State-recognized covered professionals providing services in the Freestanding Birth Center.
- Provided No limitations With limitations
- Not Applicable (there are no licensed or State approved Freestanding Birth Centers)

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND
REMEDIAL CARE AND SERVICES PROVIDED TO THE
MEDICALLY NEEDY

27. Durable Medical Equipment, Medical Supplies, Prosthetics and Orthotics

Provided No limitations With Limitations* Not Provided

*Description provided on attachment.

TN No. 03-06
Supersedes
TN No. None

Approval Date: 10/31/2003

Effective Date: 01-01-03

TELEHEALTH

The Kentucky Department for Medicaid Services program (DMS) reimburses for medically necessary health services furnished to eligible DMS members. To assist DMS' eligible members receive medically necessary services, DMS includes coverage for selected telehealth services. The department's definition of telehealth services is:

TELEHEALTH MEDICAL SERVICES: The originating-site or spoke site is the location of the eligible Kentucky Medicaid recipient at the time the telehealth service is being furnished via an interactive telehealth service communications system. The distant or hub site is the location of the provider and is considered the place of service. An interactive telehealth service communication system includes interactive audio and video equipment permitting two-way real time interactive communication between the patient and the practitioner at the originating and distant-sites. Coverage for services rendered through telehealth service, provided at the originating-site, are covered to the same extent the service and the provider are covered when not furnished through telehealth service and are considered an alternative way of providing covered services that are typically provided face-to-face and thus do not constitute a change in Medicaid coverage.

ELIGIBLE PROVIDERS: Providers of telehealth services shall be initially approved by the Kentucky e-Health Network Board. The e-Health board will oversee the operation of the statewide electronic health network. Telehealth providers must be an approved member of the Kentucky telehealth network and comply with the standards and protocols established by the Kentucky Telehealth Board.

Upon subsequent approval or verification of a DMS medical assistance provider participation agreement by DMS or its designee, OIG recognized licensed providers that meet applicable telehealth services requirements are eligible to be reimbursed for furnishing covered telehealth services to eligible DMS members.

Providers are enrolled in Medicaid before submitting a telehealth services claim for payment to the DMS claims processing contractors. DMS makes available on the CHFS/DMS website, or other program-specific websites or in hard copy format, information necessary to participate in health care programs administered by DMS or its authorized agents, including telehealth services program policies, billing instructions, utilization review instructions, and other pertinent materials. Reimbursement for services provided through an interactive, telehealth services telecommunication system can be made when the service is rendered at an allowed originating telehealth services site.

PROVIDER RESPONSIBILITIES: A provider who furnishes services to Kentucky Medicaid members via telehealth services agrees to comply with all federal and state laws and regulations relevant to the provision of medical services as specified in the DMS provider participation agreement. A provider also agrees to conform to DMS program policies and instructions as specified in this state plan amendment and its appendices, and program directions and billing instructions, as updated. A provider is also responsible for following coding manual guidelines and CMS correct coding initiatives.

COVERED SERVICES: DMS covers telehealth services and procedures that are Medicaid State Plan services and medically necessary for the diagnosis and treatment of an illness or injury as indicated by the eligible recipient's condition. All telehealth services must be furnished within the limits of provider program policies and within the scope and practice of the provider's professional standards.

TN No.: 09-008Approval Date: 03-09-11Effective Date: 10/01/2009

Supersedes

TN No.: None

The distant-site is the location where the provider agent/practitioner is physically located at time of the telehealth service. Coverage of services furnished through telehealth at the distant-site is limited to:

1. Consultations;
2. Mental health evaluation and management services;
3. Individual and group psychotherapy;
4. Pharmacologic management;
5. Psychiatric/psychological/mental health diagnostic interview examinations;
6. Individual medical nutrition services;

*All services are covered to the same extent the service and the provider are covered when not provided through telehealth.

PRIOR AUTHORIZATION AND UTILIZATION REVIEW: All telehealth services are subject to utilization review for medical necessity and program compliance. Reviews can be performed before services are furnished, before payment is made, or after payment is made. Once enrolled, the provider receives instructions on how to access provider program policies, billing instructions, utilization review instructions, and other pertinent material and to obtain answers to questions on or not covered by these materials. It is the provider's responsibility to access these instructions or ask for paper copies to be provided, to understand the information provided and to comply with the requirements.

Certain telehealth procedures or services can require prior approval from DMS or its authorized agents. Services for which prior authorization was obtained remain subject to utilization review at any point in the payment process. A service provided through telehealth is subject to the same prior authorization and utilization review requirements which exist for the service when not provided through telehealth.

NON-COVERED SERVICES: If a service is not covered in a face-to-face setting, it is also not covered if provided through telehealth. A service provided through telehealth is subject to the same program restrictions, limitations and coverage which exist for the service when not provided through telehealth.

TELEHEALTH AUTHORIZED PRACTITIONERS OR THOSE FUNCTIONING AS AGENTS OF AN AUTHORIZED PROVIDER FOR SERVICES NOT PROVIDED IN A COMMUNITY MENTAL HEALTH CENTER:

1. A psychiatrist;
2. A licensed clinical social worker directly employed by a psychiatrist if the psychiatrist also interacts with the recipient during the encounter;
3. A psychologist with a license in accordance with KRS 319.010(5) and a doctorate degree in psychology directly employed by a psychiatrist if the psychiatrist also interacts with the recipient during the encounter;
4. A licensed professional clinical counselor directly employed by a psychiatrist if the psychiatrist also interacts with the recipient during the encounter;
5. A licensed marriage and family therapist directly employed by a psychiatrist if the psychiatrist also interacts with the recipient during the encounter;
6. A physician*;
7. An ARNP*;
8. Speech-language pathologist*;
9. Occupational therapist*;

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Supersedes

TN No.: None

10. Physical therapist*;
11. Licensed dietitian or certified nutritionist*; or
12. Registered nurse or dietician*

*Certain restrictions apply for these providers and are outlined in the Kentucky Administrative Regulation, which can be found at: <http://www.lrc.ky.gov/kar/907/003/170.htm>

TELEHEALTH AUTHORIZED PRACTITIONERS OR THOSE FUNCTIONING AS AGENTS OF AN AUTHORIZED PROVIDER FOR SERVICES PROVIDED IN A COMMUNITY MENTAL HEALTH CENTER:

1. A psychiatrist;
2. A physician;
3. Psychologist with a license in accordance with KRS 319.010(5);
4. A licensed marriage and family therapist;
5. A licensed professional clinical counselor;
6. A psychiatric medical resident;
7. A psychiatric registered nurse;
8. A licensed clinical social worker;
9. An advanced registered nurse practitioner;

1. Inpatient Hospital Services

- a. Payment is made for inpatient hospital care as medically necessary. Each admission must have prior approval of appropriateness by the designated peer review organization in order for the admission to be covered under the Medicaid program, this requirement does not apply to emergency admissions. Weekend stays associated with a Friday or Saturday admission will not be reimbursed unless an emergency exists. Covered admissions are limited to those admissions primarily indicated in the management of acute or chronic illness, injury, or impairment, or for maternity care that could not be rendered on an outpatient basis. Admissions relating to only observation or only diagnostic purposes or for elective cosmetic surgery shall not be covered. Laboratory tests not specifically ordered by a Physician and not done on a preadmission basis where feasible will not be covered unless an emergency exists which precludes such preadmission testing
- b. A recipient may transfer from one hospital to another hospital when such transfer is necessary for the patient to receive medical care which is not available in the first hospital. In such situations, the admission resulting from the transfer is an allowable admission.

-
- c. The following listed surgical procedures are not covered on an inpatient basis, except when a life threatening situation exists, there is another primary purpose for the admission, or the admitting physician certifies a medical necessity requiring admission to a hospital:
- (a) Biopsy: breast, cervical node, cervix, lesions (skin, subcutaneous, submucous), lymph node (except high axillary excision, etc.), and muscle.
 - (b) Cauterization or cryotherapy: lesions (skin, subcutaneous, submucous), moles, polyps, warts/condylomas, anterior nose bleeds, and cervix.
 - (c) Circumcision.
 - (d) Dilation: dilation and curettage (diagnostic and or therapeutic non—obstetrical); dilation/probing of lacrimal duct.
 - (e) Drainage by incision or aspiration: cutaneous, subcutaneous, and joint.
 - (f) Exam under anesthesia (pelvic).
 - (g) Excision: bartholing cyst, cyndylomas, foreign body, lesions lipoma, nevi (moles), sebaceous cyst, polyps, and subcutaneous fistulas.
 - (h) Extraction: foreign body, and teeth (per existing policy).
 - (i) Graft, skin (pinch, splint of full thickness up to defect size 3/4 inch diameter).
 - (j) Hymenotomy.
 - (k) Manipulation and/or reduction with or without x—ray; cast change: dislocations depending upon the joint and indication for procedure, and fractures.
 - (l) Meatotomy/urethral dilation, removal calculus and drainage of bladder without incision.
 - (m) Myringotomy with or without tubes, otoplasty.
 - (n) Oscopy with or without biopsy (with or without salpinqogram): arthroscopy, bronchoscopy, colonoscopy, culdoscopy, cystoscopy, esophagoscopy, endoscopy, qastroscopy, hysteroscopy, laryngoscopy, peritoneoscopy, otoscopy, and sigmoidoscopy or procto sidmoidoscopy.
 - (o) Removal: IUD, and fingernail or toenails.
 - (p) Tenotomy hand or foot.
 - (q) Vasectomy.
 - (r) Z-plasty for relaxation of scar/contracture.

d. Abortion services are reimbursable under the Medical Assistance Program only when the woman suffers from a physical disorder, physical injury or physical illness, including a life endangering physical condition caused or arising from the pregnancy itself that would place the woman in danger of death unless an abortion is performed, or when the pregnancy is the result of an act of rape or incest.

2 a. Outpatient Hospital Services

Hospital outpatient services are limited to therapeutic and diagnostic service as ordered by a physician or if applicable, a dentist; to emergency room services in emergency situations; and to drugs, biologicals, or injections administered in the outpatient hospital setting (excluding "take home" drugs and those drugs deemed less-than-effective by the Food and Drug Administration)

For recipients in the Lock-In Program, non-emergency services will be covered only in the recipient's designated Lock-In hospital.

Abortion services are reimbursable under the Medical Assistance Program only when the woman suffers from a physical disorder, physical injury or physical illness, including a life endangering physical condition caused or arising from the pregnancy itself that would place the woman in danger of death unless an abortion is performed, or when the pregnancy is the result of an act of rape or incest.

2 b. Rural Health Clinic Services

Other ambulatory services furnished by a rural health clinic shall have the same limitation when provided by the rural health clinic as when provided by the usual ambulatory care provider as specified in the relevant subsections of Attachment 3.1-B pertaining to those ambulatory services, except that limitations pertaining to qualifications of provider shall not apply. Reimbursement is not made for the services of physicians assistants.

With regard to services provided on or after October 1, 1988, rural health clinics will be allowed to secure drugs for specified immunizations from the Department for Health Services free to provide immunizations for Medicaid recipients. The specified immunizations are: diphtheria and tetanus toxoids and pertussis vaccine (DPT); measles, mumps, and rubella virus vaccine, live (MNR) ; poliovirus vaccine, live, oral (any type(s)) (OPV); and hemophilus B conjugate vaccine (HBCV).

2 c. Federal Qualified Health Center Services

Federal qualified health center (FQHC) services are limited to FQHC services as defined in the Social Security Act, including ambulatory services offered by a FQHC and which are included in the state plan.

3. Other Lab and X-Ray Services**A. Coverage.**

- (1) The department shall reimburse for a procedure provided by an independent laboratory if the procedure:
 - (a) Is one that the laboratory is certified to provide by Medicare and in accordance with state regulation.
 - (b) Is a covered service within the CPT code range of 80047 – 89356 except as indicated in Section B.
 - (c) Is prescribed in writing or by electronic request by a physician, podiatrist, dentist, oral surgeon, advanced registered nurse practitioner, or optometrist; and
 - (d) Is supervised by a laboratory director; and
 - (e) Is independent of an institutional setting.
- (2) The department shall reimburse for a radiological service if the service:
 - (a) Is provided by a facility that:
 - 1) Is licensed to provide radiological services;
 - 2) Meets the requirements established in 42 CFR 440.30;
 - 3) Is certified by Medicare to provide the given service;
 - 4) Meets the requirements established in 42 CFR 493 regarding laboratory certification, registration, or other accreditation as appropriate; and
 - (b) Is prescribed in writing or by electronic request by a physician, oral surgeon, dentist, podiatrist, optometrist, advanced registered nurse practitioner, or a physician's assistant;
 - (c) Is provided under the direction or supervision of a licensed physician; and
 - (d) Is a covered service within the CPT code range of 70010 – 78999.

B. Exclusions. The department shall not reimburse for an independent laboratory or radiological service for the following services or procedures:

- (1) A procedure or service with a CPT code of 88300 through 88399;
- (2) A procedure or service with a CPT code of 89250 through 89356;
- (3) A service provided to a resident of a nursing facility or an intermediate care facility for individuals with mental retardation or a developmental disability; or
- (4) A court-ordered laboratory or toxicology test. The court-ordered exclusion does not apply when medically necessary and in the scope of the Medicaid program.

C. Provider Participation Conditions.

-
- (1) To be reimbursed by the department for a service provided in accordance with this administrative regulation, a provider of independent laboratory services or radiological services shall:
- (a) Be a Medicaid-enrolled provider;
 - (b) Be a Medicare participating facility;
 - (c) Comply with state regulations on Non-duplication of Payments and Claims processing;
 - (d) Comply with the requirements regarding the confidentiality of personal records pursuant to 42 U.S.C. 1320d-8 and 45 C.F.R. parts 160 and 164; and
 - (e) Annually submit documentation of:
 - 1) Current CLIA certification to the department if the provider is an independent laboratory; and
 - 2) A current radiological license to the department if the provider provides radiological services.
- (2) A provider may bill a recipient for a service not covered by the department if the provider informed the recipient of noncoverage prior to providing the service.

4. b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age and Treatment of Conditions FoundB. Dental Services

Kentucky will comply with the requirements in Section 1905 of the Social Security Act relating to medically necessary services to EPSDT recipients. For services beyond the stated limitations or not covered under the Title XIX state plan, the state will determine the medical necessity of the EPSDT services on a case by case basis through prior authorization.

A listing of dental services available to recipients under age 21 is maintained at the central office of the single state agency.

Services not listed will be pre-authorized when medically necessary for EPSDT eligible recipients.

(1) Out of Hospital Dental Services

A listing of dental services available to recipients under age 21 is maintained at the central office of the single state agency.

Services not listed will be pre-authorized when medically necessary for EPSDT eligible recipients.

(4) In Hospital Dental Services

A listing of dental services available to recipients under age 21 is maintained at the central office of the single state agency.

Services not listed will be pre-authorized when medically necessary for EPSDT eligible recipients.

(5) Oral Surgery Dental Services

A listing of oral surgery dental services available to recipients under age 21 is maintained at the central office of the single state agency.

Services not listed will be pre-authorized when medically necessary for EPSDT eligible recipients.

Commonwealth Global Choices

B. Hearing Services

Audiological Benefits

- (a) Coverage is available only for recipients under age 21 and is limited to the following services provided by certified audiologists:
- i. Complete hearing evaluation one time per year;
 - ii. Hearing aid evaluation one time per year;
 - iii. A maximum of three follow-up visits within the six month period immediately following fitting of a hearing aid such visits to be related to the proper fit and adjustment of that hearing aid; and
 - iv. One follow-up visit six months following fitting of a hearing aid, to assure a patient's successful use of the aid.

Services not listed above will be provided when medically necessary upon appropriate pre-authorization.

Commonwealth Global Choices

(b) Exception to the above limitations may be made through preauthorization if need is indicated in the individual case.

(2) Hearing Aid Benefits

(a) Coverage is provided only for recipients under age 21 on a pre-authorized basis for any hearing aid model recommended by a certified audiologist so long as that model is available through a participating hearing aid dealer.

(b) If medical necessity is established, these limitations do not apply to EPSDT eligible children in accordance with 1905 (r)(5) of the Social Security Act.

C. Vision Care Services

(1) Optometrists' services are provided to children under 21 years of age. Coverage includes writing of prescriptions, services to frames and lenses, and diagnostic services provided by ophthalmologists and optometrists, to the extent the optometrist is licensed to perform the services and to the extent the services are covered in the ophthalmologist portion of the physician's program.

(2) If medical necessity is established, these limitations do not apply to EPSDT eligible children in accordance with 1905 (r)(5) of the Social Security Act.

4.b EPSDT Services (continued)

- D. Discretionary Services under EPSDT. For neonatal care related to any of the following diagnoses, an infant (i.e., child not more than twelve (12) months of age) EPSDT eligible recipient may transfer from a hospital with a level III neonatal unit to a different hospital with a level II or level I neonatal unit with the transfer considered a new admission. A "level III neonatal unit" means a unit able to provide the full range of resources and expertise required for the management of any complication of the newborn; a nurse/patient ratio of 1:2 is required. A "level II neonatal unit" means a unit able to provide care to the moderately ill infant who requires various support services; a nurse/patient ratio of 1:4 is required. A "level I neonatal unit" means a unit providing care to infants with uncomplicated conditions; normal nursery staffing is required

Neonatal Related Diagnoses

- (1) Fetus or newborn affected by maternal conditions, which may be unrelated to present pregnancy.
- (2) Fetus or newborn affected by maternal complications of pregnancy.
- (3) Fetus or newborn affected by complications of placenta, cord, and membranes.
- (4) Fetus or newborn affected by other complications of labor and delivery.
- (5) Slow fetal growth and fetal malnutrition.
- (6) Disorders relating to short gestation and unspecified low birth weight.
- (7) Disorders relating to long gestation and high birth weight.
- (8) Birth Trauma
- (9) Intrauterine hypoxia and birth asphyxia.
- (10) Respiratory distress syndrome.
- (11) Other respiratory conditions of fetus and newborn.
- (12) Infections specific to the perinatal period.
- (13) Fetal and neonatal hemorrhage.
- (14) Hemolytic disease of fetus or newborn, due to isoimmunization.
- (15) Other perinatal jaundice.
- (16) Endocrine and metabolic disturbances specific to the fetus and newborn.
- (17) Hematological disorders of fetus and newborn.
- (18) Perinatal disorders of digestive system.
- (19) Conditions involving the integument and temperature regulation of fetus and newborn
- (20) Congenital anomalies and related surgical procedures.
- (21) Other and ill-defined conditions originating in the perinatal period.

4.b. Early and periodic screening and diagnosis of individuals under 21 years of age and treatment of conditions found.

E. Medicaid Services Provided in Schools

Individuals receiving Medicaid Services in schools have freedom of choice of qualified licensed providers as established in 1902(a)(23) of the Act.

(a) Audiology

Services must be medically necessary and appear in the child's Individualized Education Plan. Covered services include:

Assessment services:

Service may include testing and/or clinical observation as appropriate for chronological or developmental age for one or more of the following areas of functioning, and shall yield a written report:

Auditory sensitivity, including pure tone air and bone conduction, speech detection, and speech reception thresholds, auditory discrimination in quiet and noise, impedance audiometry including tympanometry and acoustic reflex, hearing aid evaluation, central auditory function and auditory brainstem evoked response

Treatment services:

Service may include one or more of the following as appropriate:

Auditory training, speech reading and augmentative communication

Qualifications of Providers: Providers must meet the applicable requirements of 42 CFR 440.110. A provider shall have a valid license issued by the Board of Examiners for Speech and Language Pathologists and Audiologists.

(b) Occupational Therapy

Services must be medically necessary and appear in the child's Individualized Education Plan. Covered services include:

Assessment services

Service may include testing and/or clinical observation as appropriate for chronological or developmental age for one or more of the following areas of functioning, and shall yield a written report:

Activities of daily living assessment, sensorimotor assessment, neuromuscular assessment, fine motor assessment, feeding/oral motor assessment, visual perceptual assessment, perceptual motor development assessment, musculo-skeletal assessment, gross motor assessment, and functional mobility assessment.

Treatment services

Service may include one or more of the following as appropriate:

Activities of daily living training, sensory integration, neuromuscular development, muscle strengthening, and endurance training, feeding/oral motor training, adaptive equipment application, visual perceptual training, facilitation of gross motor skills, facilitation of fine motor skills, fabrication and application of splinting and orthotic devices, manual therapy techniques, sensorimotor training, functional mobility training, perceptual motor training.

Qualifications of Providers:

Providers must meet the applicable requirements of 42 CFR 440.110. Occupational therapy assessment services must be provided by a licensed occupational therapist. Occupational therapy treatment services must be provided by a licensed occupational or a licensed occupational therapist assistant under the supervision of a licensed occupational therapist.

(c) Physical Therapy Services

Services must be medically necessary and appear in the child's Individualized Education Plan. Covered services include:

Assessment services

Service may include testing and/or clinical observation as appropriate for chronological or developmental age for one or more of the following areas of functioning, and shall yield a written report:

Neuromotor assessment, range of motion, joint integrity and functional mobility, flexibility assessment, gait, balance, and coordination assessment, posture and body mechanics assessment, soft tissue assessment, pain assessment, cranial nerve assessment, clinical electromyographic assessment, nerve conduction, latency and velocity assessment, manual muscle test, activities of daily living assessment, cardiac assessment, pulmonary assessment, sensory motor assessment and feeding/oral motor assessment

Treatment services

Service may include one or more of the following as appropriate:

Manual therapy techniques, fabrication and application of orthotic devices, therapeutic exercise, functional training, facilitation of motor milestones, sensory motor training, cardiac training, pulmonary enhancement, adaptive equipment application, feeding/oral motor training, activities of daily living training, gait training, posture and body mechanics training, muscle strengthening, gross motor development, modalities, therapeutic procedures, hydrotherapy, manual manipulation

Qualifications of Providers:

Providers must meet the applicable requirements of 42 CFR 440.110. Physical therapy assessment services must be provided by a licensed physical therapist. Physical therapy treatment services must be provided by a licensed physical therapist or a licensed physical therapist assistant under the supervision of a licensed physical therapist.

(d) Behavioral Health Services

Services must be medically necessary and appear in the child's Individualized Education Plan. Covered services include:

Assessment services

Service may include testing and/or clinical observation as appropriate for chronological or developmental age for one or more of the following areas of functioning, and shall yield a written report:

Cognitive, emotional/personality, adaptive behavior, behavior and perceptual or visual motor

Treatment services

Service may include one or more of the following as appropriate:

Cognitive-behavioral therapy, rational-emotive therapy, family therapy, individual interactive psychotherapy using play equipment, physical devices, language interpreter or other mechanisms of non verbal communication and sensory integrative therapy

Qualifications of Providers:

Minimum qualifications for providing services are licensure as follows:

1. An individual currently licensed by the Kentucky Board of Examiners of Psychology as a licensed psychologist, licensed psychological practitioner, certified psychologist with autonomous functioning, certified psychologist, or licensed psychological associate;
2. A licensed clinical social worker currently licensed by the Kentucky Board of Social Work;
3. A licensed social worker currently licensed by the Kentucky Board of Social Work;
4. A certified social worker currently licensed by the Kentucky Board of Social Work;
5. An advanced registered nurse practitioner who has a specialty area in accordance with the American Nurses' Association Statement on Psychiatric Mental Health Clinical Nursing Practice and Standards of Psychiatric Mental Health Clinical Nursing Practice.

(e) Speech

Services must be medically necessary and appear in the child's Individualized Education Plan.

Covered services include:

Assessment services

Service may include testing and/or clinical observation as appropriate for chronological or developmental age for all the following areas of functioning and shall yield a written report:

Receptive and expressive language, auditory memory, discrimination, and processing, vocal quality and resonance patterns, phonological development, pragmatic language, rhythm/fluency, oral mechanism, swallowing assessment, augmentative communication and hearing status based on pass/fail criteria

Treatment services

Service includes one or more of the following as appropriate:

Articulation therapy, language therapy; receptive and expressive language, augmentative communication training, auditory processing, discrimination, and training, fluency training, disorders of speech flow, voice therapy, oral motor training; swallowing therapy and speech reading.

Qualifications of Providers: Treatment services may be performed by a Speech/Language Pathologist with the following qualifications:

1. Current Certificate of Clinical Competence from the American Speech Hearing Association (ASHA);
2. Current license as Speech Language Pathologist from KY Board of Speech Language Pathology and Audiology;

As of August 1, 2011, Speech Therapy services will only be performed by individuals meeting applicable requirements of 42 CFR 440.110, including the possession of a Speech/Language Pathologist with a current Certificate of Clinical Competence from the American Speech Hearing Association (ASHA).

(f) Nursing Services:

Services must be medically necessary. The services may be provided in accordance with an Individualized Education Program or an Individual Family Service Plan. Nursing services must be those services that are in a written plan of care based on a physician, physician assistant or nurse practitioner's written order. The plan of care must be developed by a licensed registered nurse. Services include but are not limited to: assessments including referrals based on results, bladder catheterizations, suctioning, medication administration and management including observation for adverse reactions, response or lack of response to medication, informing the student about their medications, oxygen administration via tracheostomy and ventilator care, enteral feedings, emergency interventions, individual health counseling and instructions, and other treatments ordered by the physician and outlined in the plan of care.

Qualifications of Providers:

The Licensed Practical Nurse and Registered Nurse shall be licensed by the State of Kentucky to provide the services and practice within the Kentucky Nursing Practice Act. Nursing services can be provided under 42 CFR 440.60 and on a restorative basis under 42 CFR 440.130 (d) including services delegated in accordance with the Nurse Practice Act and the Kentucky School Health Program Manual to individuals trained to perform delegated acts by a Registered Nurse.

Services provided by a health aide may only be provided under the following conditions:

1. Is under the supervision of an advanced registered nurse practitioner or a registered nurse;
2. Has been trained by an advanced registered nurse practitioner or registered nurse for the specific nursing service provided to a specific recipient; or
3. An advanced registered nurse practitioner or registered nurse has verified in writing that the aide has appropriate training and skills to perform the specific service in a safe, effective manner.

(g) Respiratory Therapy Services:

1. Respiratory therapy are the procedures employed in the therapy, management, rehabilitation, gathering of assessment information, or other procedures administered to patients with deficiencies or abnormalities which affect their cardiopulmonary system and associated aspects of cardiopulmonary and other systems functions.

Respiratory therapy services are provided by a practitioner certified by the Kentucky Board of Respiratory Care.

- (h) Specialized Transportation Services: Specialized transportation services include transportation to receive Medicaid approved school health services. This service is limited to transportation of covered, prior authorized services.
- 1) The special transportation is Medicaid reimbursable if:
 - (a) It is provided to a Medicaid eligible EPSDT child who is a student in a public school in Kentucky.
 - (b) It is being provided on a day when the child receives a prior authorized covered service;
 - (c) The student's need for specialized transportation service is documented in the child's plan of care; and
 - (d) The driver has a valid driver's license.
 - 2) Specialized transportation services are defined as transportation that requires a specially equipped vehicle, or the use of specialized equipment to ensure a child is taken to and from the child's residence to school or to a community provider's office for prior authorized health related services.
 - (a) Transportation provided by or under contract with the school, to and from the student's place of residence, to the school where the student receives one of the health related services covered by Title XIX;
 - (b) Transportation provided by or under contract with the school, to and from the student's place of residence to the office of a medical provider who has a contract with the school to provide one of the health related services covered by Title XIX; or
 - (c) Transportation provided by or under contract with the school from the student's place of residence to the office of a medical provider who has a contract with the school to provide one of the health related services covered by Title XIX and returns to school.
 - 3) Specialized transportation services will not be Medicaid reimbursable if the child does not receive a Medicaid covered service on the same day. When claiming these costs as direct services, each school district is responsible for maintaining written documentation, such as a trip log, for individual trips provided. No payment will be made to, or for parents providing transportation.

4.b. EPSDT Services (continued)

- E. The Medicaid program shall provide such other necessary health care, diagnostic services, treatment, and other measures described in Section 1905(a) of the Social Security Act to correct or ameliorate defects and physical and mental illness and conditions discovered by the screening services, whether or not such services are covered under the state plan.

4.c. Family planning services and supplies for individuals of child-bearing age

Family planning services shall include counseling services, medical services, and pharmaceutical supplies and devices to aid those who decide to prevent or delay pregnancy. In-vitro fertilization, artificial insemination, sterilization reversals, sperm banking and related services, hysterectomies, and abortions shall not be considered family planning services.

4.d. Face-to-Face Tobacco Cessation Counseling Services for Pregnant Women

Tobacco Cessation Counseling Services for Pregnant Women shall include counseling services, medical services, and pharmaceutical supplies and devices to aid those who decide to quit tobacco. This shall include four (4) face-to-face counseling sessions per quit attempt, with a minimum of two (2) quit attempts per twelve (12) month period.

Face-to-face counseling services shall be provided:

- (i) By or under supervision of a physician;
- (ii) By any other health care professional who is legally authorized to furnish such services under State law and who is authorized to provide Medicaid coverable services other than tobacco cessation services; or
- (iii) Any other health care professional legally authorized to provide tobacco cessation services under State law and who is specifically designated by the Secretary in regulations.

5. Physicians' Services

All physician services that an optometrist is legally authorized to perform are included in physicians' services under this plan and are reimbursed whether furnished by a physician or an optometrist.

- A. Coverage for certain initial visits is limited to one visit per patient per physician per three (3) year period. This limitation applies to the following procedures:

New patient evaluation and management office or other outpatient services as identified by codes in the most current edition of the Physicians' Current Procedural Terminology.

New patient evaluation and management home or custodial care services as identified by codes in the most current edition of the Physicians' Current Procedural Terminology.

New patient evaluation and management preventive medicine services as identified by codes in the most current edition of the Physicians' Current Procedural Terminology.

- B. Coverage for an evaluation and management service with a corresponding CPT code of 99214 or 99215 shall be limited to two (2) per recipient per year, per physician. If this limit is exceeded, then DMS will reimburse any such claim as a CPT code 99213 evaluation and management visit.
- C. Outpatient psychiatric service procedures rendered by other than board-eligible and board-certified psychiatrists are limited to four (4) such procedures per patient per physician per twelve (12) month period.
- D. Coverage for laboratory procedures performed in the physician's office is limited to those procedures for which the physician's office is CLIA certified with the exception of urinalysis performed by dipstick or reagent tablet only which shall not be payable as a separate service to physician providers. The fee for this, or comparable lab tests performed by reagent strip or tablet, excluding blood glucose, shall be included in the evaluation and management service reimbursement provided on the same date of service for the same provider.

The professional component of laboratory procedures performed by board certified pathologists in a hospital setting or an outpatient surgical clinic are covered so long as the physician has an agreement with the hospital or outpatient surgical clinic for the provision of laboratory procedures.

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- E. The cost of preparations used in injections is not considered a covered benefit, except for the following:
- (1) The Rhogarn injection.
 - (2) Injectable antineoplastic chemotherapy administered to recipients with a malignancy diagnosis contained in the Association of Community Cancer Centers Compendia-Based Drug Bulletin, as adopted by Medicare.
 - (3) Depo Provera provided in the physician office setting.
 - (4) Penicillin G (up to 600,000 I.U.) and Ceftriaxone (250 mg.).
 - (5) Long acting injectable risperidone.
 - (6) An injectable, infused or inhaled drug or biological that is:
 - a. Not typically self-administered;
 - b. Not listed as a noncovered immunization or vaccine; and
 - c. Requires special handling, storage, shipping, dosing or administration.
- F. Coverage for standard treadmill stress test procedures are limited to three (3) per six (6) month period per recipient. If more than three (3) are billed within a six (6) month period, documentation justifying medical necessity shall be required.
- G. Telephone contact between a physician and patient is not a covered service.
- H. Coverage of a physician service is contingent upon direct physician/patient interaction except in the following cases:
- (1) A service furnished by a resident under the medical direction of a teaching physician in accordance with 42 CFR 415.
 - (2) A service furnished by a physician assistant acting as agent of a supervising physician and performed within the physician assistant's scope of certification.

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- J. Reimbursement for induced abortions is provided when the physician certifies that the pregnancy was a result of rape or incest or the woman suffers from a physical disorder, injury or illness, including a life-endangering physical condition cause or arising from the pregnancy itself that would place the woman in danger of death unless an abortion is performed.
- K. Any physician participating in the lock-in program will be paid for providing patient management services for each patient locked-in to him/her during the month.
- L. Regional anesthesia (e.g., epidurals) for post-operative pain management shall be limited to one (1) service per day up to four (4) days maximum for the anesthesiologist.
- M. Epidural or spinal injections of substances for control of chronic pain other than anesthetic, contrast, or neurolytic solutions shall be limited to three (3) injections per six (6) month period per recipient.
- N. Anesthesia Service limits are soft limits which means the service can be covered when medically necessary subject to prior authorization requirements described in material on file in the state agency.
- O. Coverage for an evaluation and assessment service, provided by a physician or physician assistant with a corresponding CPT code of 99407 for tobacco cessation shall be limited to two (2) per recipient per calendar year.
1. The evaluation and assessment service shall be:
 - a. Performed face-to-face with the recipient;
 - b. Be performed over a period of at least ten (10) minutes.
 2. The evaluation and assessment service shall include:
 - a. Asking the recipient about tobacco use;
 - b. Advising the recipient to quit using tobacco;
 - c. Assessing the recipient's readiness to quit using tobacco products
 - d. Compiling a tobacco usage, medical, and psychosocial history of the recipient;
 - e. Incorporating a review of the recipient's coping skills and barriers to quitting; and
 - f. Providers obtaining of a signed and dated Tobacco Cessation Referral Form from the recipient declaring the recipient's intent to quit using tobacco.
- P. Allergy testing, shots and allergy treatment for all Medicaid recipients, when medically necessary.

6. Medical Care and Any Other Type of Remedial Care

- a. Podiatry services are provided to both the categorically needy and medically needy in accordance with the following limitations.

- (1) Coverage. The Medical Assistance (Medicaid) Program will cover medical and/or surgical services provided to eligible Medicaid recipients by licensed, participating podiatrists when such services fall within the scope of the practice of podiatry except as otherwise provided for herein. The scope of coverage generally parallels the coverage available under the Medicare program with the addition of wart removal.
- (2) Exclusions from Coverage; Exceptions. The following areas of care are not covered except as specified.

Treatment of flatfoot: services directed toward the care or correction of such a service are not covered.

Treatment of subluxations of the foot: surgical or nonsurgical treatments undertaken for the sole purpose of correcting a subluxated structure as an isolated entity within the foot are not covered; this exclusion of coverage does not apply to reasonable and necessary diagnosis and treatment of symptomatic conditions such as osteoarthritis, bursitis (including bunion), tendonitis, etc., that result from or are associated with partial displacement of foot structures, or to surgical correction that is an integral part of the treatment of a foot injury or that is undertaken to improve the function of the foot or to alleviate an induced or associated symptomatic condition.

Orthopedic shoes and other supportive devices for the feet are not covered under this program element.

Routine foot care: services characterized as routine foot care are generally not covered; this includes such services as the cutting or removal of corns or calluses, the trimming of nails, and other hygienic and preventive maintenance care in the realm of self—care such as cleaning and soaking the feet, the use of skin creams to maintain skin tone of both ambulatory and bedfast patients, and any services performed in the absence of localized illness, injury or symptoms involving the foot. Notwithstanding the preceding, payment may be made for routine foot care such as

cutting or removing corns, calluses or nails when the patient has a systemic disease of sufficient severity that unskilled performance of such procedures would be hazardous; the patient's condition must have been the result of severe circulatory embarrassment or because of areas of desensitization in the legs or feet. Although not intended as a comprehensive list, the following metabolic, neurological, and peripheral vascular diseases (with synonyms in parentheses) most commonly represent the underlying systemic conditions contemplated and which would justify coverage; where the patient's condition is one (1) of those designated by an asterisk (*), routine procedures are reimbursable only if the patient is under the active care of a doctor of medicine or osteopathy for such a condition, and this doctor's name must appear on the claim form:

- *Diabetes mellitus;
- Arteriosclerosis obliterans (A.S.O., arteriosclerosis of the extremities, occlusive peripheral arteriosclerosis);
- Buerger's disease (thromboangitis obliterans);
- Chronic thrombophlebitis;
- Peripheral neuropathies involving the feet:
 1. *Associated with malnutrition and vitamin deficiency, such as: malnutrition (general, pellagra); alcoholism; malabsorption (celiac disease, tropical sprue); and pernicious anemia;
 2. *Associated with carcinoma;
 3. *Associated with diabetes mellitus;
 4. *Associated with drugs and toxins;
 5. *Associated with multiple sclerosis;
 6. *Associated with uremia (chronic renal disease);
 7. Associated with traumatic injury;
 8. Associated with leprosy or neurosyphilis; and
 9. Associated with hereditary disorders, such as: hereditary sensory radicular neuropathy, angiokeratoma corporis; and diffusum (Fabry's), amyloid neuropathy.

Services ordinarily considered routine are also covered if they are performed as a necessary and integral part of otherwise covered services, such as the diagnosis and treatment of diabetic ulcers, wounds, and infections. Diagnostic and treatment services for foot infections are also covered as they are considered outside the scope of "routine."

- (3) Provision relating to Special Diagnostic Tests. Plethysmography is a recognized tool for the preoperative podiatric evaluation of the diabetic patient or one who has intermittent claudication or other signs or symptoms indicative of peripheral vascular disease which would have a bearing on the patient's candidacy for foot surgery. The method of plethysmography determines program coverage.

Covered methods include:

- Segmental, including regional, differential, recording oscillometer, and pulse volume recorder;
- Electrical impedance; and
- Ultrasonic measure of blood flow (Doppler).

Noncovered methods include:

- Inductance;
- Capacitance;
- Strain gauge;
- Photoelectric; and
- Mechanical oscillometry.

Venous occlusive pneumoplethysmography would be appropriate only in the setting of a hospital vascular laboratory.

Commonwealth Global Choices

(6) Medical care and Any Other Type of Remedial Care

B. Optometry services are only provided to recipients under age twenty-one (21).

C. Chiropractic services are provided with the following limitations:

- (1) Fifteen (15) chiropractic visits per year for recipients age 21 and older.
- (2) Seven (7) chiropractic visits per year for recipients under 21 years of age.
- (3) If medical necessity is established, these limitations do not apply to EPSDT eligible children in accordance with 1905(r)(5) of the Social Security Act.

6. Medical Care and Any Other Type of Remedial Care

d. Other practitioner's services

Advanced Practice Registered Nurse (APRN) Services

- (1) An APRN covered service shall be a medically necessary service provided within the legal scope of practice of the APRN and furnished through direct practitioner-patient interaction so long as that service is eligible for reimbursement by Kentucky Medicaid.
- (2) APRN's participating as nurse-midwives or nurse anesthetists shall comply with the service requirements of those components for participation and reimbursement, as appropriate.
- (3) An APRN desiring to participate in the Medical Assistance Program shall:
 - (a) Meet all applicable requirements of state laws and conditions for practice as a licensed APRN;
 - (b) Enter into a provider agreement with the Department for Medicaid Services to provide services;
 - (c) Accompany each participation application with a current copy of the APRN's license: and
 - (d) Provide and bill for services in accordance with the terms and conditions of the provider participation agreement.
- (4) Administration of anesthesia by an APRN is a covered service.
- (5) The cost of the following injectables administered by an APRN in a physician or other independent practitioner's office shall be covered:
 - (a) Rho (D) immune globulin injection;
 - (b) Injectable anticancer chemotherapy administered to a recipient with a malignancy diagnosis contained in the Association of Community Cancer Centers Compendia-Based Drug Bulletin, as adopted by Medicare;
 - (c) Depo-Provera contraceptive injection;
 - (d) Penicillin G and ceftriaxone injectable antibiotics; and
 - (e) Epidural injections administered for pain control.
- (6) An outpatient laboratory procedure by an APRN who has been certified in accordance with 42 CFR, Part 493 shall be covered.

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- (7) An obstetrical and gynecological service provided by an APRN shall be covered as follows:
- (a) An annual gynecological examination;
 - (b) An insertion of an intrauterine device (IUD), including the cost of the device, or removal of the IUD;
 - (c) The insertion of an implantable contraceptive capsule, including the cost of the contraceptive capsule and related supplies, or removal of the capsule;
 - (d) Prenatal care;
 - (e) A routine newborn service to an infant born to a Kentucky Medicaid eligible recipient; and
 - (f) A delivery service, which shall include:
 - 1. Admission to the hospital;
 - 2. Admission history;
 - 3. Physical examination,
 - 4. Anesthesia;
 - 5. Management of uncomplicated labor;
 - 6. Vaginal delivery; and
 - 7. Postpartum care.
- (8) An EPSDT screening service provided in compliance with a periodicity schedule developed in conjunction with the American Academy of Pediatrics Recommendations for Preventive Pediatric Health shall be covered.
- (9) A limitation on a service provided by a physician as described in Attachment 3. I-B, pages 21, 22 and 22.1(a) shall also apply if the service is provided by an ARNP.
- (10) The same service provided by an APRN and a physician on the same day within a common practice shall be considered as one (1) covered service.
- (11) Coverage for an evaluation and assessment services with a corresponding CPT code of 99407 for tobacco cessation shall be limited to two (2) per recipient per year.
- 1. The evaluation and assessment service shall be:
 - a. Performed face-to-face with the recipient;
 - b. Be performed over a period of at least thirty (30) minutes.
 - 2. The evaluation and assessment service shall include:
 - a. Asking the recipient about tobacco use;
 - b. Advising the recipient to quit using tobacco;
 - c. Assessing the recipient's readiness to quit using tobacco products
 - d. Compiling a tobacco usage, medical, and psychosocial history of the recipient;
 - e. Incorporating a review of the recipient's coping skills and barriers to quitting; and
 - f. Providers obtaining of a signed and dated Tobacco Cessation Referral Form from the recipient declaring the recipient's intent to quit using tobacco.

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Other Licensed Practitioners' Services (continued)

- (d) Ophthalmic dispensers' services, limited to dispensing service or a repair service (for eyeglasses provided to eligible recipients), are covered. The following limitations are also applicable:
 - (1) Telephone contacts are not covered;
 - (2) Contact lens are not covered;
 - (3) Safety glasses are covered when medically necessary subject to prior authorization requirements described in material on file in the state agency.

- (e) Pharmacist - Administration of the H1N1 vaccine by a pharmacist who is employed by a pharmacy participating in the Kentucky Medicaid Program.

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND
SERVICES PROVIDED TO THE MEDICALLY NEEDY

7. Home Health Services

Home health services must be provided by a home health agency that is Medicare and Medicaid certified. The service must be medically necessary, ordered by a physician, prior authorized, provided in accordance with approved plan of care and provided in the individual's residence. A hospital, nursing facility or intermediate care facility for mentally retarded shall not be considered as an individual's place of residence. Prior authorization must be conducted by the Department and is based on medical necessity; physician's orders; the recipient's needs, diagnosis, condition; the plan of care; and cost- effectiveness when compared with other care options.

7a. Intermittent or Part-time Nursing Service

Intermittent or part-time nursing services must be ordered by a physician, be prior authorized, provided in accordance with an approved plan of care and provided in the individual's residence. Home health agencies may provide disposable medical supplies necessary for, or related to, the provision of intermittent or part-time nursing service as specified for coverage by the Medicaid Program.

7b. Home Health Aide Services

Home health aide services must be ordered by a physician, prior authorized, provided in accordance with an approved plan of care and provided in the individual's residence.

7c. Medical Supplies Suitable for Use in the Home

Each provider desiring to participate as a medical supplier provider must be a participating Medicare provider and sign a provider agreement with the Department for Medicaid Services.

1. Coverage of medical supplies for use by patients in the home, is based on medical necessity.
2. Coverage criteria established by the Medicare program will be used as a guide in determining medical necessity but will be subject to a medical necessity override.
3. The criteria used in the determination of medical necessity includes an assessment of whether the item is:
 - a. Provided in accordance with 42 CFR 440.230;
 - b. Reasonable and required to identify, diagnose, treat, correct, cure, ameliorate, palliate, or prevent a disease, illness, injury, disability, or other medical condition;
 - c. Clinically appropriate in terms of amount, scope, and duration based on generally accepted standards of good medical practice;
 - d. Provided for medical reasons rather than primarily for the convenience of the recipient, caregiver, or the provider;
 - e. Provided in the recipient's place of residence, with regard to generally accepted standards of good medical practice, where the service may, for practical purposes, be safely and effectively provided;
4. Coverage of an item of medical supply shall be in accordance with the following: shall serve a medical purpose; shall not generally be useful to a person in the absence of illness or injury; shall be appropriate for use in the home; and shall be medically necessary, and reasonable.

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND
SERVICES PROVIDED TO THE MEDICALLY NEEDY

7. D. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility

Physical therapy, occupational therapy, speech pathology services, or speech/hearing/language therapy services provided by a home health agency must be ordered by a physician, physician assistant or advanced registered nurse practitioner, be prior authorized, provided in accordance with an approved plan of treatment, which shall be developed by the appropriate qualified therapist and physician.

Occupational therapy, physical therapy and speech pathology services and speech/hearing/language therapy are limited to twenty visits per calendar year. Rehabilitative and habilitative services have a combined twenty visit limit per type of therapy. Additional visits may be granted based on medical necessity.

Audiology services are not provided under this component. Physical therapy, occupational therapy, speech pathology, or speech/hearing/language therapy services provided by a medical rehabilitation facility are not provided under this component.

Qualification of Providers

Providers performing physical, occupational or speech therapy must meet requirements defined in 42 C.F.R. 484.4. A qualified physical therapist assistant, occupational therapist assistant or speech therapy assistant must be under the direct supervision of a qualified physical, occupational or speech therapist.

8. Private Duty Nursing Services

Medically necessary private duty nursing (PDN) services for up to two thousand (2,000) hours are provided under the direction of the recipient's physician in accordance with 42 CFR 440.80 and with prior approval by the Department for Medicaid Services, or its designee. These limits may be exceeded based on medical necessity with prior authorization.

Recipients in personal care homes are not eligible for this service. In addition, recipients in hospitals, nursing facilities, intermediate care facilities for the intellectually disabled, rehabilitation centers, and other institutional settings are not eligible for this service. PDN services are not covered while an individual is being observed or treated in a hospital emergency room or similar environment.

This service is only approvable based on the need for PDN services in the patient's private residence. An individual with a medical condition that necessitates this service normally is unable to leave the home without being accompanied by a licensed nurse and leaving the home requires considerable and taxing effort. An individual may utilize the approved hours of coverage outside of his/her residence during those hours when the individual's normal life activities take the patient out of the home. The need for nursing care to participate in activities outside of the home is not a basis for authorizing PDN services or expanding the hours needed for PDN services.

Medicaid will not reimburse for Personal Care Services, Skilled Nursing Visits, or Home Health Aide Services provided during the same hours of the day as PDN services.

Medicaid Payments for PDN are made only to agencies enrolled with the Department for Medicaid Services as providers for the service. An enrolled provider must be a State licensed home health or private duty nursing agency within Kentucky that is approved in its license to provide nursing services within the State. PDN services shall be rendered by a licensed registered nurse (RN) or licensed practical nurse (LPN) who is licensed by the Kentucky Board of Nursing and employed by a licensed home care agency.

A member of the patient's immediate family (spouse, child, parent, grandparent, grandchild, or sibling, including corresponding step and in-law relationship) or a legally responsible person who maintains their primary residence with the recipient may not be employed by the provider agency to provide PDN services reimbursed by Medicaid.

9. Clinic Services

Coverage for clinic services is limited to services provided by the following clinics and includes:

1. Mental health centers licensed in accordance with applicable state laws and regulations. However, services rendered by community mental health centers to skilled nursing or intermediate care facility patients/residents are not covered.
2. Family planning clinics.
3. Clinics engaging in screening for the purposes of the early and periodic screening, diagnosis, and treatment component of the Medicaid Program.
4. Outpatient surgical clinics.
5. Other clinics authorized under 42 CFR 440.90.

- 5 a. Abortion services are reimbursable under the Medical Assistance Program only when service to provide an abortion or induce miscarriage is, in the opinion of the physician, necessary for the preservation of the life of the woman seeking such treatment or to comply with federal court order in the case of *Hope vs. Childers*. Any request for program payment for an abortion or induced miscarriage must be justified by a signed physician certification documenting that in the physician's opinion the appropriate circumstances, as outlined in sentence one of this paragraph, existed. A copy of the completed certification form and an operative report shall accompany each claim submitted for payment. However, when medical services not routinely related to the uncovered abortion service are required, the utilization of an uncovered abortion service shall not preclude the recipient from receipt of medical services normally available through the Medical Assistance Program.

5 b. Specialized Children's Services Clinics

Specialized Children's Services Clinics provide a comprehensive interdisciplinary evaluation, assessment, and treatment of sexually and physically abused children under the age of 18. A team of professionals representing a variety of medical, social, and legal disciplines and advocates assesses the child and coordinates and/or provides needed services. Sexual abuse examinations are available to children from 18 to 20 years of age through Medicaid providers who deliver and bill for the separate components of the service (physical examination and mental health screening) through the physician and mental health components of the state plan.

Medicaid coverage of services provided by clinics is limited to a sexual abuse medical exam which includes the following components:

1. A physical exam provided by a licensed physician who has received specialized training in providing medical exams of sexually abused children and the use of a colposcope; and
2. A mental health screening provided by a mental health professional under the direct supervision of a physician. Mental health professionals shall include, but not be limited to the following: social workers, psychologists, art therapists, ARNPs and other qualified therapists who are required to have specialized training in the screening and assessment of sexually abused children. Under direct supervision means the physician shall assume professional responsibility for the service provided by the mental health professional.

Providers of clinic services are employed by, under contract, or have a signed affiliation agreement with the clinic.

Reimbursement methodology is described in Attachment 4.19-B, Section XXXII.

10. Dental Services

- A. A listing of dental services available to Medicaid recipients is maintained at the central office of the single state agency.
- B. Out-of-Hospital Dental Services
A listing of dental services available to Medicaid recipients is maintained at the central office of the single state agency.
- C. In-Hospital Care
A listing of dental services available to Medicaid recipients is maintained at the central office of the single state agency.
- D. Oral Surgery
A listing of oral surgery dental services available to Medicaid recipients is maintained at the central office the single state agency.

11. Physical Therapy and Related Services – Other than Therapy Services Provided by Home Health Agencies for Rehabilitative and Habilitative Services

A. Outpatient Physical, Occupational and Speech Therapy

Physical therapy, occupational therapy, speech pathology services, or speech/hearing/language therapy services provided must be ordered by a physician, physician assistant or advanced registered nurse practitioner, be prior authorized, provided in accordance with an approved plan of treatment, which shall be developed by the appropriate qualified therapist and physician.

Audiology services are not provided under this component. Physical therapy, occupational therapy, speech pathology, or speech/hearing/language therapy services provided by a medical rehabilitation facility are not provided under this component.

Qualification of Providers

Providers performing physical, occupational or speech therapy must meet requirements defined in 42 C.F.R. 484.4. A qualified physical therapist assistant, occupation therapist assistant or speech therapy assistant must be under the direct supervision of a qualified physical, occupational or speech therapist.

B. Inpatient Physical, Occupational and Speech Therapy

Services shall be provided to inpatients of acute participating hospitals and skilled nursing facilities or to residents of intermediate care facilities for individuals with mental retardation or developmental disabilities under the following conditions:

Physical therapy, occupational therapy, speech pathology services, or speech/hearing/language therapy services provided must be ordered by a physician, physician assistant or advanced registered nurse practitioner, be prior authorized, provided in accordance with an approved plan of treatment, which shall be developed by the appropriate qualified therapist and physician.

Qualification of Providers

Providers performing physical, occupational or speech therapy must meet requirements defined in 42 C.F.R. 484.4. A qualified physical therapist assistant, occupation therapist assistant or speech therapy assistant must be under the direct supervision of a qualified physical, occupational or speech therapist.

11. Physical Therapy and Related Services – Other than Therapy Services Provided by Home Health Agencies for Rehabilitative and Habilitative Services

C. Limitations

There is a limit of twenty (20) visits per calendar year combined for inpatient and outpatient physical therapy.

There is a limit of twenty (20) visits per calendar year combined for inpatient and outpatient occupational therapy

There is a limit of twenty (20) visits per calendar year combined for inpatient and outpatient speech therapy.

If medical necessity requires additional visits, the provider must request additional visits via prior authorization guidelines in effect for recipient.

12. Prescribed Drugs, Dentures, Prosthetic Devices, and Eyeglasses

If medical necessity is established, limitations in this section do not apply to EPSDT eligible children in accordance with 1905 (r)(5) of the Social Security Act.

a. Prescribed Drugs

- (1) Coverage is provided for drugs included in the Medicaid drug lists that are prescribed for outpatient use by a physician, osteopath, dentist, podiatrist, optometrist, physician assistant, or advanced registered nurse practitioner. Drugs added to the Preferred Drug List (PDL) are based on recommendations submitted by the Pharmacy and Therapeutics Advisory Committee to the Commissioner of the Kentucky Department for Medicaid Services for approval. Drugs requiring prior authorization must follow the process listed below. Approval of prior authorization is based on FDA-approved indications or a medically accepted indication documented in official compendia or peer-reviewed medical literature.
- (2) Kentucky will provide reimbursement for covered outpatient drugs when prescribed by an enrolled licensed provider within the scope of their license and practice as allowed by State law and in accordance with Section 1927 of the Social Security Act. This will apply to drugs of any manufacturer that has entered into a rebate agreement with the Centers for Medicare and Medicaid Services (CMS). All drugs covered by the National Drug Rebate Agreements remain available to Medicaid beneficiaries, although some may require prior authorization. The prior authorization process complies with the requirements of Section 1927 of the Social Security Act and provides for a 24-hour turnaround by either telephone or other telecommunications device from receipt of request and provides for a 72- hour supply of drugs in emergency circumstances. The preferred drug list meets the formulary requirements that are specified in Section 1 927(d)(4) of the Social Security Act.
- (3) The drugs or classes of drugs listed in 42 USC 1396r-8(d)(2) are excluded from coverage unless specifically placed, either individually or by drug class, on the Medicaid drug lists or prior authorized based on FDA-approved indications or a medically accepted indication documented in official compendia or peer-reviewed medical literature. The following drugs are excluded from coverage through the Outpatient Pharmacy Program:
 - (a) A drug for which the FDA has issued a "less than effective (LTE)" rating or a drug "identical, related, or similar (IRS)" to an LTE drug;
 - (b) A drug that has reached the termination date established by the drug manufacturer;
 - (c) A drug for which the drug manufacturer has not entered into or has not complied with a rebate agreement in accordance with 42 USC 1396r-8(a) unless there has been a review and determination by the department that it shall be in the best interest of Medicaid recipients for the department to make payment for the non-rebated drug. Note: Because federal financial participation is not generally available for a non-rebated drug, state funds will be used to cover such drugs if necessary to protect the health of a Medicaid recipient and no other appropriate options exist;

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- (d) A drug provided to a recipient in an institution in which drugs are considered a part of the reasonable allowable costs under the Kentucky Medicaid Program;
 - (e) A drug or its medical use in one (1) of the following categories unless the drug or its medical use is designated as covered in the drug list:
 - 1. A drug if used for anorexia, weight loss, or weight gain;
 - 2. A drug if used to promote fertility;
 - 3. A drug if used for cosmetic purposes or hair growth;
 - 4. A drug if used for the symptomatic relief of cough and colds;
 - 5. Vitamin or mineral products other than prenatal vitamins and fluoride preparations;
 - 6. An over-the-counter drug provided to a Medicaid nursing facility service recipient if included in the nursing facility's standard price;
 - 7. A drug which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee; or
 - 8. A drug utilized for erectile dysfunction therapy unless the drug is used to treat a condition, other than sexual or erectile dysfunction, for which the drug has been approved by the United States Food and Drug Administration;
 - (f) A drug dispensed as part of, or incident to and in the same setting as, an inpatient hospital service, an outpatient hospital service, or an ambulatory surgical center service. However, a legend drug may be provided through prior authorization to a recipient admitted to an inpatient facility that does not bill patients, Medicaid, or other third-party payers for health care services.
 - (g) A drug for which the department requires prior authorization if prior authorization has not been approved; and
- (4) Except for emergencies, a recipient "locked-in" to one pharmacy due to over-utilization may receive prescriptions:
- (a) Only from his/her designated lock-in pharmacy and prescribed by his/her lock-in provider; or
 - (b) For specified controlled substances prescribed by his/her designated controlled substance lock-in prescriber.
- (5) If authorized by the prescriber, a prescription for a controlled substance in Schedule III-V may be refilled up to five times within a six month period from the date the prescription was written or ordered; a non-controlled substance may be refilled up to 11 times within a 12 month period from the date the prescription was written or ordered. In addition, a prescription fill for a maintenance drug may be dispensed in a 92-day supply if a recipient has demonstrated stability on the maintenance drug. However, a 92-day supply of a maintenance drug shall not be dispensed if a prescribing provider specifies that the quantity should be less. Also, individuals receiving supports for community living services, long term care, and personal care shall not be subject to the 92-day supply requirement.

- (6) A refill of a prescription shall not be covered unless at least 90 percent of the prescription time period has elapsed. However, a refill may be covered before 90 percent of the prescription time period has elapsed if the prescribing provider or dispensing pharmacy submits a prior authorization request by phone, fax, or web submission. Medicaid recipients residing in a long-term care facility or personal care home will be exempt from the 90 percent requirement and remain at the current 80 percent.

(7) Supplemental Rebate Program:

The state is in compliance with Section 1927 of the Social Security Act. The state has the following policies for the Supplemental Rebate Program for the Medicaid population:

- (a) CMS has authorized the Commonwealth of Kentucky to enter into the Michigan multi-state pooling agreement (MMSPA) also referred to as the National Medicaid Pooling Initiative (NMPI) for drugs provided to Medicaid beneficiaries. The NMPI Supplemental Rebate Agreement (SRA) and the Amendment to the SRA submitted to CMS on January 6, 2005 have been authorized for pharmaceutical manufacturers' existing agreements through their current expiration dates. The updated NMPI SRA (submitted to CMS on December 10, 2013) has been authorized for renewal and new agreements with pharmaceutical manufacturers for drugs provided to Medicaid beneficiaries.
- (b) CMS has authorized Kentucky's collection of supplemental rebates through the NMPI.
- (c) Supplemental rebates received by the State in excess of those required under the national drug rebate agreement will be shared with the Federal Government on the same percentage basis as applied under the national drug rebate agreement.
- (d) All drugs covered by the program, irrespective of a supplemental rebate agreement, will comply with the provision of the national drug rebate agreement.
- (e) Any contracts not authorized by CMS will be submitted for CMS approval in the future.
- (f) As specified in Section 1927(b)(3)(D) of the Act, notwithstanding any other provisions of law, rebate information disclosed by a manufacturer shall not be disclosed by the state for purposes other than rebate invoicing and verification.

Commonwealth Global Choices

b. Dentures

Dentures are not covered for adults. Dentures may be covered for children through the Early, Periodic, Screening, Diagnosis and Treatment Program (EPSDT).

c. Prosthetics

Prosthetic devices are covered under durable medical equipment in accordance with Attachment 3.1-A, page 13.

d. Eyeglasses The following limitations are applicable:

- 1) Eyeglasses are provided only to recipients under age twenty-one (21). Coverage for eyeglasses is limited to no more than \$200 per year per member.
- 2) Contact lenses are not covered.
- 3) Telephone contacts are not covered.
- 4) Safety glasses are covered when medically necessary subject to prior authorization requirements described in material on file in the slate agency.
- 5) If medically necessary, prisms shall be added within the cost of the lenses.

If medical necessity is established, these limitations do not apply to EPSDT eligible children in accordance with 1905 (r)(5) of the Social Security Act.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

Diagnostic, screening, preventive, and rehabilitative services are covered when provided by qualified providers, licensed in accordance with applicable state laws and regulations. Reimbursement for services under this authority will not be made when delivered in a long-term care environment as such services are reimbursable as a routine cost to the institution.

13a. Diagnostic Services

Diagnostic Services are described under other sections of this State Plan.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13b. Screening Services

Screening Services are described under other sections of this State Plan.

13. Other diagnostic, screening, preventive and, rehabilitative services, ie. other than those provided elsewhere in this plan.

13c. Preventive Services

- A. Eligible preventive services include all of the preventive services assigned a grade of A or B by the United States Preventive Services Task Force (USPSTF), and all approved adult vaccines and their administration, recommended by the Advisory Committee on Immunization Practices (ACIP). Such services are provided in accordance with Section 4106 of the Affordable Care Act. The state has documentation available to support the claim of the enhanced FMAP for preventive services beginning January 1, 2014. The state assures that it has a method to ensure that, as changes are made to USPSTF or ACIP recommendations, the state will update their coverage and billing codes to comply with those revisions.

In conjunction with the above and in compliance with Section 2713 of the Public Health Service Act, eligible preventive services also include preventive care and screening for infants, children and adults recommended by HRSA's Bright Futures program project, and additional preventive services for women recommended by the Institute of Medicine.

No cost sharing shall be applied to preventive services.

- B. Covered services shall be provided by a:

1. Physician;
2. Physician Assistant;
3. Advanced Registered Nurse Practitioner; or
4. Registered Nurse. A "registered nurse" is defined by state law as a person who is licensed in accordance with state law to engage in registered nursing practice. State law defines "registered nursing practice" as the performance of acts requiring substantial specialized knowledge, judgment, and nursing skill based upon the principles of psychological, biological, physical, and social sciences in the application of the nursing process in:
 - a The care, counsel, and health teaching of the ill, injured, or infirm;
 - b The maintenance of health or prevention of illness of others;
 - c The administration of medication and treatment as prescribed by a physician, physician assistant, dentist, or advanced registered nurse practitioner and as further authorized or limited by the Kentucky Board of Nursing, and which are consistent either with American Nurses' Association Standards of Practice or with Standards of Practice established by nationally accepted organizations of registered nurses. Components of medication administration include but are not limited to:
 - i Preparing and giving medications in the prescribed dosage, route, and frequency, including dispensing medications;
 - ii Observing, recording, and reporting desired effects, untoward reactions, and side effects of drug therapy;
 - iii Intervening when emergency care is required as a result of drug therapy;
 - iv Recognizing accepted prescribing limits and reporting deviations to the prescribing individual;

13. Other diagnostic, screening, preventive and, rehabilitative services, ie. other than those provided elsewhere in this plan.

13c. Preventive Services (cont.)

- v Recognizing drug incompatibilities and reporting interactions or potential interactions to the prescribing individual; and
- vi Instructing an individual regarding medications;
- d The supervision, teaching of, and delegation to other personnel in the performance of activities relating to nursing care; and
- e The performance of other nursing acts which are authorized or limited by the Kentucky Board of Nursing, and which are consistent either with American Nurses' Association Standards of Practice or with Standards of Practice established by nationally accepted organizations of registered nurses.

C. Covered services include:

1. Early and Periodic screening, diagnosis, and treatment (EPSDT):

EPSDT services are described in Attachment 3.1-A, pages 7.1.2 – 7.1.4, 7.1.7, 7.1.8, and Attachment 3.1-B, pages 16-18, 20.1, and 20.2.

2. Pediatric services:

Services include the following:

- a Diagnostic and nursing evaluation and management services;
- b Provision of all childhood immunizations as described by page 9a of this plan included in the Vaccines for Children program. Provision of other immunizations to children as recommended by the CDC;
- c Medications and other treatment procedures; and
- d Follow-up nursing care.

3. Prenatal and related services:

Services provided or arranged in accordance with the standards developed for the prenatal program include the following:

- a Pregnancy testing/confirmation;
- b Contact visit counseling;
- c Initial examination;
- d Subsequent monitoring visits;
- e Laboratory tests, as necessary;
- f Individual counseling;
- g Hands voluntary home visitation program;
- h Initial infant assessment;
- i Postpartum visit; and
- j Family planning visit.

13. Other diagnostic, screening, preventive and, rehabilitative services, ie. other than those provided elsewhere in this plan.

13c. Preventive Services (cont.)

4 Communicable disease services:

Communicable disease services include:

- a Diagnostic evaluation and management services;
- b Laboratory tests, as necessary;

- c Medications and other treatment procedures;
- d Individual counseling; and
- e Adult immunizations as recommended by the CDC.

5 Chronic disease services:

Services are provided for the following:

- a Diabetes;
- b Heart disease and stroke program;
- c Women's Cancer Screening program;
- d Substance abuse prevention program;
- e Tobacco prevention and cessation;
- f Obesity;
- g Arthritis/osteoarthritis;
- h Depression;
- i Oncology;
- j Hemophilia;
- k Sickle Cell;
- l Organ transplants; and
- m Rare disease.

6 Family planning services:

Family planning services are described in Attachment 3.1-A, page 7.1.9 and Attachment 3.1-B, page 20.3.

Services include the following:

- a Complete medical history;
- b Physical examination;
- c Laboratory and clinical test supplies; and
- d Counseling and prescribed birth control methods to best suit the patient's needs.

Services provided within these categories are those defined by procedure code under the Medicare Physician Fee Schedule.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

Rehabilitative substance use and mental health services are medical or remedial services that have been recommended by a physician or other licensed practitioner of the healing arts within the scope of his practice, under Kentucky State Law and consistent with federal regulations at 42 CFR 440.130(d).

Each medical professional is given the choice of whether or not to participate in the Kentucky Medicaid Program. From those professionals who have chosen to participate, the recipient may choose the one from whom he wishes to receive his medical care.

When the Department makes payment for a covered service and the provider accepts the payment made by the Department in accordance with the Department's fee structure, the amounts paid shall be considered payment in full except any applicable co-payment; and no bill for the same service shall be sent to the recipient for any amount above the Medicaid allowed charges (with the exception of any applicable co-payments). The provider may bill the recipient for services not covered by Kentucky Medicaid; however, the provider must make the recipient aware of the non-covered services prior to rendering those services.

Providers of medical service attest by their signatures that the presented claims are valid and in good faith. Fraudulent claims are punishable by fine and /or imprisonment.

Diagnoses shall be recorded in the health record within three visits, in order to receive Medicaid payment. The exception is for crisis services.

A billable unit of service is the actual time spent face-to-face delivering an actual service. Time spent in traveling to and from an off-site visit shall not be billed.

1. Limitations on Amount, Duration or Scope of Services

Unless a diagnosis is made and documented in the medical record within three visits, the service will not be covered. The exception is for crisis services. An appropriate mental health or substance use disorder diagnosis is required for coverage, with the exception for crisis services.

Some rehabilitative services are furnished with limitations on amount, duration, or scope of service. The limitations of these services are indicated in the service description. If there is no limitation noted within the description of the service, there are no limits on the amount, duration or scope of the service. All services, including those without specific limitations, with the exception of crisis services, must meet medical necessity and must be provided in accordance with a documented diagnosis and plan of treatment.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

1. Limitations on Amount, Duration or Scope of Services (continued)

The following services will NOT be covered by Medicaid:

- (a) Services provided to residents of nursing facilities
- (b) Services provided to inmates of local, state or federal jails, detention centers or prisons
- (c) Services to those with developmental and intellectual disabilities, without documentation of an additional psychiatric diagnosis
- (d) Psychiatric or psychological testing for other agencies such as courts or schools, which does not result in the client receiving psychiatric intervention or therapy from the independent provider. If the testing results in behavioral health treatment, then the testing was medically necessary and would be covered. School services included in a child's Individual Education Plan (IEP) may be coverable under the Medicaid School-Based Services Program.
- (e) Consultation or educational services provided to Medicaid recipients or others
- (f) Collateral therapy for ages 21 and over
- (j) Consultation or third party contracts shall be outside the scope of covered benefits. Covered services require direct patient contact except collateral services for children under age twenty-one (21), when a part of the plan of care.
- (k) Telephone calls, emails, texts or other electronic contacts
- (l) Travel time
- (m) Field trips, recreational, social, and physical exercise activity groups

2. Eligible Recipients

Unless otherwise indicated within the description of each service, services for the treatment of substance use and/or mental health are available to all Medicaid beneficiaries who meet the medical necessity criteria for these services. Except where indicated, all services will apply to both children and adults.

3. Categories of Providers

Kentucky defines the following categories of providers:

- (d) Individual Practitioner: An individual practitioner who is licensed by the respective board in the Commonwealth of Kentucky or who is supervised by a licensed practitioner to render health services and/or bill Kentucky Medicaid.
- (e) Provider group: A group of more than one individually licensed practitioner who forms a business entity to render health services and bill Kentucky Medicaid.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

3. Categories of Providers (continued)

- (f) Licensed organization: A business entity that employs licensed and non-licensed health professionals and is licensed to render health services and bill Kentucky Medicaid. This organization must also meet the following criteria:
- a. Be enrolled as a Medicaid provider in the Commonwealth of Kentucky;
 - b. Demonstrate experience serving the population of individuals with behavioral health disorders relevant to the particular services provided;
 - c. Have the administrative capacity to provide quality of services in accordance with state and federal requirements;
 - d. Use a financial management system that provides documentation of services and costs;
 - e. Demonstrate capacity to document and maintain individual case records in accordance with state and federal requirements.

4. Covered Services

Unless indicated within the description of services, all services listed below are eligible services for the treatment of both substance use, mental illness, and co-occurring conditions.

The following services, as defined by the Kentucky Department for Medicaid Services, are considered Medicaid rehabilitative mental health and substance use services:

- (a) Screening
- (b) Assessment
- (c) Psychological Testing
- (d) Crisis Intervention
- (e) Mobile crisis
- (f) Residential Crisis Stabilization
- (g) Day Treatment
- (h) Peer Support
- (i) Parent/Family Peer Support
- (j) Intensive Outpatient Program (IOP)
- (k) Individual Outpatient Therapy
- (l) Group Outpatient Therapy
- (m) Family Outpatient Therapy
- (n) Collateral Outpatient Therapy
- (o) Partial Hospitalization
- (p) Service Planning
- (q) Residential Services for Substance Use Disorders (Substance use only)

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

4. Covered Services (continued)

- (r) SBIRT – Screening, Brief Intervention and Referral to Treatment (Substance use only)
- (s) Medication Assisted Treatment (Substance use only)
- (t) Assertive Community Treatment (Mental health only)
- (u) Comprehensive Community Support Services (Mental health only)
- (v) Therapeutic Rehabilitation Program (TRP) (Mental health only)

(a) Screening

Screening shall be the determination of the likelihood that a person has a mental health, substance use, or co-occurring disorder. The purpose is not to establish the presence or specific type of such a disorder but to establish the need for an in-depth assessment.

Authorized Providers:

Rendering Practitioners practicing as an individual practitioner, a provider group, or as part of a licensed organization

- Licensed Psychologist (LP)
- Licensed Psychological Associate (LPA) working under the supervision of a LP*
- Licensed Psychological Practitioner (LPP)
- Licensed Clinical Social Worker (LCSW)
- Certified Social Worker, Master Level (CSW) working under the supervision of a LCSW*
- Licensed Professional Clinical Counselor (LPCC)
- Licensed Professional Counselor Associate (LPCA) working under the supervision of a LPCC*
- Licensed Marriage and Family Therapist (LMFT) Marriage and Family Therapist Associate (MFTA) working under the supervision of a LMFT*
- Physician
- Psychiatrist
- Advanced Practice Registered Nurse (APRN)
- Physician Assistant (PA) working under the supervision of a Physician*

* Billed through supervisor

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

4. Covered Services (continued)

(a) Screenings (continued)

Billing Providers

- Individual Practitioners
 - LP
 - LPP
 - LCSW
 - LPCC
 - LMFT
 - Physician
 - Psychiatrist
 - APRN
- Provider Groups
 - LP
 - LPP
 - LCSW
 - LPCC
 - LMFT
 - Physician
 - Psychiatrist
 - APRN
- Licensed Organizations

(b) Assessment

Assessment shall include gathering information and engaging in a process with the client that enables the provider to establish the presence or absence of a mental health and/or substance use disorder, determine the client's readiness for change, identify client strengths or problem areas that may affect the processes of treatment and recovery, and engage the client in the development of an appropriate treatment relationship. The purpose of an assessment is to establish (or rule out) the existence of a clinical disorder or service need and to work with the client to develop a treatment and service plan. This does not include psychological or psychiatric evaluations or assessments.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

4. Covered Services (continued)

(b) Assessment (continued)

Authorized Providers:

Rendering Practitioners practicing as an individual practitioner, a provider group, or as part of a licensed organization

- Licensed Psychologist (LP)
- Licensed Psychological Associate (LPA) working under the supervision of a LP*
- Licensed Psychological Practitioner (LPP)
- Licensed Clinical Social Worker (LCSW)
- Certified Social Worker, Master Level (CSW) working under the supervision of a LCSW*
- Licensed Professional Clinical Counselor (LPCC)
- Licensed Professional Counselor Associate (LPCA) working under the supervision of a LPCC*
- Licensed Marriage and Family Therapist (LMFT)
- Marriage and Family Therapist Associate (MFTA) working under the supervision of a LMFT*
- Physician
- Psychiatrist
- Advanced Practice Registered Nurse (APRN)
- Physician Assistant (PA) working under the supervision of a Physician

* Billed through supervisor

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

4. Covered Services (continued)

(b) Assessment (continued)

Billing Providers

- Individual Practitioners
 - LP
 - LPP
 - LCSW
 - LPCC
 - LMFT
 - Physician
 - Psychiatrist
 - APRN
- Provider Groups
 - LP
 - LPP
 - LCSW
 - LPCC
 - LMFT
 - Physician
 - Psychiatrist
 - APRN
- Licensed Organizations

(c) Psychological Testing

Psychological testing for individuals with mental health, substance use, or co-occurring mental health and substance use disorders may include psychodiagnostic assessment of personality, psychopathology, emotionality, and/or intellectual abilities. Also includes interpretation and written report of testing results.

Authorized Providers:

Rendering Practitioners practicing as an individual practitioner, a provider group, or as part of a licensed organization

- Licensed Psychologist (LP)
- Licensed Psychological Associate (LPA) working under the supervision of a LP*
- Licensed Psychological Practitioner (LPP)

* Billed through supervisor

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

4. Covered Services (continued)

(c) Psychological Testing (continued)

Billing Providers

- Individual Practitioners
 - LP
 - LPP
- Provider Groups
 - LP
 - LPP
- Licensed Organizations

(d) Crisis Intervention

Crisis Intervention shall be a therapeutic intervention provided for the purpose of immediately reducing or eliminating risk of physical or emotional harm to the client, or others. This service shall be provided as an immediate relief to the presenting problem or threat. It must be followed by non-crisis service referral as appropriate. It must be provided in a face-to-face, one-on-one encounter between the provider and the client.

Crisis intervention may include further service prevention planning such as lethal means reduction for suicide risk and substance use relapse prevention.

Authorized Providers:

Rendering Practitioners practicing as an individual practitioner, a provider group, or as part of a licensed organization

- Licensed Psychologist (LP)
- Licensed Psychological Associate (LPA) working under the supervision of a LP*
- Licensed Psychological Practitioner (LPP)
- Licensed Clinical Social Worker (LCSW)
- Certified Social Worker, Master Level (CSW) working under the supervision of a LCSW*
- Licensed Professional Clinical Counselor (LPCC)
- Licensed Professional Counselor Associate (LPCA) working under the supervision of a LPCC*
- Licensed Marriage and Family Therapist (LMFT)

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

4. Covered Services (continued)

(d) Crisis Intervention (continued)

- Marriage and Family Therapist Associate (MFTA) working under the supervision of a LMFT*Physician
- Psychiatrist
- Advanced Practice Registered Nurse (APRN)
- Physician Assistant (PA) working under the supervision of a Physician*
- Peer Support Specialist working under the supervision of a physician, a psychiatrist, a LP, a LPP, a LPA working under the supervision of a LP, a LCSW, a CSW with three (3) years of inpatient or outpatient clinical experience in psychiatric social work and currently employed by a hospital or forensic psychiatric facility licensed by the Commonwealth or a psychiatric unit of a general hospital or a private agency or company engaged in the provision of mental health services or a regional community mental health center; a LMFT with three (3) years of inpatient or outpatient clinical experience in psychiatric mental health practice and currently employed by a hospital or forensic facility licensed by the Commonwealth, a psychiatric unit of a general hospital, a private agency or company engaged in providing mental health services, or a regional community mental health center*

* Billed through supervisor

Billing Providers

- Individual Practitioners
 - LP
 - LPP
 - LCSW
 - LPCC
 - LMFT
 - Physician
 - Psychiatrist
 - APRN

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

4. Covered Services (continued)

(d) Crisis Intervention (continued)

- Provider Groups
 - LP
 - LPP
 - LCSW
 - LPCC
 - LMFT
 - Physician
 - Psychiatrist
 - APRN
- Licensed Organizations

(e) Mobile Crisis

Mobile Crisis provides the same services as crisis intervention, except the location for the service is not in the office. Services are available 24 hours a day, seven (7) days a week, 365 days a year. This service is provided in duration of less than 24 hours and is not an overnight service. This service provides crisis response in home or community to provide an immediate evaluation, triage and access to acute behavioral health services including treatment and supports to effect symptom reduction, harm reduction or to safely transition persons in acute crises to appropriate least restrictive level of care.

Authorized Providers

The Mobile Crisis practitioners must be employed by a licensed organization that meets the criteria of a licensed organization and the following additional criteria:

- Capacity to employ required practitioners and coordinate service provision among the rendering practitioners
- Capacity to provide the full range of mobile crisis services on a 24/7/365 basis
- Access to a board-certified or board-eligible psychiatrist on a 24/7/365 basis

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

4. Covered Services (continued)

(e) Mobile Crisis (continued)

Rendering Practitioners practicing as part of a licensed organization

- Licensed Psychologist (LP)
- Licensed Psychological Associate (LPA) working under the supervision of a LP
- Licensed Psychological Practitioner (LPP)
- Licensed Clinical Social Worker (LCSW)
- Certified Social Worker, Master Level (CSW) working under the supervision of a LCSW
- Licensed Professional Clinical Counselor (LPCC)
- Licensed Professional Counselor Associate (LPCA) working under the supervision of a LPCC
- Licensed Marriage and Family Therapist (LMFT)
- Marriage and Family Therapist Associate (MFTA) working under the supervision of a LMFT
- Physician
- Psychiatrist
- Advanced Practice Registered Nurse (APRN)
- Physician Assistant (PA) working under the supervision of a Physician
- Peer Support Specialist working under the supervision of a physician, a psychiatrist, a LP, a LPP, a LPA working under the supervision of a LP, a LCSW, a CSW with three (3) years of inpatient or outpatient clinical experience in psychiatric social work and currently employed by a hospital or forensic psychiatric facility licensed by the Commonwealth or a psychiatric unit of a general hospital or a private agency or company engaged in the provision of mental health services or a regional community mental health center; a LMFT with three (3) years of inpatient or outpatient clinical experience in psychiatric mental health practice and currently employed by a hospital or forensic facility licensed by the Commonwealth, a psychiatric unit of a general hospital, a private agency or company engaged in providing mental health services, or a regional community mental health center*

Billing Providers

- Licensed Organizations

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

4. Covered Services (continued)

(f) Residential Crisis Stabilization

Residential Crisis Stabilization services are provided in Crisis Stabilization Units. Crisis Stabilization Units are community-based, residential programs that offer an array of services including screening, assessment, treatment planning, individual, group, and family therapy, and peer support in order to stabilize a crisis and divert the individual from a higher level of care. It is not part of a hospital. They are used when individuals in a behavioral health emergency cannot be safely accommodated within the community, are not in need of hospitalization but need overnight care. The purpose is to stabilize the individual, provide treatment for acute withdrawal, when appropriate, and re-integrate them back into the community, or other appropriate treatment setting, in a timely fashion. These units provide a non-hospital residential setting and services 24-hours per day, seven days per week, 365 days a year. The estimated length of stay for children is three to five days. The estimated length of stay for adults is seven to 10 days. The component services of crisis stabilization units are screening, assessment, service planning, psychiatric services, individual therapy, family therapy, group therapy, and peer support.

Residential crisis stabilization does not include, and FFP is not available for, room and board services; educational, vocational and job training services; habilitation services; services to inmates in public institutions as defined in 42 CFR §435.1010; services to individuals residing in institutions for mental diseases as described in 42 CFR§435.1010; recreational and social activities; and services that must be covered elsewhere in the state Medicaid plan.

KY Medicaid will not pay for this service in a unit of more than 16 beds or multiple units operating as one unified facility with more than 16 aggregated beds.

Authorized Providers

The Residential Crisis Stabilization providers must be employed by a licensed organization that meets the criteria of a licensed organization and the following additional criteria:

- Capacity to employ practitioners and coordinate service provision among rendering providers
- Capacity to provide the full range of services included in the Residential Crisis Stabilization service definition
- Ability to provide Residential Crisis Stabilization services on a 24/7/365 basis
- Access to a board-certified or board-eligible psychiatrist on a 24/7/365 basis

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

4. Covered Services (continued)

(f) Residential Crisis Stabilization (continued)

Rendering Practitioners practicing as part of a licensed organization

- Licensed Psychologist (LP)
- Licensed Psychological Associate (LPA) working under the supervision of a LP
- Licensed Psychological Practitioner (LPP)
- Licensed Clinical Social Worker (LCSW)
- Certified Social Worker, Master Level (CSW) working under the supervision of a LCSW
- Licensed Professional Clinical Counselor (LPCC)
- Licensed Professional Counselor Associate (LPCA) working under the supervision of a LPCC
- Licensed Marriage and Family Therapist (LMFT)
- Marriage and Family Therapist Associate (MFTA) working under the supervision of a LMFT
- Physician
- Psychiatrist
- Advanced Practice Registered Nurse (APRN)
- Physician Assistant (PA) working under the supervision of a Physician
- Peer Support Specialist working under the supervision of a physician, a psychiatrist, a LP, a LPP, a LPA working under the supervision of a LP, a LCSW, a CSW with three (3) years of inpatient or outpatient clinical experience in psychiatric social work and currently employed by a hospital or forensic psychiatric facility licensed by the Commonwealth or a psychiatric unit of a general hospital or a private agency or company engaged in the provision of mental health services or a regional community mental health center; a LMFT with three (3) years of inpatient or outpatient clinical experience in psychiatric mental health practice and currently employed by a hospital or forensic facility licensed by the Commonwealth, a psychiatric unit of a general hospital, a private agency or company engaged in providing mental health services, or a regional community mental health center

Billing Providers

- Licensed Organizations

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

4. Covered Services (continued)

(g) Day Treatment

Day Treatment is a non-residential, intensive treatment program designed for children/youth under the age of 21 who have an emotional disability, neurobiological and/or substance use disorders and who are at high risk of out-of-home placement due to behavioral health issues. Intensive coordination/linkage with schools and or other child serving agencies is included.

Intensive coordination is needed in order to successfully transition youth recipients to a lower level of care. See below for basic components of the required linkage agreement between the provider and the local education authority that specifies the responsibility of the authority and the provider for:

- Appropriately licensed teachers and provisions for their professional development;
- Educational supports including classroom aides and textbooks;
- Educational facilities;
- Physical education and recreational therapies;
- Transportation; and
- Transition planning.

Day treatment services do not include services covered in a child's Individualized Education Plan (IEP).

Day treatment services shall be provided:

- In collaboration with the education services of the Local Education Authority (LEA) including those provided through IDEA and/or Section 504;
- On school days and during scheduled breaks;
- In coordination with the recipient's individual educational plan, if the recipient has an individual educational plan;
- With a linkage agreement to other behavioral health services with the LEA that specifies the responsibilities of the LEA and the day treatment provider.

Authorized Providers

Rendering Practitioners practicing as an individual practitioner, a provider group, or as part of a licensed organization

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

4. Covered Services (continued)

(g) Day Treatment (continued)

- Licensed Psychologist (LP)
- Licensed Psychological Associate (LPA) working under the supervision of a LP
- Licensed Psychological Practitioner (LPP)
- Licensed Clinical Social Worker (LCSW)
- Certified Social Worker, Master Level (CSW) working under the supervision of a LCSW
- Licensed Professional Clinical Counselor (LPCC)
- Licensed Professional Counselor Associate (LPCA) working under the supervision of a LPCC
- Licensed Marriage and Family Therapist (LMFT)
- Marriage and Family Therapist Associate (MFTA) working under the supervision of a LMFT
- Physician
- Psychiatrist
- Advanced Practice Registered Nurse (APRN)
- Physician Assistant (PA) working under the supervision of a Physician
- Peer Support Specialist working under the supervision of a physician, a psychiatrist, a LP, a LPP, a LPA working under the supervision of a LP, a LCSW, a CSW with three (3) years of inpatient or outpatient clinical experience in psychiatric social work and currently employed by a hospital or forensic psychiatric facility licensed by the Commonwealth or a psychiatric unit of a general hospital or a private agency or company engaged in the provision of mental health services or a regional community mental health center; a LMFT with three (3) years of inpatient or outpatient clinical experience in psychiatric mental health practice and currently employed by a hospital or forensic facility licensed by the Commonwealth, a psychiatric unit of a general hospital, a private agency or company engaged in providing mental health services, or a regional community mental health center

Billing Providers

- Individual Practitioners
 - LP
 - LPP
 - LCSW
 - LPCC
 - LMFT

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

4. Covered Services (continued)

(g) Day Treatment (continued)

- Physician
- Psychiatrist
- APRN
- Provider Groups
 - LP
 - LPP
 - LCSW
 - LPCC
 - LMFT
 - Physician
 - Psychiatrist
 - APRN
- Licensed Organizations

(h) Peer Support

Peer Support is emotional support that is provided by persons having a mental health, substance use, or co-occurring mental health and substance use disorder to others sharing a similar mental health, substance use, or co-occurring mental health and substance use disorder in order to bring about a desired social or personal change. It is an evidence based practice. Peer Support Services are structured and scheduled non-clinical but therapeutic activities with individual clients or groups provided by a self-identified consumer of mental health, substance use, or co-occurring mental health and substance use disorder services who has been trained and certified in accordance with state regulations. Services should promote socialization, recovery, self-advocacy, preservation and enhancement of community living skills for the client.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

4. Covered Services (continued)

(h) Peer Support (continued)

Peer support services must incorporate the following core components:

- Supervision – Peer support specialists must be supervised regularly by a physician, a psychiatrist, a LP, a LPP, a LPA working under the supervision of a LP, a LCSW, a CSW with three (3) years of inpatient or outpatient clinical experience in psychiatric social work and currently employed by a hospital or forensic psychiatric facility licensed by the Commonwealth or a psychiatric unit of a general hospital or a private agency or company engaged in the provision of mental health services or a regional community mental health center; a LMFT with three (3) years of inpatient or outpatient clinical experience in psychiatric mental health practice and currently employed by a hospital or forensic facility licensed by the Commonwealth, a psychiatric unit of a general hospital, a private agency or company engaged in providing mental health services, or a regional community mental health center, including receiving face-to-face individual supervision no less than once a month.
- Care coordination - Peer support services must be coordinated within the context of a comprehensive, individualized treatment plan which is developed through a person centered planning process. The peer support services must be identified on each client's individual treatment plan, and must be designed to directly contribute to the participant's individualized goals, as specified in the plan.
- Training - Peer Support Specialists have a minimum educational requirement of a high school diploma or a General Educational Development (GED) certificate and must successfully complete training approved by DBHDID. Training includes a minimum 30 hour program based on a nationally-recognized curriculum. The curriculum includes modules on problem solving, creating a wellness recovery action plan, stages in the recovery process, effective listening skills, establishing recovery goals and using support groups to promote and sustain recovery. The peer must take and pass a test (both written and oral components) before being certified as a peer specialist. In addition, Peer Support Specialists must obtain at least 6 hours of related training or continuing education per year.

Authorized Providers

Peer Support – Peer support specialists must be employed by a licensed organization or provider group that meets the criteria of a licensed organization and the following additional criteria:

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

4. Covered Services (continued)

(h) Peer Support (continued)

- Must employ qualified peer support specialists who are certified in accordance with Kentucky Administrative Regulation
- Must provide supervision by a physician, a psychiatrist, a LP, a LPP, a LPA working under the supervision of a LP, a LCSW, a CSW with three (3) years of inpatient or outpatient clinical experience in psychiatric social work and currently employed by a hospital or forensic psychiatric facility licensed by the Commonwealth or a psychiatric unit of a general hospital or a private agency or company engaged in the provision of mental health services or a regional community mental health center; a LMFT with three (3) years of inpatient or outpatient clinical experience in psychiatric mental health practice and currently employed by a hospital or forensic facility licensed by the Commonwealth, a psychiatric unit of a general hospital, a private agency or company engaged in providing mental health services, or a regional community mental health center for peer support specialists
- Capacity to provide on-going continuing education and technical assistance to peer support specialists
- Demonstrated experience serving the behavioral health population (mental health, substance use or co-occurring mental health and substance use disorders) and age range served (youth or adult peers or parent-to-parent)

Rendering Practitioners practicing as part of a provider group or licensed organization

- Peer Support Specialist working under the supervision of a physician, a psychiatrist, a LP, a LPP, a LPA working under the supervision of a LP, a LCSW, a CSW with three (3) years of inpatient or outpatient clinical experience in psychiatric social work and currently employed by a hospital or forensic psychiatric facility licensed by the Commonwealth or a psychiatric unit of a general hospital or a private agency or company engaged in the provision of mental health services or a regional community mental health center; a LMFT with three (3) years of inpatient or outpatient clinical experience in psychiatric mental health practice and currently employed by a hospital or forensic facility licensed by the Commonwealth, a psychiatric unit of a general hospital, a private agency or company engaged in providing mental health services, or a regional community mental health center

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13. Other diagnostic, screening, preventive and, rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

4. Covered Services (continued)

(h) Peer Support (continued)

Billing Providers

- Provider Groups
 - LP
 - LPP
 - LCSW
 - LPCC
 - LMFT
 - Physician
 - Psychiatrist
 - APRN
- Licensed Organizations

(i) Parent/Family Peer Support

Parent/Family Peer Support is emotional support that is provided by parents or family members of children having a mental health, substance use, or co-occurring mental health and substance use disorder to parents or family members with a child sharing a similar mental health, substance use, or co-occurring mental health and substance use disorder in order to bring about a desired social or personal change. It is an evidence based practice. Peer Support Services are structured and scheduled non-clinical but therapeutic activities with individuals or groups provided by a self-identified parent /family member of a child/youth consumer of mental health, substance use, or co-occurring mental health and substance use disorder services who has been trained and certified in accordance with state regulations. Services should promote socialization, recovery, self-advocacy, preservation and enhancement of community living skills for the client.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

4. Covered Services (continued)

(i) Parent/Family Peer Support (continued)

Peer support services must incorporate the following core components:

- Supervision – Peer support specialists must be supervised regularly by a physician, a psychiatrist, a LP, a LPP, a LPA working under the supervision of a LP, a LCSW, a CSW with three (3) years of inpatient or outpatient clinical experience in psychiatric social work and currently employed by a hospital or forensic psychiatric facility licensed by the Commonwealth or a psychiatric unit of a general hospital or a private agency or company engaged in the provision of mental health services or a regional community mental health center; a LMFT with three (3) years of inpatient or outpatient clinical experience in psychiatric mental health practice and currently employed by a hospital or forensic facility licensed by the Commonwealth, a psychiatric unit of a general hospital, a private agency or company engaged in providing mental health services, or a regional community mental health center, including receiving face-to-face individual supervision no less than once a month.
- Care coordination - Peer support services must be coordinated within the context of a comprehensive, individualized treatment plan which is developed through a person centered planning process. The peer support services must be identified on each client's individual treatment plan, and must be designed to directly contribute to the participant's individualized goals, as specified in the plan.
- Training - Peer Support Specialists have a minimum educational requirement of a high school diploma or a General Educational Development (GED) certificate and must successfully complete training approved by DBHDID. Training includes a minimum 30 hour program based on a nationally-recognized curriculum. The curriculum includes modules on problem solving, creating a wellness recovery action plan, stages in the recovery process, effective listening skills, establishing recovery goals and using support groups to promote and sustain recovery. The peer must take and pass a test (both written and oral components) before being certified as a peer specialist. In addition, Peer Support Specialists must obtain at least 6 hours of related training or continuing education per year.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

4. Covered Services (continued)

(i) Parent/Family Peer Support (continued)

Authorized Providers

Peer Support – Peer support specialists must be employed by a licensed organization or provider group that meets the criteria of a licensed organization and the following additional criteria:

- Must employ qualified peer support specialists who are certified in accordance with Kentucky Administrative Regulation
- Must provide supervision by a physician, a psychiatrist, a LP, a LPP, a LPA working under the supervision of a LP, a LCSW, a CSW with three (3) years of inpatient or outpatient clinical experience in psychiatric social work and currently employed by a hospital or forensic psychiatric facility licensed by the Commonwealth or a psychiatric unit of a general hospital or a private agency or company engaged in the provision of mental health services or a regional community mental health center; a LMFT with three (3) years of inpatient or outpatient clinical experience in psychiatric mental health practice and currently employed by a hospital or forensic facility licensed by the Commonwealth, a psychiatric unit of a general hospital, a private agency or company engaged in providing mental health services, or a regional community mental health center for peer support specialists
- Capacity to provide on-going continuing education and technical assistance to peer support specialists
- Demonstrated experience serving the behavioral health population (mental health, substance use or co-occurring mental health and substance use disorders) and age range served (youth or adult peers or parent-to-parent)

13. Other diagnostic, screening, preventive and, rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

4. Covered Services (continued)

(i) Parent/Family Peer Support (continued)

Rendering Practitioners practicing as part of a provider group or licensed organization

- Peer Support Specialist working under the supervision of a physician, a psychiatrist, a LP, a LPP, a LPA working under the supervision of a LP, a LCSW, a CSW with three (3) years of inpatient or outpatient clinical experience in psychiatric social work and currently employed by a hospital or forensic psychiatric facility licensed by the Commonwealth or a psychiatric unit of a general hospital or a private agency or company engaged in the provision of mental health services or a regional community mental health center; a LMFT with three (3) years of inpatient or outpatient clinical experience in psychiatric mental health practice and currently employed by a hospital or forensic facility licensed by the Commonwealth, a psychiatric unit of a general hospital, a private agency or company engaged in providing mental health services, or a regional community mental health center

Billing Providers

- Provider Group
 - LP
 - LPP
 - LCSW
 - LPCC
 - LMFT
 - Physician
 - Psychiatrist
 - APRN
- Licensed Organizations

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

4. Covered Services (continued)

(j) Intensive Outpatient Program (IOP)

Intensive Outpatient Program is an alternative to inpatient hospitalization or partial hospitalization for mental health and/or substance use disorders. An intensive outpatient program must offer a multi-modal, multi-disciplinary structured outpatient treatment program that is significantly more intensive than individual, group, and family therapies.

IOP services must be provided at least three (3) hours per day and at least three (3) days per week.

Programming must include individual therapy, group therapy, and family therapy unless contraindicated, Crisis Intervention as it would occur in the setting where IOP is being provided, and psychoeducation (Psychoeducation is one component of outpatient therapy for mental health conditions. During psychoeducation, the client and/or their family is provided with knowledge about their diagnosis, the causes of that condition, and the reasons why a particular treatment might be effective for reducing their symptoms. Clients and their families gain empowerment to understand and accept the diagnosis and learn to cope with it in a successful manner).

All treatment plans must be individualized, focusing on stabilization and transition to a lesser level of care.

The State does not claim IOP that is located in a hospital as a rehabilitative service.

Authorized Providers

Intensive Outpatient Services - Practitioners must be employed by a provider group or licensed organization that meets the criteria of a provider group or licensed organization and the following additional criteria:

- Access to a board-certified or board-eligible psychiatrist for consultation
- Access to a psychiatrist, other physician or Advanced Practice Registered Nurse (APRN) for medication management
- Adequate staffing to assure a minimum recipient-to-staff ratio of four clients to one staff member
- Capacity to provide services utilizing a recognized intervention protocol based on Recovery Principles
- Capacity to employ required practitioners and coordinate service provision among rendering practitioners

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

4. Covered Services (continued)

(j) Intensive Outpatient Program (IOP) (continued)

- Capacity to provide the full range of services included in the Intensive Outpatient service definition

Rendering Practitioners practicing as part of a licensed organization

- Licensed Psychologist (LP)
- Licensed Psychological Associate (LPA) working under the supervision of a LP
- Licensed Psychological Practitioner (LPP)
- Licensed Clinical Social Worker (LCSW)
- Certified Social Worker, Master Level (CSW) working under the supervision of a LCSW
- Licensed Professional Clinical Counselor (LPCC)
- Licensed Professional Counselor Associate (LPCA) working under the supervision of a LPCC
- Licensed Marriage and Family Therapist (LMFT)
- Marriage and Family Therapist Associate (MFTA) working under the supervision of a LMFT
- Physician
- Psychiatrist
- Advanced Practice Registered Nurse (APRN)
- Physician Assistant (PA) working under the supervision of a Physician

Billing Providers

- Provider Groups
 - LP
 - LPP
 - LCSW
 - LPCC
 - LMFT
 - Physician
 - Psychiatrist
 - APRN
- Licensed Organizations

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

4. Covered Services (continued)

(k) Individual Outpatient Therapy

Individual Therapy shall consist of a face-to-face therapeutic intervention provided in accordance with a recipient's identified treatment plan and is aimed at the deduction of adverse symptoms and improved functioning. Individual therapy must be provided as a one-on-one encounter between the provider and the client. Individual therapy services shall be limited to a maximum of three (3) hours per day, per client, but can be exceeded based on medical necessity.

Authorized Providers:

Rendering Practitioners practicing as an individual practitioner, a provider group, or as part of a licensed organization

- Licensed Psychologist (LP)
- Licensed Psychological Associate (LPA) working under the supervision of a LP*
- Licensed Psychological Practitioner (LPP)
- Licensed Clinical Social Worker (LCSW)
- Certified Social Worker, Master Level (CSW) working under the supervision of a LCSW*
- Licensed Professional Clinical Counselor (LPCC)
- Licensed Professional Counselor Associate (LPCA) working under the supervision of a LPCC*
- Licensed Marriage and Family Therapist (LMFT)
- Marriage and Family Therapist Associate (MFTA) working under the supervision of a LMFT*
- Physician
- Psychiatrist
- Advanced Practice Registered Nurse (APRN)
- Physician Assistant (PA) working under the supervision of a physician*

* Billed through supervisor

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

4. Covered Services (continued)

(k) Individual Outpatient Therapy (continued)

Billing Providers

- Individual Practitioners
 - LP
 - LPP
 - LCSW
 - LPCC
 - LMFT
 - Physician
 - Psychiatrist
 - APRN
- Provider Groups
 - LP
 - LPP
 - LCSW
 - LPCC
 - LMFT
 - Physician
 - Psychiatrist
 - APRN
- Licensed Organizations

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

4. Covered Services (continued)

(I) Group Outpatient Therapy

Group therapy shall be therapeutic intervention provided to a group of unrelated persons. A group consists of no more than eight persons. It is usually for a limited time period (generally 1 to 1 ½ hours in duration). In group therapy, clients are involved with one another at a cognitive and emotional level. Group therapy focuses on psychological needs of the clients as evidenced in each client's plan of treatment. Group therapy centers on goals such as building and maintaining healthy relationships, personal goal setting, and the exercise of personal judgment. The group shall have a deliberate focus and must have a defined course of treatment. Individual notes must be written for each recipient within the group and be kept in that individual's medical record.

Services shall be limited to a maximum of three (3) hours of group therapy per day, per client, but can be exceeded based on medical necessity.

Authorized Providers:

Rendering Practitioners practicing as an individual practitioner, a provider group, or as part of a licensed organization

- Licensed Psychologist (LP)
- Licensed Psychological Associate (LPA) working under the supervision of a LP*
- Licensed Psychological Practitioner (LPP)
- Licensed Clinical Social Worker (LCSW)
- Certified Social Worker, Master Level (CSW) working under the supervision of a LCSW*
- Licensed Professional Clinical Counselor (LPCC)
- Licensed Professional Counselor Associate (LPCA) working under the supervision of a LPCC*
- Licensed Marriage and Family Therapist (LMFT)
- Marriage and Family Therapist Associate (MFTA) working under the supervision of a LMFT*
- Physician
- Psychiatrist
- Advanced Practice Registered Nurse (APRN)
- Physician Assistant (PA) working under the supervision of a Physician*

* Billed through supervisor

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

4. Covered Services (continued)

(I) Group Outpatient Therapy (continued)

Billing Providers

- Individual Practitioners
 - LP
 - LPP
 - LCSW
 - LPCC
 - LMFT
 - Physician
 - Psychiatrist
 - APRN
- Provider Groups
 - LP
 - LPP
 - LCSW
 - LPCC
 - LMFT
 - Physician
 - Psychiatrist
 - APRN
- Licensed Organizations

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

4. Covered Services (continued)

(m) Family Outpatient Therapy

Family Therapy shall consist of a face to face therapeutic intervention provided through scheduled therapeutic visits between the therapist and the recipient and one or more members of a recipient's family to address issues interfering with the relational functioning of the family and improve interpersonal relationships within the home environment.

The need for family therapy shall be so stated in the client's plan of treatment. Family therapy services shall be for the benefit of the client

Authorized Providers:

Rendering Practitioners practicing as an individual practitioner, a provider group, or as part of a licensed organization

- Licensed Psychologist (LP)
- Licensed Psychological Associate (LPA) working under the supervision of a LP*
- Licensed Psychological Practitioner (LPP)
- Licensed Clinical Social Worker (LCSW)
- Certified Social Worker, Master Level (CSW) working under the supervision of a LCSW*
- Licensed Professional Clinical Counselor (LPCC)
- Licensed Professional Counselor Associate (LPCA) working under the supervision of a LPCC*
- Licensed Marriage and Family Therapist (LMFT)
- Marriage and Family Therapist Associate (MFTA) working under the supervision of a LMFT*
- Physician
- Psychiatrist
- Advanced Practice Registered Nurse (APRN)
- Physician Assistant (PA) working under the supervision of a Physician*

* Billed through supervisor

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

4. Covered Services (continued)

(m) Family Outpatient Therapy (continued)

Billing Providers

- Individual Practitioners
 - LP
 - LPP
 - LCSW
 - LPCC
 - LMFT
 - Physician
 - Psychiatrist
 - APRN
- Provider Groups
 - LP
 - LPP
 - LCSW
 - LPCC
 - LMFT
 - Physician
 - Psychiatrist
 - APRN
- Licensed Organizations

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

4. Covered Services (continued)

(n) Collateral Outpatient Therapy

Collateral services shall be limited to recipients under the age of twenty-one, who are clients of the rendering provider. A collateral service shall be a face-to-face encounter with a parent/caregiver, legal representative/guardian, school personnel or other person in a position of custodial control or supervision of the client, for the purpose of providing counseling or consultation on behalf of a client in accordance with an established plan of treatment. The parent or legal representative in a role of supervision of the client shall give written approval for this service. This written approval shall be kept in the recipient's medical record. This service is only reimbursable for a recipient under age 21.

Authorized Providers:

Rendering Practitioners practicing as an individual practitioner, a provider group, or as part of a licensed organization

- Licensed Psychologist (LP)
- Licensed Psychological Associate (LPA) working under the supervision of a LP*
- Licensed Psychological Practitioner (LPP)
- Licensed Clinical Social Worker (LCSW)
- Certified Social Worker, Master Level (CSW) working under the supervision of a LCSW*
- Licensed Professional Clinical Counselor (LPCC)
- Licensed Professional Counselor Associate (LPCA) working under the supervision of a LPCC*
- Licensed Marriage and Family Therapist (LMFT)
- Marriage and Family Therapist Associate (MFTA) working under the supervision of a LMFT*
- Physician
- Psychiatrist
- Advanced Practice Registered Nurse (APRN)
- Physician Assistant (PA) working under the supervision of a Physician*

* Billed through supervisor

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

4. Covered Services (continued)

(n) Collateral Outpatient Therapy (continued)

Billing Providers

- Individual Practitioners
 - LP
 - LPP
 - LCSW
 - LPCC
 - LMFT
 - Physician
 - Psychiatrist
 - APRN
- Provider Groups
 - LP
 - LPP
 - LCSW
 - LPCC
 - LMFT
 - Physician
 - Psychiatrist
 - APRN
- Licensed Organizations

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

4. Covered Services (continued)

(o) Partial Hospitalization

Partial Hospitalization is a short-term (average of four to six weeks), less than 24-hour, intensive treatment program for individuals experiencing significant impairment to daily functioning due to substance use disorders, mental health disorders, or co-occurring mental health and substance use disorders. Partial Hospitalization may be provided to adults or children. Admission criteria are based on an inability to adequately treat the client through community-based therapies or intensive outpatient services. The program will consist of individual, group, family therapies and medication management. Educational, vocational, or job training services that may be provided as part of Partial Hospitalization are not reimbursed by Medicaid. The program has an agreement with the local educational authority to come into the program to provide all educational components and instruction which are not Medicaid billable or reimbursable. Services in a Medicaid-eligible child's Individual Education Plan (IEP) are coverable under Medicaid.

Partial Hospitalization is typically provided for a lesser number hours per day and days per week than Day Treatment. Partial Hospitalization is typically focused on one primary presenting problem (i.e. Substance use, sexual reactivity, etc.). Day treatment is typically provided for more hours per day for more days per week, requires more treatment components and often lasts for a longer period of time E.g., three months), compared to partial hospitalization. Day treatment may focus on resolving multiple mental health and/or substance use issues and is typically provided as an alternative to a school or other traditional day time setting for children.

Authorized Providers

Partial Hospitalization – Practitioners must be employed by a licensed organization that meets the criteria of a licensed organization and the following additional criteria:

- Programs must provide the following medical coverage: An Advanced Practice Registered Nurse (APRN), Physician Assistant (PA) or Physician available on site and a board-certified or board-eligible psychiatrist available for consultation
- Capacity to provide services utilizing a recognized intervention protocol based on Recovery Principles
- Capacity to employ required practitioners and coordinate service provision among rendering practitioners
- Capacity to provide the full range of services included in the Partial Hospitalization definition

13. Other diagnostic, screening, preventive and, rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

4. Covered Services (continued)

(o) Partial Hospitalization (continued)

Rendering Practitioners practicing as part of a licensed organization

- Licensed Psychologist (LP)
- Licensed Psychological Associate (LPA) working under the supervision of a LP
- Licensed Psychological Practitioner (LPP)
- Licensed Clinical Social Worker (LCSW)
- Certified Social Worker, Master Level (CSW) working under the supervision of a LCSW
- Licensed Professional Clinical Counselor (LPCC)
- Licensed Professional Counselor Associate (LPCA) working under the supervision of a LPCC
- Licensed Marriage and Family Therapist (LMFT)
- Marriage and Family Therapist Associate (MFTA) working under the supervision of a LMFT
- Physician
- Psychiatrist
- Advanced Practice Registered Nurse (APRN)
- Physician Assistant (PA) working under the supervision of a Physician

Billing Providers

- Licensed Organizations

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

4. Covered Services (continued)

(p) Service Planning

Service planning involves assisting the recipient in creating an individualized plan for services needed for maximum reduction of mental disability and restoration of a recipient to his best possible functional level. A person centered planning process is required. The plan is directed by the recipient and must include practitioners of the recipient's choosing. The providers include more than licensed professionals – it may include the recipient (and his guardian if applicable), care coordinator, other service providers, family members or other individuals that the recipient chooses.

Authorized Providers:

Rendering Practitioners practicing as an individual practitioner, a provider group, or as part of a licensed organization

- Licensed Psychologist (LP)
- Licensed Psychological Associate (LPA) working under the supervision of a LP*
- Licensed Psychological Practitioner (LPP)
- Licensed Clinical Social Worker (LCSW)
- Certified Social Worker, Master Level (CSW) working under the supervision of a LCSW*
- Licensed Professional Clinical Counselor (LPCC)
- Licensed Professional Counselor Associate (LPCA) working under the supervision of a LPCC*
- Licensed Marriage and Family Therapist (LMFT)
- Marriage and Family Therapist Associate (MFTA) working under the supervision of a LMFT*
- Physician
- Psychiatrist
- Advanced Practice Registered Nurse (APRN)
- Physician Assistant (PA) working under the supervision of a Physician*

* Billed through supervisor

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

4. Covered Services (continued)

(p) Service Planning (continued)

Billing Providers

- Individual Practitioners
 - LP
 - LPP
 - LCSW
 - LPCC
 - LMFT
 - Physician
 - Psychiatrist
 - APRN
- Provider Groups
 - LP
 - LPP
 - LCSW
 - LPCC
 - LMFT
 - Physician
 - Psychiatrist
 - APRN
- Licensed Organizations

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

4. Covered Services (continued)

(q) Residential Services for Substance Use Disorders (SUDS) TREATMENT FOR SUBSTANCE USE ONLY

Residential services for substance use disorders is residential treatment (24 hour/day) that may be short-term or long-term for the purposes of providing intensive treatment and skills building, in a structured and supportive environment, to assist individuals (children and adults) to obtain abstinence and enter into alcohol/drug addiction recovery. This service is provided in a 24 hour live- in facility that offers a planned and structured regimen of care that aims to treat persons with addictions or substance use disorders and assists them in making the necessary changes in their lives that will enable them to live drug or alcohol free lives. Individuals must have been assessed and meet criteria for approval of residential services, utilizing a nationally recognized assessment tool (e.g., American Society of Addiction Medicine (ASAM) as approved by the DBHDID.

Services should have more than eight (8), but less than or equal to 16 patient beds; be under the medical direction of a physician; and provide continuous nursing services.

Residential treatment services shall be based on individual need and may include:

- Screening
- Assessment
- Service Planning
- Individual Therapy
- Group Therapy
- Family Therapy
- Peer Support

Service provision must be in accordance with KY licensure for procedures and standards for persons and agencies operating nonmedical/non-hospital based alcohol and others drug abuse treatment programs and the individually credentialed personnel as outlined in the state law. (908 KAR 1:370)

There are two levels of residential treatment:

- Short term –length of stay-14-28 days
- Long term- length of stay 28- 90 days

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

4. Covered Services (continued)

(q) **Residential Services for Substance Use Disorders (SUDS) TREATMENT FOR SUBSTANCE USE ONLY (continued)**

Short Term

Short-term services should have a duration of less than thirty (30) days, but can be exceeded based on medical necessity. 24 hour staff as required by licensing regulations.

Planned Clinical program activities constituting at least 15 hours per week of structured professionally directed treatment services to stabilize and maintain a person's substance use disorder and to help him or her to develop and apply recovery skills.

Services may include:

- Screening
- Assessment
- Service Planning
- Individual Therapy
- Group Therapy
- Family Therapy
- Peer Support

Long Term

24 hour staff as required by licensing regulations

Planned clinical program activities constituting 40 hours per week of structured professionally directed treatment services to stabilize and maintain a person's substance use and or substance use and mental health disorder and to help him or her to develop and apply recovery skills

Services may include:

- Screening
- Assessment
- Service Planning
- Individual Therapy
- Group Therapy
- Family Therapy
- Peer Support

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

4. Covered Services (continued)

(q) Residential Services for Substance Use Disorders (SUDS) TREATMENT FOR SUBSTANCE USE ONLY (continued)

Residential SUD treatment programs do not include, and FFP is not available for, room and board services; educational, vocational and job training services; habilitation services; services to inmates in public institutions as defined in 42 CFR §435.1010; services to individuals residing in institutions for mental diseases as described in 42 CFR§435.1010; recreational and social activities; and services that must be covered elsewhere in the state Medicaid plan. Services must be provided in a residential unit with 16 or fewer beds or, if provided within multiple units operating as on unified facility, 16 or fewer aggregated beds.

Authorized Providers

Residential Services for Substance Use Disorders (SUDS) – Practitioners must be employed by a licensed organization which meets the criteria of a licensed organization and the following additional criteria:

- Licensure as a non-medical/non-hospital based alcohol and other drug abuse treatment program in accordance with 908 KAR 1:370
- Capacity to employ required practitioners and coordinate service provision among rendering practitioners
- Capacity to provide the full range of services included in the service definition

Rendering Practitioners practicing as part of a licensed organization

- Licensed Psychologist (LP)
- Licensed Psychological Associate (LPA) working under the supervision of a LP
- Licensed Psychological Practitioner (LPP)
- Licensed Clinical Social Worker (LCSW)
- Certified Social Worker, Master Level (CSW) working under the supervision of a LCSW
- Licensed Professional Clinical Counselor (LPCC)
- Licensed Professional Counselor Associate (LPCA) working under the supervision of a LPCC
- Licensed Marriage and Family Therapist (LMFT)
- Marriage and Family Therapist Associate (MFTA) working under the supervision of a LMFT

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

4. Covered Services (continued)

(q) Residential Services for Substance Use Disorders (SUDS) TREATMENT FOR SUBSTANCE USE ONLY (continued)

- Physician
- Psychiatrist
- Advanced Practice Registered Nurse (APRN)
- Physician Assistant (PA) working under the supervision of a physician
- Peer Support Specialist working under the supervision of a physician, a psychiatrist, a LP, a LPP, a LPA working under the supervision of a LP, a LCSW, a CSW with three (3) years of inpatient or outpatient clinical experience in psychiatric social work and currently employed by a hospital or forensic psychiatric facility licensed by the Commonwealth or a psychiatric unit of a general hospital or a private agency or company engaged in the provision of mental health services or a regional community mental health center; a LMFT with three (3) years of inpatient or outpatient clinical experience in psychiatric mental health practice and currently employed by a hospital or forensic facility licensed by the Commonwealth, a psychiatric unit of a general hospital, a private agency or company engaged in providing mental health services, or a regional community mental health center

Billing Providers

- Licensed Organizations

(r) Screening, Brief Intervention, and Referral to Treatment (SBIRT) TREATMENT OF SUBSTANCE USE ONLY

SBIRT is an evidence-based early intervention approach that targets individuals with non-dependent substance use to provide effective strategies for intervention prior to the need for more extensive or specialized treatment. SBIRT consists of three major components:

Screening – Assessing an individual for risky substance use behaviors using standardized screening tools;

Brief Intervention – Engaging a patient showing risky substance use behaviors in a short conversation, providing feedback and advice; and

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

4. Covered Services (continued)

**(r) Screening, Brief Intervention, and Referral to Treatment (SBIRT)
TREATMENT OF SUBSTANCE USE ONLY (continued)**

Referral to Treatment – Provides a referral to additional mental health, substance use, or co-occurring mental health and substance use disorder services to patients who screen in need of additional services to address substance use. The Referral to Treatment is part of the Brief Intervention and thus to a behavioral health rehabilitative service.

Authorized Providers:

Rendering Practitioners practicing as an individual practitioner, a provider group, or as part of a licensed organization

- Licensed Psychologist (LP)
- Licensed Psychological Associate (LPA) working under the supervision of a LP*
- Licensed Psychological Practitioner (LPP)
- Licensed Clinical Social Worker (LCSW)
- Certified Social Worker, Master Level (CSW) working under the supervision of a LCSW*
- Licensed Professional Clinical Counselor (LPCC)
- Licensed Professional Counselor Associate (LPCA) working under the supervision of a LPCC*
- Licensed Marriage and Family Therapist (LMFT)
- Marriage and Family Therapist Associate (MFTA) working under the supervision of a LMFT*
- Physician
- Psychiatrist
- Advanced Practice Registered Nurse (APRN)
- Physician Assistant (PA) working under the supervision of a Physician*

* Billed through supervisor

Billing Providers

- Individual Practitioners
 - LP
 - LPP
 - LCSW

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

4. Covered Services (continued)

**(r) Screening, Brief Intervention, and Referral to Treatment (SBIRT)
TREATMENT OF SUBSTANCE USE ONLY (continued)**

- LPCC
- LMFT
- Physician
- Psychiatrist
- APRN
- Provider Groups
 - LP
 - LPP
 - LCSW
 - LPCC
 - LMFT
 - Physician
 - Psychiatrist
 - APRN
- Licensed Organizations

(s) Medication Assisted Treatment (MAT) TREATMENT FOR SUBSTANCE USE ONLY

Any opioid addiction treatment that includes a U.S. Food and Drug Administration (FDA) approved medication for the detoxification or maintenance treatment of opioid addiction (e.g., methadone, levo-alpha acetyl methadol [LAAM], buprenorphine, buprenorphinenaloxone, naltrexone) along with counseling and other supports, including urine drug screen. Services may be provided in an Opioid Treatment Program (OTP), a medication unit affiliated with an OTP, or, with the exception of Methadone, a physician's office or other community based setting including the recipient's home/residence, homeless shelter, school (only if not an IEP covered service), or other community setting where the recipient may wish/need to receive a service. Providers are instructed through regulations that the confidentiality of the client must be maintained in any setting where a service may occur. MAT increases the likelihood for cessation of illicit opioid use or of prescription opioid abuse. MATs are non-residential and must comply with all state laws.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

4. Covered Services (continued)

(s) Medication Assisted Treatment (MAT) TREATMENT FOR SUBSTANCE USE ONLY (continued)

Opioid Treatment Program or “OTP” means a substance abuse program using approved controlled substances and offering a range of treatment procedures and services for the rehabilitation of persons dependent on opium, morphine, heroin or any derivative or synthetic drug of that group. A “medication unit affiliated with an OTP” means a Medication Station or Dosing Location that obtains its drug supply from the main program site and retains all records (except dosing, urine screens) at the main location. Main program means the location of the MAT program where all administrative and medical information related to the narcotic treatment program is retained for the purpose of on-site reviews by federal agencies or the state narcotic authority or state opioid treatment authority designee. Service components include:

- Individual and Group therapy
- Dosing
- Medication
- Assessment and
- Urine Drug screens

Authorized Providers:

Rendering Practitioners practicing as an individual practitioner, a provider group, or as part of a licensed organization – must obtain specific certification to deliver this service

- Physician
- Psychiatrist

Billing Providers

- Individual Practitioners
 - Physician
 - Psychiatrist
- Provider Groups
 - Physician
 - Psychiatrist
- Licensed Organizations

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

4. Covered Services (continued)

(t) Assertive Community Treatment (ACT) TREATMENT OF MENTAL HEALTH

Assertive community treatment (ACT) is an evidence-based psychiatric rehabilitation practice which provides a comprehensive approach to service delivery for consumers with serious mental illnesses. ACT uses a multidisciplinary team of professionals including psychiatrists, nurses, case managers, therapists and peer support specialists. Component services include assessment, treatment planning, case management, psychiatric services (including evaluation diagnosis and treatment of mental health and/or substance use disorders, case consultation, prescribing, and medication management delivered by a licensed professional), medication management including administration, individual and group therapy, peer support, mobile crisis intervention, mental health consultation, family support and basic living skills. Mental health consultation involves brief, collateral interactions with other treating professionals who may have information for the purposes of treatment planning and service delivery. Family support involves the ACT team working with the recipient's natural support systems to improve family relations in order to reduce conflict and increase recipient autonomy and independent functioning. Basic living skills are rehabilitative services focused on teaching activities of daily living (i.e., taking medications, housekeeping, meal preparation, hygiene, interacting with neighbors) necessary to maintain independent functioning and community living. Psychiatric services as a component of the ACT service includes evaluation, diagnosis and treatment of mental health and or substance use disorders, case consultation, prescribing and medication management delivered by a licensed professional (i.e. psychiatrist, APRN)

Authorized Providers

Assertive Community Treatment (ACT) – Team members must be employed by a licensed organization that meets the criteria of a licensed organization and the following additional criteria:

- Must employ one or more teams led by one of the rendering practitioners listed below and including, at a minimum, four full time equivalents including a nurse and the rendering practitioners listed below.
- Adequate staffing to assure a caseload size no greater than 10 participants per team member
- Capacity to coordinate service provision among team members
- Capacity to provide the full range of services included in the ACT service definition

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

4. Covered Services (continued)

(t) Assertive Community Treatment (ACT) TREATMENT OF MENTAL HEALTH (continued)

Rendering Practitioners practicing as part of a licensed organization

- Licensed Psychologist (LP)
- Licensed Psychological Associate (LPA) working under the supervision of a LP
- Licensed Psychological Practitioner (LPP)
- Licensed Clinical Social Worker (LCSW)
- Certified Social Worker, Master Level (CSW) working under the supervision of a LCSW
- Licensed Professional Clinical Counselor (LPCC)
- Licensed Professional Counselor Associate (LPCA) working under the supervision of a LPCC
- Licensed Marriage and Family Therapist (LMFT) Marriage and Family Therapist Associate (MFTA) working under the supervision of a LMFT
- Physician
- Psychiatrist
- Advanced Practice Registered Nurse (APRN)
- Physician Assistant (PA) working under the supervision of a MD
- Registered Nurse (RN)
- Licensed Practical Nurse (LPN)
- Peer Support Specialist working under the supervision of a physician, a psychiatrist, a LP, a LPP, a LPA working under the supervision of a LP, a LCSW, a CSW with three (3) years of inpatient or outpatient clinical experience in psychiatric social work and currently employed by a hospital or forensic psychiatric facility licensed by the Commonwealth or a psychiatric unit of a general hospital or a private agency or company engaged in the provision of mental health services or a regional community mental health center; a LMFT with three (3) years of inpatient or outpatient clinical experience in psychiatric mental health practice and currently employed by a hospital or forensic facility licensed by the Commonwealth, a psychiatric unit of a general hospital, a private agency or company engaged in providing mental health services, or a regional community mental health center

Billing Providers

- Licensed Organizations

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

4. Covered Services (continued)

(u) Comprehensive Community Support Services TREATMENT OF MENTAL HEALTH ONLY

Comprehensive Community Support Services covers activities necessary to allow individuals with mental illnesses to live with maximum independence in the community. Activities are intended to assure successful community living through utilization of skills training as identified in the individual service plan. Skills training is designed to reduce mental disability and restore the recipient to his best possible functional level.

Comprehensive community support services consists of using a variety of psychiatric rehabilitation techniques to improve daily living skills (hygiene, meal preparation, medication adherence), self-monitoring of symptoms and side effects, emotional regulation skills, crisis coping skills and developing and enhancing interpersonal skills.

Authorized Providers:

Rendering Practitioners practicing as an individual practitioner, a provider group, or as part of a licensed organization

- Licensed Psychologist (LP)
- Licensed Psychological Associate (LPA) working under the supervision of a LP*
- Licensed Psychological Practitioner (LPP)
- Licensed Clinical Social Worker (LCSW)
- Certified Social Worker, Master Level (CSW) working under the supervision of a LCSW*
- Licensed Professional Clinical Counselor (LPCC)
- Licensed Professional Counselor Associate (LPCA) working under the supervision of a LPCC*
- Licensed Marriage and Family Therapist (LMFT)
- Marriage and Family Therapist Associate (MFTA) working under the supervision of a LMFT*
- Physician
- Psychiatrist
- Physician Assistant (PA) working under the supervision of a Physician*
- Advanced Practice Registered Nurse (APRN)

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

4. Covered Services (continued)

(u) Comprehensive Community Support Services TREATMENT OF MENTAL HEALTH ONLY (continued)

- Peer Support Specialist working under the supervision of a physician, a psychiatrist, a LP, a LPP, a LPA working under the supervision of a LP, a LCSW, a CSW with three (3) years of inpatient or outpatient clinical experience in psychiatric social work and currently employed by a hospital or forensic psychiatric facility licensed by the Commonwealth or a psychiatric unit of a general hospital or a private agency or company engaged in the provision of mental health services or a regional community mental health center; a LMFT with three (3) years of inpatient or outpatient clinical experience in psychiatric mental health practice and currently employed by a hospital or forensic facility licensed by the Commonwealth, a psychiatric unit of a general hospital, a private agency or company engaged in providing mental health services, or a regional community mental health center*

* Billed through supervisor

Billing Providers

- Individual Practitioners
 - LP
 - LPP
 - LCSW
 - LPCC
 - LMFT
 - Physician
 - Psychiatrist
 - APRN
- Provider Groups
 - LP
 - LPP
 - LCSW
 - LPCC
 - LMFT
 - Physician
 - Psychiatrist
 - APRN
- Licensed Organizations

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

4. Covered Services (continued)

(v) Therapeutic Rehabilitation Program TREATMENT OF MENTAL HEALTH

A Therapeutic Rehabilitation Program is a rehabilitative service for adults with serious mental illnesses and children with serious emotional disabilities designed to maximize reduction of mental disability and restoration of the recipient's best possible functional level. Services shall be designed for the reduction in disabilities related to social, personal, and daily living skills, as well as the restoration of these skills. The recipient establishes his own rehabilitation goals within the person centered service plan. Component services are delivered using a variety of psychiatric rehabilitation techniques and focus on improving daily living skills (hygiene, meal preparation, and medication adherence), self-monitoring of symptoms and side effects, emotional regulation skills, crisis coping skills and interpersonal skills. Services may be delivered individually or in a group.

Authorized Providers

Rendering Practitioners practicing as an individual practitioner, a provider group, or as part of a licensed organization

- Licensed Psychologist (LP)
- Licensed Psychological Associate (LPA) working under the supervision of a LP*
- Licensed Psychological Practitioner (LPP)
- Licensed Clinical Social Worker (LCSW)
- Certified Social Worker, Master Level (CSW) working under the supervision of a LCSW*
- Licensed Professional Clinical Counselor (LPCC)
- Licensed Professional Counselor Associate (LPCA) working under the supervision of a LPCC*
- Licensed Marriage and Family Therapist (LMFT)
- Marriage and Family Therapist Associate (MFTA) working under the supervision of a LMFT*
- Physician
- Psychiatrist
- Advanced Practice Registered Nurse (APRN)
- Physician Assistant (PA) working under the supervision of a Physician*

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

4. Covered Services (continued)

(v) Therapeutic Rehabilitation Program TREATMENT OF MENTAL HEALTH (continued)

- Peer Support Specialist working under the supervision of a physician, a psychiatrist, a LP, a LPP, a LPA working under the supervision of a LP, a LCSW, a CSW with three (3) years of inpatient or outpatient clinical experience in psychiatric social work and currently employed by a hospital or forensic psychiatric facility licensed by the Commonwealth or a psychiatric unit of a general hospital or a private agency or company engaged in the provision of mental health services or a regional community mental health center; a LMFT with three (3) years of inpatient or outpatient clinical experience in psychiatric mental health practice and currently employed by a hospital or forensic facility licensed by the Commonwealth, a psychiatric unit of a general hospital, a private agency or company engaged in providing mental health services, or a regional community mental health center*

* Billed through supervisor

Billing Providers

- Individual Practitioners
 - LP
 - LPP
 - LCSW
 - LPCC
 - LMFT
 - Physician
 - Psychiatrist
 - APRN
- Provider Groups
 - LP
 - LPP
 - LCSW
 - LPCC
 - LMFT
 - Physician
 - Psychiatrist
 - APRN
- Licensed Organizations

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

5. Community Mental Health Centers (CMHC)

CMHCs provide a comprehensive range of coordinated mental health and substance use rehabilitation services. Reimbursement is available for all rehabilitation services described above under covered services subject to the following:

1. Medicaid will reimburse for community mental health center rehabilitation services when provided to persons diagnosed with a mental health disorder or substance use or co-occurring disorder when provided by qualified mental health professionals listed below. Service limitations applicable to other provider types are also applicable to CMHCs.
2. Professionals qualified to provide mental health or substance use rehabilitation services in the CMHCs include:
 - Licensed Psychologist (LP)
 - Licensed Psychological Practitioner (LPP)
 - Licensed Clinical Social Worker (LCSW)
 - A psychiatric social worker with a master's degree from an accredited school
 - Licensed Professional Clinical Counselor (LPCC)
 - Licensed Marriage and Family Therapist (LMFT)
 - Psychiatrist
 - Physician
 - A psychiatric nurse licensed in the state of Kentucky with one of the following combination of education and experience:
 - i. Master of Science in Nursing with a specialty in psychiatric or mental health nursing. No experience required.
 - ii. Bachelor of Science in Nursing and 1 year of experience in a mental health setting.
 - iii. A graduate of a three-year educational program with 2 years of experience in a mental health setting.
 - iv. A graduate of a two-year educational program (Associate degree) with 3 years of experience in a mental health setting.
 - A professional equivalent, through education in a mental health field and experience in a mental health setting, qualified to provide mental health services. Professional equivalents may include practitioners obtaining experience to qualify for licensure in their behavioral health profession or individuals with a bachelor's degree or greater, with experience in behavioral health. Education and experience are as follows:
 - i. Bachelor's degree and 3 years of full-time supervised experience.
 - ii. Master's degree and 6 months of full-time supervised experience.
 - ii. Doctoral degree. No experience.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

5. Community Mental Health Centers (CMHC) (continued)

- The following professionals may provide services with appropriate supervision:
 - i. A mental health associate with a minimum of a Bachelors degree in psychology, sociology, social work, or human services under supervision of one of the above professionals;
 - ii. A licensed psychological associate working under the supervision of a licensed psychologist;
 - iii. A licensed professional counselor associate working under the supervision of a licensed professional clinical counselor;
 - iv. A certified social worker, Master Level working under the supervision of a licensed clinical social worker;
 - v. A marriage and family therapy associate working under the supervision of a licensed marriage and family therapist;
 - vi. A physician assistant working under the supervision of a physician;
 - vii. A peer support specialist who meets the qualifications in 908 KAR 2:220, has completed required training, and who is working under the supervision of a physician, a psychiatrist, a LP, a LPP, a LPA working under the supervision of a LP, a LCSW, a CSW with three (3) years of inpatient or outpatient clinical experience in psychiatric social work and currently employed a regional community mental health center; a LMFT with three (3) years of inpatient or outpatient clinical experience in psychiatric mental health practice and currently employed by a regional community mental health center;
 - viii. A certified alcohol and drug counselor (CADC) working under the supervision of a CADC who has at least two (2) years of post-certificate experience and who provides supervision to not more than twelve (12) applicants in an individual or group setting at any one (1) time, and whose certificate is currently in good standing with the (CADC) board;
 - ix. A community support associate who is working under the supervision of a physician, a psychiatrist, a LP, a LPP, a LPA working under the supervision of a LP, a LCSW, a CSW with three (3) years of inpatient or outpatient clinical experience in psychiatric social work and currently employed a regional community mental health center; a LMFT with three (3) years of inpatient or outpatient clinical experience in psychiatric mental health practice and currently employed by a regional community mental health center, or professional equivalent.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

7. Qualifications of Providers

Qualified providers are approved practitioners, licensed or certified under state law, operating within the scope of their licensures (or under the appropriate supervision).

2. APRN – KRS 314.042 states that an applicant for licensure to practice as an advanced practice registered nurse shall:
 - (a) File with the board a written application for licensure and submit evidence, verified by oath, that the applicant has completed an approved organized post basic program of study and clinical experience; has fulfilled the requirements of KRS 214.615(1); is certified by a nationally established organization or agency recognized by the board to certify registered nurses for advanced practice registered nursing; and is able to understandably speak and write the English language and to read the English language with comprehension.
 - (b) The board may issue a license to practice advanced practice registered nursing to an applicant who holds a current active registered nurse license issued by the board or holds the privilege to practice as a registered nurse in this state and meets the qualifications of subsection (1) of this section. An advanced practice registered nurse shall be:
 - i. Designated by the board as a certified nurse anesthetist, certified nurse midwife, certified nurse practitioner, or clinical nurse specialist; and
 - ii. Certified in a least one (1) population focus.
 - (c) An advanced practice registered nurse shall maintain a current active registered nurse license issued by the board or hold the privilege to practice as a registered nurse in this state and maintain current certification by the appropriate national organization or agency recognized by the board.
 - (d) Before an advanced practice registered nurse engages in the prescribing or dispensing of nonscheduled legend drugs as authorized by KRS 314.011(8), the advanced practice registered nurse shall enter into a written "Collaborative Agreement for the Advanced Practice Registered Nurse's Prescriptive Authority for Nonscheduled Legend Drugs" (CAPA-NS) with a physician that defines the scope of the prescriptive authority for nonscheduled legend drugs.
 - (e) Before an advanced practice registered nurse engages in the prescribing of Schedules II through V controlled substances as authorized by KRS 314.011(8), the advanced practice registered nurse shall enter into a written "Collaborative Agreement for the Advanced Practice Registered Nurse's Prescriptive Authority for Controlled Substances" (CAPA-CS) with a physician that defines the scope of the prescriptive authority for controlled substances.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

7. Qualifications of Providers (continued)

2. Certified Social Worker, Master Level – KRS 335.08 states the board shall issue a license as “certified social worker” to an applicant who meets the following requirements:
 - (a) Is at least eighteen years of age;
 - (b) Is a person of good moral character;
 - (c) Has received a master’s degree or doctorate degree in social work from an educational institution approved by the board;
 - (d) Has passed an examination prepared by the board;
 - (e) Has not, within the preceding three months failed to pass an examination given by the board;
 - (f) A Certified Social Worker, Master Level may engage in the practice of clinical social work by contracting, in writing, with a licensed behavioral health professional who meets the requirements of the respective KY Board of Licensure for supervision of the Certified Social Worker, Masters Level. The supervising licensed behavioral health professional shall assume responsibility for and supervise the MFTA’s practice.
3. Licensed Clinical Social Worker (LCSW) – KRS 335.100 states that the LCSW must:
 - (a) Have received a master's degree or doctoral degree in social work from an educational institution approved by the board;
 - (b) Have had a minimum of two (2) years of full time post-master's experience, consisting of at least thirty (30) hours per week, or three (3) years of part time, consisting of at least twenty (20) hours per week, post-master's degree experience acceptable to the board in the use of specialty methods and measures to be employed in clinical social work practice, the experience having been acquired under appropriate supervision as established by the board by promulgation of an administrative regulation;
 - (c) Have paid to the board an examination fee established by the board by promulgation of an administrative regulation;
 - (d) Have passed an examination prepared by the board for this purpose; and
 - (e) Have not, within the preceding three (3) months, failed to pass an examination given by the board;
4. Licensed Marriage and Family Therapist (LMFT) – KRS 335.330 states the LMFT has
 - (a) Completed a master's or doctoral degree program in marriage and family therapy, from a regionally-accredited educational institution, or a master's, post-master's, or doctoral program approved by the Commission on Accreditation for Marriage

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

7. Qualifications of Providers (continued)

and Family Therapy Education or any of its successor organizations, or an equivalent course of study as defined by the board by promulgation of administrative regulations.

- i The degree or equivalent course of study shall contain specific coursework on psychopathology and the Diagnostic and Statistical Manual; and
 - ii In determining equivalency, the board shall use the criteria for marriage and family therapy education and clinical training approved by the United States Department of Education;
- (b) Completed each of the following:
- i At least two (2) years' experience in the practice of marriage and family therapy, acceptable to the board and subsequent to being granted a master's degree; and
 - ii A minimum of two hundred (200) hours of clinical supervision acceptable to the board and subsequent to being granted a master's degree; and
- (c) Passed a written examination prescribed by the board by promulgation of administrative regulations.
5. Marriage and Family Therapist Associate (LMFTA) – KRS 335.332 states the LMFTA has
- (a) Completed a master's or doctoral degree program in marriage and family therapy, from a regionally-accredited educational institution, or a master's, post-master's, or doctoral program approved by the Commission on Accreditation for Marriage and Family Therapy Education or any of its successor organizations, or an equivalent course of study as defined by the board by promulgation of administrative regulations.
 - i The degree or equivalent course of study shall contain specific coursework on psychopathology and the Diagnostic and Statistical Manual; and
 - ii In determining equivalency, the board shall use the criteria for marriage and family therapy education and clinical training approved by the United States Department of Education;
 - (b) A MFTA shall engage in the practice of marriage and family therapy while receiving qualifying experience by contracting, in writing, with a licensed behavioral health professional who meets the requirements of the respective KY Board of Licensure for supervision of the MFTA. The supervising licensed behavioral health professional shall assume responsibility for and supervise the MFTA's practice.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

7. Qualifications of Providers (continued)

6. Licensed Professional Clinical Counselor – KRS 335.525 states that the board shall issue a "professional clinical counselor" license to an applicant who:
 - (a) Has paid the application fee and the appropriate examination fee to the board;
 - (b) Is of good moral character;
 - (c) Has received a master's, specialist, or doctoral degree in counseling or a related field from a regionally accredited institution;
 - (d) Has completed a minimum of sixty (60) graduate semester hours in the following:
 - i The helping relationship, including counseling theory and practice;
 - ii Human growth and development;
 - iii Lifestyle and career development;
 - iv Group dynamics, process, counseling, and consulting;
 - v Assessment, appraisal, and testing of individuals;
 - vi Social and cultural foundations, including multicultural issues;
 - vii Principles of etiology, diagnosis, treatment planning, and prevention of mental and emotional disorders and dysfunctional behavior;
 - viii Research and evaluation; and
 - ix Professional orientation and ethics;
 - (e) Has completed a minimum of four thousand (4,000) hours of experience in the practice of counseling, all of which must have been obtained since obtaining the master's degree and must be under approved supervision and shall include but not be limited to a minimum of one thousand six hundred (1,600) hours of direct counseling with individuals, couples, families, or groups and a minimum of one hundred (100) hours of individual, face-to-face clinical supervision with an approved supervisor. Each applicant is encouraged to include as part of the total hours of experience a minimum of ten (10) hours of direct counseling with individuals in a jail or corrections setting. All applicants shall complete an organized practicum or internship consisting of at least four hundred (400) hours; and
 - (f) Has achieved passing scores on all portions of the examinations required by the board.

7. Licensed Professional Counselor Associate – KRS 335.525 states that the board shall issue a "professional clinical counselor" license to an applicant who:
 - (a) Has completed all requirements under paragraphs (a) to (d) as outlined under Licensed Professional Counselor above;
 - (b) Has not met the requirements of paragraphs (e) or (f) as outlined under Licensed Professional Counselor above; and

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

7. Qualifications of Providers (continued)

- (c) Has obtained a board-approved supervisor of record.
 - (d) A licensed professional counselor associate shall maintain ongoing supervision with a licensed behavioral health professional who meets the requirements of the respective KY Board of Licensure for supervision of the Licensed Professional Counselor Associate. The supervising licensed behavioral health professional shall assume responsibility for and supervise the MFTA's practice. .
8. Licensed Psychological Associate – KRS 319.064 states a licensed psychological associate shall:
- (a) Have received a master's degree in psychology from a regionally accredited educational institution.
 - (b) Have passed an examination procedure in psychology.
 - (c) A licensed psychological associate shall not practice independently, except under the employment and supervision of any board-approved licensed psychologist.
9. Licensed Psychological Practitioner – KRS 319.053 states a person holding a credential as a certified psychologist or as a licensed psychological associate may apply for a license to perform certain functions within the practice of psychology without supervision and use the title of "licensed psychological practitioner" when all of the following conditions are met:
- (a) Submission of three letters of endorsement to the board to sit for the examination:
 - i one of the letters shall be from the applicant's current board approved supervisor of record and shall include a statement describing the scope of practice demonstrated in the clinical experience of the applicant; and
 - ii Two letters shall be from licensed mental health professionals who are acceptable to the board and who are familiar with the clinical work of the applicant.
 - (b) Documentation of at least sixty semester hours of graduate study in psychology or a related field or its equivalent acceptable to the board; and
 - (c) Completion, after credentialing by the board as a certified psychologist, psychological associate, or licensed psychological associate, of the equivalent of five full-time years of professional experience under the supervision of a board-approved licensed psychologist.
 - (d) An applicant for licensure shall be required by the board to pass the national objective examination known as the EPPP, with an equal to or exceeding the score required for the passage for a licensed psychologist candidate at the doctoral level at the time the examination is taken.

13. Other diagnostic, screening, preventive and, rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

7. Qualifications of Providers (continued)

- (e) The board shall require an applicant for licensure under this section to pass an examination of psychological practice, ethical principles and the law.
10. Licensed Psychologist – Per KRS 319.050, a licensed psychologist shall pass an examination in psychology and fulfill all requirements for supervised experience.
- (a) The psychologist shall:
 - i Have received a doctoral degree in psychology that is acceptable to the board from a regionally accredited educational institution; provided, however, the board may grant a license to an individual otherwise qualified under this chapter who has received a doctoral degree in psychology that is acceptable to the board from an educational institution outside the United States, if the educational institution would otherwise be accredited by a regional accrediting body if located in the United States;
 - ii Have passed the national EPPP examination at the doctoral level; and
 - iii Have had at least two (2) years of supervised professional experience satisfactory to the board, one (1) year of which shall be an internship.
 - (b) Upon acceptance of the application to sit for the examination in psychology, the applicant may practice psychology under the supervision of a licensed psychologist under conditions of supervision and temporary licensure established by the board. The board shall establish a grace period not to exceed sixty (60) days to allow for the employment and supervision of the applicant by an agency from the time the applicant's degree requirements are completed to the submission of the complete application. During this period of supervision, the applicant for licensure may not supervise certified psychologists, licensed psychological associates, other applicants for licensure, or temporarily licensed persons, nor shall he engage in an independent practice, except under the employment of his supervising psychologist. Upon certification to the board of completion of the two (2) years of supervision satisfactory to the board, the applicant shall be examined on psychological practice, ethical principles, and the law.
 - (c) Licensed psychologists may function independently without supervision. Licensed psychologists who have the designation "health service provider" may retain that designation and may employ and supervise certified psychologists and licensed psychological associates. Licensed psychologists who have the designation "health service provider" may supervise no more than a total of six (6) certified psychologists, licensed psychological associates, or applicants for licensure at one (1) time.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

7. Qualifications of Providers (continued)

11. Physician – KRS 311.571 states that any applicant who is a graduate of a medical or osteopathic school shall be eligible for a regular license to practice medicine in the Commonwealth if they:
 - (a) Are able to understandably speak, read, and write the English language;
 - (b) Has graduated from an accredited college or university or has satisfactorily completed a collegiate course of study necessary for entry into an approved medical or osteopathic school or college;
 - (c) Has graduated from a prescribed course of instruction in a medical or osteopathic school or college situated in the United States or Canada and approved by the board;
 - (d) Has satisfactorily completed a prescribed course of postgraduate training of a duration to be established by the board in an administrative regulation; and
 - (e) Has successfully completed an examination prescribed by the board;
12. Physician Assistant – Has graduated from a physician assistant or surgeon assistant program accredited by the Accreditation Review Commission on Education for Physician Assistants or its predecessor or successor agencies and has passed the certifying examination administered by the National Commission on Certification of Physician Assistants or its predecessor or successor agencies; or (b) Possesses a current physician assistant certificate issued by the board prior to July 15, 2002;
13. Psychiatrist – Licensed under the laws of Kentucky to practice medicine or osteopathy, or a medical officer of the government of the United States while engaged in the performance of official duties, who is certified or eligible to apply for certification by the American Board of Psychiatry and Neurology, Inc.
14. KY Credentialed Peer Support Specialist – Kentucky regulation states that an applicant shall:
 - (a) Complete and submit an application for training to DBHDID;
 - (b) Complete the DBHDID peer specialist training program;
 - (c) Successfully complete the DBHDID peer specialist examination;
 - (d) Complete and maintain documentation of a minimum of six (6) hours of job related training or education in each subsequent year of employment; and
 - (e) Deliver services working under the supervision of a physician, a psychiatrist, a LP, a LPP, a LPA working under the supervision of a LP, a LCSW, a CSW with three (3) years of inpatient or outpatient clinical experience in psychiatric social work and currently employed by a hospital or forensic psychiatric facility licensed by the Commonwealth or a psychiatric unit of a general hospital or a private agency or company engaged in the provision of mental health services

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

13d. Rehabilitative Services

A. Treatment Services for Substance Use Disorders and Mental Health Disorders

7. Qualifications of Providers (continued)

or a regional community mental health center; a LMFT with three (3) years of inpatient or outpatient clinical experience in psychiatric mental health practice and currently employed by a hospital or forensic facility licensed by the Commonwealth, a psychiatric unit of a general hospital, a private agency or company engaged in providing mental health services, or a regional community mental health center, including regularly scheduled face-to-face supervision.

15. Certified Alcohol and Drug Counselor (CADC): KAR 309.083 states that shall:
- (a) Be at least eighteen (18) years of age;
 - (b) Have obtained a baccalaureate degree;
 - (c) Have completed six thousand (6,000) hours of board-approved experience working with alcohol or drug dependent persons, three hundred (300) hours of which shall have been under the direct supervision of a certified alcohol and drug counselor who has at least two (2) years of post-certification experience; (4) Have completed at least two hundred seventy (270) classroom hours of board-approved curriculum;
 - (d) Have passed a written examination that has been approved by the International Certification Reciprocity Consortium on Alcoholism and Drug Abuse and an oral examination approved by the board;
 - (e) Have signed an agreement to abide by the standards of practice and code of ethics approved by the board;
 - (f) Have completed at least six (6) hours of ethics training and two (2) hours of training in the transmission, control, treatment, and prevention of the human immunodeficiency virus;
 - (g) Have submitted two (2) letters of reference from certified alcohol and drug counselors; and
 - (h) Be supervised by a certified alcohol and drug counselor who has at least two (2) years of post-certificate experience and who provides supervision to not more than twelve (12) applicants in an individual or group setting at any one (1) time, and whose certificate is currently in good standing with the (CADC) board.
 - (e) Work under the supervision of a physician, a psychiatrist, a LP, a LPP, a LPA working under the supervision of a LP, a LCSW, a CSW with three (3) years of inpatient or outpatient clinical experience in psychiatric social work and currently employed by a regional community mental health center; a LMFT with three (3) years of inpatient or outpatient clinical experience in psychiatric mental health practice and currently employed by a regional community mental health center or a professional equivalent.

14.b. Nursing Facility Services for Individuals Age 65 or Older in Institutions for Mental Diseases.
and
C.

A. Definitions:

1. "High intensity nursing care services" means care provided to Medicaid eligible individuals who meet high intensity patient status criteria which shall be equivalent to skilled nursing care standards under Medicare.
2. "Low intensity nursing care services" means care provided to Medicaid eligible individuals who meet low intensity patient status criteria which shall be equivalent to the former intermediate care patient status standards.
3. "Intermediate care for the mentally retarded and persons with related conditions services" means care provided to Medicaid eligible individuals who meet ICF-MR patient status criteria by ICF-MRs participating in the Medicaid Program.

B. Services:

Program benefits are limited to eligible recipients who require nursing facility care services meeting the above definitions. These services must be preauthorized and must be reevaluated every six (6) months. If the reevaluation of care needs reveals that the patient no longer requires high intensity, low intensity, or intermediate care for the mentally retarded services and payment is no longer appropriate in the facility, payment shall continue for ten (10) days to permit orderly discharge or transfer to an appropriate level of care.

All individuals receiving nursing facility care must be provided care in appropriately certified beds. The following services are payable by the Medicaid Program when they are medically necessary and ordered by the attending physician. The facilities may not charge the Medicaid recipient for these services. (Also see Attachment 4.19-D Exhibit B for a detailed explanation of each service or item.)

- (1) Routine services include a regular room (if the attending physician orders a private room, the facility cannot charge the family or responsible party any difference in private/semi-private room charges; the facility enters their charges for a private room when billing Medicaid), dietary services and supplements, medical social services, respiratory therapy and supplies, nursing services, the use of equipment and facilities, medical and surgical supplies, podiatry services, items which are furnished routinely and relatively uniformly to all patients, prosthetic devices, and laundry services (including laundry services for personal clothing which is the normal wearing apparel in the facility).
- (2) Ancillary services are those for which a separate charge is customarily made. They include physical therapy, occupational therapy, speech therapy, laboratory procedures, x-ray, oxygen and oxygen supplies, and ventilator use.

15.a. Services in an Intermediate Care Facility for the Mentally Retarded and Developmentally Disabled (Other Than Such Services in an Institution for Mental Diseases) for Persons Determined, in Accordance with Section 1902(a) (31) (A) of the Act, to be in Need of Such Care

Program benefits are limited to eligible recipients who require active treatment. These services must be preauthorized and must be reevaluated every six (6) months, lithe reevaluation of care reveals that the patient no longer requires skilled, nursing facility level of care, or intermediate care for the mentally retarded and developmentally-disabled services and payment is no longer appropriate in the facility, payment shall continue for ten (10) days to permit orderly discharge or transfer to an appropriate level of care.

All individuals receiving nursing facility care must be provided care in appropriately certified beds

The following services are payable by the Medicaid program when they are medically necessary and ordered by the attending physician. The facilities may not charge the Medicaid recipient for these services. (Also see Attachment 4.19- D Exhibit B for a detailed explanation of each service or item.)

- (1) Routine services include a regular room (if the attending physician orders a private room, the facility cannot charge the family or responsible party any difference in private/semi-private room charges; the facility enters their charges for a private room when billing Medicaid), dietary services and supplements, medical social services, respiratory therapy and supplies, nursing services, the use of equipment and facilities, medical and surgical supplies, podiatry services, items which are furnished routinely and relatively uniformly to all patients, prosthetic devices, and laundry services (including laundry services for personal clothing which is the normal wearing apparel in the facility).
- (2) Ancillary services are those for which a separate charge is customarily made. They include physical therapy, occupational therapy, speech therapy, laboratory procedures, x- ray, oxygen and oxygen supplies, and ventilator use.

16. Inpatient Psychiatric Facility Services for Individuals Under 22 Years of Age

The following limitations are applicable for inpatient psychiatric facility services for individuals under 21 years of age (or under 22 years of age if an inpatient in the facility on the individual's 21st birthday):

- (1) Program benefits are limited to eligible recipients who require inpatient psychiatric facility services on a continuous basis as a result of a severe mental or psychiatric illness (including severe emotional disturbances) as shown in ICD-9-CMs (except as further excluded in item 3, below). **handwritten note in margins, "P&I HCFA 9-11-91"** Services shall not be covered if appropriate alternative services are available in the community. Services must be preauthorized and reevaluated at thirty day intervals.
- (2) Service may be provided in a psychiatric hospital; or in a licensed psychiatric residential treatment facility which meets the requirements of 42 CFR 441 Subpart D.

18. Hospice

A. Benefits

The Kentucky Medicaid Hospice Program follows the amount, duration, and scope of services specified in the Medicare Hospice Program.

Any terminally ill Medicaid recipient may elect hospice coverage (where hospice care is provided by a participating hospice program in his service area) Each recipient will be required to make his voluntary selection in writing, and must present a statement from a physician (or such statement must be available) to show that the recipient's illness is terminal and that death is expected to occur within six (6) months. In doing so, the recipient waives rights to other Medicaid services that are related to the treatment of his or her terminal illness(es) with the exception of individuals less than 21 years of age. Individuals less than 21 years of age may receive concurrent hospice and acute care treatment. The recipient has the right to cancel the election at any time without forfeiting additional Medicaid hospice coverage at a later time. The recipient does not waive rights to Medicaid services for conditions not related to the terminal condition.

Medicaid beneficiaries under the age of 21 may receive hospice benefits, including curative treatment without foregoing any other service to which the child is entitled under the Medicaid program, pursuant to Section 2302 of the Patient Protection and Affordable Care Act of 2010.

B. Limitations

Dually eligible (Medicare and Medicaid) recipients must participate in the Medicare and Medicaid hospice programs simultaneously in order to receive Medicaid hospice services.

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23. Any other medical care and any other type of remedial care recognized under the state law, specified by the Secretary.
- A. Transportation
1. Definitions.
- a. Ambulance transportation includes air and ground transportation provided at advanced life support level or basic life support levels by an appropriately licensed carrier.
- b. Medical service area is made up of the recipient's county of residence or a contiguous county.
2. Ambulance Services.
- a. An emergency ambulance service shall be provided without prior authorization to and from the nearest hospital emergency room. If a hospital emergency room is not available, a statement from an attending physician associated with the facility from which the patient receives services verifying medical necessity of stretcher ambulance services and the nature of the emergency services provided to the patient shall be required.
- b. A non-emergency ambulance service to a hospital, clinic, physician's office or other medical facility for provision of a Medicaid covered service, exclusive of a pharmacy service, shall be covered upon referral from a licensed medical professional for a recipient whose medical condition warrants transport by stretcher.
- c. When it is determined by the attending physician that ground ambulance is not appropriate, a referral may be made for air ambulance transport to a medical facility beyond the recipient's county of residence or state boundaries. Medically necessary air travel will be covered within the parameters of the allowed reimbursement amounts specified in Attachment 4.19-B, page 20.11. Special authorization by the Commissioner or his designated representative is required for air transportation provided at a cost in excess of these amounts.
- d. Ground ambulance transport for in-state non-emergency ambulance travel outside the medical service area shall be covered if prescribed by the attending physician.
- e. Ground ambulance transport for out-of-state non-emergency ambulance transport shall only be covered if prior approval is obtained from the Department.
- f. Only the least expensive available transportation suitable for the recipients needs shall be approved.

3. Specially Authorized Non-emergency Medical Transportation

- a. A specially authorized transportation service is non-emergency transportation necessary under extraordinary circumstances in which the recipient is required to travel out-of-state for medical treatment unavailable in-state.
- b. The Department assures provision of necessary transportation to and from a provider if the recipient has no other transportation resources.
- c. If transportation is not available free of charge, the Department will cover the least expensive means of appropriate transportation.
- d. Prior approval is required for all specially authorized transportation. When the recipient's medical needs cannot be met within the state, the Department will only approve travel to the nearest facility where those needs can be met.
- e. The Department will cover the following specially authorized transportation services:
 - (1) Transportation for a recipient;
 - (2) Lodging for a recipient, and a parent or attendant, if necessary;
 - (3) Meals, when necessary for the recipient to remain away from home and outside a medical facility while receiving treatment;
 - (4) Transportation and meals for one parent or guardian to accompany a dependent child receiving covered medical services, when treatment requires the child to remain away from home; and
 - (5) Transportation and meals for an attendant who accompanies a recipient receiving medical services, when there is a justifiable need for an attendant. The attendant can be a parent.

23.e. Emergency Hospital Services

Coverage is limited to the provision of emergency services provided in hospitals which have been determined to meet Title XVIII's definition of an emergency hospital.

TN No. 90-36
Supersedes
TN No. None

Approval Date: Nov 14, 1994

Effective Date 10-1-90

State/Territory: Kentucky

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND
REMEDIAL CARE AND SERVICES PROVIDED TO THE
MEDICALLY NEEDY

27. Durable Medical Equipment, Medical Supplies, Prosthetics and Orthotics

An item of durable medical equipment, prosthetic, or orthotic shall be durable in nature and able to withstand repeated use. Coverage of an item of durable medical equipment, medical supplies, prosthetics and orthotics shall be in accordance with the following: shall serve a medical purpose; shall not generally be useful to a person in the absence of illness or injury; and shall be medically necessary and reasonable.

- a. A provider must be Medicare and Medicaid certified. Items must be medically necessary and, if required, prior authorized.
- b. All miscellaneous codes require prior authorization. Any item that does not have a designated HCPCS code and is determined by the department to be a covered item will use the designated miscellaneous HCPCS code from the HCPCS Coding Book and require prior authorization.
- c. Any item designated by a covered HCPCS code being reimbursed at \$150.00 or more will require prior authorization.
- d. All items of durable medical equipment, prosthetic, orthotic, or medical supply will require a Certificate of Medical Necessity to be kept on file at the provider's office for five (5) years.
- e. The following general types of durable medical equipment, medical supply, prosthetics or orthotics are excluded from coverage under the durable medical equipment program:
 1. Items which would appropriately be considered for coverage only through other sections of the Medicaid Program, such as frames and lenses, hearing aids, and pacemakers;
 2. Items which are primarily and customarily used for a non-medical purpose, such as air conditioners and room heaters;
 3. Physical fitness equipment, such as exercycles and treadmills;
 4. Items which basically serve a comfort or convenience of the recipient or the person caring for the recipient, such as elevators and stairway elevators;
 5. Items needed as a resident of an inpatient program of a hospital, or nursing facility, and
 6. Items considered educational or recreational.
- f. A cast or splint shall be limited to two (2) per ninety (90) day period for the same injury or condition.

TN No: 06-013
Supersedes
TN No: 03-006

Approval Date: 06-12-08

Effective Date: 07/01/06

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Agency: Kentucky

MEDICAID PROGRAM: REQUIREMENTS RELATING TO
COVERED OUTPATIENT DRUGS FOR THE MEDICALLY NEEDY

Citation

Provision(s)

1935(d)(1)

Effective January 1, 2006, the Medicaid agency will not cover any Part D drug for full-benefit dual eligible individuals who are entitled to receive Medicare benefits under Part A or Part B.

TN No.: 05-010
Supersedes
TN No.: NEW

Approval Date: 11/25/05

Effective Date: 01/01/06

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Agency: Kentucky

MEDICAID PROGRAM: REQUIREMENTS RELATING TO PAYMENT FOR COVERED
OUTPATIENT DRUGS FOR THE MEDICALLY NEEDY

Citation(s)	Provision(s)
1927(d)(2) and 1935(d)(2)	<p>1. The Medicaid agency provides coverage for the following excluded or otherwise restricted drugs or classes of drugs, or their medical uses to all Medicaid recipients, including full benefit dual eligible beneficiaries under the Medicare Prescription Drug Benefit -Part D.</p> <p>The following excluded drugs are covered:</p> <ul style="list-style-type: none"><input type="checkbox"/> (a) agents when used for anorexia, weight loss, weight gain (see specific drug categories below)<input type="checkbox"/> (b) agents when used to promote fertility(see specific drug categories below)<input type="checkbox"/> (c) agents when used for cosmetic purposes or hair growth (see specific drug categories below)<input type="checkbox"/> (d) agents hen used for the symptomatic relief cough and colds (see specific drug categories below)<input type="checkbox"/> (e) prescription vitamins and mineral products, except prenatal vitamins and fluoride (see specific drug categories below)<input checked="" type="checkbox"/> (f) nonprescription drugs (see specific drug categories below)

TN No.: 05-010
Supersedes
TN No.: NEW

Approval Date: 11/25/05

Effective Date: 01/01/06

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Agency: Kentucky

MEDICAID PROGRAM: REQUIREMENTS RELATING TO PAYMENT FOR COVERED
OUTPATIENT DRUGS FOR THE CATEGORICALLY NEEDY

Citation(s)	Provision(s)
1927(d)(2) and 1935(d)(2)	<input type="checkbox"/> (g) covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee (see specific drug categories below) (The Medicaid agency lists specific category of drugs below) Kentucky Medicaid will cover all nonprescription drug categories for full benefit dual eligible beneficiaries, which is consistent with Kentucky's policy of covering all nonprescription drug categories for non-dual recipients. Herbal products are not covered.
	<input type="checkbox"/> No excluded drugs are covered.

TN No. 13-026
Supersedes
TN No.: 11-011

Approval Date: 1/23/2014

Effective Date: October 1, 2013

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kentucky

CASE MANAGEMENT SERVICES

- A. Target Groups: By invoking the exception to comparability allowed by 1915 (g)(1) of the Social Security Act, this service will be reimbursed when provided to persons who are:
1. Aged 0-21 and meet the medical eligibility criteria of Commission for Handicapped Children, the state's Title V Crippled Children's Agency, and
 2. Persons of all ages meeting the medical eligibility criteria of the Commission for Handicapped Children and having a diagnosis of hemophilia.
- The individuals in the target groups may not be receiving case management services under an approved waiver program.
- B. Areas of State in which services will be provided:
- Entire State.
- Only in the following geographic areas (authority of Section 1915 (g)(1) of the Act is invoked to provide services less than statewide:
- C. Comparability of Services
- Services are provided in accordance with Section 1902(a)(10)(B) of the Act.
- Services are not comparable in amount, duration, and scope. Authority of Section 1915(g)(I) of the Act is invoked to provide services without regard to the requirements of Section 1902(a)(10)(B) of the Act.
- D. Definition of Services: Case management is a service instrument by which service agencies assist an individual in accessing needed medical, social, educational and other support services. Consistent with the requirements of Section 1902 a(23) of the Act, the providers will monitor client treatment to assure that clients receive services to which they are referred. One case management unit is the sum of case management activities that occur within a calendar month. These activities include:

STATE PLAN UNDER TITLE XIX OF TITLE SOCIAL SECURITY ACT

State/Territory: Kentucky

CASE MANAGEMENT SERVICES

D. Definition of Services: (Continued)

1. Assessment of client's medical, social, and functional status and identification of client service needs;
2. Arranging for service delivery from the client's chosen provider to insure access to required services;
3. Insure access to needed services by explaining the need and importance of services in relation to the client's condition;
4. Insure access, quality and delivery of necessary services, and
5. Preparation and maintenance of case record documentation to include service plans, forms, reports, and narratives, as appropriate. •

E. Qualification of Providers:

Providers must be certified as a Medicaid provider meeting the following criteria:

1. Demonstrated capacity to provide all core elements of case management
 - (a) assessment
 - (b) care/services plan development
 - (c) linking/coordination of services
 - (d) reassessment/followup
2. Demonstrated case management experience in coordinating and linking such community resources as required by the target population.
3. Demonstrated experience with the target population. -
4. An administrative capacity to insure quality of services in accordance with state and federal requirements.
5. A financial management system that provide8 documentation of services and costs.
6. Capacity to document and maintain individual case records in accordance with state and federal requirements.
7. Demonstrated ability to assure a referral process consistent with Section 1902 a(23), freedom of choice of provider.
8. Demonstrated capacity to meet the case management service needs of the target population.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Kentucky

CASE MANAGEMENT SERVICES

E. Qualifications of Providers (continued)

Qualifications of Case Manager (Only the following can be case managers)

1. Registered Nurse - Must be licensed as a Registered Nurse or possess a valid work permit issued by the Kentucky Board of Nursing.
2. Social Worker - A master's degree in social work supplemented by one year of professional social work experience; or a graduate of a college or university with a bachelor's degree supplemented by two years of professional social work experience.

F. The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of Section 1902(a)(23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services.
2. Eligible recipients will have free choice of the providers of other medical care under the plan.

G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

State: Kentucky

Targeted Case Management Services for Severely Emotionally Disturbed Children

- A. Target Groups: By involving the exception to comparability allowed by 1915(g)(1) of the Social Security Act, this service will be reimbursed when provided to persons who are:
1. Age 0-21 and meet the state's conditions and circumstances to be defined as a "severely emotionally disturbed child."
- The individuals in the target groups may not be receiving case management services under an approved waiver program.
- B. Areas of State in which services will be provided;
- Entire State.
- Only in the following geographic area (authority of Section 1915(g)(1) of the Act is involved to provide services less than statewide:
- C. Comparability of Services
- Services are provided in accordance with Section 1902(a)(10)(B) of the Act.
- Services are not comparable in amount, duration, and scope. Authority of Section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.
- D. Definition of Services: Case' management is a service instrument by which service agencies assist an individual in accessing needed medical, social, educational and other support services. Consistent with the requirements of Section 1902 a(23) of the Act, the providers will monitor client treatment to assure that clients receive services to which they are referred. One case management unit is the sum of case management activities that occur within a calendar month. These activities include:

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- (1) A written comprehensive assessment of the child's needs;
- (2) Arranging for the delivery of the needed services as identified in the assessment;
- (3) Assisting the child and his family in accessing needed services;
- (4) Monitoring the child's progress by making referrals, tracking the child's appointments, performing follow-up on services rendered, and performing periodic reassessment of the child's changing needs;
- (5) Performing advocacy activities on behalf of the child and his family;
- (6) Preparing and maintaining case records documenting contacts, services needed, reports, the child's progress, etc.;
- (7) Providing case consultation (i.e. consulting with the service providers/collateral's in determining child's status and progress); and
- (8) Performing crisis assistance (i.e., intervention on behalf of the child, making arrangements for emergency referrals, and coordinating other needed emergency services).

E. Qualification of Providers;

Provider participation shall be limited to the Kentucky Department for Social Services and the fourteen Regional Mental Health Mental Retardation Centers, licensed in accordance with state regulations.

Qualification of Case Manager and Supervision Requirement

- (1) Case Manager Qualifications. Each case manager shall be required to meet the following minimum requirements:
 - (a) Have a Bachelor of Arts or Bachelor of Sciences degree in any of the behavioral sciences from an accredited institution; and
 - (b) Have one (1) year of experience working directly with children or performing case management services (except that a master's degree in a human services field may be substituted for the one (1) year of experience); and
 - (c) Have received training within six (6) months designed and provided by each participating provider directed toward the provision of case management services to the target population; and

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- (d) Have supervision for a minimum of one (1) year by a mental health professional; i.e., psychiatrist, psychologist, master's level social worker (MSW), psychiatric nurse or professional equivalent (a minimum of a bachelor's degree in a human services field, with two (2) years of experience in mental health related children's services). The supervisor shall also complete the required case management or training course.
 - (2) Case Manager Supervision Requirement. For at least one (1) year, each case manager shall have supervision performed at least once a month for each case plan.
- F. The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.
 - (1) Eligible recipients will have free choice of the providers of case management services.
 - (2) Eligible recipients will have free choice of the providers of other medical care under the plan.
- G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purposes.

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Targeted Case Management Services for Children in the Custody of or at Risk of Being in the Custody of the State, and for Children under the Supervision of the State, and for Adults in Need of Protective Services

- A. Target Groups: By invoking the exception to comparability allowed by 191 5(g)(1) of the Social Security Act, this service will be reimbursed when provided to persons who are:
1. Age 0-21 and meet the state's conditions and circumstances to be defined as a child in the custody of or at risk of being in the custody of the state, or a child who is under the supervision of the state, and
 2. Adults who meet the state's conditions and circumstances to be defined as an adult in need of protective services.
- B. Areas of State in which services will be provided:
- Entire State.
- Only in the following geographic areas (authority of Section 1915(g)(1) of the act is invoked to provide services less than statewide):
- C. Comparability of Services
- Services are provided in accordance with Section 1902(a)(10)(B) of the Act.
- Services are not comparable in amount, duration and scope. Authority of Section 191 5(g)(1) of the Act is invoked to provide services without regard to the requirements of Section 1902(a)(10)(B) of the Act.
- D. Definition of Services: Case management is a service that allows providers to assist eligible individuals in accessing needed medical, social, educational and other support services. Consistent with the requirements of Section 1 902(a)(23) of the Act, the providers will monitor client treatment to assure that clients receive services they are referred to. One case management unit is the sum of case management activities that occur within a calendar month. These activities include:

- (1) A written assessment of the child or adult's needs;
- (2) Arranging for the delivery of the needed services as identified in the assessment;
- (3) Assisting the child and his family, or the adult, in accessing services needed by the individual child or adult;
- (4) Monitoring the child or adults progress by making referrals, tracking the child or adult's appointments, performing follow-up on services rendered, and performing periodic reassessments of the child or adult's changing needs;
- (5) Performing advocacy activities on behalf of the adult, or the child and his family, to assure that the individual adult or child gains access to the services he or she needs;
- (6) Obtaining, preparing and maintaining case records documenting contacts, services needed, reports, the child or adult's progress, etc. following provision of service to the child or the adult on behalf of the child or adult;
- (7) Providing case consultation (i.e., consulting with the service provider/collateral's in determining the child or adult's status and progress); and
- (8) Performing crisis assistance (i.e., intervention on behalf of the child or adult, making arrangements for emergency referrals, and coordinating other needed emergency services).

E. Qualification of Providers:

Providers must be certified as a Medicaid provider meeting the following criteria:

- (1) Demonstrated capacity to provide all core elements of case management including
 - (a) assessment;
 - (b) care/services plan development;
 - (c) linking/coordination of services; and
 - (d) reassessment/follow-up.
- (2) Demonstrated case management experience in coordinating and linking such community resources as required by one of the target populations.

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- (3) Demonstrated experience with one of the target populations.
- (4) An administrative capacity to insure quality of services in accordance with state and federal requirements.
- (5) A financial management system that provides documentation of services and costs.
- (6) Capacity to document and maintain individual case records in accordance with state and federal requirements.
- (7) Demonstrated ability to assure a referral process consistent with Section 1 902(a)(23) of the Act, freedom of choice of provider.
- (8) Demonstrated capacity to meet the case management service needs of one of the target populations.

Qualifications of Case Manager (Only the following can be case managers)

Each case manager must be employed by an enrolled Medicaid provider or by an approved subcontractor of an enrolled Medicaid provider and must meet the following minimum requirements:

- (1) Have a Bachelor of Arts or Bachelor of Sciences degree in any of the social/behavioral sciences or related fields from an accredited institution; and
 - (2) Have one (1) year of experience working directly with the targeted case management population or performing case management services or have a master's degree in a human service field.
- F. The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of Section 1 902(a)(23) of the Act.
- (1) Eligible recipients will have free choice of the providers of case management services.
 - (2) Eligible recipients will have free choice of the providers of other medical care under the plan.
- G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Targeted Case Management Services for children birth to 3 Participating in the Kentucky Early Intervention Program

A. Target Groups: By invoking the exception to comparability allowed by 1915(g)(1) of the Social Security Act, this service will be reimbursed when provided to persons who are:

1. Children birth to three years of age who have developmental disabilities and who meet the eligibility criteria of and are participants in the Kentucky Early Intervention Program.

The individuals in the target groups may not be receiving case management services under an approved waiver program.

B. Areas of State in which services will be provided:

- Entire State
- Only in the following geographic areas (authority of Section 1915(g)(1) of the Act is involved to provided services less than statewide:

C. Comparability of Services

- Services are provided in accordance with Section 1902(a)(10)(B) of the Act.
- Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

D. Definition of Services: Case management is a service which allows providers to assist eligible individuals in gaining access to needed medical, social, educational, and other services. Consistent with the requirements of Section 1902(a)(23) of the Act, the providers will monitor client treatment to assure that clients receive services to which they are referred.

Case management is an active, ongoing process that involves activities carried out by a case manager to assist and enable a child eligible for services under the Kentucky Early Intervention Program in gaining access to needed medical, social, educational and other services. There are two parts to case management: Initial Service Coordination and Primary Service Coordination. Initial Service Coordination assists the child and child's family, as it relates to the child's needs, from the notice of referral through the initial development of the child's needs-identified Individualized Family Services Plan (IFSP). Primary Service Coordination assists the child and child's family, as it relates to the child's needs, with ongoing service coordination, for the child, provided by the individual service coordinator selected at the time the IFSP is finalized. A child would only have one service coordinator at a time.

These activities include:

- (1) Assessment of child's medical, social and functional status and identification of service needs;
- (2) Initial service coordination from notice of referral through initial IFSP development;
- (3) Assuring that all procedural safeguards are met during intake and IFSP development;
- (4) Arranging for and coordinating the development of the child's IFSP;
- (5) Arranging for the delivery of the needed services as identified in the IFSP;
- (6) Assisting the child and his family, as it relates to the child's needs, in accessing needed services for the child and coordinating services with other programs;
- (7) Monitoring the child's progress by making referrals, tracking the child's appointments, performing follow-up on services rendered, and performing periodic reassessments of the child's changing service needs;
- (8) Performing activities to enable an eligible individual to gain access to needed services; -
- (9) Obtaining, preparing and maintaining case records documenting contacts, services needed, reports, the child's progress, etc.;
- (10) Providing case consultation (i.e., with the service providers/collaterals in determining child's status and progress);

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- (11) Performing crisis assistance (i.e., intervention on behalf of the child, making arrangements for emergency referrals, and coordinating other needed emergency services); and
 - (12) Facilitating and coordinating development of the child's transition plan.

E. Qualifications of Providers:

As provided for in Section 1915 (g)(1) of the Social Security Act, qualified providers shall be the Title V agencies and their subcontractors who meet the following Medicaid criteria in order to ensure that case managers for the children with developmental disabilities target group are capable of ensuring that such individuals receive needed services:

1. Demonstrated capacity to provide all core elements of case management including:
 - a) assessment;
 - b) care/services plan development;
 - c) linking/coordination of services; and
 - d) reassessment/follow-up
2. Demonstrated case management experience in coordinating and linking such community resources as required by the target population;
3. Demonstrated experience with targeted population;
4. An administrative capacity to insure quality of services in accordance with state and federal requirements; and
5. A financial management system that provides documentation of services and costs.

Qualifications of Case Manager (only the following can be case managers)

Each case manager must be a Kentucky Early Intervention Program certified service provider, and:

- A. Have a Bachelor's degree; and
 - (1) 2 years experience in service coordination for children with disabilities up to age 18; or
 - (2) 2 years experience in service provision to children under six years of age; or

- B. Meet one of the following professional criteria:
 - 1. Audiologist - Licensed or Certified,
 - 2. Family Therapist - M.A. and Certified,
 - 3. Developmental Interventionist - Certified or working toward an Interdisciplinary Early Childhood Certificate as demonstrated by implementing a professional development plan approved by the Cabinet for Health Services,
 - 4. Developmental Associate,
 - 5. Registered Nurse,
 - 6. Advanced Registered Nurse Practitioner,
 - 7. Dietitian - Licensed,
 - 8. Occupational Therapist - Licensed,
 - 9. Occupational Therapist Assistant - B.S. and Licensed,
 - 10. Orientation and Mobility Specialist - Certified,
 - 11. Physical Therapist - Licensed,
 - 12. Psychologist - Licensed or Certified,
 - 13. Speech Language Pathologist - Licensed or Certified,
 - 14. Speech Language Assistance - licensed,
 - 15. Social worker - Licensed,
 - 16. Physician, Licensed,
 - 17. Nutritionist, Licensed

- F. The State assures that the provision of case management services will not unlawfully restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.
- (1) Eligible recipients will have free choice of the available providers of case management services.
 - (2) Eligible recipients will have free choice of the available providers of other medical care under the plan.
- G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for the same purpose.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

CASE MANAGEMENT SERVICES

- A. Target Group: By invoking the exception to comparability allowed by 1915(g)(1) of the Social Security Act, this service will be reimbursed when provided to persons who are:
1. Pregnant women who have not reached their twentieth birthday and will be first time teen parents;
 2. Pregnant women who are twenty years of age or older, will be first time parents, and screen positive for the home visitation program, Health Access Nurturing Development Services (HANDS). High risk screening factors include: first time mothers who are single, separated or divorced; those who had late, sporadic or no prenatal care; those who sought or attempted an unsuccessful abortion; partner unemployed; inadequate income or no source of income; unstable housing; no phone; education less than 12 years; inadequate emergency contacts; treatment of or current substance abuse; treatment of abortion; treatment of psychiatric care; relinquishment for adoption, sought or attempted; marital or family problems; treatment of or current depression;
 3. Infants and toddlers up to their third birthday who are children in families described in A.1 and A.2 of this subsection;
 4. First born infants up to twelve (12) weeks of age whose families were not identified prenatally and who assess into the program.
- B. Areas of State in which services will be provided:
- Entire State
- Only in the following geographic areas (authority of Section 1915(g)(1) of the Act is involved to provide services less than state wide:
- C. Comparability of Services:
- Services are provided in accordance with 1902(a)(10)(B) of the Act.
- Services are not comparable in amount, duration and scope. Authority of 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of 1902(a)(10)(B).
- D. Definition of Services
- Case management is a service which allows providers to assist eligible individuals in gaining access to needed medical, social, education, and other services. Consistent with the

requirement of Section 1 902(a)(23) of the Act, the providers will monitor client treatment to assure that clients receive services to which they are referred.

Case management is an active, ongoing process that involves activities carried out by case managers to assess and enable first time mothers and infants/toddlers who are eligible for services under the Kentucky HANDS (Health Access Nurturing Development Services) Program. There are two phases to case management - assessment and home visitation. Both phases include assisting the infant/toddler, mother, or family in accessing needed services, developing a treatment plan, coordinating needed services, monitoring progress, preparing and maintaining case records, providing case consultation as specified by the plan, and providing follow-up and evaluation.

The service activities include:

1. Assessment
 - a) Provided by a Registered Nurse, Social Worker or Early Childhood Development Specialist;
 - b) Conducts a face-to-face needs assessment with the child, mother and family. The assessment shall include:
 - 1) parent's childhood experience;
 - 2) lifestyle behaviors and mental health status;
 - 3) parenting experience;
 - 4) stressors, coping skills and support system for the new family;
 - 5) anger management skills;
 - 6) expectations of infant's developmental milestones and behaviors;
 - 7) perception of new infant, and bonding and attachment issues;
 - 8) plans for discipline; and
 - 9) family environment and support system.
 - c) Develops a written report of the findings and a service plan for the family.
 - d) Assigns home visitor and arranges for the delivery of the needed services by other Medicaid and community providers as identified in the treatment plan.

2. Home Visitation

- a) A public health nurse, social worker, or family support worker who is supervised by a public health nurse, social worker, or early childhood development specialist may perform a home visit;
- b) Assist the child and family, as it relates to the treatment plan, in accessing needed services and coordinating services with other programs;
- c) Monitor progress by making referrals, tracking the appointments, performing follow-up services, and performing periodic evaluation of the changing needs;
- d) Perform activities to enable the child and family to gain access to needed services;
- e) Prepare and maintain case records documenting contacts, services needed, reports, progress;
- f) Provide case consultation (i.e., with the service providers/collaterals in determining child's status and progress); and
- g) Perform crisis assistance (i.e., intervention on behalf of the child, making arrangement for emergency referrals, and coordinating other needed emergency service).

E. Qualifications of Providers:

1. Providers must be certified as a Medicaid provider meeting the following criteria:

- a) Demonstrated capacity to contract statewide for the case management services for the targeted population;
- b) Demonstrated capacity to ensure all components of case management including:
 - 1) screening,
 - 2) assessment,
 - 3) treatment plan development,
 - 4) home visiting,
 - 5) linking/coordination of services, and
 - 6) follow-up and evaluation:
- c) Demonstrated experience in coordinating and linking such community resources as required by the target population:
- d) Demonstrated experience with the target population;

- e) Administrative capacity to insure quality of services in accordance with state and federal requirements;
- f) Demonstrated capacity to provide certified training and technical assistance to case manager;
- g) Financial management system that provides documentation of services and costs;
- h) Capacity to document and maintain individual case records in accordance with state and federal requirements;
- i) Demonstrated ability to assure a referral process consistent with Section 1902a(23), freedom of choice of provider; and
- j) Demonstrated capacity to meet the case management service needs of the target population.

2. Qualifications of Case Manager

The case manager shall meet one of the following professional criteria:

- a) Registered Nurse - Must have a valid Kentucky Board of Nursing license as a registered nurse or advanced registered nurse practitioner.
- b) Social Worker - Meet the requirement of KRS Chapter 335 for licensure by the State Board of Examiners of Social Work, have a masters degree in social work, or have a bachelors degree in social work from an accredited institution.
- c) Early Childhood Development Specialist - have a bachelors degree in Family Studies, Early Childhood Education, Early Childhood Special Education, or a related Early Childhood Development Curriculum.
- d) Family Support Worker (FSW) - Have a high school diploma or GED, be 18 years of age or older, and have received core training prior to having family contact on assessment of family strengths and needs, service plan development, home visitor process, home visitor role, supporting growth in families, observing parent-child interactions, knowing indicators of parent-infant attachment, keeping home visit records, conducting service coordination and reassessment. In addition to the core training the family support worker receives continuing training on selected topics including confidentiality, community resources, developmental milestones, family violence, substance abuse, ethical issues, communication skills, I-H V/ training, and interviewing techniques. The FSW must be supervised by a registered nurse or social worker.

- F. The state assures that the provision of case management services will not unlawfully restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.
1. Eligible recipients will have free choice of the providers of case management services.
 2. Eligible recipients will have free choice of the available providers of other medical care under the plan.
- G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for the same purpose.

Targeted Case Management services for pregnant women including postpartum women for sixty (60) day period after the pregnancy ends and any remaining days in the month in which the 60th day falls.

- A. By invoking the exception to comparability allowed by 1915(g)(1) of the Social Security Act, this service will be reimbursed when provided to persons who are:
- (1) Women diagnosed as a pregnant woman or postpartum woman up to the end of the month of sixty days following the date of delivery who has applied for or is receiving substance abuse services through Medicaid.
- B. Areas of State in which services will be provided:
- Entire State
- Only in the following geographic areas (authority of Section 1915(g)(1) of the Act is involved to provided services less than statewide:
- C. Comparability of Services
- Services are provided in accordance with Section 1902(a)(10)(B) of the Act.
- Services are not comparable in amount, duration, and scope. Authority of Section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of Section 1902(a)(10)(B) of the Act.
- D. Definition of Services Case management is a service which allows providers to assist eligible individuals in gaining access to needed medical, social, education, and other services. Consistent with the requirements of Section 1 902(a)(23) of the Act, the providers will monitor client treatment to assure that clients receive services to which they are referred
- (1) Substance abuse case management services.
 - (a) Case management shall be.
 1. A face-to-face or telephone contact between or on behalf of an individual and a qualified substance abuse professional; and
 2. For the purpose of reducing or eliminating an individual's substance abuse problem by assisting an individual in gaining access to needed medical, social, educational and other support services
 - (b) Case management services shall include:
 1. The development of a service plan that identifies an individual's case management needs and projected outcomes; and
 2. Activities that support the implementation of an individual's service plan
 - (c) Case management services shall not be connected with a specific type of substance abuse treatment but shall follow an individual across the array of substance abuse treatment services identified in an individual's treatment plan.

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- (d) Service limitations. The following activities shall not be reimbursed by Medicaid:
1. An outreach or case-finding activity to secure a potential individual for services;
 2. Administrative activities associated with Medicaid eligibility determinations; and
 3. The actual provision of a service other than a case management service.

A. Qualifications of Providers:

- (1) Services are covered when provided by any mental health center, and their subcontractors, and any other qualified providers, licensed in accordance with applicable state laws and regulations.
- (2) Demonstrated capacity to provide all core elements of case management including: Assessment skills, care/services plan development, linking/coordination of services, reassessment/follow-up, training specific to the target population, an administrative capacity to insure quality of services in accordance with state and federal requirements and a financial system that provides documentation of services and costs.
- (3) The provider shall employ or have a contractual agreement with a physician licensed in Kentucky.
- (4) A provider must have staff available to provide emergency services for the immediate evaluation and care of an individual in a crisis situation on a twenty-four (24) hour a day, seven (7) day a week basis.
- (5) Qualifications for case management services:
 - (a) An alcohol and drug counselor certified by the Kentucky Board of Certification for Alcohol and Drug Counselors;
 - (b) An individual who has a bachelors degree or greater in any field, from an accredited college or university who meets the training, documentation and supervision requirements;
 - (c) A Kentucky licensed physician.
 - (d) A psychiatrist who is licensed in Kentucky.
 - (e) A psychologist licensed or certified by the Kentucky Board of Examiners of Psychology;
 - (f) A psychological associate certified by the Kentucky Board of Examiners of Psychology;

- (g) A social worker licensed or certified in Kentucky;
 - (h) A Kentucky licensed registered nurse with the following combinations education and work experience:
 - 1. A registered nurse with a masters degree in psychiatric nursing from an accredited college or university;
 - 2. A bachelor of science degree in nursing from an accredited college or university and one year of clinical work experience in the substance abuse or mental health field;
 - 3. A diploma graduate in nursing and two years of clinical work experience in the substance or mental health field; or
 - 4. An associate degree in nursing from an accredited college or university and three years of clinical work experience in the substance abuse or mental health field;
 - (i) A Kentucky licensed advanced registered nurse practitioner;
 - (j) A marriage and family therapist licensed by the Kentucky Board of Licensure of Marriage and Family Therapists;
 - (k) A Kentucky-certified professional counselor; or
 - (l) A Kentucky-certified professional art therapist.
- F The State assures that the provision of case management services will not unlawfully restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.
- (1) Eligible recipients will have free choice of the available providers of case management services.
 - (2) Eligible recipients will have free choice of the available providers of other medical care under the plan
- G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for the same purpose

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Kentucky

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Page 9.1

STANDARDS AND METHODS OF ASSURING HIGH QUALITY CARE

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Transportation (For Categorically Needy and Medically Needy)

- A. The Department for Medicaid Services assures that medically necessary transportation OF recipients to and from providers of service will be provided. The methods that will be used are as follows:
1. Any appropriate means of transportation which can be secured without charge through volunteer organizations, public services such as fire department and public ambulances, or relatives will be used.
 2. If transportation is not available without charge, payment will be made for the least expensive means of transportation suitable to the recipient, whenever determined to be medically necessary through preauthorization, postauthorization, or through the patient's meeting certain specified criteria relating to destination, point of departure, and condition.
 3. When transportation is required on a predictable basis, an amount to cover the transportation is allowed as a spenddown by the medically needy.
 4. When medical transportation is required, a preauthorization system at the local level is used for nonemergency transportation.
 5. Payments for locally authorized medical transportation shall be made directly to participating providers by the Medicaid Program.
 6. All Medicaid participating medical transportation providers, including private automobile carriers, shall have a signed participation agreement with the Department for Medicaid Services prior to furnishing the medical transportation service.
 7. Locally authorized medical transportation shall be provided on an exceptional postauthorization basis for nonemergency, medically necessary transportation under the following conditions: the client can justify the need for medical transportation arose and was provided; was provided outside the normal working hours; payments for the transportation has not been made; client was traveling to or from a medical service covered under the state plan, except for pharmaceutical services; and service was determined medically necessary by the state agency.

- B. Ambulance service shall be reimbursable only when it is the least expensive and most appropriate for the recipient's medical needs and the following criteria shall be met.
1. Emergency ambulance services to the nearest appropriate medical facility are provided without preauthorization when the emergency treatment is specified and rendered.
 2. Nonemergency ambulance services to a hospital, clinic, physician's office, or other health facility to secure medically necessary Medicaid covered services for a "stretcher bound" Medicaid recipient. "Stretcher bound" denotes the inability to get up from bed without assistance, the inability to ambulate, and the inability to sit in a chair or wheelchair.
 3. Any determination of medical necessity of transportation, and provision of preauthorization and postauthorization, is made by the Department for Medicaid Services or by the Department's authorized representative. Transportation only within the medical service area is approved unless preauthorized by the agency (or postauthorized in certain instances), unless previously designated criteria for transportation not requiring authorization are met.

State/Territory: Kentucky

STANDARDS FOR THE COVERAGE OF ORGAN TRANSPLANT SERVICES

General Coverage Criteria. The following general coverage criteria shall be applicable with regard to organ transplants.

1. For an organ transplant to be covered under the Medicaid Program, it must be the opinion of the transplant surgeon that the transplant is medically necessary; the failure to perform the organ transplant would create a life-threatening situation; and the prognosis must be that there is a reasonable expectation the transplant will be successful and result in prolonged life of quality and dignity.
2. The hospital and physician performing the transplant must be recognized by the Medicaid Program as being competent to perform the transplant. A staff and functioning unit at the hospital designed for and/or accustomed to performing transplants of nature envisioned, recognized as competent by the medical community, will ordinarily be considered competent by the program.

Reimbursement for Organ Transplants. Hospital payments for organ transplants will be set at eighty (80) percent of actual usual and customary charges with total payments not to exceed \$75,000 per transplant without regard to usual program limits on hospital length-of-stay. An exception to the maximum payment limit can be made by the Commissioner, Department for Medicaid Services on a case by case basis when the maximum payment limit restricts medically appropriate care or prohibits the availability of the needed transplant procedure or service. Physician payments for organ transplants will be at the usual Medicaid Program rates.

Application of Organ Transplants Policy. It is the intent of the Department for Medicaid Services that the organ transplant policy be applied uniformly and consistently so that the similarly situated individuals will be treated alike. To accomplish this goal the Department will use the methodology specified in this section in receiving and processing requests for coverage and payments for organ transplants.

1. All requests for authorization for organ transplants must be sent to the Commissioner, Department for Medicaid Services.

State/Territory: Kentucky

2. The Commissioner will assign the request to appropriate staff for investigation, report and recommendation. The report must show whether the person requesting the transplant is Medicaid eligible (or approximately when the person will become eligible); the type of transplant requested; the name of the facility (and physician if considered necessary) where the transplant is to be performed; any fee arrangement that has been made with the facility and/or physician (or a statement as to whether there is a disagreement with regard to fees); the proposed date of the transplant; the prognosis; a finding as to whether the facility/physician is considered qualified for the transplant being considered; and a finding as to whether program criteria for coverage is met.
3. After consideration of the report and recommendation, the Commissioner will determine whether the general coverage criteria are met and payments for the transplant should be made. If the decision is to provide coverage, Medicaid Program staff will assist the recipient with necessary arrangements for the transplant. If the decision is negative, the recipient will be notified of the manner in which the request does not meet agency guidelines.

Scope of Coverage. This organ transplant policy is applicable with regard to the following types of transplant: heart, lung, bone marrow and liver. Other types of transplants will also be covered under this policy upon identification and request except when special treatment of the transplant services is not considered necessary (i.e., usual program coverage and reimbursement is considered adequate), or when the transplant is considered by the Department for Medicaid Services to be experimental in nature. The Medicaid Program will not cover experimental transplants, i.e., those which have not previously been proven effective in resolving the health problems for which the transplant is the proposed preferable treatment mode.

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Citation	Condition or Requirement
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1932(a)(1)(A) AA Section 1932(a)(1)(A) of the Social Security Act.

The State of Kentucky enrolls Medicaid beneficiaries on a mandatory basis into managed care entities (managed care organization (MCOs) and/or primary care case managers (PCCMs)) in the absence of section 1115 or section 1915(b) waiver authority. This authority is granted under section 1932(a)(1)(A) of the Social Security Act (the Act). Under this authority, a state can amend its Medicaid state plan to require certain categories of Medicaid beneficiaries to enroll in managed care entities without being out of compliance with provisions of section 1902 of the Act on statewideness (42 CFR 431.50), freedom of choice (42 CFR 431.51) or comparability (42 CFR 440.230). This authority may *not* be used to mandate enrollment in Prepaid Inpatient Health Plans (PIHPs), Prepaid Ambulatory Health Plans (PAHPs), nor can it be used to mandate the enrollment of Medicaid beneficiaries who are Medicare eligible, who are Indians (unless they would be enrolled in certain plans—see D.2.ii. below), or who meet certain categories of “special needs” beneficiaries (see D.2.iii. - vii. below)

B. General Description of the Program and Public Process.

A recipient, who has utilized Medicaid services at a frequency or amount that is not medically necessary, as determined in accordance with utilization guidelines established by the State, will be restricted to one or more of the following:

- (1) *One (1) primary care provider who:*
 - a. *Shall be accessible to the recipient within normal time and distance standards for the community in which the recipient resides;*
 - b. *Shall provide services and manage the lock-in recipient’s necessary health care services;*
 - c. *If the lock-in recipient needs a specialty service that the designated primary care provider is unable to provide, the designated primary care provider shall refer the lock-in recipient to other providers as necessary so the recipient receives all medical necessary services.*
 - d. *Shall participate in the recipient’s periodic utilization review*
 - e. *If the designated primary care provider is a physician, he may also serve as the lock-in recipient’s designated controlled substance prescriber; or*
- (2) *One (1) prescriber for non emergency prescriptions for controlled substances. This provider shall serve as the sole prescriber and manager of controlled substances for the lock-in recipient.*

For B.1 and B.2, place a check mark on any or all that apply.

Citation	Condition or Requirement
1932(a)(1)(B)(i) 1932(a)(1)(B)(ii) 42 CFR 438.50(b)(1)	1. The State will contract with an ___ i. MCO <u>X</u> ii. PCCM (including capitated PCCMs that qualify as PAHPs) ___ iii. Both
42 CFR 438.50(b)(2) 42 CFR 438.50(b)(3)	2. The payment method to the contracting entity will be: ___ i. fee for service; ___ ii. capitation; <u>X</u> iii. a case management fee; ___ iv. a bonus/incentive payment; ___ v. a supplemental payment, or ___ vi. other. (Please provide a description below).
1905(i) 42 CFR 440.168 42 CFR 438.6(c)(5)(iii)(iv)	3. For states that pay a PCCM on a fee-for-service basis, incentive payments are permitted as an enhancement to the PCCM's case management fee, if certain conditions are met.

Not applicable

If applicable to this state plan, place a check mark to affirm the state has met **all** of the following conditions (which are identical to the risk incentive rules for managed care contracts published in 42 CFR 438.6(c)(5)(iv)).

- ___ i. Incentive payments to the PCCM will not exceed 5% of the total FFS payments for those services provided or authorized by the PCCM for the period covered.
- ___ ii. Incentives will be based upon specific activities and targets.
- ___ iii. Incentives will be based upon a fixed period of time.
- ___ iv. Incentives will not be renewed automatically.
- ___ v. Incentives will be made available to both public and private PCCMs.
- ___ vi. Incentives will not be conditioned on intergovernmental transfer agreements.

Citation	Condition or Requirement
	<p><u>X</u> vii. Not applicable to this 1932 state plan amendment.</p>
CFR 438.50(b)(4)	<p>4. Describe the public process utilized for both the design of the program and its initial implementation. In addition, describe what methods the state will use to ensure ongoing public involvement once the state plan program has been implemented. <i>(Example: public meeting, advisory groups.)</i></p> <p><i>In order to implement this program, the State had to file an Administrative Regulation with the Legislative Research Commission. As a result, a Public Hearing was conducted allowing the public to testify in support of or in opposition of this new program.</i></p> <p><i>The state also published Public Notices in the states three largest newspapers outlining this program.</i></p> <p><i>In addition, letters were sent to all providers and hospitals prior to implementation. The state also sent a letter to all current Lock-In participants explaining the new program.</i></p> <p><i>The state will continue to work with providers, legislators, advocates and recipients as this program is implemented through provider education meetings and letters.</i></p>
1932(a)(1)(A)	<p>5. The state plan program will ____/will not <u>X</u> implement mandatory enrollment into managed care on a statewide basis. If not statewide, mandatory <u>X</u>/voluntary____ enrollment will be implemented in the following county/area(s):</p> <p><i>The Lock In program will be in all counties of the state except the current 16 counties covered through Passport. Passport (PHP) does their own Lock-In Program and oversees their locked in population/members for the 16 counties in the greater Louisville area</i></p> <p><i>Mandatory enrollment shall be initiated for a recipient if in any two (2) 180 calendar day periods within an eighteen (18) months' timeframe.</i></p> <ul style="list-style-type: none"><i>(a) Received services from at least five (5) different providers;</i><i>(b) Received at least ten (10) different prescription drugs; and received prescriptions from at least three (3) or more different pharmacies; or</i><i>(c) Had at least four (4) hospital emergency department visits for a condition that was not an emergency medical condition; or</i><i>(d) Received services from at least three (3) different hospital emergency departments for a condition that was not an emergency medical condition.</i>

Citation	Condition or Requirement
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- i. county/counties (mandatory) _____
- ii. county/counties (voluntary)_____
- iii. area/areas (mandatory)_____
- iv. area/areas (voluntary)_____

C. State Assurances and Compliance with the Statute and Regulations.

If applicable to the state plan, place a check mark to affirm that compliance with the following statutes and regulations will be met.

1932(a)(1)(A)(i)(I)
1903(m)
42 CFR 438.50(c)(1)

1. The state assures that all of the applicable requirements of section 1903(m) of the Act, for MCOs and MCO contracts will be met.

1932(a)(1)(A)(i)(I)
1905(t)
42 CFR 438.50(c)(2)
1902(a)(23)(A)

2. The state assures that all the applicable requirements of section 1905(t) of the Act for PCCMs and PCCM contracts will be met

Exception would be freedom of choice as outlined in 42CFR 431.54.

1932(a)(1)(A)
42 CFR 438.50(c)(3)

3. The state assures that all the applicable requirements of section 1932 (including subpart (a)(1)(A)) of the Act, for the state's option to limit freedom of choice by requiring recipients to receive their benefits through managed care entities will be met.

1932(a)(1)(A)
42 CFR 431.51
1905(a)(4)(C)

4. The state assures that all the applicable requirements of 42 CFR 431.51 regarding freedom of choice for family planning services and supplies as 1905(a)(4)(C) defined in section 1905(a)(4)(C) will be met.

1932(a)(1)(A)
42 CFR 438
42 CFR 438.50(c)(4)
1903(m)

5. The state assures that all the applicable requirements 42CFR Part 38The state as for MCOs and PCCMs will be met.

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Citation	Condition or Requirement
1932(a)(1)(A) 42 CFR 438.6(c) 42 CFR 438.50(c)(6)	6. ___ The state assures that all applicable requirements of 42 CFR 438.6(c) for payments under any risk contracts will be met. Not applicable – this is not an “at risk” contract.
1932(a)(1)(A) 42 CFR 447.362 42 CFR 438.50(c)(6)	7. <u>X</u> The state assures that all applicable requirements of 42 CFR 447.362 for payments under any non-risk contracts will be met.
45 CFR 74.40	8. <u>X</u> The state assures that all applicable requirements of 45 CFR 92.36 for procurement of contracts will be met.
	D. <u>Eligible groups</u>
1932(a)(1)(A)(i)	1. List all eligible groups that will be enrolled on a mandatory basis. <i>Eligible groups are as identified in Section B-5 of the pre-print as over utilizing Medicaid services. Any Medicaid recipient that is at least 19 years of age or not in the Passport service area that has been found to over utilize Medicaid services will be placed in the Lock-In program.</i>
	2. Mandatory exempt groups identified in 1932(a)(1)(A)(i) and 42 CFR 438.50. Use a check mark to affirm if there is voluntary enrollment any of the following mandatory exempt groups. <i>Not applicable – no voluntary enrollment</i>

Citation	Condition or Requirement
1932(a)(2)(B) 42 CFR 438(d)(1)	i. ___ Recipients who are also eligible for Medicare. If enrollment is voluntary, describe the circumstances of enrollment. (<i>Example: Recipients, who become Medicare eligible during mid-enrollment, remain eligible for managed care and are not disenrolled into fee-for-service.</i>)
1932(a)(2)(C) 42 CFR 438(d)(2)	ii. ___ Indians who are members of Federally recognized Tribes except when the MCO or PCCM is operated by the Indian Health Service or an Indian Health program operating under a contract, grant or cooperative agreement with the Indian Health Service pursuant to the Indian Self Determination Act; or an Urban Indian program operating under a contract or grant with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act.
1932(a)(2)(A)(i) 42 CFR 438.50(d)(3)(i)	iii. ___ Children under the age of 19 years, who are eligible for Supplemental Security Income (SSI) under title XVI.
1932(a)(2)(A)(iii) 42 CFR 438.50(d)(3)(ii)	iv. ___ Children under the age of 19 years who are eligible under 1902(e)(3) of the Act.
1932(a)(2)(A)(v) 42 CFR 438.50(3)(iii)	v. ___ Children under the age of 19 years who are in foster care or other out-of-the-home placement.
1932(a)(2)(A)(iv) 42 CFR 438.50(3)	vi. ___ Children under the age of 19 years who are receiving foster care or adoption assistance under title IV-E.
1932(a)(2)(A)(ii) 42 CFR 438.50(3)(v)	vii. ___ Children under the age of 19 years who are receiving services through a family-centered, community based, coordinated care system that receives grant funds under section 501(a)(1)(D) of title V, and is defined by the state in terms of either program participation or special health care needs.

E. Identification of Mandatory Exempt Groups

Children, under the age of 19 years of age are exempt from the Lock-In Program

1932(a)(2) 42 CFR 438.50(d)	1. Describe how the state defines children who receive services that are funded under section 501(a)(1)(D) of title V. (<i>Examples: children receiving services at a specific clinic or enrolled in a particular program.</i>)
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Children, under the age of 19 years of age are exempt from the Lock-In Program

Citation	Condition or Requirement
1932(a)(2) 42 CFR 438.50(d)	<p>2. Place a check mark to affirm if the state's definition of title V children is determined by:</p> <p><i>Not applicable because no one under the age of 19 will be enrolled into the Lock – In</i></p> <ul style="list-style-type: none"><input type="checkbox"/> i. program participation,<input type="checkbox"/> ii. special health care needs, or<input type="checkbox"/> iii. both
1932(a)(2) 42 CFR 438.50(d)	<p>3. Place a check mark to affirm if the scope of these title V services is received through a family-centered, community-based, coordinated care system.</p> <p><i>Not applicable because no one under the age of 19 will be enrolled into the Lock – In</i></p> <ul style="list-style-type: none"><input type="checkbox"/> i. yes<input type="checkbox"/> ii. no
1932(a)(2) 42 CFR 438.50 (d)	<p>4. Describe how the state identifies the following groups of children who are exempt from mandatory enrollment: (<i>Examples: eligibility database, self-identification</i>)</p> <p><i>Children, under the age of 19 years of age are exempt from the Lock-In Program. Children will be identified through age edits in the MMIS system. This response is applicable to item i. – iv. Below.</i></p> <ul style="list-style-type: none">i. Children under 19 years of age who are eligible for SSI under title XVI;ii. Children under 19 years of age who are eligible under section 1902 (e)(3) of the Act;iii. Children under 19 years of age who are in foster care or other out-of-home placement;iv. Children under 19 years of age who are receiving foster care or adoption assistance.

Citation	Condition or Requirement
1932(a)(2) 42 CFR 438.50(d)	<p>5. Describe the state's process for allowing children to request an exemption from mandatory enrollment based on the special needs criteria as defined in the state plan if they are not initially identified as exempt. <i>(Example: self-identification)</i></p> <p><i>All children under 19 years of age are exempt from the Lock-In Program.</i></p>
1932(a)(2) 42 CFR 438.50(d)	<p>6. Describe how the state identifies the following groups who are exempt from mandatory enrollment into managed care: <i>(Examples: usage of aid codes in the eligibility system, self-identification)</i></p> <p>i. Recipients who are also eligible for Medicare.</p> <p><i>Medicare recipients are exempt from the Lock-In Program and will be identified through MMIS edits.</i></p> <p>ii. Indians who are members of Federally recognized Tribes except when the MCO or PCCM is operated by the Indian Health Service or an Indian Health program operating under a contract, grant or cooperative agreement with the Indian Health Service pursuant to the Indian Self Determination Act; or an Urban Indian program operating under a contract or grant with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act.</p> <p><i>Not applicable – Kentucky does not have Indian Tribes</i></p>
42 CFR 438.50	<p>F. List other eligible groups (not previously mentioned) who will be exempt from mandatory enrollment</p> <p><i>Nursing facility patients that have been in the nursing home or long-term care facility for more than 30 days in a given calendar year are exempt</i></p>
42 CFR 438.50	<p>G. <u>List all other eligible groups who will be permitted to enroll on a voluntary basis</u></p> <p><i>Not applicable.</i></p>

Citation	Condition or Requirement
	H. <u>Enrollment process.</u>
1932(a)(4) 42 CFR 438.50	1. Definitions <ul style="list-style-type: none">i. An existing provider-recipient relationship is one in which the provider was the main source of Medicaid services for the recipient during the previous year. This may be established through state records of previous managed care enrollment or fee-for-service experience or through contact with the recipient.ii. A provider is considered to have "traditionally served" Medicaid recipients if it has experience in serving the Medicaid population.
1932(a)(4) 42 CFR 438.50	2. State process for enrollment by default. <p><i>Computer generated reports based on the criterion outlined will be run on a quarterly basis and manually reviewed for enrollment in the Lock In program.</i></p> <p>Describe how the state's default enrollment process will preserve:</p> <ul style="list-style-type: none">i. the existing provider-recipient relationship (as defined in H.1.i).<p><i>If the recipient's provider has agreed to be a Lock In provider, the recipient will be allowed to continue treatment with the existing provider.</i></p>ii. the relationship with providers that have traditionally served Medicaid recipients (as defined in H.2.ii).<p><i>If the recipient's provider has agreed to be a Lock In provider, the recipient will be allowed to continue treatment with the existing provider.</i></p>iii. the equitable distribution of Medicaid recipients among qualified MCOs and PCCMs available to enroll them, (excluding those that are subject to intermediate sanction described in 42 CFR 438.702(a)(4)); and disenrollment for cause in accordance with 42 CFR 438.56 (d)(2). <i>(Example: No auto-assignments will be made if MCO meets a certain percentage of capacity.)</i>

Citation	Condition or Requirement
1932(a)(4) 42 CFR 438.50	<p>3. As part of the state's discussion on the default enrollment process, include the following information:</p> <ul style="list-style-type: none">i. The state will <u>X</u> /will not ____ use a lock-in for managed care managed care.ii. The time frame for recipients to choose a health plan before being auto-assigned will be 30 days.iii. Describe the state's process for notifying Medicaid recipients of their auto-assignment. <i>(Example: state generated correspondence.)</i> <i>Lock-In recipients will receive a letter from the KY Department for Medicaid Services informing them that they are being placed in the Lock-In Program. The letter will outline the reason they are being placed in the Program, and allowing them 30 days to select their Primary Care Physician (PCP) or narcotic provider or one will be assigned for them. Medicaid recipients shall have a choice from at least two (2) participating providers in their area</i>iv. Describe the state's process for notifying the Medicaid recipients who are auto-assigned of their right to disenroll without cause during the first 90 days of their enrollment. <i>(Examples: state generated correspondence, HMO enrollment packets etc.)</i> <i>Not applicable under authority of 42 CFR 431.54</i>v. Describe the default assignment algorithm used for auto-assignment. <i>(Examples: ratio of plans in a geographic service area to potential enrollees, usage of quality indicators.)</i> <i>Computer generated reports based on the criterion outlined will be run on a quarterly basis and manually reviewed for enrollment in the Lock In program</i>

Citation	Condition or Requirement
1932(a)(4) 42 CFR 438.50	<p>vi. Describe how the state will monitor any changes in the rate of default assignment. <i>(Example: usage of the Medical Management Information System (MMIS), monthly reports generated by the enrollment broker)</i></p> <p><i>Computer generated reports based on the criterion outlined will be run on a quarterly basis and manually reviewed for enrollment in the Lock In program</i></p> <p>I. <u>State assurances on the enrollment process</u></p> <p>Place a check mark to affirm the state has met all of the applicable requirements of choice, enrollment, and re-enrollment.</p> <p><i>Not applicable for this program under authority of 42 CFR 431.54</i></p> <p>1. <input checked="" type="checkbox"/> The state assures it has an enrollment system that allows recipients who are already enrolled to be given priority to continue that enrollment if the MCO or PCCM does not have capacity to accept all who are seeking enrollment under the program.</p> <p>2. <input checked="" type="checkbox"/> The state assures that, per the choice requirements in 42 CFR 438.52, Medicaid recipients enrolled in either an MCO or PCCM model will have a choice of at least two entities unless the area is considered rural as defined in 42 CFR 438.52(b)(3).</p> <p><i>Except as outlined in 42 CFR 431.54</i></p> <p>3. <input checked="" type="checkbox"/> The state plan program applies the rural exception to choice requirements of 42 CFR 438.52(a) for MCOs and PCCMs.</p> <p><input type="checkbox"/> This provision is not applicable to this 1932 State Plan Amendment.</p> <p>4. <input type="checkbox"/> The state limits enrollment into a single Health Insuring Organization (HIO), if and only if the HIO is one of the entities described in section 1932(a)(3)(C) of the Act; and the recipient has a choice of at least two primary care providers within the entity. (California only.)</p> <p><input checked="" type="checkbox"/> This provision is not applicable to this 1932 State Plan Amendment.</p>

Citation	Condition or Requirement
1932(a)(4) 42 CFR 438.50	<p>5. <u>X</u> The state applies the automatic reenrollment provision in accordance with 42 CFR 438.56(g) if the recipient is disenrolled solely because he or she loses Medicaid eligibility for a period of 2 months or less.</p> <p><u> </u> This provision is not applicable to this 1932 State Plan Amendment.</p> <p>J. <u>Disenrollment</u></p> <p>1. The state will <u>X</u> /will not <u> </u> use lock-in for managed care.</p> <p>2. The lock-in will apply for <u>24</u> months (up to 24 months).</p> <p><i>We initially lock the member in for 24 months but at 12 months intervals, member utilization reviews are conducted. (Any subsequent lock in period is for 12 months at a time)</i></p> <p><i>Per authority of 42 CFR 431.54</i></p> <p>3. Place a check mark to affirm state compliance.</p> <p><u>X</u> The state assures that beneficiary requests for disenrollment (with and without cause) will be permitted in accordance with 42 CFR 438.56(c).</p> <p><i>The state does not allow disenrollment without cause.</i></p> <p>4. Describe any additional circumstances of "cause" for disenrollment (if any).</p> <p><i>Recipient or provider may request to disenroll from the Lock In program if:</i></p> <p>(a) <i>the designated provider submits to the department a written request for a release from serving as the recipient's designated provider. The provider shall continue to serve as the recipient's designated provider until a comparable designated provider is selected;</i></p> <p>(b) <i>The recipient relocates outside of the designated provider's geographic area;</i></p>

Citation	Condition or Requirement
	(c) The recipient submits a written request to the department which: 1. Requests a designated provider change; and 2. Includes information to support cause or a necessary reason for the change, including the recipient: (d) Was denied access to a needed medical service; (e) Received poor quality of care; or (f) Does not have access to a provider qualified to treat the recipient's health care needs; (g) The designated provider withdraws or is terminated from participation in the Medicaid Program; or (h) The department determines that it is in the best interest of the lock-in recipient to change the designated provider.
	<u>K. Information requirements for beneficiaries</u> Place a check mark to affirm state compliance.
1932(a)(5) 42 CFR 438.50 42 CFR 438.10	<u>X</u> The state assures that its state plan program is in compliance with 42 CFR 438.10(i) for information requirements specific to MCOs and PCCM programs operated under section 1932(a)(1)(A)(i) state plan amendments. (Place a check mark to affirm state compliance.)
1932(a)(5)(D) 1905(t)	<u>L. List all services that are excluded for each model (MCO & PCCM)</u>

Citation	Condition or Requirement
1932 (a)(1)(A)(ii)	<p>M. <u>Selective contracting under a 1932 state plan option</u></p> <p>To respond to items #1 and #2, place a check mark. The third item requires a brief narrative.</p> <p><i>Not applicable</i></p> <ol style="list-style-type: none">1. The state will____/will not <u>X</u> intentionally limit the number of entities it contracts under a 1932 state plan option.2. ____ The state assures that if it limits the number of contracting entities, this limitation will not substantially impair beneficiary access to services.3. Describe the criteria the state uses to limit the number of entities it contracts under a 1932 state plan option. (<i>Example: a limited number of providers and/or enrollees.</i>)4. <u>X</u> The selective contracting provision in not applicable to this state plan.